

Virtual Mentor

American Medical Association Journal of Ethics
May 2009, Volume 11, Number 5: 402-405.

MEDICAL NARRATIVE

On Money in Medicine and the Angst It Creates for Medical Students

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From the outside, it is an office building like any other—angular, uninviting, tones of brown and gray. The noise from the highway is still audible in the dark lobby. There is a distinct odor that I can't place, but it somehow smells medical. I reach the office of Richard Bligh, MD, MBA, and as I enter the waiting room I go from unassuming hallway to what looks like someone's living room. The hues of pink and taupe are a welcome change from the dark corridor. Occupying one wall is a serene landscape that complements the decorative rug. The smell, I now notice, is gone. The receptionist offers me a seat, and I barely have time to savor the softness of the cushion before I am led to a small conference room for my interview with Dr. Bligh, the concierge internist.

Dr. Bligh has succeeded in an undertaking that many considered a gamble on his part. The concierge model involves patients' paying an annual retainer in exchange for, according to Dr. Bligh's web site, "the kind of treatment that the traditional healthcare system is unable to offer." His patients are guaranteed an appointment in a timely manner, and are given ample time when they are seen—often 45 minutes to an hour and a half. They have access to his cell phone number and are invited to call at any time, day or night—which Dr. Bligh says has not been a problem.

"If anything, I get fewer calls," he tells me from across the table. His manner is grandfatherly and easygoing. Not once does he peer at a timepiece, nor does his attention ever appear to waiver. Many of his patients come from referrals, and I imagine that's because he uses this same demeanor in the exam room. In fact, he has recently taken on a partner to accommodate his patient load of 500. He cites disgruntlement with 3,000 to 4,000 patients at his previous internal medicine group as a major reason for his shift to a concierge practice.

"An accountant told our group that if we each saw 1.2 more patients per hour, we wouldn't have to cut back salaries," says Dr. Bligh. "I never saw 0.2 patients in my life."

To a medical student drawn toward primary care but struggling with the prospect of long work hours and dwindling reimbursement, this model seems wildly attractive. More time with patients? Fewer hours per week? No pressure to squeeze in more visits? Where do I sign up? The reality, though, is that rewards from the concierge model come with considerable risk. As with any business there must, by definition, be a customer base, and for many people having a doctor on retainer is neither

affordable nor necessary. There are also significant start-up costs. Though Dr. Bligh has an MBA, he hired a professional to help structure his practice. He had an initial advertising budget of \$30,000 per month, and now spends roughly \$10,000 per month.

Despite these challenges, Dr. Bligh has maintained a thriving business for the past 6 years. He began by sending out a questionnaire to gauge what sort of interest there might be in this form of service. The comforting atmosphere of his office and the time and care he affords his patients have kept them coming back and prompted them to tell their friends. He also offers cosmetic and age-management services that include hormone-replacement therapy, which further bolsters his business.

“Anyone who has entrepreneurial drive can do it,” Dr. Bligh says of the success he has seen with the concierge model. “But if you’re averse to risk, it’s not a good thing to try.”

Dr. Bligh’s practice is an example of the creative methods some primary care physicians have been driven to employ in recent years in order to turn a profit while maintaining their sanity. The fact that his business has done well indicates that patients, too, are fed up with having to compete for their doctor’s attention. Though we constantly hear about the increasing dissatisfaction with primary care, Dr. Bligh has shown that it’s possible to do more than merely survive in this field, given the proper motivation and wherewithal.

As a second-year medical student, I wonder at what point we should start thinking about these sorts of practice issues. How heavily should income and number of patients seen in a day factor into our choice of specialty? For Jason Givan, MD, a fourth-year resident in dermatology at Saint Louis University, these questions have renewed significance as he decides how to put his degree to use. “It’s a whole area that’s not well-addressed in med school,” he says of the basics of running a practice. “You have to be very self-motivated to be in private practice and stay up-to-date.” Yet with physicians finding it more and more difficult to operate independently, and new doctors opting to join groups as salaried employees rather than deal with the hassle of office management, would it not be worthwhile to introduce these topics at the medical school level? In this country medicine is a business, and those of us who are poised to enter the “real world” should have as much information as possible to help us figure out whether or not the job we think we want will prove fulfilling. It seems that no matter how enthralled one might be with family medicine, that thrill may very easily turn to resentment if one is unable to pay bills or must spend the bulk of one’s time doing paperwork rather than seeing patients. Especially discouraging are the admonishments of those already in the field—particularly those like Dr. Bligh who have done relatively well.

“If I had a child who was in medical school I would not encourage him or her to go into internal medicine,” he says.

As a result, there is understandably a strong desire to enter specialty areas in which these problems are minimal. Lifestyle, too, has become a greater incentive. Though Dr. Givan cites his love of “fine detail work” as being the main draw of dermatology, time flexibility was a factor he also considered. His workweek at the moment averages 50 to 60 hours, a schedule with which he has no complaints. “It’s important to have a life outside of medicine,” he states, echoing the concierge doctor’s stance on the matter.

“People want to have more balance in their lives,” states Dr. Bligh. “We’re learning that people don’t want to spend all their life at work, and there’s nothing wrong with that.”

Is it wrong to want to work less? Is our generation of physicians somehow “weaker” because we’d rather not spend our entire lives at the office? Physicians who trained and practiced under more grueling conditions might argue as much. How, they wonder, can we expect to be competent physicians if we don’t work at it? And yet, how could our predecessors have anticipated the direction in which medicine has turned? Surely they would have to agree that being paid a couple hundred dollars to remove a mole in a matter of minutes seems preferable to spending nearly an hour taking a thorough history and performing a physical exam and being paid a fraction of that amount, if anything.

If it were up to Dr. John Morley, choosing a specialty would be a much simpler decision, based solely on whatever piques your interest. Dr. Morley, director of the Division of Geriatric Medicine at SLU, hails from South Africa, where doctors of all specialties are paid equally. Their tuition is covered by the government, eliminating student debt as an influencing factor. “American students would rather specialize in fields that make more money,” he laments, adding that 60 to 70 percent of applicants for the geriatrics fellowship are international, with the few native applicants ranking income as lower on their list of priorities. “You’ll find more people who love it and not people who are doing it for the money,” he says. He asks what I want to be when I grow up, and, when I tell him I’m interested in gastroenterology, he groans. I find myself feeling guilty for this statement because I know that money and lifestyle are partial reasons for my interest, and part of me feels they shouldn’t be. The GI system is by far my favorite and one I would love to work with on a daily basis, but I can’t deny my awareness that gastroenterology is a relatively high-earning field.

Should such business-like considerations enter into decision making in what is often perceived to be a calling rather than a career? In a country grounded in the Protestant work ethic and one that (purposely) does not confer peerage or nobility, material wealth has always been viewed as the reward for success. For natives and immigrants alike, a “better life” means more money.

It seems inevitable—particularly in the area of primary care—that medicine will never again be the highly profitable field it once was. For those of us who nevertheless believe it is the best fit, we must either come to terms with working

more for less pay or attempt to circumvent the system, as Dr. Bligh has done. The only advice anyone can give at the moment, and what is ultimately the most important, is simply, “do what you love.” As Dr. Morley said of the research work for which he is so passionate, “If nobody paid me for it I’d be really happy; it would be the same as playing tennis or chess for me.” I hope I will be able to find a career in medicine about which I can feel the same. And should that happen to be primary care, now seems an opportune time to become accustomed to asceticism.

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