

# President's Message

by Raynor Casey, MD



## THE ECONOMICS OF MEDICAL CARE IN WAKE COUNTY

The biggest role of the president of the Wake County Medical Society seems to be signing tax forms and writing these four quarterly columns. In all honesty, I must confess that my science and math scores were a major part of going to medical school. However, just as big a role was my inability to write a decent essay or short answer test. Please bear with me as I climb this soapbox once again in my final act as president.

The stated role of the Wake County Medical Society is, "To serve and represent the interests of our physicians; to promote the health of all people in Wake County; and to uphold the highest ethical practice in medicine."

So what is the biggest problem facing doctors and patients of Wake County? I have asked many of you over the past year and the only common thread I could find is Medicare. It is a rapidly expanding problem since the 65 and over age group is the fastest growing population. So what is the problem? Simply put, Medicare reimburses only enough to keep the doors open.

Many of our Wake County primary care physicians, internists and family doctors do not accept new Medicare patients. Some are actively releasing their current patients: Why? Again, it is simple: the costs

of seeing patients EXCEED the Medicare allowable or reimbursement. To further compound the problem, in North Carolina, we are reimbursed lower than the national average.

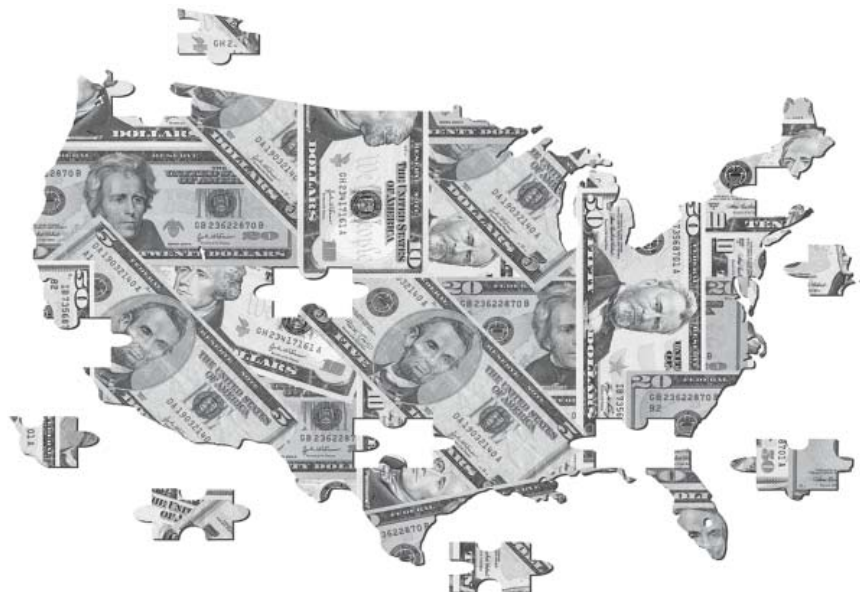
Let us look at a simple code that physicians use for a patient visit - 99213... in North Carolina, Medicare allows \$58.89, while the national average is closer to \$62, for a difference of three dollars, even though Wake County has higher overheads than the national average. A review of the government's website covering Medicare issues, [www.cms.gov](http://www.cms.gov), shows that New Hampshire reimburses \$61.79 for the same service. So they get approximately 5%

Hampshire, its largest city, is 8% cheaper than Raleigh, and that the biggest difference is housing, which is 30% less expensive in Manchester.

Even comparing Raleigh to other cities in North Carolina, it is apparent that the cost of living is not uniform throughout our state. Where should I start? How about my hometown, Greenville, with its own thriving medical center: Raleigh is 24% more expensive. As [www.bestplaces.net](http://www.bestplaces.net) explains, "Housing is the biggest factor in the cost of living difference," and compared to Greenville, housing is 81% more expensive in Raleigh.

You may not consider this a fair comparison, how about looking at North Carolina's largest city? Raleigh is 17% more expensive than Charlotte, with housing being 41% more expensive in Raleigh. On the other hand, compared to a small town, Raleigh is 37% more expensive than Clinton, and housing is 188% more expensive in Raleigh. What does this matter? Well, the cost of renting or buying one's medical office varies greatly upon housing costs. Subsequently, our employees also have to pay the increased housing costs and need to be paid more.

So there you go, those are the numbers. It costs more to run an office in Raleigh and Wake County than throughout most of North Carolina. However, the physicians cannot participate and charge Medicare patients more due [Continued on page 21]



more for the same work?

The fact that allowable reimbursements are higher in New Hampshire is interesting. Does it cost more to live there? No, it does not cost more than Wake County. In fact, a cost calculator on the website [www.bestplaces.net](http://www.bestplaces.net) states that Manchester, New

# SURGERY IN NORTH CAROLINA PRIOR TO THE CIVIL WAR

by Memory F. Mitchell

Patients who underwent surgery in the early to mid-1800s were brave souls. Noteworthy was the case of one Mrs. Woodward of Wake County. Her jaw was split open from behind the ear to the mouth without any kind of chloroform. The *Raleigh Star's* edition of February 9, 1848, reported that the operation was performed by Dr. Fabius J. Haywood "with the skill and nerve" for which he was well known. And poor Mrs. Woodward was characterized as one who withstood the procedure "with the firmness and fortitude" for which her sex was noted. The problem that necessitated the operation was not recorded.

Dr. Haywood, who was born in 1803, was a graduate of the University of North Carolina who received his medical degree from the University of Pennsylvania School of Medicine in 1827. The Raleigh native returned to his hometown to establish his medical practice.

General practitioners were the ones who usually performed surgery during those years. Some North Carolinians traveled to northern cities for surgery because there were more skilled doctors there. For example, John Butler of Halifax went to Philadelphia to have a tumor removed from his neck.

Many people relied on almanacs and family medicine books for instructions when emergencies arose, because no doctors were available. Individuals who attempted to set broken bones, deal with cuts or gunshot wounds, etc., often met with sad results.

But Dr. Haywood became known as a competent surgeon, and he is credited with being the pioneer in the use of chloroform. That case involved the removal of a growth under the arm of Leroy Moore, also of Wake County; the removed wen weighed one pound, four ounces. The *Star* published an account of that operation, reporting that "The effect was as perfect and happy as if an allwise and merciful Providence had prepared it especially for the purpose." It is of interest that reports of the two operations were published in the same edition of the newspaper, leading one to wonder why chloroform was not also give to Mrs. Woodward.

Surgical procedures were usually carried out in the doctor's office or in the patient's home. Before the use of chloroform, the most a patient could hope for in relief from pain during surgery would be laudanum, with its high opium content, or a big dose of whisky. He would then be tied down and held by assistants. Dr. J. L. Ludlow's *Manual of Examinations* gave directions for preparing a patient for a pelvic operation: "He should be placed upon his back on a low table, with his hips and shoulders elevated, and his pelvis resting upon the edge of the table; a roller is then fastened to each wrist, and while the patient grasps the soles of his feet, his hands and feet are securely fastened together by the rollers, and the patient's legs and thighs held firmly by assistants on each side."

Though general practitioners usually performed all kinds of operations, there were a few specialists. Dr. John Beckwith of Raleigh treated diseases of the eye for more than twenty years. The *Raleigh Register* of September 7, 1839, reported that he had had few instances of failure in operations to relieve blindness. During that time Drs. Edmund Strudwick of Hillsborough and Edwin Anderson of Wilmington were also having success with eye operations.

By the 1850s more attention was being given to surgery as a special branch of medicine, with the result that North Carolina was able to supply numbers of surgeons to the medical corps of the Confederate Army when the Civil War erupted in 1861. ☺

Sources: Direct quotations and other information is taken from Guion Griffis Johnson, *Ante-bellum North Carolina: A Social History* (Chapel Hill: The University of North Carolina Press, 1937), 743-745; Sketch of Fabius Julius Haywood, by Vance E. Swift, in William S. Powell (ed.) *Dictionary of North Carolina Biography* (Chapel Hill: The University of North Carolina Press, 6 volumes, 1979-1996), III, 85.

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to federal regulations. Currently, due to the greatly flawed SGR or "sustainable growth rate," Medicare is scheduled to "provide" a 21% cut as of January 2010. Therefore, instead of receiving \$60 for services rendered, physicians will receive \$48! How will that work?

What do we do, and what do we tell our patients? The only answer so far is that the local non-profits or hospital systems have opened senior centers, hiring their own physicians. The centers can make some profit off blood and imaging tests to counter the losses from the physician codes. If patients are lucky enough to get in, they often end up paying for parking at the bigger centers and will be out another five or ten dollars anyway! Be prepared for a growth industry

of senior centers in 2010. It may be our first insight into our health care reform.

What else can be done? As individuals you can lobby our United States Senators and Representatives to fix Medicare, namely to stop the SGR and implement an inflation adjustment to increase the codes yearly. That is a start. Nevertheless, if increased access is a goal, I think it would help to let physicians charge above the Medicare allowable to meet their local costs. It is Economics 101, supply and demand. Currently there is increasing demand but with fixed prices, the supply curve cannot shift.

Some doctors are in higher demand; maybe they have a comfortable office, a nice bedside manner, a good location, coffee in the waiting room, and free parking. If

people are willing to spend more for those extras, they should be allowed... we are still in America right. If not, patients (and their sons and daughters) end up driving further and spending more time in the super senior centers.

It has been an honor to serve as your president this year. Thanks to our Executive Director, Paul Harrison, the Wake County Medical Society increased its dues paying membership by 10%, added some new social events, and expanded programs with a new vaccination grant. Good luck to our next president, Dr. Mike Thomas. ☺

*Where there is no vision, the people perish:*  
Proverbs