Primary Care Cures

Episode 56: Dr. Eric Bricker

Ron: You know, most problems in healthcare are fixed already. Primary care is already cured on the fringes. Reversing burnout, physician shortages, bad business models, forced buy outs, factory medicine, high deductible insurance that squeezes the docs and is totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of costs and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with host Ron Barshop, CEO of Beacon clinics. That's me.

Ron: Healthcare is an epic profit center. You're benefit advisor is a dinosaur walking dead if lacking this next gen healthcare agenda. New era health plans offer some blend of these. Okay, so really, really good in my book, and this is totally my opinion, are value based insurance design, VBID it's known as. Why? Because they still deal with the administrative bloat that insurers demand. And I don't know that VBC is going to be around forever because they get capitated down to zero. That seems to be the logical solution, and that's where the industry has gone over the last 30 years.

Ron: The better solution I think is reference based pricing models and captive medical plans, captives they're known as, and next gen association health plans that incorporate some of these next ideas that I think are the best. So I've told you good, better, now we're into the best category.

Ron: Direct contracting with surgery, imaging, pharma, virtual primary care, direct primary care, known as DPC, medical tourism for medications and for surgery, and high performing Centers of Excellence, which is a Walmart pioneering. So I want to think of the latter five like a massive stimulus package for employees who pocket up to 8,000 per year per employee versus old world care. That's every year they pocket that kind of money. So unlike federal government bumps, one year only, or federal stimulus packages for a few hundred bucks, these are multi thousand dollar stimulus packages, and they're annual. They're very tasty donuts for that reason.

Ron: This employer generated stimulus in a donut factory, $8,000. So that's $130,000 mortgage for every employee that doesn't have to spend that $8,000. That's the average spend. That's also paying off most of the credit card debt in America because it's under 8,000 per family. That's also a savings account for the first time for a lot of employees because 56% of Americans cannot put together a thousand in savings, much less 8,000 in savings.

Ron: So ask your best people if they've ever had a savings account, and you'll be surprised by your answer. Ask them if they've ever had a vacation somewhere nice. You'll be surprised by the answer. Ask your under $20 an hour 56% if they've ever thought about paying off credit card debt, and you will be surprised by the answer. It's better than a donut factory for us employers. We would love to have double or triple or 10 X sales to squeeze easy money margins like this baked into our benefits. This is chocolate magma in a cake that nobody thinks about. It's the golden ticket in a chocolate bar.

Ron: The 2020s is going to be an era of heroes coming from HR and finance because 90% of the CEOs are still asleep at the wheel. We will awaken. I'm a CEO that did two years ago. We are awakening. The bigs are being told by their best customers that they've got maybe three years, and then they are outtie. This is happening weekly with very large employers around the country, and it's going to soon be a daily occurrence, I believe.

Ron: For my small company, this is not only a chocolate magma cake in a donut factory, it's radically changed our culture and that's another show. Our next guest needs no introduction. Dr. Eric Bricker is known for his AHealthcareZ, is an epic performer in front of a whiteboard talking about subjects everybody should know something about, and we all know nothing about. And he can dive steep and he dives interestingly, and he's quite entertaining. If you go on LinkedIn, you'll see AHealthcareZ, hundreds and hundreds of videos, and you will learn something, I guarantee you, each one. Welcome to the show, Eric Bricker.

Eric: Hey Ron, thanks so much for having me.

Ron: Good. Well we've got a lot to talk about. We only have a half hour to talk about it. So my interest in creating Primary Care Cures is to figure out what is it that is the grand fix for primary care. Because once we fix the backbone, it seems like the rest of it should be able to work itself out. So I'm at a direct primary care conference. Health Rosetta is promoting a lot of interesting ideas. What ideas do you see out in the marketplace with your sort of 20,000 foot view of the market that could be the grand fix if there is one for primary care, and ultimately, healthcare?

Eric: Yeah, so it's a great question. And you're right, that primary care really is the backbone of really improved health and improved health care for companies and employees and their family members. And I actually want to want to take you to the Intermountain Healthcare System, which of course is very famous. Most people in America are aware of how Intermountain and Geisinger and some of these other healthcare systems are incredibly innovative.

Eric: One of the things that makes them so innovative is that they have the correct financial alignment because the Intermountain Health System runs its own health insurance company. So they collect premium from people in the Salt Lake City,

Utah area, and then they provide care for those same members. Likewise does Geisinger. Now it's not all they do, right? So they had patients coming who don't have Intermountain Healthcare insurance, but they have that company.

Eric: Okay, so what does that have to do with primary care? They're sort of head of innovation at Intermountain said that, "Listen, we realized a few years ago then Intermountain Healthcare doesn't run one health system. It runs two health systems. We run a health system of primary care and we want a health system of specialty care, like orthopedic surgeons and ophthalmologists." And primary care physicians have a very different way of seeing patients and a very different agenda than your ophthalmologist or your orthopedic surgeon.

Eric: So the primary care physician is really trying to keep people healthy. They're trying to prevent disease. A hospitalization is seen as a failure, not as a success, whereas the orthopedist or the ophthalmologist, they are much more "transaction related." You have a broken bone that needs to be pinned, you have a detached retina that needs to be reattached.

Eric: And so the way that the physicians in each of those areas is compensated accordingly needs to be very different. And at a very basic level, that means that those specialist physicians, maybe it makes sense for them to be paid on a fee for service basis. But for the primary care physicians, sometimes if they're really doing a great job, the patient would see the primary care physician even less. So if the primary care physician is being paid on a fee for service basis, that actually doesn't create the right incentives. And so even within Intermountain, they're trying to create the right type of environment where the primary care physicians are incentivized one way and the specialists are another way. Okay.

Eric: The other way that they run two health systems is that the orthopedist kind of functions on their own and does their own thing. Whereas the primary care physician needs to work as a team, right? And it's one of the reasons that I'm an internist. I'm an internal medicine physician because I love treating the entire person, not just one particular organ. And so they realized that they needed to treat the entire person in those primary care clinics for Intermountain.

Eric: So what did they do? They put counselors and psychologists and psychiatrists in the offices with the primary care physicians because if you're depressed or if you have anxiety, if you can't think straight because of some sort of mental illness, you're going to have a really hard time taking care of yourself or even following directions about which medications to take when, if you're in the fog of depression. And so they've incorporated, and you also need care coordination services, and you need dieticians. So you need all of these things working together as a team in the primary care setting. So, it's the correct financial incentives and the team based approach that really need to be their sort of own unique sort of system within a system within Intermountain.

Eric: Okay. That brings us to direct primary care. What direct primary care does, is it essentially replicates that exact same scenario at the employer specific level. So this is where the employer is going to pay a subscription to a primary care physician or a group of primary care physicians. And the patients are going to be able to see them an unlimited amount. Maybe it makes sense to get on a phone call, maybe it makes sense to do an email. Maybe it makes sense to come in and actually do a visit in the office. Who knows?

Eric: There's going to be some situations where you might want to have them come in and you might not. That's totally okay because the physician is financially aligned, they're going to get paid the same amount every month regardless of how many visits that they have come in. And so that's one. That's the sort of financial model that sort of aligns incentives.

Eric: And then two, those primary care physicians, now I will tell you that I have seen this firsthand because when I did my residency training at Johns Hopkins, guess what? All of the physicians there, not just the primary care physicians, but also the specialists, they're all on salary. And so one of the primary concerns about having a physician on salary is that they're just going to drag their feet, or be lazy, or not treat the patients as much as maybe they should be treated, or they will under-treat them. Right? It's the opposite problem of fee for service and over-treatment.

Eric: And I will tell you that, by and large, I did not see that. And I think that if you talk to other people that have experienced direct primary care, they will tell you that they did not see that either. Because we really took the Hippocratic Oath to do what's best for the patient, and the patient comes first. And for those clinics that then set up additional metrics around whether it be certain degree of outcomes, or even hemoglobin A1C for a diabetic, if you put the patient first, and do what's best for the patient first, that in the long run, that absolutely will turn out into the best financial performance for that patient as well.

Eric: And I'm going to add one final component as to what the primary care, the DPC model does, is it allows then when that specialty care is needed, it allows, not in a forced gatekeeper HMO fashion, but it allows that primary care physician to direct the member to the specialist and to the facility that is going to be high quality and cost effective.

Eric: Because many primary care physician groups that are owned by hospital systems today are used as a referral source for the exact opposite purpose. They're using those primary care physicians as a funnel to bring people into the "highly reimbursed service lines" at the hospital. A highly reimbursed service line might be cardiovascular services because they get paid $8,000 for every stress test. So they have people coming into the primary care physicians so that they can be referred over to the cardiologist so they can get their $8,000 stress tests.

Eric: So there, the financial incentives are not aligned necessarily in the correct fashion, but in a DPC model where there is no financial connection between that PCPs referral and the specialists that they're going to, then they're really going to do what's best for the patient, and not just something that's going to "increase patient volume" for a highly compensated service line. So I'm just going to pause there, and maybe we just all digest that a little bit.

Ron: Okay. There's just about 27 things to take apart. Let me just tell you my first thought is we've had a lot of interesting people on this show, and Dr. Clint Flanagan in Colorado has hired 60 DPC docs that have come on board. He's got a couple of NPs, he's got a naturopath in Boulder because that fits the market there. He's got one or two PA's. But it's mostly family doctors because of their scope of practice. He's hired one hospitalist in the last 10 years. And I asked why, and he said, "Think about how deep they go with the patient. They're almost like an urgent care relationship. They don't have the full scope that you as an internal medicine doc would have if it's a relationship with your practice."

Ron: So this show is not about knocking hospitalists or knocking hospitals or knocking big anything, but how do you feel about a hospitalist? This gentleman who's been on our show, that's the largest VBC in the country, is knocking hospitals just because of their scope and because of their training. And they don't know the community. They're not embedded in the community. How do you feel about hospitalists getting back into primary care again in the community? Is that going to be a problem for them?

Eric: So, this is a great question. I have some firsthand knowledge about this as well because I actually used to practice as a hospitalist. So after I was done with my internal medicine residency, I worked as a hospitalist. And I would say that if you come out as a general internist, that becoming a hospitalist is probably the main direction that most people go in terms of their employment.

Eric: Now, here is the challenge. Here's the good and the bad of a hospitalist physician is that a hospitalist physician is great in that they are there to be able to see the patient. Because when people are in the hospital, they're there typically because they're sick. And guess what? Their clinical situation can change in the blink of an eye, and you will have people decompensate on the floor very quickly.

Eric: And then the old model where the doctor was in the clinic, either across the sky bridge, or across the street, or across town from the hospital, their ability to address that patient's decompensation in the hospital rapidly is compromised. You can't do it. But if you're there, you can see them.

Eric: One of the worst things I would ever hear a nurse say to me on the phone, they would page me, and they'd say, "Dr. Bricker, so-and-so just doesn't look right." And any time a nurse has a sixth sense about a patient not looking right, I would run to the bedside. Because typically, that's something's very wrong with them,

but the nurse just couldn't put their finger on it. Right? So that is absolutely one of the positive things about a hospitalist.

Eric: Again, the negative thing about the hospitalist is the financial incentive. So hospitalists will bill if a patient visits almost in a similar fashion to what an outpatient primary care physician would do. Right? So you have like 99201. I mean, you bill CPT codes for visits of various levels of complexity, one through five, depending upon the amount of time and the problem list, yada, yada, yada. Okay, so those are the professional fees for the hospitalists.

Eric: Now, hospitalist groups would typically also be paid a stipend by the hospital in addition to their professional fees that they bill out to Medicare, Medicaid, Blue Cross, United, Cigna, blah, blah, blah. Okay. In certain situations, in talking to my hospitalist peers, that stipend from the hospital is contingent upon various metrics. It could be patient satisfaction metrics, it could be volume of tests for procedures, ordered metrics.

Eric: Therefore, there is a connection between the compensation paid to the hospitalist and the amount of stuff they order in the hospital. Okay. I'm not saying it happens all the time. I'm not saying it happens a lot. I'm not saying it happens a little. I don't know exactly how often it happens. But from anecdotally, from the hospitalists that I talk to, it absolutely does happen. So I think the matter is, in my opinion, the matter is not whether a hospitalist is or is not good for the patient relationship. I think if it's financially aligned correctly, it can be fantastic. But in certain situations, it can be arranged in a way that's not necessarily in the best interest in patient.

Ron: My son and daughter in law were at Brigham Women's the last three years. He's now doing his fellowship in GI, and she's an entrepreneur starting a company in New York City. And they're both taken a little different path, but there was literally no incentive for them to run unnecessary tests. There's no incentive for them to order procedures that were extra. There was no coaching on that, in other words.

Ron: And the only reason they ordered extra test, for example, and you didn't bring this up, is because sometimes a referring physicians said I want this done. And they said to themselves, really. He knows he doesn't need that, and we know that he doesn't need that. But we don't want to upset the relationship. Or a patient will come in the door and say a WebMD tells me I need to order these three tests. And my [inaudible 00:16:02] is going, please. WebMD is not your authoritative source. It's me. But I'm not going to fight you because it's lot easier to just go with City Hall than fight City Hall.

Ron: And the third reason is to cover his rear end, right? Because they always teach them that. You can't over order tests. But in terms of doing procedures, and when necessary, skipping days like we've heard today about, if you're doing an

endoscopy, upper, do it day one, you do it second day, and then you can bill it two different days and get a higher reimbursement. They never coached them on that kind of stuff. And I doubt that many people are getting coached on that until they go maybe into a private practice or group. So I'm not trying to demonize physicians. We both know they're, in the power play game, the least powerful group at the Thanksgiving table. They don't get much of the scraps of these big bills that get passed.

Ron: Let's talk about it. If you could eliminate medical tests, I have a theory that if we had some sort of an artificial intelligence ordering system that you had to check with before you ordered a test, that would pretty much obviate the need to not have an x-ray when it's a dumb thing, or an ultrasound when it's a dumb thing, or even a CT scan. There's ways to have maybe a second opinion on whether you really need that test. Do you think anything like that is in our future?

Eric: So it's a great question. The short answer is yes. And to a certain extent, it's already being done. So in most electronic medical record systems, and what's called physician order entry or POE, there is some degree of what's also referred to as decision support. Right? In healthcare, we have to have all this jargon, right? So there's a couple of pieces of jargon here. Okay.

Eric: Now that decision support, when I started in medical school in the year 2000, that was there. And at the University of Illinois where I went to medical school, they actually had an electronic medical record, and they actually had it in place for several years. It was a Cerner system in 2000. So actually, I've grown up with an EMR. I've worked in hospitals that did not have them, but I kind of grew up with it. Okay.

Eric: And they have decision support around things like making sure your patient has had stool softeners if they were put on narcotic medication. Because narcotics, they slow down your bowels, they cause constipation. So they would want to put you on a stool softener at the same time so that you wouldn't get all blocked up. It's sort of the bane of existence in the hospital is constipation. Okay, fine.

Eric: That type of decision support has been there for two decades. Is there an opportunity to make it much more sophisticated? Of course. Now, I will say at the same time that there are things you can do within the EMR that are much less sophisticated that they have already done that are highly effective.

Eric: And I will tell you one that they did at Johns Hopkins. What they did in the physician order entry system is they put the price. And they didn't do it for all labs, but they did it for routine blood work. So like a CBC for your red blood cells, white blood cells, and platelets. For what's called a BMP, or basic metabolic panel, which is like your sodium, potassium chloride, creatinine, BUN. They did it for a handful of other ones.

Eric: And they put the amount of money that each one of those tests costs next to where you would click the button to order it. And guess what they found? These are residents. They're getting paid $45,000 a year no matter what. There's no change whatsoever. Okay? There is no recourse to them at all. They're not going to get kicked out of their residency program. They're not going to get a bonus. They're not going to get their pay docked. Right?

Eric: And they found that the residents automatically ordered fewer blood tests. And one of the common things to do is you order a BMP instead of a CMP. So a comprehensive metabolic panel is I think like 14 lab values and a basic one is, it's only like seven lab values. So it's seven less lab values. It's a lot less money. Let's say a CMP might be 110 bucks, and a BMP might only be 17. And they found that they self-selected the BMPs over the CMPs, just when they were shown the price. And they also just ordered all the CBCs, and the blood tests and all that, just less frequently when they were shown the price. All they had to do was put the money on there. So that's not even artificial intelligence.

Ron: He was shielded.

Eric: That's just like-

Ron: He was shielded from the price. He was not even allowed to see what things cost. Not because it's a cost factor, they just don't want them thinking about money when they're ordering on behalf of their patients. They want them to do the right thing regardless.

Eric: Yeah. And actually, and so we had Dr. [Myrna Kerry 00:20:09] talk here at the conference. And Maryland is such an interesting place because that would not have any financial repercussions for what the hospital was even paid. Because Maryland is the only state that has state regulation of what the insurance reimbursements to hospitals are. So the hospitals can't negotiate their rates. The state commission tells the hospitals in Maryland.

Eric: So there's so much control that in Maryland it wasn't impacting what the hospital was getting paid at all. And it was just a little experiment. I think they only did it in the Department of Medicine. But I think that it just shows that, obviously there's been a lot written about nudges, right? And so depending upon what your "incentives" are, you can be nudged in the direction of increasing healthcare costs, or you can be nudged in the direction of decreasing healthcare costs. And depending on which side of the fence you're sitting on, you might want one of those opposing nudges to occur.

Ron: So Eric, I started this show with the idea of Sherlock Holmes-ing the problem of the comprehensive solution to healthcare. There's got to be some kind of a fix that takes care of the patient, the employer, and the doctor. So the employer being the

funder, the doctor and the patient exam being the sacred tenant of which all healthcare's based.

Ron: And the employer employee relationship is a sacred one too. We're going to get you in the nest and protect you from financial ruin. We're going to protect you from medical ruin. And those promises have been shattered. But we're building them back very slowly with DPC. I had a conversation with Chris Crow, another speaker of ours today. Chris is the largest ACO in North Texas. He's, along with VillageMD, one of the two biggest in Texas, with Clive Fields, who's a future guest on our show.

Ron: And the question I asked him was, "How do you feel about DPC, and are you ever going to go into that business?" And he said, "Well, the problem is there's not enough PCPs. You already have a shortage. And we're taking a panel from 2,600 to 600." And what was told to me by Paul Thomas, who's our first PCP guest I ever had, at Plum Health. Paul said, "Ron, it's not what you think it is. How many PCPs are in America?" And I said, "Well, there's 350,000." He goes, "What about extenders?" I go, "Oh, okay, maybe 505,000. And he goes, "So what's 505,000 times 600," our size of a panel. I said, "Well, that's about 300 million." He goes, "How many people live in America?" And I went, "Okay, you got me there, buddy."

Ron: He goes, "We don't have a problem. We have an efficiency problem. Because somebody is typing for 20 minutes into something and talking eyeball to eyeball for seven, that's an efficiency problems. You don't need to be seeing 26 people. That's just a game they're playing because they're pleasing the overlords." So he had a pretty good point. What do you think of that point he made?

Eric: I believe there are, it's probably at the state level, laws around who can actually enter the information into the EMR. And so I think to a certain extent, it's either mandated, whether it's by hospital policy, or by the state, that it's the physician that has to directly enter that information.

Eric: But many people have said before that electronic medical records are actually just billing systems in disguise. And so you have essentially turned a physician into, I don't want to call him a medical coder. I mean medical coders are wonderful people. That's not what I'm saying. But what I'm saying is that you're giving physicians responsibility, because you can, that is taking away their time from what they should be doing in terms of the physical exam or the history or the review of systems.

Eric: And so in my opinion, I have absolutely seen medical transcriptionists work in conjunction, side by side. They're basically the physician's shadow. And I saw this at a dermatology office in Baltimore. And the physician didn't even write her own prescriptions because it was a nurse and she is the transcriptionist, which is write down everything in the chart that the physician said so that they would document

it in the chart. And would write all the prescriptions for the person as well. And they could see that patient in about 15 minutes. And in that 15 minutes, they spent 14 minutes talking to the patient and doing an exam, and no time on the EMR.

Ron: So PCP, depending on PDL [inaudible 00:23:59] general medicines, who make 60 to 80 bucks an hour in Texas, if you have a $20 an hour scribe following you around everywhere, you just took a pay cut. And you could be more efficient theoretically, but scribes are a little too expensive for primary care today. Now maybe we'll have virtual scribes that somebody in the Philippines will be typing simultaneously, but that's a little ways off. We're not quite there yet.

Ron: Let's talk about another interesting problem. I just started thinking about this the last couple of weeks. Everybody that surrounds a primary care visit, let's call them MAs, medical assistants. I looked at the list of people that I see in a typical primary care office, and I've been in 800 of them in my career. I see a front desk transaction. She gives me a clipboard. I have somebody that's taking my payment. That's a different transaction. I've got a triage nurse. She's actually into care. She's getting my blood pressure and she's rooming me. I've got an outtake, here's your copay.

Ron: Then I have a whole bunch of people I never see behind there like a practice manager, a biller coder, a collector. We have scrubbers on the insurance side. We have payment clerks. We have people that [inaudible 00:24:58] that sue us to try to get their money back. We have clerks that are about recoupments. There's a whole series of 12 to 14 people in each PCP visit.

Ron: And I looked at the math. And an independent doctor makes 25 cents on the dollar of that visit. If they work for a hospital, it's closer to eight percent because there's a lot more money involved. So 25 cents on the dollar goes to the bottom line of that doctor versus all of this team that he has to pay, almost all of which are transaction clerks. And yet we send these MAs to school, and they're learning phlebotomy and medical terms they never get to use because they're now, they're really transaction assistants, not medical assistants. It's almost like a bait and switch that we're doing on 500,000 people that are right in the heat of battle of this system.

Eric: Yeah, and I will tell you that over the years when I talked to older primary care physicians, of course they were the ones that told me to never go into medicine. I don't have any doctors in my family, but every single doctor I talked to said, "Whatever you do, don't go into medicine." And this was in the 90s, when "managed care" was ruining it. And if anything, it's gotten worse since then.

Eric: And that's why I went and worked as a hospital finance consultant for two years before going into medical school because I wanted to see firsthand what is this bureaucracy and paperwork requirement or headache that's causing physicians to not like their jobs so much. And I think one of the big differences is that in, I don't

know, the last five, 10, maybe 15 years, I think most people when they go into medical school, and especially when they go into primary care, they kind of go in eyes wide open with the expectation of that's kind of how it is.

Eric: And typically there is a, and I wrote about this in my book, where there's really a hierarchy of physician specialties based upon your USMLE Step one and Step two scores. So those are the standardized tests that you take in medical school. The higher you score on that USMLE score, then you can get into a more highly paid specialty like orthopedic surgery or dermatology or ENT.

Eric: And so that oftentimes the people who go into primary care either, one, they just have a passion about it for some sort of personal reason. They were the child of a family practice doctor. They came from a small town so they saw the difference that a primary care physician could make in the lives of the community. Or, because they didn't score very well on their tests, or because they were a foreign medical grad. Right? Because there's about twice as many residency spots every year as there are graduates from US medical schools.

Eric: So there's always almost 50% of the residency positions that need to be filled by FMGs, foreign medical grads. And typically those are primary care residency positions. And the hospitals and the residency programs, they have to fill them because they use them as a cheap labor source. And so it is often, I don't want to say all the times, but sometimes people go into primary care as sort of, I don't want to call it the path of least resistance. It's sort of the plan B or the plan C. And it doesn't have to be that way. And it shouldn't be that way.

Eric: And in every specialty, including primary care, there is such a bell shaped curve in terms of competency and expertise, that are there primary care physicians that do not know what they are doing? Yes, absolutely. At the other end of the spectrum, there are fantastic primary care physicians. But the direct primary care model allows for at least the environment for as many of those, let's just call them, the middle 60% of primary care physicians to at least put them into an environment where they can thrive with their competency.

Eric: Because if you put a, let's just call it, a 50 percenter in that very complex environment that you just described, it might be kind of hard for them to succeed clinically in order to be able to spot that swelling in the leg that's actually a blood clot, or a DVT that might turn into a pulmonary embolism and sudden death. Right? They might be distracted from being able to actually see that.

Eric: But if you put them in the right environment, they're are better apt to clinically succeed. So I would say that, money aside, forget about the money, the direct primary care model, if anything, is just going to be able to allow the clinical skills of the majority of primary care physicians to come to fruition, to actually do what it's supposed to do.

Eric: Whereas right now, for the reasons that you described, they're really handicapped in ways where, yes, can some people be successful at it? Yeah, but they're really your superstars. Maybe they're like one out of ten primary care physicians that can actually spin eight plates at a time and pull it off. But that's unrealistic to think that most people are going to be able to do that.

Ron: But to your point, Eric, so again, I'm referring back to my son and daughter in law. She's Harvard and he's Pritzker. So top 5% tier schools. I asked how many of the 200 graduates from their medical school were going on to something beyond primary care. And they said all of them, but two or three. So basically two or three out of a top tier school are going into the PCP world.

Ron: Then I was treated by a dermatologist about 10 days ago. And I asked, and she's in a bottom tier school. Not proudest for my hometown. I said, "How many of your graduates out of 200," and she had a pretty big graduating class, "went on to primary care versus specialty? You, you're a dermatologist. That's a choice spot." And she said most of them had to go into primary care. I said, "What do you mean, had to?" And she goes, "They couldn't get the specialty slots. All the better students get them first."

Ron: So to your point, we're not getting the best and brightest going into primary care. That's the default. What a sad thing. I talked to Atlas MD, my friend Josh Umbehr, who's been on the show, and Kirk Umbehr. And they have rotations to go through their practice. Now, they're a mature DPC. So that they have a lot of services that are for free. They have cryogenics and DEXA scans. It's all free. And it's just because they pay for the equipment, and it's a service they want to provide.

Ron: And they're always thinking of what now could we add that would be valuable. So super cool practice. 50 bucks a month. Kids are 10 bucks a month. It's ridiculous. It wouldn't work in Houston, Texas, and may not work where you live. But by doing rotations there he's got a ready pool of DPC ready graduates that are ready to go because they see a sweet thing. It's a lovely life. Let's just live in the world of fantasy for a minute. Do you think burnout would go away if everybody was a DPC seeing six patients a day?

Eric: And I think that you bring up a very good point. And I'm a fan, PAs and nurse practitioners that actually have sort of script writing ability, they hate to be called physician extenders or mid levels.

Ron: They hate it. They hate it.

Eric: If I was them, I would hate it too. Bell shaped curve. There are people that are really good at what they do, and they can be highly effective. And then there are ones that are not as good. Right? But to your point, and the previous gentleman's point, around there being not enough of these doctors to go into primary care, I

think that's where you get them from. I think you could get them from the residency programs and the medical schools. And they could see a career of leaving medical school and going into a residency program in family medicine, or internal medicine, or pediatrics with the end goal of being a DPC physician.

Eric: Kind of like what big companies do now in sending people for their MBA. It's like we'll pay for your MBA, come back in a few years, and you've got to work for us because we sent you that. Same thing, you got to go to that family practice residency, and then come back and do DPC for us. And I think you would get a lot of residents and a lot of medical students who would be interested.

Eric: Because in my opinion, the lifestyle is right. And what I mean by lifestyle, I mean it's not a general term. It means sleep deprivation from not being able to sleep at night. Very specifically. It means having to work weekends and having to work holidays. It's overnight, weekends ,and holidays. I mean, my friends in their 40s, sort of prime physicians in their career, that work various specialties, they are working... I got one buddy who works three weekends a month. He gets one weekend a month. The other ones are getting, they have to work one weekend a month, and the other folks are working two out of the four weekends a month.

Eric: So you're working a lot of weekends. One of my buddies said that he got Christmas off this year for the first time in five years. It ain't going to happen. Okay? And again, he's in his 40s. He's not the junior partner in his practice. And the other thing you have to do is you have to set out your schedule in a lottery system. My buddies that are anesthesiologists, they have scheduled lotteries for the year. And your days off are set for the year. And you can do some trading, yada, yada, yada. But at the end of the day, especially if you have a family, it's really hard to set your schedule for the year in advance of when you're working and when you're not working. So if you could do that through a DPC career, I think that would be highly attractive.

Ron: Well, I promised you a half hour. We could do a second show if you have time to do this another time. But we're going to go ahead and close the show out. I always like to ask my guests my stumper question they're not prepared for. If you can fly a banner over America, what would that banner say?

Eric: Love each other.

Ron: I love it. Okay. You can't close better than love each other, folks. So thank you Eric Bricker. We'll look forward to our next show together as soon as possible. We'll talk to you soon.

Eric: Thanks Ron.

Ron: Thank you for listening. You want to shake things up, there's two things you can do for us. One, go to primarycarecures.com for show notes and links to our

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