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Innovative Practices Aim for Mainstream

Physicians are developing innovative medical practices in an attempt to get out from under the restrictions, hassles, and low pay of managed care.

One organization that supports physicians in these practices is the Society of Innovative Medical Practice Designs in Seattle, Wash. Its web site (at www.simpd.org) offers information and a newsletter about these practices. The society is an organization of providers who promote a direct financial relationship between physicians and patients. The members have a variety of financial arrangements with patients. They run retail and cash practices and operate on a retainer. They are committed to delivering patient-focused medicine and seek to improve the patient-physician relationship, the society says.

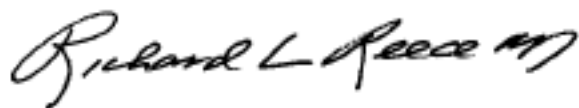
Two significant innovations were started in the 1990s in Washington State. Tired of the hassles and low pay of traditional practice, two internists in Seattle, Garrison Bliss, MD, and Mitchell Karton, MD, started a concierge practice in 1996. For an annual fee of \$1,000 to \$2,000, this concierge practice promised access to a physician 24 hours a day, 365 days a year and uninterrupted time with a physician. Today, there are about 300 such concierge practices in 28 states.

Since 1982, medical practices have doubled the number of non-clinical employees they have hired and practice costs have doubled, the society says. The increase in administrative costs is primarily due to the increased cost of billing and collecting from health plans, the society says. Minimizing or eliminating relationships with third-party payers means physicians could charge less.

Another organization that supports physicians in getting paid by patients in cash is SimpleCare, in Renton, Wash. A visit of 10 minutes with a SimpleCare physician costs \$35, a visit of 20 minutes cost \$65, and a 30-minute visit cost \$95. There are 103 such practices in Washington State. Working within these 103 practices are family physicians, pediatricians, medical and surgical specialists, and other providers.

SimpleCare (at www.simplecare.com) says patients pay in full at the time of service and these doctors charge 25% to 50% less than physicians who collect reimbursement from insurers. In conjunction with a regular catastrophic health insurance policy to cover expensive procedures, a healthy cash-paying individual or family could save \$5,000 per year, SimpleCare says.

Despite the convenience and innovation of these new practices, these new forms of delivering care remain on the fringes of traditional medicine. The true test of the viability of innovative practices will hinge on whether Americans see enough value in them to pay for them.



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Experts Say Testing Is Required in Certain GERD Cases

Experts make a distinction between gastroesophageal reflux (GER) and gastroesophageal reflux disease (GERD or GER with a complication). GER is common in infants and children; occurs frequently at a low, physiologic level; and usually is not associated with health problems. Evaluation for significantly burdensome symptoms or complications is typically straightforward and commonly accomplished via a thorough history and physical examination.

But when significant symptoms or complications do develop (GERD), then consultation with a pediatric gastroenterologist and testing aimed at identifying important complications (such as esophagitis) or detecting dangerous co-morbid conditions (such as congenital GI tract anomalies) may be warranted.

The Typical Symptoms

Because reflux is relatively common in children, pediatricians are usually quick to consider the diagnosis in children who present with typical reflux symptoms, such as vomiting, upper abdominal pain, refusal to feed, irritability, and heartburn. Rarely is reflux diagnosis delayed to the point at which serious consequences have occurred.

“Damage to the esophagus typically occurs only after many years of symptoms,” says Adam Mezzoff, MD,

professor of pediatrics at Wright State University’s Boonshoft School of Medicine and director of gastroenterology and nutrition at the Children’s Medical Center of Dayton, Ohio. “Most infants typically outgrow reflux within a year or two. Serious consequences of untreated reflux, such as scarring in the esophagus or Barrett’s esophagus, can occur after many years, but reflux is typically diagnosed and treated before that.”

Many pediatricians give patients with suspected reflux a course of medical therapy. In many cases, symptoms resolve and do not recur. “If a child is a little irritable and spitting up but is otherwise well, it is very appropriate to do a trial of medical therapy and see if the patient improves,” Mezzoff says.

A Difficult Diagnosis

But reflux can be difficult to diagnose if symptoms are atypical or do not resolve with treatment. “Reflux can have many different and unusual symptoms, including chronic cough, constant clearing of the throat, or dental problems,” Mezzoff explains. “In addition, reflux may be associated with some conditions, such as congestion and ear infections, that are more often caused by other factors.”

Several types of side effects of reflux should raise a concern among

pediatricians and indicate the need for specialist referral, Mezzoff explains. “Typical side effects include irritability in babies and heartburn in older children,” he says. “In these cases, if the patient is given a course of medication and the symptoms do not resolve or return after medication is stopped, the pediatrician should reevaluate the diagnosis.”

Second, reflux can lead to breathing problems. “Significant coughing, recurrent pneumonias or ongoing wheezing could be due to reflux,” Mezzoff says. “But because these symptoms could be caused by other conditions, a history and physical is typically not sufficient for a diagnosis of reflux.”

A third concern is if the symptoms are causing weight loss, especially if the patient is an infant. “While reflux can cause weight loss, so can other conditions,” Mezzoff notes. “In general, when the symptoms are more severe, the physician should definitively identify the causes of those symptoms so that the right treatment decisions can be made.”

Diagnostic Testing

To get a definitive diagnosis, pediatricians can refer their patients with more concerning symptoms to a pediatric gastroenterologist. Pediatric gastroenterologists likely will do several diagnostic tests to confirm a

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—Adam Mezzoff, MD, Children’s Medical Center of Dayton

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diagnosis of GERD. Clinical practice guidelines issued by the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, in Flourtown, Pa., outline the decisions regarding testing and evaluation that pediatric gastroenterologists should follow.

Reflux Monitoring

One test involves esophageal pH monitoring. This evaluation can verify the presence of acid reflux and is useful for determining a temporal association between reflux and the symptoms the patient is experiencing and for assessing the adequacy of treatment. "Esophageal pH monitoring is a good method of diagnosing reflux in patients who have breathing symptoms such as wheezing," Mezoff says. "But the physician has to decide how important it is to confirm the diagnosis. For example, if a baby is spitting up throughout the day but is happy, gaining weight, and has no breathing problems, a pH probe is not really necessary. A history and physical will be sufficient to diagnose the reflux."

Jeffrey Teckman, MD, associate professor of pediatrics at St. Louis University and director of pediatric gastroenterology at SSM Cardinal Glennon Children's Medical Center in St. Louis, says the pH probe is of limited utility. "In most cases, pH testing will not add very much information to the diagnosis, because it does not indicate the cause of the reflux," he explains. "However, in some instances the pH probe can be quite useful."

The barium swallow is another diagnostic test pediatric gastroenterologists use. "In young patients

Guidelines for GERD Diagnosis and Treatment

The *Pediatric Gastroesophageal Reflux Clinical Practice Guidelines*, published in January 2001 as Supplement 2 in the *Journal of Pediatric Gastroenterology and Nutrition*, outline the official recommendations of the North American Society for Pediatric Gastroenterology and Nutrition (now the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition) regarding the diagnostic approaches, treatment, and evaluation and management of infants and children with gastroesophageal reflux disease.

In addition to detailed recommendations based on clinical evidence, the guidelines offer algorithms to help clinicians determine subsequent steps in diagnosis, treatment, and referral to a pediatric gastroenterologist. The algorithms address the following:

- Management of infants with uncomplicated GER
- Management of infants with vomiting and poor weight gain
- Management of children and adolescents with chronic heartburn
- Continued management of a child or adolescent with esophagitis
- Management of a child or adolescent with persistent asthma and suspected GER.

The guidelines are useful for both pediatricians and pediatric gastroenterologists, given the frequency with which patients with GER and GERD present in the office setting. —DJN

who present with chronic coughing, we might perform a barium swallow to see if they are aspirating, or swallowing formula down the wrong pipe," Mezoff explains. "Aspiration is not necessarily caused by reflux, but is certainly exacerbated by it."

Conditions to Consider

In patients who are not gaining weight, the physician must consider a number of other conditions, Mezoff notes. "In this case, blood work and x-rays might be warranted," he says. In particular, an upper GI series can help rule out anatomic abnormalities, such as pyloric stenosis, malrotation, annular pancreas, hiatal hernia, or esophageal stricture, he adds.

Endoscopy may be warranted depending on the circumstances and the complications individual patients experience. "For instance, if the patient has been diagnosed with reflux but now has trouble swallowing, endoscopy can help the physician determine whether scar tissue or severe inflammation is causing the problem," Mezoff explains. "Also, if a patient is treated for reflux for more than three to six months and is not improving or relapses when medication is stopped, endoscopy can be used to detect the presence of esophagitis." Endoscopy also can detect the presence and severity of Barrett's esophagus and strictures, and can exclude other diagnoses,

"While most children with reflux do not require endoscopy, we commonly do the procedure in children who seem to have some other problem that might be related to reflux."

—Jeffrey Teckman, MD, St. Louis University

Key Points to Consider for Reflux Care

Jeffrey Teckman, MD, an expert on gastroesophageal reflux disease (GERD) in infants and children, notes that in prospective clinical trials, most infant crying has not been found to be acid-related. "There is a normal, physiological level of reflux in all infants related to lower esophageal sphincter immaturity," he points out. "Therefore, there is no need to treat an infant who spits up often but who is happy and gaining weight."

Diagnosis and treatment, however, can be more complicated in patients with more significant symptoms. "Diagnostic testing is usually reserved for infants with complicated symptoms, such as forceful or bilious vomiting, weight loss, poor feeding, or hematemesis," Teckman explains. Furthermore, both GER (gastroesophageal reflux whereby gastric contents reenter the esophagus) and GERD (GER with a complication) can be secondary to another disease process, such as malrotation, brain tumor, or metabolic disease, he adds. "Pediatricians should know how to identify the red flags and then refer on," Teckman says. "Even in marginal cases, it is definitely beneficial to refer to a subspecialist."

An associate professor of pediatrics at St. Louis University and director of pediatric gastroenterology at SSM Cardinal Glennon Children's Medical Center in St. Louis, Teckman offers several key points for pediatricians to remember when treating patients when GERD is suspected.

In infants, there is no gold standard test for diagnosing all GER. Usually, GER is diagnosed via clinical judgment. Although there is no way to confirm that reflux is the cause of infant irritability, a trial of acid blockade in an irritable infant is common practice, and can help alleviate any discomfort. Upper GI x-rays should not be used to diagnose GER, but can be used to

rule out congenital anomalies. To diagnose GER in a vomiting infant, pH probes are not required but can provide useful information in three circumstances.

1. They can be used to diagnose GER in a patient suspected of having a complication but who is not vomiting. This diagnosis would be done off therapy.
2. They can be used to establish the effectiveness of therapy by showing a neutral esophagus. This diagnosis would be done on therapy.
3. They can be used to associate a symptom, such as a breathing problem, with an episode of GER. This diagnosis would be done off therapy.

Despite conventional wisdom, studies show little, if any, correlation between GER and apnea unless another health issue, such as prematurity, RSV, neuromuscular disease, or seizures, is present. GER can still occur in an infant taking an acid blockade, since the neutral fluid may be distressing and may cause poor feeding.

In the absence of an unusual medical need, infants should sleep on their backs. There is no evidence of improved health outcomes related to GER from prone sleeping, but studies have shown that prone sleeping at least doubles the risk of death in infancy.

In cases involving children, idiopathic GERD can continue for years, requiring acid blockade to control complications (usually esophagitis). This circumstance has a strong familial link and the genetic basis is under study.

A vomiting illness in children can cause esophagitis, requiring acid blockade in a previously well child. Some children with asthma improve with acid blockade, even if esophagitis is not present. Children with severe esophagitis do not always report heartburn or chest pain.

—DJN

such as Crohn's disease.

"While most children with reflux do not require endoscopy, we commonly do the procedure in children who seem to have some other problem that might be related to reflux, such as *helicobacter pylori* infection in the stomach, or a complication of reflux, such as esophagitis," Teckman explains. "Endoscopy is very safe in children, and complications are rare."

Pediatricians also should be aware of the possibility that patients with symptoms of GERD may suffer from

allergic eosinophilic esophagitis. Allergic eosinophilic esophagitis occurs when eosinophils (a type of white blood cell) grow uncontrolled in the esophagus, causing inflammation. Eosinophils are not normally found in the esophagus. High levels often indicate an allergic response. By detecting inflammation with a high level of eosinophils, endoscopy can be used to help diagnose this condition.

The symptoms of allergic eosinophilic esophagitis include vomiting, abdominal or chest pain,

refusal to feed or failure to thrive (in young children), and difficulty swallowing. Some patients present with a history of food impaction. Antireflux medications may help alleviate symptoms in certain patients, but generally do not improve the eosinophilic inflammation. Awareness of this condition among community physicians is important when helping to make this diagnosis.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

Assets Need Protection in Lawsuit

By David B. Mandell, JD, MBA, and Beryl N. (Sandy) Stokes, III, CPA, MBA, MS-Tax, CWPP

There is a common misconception regarding asset protection. Many professionals believe this area of financial planning is unimportant. These physicians and their financial advisers believe incorrectly that there is little to any risk of a physician losing his or her personal assets in a malpractice claim, especially if the physician has a typical malpractice insurance policy of \$1 million/\$3 million in place.

Thinking that personal assets are not at risk in such a lawsuit is a myth. In fact, there is a benefit to engaging in financial planning to protect these assets. Even if the risk of such a financial catastrophe is extremely small, it is still well worth the time and effort to do such planning.

Data Analysis

Physicians typically want to see data before making a decision. Financial planners are similar in that they prefer to see data before they make judgments or form opinions. But in this area, gathering data on how many

physicians have lost personal assets in malpractice actions is very difficult, if not impossible, to do. The courts publish filed cases and judgments rendered, but do not publish collections in cases that result in judgments. Lawyers can consult the local litigation report to see a monthly, quarterly, or annual review of the

insurance coverage in these large cases, but there may be at least two reasons why they may not settle for the coverage limits.

Seeking Payment

It's not unusual to hear physicians and their financial advisers say, "I have never personally heard of any-

When an ob-gyn lost a malpractice case, the judgment against her was \$4 million. This amount was \$2 million more than her personal malpractice coverage.

medical malpractice judgments from area courts. There will be judgments for the defense and plaintiffs, and some large judgments above coverage limits. Beyond that, there is little other information.

There are no reports on what happens once a judgment is rendered. Facing a judgment in excess of coverage limits, did the plaintiff simply settle for the amount of the medical malpractice insurance? Or, did the plaintiff and his or her attorney pursue the personal assets of the physician and his or her family to satisfy any excess beyond the coverage limits? These are questions for which there are no answers in the published materials.

Each week in just two states, New York and California, numerous malpractice actions are decided and reported. Most decisions are for the physician defendant, and some are small judgments for the plaintiff. Each week, there are a few large judgments for the plaintiff. Many physicians and their financial advisers simply assume that the plaintiffs in these cases will settle for the malpractice

one losing his or her home in a lawsuit." Therefore, they conclude it doesn't happen. And, it's not surprising that one may not hear about such loses. What occurs instead of eviction is that the plaintiff with the judgment will file a lien on real estate, levy bank accounts, or put liens on them. Essentially, the plaintiff will seek levies or liens on any assets of the physician to the amount of the judgment owed to them. The goal is not to kick the physician out of his or her home, but to make the doctor take a loan against the home to pay off the excess judgment. This scenario happens frequently.

When doing research for this article, I emailed members of a national network of financial advisers to physicians called the Wealth Protection Alliance (WPA). I asked for stories of physician clients who had been sued successfully for large judgments. These advisers sent more than 20 stories about clients who had been sued successfully, the judgment had been beyond coverage limits, and the plaintiffs had gone after the doctors' assets.

David B. Mandell, JD, MBA is an attorney, lecturer, and a co-author of Wealth Protection, MD, the Ultimate Financial Guide for 21st Century Physicians, (Guardian Publishing LLC: January 2004). He is a principal at Jarvis & Mandell, LLC, a company in Los Angeles that specializes in developing wealth protection strategies for professionals and business owners, and is a co-founder of the Wealth Protection Alliance (WPA), a nationwide network of independent financial advisers. Beryl N. (Sandy) Stokes, III, CPA, MBA, MS-Tax, CWPP, is president of Stokes Accounting & Business Consultants, PA, and provides business planning to physicians nationwide. Stokes Accounting & Business Consultants, PA, in Orlando, Fla. is a charter member of the WPA.

The plaintiffs were not looking for eviction. Instead, they wanted payment of the excess judgment. In these cases, the physicians were forced to take loans against assets, liquidate retirement accounts, and sell various assets to pay the judgment. Of course, none of these cases was published in newspapers and so there was no record of these results.

Consider this case: In New York, I had clients who were married. He was a plastic surgeon and she was an ob-gyn. As a result of working with this couple, I made several recommendations for tax, estate planning, and asset protection. While they implemented some of the planning, they did not choose to do anything to protect their home, which at the time had over \$1.5 million in equity. About a year ago, the plastic surgeon called to say that his wife had been successfully sued in a bad baby case and the judgment rendered against her was \$4 million. This amount was \$2 million more than her personal malpractice coverage. At the time, there was nothing I could do since there was already a judgment against her and I have not spoken to the client since.

Placing a Lien

It does not seem likely that the plaintiff who won the \$4 million judgment would simply settle for the \$2 million limit of the insurance coverage. Consider that the plaintiff's attorney could put a lien on the \$1.5 million

of equity in the defendant's home in a matter of hours and the fee would be about \$500. The plaintiff's attorney has a professional and ethical obligation to represent his or her client to the fullest extent of the law. An attorney who does not pursue such an asset would be liable for malpractice toward his or her client.

Despite these facts, there is a misconception among physicians and their advisers that plaintiffs and attorneys won't go after their assets because of some kind of ethical consideration. Also, of course, there is not much data on this troubling situation because the solution does not involve an eviction but rather a sale or leveraging of assets to get the judgment paid. So it is easy to see that this misconception would be commonly held.

A Risk of Action

While it is possible to lose personal assets in a malpractice case, there is still a statistically low risk that you will actually lose personal assets in a liability action, regardless of specialty. So, even though the risk is low, it is important to consider asset protection planning for this reason alone. But there are numerous financial, tax, and estate planning benefits as well. Simply having a financial adviser review one's assets can uncover numerous vulnerabilities that are not obvious to the physician. Financial advising is outside of the typical physician's area of expertise and so a physician is not likely to know where

the hidden risks lie.

In fact, many financial advisers tell physicians to think of financial planning as they think of the reasons one would recommend a colonoscopy. Physicians know that colon cancer is one of the most preventable forms of cancer. To help prevent it, patients simply need to get a colonoscopy performed on a regular basis. The medical field spends its time motivating and educating patients about the benefits of getting a colonoscopy. And even though the chance of getting cancer may be low, we know that having a colonoscopy is advisable. Nonetheless, many patients still get colon cancer in part because they don't get colonoscopies.

Many physicians seem to have a similar attitude toward asset protection planning. They think it is going to be expensive and difficult, perhaps even scary and painful. However, when they realize that proper asset protection is not overly complicated, not overly expensive, and often benefits them in many other ways, they will move forward even with the knowledge that the chance of being sued is small. If physicians realized that asset protection planning could benefit them in so many ways, they wouldn't be paralyzed by the improper assumption that asset protection isn't needed.

—More information on asset protection is available from Jarvis & Mandell at 800-554-7233 or info@wealthprotectionalliance.com. More information on practice strategies is available on our Web site (see page 8).

It's not unusual to hear physicians and their financial advisers say, "I have never personally heard of anyone losing his or her home in a lawsuit." Therefore, they conclude it doesn't happen. And, it's not surprising that one may not hear about such loses. What occurs instead of eviction is that the plaintiff with the judgment will file a lien on real estate, levy bank accounts, or put liens on them.

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