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SERIES

MEET DR. PETER VANCE

Dr. Peter Vance is a general practitioner from Holland, Michigan who has been a member of the M3 Global Research physician panel since February 2008. Dr. Vance has worked since 1997 as a family practice physician with the first four years of his career spent in the Air Force and then in private practice.

What Dr. Vance finds the most interesting about participating in market research is the variety of studies he can participate in. Because there are so many different topics in so many different areas, he feels it provides him with a chance to have a voice in many different aspects of medical practice.

What Dr. Vance finds most challenging about practising medicine in the United States is that it's no longer the case that the patient and the physician come together to decide the treatment plan, how it gets done, and how it gets paid for. In almost every case, there are three parties represented in the room: the physician, the patient, and the payor—which could be a government agency such as Medicare, Medicaid, or military insurance or a private insurance company. He can assemble the best treatment plan and the best medication, the best x-rays and MRIs for a patient, but if the insurance won't cover the cost for it, the chances are his patient won't follow the treatment plan because the medical expenses will be too high. That complexity is what makes the US so unique.

Dr. Vance did not encounter this issue when he practised medicine in the military, before coming to private practice, because he was part of the organisation that was paying for it; when he wrote the orders they would get done. But, in private practice outside of the military, he finds that he needs to justify and argue and present all the data about what he deems to be the best medical care.

When Dr. Vance is doing missionary work in Honduras, Peru, Guatemala, or Ecuador, it's different because medical staff don't have all the resources available to them that are available in the US. However, he can make whatever he has available to the patient right away, while in the US there would be a delay while waiting for the insurance to agree to, for example, an x-ray.

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During his missionary work in Peru, Dr. Vance was once contacted about an entire village with symptoms of fever, bloody cough, and diarrhoea. The state had provided the villagers with penicillin shots, but they were not recovering. He went to evaluate the situation and the solution was easy: they all had hookworm and it was an inexpensive cure of 120 doses of Mebendazole for literally pennies.

Dr. Vance became interested in addiction medicine through treating one of his patients who had very bad lower back pain for a long time with degenerative disc disease. The patient had multiple surgeries that didn't help and had been suffering from chronic pain for over a decade. The patient had gotten into a cycle of overusing his medications then withdrawing from the medications and then going back to them and overusing them again.

When the drug Suboxone—a narcotic used to treat pain as well as addiction to narcotic pain relievers—had been on the market for a couple of years, and it looked like a safe medication, Dr. Vance became licensed to prescribe it. Shortly after that he began recognising the same problem in not only his other patients, but also in his partners' patients. It was a natural move to incorporate those patients and treat them, too.

As a general practitioner, already providing cradle-to-grave medicine in all components and facets of life—as well as taking care of the psychology and the spiritual aspects of the situation—Dr. Vance decided to approach the problems around addiction, too. He began to address the misuse of medications that were presented initially for the good intention of controlling pain, that were being used to control a different kind of pain, or to escape rather than to merely control pain.

Since that first patient, Dr. Vance has taken care of cancer patients, and has gone through the extra work of getting licensed for prescribing rapid release oral Fentanyl for patients who really need it. He's also had good experience with use of Methadone for patients with chronic opiate abuse and helping them to withdraw, especially for patients that don't have good insurance who can't afford the Suboxone and most recently the once-a-month Vivitrol injections. This new tool is a huge help for his alcohol and narcotic addicted patients.

Dr. Vance has noted that the number of patients

who are seeking addiction treatment has increased over the years as treatments become available, because viable treatments make it easier to seek help. The other thing that's making it easy to seek help and seek care, is the pressure of the difficulty of getting access to narcotics. It's recently become more difficult for even well-established chronic pain patients who have been stable on their pain regimen, and are not addicted, let alone the ones who are misusing or overusing.

It is satisfying for Dr. Vance when he sees his patients starting to change and when they are using less medication or they've gone a week without a rapid-acting narcotic medicine, never feeling that feeling of getting high, but being satisfied enough that they don't crave the next dose.

However, Dr. Vance still faces one disappointing challenge that he has always faced: a number of patients just don't want to change. They're in his office because they've been caught or because they've made a promise to someone that they're going to try to get sober, but they don't have any true desire to get away from the narcotics. He invests his time and energy into them, fights the insurance companies, prescribes the medicines, and thinks he's going to help them, only for them to not even try.

Dr. Vance thinks it's good that there's so much media attention about opioid dependency, because patients are recognising that there is a true danger, that people do die of this, and that they should treat it with respect. It inspires them to re-evaluate themselves based on what they're hearing and with some introspection and honest reflection, they can maybe start asking those questions: am I addicted, and if I'm addicted, do I need to be addicted? Is there something I could do to make a change? Many people feel hopeless because they don't know there's something that can be done until the media lets them know that they have options.

Dr. Vance's general recommendation to an intern heading into practice is that if they're doing it for money they should go and find somewhere else to work. The days where the doctor gets rich are gone.

Dr. Vance also has warnings for the young interns who aren't doing it for money; the ones doing it out of true altruistic motivations. He warns them that when you help people, it feels good, and that good feeling can be addictive itself. It's been

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said that medicine is a jealous mistress, and she will steal as much of your time as she can. He cautions that this is what needy patients can do to a doctor; it feels good to help them, and the more that you help, the better it feels to help until you're spending all your time on your patients and you forget to focus on your own life and family. He recommends guarding against that and keeping a healthy separation between medical practice and personal life. He also recommends they put a limit to the number of patients they take on in the addiction field to help keep things manageable.

Dr. Vance appreciates the technological advances that have helped him with addiction medicine. He particularly likes electronic medical records that provide his patients the access to a portal to, for example, request a refill for their Suboxone. He can use the feature that allows him to see all the prescriptions that patient has gotten in all the surrounding states that are controlled substances of any sort, whether that be Ritalin or Ativan or any narcotics. Then he can send the prescription through a coded, protected service directly to the pharmacy.

What Dr. Vance is most concerned about in the near future is all the paperwork required, all the time on the phone required to argue, petition, and advocate for patients who really do need the narcotic pain control. He is concerned that medications, specifically narcotics, will not be covered at the correct dose by insurance companies. When opioid overuse was first being recognised as a problem, many insurance companies restricted their formularies and many patients who were legitimately on large doses of medications could no longer have those appropriately large doses covered. The insurance companies have already determined exactly which medications are approved for breakthrough breakthrough medicine every 90 days. Once patients reach a daily morphine equivalent of 100mg, they are responsible for the cost of any narcotic needed beyond that.

Dr. Vance says this has led to patients having to go to pain clinics and get injections to go through a withdrawal process to reduce their intake to that limited covered amount. He also is sure that many others will have gone to the streets to get their narcotics through other means just to control the pain.

In the longer-term future, he believes the biggest problem we're going to have, is one that we've

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always had: that newer, better medications are launched, but they always come out with a bigger price tag. This means the newer medicines won't be available to the majority of his patients, and doctors will have to figure out how to make the older medicines do for the patients that cannot afford the new ones.

What he enjoys most about his career is helping his patients make a difference in their own lives because of the exercise instructions he provided. He feels he was born to be a teacher, and loves teaching his patients and gets great satisfaction when he sees the understanding in their eyes and knows he has empowered them to make a difference in their own lives. When they come back a few months after a visit and their weight is down, or their blood pressure is lower, or their pain is under control, or their back is stronger because of the exercises he provided, then he says he has the rewarding feeling that "we accomplished something great together, the two of us, the patient and I, and that's twice as much joy than if either of us had done it alone."

Dr. Vance loves general practice because he loves the variety it offers him. He sees children and old patients, women and men, and treats everything from diabetes through hypertension and stitching to taking off lumps and bumps. But if he had to cut back, he would switch to emergency medicine or urgent care—somewhere that would still provide the variety. If he were to choose another career completely outside of medicine, he'd like to be a general contractor and do a little plumbing, a little electrical work, a little structural work with cement or with wood.

When he's not at work, he enjoys outdoor activities like cutting down trees and making firewood and camping. He also enjoys helping with home improvement projects in the neighbourhood. He likes to restore parts of a building that aren't working well such as replacing a wall that's starting to cave in by taking the wall apart, evaluating it and figuring out why it failed, then rebuilding it better than it was before.

This fits perfectly with the same themes we see above where Dr. Vance likes to contribute to improving medicine through his market research contributions, improving the lives of the people he does his missionary work with, and helping his patients improve their lives.

