When a Dartmouth Medical School graduate finishes her training and enters practice, she learns that the patient-care part of medicine, which she loves, is subsumed in a sea of insurance contracts and billing codes. In this excerpt from a book about her experiences, she tells of navigating a whole new aspect of medicine.

Transue, an internist in Seattle, Wash., is a 1996 graduate of Dartmouth Medical School. She began writing patient narratives while she was a student at DMS as a way to process the emotions of medicine. Many of her stories have appeared in Dartmouth Medicine during the years since then. She is also the author of two books published by St. Martin’s Press—On Call: A Doctor’s Days and Nights in Residency and Patient by Patient: Lessons in Love, Loss, Hope, and Healing from a Doctor’s Practice. This feature is excerpted from the latter book by permission of St. Martin’s Press, LLC; it is copyright 2008 by the author.

**AVOIDING THE SHOALS OF CONTRACTS AND CODES**

By Emily R. Transue, M.D.

As I pressed the new parking sticker carefully onto my windshield, I paused to consider what the small sliver of plastic represented. At the age of 29, after 24 continuous years of education, I was about to begin what could be called my first real job. My new business card burned in my pocket: “Emily R. Transue, M.D., General Internal Medicine.” I was starting practice as a primary-care physician.

With a laugh, I thought back to the day I’d decided to go to medical school. It was early in my senior year of college; a biology major, I was scrambling for a new career path after realizing I didn’t want to spend my life at a lab bench. I’d done Parkinson’s research with primates and reasoned that if monkeys were interesting, people must be even more so.

I called my grandparents to announce my momentous decision. “But we hate doctors,” my grandmother protested. Through all my years of medical training, whenever a physician amputated the wrong leg, administered the wrong medication, or made some other terrible mistake, my grandmoth- er would send me a news clipping. I was never sure if these were warnings about what might occur if I applied myself inadequately, or simply further evidence that physicians were an untrustworthy lot.

Still, here I was. Absurdly, the parking sticker brought home what my employment contract, application for hospital privileges, and order for business cards had not. During the eight years since I’d started medical school, everything I had done had been temporary. Student clerkships lasted four to eight weeks, residency rotations a month. My year as chief resident, helping run the program I’d finished the year before, was the longest I had spent in any single role; and even that was clearly defined as transient, for my successor had been chosen before I started. In all that time, I had hung temporary parking placards from my rearview mirror. The sticky teal rectangle I was now putting on my windshield seemed to symbolize an end to transience. After eight years of working toward this point, I was entering an unfamiliar permanence.

During my second year at Dartmouth Medical School, my grandmother called to tell me my grandfather had developed atrial fibrillation, an irregular heart rhythm. It’s usually treated with blood thinners, to reduce the risk of clotting, and with cardioversion, a brief electrical shock to restore the heart’s rhythm. “They’re giving your grandfather rat poison,” my grandmother declared. Rat poison is made from warfarin, the same compound used medicinally to thin blood. “Then they’re going to electrocute him,” she added. I had to admit that these were precisely the kinds of barbaric things people in my chosen profession did.

A few weeks earlier, the ink barely dry on my employment contract, I had signed another sheaf of papers, buying my first house. My possessions were still in boxes, the wonder of owning a piece of land
The clinic building has several wings built at different times. Medical buildings, ever-expanding structures, were spread from California to Massachusetts. My grandparents, the ones who hated doctors, were in Pennsylvania.

Nonetheless, I had put down roots in Seattle. I could feel them under the maple tree in my new front yard, even in the glare of the parking stickers. I was about to walk into the clinic and begin to grow roots of another sort—putting on my white coat and meeting strangers who would become my patients, as I grew into my role as their doctor.

I had finished the hard years of residency, the 100-hour weeks and 36-hour shifts, the drama of the hospital and the emergency room. I had seen a lot of people die or nearly die during those years, and I thought I knew plenty about grief and loss and survival. I little imagined how much more I would learn in the coming years. Much of my new-found knowledge would come from patients I would care for, not just in the episodic crises of the hospital but in the slower, richer arc of sickness and health that a primary-care doctor sees.

Meantime, I was learning a new kind of medicine. Residency had trained me brilliantly to think of things to worry about; I was not yet adept at deciding which of those I needed to take seriously. Much of my training had been in the hospital, where we were dealing with urgent issues and often talked in terms of the presence or absence of a disease process and the problem as soon as possible. The rhythm of clinic medicine was different; few problems were emergencies, and it was usually better to approach the evaluation one step at a time. Furthermore, in contrast to the hospital, where almost everyone had something seriously wrong, in the clinic half of my job involved figuring out who was not sick. And a good part of the remaining half involved reassuring people who were really sick that their bodies just needed time to heal on their own.

Though the approach was different, the learning curve was as steep as it had been in residency—those packed years of specialty training after medical school. A lot of the time I felt the way I had there: excited, exhausted, and thrilled to finally be doing something I’d been learning about for so long. Didn’t I know I was going to be a doctor by the end of the day, the fact that I didn’t have to run things by anyone didn’t seem strange. By the end of the first week, I had stopped even thinking about it.

My clinic is a large, doctor-owned group that has a floor for almost all the medical specialties. I choose it partly for this fact, so I’d have colleagues to talk to, to ask questions of, to learn from. I had completed four years of residency training on top of four years of medical school. I had used the specialty boards in internal medicine. “It’s like being a peacock for dranicians for adults,” I explained to friends who didn’t know what an internist was. “No kids, no OBGYN, no surgery, but pretty much everything else.” I had the tools I needed, but there was a lot of practical, day-to-day knowledge I had yet to learn. They called it “practice” for a reason I’d only slowly begun to understand.

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I could only begin to glimpse all that lay in my future, as the sliding doors of the clinic opened to admit me to the cool, quiet air inside. My heart sped with a mix of anxiety and excitement. I stepped inside, and the hold that sat on it still fresh. As I finished affixing the parking sticker and walked into the angular brick and glass building housing the clinic I’d joined, I was bewitching with the richness and strangeness of my new life. I had a job, a piano, two cats, a house. I was a long way from Ohio, where I grew up, and from New Hampshire, where I went to medical school. I was a long way from my family, who were spread from California to Massachusetts. My grandparents, the ones who hated doctors, were in Pennsylvania.

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I had a long and baffling meeting with the people from the Coding and Compliance department. They had the unenviable task of teaching me a business as well as a calling.

This had barely been addressed during my four years of graduate training, and nobody had acknowledged that this was their responsibility. In the previous day’s session, however, I was a quivering wreck. By the end of the Coding and Compliance seminar, however, I was a quivering wreck.

I struggled to catch up to what Karen had been saying in the meantime. “... remember that follow-up is one thing, but the other is, is it new?...”

Karen nodded but didn’t elaborate. “And when you’re not sure—when you think you need to remember your E code; nobody likes it but it’s important or the claim will get denied.”

“Excuse me?” I asked weakly.

Karen nodded and said, “You won’t pay for anything if they think someone else should be paying it. Like L and L and I...”

Karen had divulged a state secret. “What’s that?” I asked the question, I noticed.

Karen’s tone suggested I should have learned that at my grandmother’s knee, if I had a clear question, so I started out briskly. “I’m wondering...”

Karen answered that “E and M” stood for “evaluation and management,” the code for a visit about a problem.

Karen began, “You’ve got your basics, your E and M, and your preventatives.” I took a breath to ask what these terms meant, but she had already moved on. I vaguely remembered having heard “E and M” somewhere before, but I was confused, perhaps because it had been a few hours since I’d read a book, or through my mind: A&P, grocery stores, A&W root beer, B&O railroad... Wait, had I told Karen and M stood for “evaluation and management,” the code for a visit about a problem.

Karen was excited to say that there was a lot to know, and yes, this would be different from being a resident. But this was it—real, it was what I’d been working toward all these years. By the end of the Coding and Compliance seminar, however, I was a quivering wreck.

“I can’t do it,” I announced to a friend that evening. “Every single thing is a terrible mistake. I just can’t do it.”

Karen added, “Let me think about this.” I took a breath to ask what these terms meant, but she had already moved on. I vaguely remembered having heard “E and M” somewhere before, but I was confused, perhaps because it had been a few hours since I’d read a book, or through my mind: A&P, grocery stores, A&W root beer, B&O railroad... Wait, had I told Karen and M stood for “evaluation and management,” the code for a visit about a problem.

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about that for a bit.” What I was thinking was something like, Boy, I could save myself a lot of headaches and just open a coffee shop instead. There are no dot-two-five modifiers for coffee.

But what I actually said was, “My other question is simpler. I’m trying to figure out how to bill a physical. I had someone complain last week because I billed for a physical and it wasn’t covered. But she said her insurance told her they would cover a Pap.”

Risk management was the name of the game. The insurance companies are counting every dollar from our patients’ insurance companies and from our malpractice insurer. Be efficient, we were told; don’t give anyone narcotics, one colleague told us; leave no stone unturned or you’ll be susceptible to a lawsuit.

I also got advice about managing calls on nights and weekends. “Send people to the ER,” one colleague said. “Get your hands dirty.” I was exhausted with every hour bringing a new piece of wisdom, each one contradicting the last, I was struck that my patient had been reduced to “a return,” just as I’d become “a primary care.” We all get abbreviated to our billing functions, I thought.

“Of course I am,” I answered. “Most of the time in young people those are pretty simple, but they could turn up something important.”

“I’m just doing a Pap you could code a V72.3—gynecological exam with routine cervical Pap.”

“No, V70.0 is better. A V72.3 assumes you’re doing something with the cervix; even assuming her story about the kidney stones was real, I didn’t want to miss a diagnosis or near the wrong thing,” I said.

She responded with a scathing letter saying that I was hateful and mean and shouldn’t be allowed to see patients. Then, she started calling when other docs were on call, telling them an untrue story about how I’d put her on stronger painkillers than she wanted and asking them to phone in a prescription for “something mid and mild.” Who, health maintenance organizations, I thought to myself, trying to take comfort from recognizing another acronym. “If someone is calling in the middle of the night and you can’t figure out for sure what’s going on, just send them,” one colleague said.

“Don’t send anyone to the ER unless you absolutely have to,” another advised. “New docs absolutely have to,” another colleague told me. “There will be people in your office acting as a crisis squad, electrocution, beheading, and other means to prevent me from repeating their mistakes. Still, there are no right answers, I realised there is no way to do right.”

Happily, at last, I came to see this as a blessing as well as a curse. If there was no right answer, I couldn’t have been expected to have one. As the months went by, I made some mistakes and averred some to later that I was no longer as certain about what I was doing, that I was doing it to my patients’ best interest, to prevent me from repeating their mistakes. Still, there was no right answer, I was simply to find my own way.

People pricked their fingers.” “I think she really had stones.” “Talk to me in three months.”

In three months, the “nice young woman” had come back to me four times for refills of narcotics painkillers. I pushed her harder about getting a scan, or at least obtaining old records documenting her disease; even assuming her story about the kidney stones was real, I didn’t want to miss a diagnosis or near the wrong thing.

My colleague looked at me knowingly. “Let me guess. She was allergic to contrast dye so she couldn’t have a scan, or, no, it was under her deductible and she couldn’t afford it.”

One day we had a long meeting about how expensive transcription was and how all the doctors in the clinic would have to cut down on the length of their dictations. The next day there was a risk-management meeting to inform us that we didn’t document every thought in our heads and every detail and nuance of each conversation with our patients, we were liable to get sued.

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