

# CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

October 15, 2003

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## CRP Helps Cardiologists Manage Patients' Risks

**C**ertain risk factors for cardiovascular events—such as obesity, high blood pressure, and high cholesterol—have been known for years. Recent research suggests that another marker—C-reactive protein, or CRP—may be an even better indicator of an individual's risk for heart disease.

“Numerous research studies have proven that CRP is an excellent predictor of first-ever heart attacks, stroke, and peripheral heart disease in both men and women,” says Paul Ridker, MD, MPH, a cardiologist at Brigham and Women's Hospital in Boston and head of the hospital's Center for Cardiovascular Disease Prevention. A professor of medicine at Harvard Medical School, Ridker is an expert on arterial inflammation, the second most common cause (after high cholesterol) of acute myocardial infarction. He is also a leader in CRP research.

A blood protein that is produced by the liver, CRP increases as a result of inflammation. Inflammation in the arteries can cause arterial plaque to loosen, potentially leading to the formation of a blood clot that causes a heart attack or stroke. Similar to LDL cholesterol, CRP can be measured by a simple blood test at a relatively low cost (about \$20).

### Increased Accuracy

“Practicing cardiologists often provide primary preventive care,” says Christie Ballantyne, MD, who focus-

es on preventive cardiology. “Frequently, patients with a family history of heart disease are concerned that they will suffer a major cardiac event. The problem is that the results of a stress test and their LDL cholesterol levels may be normal. So how can we identify their risk? CRP can better pinpoint individuals who might need preventive therapy.” Ballantyne is director of the Center for Cardiovascular Disease Prevention at Methodist DeBakey Heart Center and a professor at the Baylor College of Medicine, in Houston.

Under Ridker's leadership, scientists at Brigham and Women's Center for Cardiovascular Disease Prevention have performed numerous large-scale studies demonstrating the power of CRP as a marker for heart disease.

The researchers' findings on the role of CRP first appeared in *NEJM* (April 3, 1997). Additional results were published over the next several years. “Several groups, including the National Institutes of Health and the Centers for Disease Control and Prevention, decided that a very large population-based study needed to be done before national guidelines could be changed to include the use of CRP as a marker,” Ridker explains.

Results of this large study were published in *NEJM* (Nov. 14, 2002). In this study, Ridker and his colleagues measured cholesterol and CRP levels in 27,939 initially healthy middle-aged American

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## Physicians Need More Time for Patient Care

**F**rustrated by the lack of time they have for patient care, physicians complain that paperwork is taking too much of their time. Every day, they must spend hours doing dictation, writing notes in patients' charts, and filling out insurance forms, and this is time that could be spent with patients, they say.

A recent report by the Center for Studying Health System Change shows that these complaints by physicians are indeed valid. *So Much to Do, So Little Time: Physician Capacity Constraints 1997-2001*, was based on telephone surveys of 8,000 doctors over four years. A number of factors are at work, the report says. Technological advances and increased disease treatment complexity are forcing doctors to spend more time with each patient. Also, insurers and the government are asking physicians to follow recommendations aimed at preventing disease and injury, and meeting these requirements takes time.

Using information systems at the point of care to record the data needed to comply with the documentation requirements of insurers and the government may be one solution to this problem. For the past seven years, for example, John Bachman, MD, head of primary care at the Mayo Clinic in Rochester, Minn., has used a computer while interviewing patients. In so doing, he has become one of the most productive primary care physicians at Mayo.

But before large numbers of primary care physicians will embrace computers, they need to overcome a number of barriers, according to an article in the July 9 issue of JAMA. Those barriers include the perception among physicians that e-health takes too much time and is too expensive, that the quality of medical information on the Web is inadequate, and that the computer could interfere with the patient-physician relationship. If primary care practices are to benefit from the electronic revolution, they must redesign their clinical processes to ensure that e-health facilitates rather than hinders the work of physicians, say the researchers from San Francisco General Hospital in the JAMA article, "Electronic Technology: A Spark to Revitalize Primary Care?"

"The supply of time is inelastic," management consultant Peter Drucker has said. "No matter how high the demand, the supply will never go up. Moreover, time is perishable and cannot be stored. Yesterday's time is gone forever and will never come back. Time, therefore, is always in short supply. Time is totally irreplaceable."

By using computers, physicians may not be able to replace time lost, but they can become more efficient in how they use their time: They may spend less time retrieving records, waiting to be paid for work done, correcting rejected claims, and dictating and writing each patient's history, all of which would give them more time for their patients.



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# EMR Adds Efficiency to Group Practice

By Richard L. Reece, MD, editor in chief

**C**urrent health care computer technology options, including electronic medical record systems, can greatly enhance the efficiency and effectiveness of a family practice, says Charles Zelnick, MD, assistant director of the Cedar Rapids Medical Education Foundation in Iowa. Zelnick refers to his program as an electronic family practice residency because it focuses on how physicians can use computer systems at the point of care.

The foundation trains residents in a three-year family practice program, as well as third- and fourth-year medical students and ancillary personnel, such as pharmacists, from the University of Iowa. The participants complete rotations of four to six weeks. The program is currently training 20 residents, who work in the program's Family Practice Center and at local hospitals and in physicians' offices. All of the foundation's faculty members have teaching appointments at the University of Iowa in Iowa City.

## A Shift in Care

"Just as the development of the CAT scan and the MRI has changed radiology and the laparoscope has changed surgery, the computer will prompt a paradigm shift in primary care," Zelnick comments. "That's why the program heavily emphasizes the appropriate use of information technology in its training."

Zelnick went to medical school at the University of Cincinnati and then did his residency through a community program sponsored by Wright State University in Springfield and Xenia, Ohio. After completing his residency in 1982, Zelnick spent 10 years as a country doctor in Quincy, Wash. He taught

students and residents in his private practice for several years before he chose to leave his practice in 1992 to assume his current position.

"Ten years ago, we had residents and even faculty who were not comfortable with the computer," Zelnick says. "Some did not even know how to type. So we had to start teaching basic computer skills." But the situation has changed over the last five or six years. In fact, fostering comfort with computer usage becomes easier each year as younger residents join the program, he adds.

**"Just as the development of the CAT scan and the MRI has changed radiology and the laparoscope has changed surgery, the computer will prompt a paradigm shift in primary care."**

**—Charles Zelnick, MD  
Cedar Rapids Medical Education Foundation**

"The residents who enter our program now are very comfortable with e-mail and other computer functions," Zelnick says. "But still, everyone is at a different skill level with regard to computer proficiency."

## Improving Skills

To make the most of their residency, the residents must quickly learn to use the computer technology that the program offers. To facilitate learning, the program provides every resident with a laptop computer to use during his or her three years in Cedar Rapids.

"Because the residents have a laptop to use as their own, training is expedited," Zelnick explains. "They become very comfortable with this

tool in a short time. They learn how to use it, how to repair it, and how to call the technical personnel if there is a problem. They take it home and use it to send e-mail, play games, surf the Internet, and look up medical references. This leads to a general proficiency that helps them become more comfortable accessing the electronic medical record system and the patient education resources we provide.

"We can also get our rotating medical students up and running on our computer system in a day or so," Zelnick continues. "We lend them a

laptop for the month, and they go right to work seeing patients."

Each faculty member has a laptop as well. "It was cheaper for us to give everyone his or her own laptop and put the laptops on a wireless network than it was to put a computer in every examination room," notes Zelnick, who believes that the program's wireless health care network, installed in 1998, was the first in the state of Iowa.

The laptops enable residents and faculty to become comfortable with information technology in small, incremental steps. "It is difficult to go from the typical process of seeing patients and dictating notes to suddenly using an electronic medical record," observes Zelnick. "That is a

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big, big step. Every organization that has taken that step in one leap has had a hard time getting physicians to accept the electronic medical record.

"We, too, had some difficulty adopting an electronic medical record, but it would have been even harder if we had not allowed the physicians time to play with their laptop computers and execute simpler tasks," Zelnick adds. "For example, we found that the residents who were trained in 1998 to use the computer in the exam room to educate patients and print out customized handouts were later able to adapt quickly when we added the EMR in 1999."

### Benefits of an EMR

For physicians seeking a return on their investment in an EMR, Zelnick offers three possibilities. "First, one of the easiest ways to achieve some return on the investment involves the elimination of dictation," he says. "During the first year we had our electronic medical record, we saved \$40,000 on transcription costs alone."

Second, physicians will have an opportunity to use the EMR to improve documentation. "With better documentation and system feedback with regard to proper coding, it is easier to code a visit properly," Zelnick says. "Because of more thorough documentation, undercoding is no longer a problem. We are able to substantiate the extra work that we are doing and thus recapture some of our investment that way."

Third, to maximize their return on investment, physicians must aggressively seek opportunities to use the

EMR to increase practice efficiency and productivity. "If physicians have a great system but do not use it correctly, it will not improve productivity," Zelnick says. "Therefore, physicians must be aware of opportunities to use the tool and to take advantage of those opportunities. They have to look at how they can use the EMR to offer higher quality medicine and to see patients more efficiently."

### Point-of-Care Prompts

Arming a physician with powerful information at the point of care is key to quality and efficiency. "Physicians spend 80% of their time doing about 20 things," Zelnick says. "It makes sense to examine those 20 things from an industrial engineering point of view and strive to perform them efficiently. For a family physician, activities involved in a well-child visit, a visit for an ear infection, a hypertension visit, and a diabetes visit should be well engineered as far as work flow."

To improve work flow, physicians can build prompts and reminders into the EMR. "For example, immediately before a visit with a patient who has diabetes, I can call up the electronic record and instantly find out the date of that patient's last A<sub>1C</sub> test, last eye exam, and last urinalysis," Zelnick offers. "The system also prompts me as to what medicines the patient should be taking—perhaps, for example, an ACE inhibitor to protect kidney function. I find that the system actually speeds up the visit. When I look at the record before I enter the exam room, I know what needs to be done."

The EMR enhances both practice efficiency and care quality by issuing reminders for flu shots, vaccines, Pap smears, colon-cancer screenings, and other preventive care measures that physicians in a busy practice may forget. "There is no doubt that prompting the physician at the point of care to provide these services is key to ensuring that high-quality care is provided at a time when it is doable and efficient," Zelnick comments.

Technology also improves work flow for unusual cases. "I recently saw a patient with a condition I had never seen before, and I have been in practice more than 20 years," Zelnick says. "I did an Internet search and immediately found some relevant information that helped me learn about the condition and enabled me to provide information to the patient. Computer technology is like having a magic crystal ball that we can use to reference information efficiently, right at the point of care."

### Power of Technology

During 10 years in family practice, Zelnick recognized the power of computer technology. "Even the simplest billing program can give physicians some information that can help them understand their practices better," he notes. "In the 1980s, we installed a simple billing system on a personal computer. After about three or four months of using the system, I realized that the system could run a report analyzing the types of conditions the practice was treating. To my amazement, the most common chronic disease that we were billing for was diabetes. I knew we had patients

**"It is difficult to go from the typical process of seeing patients and dictating notes to suddenly using an EMR," Zelnick says. "That is a big, big step. Every organization that has taken that step in one leap has had a hard time getting physicians to accept the EMR."**

with diabetes, of course, but I did not realize that they comprised our most common office visit for a chronic disease.

"The computer enabled us to assess quickly our disease mix and prompted us to provide patient education and otherwise focus on the needs of this patient population," Zelnick continues. "In fact, we trained a nurse to become a diabetes educator. Given that we were located in a rural area, our patients would have had to travel 180 miles to diabetes classes. So we started teaching patients in our office because the data revealed that diabetes was a big problem in our practice."

Overall, using computer technology has contributed to Zelnick's professional satisfaction. "I enjoy coming to work every day because of the new challenges computer technology provides," he says. "There is always something new to work on. Once physicians start using these tools, they want more and better tools. So we try a lot of new things."

### **Improving Teamwork**

Computer technology enhances the spirit of teamwork in a practice. "Our electronic medical record has a flag system, which is like putting sticky notes on the charts and passing them around electronically," Zelnick explains. "We can easily flag a nurse to highlight a patient need. Office staff can easily flag us about a patient call. This function has increased the efficiency of everyone in the office—physicians, nurses, and other staff members—because we do not have to go through piles of paper messages or e-mail unattached to the chart. And the charts are never lost."

One of the often-promised goals of EMR companies is the paperless

office, and Zelnick believes these systems offer such potential. "We are getting close to having a paperless office," he says. "We are even scanning in all of our referral letters and other papers that come in from outside our practice. As a result, the amount of paper flow back and forth has diminished tremendously. In fact, we were able to cut our mailbox sizes in half. We had a record room that was full of big racks of records; we took all of the big shelves out and now the room is a lounge for the physicians. We've got couches and furniture in there and we put a big desk in the center with computer terminals so that people can sit down, answer their phone calls, read mail, check flags and charts, and most important, talk with each other. It's probably the best teaching environment in the whole office."

It is likely that there will always be a need for some paper in a medical practice, particularly for legal purposes, the physician admits. "We still keep paper charts, which are located in a locked room for compliance purposes," he says. "But they never leave that room. They don't have to, because there are only a few things that are going into the paper chart, such as signed copies of advanced directives."

### **Meeting New Challenges**

The challenge for Zelnick and his colleagues is to provide efficient, high-quality service to patients at the point of care. "Using the EMR, we can identify performance measures for chronic diseases such as diabetes or hypertension," he explains. "We are finding that the patients who have uncontrolled conditions are the same patients who have not been seen in the office for a long time. Our chal-

lenge is to determine how we can do a better job of reaching those people."

In recent years, the training of family physicians has changed significantly. "In many ways, we are faced with the same problem as the military academies: They need to train their cadets in the history of previous wars, but they do not want them to fight the last war. They want them to fight the next war," Zelnick says.

"In medicine, we are faced with a similar problem," Zelnick continues. "It is important to know where we have been in the past, but to train physicians to combat the medical priorities of the 1980s and 1990s is missing the point because new challenges arise constantly. For example, AIDS was not even recognized when I was in medical school. We thought ulcers were caused by too much stomach acid instead of an infectious disease. And now we have bioterrorism, and SARS; who knows what will come next? Medical knowledge and medical challenges will always be dynamic."

Today, training must incorporate some of the new challenges of medicine. "We now have a tremendous body of knowledge about what constitutes high-quality, cost-effective medicine, along with optimal care guidelines for many conditions," Zelnick points out. "The challenges are to be able to apply that knowledge effectively in a 15-minute office visit, and to keep up with new knowledge as it is developed. To meet these challenges effectively, it is essential that computer technology be properly incorporated into health delivery systems to improve patient care and outcomes in an efficient manner."

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

**"If physicians have a great system but do not use it correctly, it will not improve productivity," Zelnick says.**

# Crisis Requires Asset Protection

By Christopher R. Jarvis, MBA, and David B. Mandell, JD, MBA

**A**s professionals with many physician clients, we have been inundated with questions over the past few years regarding the malpractice insurance crisis. Doctors from all specialties nationwide have called seeking ways to reduce their malpractice premiums or to find alternatives to the traditional insurers.

Many of these doctors are frustrated because they are paying much more than they had previously paid or they are finding that liability insurance coverage is not even available in their market at any price. In this environment, these physicians are concerned about their practices and the risks they face in a litigious society.

Many organizations are working to address this insurance crisis by making changes in state or federal laws. This solution is problematic, not only because these changes take time, but also because some of the revisions being considered may not even solve

the problem in many locations. As such, it may be best for physicians to consider the actions they can take individually or as a part of a medical group to shield their assets and reduce the cost of insurance. Typically, we outline three strategies every physician should consider: First, make asset protection a priority; second, consider a captive insurance company; and third, evaluate risk-retention groups.

## **A Lawsuit Shield**

Regardless of the status of the malpractice insurance market, physicians should always consider asset protection an important part of their business and personal financial plans. We use the term "asset protection" to mean shielding the assets of the practice as well as the physicians' personal assets from all potential lawsuits, including malpractice claims.

At no time has this strategy been more important than now, during the current insurance crisis. Because premiums have become so expensive, many physicians are considering reducing their coverage from traditional limits. While doing so may make sense, it is only part of the equation: Any physician who decides to reduce his or her malpractice insurance coverage must also consider implementing an asset protection plan to protect both the value of the practice and the physician's personal wealth.

An ideal solution would reduce the cost of malpractice insurance, as well

as provide the same level of protection for the assets. It makes no sense to reduce coverage limits because premiums are expensive and then leave the assets of the practice and the physician exposed to lawsuits.

Although an in-depth discussion of the strategies asset protection professionals use is beyond the scope of this article, it is important to consider at least the following three tactics. Unquestionably, these strategies and tools must be implemented before a problem occurs. For this reason, it is important to engage in asset protection planning as early as possible.

## **Protecting Receivables**

One of the first strategies involves shielding the practice's most valuable asset: its accounts receivable. To do so, physicians can use a leveraging (or factoring) strategy. Often, using this strategy can create significantly more after-tax retirement wealth than would otherwise be the case and protect the accounts receivable from medical malpractice claims.

There are several ways to shield this asset. One involves taking a loan against the accounts receivable and investing the loan proceeds in an asset that is protected and grows in a way that is tax beneficial. To do so, the practice and the physicians would co-invest in a limited liability company. Depending on how the LLC operating agreement is drafted, there may be significant tax benefits, giving the physicians the opportunity to build retirement wealth if the loan

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**It may be best for physicians to consider the actions they can take individually or as a part of a medical group to shield their assets and reduce the cost of insurance.**

## **There is evidence that, by being protected and having lower coverage, physicians may become less desirable targets for lawsuits.**

terms can be negotiated at a reasonable level. The accounts receivable would be shielded by the lender's security interest in the receivables.

Another way to shield this asset is to sell the accounts receivable to a particular type of factoring company. Unlike the typical factoring firm, which makes money by buying the accounts receivable for less than the total owed, the factoring firm that physicians would use to shield their accounts receivable would offer a pass-through type of arrangement in which the physician group can set the purchase discount at whatever level it wants, within reasonable parameters, thereby shielding the accounts receivable because of the factoring company's ownership of the receivables.

### **Other Assets**

Another asset protection strategy involves shielding the practice's equipment or real estate, if any, by implementing an LLC that would own the real estate or equipment and lease back the assets to the practice. Because the practice would no longer own the equipment or real estate, lawsuits against the practice or any of the physicians would no longer threaten these assets.

Physicians can also protect personal assets through the provisions allowed under state and federal laws and by using legal entities, such as LLCs, family limited partnerships, and trusts. Each of these tools can play an important role in an asset protection plan.

By shielding the assets of the practice and their own personal assets, physicians gain a certain level of flex-

ibility. No longer financially exposed to a malpractice claim, they can lower coverage limits and benefit from reduced premiums. Further, there is evidence that, by being protected and having lower coverage, physicians may become less desirable targets for lawsuits.

### **Captive Insurers**

A captive insurance company is created by the physician owners of a medical group to insure the practice. Often, a CIC may use a third party or a fronting company to write the initial malpractice policies, which are then reinsured by the physicians' captive insurers. In this way, any profits on the insurance business, as well as the investment on the reserves, are held by a company ultimately owned by the physicians.

Under this scenario, the physicians could recapture a significant portion of their premium payments as well as receive compounded investment gains. Such recapture may be possible if the CIC is created under one of the tax provisions that give beneficial tax treatment to small insurers, particularly those created under Section 501(c)(15) or 831(b) of the Internal Revenue Code.

Consider, for example, the tax benefits that resulted when John Smith, MD (a hypothetical name) established a CIC. Smith is a successful physician who had been paying what he considered exorbitant malpractice premiums, particularly because he had not incurred a successful judgment against him in 20 years of practice. He reduced his third-party coverage and

made up the difference with a policy written by a CIC that he had established. The return on the reserves that the CIC holds could grow each year that Smith owns the insurer, providing him with another source of income when he wants to close the company.

### **Risk-Retention Groups**

Yet another asset protection strategy involves using a risk-retention group; RRGs are member-owned liability insurance companies. During the last liability crisis, Congress passed the Risk Retention Act of 1986 to allow industries of like kind to band together to create an insurer. Under this law, many insurance professionals are working with physicians to form RRGs for medical groups.

Often, RRGs can offer their members insurance coverage that costs less than what commercial insurers would charge. Or, they offer coverage at the same price that a commercial insurer would have charged if one had been available and willing to offer such insurance. In other words, RRGs provide a market for liability insurance in areas where such insurance is either unaffordable or unavailable at any cost. Also, if the malpractice RRG is a physician-owned company, it would be able to offer its insureds more control over their professional liability programs than a traditional insurer would provide.

—Readers interested in receiving a report from Jarvis & Mandell, LLC, What to Do About the Medical Malpractice Crisis, may call 800/554-7233. More information on physician practice strategies is available on our Web site (see page 16).

## **Often, risk reduction groups can offer their members insurance coverage that costs less than what commercial insurers would charge.**

**Individuals who had high CRP levels and low LDL cholesterol were at a higher risk for cardiovascular events than were those with high LDL cholesterol and low CRP levels, says researcher Paul Ridker, MD, of Brigham and Women's Hospital.**

(Continued from page 1)

women who were then tracked over eight years for incidence of heart attack, ischemic stroke, coronary revascularization, or death from cardiovascular causes. This study was the first large-scale examination that directly compared cholesterol levels and CRP as cardiovascular disease markers.

The analysis revealed at least two critical findings. "First, CRP level proved to be a stronger predictor of future vascular events than LDL cholesterol," Ridker says. "This held true for all cardiovascular events, including heart attacks, bypass surgeries, strokes, and cardiovascular deaths."

Second, the analysis showed that a patient's CRP level cannot be predicted based on his or her cholesterol level. "CRP and LDL cholesterol are only minimally correlated," Ridker explains. "Therefore, screening for both biologic markers will provide better information about cardiovascular disease risk than screening for either alone."

**Risk Stratification**

Not surprisingly, patients with high levels of both CRP and cholesterol were at highest risk of having a cardiovascular event, and patients with low levels of both CRP and cholesterol were at lowest risk. "But more

important, we determined that the individuals who had high CRP levels and low LDL cholesterol were at a higher risk for cardiovascular events than were those with high LDL cholesterol and low CRP levels," Ridker says. "This is a very controversial finding because the high CRP/low LDL patients are not currently being targeted for prevention, while the patients with high LDL and low CRP are receiving preventive care, despite being at a lower risk."

In the study population, 77% of all future vascular events occurred among individuals with LDL cholesterol levels that are currently considered acceptable (below 160 mg/dL), and 46% occurred among those with LDL cholesterol levels below 130 mg/dL. "By relying on LDL cholesterol levels alone to determine who should receive preventive therapies, we are clearly missing the great majority of future heart attacks," Ridker asserts.

Finally, the researchers demonstrated that CRP level adds more information about risk to that provided by an individual's Framingham risk score, a measure of risk that cardiologists use frequently.

Another recent study by Ridker and his colleagues was published in the Jan. 28 issue of *Circulation*. The

study showed that CRP has predictive value at all levels of a prediabetic syndrome (formerly known as "Syndrome X") that often requires management by a cardiologist. "The *Circulation* study demonstrates that C-reactive protein can be used to identify patients who have the metabolic syndrome," Ridker says. "Moreover, CRP is an excellent marker of cardiovascular risk among patients with the metabolic syndrome. These findings are crucial for cardiology care because they highlight a direct link between atherosclerosis, diabetes, arterial inflammation, and CRP levels."

**Implications**

CRP has long been identified as a marker for cardiovascular disease risk, but it has only recently been highlighted more broadly, particularly in the popular press. Altogether, Ridker and other researchers have published 19 large-scale prospective studies showing that CRP is a strong predictor of cardiovascular risk.

"Like any new concept, a new idea for screening and prevention requires confirmation in many different settings," Ridker says. "There is now overwhelming evidence that a patient's CRP level is highly predictive of future risk of heart attack and

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**When the results of a stress test and LDL cholesterol levels are normal, CRP may be a better way to pinpoint the individuals who might need preventive therapy, says Christie M. Ballantyne, MD, of Baylor College of Medicine.**

## AHA Outlines Role of CRP

**T**he American Heart Association in Dallas has set forth guidelines for using high-sensitivity C-reactive protein (CRP) assays to determine cardiovascular risk. The AHA (at [www.americanheart.org](http://www.americanheart.org)) issued the guidelines after noting that CRP has been shown to be a strong predictor of new and recurrent cardiovascular events.

The AHA suggests that if a person's cardiovascular risk score has been evaluated by a global risk assessment based on data from the Framingham Heart Study and is low (meaning the possibility of developing cardiovascular disease is less than 10% in 10 years), no CRP test is warranted immediately. If the risk score is in the intermediate range (of 10% to 20% in 10 years), such a test can help predict a cardiovascular and stroke event and help direct further evaluation and therapy. (The AHA emphasizes that the benefits of such therapy based on this strategy remain uncertain.) Finally, the AHA recommends that a person with a high-risk score (of greater than 20% in 10 years) or established heart disease or stroke should be treated intensively regardless of CRP levels.

The AHA also specifies that if the CRP level is lower than 1.0 mg/L, a person has a low risk of developing cardiovascular disease; if the CRP is between 1.0 and 3.0 mg/L, a person has an average risk, and if the CRP is higher than 3.0 mg/L, a person is at high risk. —DJN

(Continued from page 8)

stroke in both men and women." Based on such research, the American Heart Association has recognized CRP evaluation as a useful way to help physicians assess cardiovascular risk.

While there is evidence that CRP levels also predict recurrent coronary events and acute coronary ischemia, the main use of CRP will be to help identify patients who are at high risk of first-time cardiovascular events despite low cholesterol levels, Ridker explains. "Cardiologists can be critically useful in their communities because knowledge of prevention is transmitted from the cardiologists to the primary care physicians," he says.

Testing for CRP levels will certainly identify more people who need preventive care. "If 77% of all future heart attacks and strokes occur in people who have cholesterol levels below 160 mg/dL, we have to move beyond cholesterol evaluation as our only tool in determining who is a

high-risk patient and who is a low-risk patient," Ridker says.

Also, identifying a patient's CRP level can be a very effective tool cardiologists can use to motivate patients to make the lifestyle changes—such as losing weight, maintaining a healthy diet, getting exercise, and quitting smoking—that have been proven to reduce cardiovascular event rates.

In other analyses, Ridker and his colleagues have shown that CRP levels can be reduced through statin therapy. "We have just launched JUPITER, a 15,000-patient nationwide trial that is specifically designed to determine whether patients with a high CRP level but low LDL cholesterol can benefit from statin therapy," he comments. "This study has the potential to pivotally change national guidelines for statin therapy use."

If so, cardiologists may see a higher volume of patients over the next few years. "The implication of the CRP

data is that far more patients at risk for heart disease are going to be identified and will require cardiovascular evaluation," Ridker believes. "In addition, exciting new areas of research related to the ability of CRP to predict outcomes—even among patients who have survived myocardial infarction, as well as post-bypass and post-angioplasty patients—will directly impact cardiovascular care and treatment." If CRP is used to identify patients with the metabolic syndrome, those patients will require more aggressive care as well, Ridker comments.

### Predictive Value

Ballantyne believes that as assessment of risk for heart disease becomes more sophisticated, measuring CRP levels may become routine in targeted cardiac care. "The future of cardiology care may involve a strategy that starts with enhanced blood tests for risk assessment," he offers. "If those were abnormal, they would be followed by some type of imaging modality or noninvasive testing (such as exercise stress tests, stress echocardiograms, EBCT, or spiral CT scans for calcium evaluation) to further define risk. If the results of the noninvasive tests are abnormal, then cardiologists could move to a third level of assessment involving invasive testing to determine the need for revascularization."

Still, Ridker is quick to note that more research is needed before CRP levels can be used as sole justification for further diagnostic testing. "Whether or not it is appropriate to use CRP to drive other diagnostics is very unclear, and it would be inappropriate to have patients undergo catheterization or stress testing on the basis of an elevated CRP alone," he cautions.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

# Kaiser Shows How Computerized Systems Improve Efficiency, Cut Costs

By Richard L. Reece, MD, editor in chief

**K**aaiser Permanente, the largest nonprofit health system in the United States, is also a frontrunner in the industry in terms of developing, implementing, and promoting computerized systems that can improve the efficiency and lower the costs of care.

“One of the biggest benefits to a health care organization of larger scale is greater resources,” says George Halvorson, chairman and CEO of Kaiser Permanente, in Oakland. Prior to this position, Halvorson served as president and CEO at HealthPartners, a large integrated health system in Minneapolis. “While HealthPartners had \$20 million to \$30 million a year to spend on creating automated medical records, at Kaiser we have been spending \$200 million to \$300 million a year. The health plan has more than 8.5 million members, 128,000 employees, and 12,000 physicians. Halvorson and George Isham, MD, medical director and chief health officer of HealthPartners, have written *Epidemic of Care* (Jossey-Bass Publishers, in Hoboken, N.J. 2003).

## Commitment to Excellence

Regardless of where he has worked, Halvorson has been committed to improving health care, he says. “In particular, I want to help create a sup-

port system for physicians that provides them with all the relevant information about the patient’s care and needs, as well as information about best practices—all available instantaneously in the examination room,” he adds. “That was the dream I had in Minnesota. Kaiser Permanente had the same dream, and we are going to realize it at Kaiser Permanente. It is a major initiative and a major focus of my work.”

As many industry experts know, poor care and high costs are inextricably linked. In fact, one of the principal drivers of health care costs is simply poor care. “Two thirds of people with diabetes and 40% of heart attack victims get unsafe care,” Halvorson says. “The Institute of Medicine studies, the Wennberg studies, and the new Rand studies all make that point very well. I believe we can remedy many of those problems through computerized physician support systems.”

One way to control health care costs is to deploy complete information systems adroitly, Halvorson says. “Right now, health care is one of the only sectors in the U.S. economy that has not figured out a way to use computers to improve the product,” he asserts. “Kaiser’s pilot studies have shown that this can, in fact, be done. We are going to have an exciting cou-

ple of years as we implement these systems across the organization.”

A computerized physician support system will eventually operate in all Kaiser plans. “We have eight plans across 10 states, and we will roll the new physician support system out across the entire country,” says Halvorson. “We have been spending a lot of time figuring out exactly what should be rolled out. Kaiser has been going down this path for the better part of a decade and has ongoing pilots in four states that have been very successful. These are not complete systems; still, they have all been successful.”

## Decision Support

One pilot program in Ohio involving heart disease improves efficiency by providing physicians with information in the examination room on each heart patient. The system includes a computerized support system and identifies all prior care, current health status, and appropriate protocols.

“The goal of the system is very much like that of the systems architects use to help design homes: to let the architect be a more complete professional by creating computer support,” Halvorson observes. “The program helps physicians deliver care more efficiently because they do not

**“Right now, health care is one of the only sectors in the U.S. economy that has not figured out a way to use computers to improve the product. Kaiser’s pilot studies have shown that this can, in fact, be done.”**

**—George Halvorson, Kaiser Permanente**

have to remember exactly what needs to be done with each patient.” Using this system, Kaiser has improved quality. In four years, the program has cut the mortality rate of all three major types of heart disease by one third.

In a second pilot program, Kaiser has developed an automated system to help physicians manage care for patients with diabetes in Northern California. The program has helped to cut blindness as a complication of diabetes, thanks to systematic follow-up of early warning signs. “Robert Pearl, MD, has been a pioneering leader in that effort,” Halvorson adds.

A system at Kaiser’s Colorado health plan identifies a week ahead of surgery whether a patient has been taking a prescription that may have the side effect of thinning the blood, a side effect that would be dangerous during surgery. “The plan identifies those patients and then the physician works with a pharmacologist to get them on a different prescription for that time period prior to surgery,” explains Halvorson.

### **Physician-Directed Care**

“This system has reduced the number of complications from bleeding during surgery by 87% over two years,” the CEO continues. “This represents a commonsense application of information by very bright physicians. That’s the kind of tool that medicine needs. We’re going to invest a lot of money in putting that tool, and others like it, into play.”

The system supports the care of patients following a heart attack, coronary bypass surgery, or angioplasty. “The system offers reminders to physi-

cians to put these patients on beta blockers, aspirin, or other appropriate therapies,” Halvorson explains. “The system is also designed to compile a useful printout that can be given to patients when they leave the examination room. The printout provides information about specific diseases and identifies the next steps to be taken for the patient. This printout is helpful because a number of studies have shown that a patient’s memory tends to be fairly unreliable in such circumstances. If patients are asked to do five things, by the time they get to the parking lot, they remember only four. Thus, we are giving patients information about their own care, including, ultimately, several years’ worth of computerized access to their own complete medical records.” In addition to enhancing care quality, such systems can help physicians use their time more efficiently, Halvorson contends.

Eventually, Halvorson envisions a complete electronic medical record at the point of care that can enable physicians to determine optimal treatment, using the support system to identify protocols, guidelines, and best practices. “For example, when a physician prescribes a medication, the system will not only identify the most effective recommended dosage for that medication, but also whether that particular patient is taking other medications that might result in a harmful drug interaction,” he says. Adverse events related to medications are widely recognized to be a major factor causing costs to rise unnecessarily.

Another key factor driving up health care costs is delivering too much health care, such as care deliv-

ered in hospitals. Information systems can address such overtreatment by helping to provide patients with information about their conditions and treatment options. “Research has shown that if patients are given full information about all of their options and the possible outcomes of those options, patients on their own will make care decisions that tend to reduce the overuse of care,” Halvorson says. “Having better informed patients is going to help manage costs. It will also help improve quality of care. When patients have full information, they become members of the health care team, and that results in higher quality care.”

### **Using Best Practices**

Achieving support among staff for new processes of care, such as those often required when adopting new information systems, can be a challenge in any organization and particularly in one as large as Kaiser. But Halvorson finds that building support for new processes has not been a formidable obstacle to adopting new technology systems. “Each of the plans had its own personality and to some degree its own culture,” Halvorson notes. “That’s one of the strengths of our system. For example, the Hawaii plan has its own culture, which is to treat patients like family. But all regional plans approve and support the adoption of an electronic medical record.”

Such widespread support is due, in part, to the flexibility Kaiser affords each health plan while also promoting optimal care practices. “We know from the premium needed to support full benefits that our overall costs are

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**The system represents a commonsense application of information by very bright physicians, according to Halvorson: “That’s the kind of tool medicine needs, and we’re going to invest a lot of money in putting that tool, and others like it, into play.”**

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already currently lower than other plans by 5% to 10%, depending on the region," Halvorson explains. "We believe that as we implement best practices consistently, costs will continue to drop even as quality rises.

"Our analyses reveal that if we took the very best level of care in the system for heart care, diabetes care, and other conditions, and ran it across the entire system, our costs would drop by another \$300 million to \$400 million," Halvorson continues. "So I am certainly an advocate of implementing the best-care practices, and one of the easiest ways to achieve the best care is by having consistent approaches to care.

"Still, there is no place in the process for hard and fast rules, or for penalties for not following the rules," Halvorson continues. "Neither the plan nor our medical group leaders try to hamstring the doctors with mandatory protocols and guidelines. Certainly, we offer a lot of advice about protocols and guidelines, but the care decisions are up to the doctors. That's the only way to deal with a professional service."

A recent study in California showed that Kaiser physicians were more responsive to guidelines than physicians outside of the system, meaning doctors in other HMOs. The implication was that the Kaiser physicians were more trusting of the information they received about quality. "The reason is that the development of all our protocols and guidelines is completely and totally governed by the medical group," Halvorson says. "There is no plan involvement in developing the protocols, nor should there be. Most health plans develop protocols and then say to the doctors, 'This is the

protocol.' Kaiser doesn't do that. Kaiser and the medical group have created the Care Management Institute, a group of physicians who study medical evidence and determine the best care protocols. That information is disseminated as an advisory, and not as an edict, to other Kaiser Permanente physicians."

Best practices need not be forced on physicians, Halvorson asserts: "Just by disseminating advisory guidelines, Kaiser Permanente physicians have dramatically cut the incidence of blindness, kidney failure, and amputations in our population of patients with diabetes."

### Leveraging Size

Minnesota and California are characterized by big group practices, but across the nation about 80% of doctors are in groups of 10 or fewer, and 60% are in groups of five or fewer. Big groups may become more prevalent elsewhere in the country. "There are some real, functional advantages to a large group," Halvorson observes.

When best practices are stored on computerized systems, they are easily available to large groups, which may mean the groups will improve efficiency, lower care costs, and have better patient outcomes as a result. "Eventually, it will become obvious that statistically better outcomes are generated by large groups that have systematic approaches to care," Halvorson explains.

Smaller physician groups will begin to create virtual groups that will make them the functional equivalent of large group practices. "They will band together with electronic connectivity to accomplish some of the same protocol developments as accomplished

by some of the larger groups," Halvorson comments. "With greater interest in specialty cooperation, there is a high likelihood of small groups merging into some form of local care teams, even if they can't or won't merge into consolidated business entities. Eventually, we will see numerous examples of electronically interconnected care teams that create virtual medical groups."

Increasingly, employers will send business to the large groups or to groups that are interconnected in this way, Halvorson says. "Employers want the cost and quality results that large medical groups can offer," he adds. "If buyers can reduce their employees' sick days by contracting with that model, they are going to turn to nongroup physicians and say, 'How can you achieve the same goal?' The only way to achieve that goal is by creating a virtual medical group with electronic connectivity.

"In the past, physicians had to form a business entity to achieve some of these results," Halvorson continues. "But computers are going to give us connectivity and options that will let teams of physicians function together without having to merge."

As a result of the interconnectivity fostered by information technologies, physician groups will evolve from having a focus on vertical integration to one focused on horizontal integration, and information will help all groups succeed, Halvorson believes. "Information is extremely useful in health care, and the availability of that information is going to increase exponentially," he predicts.

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More practice strategies are available on our Web site (see page 16).*

**"We offer a lot of advice about protocols and guidelines, but the care decisions are up to the doctors," says Halvorson. "That's the only way to deal with a professional service."**

# Career Change May Open New Doors

By Bob Priddy and Lorne E. Weeks, MD

**T**he frustration many physicians are feeling in today's health care environment is spurring a large number of them to consider leaving the clinical practice of medicine. But just the idea of doing so makes many of these physicians feel guilty, a reaction that is understandable given that being a doctor is a profession they love and one they entered in a desire to serve others.

Any physician who is burdened with such guilt is not alone, at least according to the results of recent surveys. For example, a survey by the California Medical Association showed that 75% of the responding physicians had become less happy in their practices within the preceding five years. Another survey, by Merritt Hawkins & Associates, a physician search and consulting firm in Irving, Texas, showed that 60% of physicians over age 50 were planning to leave their present practices within three years.

The message is clear: U.S. physicians are frustrated by the growing hurdles of government intrusion,

angered by declining reimbursement, irritated by increasing reporting requirements, and tired of seeing more of their personal time going to administrative demands and paperwork.

## Changes to Consider

Consultants and advisers to physicians who have heard their complaints have also found that many physicians have no idea what they would be doing if they were not seeing patients every day. After many years of education, focused training, and practice, doctors feel as if they have painted themselves into a corner, even though the time was spent acquiring the skills and experience they once coveted.

Often, these physicians believe there are only a few narrow avenues open to them. One could, for example, be a sales representative for medical company or a medical director for a biotechnology firm. Or, one might, perhaps, work as an administrator for a managed care company. However, they rarely consider the broader career paths open to them.

For each physician considering a career move, determining the best steps to take is critical for making the move a success. Undoubtedly, taking the steps required to make a change can be difficult. Even so, here are some ideas that may help make the process more manageable.

First, any physician thinking about embarking on a new career should remember that we all find comfort in

what is familiar to us, so we are likely to be uncomfortable in the uncharted waters between the career we have known and the new one we are seeking. Many physicians have never been unemployed in their adult lives, so the concept of unemployment for a highly skilled and respected physician is often unthinkable and quite different from anything many physicians have ever experienced.

What's more, given the large numbers of physicians who are leaving practice today, doctors are being viewed by hiring companies as commodities even more so now than they were in the past. In other words: The market is not as welcoming to physicians as it once was.

## The Right Approach

But there are reasons to be optimistic when making a career change. With critical objective analysis and the right approach, physicians can find jobs they like even better than the ones they had previously. Consider the experience of Robert L. Cox, MD, who was once one of the most respected infectious disease specialists in Denver.

After health concerns sidelined him from practice, Cox began to ask himself what he could do next. He worked closely with career advisers to help him answer this question. "I tore apart my life and analyzed the things I liked most and the things I disliked the most," Cox told the *Denver*

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**After many years of education, focused training, and practice, doctors feel as if they have painted themselves into a corner, even though the time was spent acquiring the skills and experience they once coveted.**

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*Business Journal* in an article this summer. "It helped me determine the things I wanted to have in my future. I found that whatever I did in the future had to contain medicine, speaking, and travel, and so I looked at different opportunities that would allow me to combine those three."

During the data-gathering process with his career advisers, Cox revealed that he had long been interested in making presentations to groups. In other words, he believed he would enjoy transferring his vast medical knowledge and experience to interested listeners, and he thought if he could combine this work with travel to interesting places, he would have the ideal job.

Cox's advisers gathered objective data about him using the Birkman method, a career testing and assessment model designed for mid-career executives and professionals by Birkman International in Houston. This method is used to assess human potential and help enhance performance. The Birkman results for Cox reinforced what he was saying about his ability to communicate and teach, as well as his deep interest in medicine. As a result of this information, his advisers introduced him to experts who could help him shape his natural presentation skills into a polished and compelling style.

Earlier this year, Cox established BioForecasts, a company in Denver. He now speaks to both medical and nonmedical groups, helping audiences understand how developments in biomedicine will change the world, in terms of health, longevity, ethics, economics, and warfare.

While there were many jobs Cox could do, his new position is what he

loves and should be doing. "It's absolutely perfect for me," he told the *Journal*. "It gives me flexibility, and the stress level is lower and manageable. I can continue to do this as long as I want to."

### Data and Analysis

Cox's experience offers an example of what the best career advisers can do for their clients. In fact, the career counselors who are most effective will follow a continuum of client care that is modeled on the patient examination process exhibited in the SOAP model (an acronym for subjective and objective assessment, and plan).

First, the counselors will obtain subjective information from an interview with the client. Next, they will gather objective data using a tool such as the Birkman data-gathering method. While both of these data-mining tools are important, the objective tool can be used to help confirm the professional's assessment.

The Birkman method is one of the best ways to assess a client objectively. It helps a career adviser primarily by identifying what the client would ideally like to do and then translating that information into specific industries and job titles. By combining the objective data with the subjective evaluation, the career adviser obtains a clear assessment of the client's situation. Based on that assessment, the client works with the career adviser to develop an implementation plan.

Physicians relate well to the SOAP model because it is based on principles similar to those they have used daily throughout their careers in clinical practice. The model also is useful because it helps to keep the process focused and on track. To suggest an

analogy: Physician clients seeking career advice are like most patients in that they want immediate results and they prefer to begin implementing a "treatment" plan without delay.

By following the SOAP format, the most effective career advisers will help their clients focus on their present needs, while emphasizing the importance of diagnosing the problem before making a treatment decision. What's more, the SOAP format enables physicians to remain with the program of treatment while they evaluate the results of their decision.

### Seeking Positive Outcomes

For many physicians, moving from the known (a job they have held for many years) to the unknown (a new career) is extremely difficult. Some resent the fact that they have to pay for career advice or for help in finding a job. Yet, the reality is that most physicians do not know how to search for a job, to evaluate their career options, or to start down a new career path. What's more, after having paid for their career counseling, many physicians expect a guarantee of success. Unfortunately, finding a new career is like any other endeavor in life: There are no guarantees.

The most effective career advisers are likely to relate to physicians just as doctors relate to patients. In other words, as physicians do with their patients, career consultants make commitments to their clients that they will use their best efforts and all appropriate resources to help them reach their career objectives, but they can offer no guarantees that the outcome will be positive.

Interestingly, the career counseling business is changing in some of the

**After leaving his clinical practice, one physician started a new business making presentations to medical and nonmedical groups on how developments in biomedicine will change the world.**

## The best career counseling firms have a variety of expertise available to their clients, including legal, financial, and practice evaluation services.

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same ways that the practice of medicine is changing. For example, many physicians are now doing more than simply working to treat patients who are ill; some are taking a more active role in seeking to maintain the health of their patients by offering wellness services. Similarly, career advisers are looking to do more for their physician clients than simply offering advice on how to find a new job.

As a result, it makes sense for physicians to seek a career counseling firm that has expertise in many areas of specialization (such as medical school, residency, fellowship, private practice, academic medicine, corporate employment, nonclinical careers, retirement, and even postretirement). In fact, some of the best career counseling firms are becoming involved in many different aspects of a physician's practice (such as contracting, practice evaluation and management, and financial planning), as well as providing lawyers to offer legal services.

The case of one client (whom we will call Jane Doe, MD) exemplifies the range of services that are currently available to physicians who are seeking help from career counseling firms.

After completing her residency earlier this year, Doe was referred to a career counselor for an initial consultation. Subsequently, the legal affiliate of the career counselor's firm reviewed the contracts Doe had been offered. The financial advisers helped her develop a financial plan, and a specialist in practice evaluation and management represented her to med-

ical groups seeking to hire new physicians. Doe also met with a physician working for the career counseling firm, who provided advice and assistance as Doe makes the transition from residency to practice.

### Getting Results

Physicians seeking the advice of a career counselor do so for a variety of reasons. Some, like Doe, are seeking direction in their careers. Others may simply want to reenergize an existing practice, find a network of their peers to seek solutions to common problems, or voice their career frustrations. Some may want to move into a nonclinical role, or they may wish to plan for a satisfying career after their retirement. Career counselors should be able to provide all of these services.

There are two things that most physicians who go to a career counselor do not want. First, they do not want to have to pay an hourly rate for career consulting services, as many have done in the past. In other words, the physicians are willing to pay for results but they do not want to have to watch the meter run every time they call the counselor to ask a question. Today, the best career counseling firms charge their clients a fee that allows them to call at any time with a question at no extra charge.

Second, physicians do not want to have to shop for related counseling services; they want one-stop-shopping. In other words, if they find out during a meeting with a career adviser that they may need contract advice

before they can leave or change their practice environment, many would prefer not to have to stop working with their career counselor in order to shop for an attorney.

The best career counseling firms have such expertise available to their clients, as well as financial advice and practice evaluation services as needed.

The new career move for physicians doesn't need to be dramatic; for some, the change could involve remaining in clinical practice while adding some nonclinical pursuits as well. Chet Cedars, MD, a successful family practitioner in Denver, is a good example of someone who made some career changes after he recognized that the practice of medicine might not be leading him to a future in which he would feel comfortable. After meeting with a career adviser, Cedars made some career changes that allow him to practice part-time and serve as a health care consultant to physician groups and health care provider organizations that are introducing electronic medical records to their practices.

Cedars is like Cox and Doe in that—with the help of career counselors—these physicians have made a career change that is not only satisfying to them, but is also allowing them to pursue the medical career they should have based on their own wants and needs.

—More information on physician practice strategies is available on our Web site (see page 16).

**Physicians today may seek career counseling to help them reenergize an existing practice, find a network of their peers to seek solutions to common problems, or voice their career frustrations.**

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