JEFF BELDEN

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Dr. Fitzhugh Mullan,
interviewer

Mullan: Why don't you tell me about your background in terms of where you grew up and how you got interested in medicine and going to medical school.

Belden: I grew up in St. Elmo, Illinois, a town of about 1,500 in southern Illinois, on Interstate 70. I spent my whole life there. In high school, one of my science teachers took a particular interest in a few kids. He had wanted to go to medical school when he was a kid but he couldn't afford to go. He thought I could since there was scholarship money available at the time, so he suggested it as an idea. I'd been thinking of teaching or engineering. I thought, "Medical school sounds okay. That sounds like it would involve things I like to do--using my brain and working with people." So I got interested in medical school when I applied for college.

Then when I was in college--

Mullan: Where were you in college?

Belden: I went to the University of Illinois in Urbana. So during college, my aunt said, "Why don't you talk to Dr. Huelskoetter in Altamont, Illinois," about six miles away, "because he's a family doc and he'd like to meet you." So then

for the next few years in college, when I would come home for the weekends, I'd go with Dr. Huelskoetter at 6 a.m. to make his rounds at the hospital ten miles away. He liked to go at 6 a.m. because people weren't awake yet and wouldn't ask you too many questions, and families were never there. But aside from that efficiency move, he really was a good GP and, I think, for me he was a great role model, and I liked what I saw. At that time I thought, "Okay, general practice." It sort of confirmed what I thought would be a good idea. So I think that's where my interest in family practice got started.

By the time I got to medical school, I had pretty much decided I wanted to be a family physician.

Mullan: Were there any other people in your family who were in medicine or health care at all?

Belden: No, not really in my family. My grandmother's best friend was Dorothy Lewis, and her husband, Dr. Lewis, was the doctor who delivered me. That's my middle name, Lewis, so I was named after her best friend. But other than that, no, I didn't really have an exposure to medicine as I was growing up, other than going to the doctor.

Mullan: How about any early observations in medical school about GPs versus non-GPs and generalists versus specialists?

Belden: Well, in the town I grew up in, all we had was GPs. We

had Dr. Lewis and then after a while we had a series of different doctors who had immigrated from Cuba. Then when I was in fifth grade, I had a hernia repair and some urologic surgery, so I went to the hospital fifteen miles away and had an itinerant urologist operate on me. I don't really have a personal recollection.

Mullan: Your identity was more with the GPs in town, or Dr. H?

Belden: Right. Dr. H,, Dr. Huelskoetter.

Mullan: Was your family supportive or non-supportive?

Belden: Yeah, they were real supportive. I had an easy time academically. It was easy to be the valedictorian, and when I went to college, I did my studying and was ready for the tests a couple of days ahead of time, and always went out to a movie or play the night before so I'd be relaxed the next day. Medical school, of course, was different. I had never felt behind in my work before that.

Mullan: Where did you go to medical school?

Belden: SIU School of Medicine in Springfield, Illinois.

Mullan: Southern Illinois University.

Belden: Right. It was a three-year school back then. The first

twelve months were in Carbondale, and the last twenty-four months were in Springfield, and there was very little vacation time, not any flexible time.

Mullan: Why did you choose that?

Belden: Well, I applied to about five schools. SIU was a brand-new school, and they had an advanced-standing class only when I applied. I thought of SIU as like a party school, because that's what the undergraduate school was. When I went to interview, though, I was really impressed by the educational philosophy that they had. They were problem oriented, laid out all their learning objectives, laid out various routes to get to the objectives, had very little lecture. By that time, I had really decided that my style of learning was not lectures, but small group and reading, self-directed learning. So I withdrew applications from several medical schools at that point, since I felt like it was the right place to go.

Mullan: Were you satisfied with it?

Belden: Oh, yeah. I really liked it.

Mullan: What was the attitude of the school towards family medicine? Let me get a couple of dates. When did you graduate from college and went to medical school?

Belden: 1973, summer of '73. I'm in medical school '73 to '76.

Mullan: What was your date of birth?

Belden: 9/2/51.

Mullan: In medical school, tell me about what the culture was like, how you found the school, and what the generalist/specialist views were.

Belden: SIU had three missions, and I probably can't recall all three missions, but one of the missions was to serve the people of southern and central Illinois. Another mission was to create generalists, to create primary care physicians. I forget what the third one was, to use existing resources to the maximum amount possible, I think it was. Thus they used two existing hospitals in Springfield and the basic science campus in Carbondale. So it was very, very strongly supportive of primary care and family practice, in particular.

Mullan: That's interesting, because so many of the schools founded back then had that kind of rhetoric, but they didn't deliver, including University of Missouri, I think.

Belden: Yes, but the University of Missouri really had a whole different culture. It was an academic medical center with all the traditional basic science faculty that were very traditional

in their orientation. It took them a long time to get around to problem-based learning.

Mullan: But SIU had it from the start?

Belden: Oh, yeah, from the start.

Mullan: When was it founded?

Belden: This is the twenty-fifth anniversary? I think this is the twenty-fifth anniversary of the founding of the school. Dean Moy came to Springfield, Illinois, and he was the School of Medicine for a few weeks, and then he started hiring people. His vision was to have a school like this, and he was the dean there for like fifteen years or twenty years, because he just retired within the last few years, so he had the longest longevity of any medical school in the U.S. dean for a long time.

Mullan: So how many years before you got there?

Belden: I went there in '73.

Mullan: Then it had a couple of classes before you?

Belden: It had one advanced-standing class of people that came from North Dakota and some other States that had two-year medical schools without clinical campuses.

Mullan: So you were the first regular class.

Belden: Right.

Mullan: Did Moy come from the University of Chicago?

Belden: Yes.

Mullan: He was one of my teachers.

Belden: Was he?

Mullan: Yes. So his notion was to eventually have a "full bells and whistles" traditional school? I thought that's what you were saying.

Belden: No.

Mullan: He was dedicated to the notion of a primary care-oriented, pragmatically oriented school?

Belden: Right.

Mullan: Built that and maintained that.

Belden: Right.

Mullan: And is that yet today?

Belden: Yes. Oh, yes.

Mullan: So within your class, how did people sort out in terms of how many went into generalism?

Belden: I don't know if I can quote you percentages, but it was like among the highest percent. I mean, if you look at the spectrum of all the medical schools, it was always in the top decile of who was going into primary care.

Mullan: Tell me about your progress through the school. Did this conform to what you were thinking when you went in, or not?

Belden: Let's see. When I first started, I hadn't really ever had the situation where I felt behind academically, so within the first few weeks, I felt like, "I'm not ever going to be caught up in learning what there is to learn." So the basic science campus, well, it was the first year, so they were getting some of the bugs out. We filled out lots of evaluation forms for the faculty, to let them know how things were going. There were a few faculty that came from other institutions and sort of had a bit of a traditional orientation to the basic science teachings, so they kind of had to come around as far as understanding, to keep it a clinical focus as they delivered their material. But overall, I was real satisfied with the experience.

In the next two years, well, there was the matter of falling in love with Sandy and devoting time to her and learning how to balance paying attention to academics and paying attention to my relationship.

Mullan: You met in school?

Belden: We met in Springfield in '74. We met the first day I got to Springfield. I went to buy groceries with my roommate, to buy milk, toilet paper, essentials. She was in line buying chips and beer with some guy.

Sandy Belden: We don't need to have that in there. [Laughter]

Mullan: This is good stuff. [Laughter]

Belden: Chips and dip. Do you remember what kind of dip it was? [Laughter]

Then at the orientation lecture the first day of school, that Monday, whatever it was, we had our first meeting in the big nursing lecture hall, so I saw this girl's sweater in there that I thought was kind of familiar from the grocery store.

Mullan: You were going to nursing school?

Sandy Belden: Yes.

Mullan: Just starting?

Sandy Belden: No, I was in my second year when they came along.

Mullan: "They." [Laughter]

Sandy Belden: They invaded our space.

Belden: The medical students did invade their space.

Sandy Belden: They actually did. They took our dorm for classes and offices, and we had to move out into apartments.

Mullan: Doctors do it again. [Laughter] [Tape recorder turned off.]

We're as far as chips and dips.

Belden: Okay. So let's see. Refresh my memory about where we were in the questions.

Mullan: We were about to leave medical school, but it turned out that Sandy intervened, and we need to pick up on that part of the story, get you back to school with Sandy.

Belden: Actually, a very good part of the medical school was that there was a longitudinal primary care experience in the last two years of medical school in Springfield. I didn't see a whole

lot of patients, but I really did get a very good feel for following a small cohort for two years in the Family Practice Center there, so that was part of the primary care education. That stands in sharp contrast to some experiences during my first year of residency, where I felt like I wasn't doing anything like what I went into medicine for--you know, medicine rotations where you get the old ladies with chronic pain rolling in from five hours away, and I've going to see them for three days and do a bunch of unnecessary GI workup and then send them back to their family physician. It was totally counter to what I thought I was supposed to be doing. So anyway, I loved the primary care experience.

Mullan: And decided you wanted to do family medicine?

Belden: Yes.

Mullan: When did you decide that?

Belden: Well, I knew pretty much that was what my primary interest was. Then during medical school, the only competing field for me was psychiatry. A good friend of mine was interested in psychiatry. I remember going out to one of the faculty psychiatrists' house to have dinner with a few people and talk about residency choices, and I just decided that psychiatry was too narrow. I could only take so much psychosis and depression until I'd be wanting to look for more variety. I like

psychosis and I like depression, and I like to take care of them in primary care, but I wouldn't want to do that all the time.

Mullan: So how did you approach residency, and what did you do?

Belden: Well, I don't know. We had two criteria. One was, we were trying to stay reasonably close geographically to our family, but the residency in Charleston, South Carolina had a real strong behavioral component, I had heard, so we went down there. That also was our honeymoon. [Laughter]

So we got married, and not too long after that, got in the car and drove to Charleston, South Carolina, taking the scenic route along the river. We later realized that we were going to have to step on it to get there, so we drove all through the night, the night before the interviews, and got there at like three in the morning, and I woke up with traveler's diarrhea. We went to this residency interview, which was a positive interview, but the Deep South culture and that learning environment was a real traditional academic center where you're a first-year intern doing everything. You're putting the chest tubes and all kinds of procedures. In my experience at SIU , I was sheltered because they had two private hospitals and the paid staff did everything, ran EKGs, and drew lab, etc. So it would have been too much of a leap for me, without the base of experience at procedures, to have gone to South Carolina, so I withdrew my application then.

Then we looked at several places in the Midwest and really liked the town of Columbia. Everybody was so friendly at the

residency, it seemed like the right style for us.

Mullan: So that's what you picked?

Belden: That's what I picked.

Mullan: How was it?

Belden: Great. The first-year internship was real depersonalizing for me, though. It was exhausting. I remember during the first year, first we had a month of team-building, with just family practice residents, which was great. We each had a partner, and in our rotations the partnership would fill a slot, so that one of us could be in clinic and the other one could be on the wards. I really liked that.

But during the first three-month rotation on internal medicine at the VA Hospital, it was hard for me. I wasn't used to the sleep deprivation. I remember one night admitting this old guy, trying to look through the microscope at his blood smear, and having my eyes keep banging into the eyepieces from drowsiness. I counted bands and I wrote down information, but I had no processing function. The next morning, you know, the people who were awake could tell that I had missed some stuff clinically because I just couldn't think. All I could do is just barely function.

I think there were other experiences like that. There was another difficult admission where I went and took a totally

incoherent history, and my resident went back with me and he somehow got a coherent history out of the patient. That was a real difficult low point. I think I certainly was depressed. I don't know that I had clinical depression. There were times when I had sleep deprivation, and felt like I wasn't fulfilling my purpose as a doctor. That was a real challenge. I think it took its toll on our marriage relationship, because I was not much to relate to during that time.

Mullan: It was every third night?

Belden: Yeah, pretty much every third night. I couldn't imagine doing it every second night in a surgical residency for five years like some of my colleagues.

Mullan: And you didn't have kids yet?

Belden: No, not 'til we moved to Illinois into private practice.

Mullan: So you finished out the residency here at Columbia.

Belden: Yes. The second and third years were much better. The sleep deprivation was less common, and the rotations were easier. Third year, I was one of the chief residents and got to use some management skills, and that was fun. Got to play basketball at the end of the day. Basketball's always been a wonderful highlight. In medical school, that kept us sane the whole first

year in Carbondale. We'd play basketball almost every night from nine to ten, 'til the gym closed.

Mullan: So you got to play more of that in the second and third year.

Belden: Third year particularly.

Mullan: How were you feeling about family practice? Let me back up. As you chose family practice, family medicine, coming out of medical school, did that meet with approbation, approval, disapproval?

Belden: Oh, yeah, with everybody that I knew and that I had anything to do with, my family.

Mullan: Met with approval?

Belden: Approval.

Mullan: Anybody try to discourage you?

Belden: One of my roommates in medical school, the surgeon, thought it was like glorified social work. He's the only person who had a real particularly negative attitude about it.

Mullan: As you went through residency, how were you feeling

about it?

Belden: I had decided to just hang in there for the first year. By the end of the first year, going into the second year, I could see the light at the end of the tunnel.

Sandy Belden: [unclear]

Belden: Yeah, that may be in the neonatal unit, but actually on the pediatric unit, the nurses always were happy to have family practice residents, because we always had a lot better personal skills than the pediatric residents did at this institution. I'd hear that all the time.

Mullan: But what, as you looked to getting out, did you plan to do, and what did you do?

Belden: I always thought that I would go back to a shortage area and do primary care practice and private practice, and so I had a Public Health Services Corps scholarship to go back to home county, but by the time I was finishing medical school, I realized I didn't really want to go back to my home town or to my home county, because I just needed to have a little--

Mullan: Let me be clear. This was a National Health Service Corps scholarship?

Belden: Right.

Mullan: Which is to go to a shortage area. You hoped to go to a shortage area, you originally intended, where you'd grown up.

Belden: Right.

Mullan: Which was a shortage area.

Belden: Which was a shortage area originally, and when I finished, it wasn't a shortage area. I could have gone there anyway, and they could have used family doctors, or I could have gone to another shortage area. Instead I decided it was more important to go where it made the most sense to settle ultimately and just pay back the money as a loan and not view it as a scholarship. So I did that, and paid off the loan. It was a $9,000 loan, and I paid off $16,000 (with the interest) or something like that. Compared to today's standards, that was not much.

I went to Jacksonville, Illinois. We went around and looked at different places, mainly in Illinois, to be closer to Sandy's family and my family.

Mullan: Where is that in Illinois?

Belden: It's in west central Illinois about forty-five minutes west of Springfield, the capital.

Mullan: Farm country?

Belden: Yes, it's farm country, a town of about 25,000 people. It's a county seat, had two small private colleges. Had a lot of parallels to Fulton, Missouri, where I did some of my rural training. My residency here had a rural component in Fulton. That was the most fun primary care clinic, which we got to do in the second or third year, and it was wonderful. It was nothing like the practice at the university clinic. The university had lots of difficult, chronic, multiple problem, poor socioeconomic patients, and over in Fulton you had sort of a general variety, like a private practice. People would come in with real interesting problems. Some people would come in with advanced disease and had rarely been to doctors, so it was a fun practice.

Mullan: And you did everything? You'd do OB?

Belden: We did OB. When I started practice in Illinois, another guy who was also looking for a place to practice met me through the recruiter in Jacksonville, and then we interviewed each other. Jacksonville paid for my flight to Peoria, Illinois to interview him at his home so we could decide it was the right thing. I enjoyed working with him.

Mullan: You both relocated to Jacksonville?

Belden: To Jacksonville. Had some financial support from the

hospital there. It was pretty easy getting the practice built up and getting started.

Mullan: Which years were these, now?

Belden: '79 to February '82.

Mullan: What happened?

Belden: Sandy went from being Sandy Belden, R.N., well known at the university, who was known for her abilities and her skills, to "Mrs. Dr. Belden," in a smaller town where the culture there was different than we expected. I was real busy with practice, and I also, I think, was a perfectionist and idealistic and devoted too much time to having the best possible practice. It was two doctors, so we took turn being on OB calls. When I was off, I was off, but I'd stay late to get patient education materials compiled, and I would come home reading the *New England Journal of Medicine*, walking up the sidewalk to the house. Had a lot of habits that I look back on now and realize were destructive in terms of my personal growth and in terms of our relationship as a couple.

So as far as the practice of medicine went in Jacksonville, it was very rewarding. I had a lot of opportunities, and financially it was fine. I was asked to be the doctor for the deaf school there, which would have been a half-time position, was asked to be the director of the regional continuing education

center for SIU's outreach thing. So I had plenty going on, but Sandy really was not liking Jacksonville. I mean, there were a lot of things, but to oversimplify, she wasn't liking Jacksonville. It was a big reason we thought about moving.

Also there were some questions about what was going to happen with the practice in the future, because my partner didn't want to do OB for a much longer, and I was thinking I wanted to do it for an extended period, so it was unclear how that "marriage" was going to work over the long haul. We were talking to some other family docs and thinking about reaffiliating in a bigger way. The only other guy that wanted to do OB long term was solo and wanted to stay solo, so that ended that. I think those two factors were the main reasons for coming back here. We both really like Columbia, and Sandy really loved it, in particular.

So we went off to a retreat setting for a long weekend on the Mississippi River, to a little town, somebody's cabin, and thought about it.

Mullan: Just the two of you, or this was a group?

Belden: The two of us with our young son. We went off to a little town, Hamburg. Called back to Columbia while we were there and said, "We're thinking about making a move. What's going on there?"

And they said, "One of our guys is moving out, and we need somebody. So either you decide within the next two months or

we're going to start recruiting."

Mullan: Who was saying this?

Belden: Bill Birkby and George Prica at Family Health Care. Bill's now a pathologist and George is the senior partner in our group.

Mullan: So these are people who you knew in practice in Columbia.

Belden: Right. In fact, I had actually been recruited to the practice in Columbia, but chose to go to Illinois originally. So I knew Bill real well, and I hadn't met George yet.

Mullan: So you decided in the affirmative?

Belden: We decided to think it over real quick. Then within a real short period of time we called and said, "Okay, we'll do it." That meant leaving my practice sooner than I wanted to. I originally thought I would leave in July, because that would finish up the group of OB patients that we had committed. So this earlier move it meant leaving my partner with some OB patients that he wouldn't have taken otherwise. So I felt a little guilty about that, but I also felt like there wasn't much flexibility in the offer. I think it was the right decision to come back here, though.

Mullan: What year was this?

Belden: That was February '82.

Mullan: Let me go back to the National Health Service Corps Scholarship. Was that a difficult decision? Did the Corps give you a hard time?

Belden: They didn't really give me a hard time at all. I called them and they said, "You'll just pay it off as a loan at," 9 percent interest," lower than the interest rates at the time.

Mullan: So the Corps didn't give you a hard time?

Belden: No.

Mullan: How about in your head? Any problem with that?

Belden: Yeah, I did have trouble for a while. I really felt that I had an obligation to go to a shortage area, and I really saw the clear-cut need for family physicians in shortage areas. I also saw how difficult it was to find people that were compatible with shortage areas. In my home town we had a string of international medical graduates that came through and had more or less success.

Mullan: If your town had stayed designated, would you have gone?

Belden: No, I think by that time I didn't want to be in the same town that I grew up in. I saw disadvantages to doing that. I know docs that do that now, who feel that it's an advantage.

Mullan: So you moved back to Columbia. Tell me about the practice and how it's developed.

Belden: When I came back, I remember having dinner with Bill Birkby and George Prica, the senior partners. We talked about how big did we want the group. We all said three or four, probably, maybe five.

So then later we added Ken Weston, a fourth. In the process of adding Ken, we needed to expand, so the building we were in added a new addition. As we were building the rooms, we thought, "This room back here could be for another doctor." [Laughter] So before very long, we were looking for another doctor, because we were all getting busy.

So we've been as many as six doctors, and we just had one physician move away because her husband finished his training here, and now we've got one of our former partners, Ellen McQuie, formerly Bruno, has moved back to join us. She has divorced in the meantime. Her husband is staying in Hannibal and she's moving back to join us this June. So we'll be six doctors again, but actually we've made an offer to a seventh.

I don't know. I figure that probably the market for private family physicians is somewhere between six and ten, but with managed care, we've had an unanticipated demand for our

services, so I could see that eight or ten is more likely the number.

Mullan: This is '82 to '94, fourteen years. What has been the nature of your development personally, medically, and what has been the changes you've observed in primary care family medicine over that time?

Belden: In '82, when I came, we were all delivering babies. In Columbia, the OB market was different than in Jacksonville, Illinois. Here it was more competitive and we would each agree to deliver our own babies, because that's what the OB doctors agreed to do, so that meant if I had three deliveries due in a month, then I was on call for those three deliveries, whenever they were going to happen. If I was going to be out of town, I'd sign off to a partner.

Mullan: Why did you handle those, "whoever was on call?"

Belden: Because we thought that in order to be appealing to the patients. We needed to do what the OB doctors were doing, and they were saying they would do their own deliveries. They don't do that anymore. That changed a few years ago. We used to do about twenty-five a year each, two a month, and that started to dwindle about the same time that malpractice rates started to skyrocket. So we hung in there for about three years when it was really a losing financial proposition, with declining numbers and

increasing costs. Finally the hospital required us to raise the limits on our liability insurance. There was a weird wording to the law in Missouri, and the hospital looked at the wording one way and we looked at it another way. We all got opinions from attorneys, and they all made it clear that we needed to get higher limits on our malpractice insurance. That was kind of the final blow, so we quit.

We were not emotionally ready to quit, but now that we have quit, I really do like sleeping through the night. I wouldn't go back to doing OB now, just because I'm now that much older and that much more intolerant to being up all night long. It would be real hard to do physically now.

Mullan: And the dwindling number of OB patients was what?

Belden: There was an increasing number of OB physicians in town, and also I think we may have shot ourselves in the foot by making stray comments like, "We're still doing OB," or, "If we're still doing OB next year," suggesting we might quit soon. You know, as the malpractice premiums went up every year, we'd start to make these comments out loud about, "Can we keep doing this?" I don't know, part of it might have been the patients heard that and thought, "I want to see a doctor who's going to keep delivering babies."

Mullan: So you'd gotten out of the OB business. How about the surgery business?

Belden: We never did surgery, per se. One of my partners did vasectomies and another partner did suction D and Cs for incomplete abortions, and none of us really did anything else beyond that. So we all had intensive care unit privileges. We all managed ventilator patients. In Illinois I did a few central lines, but here there were all kinds of people doing central lines, and it was just easier to not do them. One of my partners, when he started, applied for psychiatric floor privileges and got some resistance for that, but he was asking for things that none of the rest of us asked to do, and it was probably appropriate to have those denied.

Did I ask for anything? One hospital, I asked for routine primary care orthopedic privileges and had no problem. At the other hospital, it was dominated by the orthopedic surgeons. They put up resistance for several different privileges, and I just said, "Well, forget it. I don't want them, then."

Mullan: Over this decade, how have you seen the practice of medicine change? Malpractice rates went up for OB, but beyond that?

Belden: Technologically, things have changed. In cardiac care, I don't really do MI care anymore, unless the person sort of wants to die. I mean, if it's an elderly nursing home patient who happens to be in the hospital with an MI, we'll take care of them, but if it's anybody else, nowadays they get taken to the cath lab for angioplasty or thrombolysis and bypass surgery.

When I came here, we would take care of the non-Q-wave MIs, and we'd call in the cardiologist when needed, and now you'd be crazy to do that just because the technology has changed. And with ventilator patients, they're fewer and farther between, and I don't feel as comfortable with them anymore, so I'm happy to just call in the pulmonologist or the intensivist and let them do that now, which makes my life is easier. I don't worry about it as much. So that's changed, but I don't really miss acute care that much.

Mullan: Tell me about managed care. Where did it come from and what's it doing?

Belden: Managed care in Columbia has been slower than it has arriving in St. Louis and Kansas City. It probably got there four to ten years earlier. So it's been within the last two years that we've had capitated care, and it's gone from 0 percent of our practice to 12 percent at the end of the first year and about 30 or 40 percent at the end of the second year. No, maybe 25 at the end of the second year and about 30 or 40 percent now.

Mullan: And this is [unclear] arrangements?

Belden: These are HMOs where insurance company organizations come in and contract with hospitals and physicians.

Mullan: And for a capitated rate?

Belden: For a capitated rate.

Mullan: So you take on Mrs. Jones--

Belden: So primary care is capitated and the specialists, in general, in this community are getting discounted fee schedule, fee for service.

Mullan: So Mrs. Jones is your patient. She has chosen you or the insurance company has assigned her to you.

Belden: Right.

Mullan: They give you a fixed rate?

Belden: What they do, they give us a fixed capitated rate, which is based on the person's age, so that pediatric cases we get paid maybe $20 a month, and a thirty-year-old man, we get paid maybe $5 to $10 a month, and then older folks, it starts going up as the disease burden increases.

Fortunately, we have one partner, Ken Weston, who has a good business mind and has just finished getting his master's degree in health services management, and he has been at the forefront of our contracting with the capitation people, with the HMOs, and he's a good negotiator and he's real savvy at calculating things. Were it not for him, we might have some much worse capitation rates. But we've done great financially with capitation so far.

It's been better than fee for service.

Mullan: And what are you at risk for? Just the primary care?

Belden: What we're at risk for, it's a little different for each HMO, basically. Most of them have a 15 to 20 percent withhold. They all have some kind of formula that looks at utilization, looks at specialty referral, looks at some kind of patient satisfaction measurement, and then looks at some kind of quality measurement. The quality measurement might be a chart review, which it is for a couple of the HMOs. Patient satisfaction scores are usually surveys mailed out to randomly selected patients by a panel.

We thought, based on our observations of practice patterns--well, I'd better not say this. I'll say it. We thought that based on observations of other practice patterns in town that we would probably be more efficient in primary care management, so with one HMO we negotiated to have our own risk pool, just our five doctors, because otherwise we'd have been thrown in with all the primary care docs. It turned out to be a good decision.

Basically, do I practice medicine differently? Not really. I fill out a lot more forms for HMOs, but my decision-making and my choice of economic alternatives and my parsimony in using services, I think is about the same as it's always been. I always tried to do whatever was cheapest for my patients, tried to do it in the most economical way, tried to ask the question, "Is this test result going to change what we're going to do or

not? If it's not, then do we really need to do it?" And we probably wouldn't do it. So having a solid diagnosis was not as important as knowing how you're going to treat that patient and thinking what's important to not miss here.

Mullan: On the risk question, if you send a patient for a procedure, let's take an X-ray, you pay for that?

Belden: No, basically somebody's keeping little tally marks over here, and at the end of the year they're going to run it through their big formula that not even executives claim to understand. [Laughter] They certainly won't divulge the formulas to us.

Mullan: If you're low, you get the withhold back?

Belden: Yeah.

Mullan: If you're not, they keep the withhold.

Belden: Right. They'll keep a graduated percentage of the withhold, depending on how much we spend.

Mullan: How does that work? Do you feel abused by that?

Belden: No, I don't feel abused by it. See, I think that we always have been doing what HMO managers want.

Mullan: In your practice.

Belden: In our practice. Long before HMOs came along. I've thought for ten or fifteen years that it would be smart for us to get capitated contracts because we'd be good at it. But there wasn't any market in town, really, for a long time.

Mullan: So you feel you were there and ready when it came along.

Belden: We were ready for it, right. The only thing we weren't ready for was knowing what it cost us, knowing what our costs were, to know if the capitation rate was going to be adequate or not, because we had no denominator. How many patients really consider us their doctor?

Mullan: As things have developed, you feel that it's a system that you've done okay thus far.

Belden: Yeah.

Mullan: You feel it's going to continue to be that way?

Belden: I think what will happen is that the power will concentrate in a few big corporations and that they will then be able to rachet down costs, including what they pay primary care doctors. It depends on the philosophy of the organization. I think there are some organizations that are probably more

enlightened, and realize that enlightened workers that are allowed to do what they do best and given a fruitful environment to work in will be the most productive kind of workers, as opposed to a company that thinks, "We're going to downsize. We're going to get the bottom line as low as we can. If you don't like it here, we'll hire somebody else." I hope we don't have too many of those latter kind of corporations that get the power.

Mullan: So I gather from what you say that the advent of managed care has not been destructive or even terribly intrusive on your personal and group patterns of practice, is that fair?

Belden: Not particularly intrusive. The forms that you fill out, having to know which specialist is on which plan adds another layer of hassle, but compared to the layers of hassle that we'd already encountered from Medicare and Medicaid and the bigger organizations that created bureaucratic barriers and bureaucratic sludge to wade through, this wasn't really an order of magnitude worse. It was about like dealing with Medicare.

The reason they're doing all this is to help them collect data to know what's happening in their system. We'd be just as efficient without having to do all their paperwork for them. If we all had information systems that would track this automatically, we wouldn't have to be doing this, but there isn't an information system out there yet that will do what the managed care people need and what we need.

Mullan: I'm going to turn the tape over now.

[Begin Tape 1, Side 2]

Mullan: This is Jeff Belden, side two.

Further observations about managed care.

Belden: So there's the bureaucratic hassles of filling out the forms.

Then another thing that's been more challenging than I thought is this shifting relationship of having a bunch of patients come in that are used to just going to a specialist when they want to, who now have to deal with having a primary care doctor. There are several aspects to that. One is, some of these people don't understand what primary care doctors do, so there's the issue of educating them and teaching them about what it is that we're capable of managing. If that's the only thing we have to do, then it's not so bad, because we just talk to them and they say, "Okay, I'd love to not have to go to another doctor. You take care of it."

Then there's the cohort of people that have had this long-term relationship with their rheumatologist or their cardiologist, or whatever it is, and so not only are you telling them, "Well, you need to have a family doctor now to do this," but you're telling them, "You need to change this long long-term relationship," which I think is the worst thing to have to do, is ask patients to stop that relationship. So there are times when

I'll give them referrals that I wouldn't give them otherwise, just because I value the long-term relationship.

There's other people that are seeing a primary care internist in town who's not signed up with their plan now, and after twenty years they're coming over to Jeff Belden, after seeing another doctor that they value, just because the plan changed.

Mullan: They have a bad attitude, I presume.

Belden: They don't have such a bad attitude, because to them there's not any other real window or door open. It's like, "I'm yours now," you know. "You can't send me back to my old primary care doctor." Whereas if it's the rheumatologist they've been seeing for twenty years, "Why don't you just sign the form? That's all I want you to do and send me." So that's a little trickier.

Then there's people that just don't think primary care doctors should be doing most of this stuff. They just want to go see the rheumatologist and the skin doctor, and those are the ones that are the much harder sell.

The biggest challenge for me is finding that there are people that want to go see the specialist, and I think we can take care of your problem. And in the old days, before HMOs, if that person had come in and said, "I really want to go see this specialist," then I would just say, "Then go ahead, because I think it will be good for you to get the second opinion, and if

they agree with what we're doing already, you'll feel better and I'll feel better, and you can either see them or you can see me."

But nowadays, with HMOs, there's several aspects to it. There's the conflict of interest where I get the financial benefit if I control utilization. There's the aspect that I have a responsibility somewhat to the plan to help control costs, so not only am I trying to choose reasonable cost antibiotics, but if they really don't need to see this other specialist at all, if there's no reason, then I don't think it's a prudent thing to send them. I persuade longer to try to talk them out of it.

Mullan: Successfully?

Belden: Yeah, yeah, by and large. There are times that you can tell that the other person is not totally thrilled about the idea. Then usually I just try to enter into some negotiation with them. I might say, "Why don't I just go ahead and send you this time, and then why don't you see how our relationship goes over the next year or so. If you really feel like a year from now you still want to see the cardiologist, let's talk about it again."

So it's been helpful to have some articles to read in some of the family practice journals about how to handle that, because it was a whole new thing for us. We would talk it over among ourselves over the first few months. "You know, gee, how do you feel?" So it was really good to have the group to bounce ideas off of.

Mullan: Are you happy with your practice? Are you satisfied as a family doc?

Belden: Yeah, I am. I like doing administrative things, and during the past few years I've done medical directing for skilled nursing units and I kind of got interested in occupational medicine, was doing some special focus and study in that. I looked into being a medical director for an occupational health unit in town, but there was not a good way for me to stay in my group and meet my group's overhead and simultaneously do it at a price that the occupational medicine people felt like they could afford to pay. So that just didn't work out.

I like administrative things, and so I'm at a stage right now where I'm thinking "what can I do in that regard?" Do I want to keep just doing primary care practice where I am? I do. I really want to keep seeing patients. I like that. I have kind of another dream that I've been pursuing on the back burner, that I think I would continue to do practice and maybe--I don't know what shape this would take. I can tell you about that in a minute, too. [Tape recorder turned off.]

Mullan: You had a dream.

Belden: Yeah, the dream is to be part of a system that nurtures physicians rather than punishing them if they're having trouble, either having trouble with clinical competence or getting marginal clinical competence.

I've had a couple of experiences with physicians that I know, one, an older doctor in Illinois who got sanctioned by the PRO pretty heavily, partly because he was just ignoring the warning letters. If he had just responded appropriately, he'd have probably kept his butt out of trouble, but ultimately he got sanctioned hard. Two of the people sitting on that sanctioning board were classmates of mine from medical school, so I felt a real strong personal connection to that physician and to at least two of the doctors that were part of the sanctioning process. I saw the personal effect that it had on him. I was in touch with him over those couple of years when he really tried to deal with that emotionally.

Then also a person that I've worked with here in Columbia who had a process related to a malpractice suit, and then also had attempts at sanctioning by the state medical board on top of that. There wasn't any pattern of bad events. He was a good doctor. There wasn't really anything else that needed to be done, as far as I'm concerned. The malpractice insurance company settled it. The State Medica Board should have butted out. But that carried on for a couple of years in his life and is another example of the system gone wrong, in my opinion.

The model that I first became aware of was the Ontario province that has a coalition among the medical schools, the state regulatory agency, and the provincial medical association. They monitor physicians in practice. They identify risk factors. They have a program for assessment, where you spend a whole day assessing a doctor with simulated patients and simulated chart

recall and a variety of things. Then they had a rehabilitation portion. So that's been a neat model that I've been aware of.

In the past year, I've started talking to people about, "How would I go about checking this out?" and talking to friends of mine locally. Then I got a job offer to direct a residency program, which I wasn't really looking for, and I said, "No, I don't really want to do that. Why would I want to do that?" But then I started thinking, "Well, maybe that could be sort of a springboard to the dream. I could do that and then part time develop grant funding and get experience at dealing with residents having troubles, and make it blossom." So I did a lot of intense calling around, all around the country, talking to people that were--

Mullan: Where was the residency program?

Belden: Here. So I called around to the guys in Ontario, and I called John Henry Pfifferling, Ph.D. at Center for Professional Well Being out in North Carolina. I talked to the state board of healing arts, and I talked to people with the State impaired physician program. Their piece is related to emotional illness and chemical dependency, but they don't address really the issue of what if you just get a doctor that's just out of date, not doing real well.

Then I started thinking I could do it through a university or I could do it through the state medical society and get funding that way, or I could do it through BJC Health Systems,

which our hospital is a part of. It might be in their best interest to have a component that "repairs" their doctors that they've already invested a lot of resources in. So I don't know where it's going to go right now, but it's pretty appealing.

Also in the last few years I've gotten interesting in my own spiritual dimension and spiritual aspect of physicianhood. One of the talks that I gave to our twentieth anniversary family practice residency was taking the patient's spiritual history, which felt like a risky thing to do. It went real well and I was real glad that I did it. So part of what I've been interesting in is physician spirituality and our patients' spirituality and how we handle all that.

Mullan: Tell me more about what you do or how you envision that if you were doing it.

Belden: The spiritual piece?

Mullan: Yes. Are you doing that as part of your practice?

Belden: Yeah, actually. Yeah. It's all a lot of my own spiritual journey. I grew up raised in the Methodist Church, and we went to church and Sunday school and Wednesday night prayer meeting and everything. I had no problems with that 'til I went to college, then was exposed to the big, broad world, and realized that central Illinois Methodism isn't the only way to go.

I really, during college, became pretty much atheist, and for a long time just didn't want to deal with the issue of God because I couldn't reconcile it all in my head, 'til Sandy and I got married. She wanted to get married in a church, so I at least talked to a minister about my beliefs at that time, and he was real accepting and said, "Is it okay if I pray. You don't have to believe."

Then for many years, a number of hurts accumulated in our marriage relationship. I think part of my emotional immaturity--for instance, not being able to recognize or handle anger from somebody else, and not believing that I ever got angry--was a real problem in our relationship. That, among other things, over a period of time really took a toll just in our personal lives. So in the last few years, we've gone to counseling a couple of series. We went just long enough to patch up temporarily whatever was the biggest issue, but never really enough to heal the wounds. I've told this story. Sandy wouldn't mind me telling you this story.

In the last five years or so, probably, we've had a lot of healing through a variety of ways. Part of it has been me doing some counseling working individually, part of it has been me taking care of the spiritual side of me, finding out how I relate to God in a bigger way, doing a lot of men's work, being in a men's group for more than five years.

Mullan: Sounds like hard work.

Belden: It was great. It was wonderful. It was really nurturing, did a lot of growth there. I learned how to deal with anger, learned how to deal with conflict. So I can be in conflict now and hang in there.

My counselor was a chaplain, so part of his style is for you to deal with your emotions, you deal with the spirit, it's just all one thing. So he helped make it possible for me to keep my own integrity as a scientist and still explore how to have a relationship with God. So that's been really neat.

Then we started going to a church that was real user-friendly, kind of a seeker church modeled on Willow Creek Church in Barrington, Illinois. That enabled me to start looking at things in a different way, and that was another piece of it. So we've got lots of good relationships established with people through that community, that faith community. Sandy and I have had lots of good healing and reconciliation. She's been able to find a lot of forgiveness in her heart for hurts that I've done, and I've grown a lot personally. It's been emotional, spiritual, learning, and I don't know, all those pieces.

Mullan: How is that playing in your practice?

Belden: I can understand people's problems a lot better, having experienced many of them. I can truly understand hope, because I'm an example of healing in many ways. I've been at all ends of the spectrum. I've been to where I wouldn't have wanted anybody to talk about spirituality or God with me. I can have a real

open attitude toward anybody's spiritual pretty much now. I don't have to proselytize anybody to believe my particular set of beliefs. I can ask patients, if they're going through grief, I can say, "Where do you find help?" And if they talk about people, I can ask them who their supports are. If they say, "I don't know," I can say, "Do you pray?" And depending on how they respond, if they say, "Yeah, I pray," I say, "What do you ask for? Do you get your prayers answered?" And it seems real natural now. Five years ago it would have seemed, "How can you possibly ask that?" It's easier for me to ask a spiritual history than it is to ask the sexual history, probably, because I'm more comfortable with my spirituality than I had been with my sexuality. But that's changing, too.

Mullan: Do you use it as a regular intervention or a regular element of history-taking, or when it comes up?

Belden: When it comes up. I think that there will be a time when I probably have it as a regular element. I've talked to doctors who do that. They ask, "Do you have a religious preference and do you go to church regularly?" Those would probably be the two questions. Or I might add a third question, "How do you express your spirituality?" to the people that don't view it as a piece of church.

Mullan: Do your partners engage in, or understand, what you're doing?

Belden: Well, some of them were at the talk I gave. For the guys that weren't, we drove to our annual practice retreat, we talked about personal growth and that stuff.

Mullan: Interesting.

Belden: So it's been real neat.

Mullan: Good. Let me ask about the future. Actually, let me ask one more question about the present. You lived through what some have called the revitalization or reappreciation of the generalist. How do you see that? Is it real?

Belden: Yeah, there's been a couple of different cohorts of people that have appreciated it. There's the people that always liked general practitioners and were wondering where they disappeared to. When we reappeared in the seventies, they were waiting for us and they were glad to find us. Now with the HMO/managed care era, there's going to be a group of people that never knew anything about family primary care doctors, never really were looking for them, and now are going to be placed in their care. Some of them are going to be happy because they're going to see the value and they're going to appreciate it. Some are not going to be happy, because, frankly, not everybody really ought to have a family physician do most of their stuff for them. There will be some people that will never be comfortable that way. They ought to have the option to buy something a little

more expensive and go see whoever they want to see, but it's going to probably cost them more, because it probably will turn out to be a little more costly service.

Mullan: Do you see your own value in the community and practice and other practice settings moving up as the primary care wave hits, or not?

Belden: Our value?

Mullan: Financially, job opportunities, social respect.

Belden: Well, my wife hurt her knee recently and we went to the orthopedic surgeon, and about the second visit, the question came up, Sandy was saying, "How much longer do I have to wear this knee mobilizer?"

And he's saying, "A couple more weeks."

"Well, if we're going to have to do surgery, can't we just..." She was feeling impatient.

And he said, "We could do an MR scan and see if anything's going on in there."

I said, "Is it going to change what you're going to do today?"

He said, "Well, no, but the insurance will pay for it and we'll know, it'll be another piece of information."

And I'm saying, "John, some day in about two years, I'm going to be giving workshops to specialists telling them that if

a test isn't going to change what you do, you don't want to do it. When you're at financial risk, you're going to want to know that philosophy. Right now it still doesn't affect you, because you're getting paid discounted fee for service, and you still don't have to live with capitation yet."

So I think that in a few years, the specialists are going to be asking us how we do it.

Mullan: You think that the growth in value of the generalist is still--

Belden: Yeah. I don't know that we're going to get paid more. That's not necessarily the case. It's clear to me that more generalists are going to be in decision-making leadership positions in managed care organizations because we have the background and understanding and the skills. Not only that, for us it's generally a salary increase, and for cardiologists it's generally a big salary drop to go into an administrative position. So for those two reasons, we have the skills and we can afford to move into it.

Mullan: Nurse practitioners, PAs. Have you worked with them?

Belden: Yes, we've had nurse practitioners in this practice for a long, long time, and I think for a long time we weren't fully dedicated to using them appropriately, and we just sort of used them to pick up the slack for what we couldn't manage to see

ourselves, and if we hired a new doctor, the nurse practitioner would get crowded out and she couldn't work full time, she'd have to work more part time.

But recently, with managed care coming on, the financial incentives are clear that if we can get capitated contracts and we can pay a cheaper provider to do the same service, it's to our financial benefit to do it, and it's easier to find more nurse practitioners than it is to find more family physicians. The nurse practitioners are also filling a niche that they're going to be better at than we are with some chronic disease education, with some health supervision, health promotion kinds of things that they're going to be particularly strong in.

Mullan: How many do you have in the practice?

Belden: We have two right now, one that's full time, one that's part time.

Mullan: The future. Where do you see it all headed? You described some of the issues of the potential increased management opportunities for family docs. There are those who see the future as bright and shiny for the generalist, and there are those who say that we are passing the zenith of generalist opportunities right now and, in fact, the future is one of increased dedicated specialism and, in fact, maybe the primary care doc will be squeezed out altogether and you'll have medical specialists and nurse practitioners.

Belden: I doubt that that is going to be the scenario. I don't have a model. My paradigm is not that one kind of doctor is in more esteem than another. I don't look at it that way in the big picture. I look at it that we're all out there doing our individual jobs, and sometimes there's poor collaboration and sometimes there's better collaboration in understanding our separate roles, and there's overlap in the roles, whether it's physician, nurse practitioner, or specialist.

In the era of managed care right now, the momentum is toward making sure that the most economical providers--at least our current model is that the family physician must be the most economical, and that is the best way to do it. I think what will really happen is that over the next few years, as the data begins to accumulate, we'll find out that actually sometimes the family physician isn't the most economical provider to use. It's better to use the higher tech, more expensive route earlier for a certain group of patients and get the health outcome quicker and cut the disease burden faster. We don't know how to identify those people right now. The assumption now is it's probably going to be better to do it cheaper, let's do it that way.

Mullan: But your premise is that it won't necessarily hold.

Belden: No, it's not going to hold. Hell, no. The most interesting study that's been published in the last year was the one that looked at treatment of low back pain, comparing chiropractors, orthopedic surgeons, and family physicians. Do

you know about that one?

Mullan: I think I saw it.

Belden: The basic results were that the family physicians were the cheapest, the health outcomes were the same in all the groups, and the patient satisfaction surveys were higher for orthopedic surgeons and chiropractors. And what were the costs? Well, the chiropractor saw the patients a lot more and orthopedic surgeons ordered a lot more tests. So what's the best? I don't know. I mean, I'll see the patients more often if you want, if you'll pay me more to see them more, and I'll hold their hands longer and I'll order a few more tests if you want to pay me to do that, but I never have thought that's the best way to do it. If the orthopedic surgeons are at financial risk for ordering the MR scans and stuff, they may decide that it's probably smart to cut down a little bit.

How do you balance satisfaction with cost reduction? I don't know. You may have Cadillac HMOs and you may have Volkswagen HMOs that sell to different markets. Shoney's may be buying Volkswagens for their employees and 3-M may be buying Buicks for theirs.

Mullan: It's been very good in terms of your sense as a practical online primary care window or vision. Is there anything that you'd like to add in terms of commentary about the system, your experience that you're having now or as you see in

the future?

Belden: We haven't really addressed the access-to-care problem real well yet. In Missouri now, we've just started with Medicaid managed care, and everybody has mixed feelings about it. The managed care companies are all eager because they're going to get their management portion no matter what, so they're excited to get the contracts. It's interesting. We're signed up for managed care Medicaid, whereas we had kind of been restricting Medicaid patients for a while. We'd taken care of our cohort, but we weren't adding new ones, and we are now because it looks like it's going to pay off financially.

There's a part of me that really is very egalitarian and altruistic and wants to just chuck the finances and say, "I'm just going to take care of whoever and not worry about the cost," but there's other parts of me that are not willing to do that, so I can always say, "My partners aren't willing to do that," but I haven't really advocated it real strongly either, haven't argued hard. So in my own practice, I haven't really dealt with the access-to-care issue.

Mullan: Pretty hard as an individual.

Belden: Yes, it is. It's scary to think, well, what if just 40 or 50 percent of my practice all of a sudden were not covering my costs?

Mullan: Pretty scary.

Belden: It is.

Mullan: Right now what's the breakdown in the practice?

Belden: It's changing. It's going to change rapidly now with Medicaid managed care. We probably have 5 percent Medicaid, 10 percent Medicare, and the managed care portion, the HMO portion, has just been growing rapidly, so well over 50 percent of our-- well, two years ago, well over 50 percent of our patients, somebody else controlled our fees, and now it's probably 75 percent somebody else sets the fees. It's less than 25 percent fee for service.

Mullan: Other thoughts? You touched on access, which is a thorny issue.

Belden: My dream has to do with taking care of doctors that might be having trouble with their competence. That's going to be an exploding population of doctors, because the way that we deal with information is just getting more challenging all the time. The way we convert information into knowledge is rudimentary right now. I mean, you can get on the Internet and find out all kinds of stuff, but how do you make stuff into knowing what to do? In my mind, I can envision ways that our information systems will actually help us, in the same way that I

can envision ways that my computer could do all these other things that I want it to do, but it's either going to cost way too much or somebody's going to have to program it for $500 to do my $50 task. It's like so many of us now see what our computer could do, we want it to do, but they don't do it yet. And the same way I see information systems that physicians need in day-to-day practice, it's doable, but it's just about three or four technological steps away. All the pieces are there, but nobody's integrated them.

Mullan: There is, I guess, growing technological use both for billing and for information retrieval.

Belden: Yeah, billing is a piece of cake. Billing's there solid. Information retrieval, like for doing MedLine searches, I grab patient stuff off the Internet. I tell patients, "You've got Internet access? Why don't you go look up fibromyalgia and you'll find some stuff there." And I get some blood sugars from one patient of mine, and I've got another guy who's bought an island and he's moved to an island for two years, and he's going to tell me how his antidepressants are working by E-mail, when it's time to renew. [Laughter]

In our office, we've got StatRef on a CD-ROM, and it's really the one most helpful tool right now to look up stuff, but it's expensive. If you're a solo doc, you know, paying $500 a year just for the CD-ROM and it's only one CD-ROM, that's still prohibitive for some of us.

So what I want is to be able to go into the office and have my patients' lab data and clinical history, their whole problem list and their current list of medicines, in the system, so that when I ask the question, "What if I add cyclosporin or what if I add terfenidene to their medicine list?" I don't have to type in all that stuff. It will know their creatinine, it will know what other medicines they're taking, and it'll say, "Watch out. Drug interaction with this drug. Consider using another drug." It'll know what the diagnosis is and it'll just guide me to the next thing. If I try to order the wrong thyroid profile test or the wrong liver profile test, it'll tell me, "If you're thinking of acute hepatitis, you want to order this panel. If you're thinking of such and such, you want to order that panel." And it's doable, but somebody needs to maintain all the knowledge base to make sure we incorporate the right knowledge behind that. Somebody needs to filter the knowledge base.

I mean, we're just getting into clinical practice guidelines and into practice parameters and that kind of stuff, and the way we do that is primitive. It needs to be evidence-based, and most of our clinical guidelines are not evidence-based, they're expert opinions: sit down in the room until they come to some agreement. So, boy, you know, I mean, we've got a lot of growing to do as a science to be able to do that, but that's what we need. It's going to be critical that we do it right to pull it off.

Mullan: Good. Any other burning items?

Belden: Not that I can think of.

Mullan: Good. Thank you.

Belden: My pleasure.

[End of interview]

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