

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

June 15, 2003

CONTENTS

Features

Commentary
Author Finds Primary
Care at Risk 3

Strategy
Hepatitis C Patients
Can Benefit From
Provider Education
Efforts 8

Interview
Strategic Changes
Can Help Boost
Entrepreneur's Job
Performance 13

Departments

Editorial
Court Ruling
Helps Increase
Access to Care 2

Practice Management
Internet Use Rising,
Report Says 6

Shortages Let Some Physicians Pick Ideal Jobs

For some physician specialists looking for new positions, grandiose inducements to accept employment have become routine in recent months, according to physician recruiters.

"Incentive packages have never been as rich or seductive as they are today," says Larry Stewart, president at Physician Search Group, Comp-Health, in Salt Lake City. Stewart has been working as a physician recruiter for 20 years.

As fed-up, demoralized, and disheartened doctors leave medical practice for other careers, retire, move, limit or change their practice patterns because of rising malpractice premiums, frivolous lawsuits, litigious patients, mountainous paperwork, government regulation, managed care oversight, Medicare cuts, and more, the voids they leave behind are producing uncommon advantages for other physicians, recruiters say.

Lucrative Incentives

"Opportunities for specialists are unprecedented, more than I've seen in 17 years in the physician recruitment business," says Carol Westfall, president, Cejka & Co., in St. Louis. "The demand for primary care is also robust but the lack of supply of candidates is not as severe."

Sky-high starting compensation, \$50,000 signing bonuses, training stipends, school loan forgiveness, mortgage assistance, car allowances, shortened partnership tracts, promises

of equipment purchases, reduced buy-in fees, and relocation allowances of as much as \$25,000 are just some of the lures used to attract physicians, experts say.

"Five or ten years ago, the most attractive recruiting incentive would have been reduced office rent and help with operating expenses," says Stewart. "Now those incentives are routine for the most in-demand specialists."

Almost 90% of U.S. hospitals are actively recruiting physicians, according to a 2002 survey of hospital recruitment trends by Merritt Hawkins & Associates (MHA), physician recruiters in Irving, Texas. Some 56% of those not actively recruiting planned to do so in the next six months. Hospitals rated radiologists as the most difficult specialists to recruit, followed by orthopedic surgeons, anesthesiologists, and cardiologists. Family practitioners were the easiest.

"Ninety-five percent of hospitals in the country would add another radiologist or cardiologist to their staffs if they could," reports MHA President James Merritt. "But there simply are not enough physicians to go around."

From 1998 to 2002, MHA saw a 23% increase in physician search requests, from 1,807 to 2,220. Most of those search requests were consistently and overwhelmingly for physicians to join group practices, followed by hospitals, solo practices, and partnerships.

Group practices and hospitals are

(Continued on page 10)

Court Ruling Helps Increase Access to Care

The U.S. Supreme Court ruling in April to let states pass laws forcing HMOs to open networks to doctors undermines a basic cost-control strategy that HMOs use to drive hard bargains with selected groups of physicians. It does so by allowing states to prohibit HMOs from limiting patient choice.

At one time, HMOs severely limited patient choice, but such tight controls have been losing favor for several years. In 1999, membership in HMOs had peaked at 81 million, and patients were moving out of tightly controlled plans into PPOs that gave them more choice and larger networks of physicians. Today, fewer than 80 million Americans belong to HMOs, while 110 million are in PPOs.

Traditional HMOs gained favor in the late 1980s by stressing low costs as a result of developing small networks of physicians and hospitals. HMOs asked gatekeeper physicians to control costs by, in some cases, paying them to limit patient access to care. But patients and physicians rebelled at such severe limits.

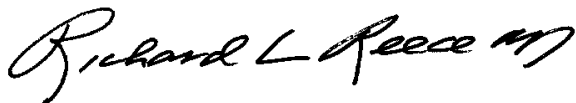
At the time, Regina Herzlinger, PhD, professor of business at Harvard Business School, commented that patients, physicians, and legislators were working together to make it impossible for managed care organizations to control costs by passing laws to restrict the ability of managed care to set limits. "The result is HMOs simply will not be able to compete as cost-effective organizations," she said. "They will have high administrative expenses and will become noncompetitive and fail."

As a result of the growth of PPOs and the enactment of laws that restrict the ability of HMOs to set limits, the issue went away, says Paul Ginsburg, an economist at the Center for Studying Health System Change, in Washington, D.C.

HMOs may be an economic success, but they are a political failure, comments James Robinson, PhD, a professor of public health at the University of California. "The strategy of giving with one hand while taking away with the other, of offering comprehensive benefits while restricting access through utilization review, has infuriated everyone involved," he wrote in JAMA.

Last year, Drew Altman, president of the Kaiser Family Foundation, succinctly put the matter in historical context: "We killed managed care, or evolved it into a form more tolerable for the American people. And nobody has a big idea, or a good idea, of what comes next."

Whatever comes next and whatever effect it will have on consumers and physicians, the Supreme Court's ruling has affirmed the right of patients to choose their own physicians.



Richard L. Reece, MD
 Editor in chief
 Phone: 860/395-1501
 Fax: 860/395-1512
 E-mail: Rreece@premierhealthcare.com

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher
 Premier Healthcare Resource, Inc.
 150 Washington St.
 Morristown, NJ 07960
 888/457-8800; Fax: 973/682-9077
 publisher@premierhealthcare.com

Editor
 Joseph Burns
 508/495-0246
 editor@premierhealthcare.com

Neil Baum, MD
Urologist
 New Orleans

Daniel Beckham
President
 The Beckham Co.
 Physician and Hospital Consultants
 Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
 Policy Planning Associates
 Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President
 Premier, Inc. and
 Premier Practice Management
 San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
 Minneapolis

Nathan Kaufman
President
 The Kaufman Group
 Division of Superior Consultant Co. Inc.
 Physician and Hospital Consultants
 San Diego

Paul H. Keckley
President and CEO
 webEBM
 Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
 Cap Gemini Ernst & Young
 Vienna, Va.

Richard Liliedahl, MD
National Director of Clinical Economics
 Ernst & Young
 San Diego, Calif.

John W. McDaniel
President and CEO
 Physician Management Group
 New Orleans, La.

Lee Newcomer, MD
Executive Vice President
 Vivius Inc.
 St. Louis Park, Minn.

James G. Nuckolls, MD
Medical Director
 Carilion Healthcare Corp.
 Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
 BAR Health Strategies
 New Brunswick, N.J.

Jacque Sokolov, MD
Chairman
 Sokolov Schwab Bennett
 Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
 Townsend Frew & Co., LLC
 Investment Banking
 Durham, N.C.

Author Finds Primary Care at Risk

By Richard L. Reece, MD, editor in chief

Under managed care, specialists seem to have more market clout than primary care physicians. In many cases, specialists get paid more, while the average pay for PCPs is typically among the lowest of all physicians. Yet, a new book by Fitzhugh Mullan, MD, emphasizes the importance of primary care and cautions that this critical sector of the industry is at risk.

"Over the years I have become a strong advocate for the policy and administrative medicine perspective of primary care," says Mullan. "In my opinion, any system of health care that is built on a firm foundation of primary care is going to be less expensive and more effective."

Mullan is the author of *Big Doctoring in America: Profiles of Primary Care* (University of California/Milbank Fund, New York, 2002). He is also a clinical professor of pediatrics and public health at George Washington University and a contributing editor to the journal *Health Affairs*.

An Unfriendly System

Trained as a pediatrician, Mullan spent 25 years in the U.S. Public Health Service and ran the National Health Service Corps from 1976 to 1981. Also, he served as director of the Bureau of Health Professions, the health profession's medical, nursing, and dental education unit in the federal Department of Health and Human Services from 1990 through 1995.

"When I retired in 1996, I wanted

to get back into practice and reclaim my stripes as a primary care practitioner and reconnect with the primary care community across the country," Mullan explains. He worked at the Children's National Medical Center in Washington, D.C., and at the Upper Cardozo Community Health Center in inner-city Washington. At about that time, he started interviewing PCPs, family physicians, internists, pediatricians, nurse practitioners, and physician assistants nationwide and recording the interviews on audiotape.

These interviews were designed to allow the clinicians to tell Mullan about themselves as people, as physicians, and as primary care providers. "The interviews were very interesting in terms of different practitioners' experiences, and they were very instructive in illuminating the world of primary care," Mullan notes. Of the 75 interviews he did, five were published in *JAMA* in 1998, and several others were published by *Medscape* in 1999.

For the book, Mullan arranged the interviews into five themes. "One theme is called the new GPs, representing the return to generalist medicine after the movement toward subspecialization that has occurred since the 1960s," Mullan explains. Another theme is the development of new practitioners, such as physician assistants and nurse practitioners. A third theme concerns system doctors, or physicians who have become very active with managed

care. The fourth is called "roots revisited," involving the generalist movements in internal medicine and pediatrics. The fifth theme is called "the Quixote factor," which involves physicians doing interesting and unusual work.

As a result of gathering so much oral history, Mullan provides a look forward. "I discuss in my book where the health care industry is headed and why primary care is essential to the system, but is at risk," he says.

Generalist vs. Specialist

Again and again, the book addresses the role of the generalist versus that of the specialist. The market-driven system common today is not friendly to PCPs, Mullan says.

"We have a very perplexing situation at the moment," he notes. "Unquestionably, medical science and our unfolding understanding of human biology are generating many exciting areas of highly refined clinical science. Specialization, which is a tendency in all areas of industry, is an important and useful way to deal with highly refined technologies that are intellectually and physically demanding. The problem is that when we allow the system to become increasingly fragmented, we have both relatively poor care at the center and a tendency to overuse the specialty modalities. Both of these results are inefficient and expensive, and ultimately result in poor patient care and poor population care."

Primary care practice involves

(Continued on page 4)

"In my opinion, any system of health care that is built on a firm foundation of primary care is going to be less expensive and more effective," Mullan says.

(Continued from page 3)

more traditional and more standardized interventions and medication than other specialties. “In many cases, care does not involve interventions and medications at all, but rather counsel, advice, and navigation,” Mullan points out. “These are key value-added functions. And, of course, there is no commercial sector that stands to benefit from that type of care. To rein in the hyper-inflation of our health care system that is partly caused by this very effective commercial sector in health care, we need a counterbalance that provides far greater support for primary care.” A good example is in medical education, where the emphasis is on specialty care. “Specialties are more lucrative, and frankly are perceived as an easier way of life,” he explains.

Population Health

In no way does Mullan intend to denigrate specialists or specialty training. “However, what keeps most people healthy most of the time is good general medical care: good public health, good water, good school systems, good income,” he asserts. “The most important factors in population health are health-related, but not necessarily the grist of day-to-day clinical practice. Within clinical practice, good prevention, good immunization, good anticipatory care, and good management of chronic diseases keep people alive and decrease the years of productive life lost.”

Much of clinical and specialty science addresses keeping patients alive longer or under better circumstances than they would be without such care. “Of course, this is the care that we all want,” Mullan concedes. “But

a market system that will pay for that care drives clinicians and patients to pursue highly specialized care that sometimes will improve health only marginally. We should certainly have access to such services. Still, unless and until we have a good primary care base at the center of the system, covering the whole population, we are going to be paying a high price for a somewhat ineffective form of health care delivery.”

A tendency to revere heroic interventions means the American culture has not emphasized and celebrated primary care. “Furthermore, the individualistic approach has been very potent for us in industry and in our economy,” Mullan comments. “Still, that approach does not necessarily add up to good medical care. The PCP is at the center of care, working in a somewhat less spectacular way than some of the specialists, and not being well rewarded for those efforts.”

Income Disparity

In particular, experts have found that for primary care, the overall income or reimbursement patterns under various insurance schemes are about half of what they are for specialists. “Put differently, the specialist is being paid at double the rate per hour as the generalist,” Mullan says. “We need to rectify that, starting with Medicare and followed by other insurance systems. For the immediate future, we need to hold specialists’ salaries constant and pay the generalists more.”

Moreover, the culture of U.S. medical schools needs to change, Mullan adds. “We need primary care to be more central to medical education,” he says. “We need more deans who

are PCPs by training. We need more department chairs who are generalists by background and identity.”

Also, the definition of primary care should be reengineered. “Primary care is a very complicated but very exciting area,” Mullan states. “Most primary care physicians today are running triple time and not doing particularly well in a financial sense. Someone I interviewed called this ‘hamster health care.’ The system has put PCPs in this position. To rectify this problem, a reengineering of primary care is necessary.”

The solo primary care practitioner is, at best, inefficient, the author opines. “He or she cannot manage all that needs to be done, and do it alone. Given all the information management necessary for care, PCPs need ready referrals, nurses, and nurse practitioners to work with; excellent medical information systems; and an electronic medical record. New paradigms, such as group visits and patient support groups, need to be part of the primary care of the future. Between the information revolution, which can really benefit the PCP, and restructuring the practice so that teams are created, primary care practice can be reengineered to be a more successful medical career, a high-tech, high-touch practice, with the PCP at the center.”

In particular, electronic medical records and integrated information systems are of significant value, Mullan says. “Many of us are a long way from an electronic medical record, but this is an area that will develop rapidly,” he says. “Primary care should be at the forefront of this movement because the record should be primary care-friendly, both for the quality of care for the individual patient in that practice setting and for

“Within clinical practice, good prevention, good immunization, good anticipatory care, and good management of chronic diseases keep people alive and decrease the years of productive life lost.”

the swift and accurate referral to other practitioners as necessary.”

Developing a primary care team also will enhance the quality and efficiency of primary care. “All kinds of configurations of teams exist, but certainly PCPs should form groups, especially when almost half of PCPs are female and are looking to balance work and home life,” Mullan says. “In addition, a group practice can become big enough to support a good front office staff, dieticians, and other kinds of providers. Integrated service delivery is where we are headed.”

Historical Factors

In his book, Mullan explains that in 1991, only 14.6% of medical students opted for primary care residencies. From that year forward, managed care began to grow rapidly, and health plans promoted the gatekeeper model. The number of medical students going into primary care rose as a result. Now, with the backlash against managed care, the gatekeeper model has become unpopular.

“When managed care was growing, the industry focused on having a strong primary care center,” Mullan explains. “But the most pernicious forms of the gatekeeping function—in which physicians were paid incentives to limit referrals, hospital utilization, and lab tests—put physicians in a very difficult conflict of interest. Also, some patients exhibited a general disgruntlement with the notion that they were going to be forced to follow a form of pattern referral.”

This interpretation of gatekeeping conflicts with a system in which the PCP is the preferred first stop for any patient, says Mullan. “Given that we have limited health care dollars, we

need to use them sensibly,” he notes. “Therefore, the best system will be managed in some fashion around primary care. Such systems are more successful in terms of containing costs and providing good service. The principle underlying a gatekeeper system is not that patients can’t tell when they need to see a specialist, but that in general most every-day conditions are well handled by a competent generalist. Therefore, referrals should occur only for care that cannot be well handled in that setting.”

One negative result of managed care is that it has given many patients the notion that primary care is managed care, and that is not a good thing, Mullan believes. “We need to reverse that thinking,” he asserts. “There are a variety of ways in which primary care can make its benefits and its presence felt, but it will involve a bit of a fight against public perception.”

Looking Ahead

Adversity, rather than smart collective planning, will shape a more sensible system, Mullan contends. “Our rate of growth in health care expenditures is not sustainable,” he says. “Our current economy is weak, partly due to disproportionate health care spending. We certainly lived through a period of irrational exuberance through the late 1990s when everyone believed the notion that we could have it all. But we are hitting hard economic times. More people are losing their health insurance; more people cannot afford health insurance; companies are laying off workers; and the ranks of the uninsured and the partially insured are growing. These circumstances will ultimately lead to a situation in which there will be

enough political pressure to undertake a major health care reform, a sensible one that will likely build on a primary care base with managed use of hospitals and specialists.”

To get through today’s difficult environment, Mullan encourages primary care physicians to recognize the value of their efforts. “The work they do is enormously important to the well-being of the individuals they care for,” he says. “In addition, primary care is an important symbol, an important tradition, and an important legacy. Many physicians are discouraged. They are retiring early or seeking other careers or telling their children to avoid a career in primary care. While understandable, these tendencies need to be put into perspective. PCPs need to take a stand for the work that they are doing, which is critical to a good and viable system.”

Furthermore, primary care physicians should not hesitate to become politically active, Mullan advises. “Activism, both individually and through their organizations, will help make primary care a central issue in health care reform,” he notes. “Physicians do not necessarily have to participate at a national level. Rather, they can help bring about changes that will upgrade primary care within their medical organizations and local organizations. Primary care physicians need to fight for equity both in perception and in reimbursement. Also, by becoming involved in teaching, PCPs can become role models and pass along the legacy of being a warrior in primary care.”

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

"Soon there will be enough political pressure to undertake a major health care reform, a sensible one that will likely build on a primary care base with managed use of hospitals and specialists."

Internet Use Rising, Report Says

The information physicians find online influences their medical decisions and the way they do business, according to a report by The Boston Consulting Group, consultants and researchers in Boston. The medical knowledge, diagnoses, and prescribing decisions of doctors are changing as e-health becomes widespread and professional use of the Internet increases, says the report. At the same time, e-health is affecting patients' expectations about the care they receive.

"Our survey revealed that doctors are turning to online patient care tools in greater numbers than before," the report says. "More important, they are being influenced in greater numbers by the information they find online."

Physicians and Patients

Published in January, *Vital Signs: E-Health in the United States* was based on a survey last year of about 400 physicians and 10,000 patients. E-health is altering health care by enhancing access to information and services, and by improving the quality, efficiency, accuracy, and the cost-effectiveness of physician practices, the report says.

"As e-health evolves, it is changing the economics, interrelationships, and competitive landscape in the industry, gradually but fundamentally," say the authors. "Health care players must keep pace with these changes by honing their strategies and experimenting with new ones. Rather than being viewed as a separate and distinct

channel, the Internet should be integrated closely with offline capabilities currently used to reach patients."

The use of some online tools for diagnosing, monitoring, and managing health conditions has grown beyond a core group of early adopters, says the report. Last year, two out of five physicians surveyed said they added at least one of three online tools—electronic prescribing, electronic medical records, and remote disease monitoring—to their practices. A fourth major tool is online communication with patients.

Professional Use

But the primary way physicians use the Internet is to gather information. Among physicians surveyed, 90% search the Internet for information about health-related topics. Physicians spend about three hours a week online for professional reasons. More than half of that time is at home, free from the distractions of the office.

Most physicians in the study (91%) reported that the information they find on the Internet increases their knowledge about symptoms, treatment options, and possible diagnoses. About three quarters (73%) reported that the information they find online has an effect on their prescribing decisions.

Two trends are causing physicians to use the Internet more frequently. First, virtually every physician engaged in patient care has access to the Web. The proportion of surveyed doctors who use Web-based technologies rose from 89% in 2001 to 96% in 2002, the report says. Among

physicians online, 99% use Internet-based technologies for professional reasons, and 60% spend at least one fifth of their time online for this purpose.

Second, physicians who use the Internet for professional reasons are getting more involved in it, the report says. The percentage of physicians attending virtual conferences went from 31% in 2001 to 42% last year, and the percentage taking online continuing education courses went from 45% in 2001 to 58% last year, the report says. Also, physicians have now begun using more disease- and specialty-specific Web sites rather than more general health sites, according to the report.

"These two trends make the Internet an increasingly relevant medium for reaching physicians, who are inundated with information," says the report. "Today, doctors are finding that simply hearing messages from health care players, much less choosing which ones to heed, is difficult and growing more so every day."

Electronic Prescribing

The fastest growing of all the patient-care tools is e-prescribing, which allows physicians to use Web-based technologies to check prescriptions automatically against drug formularies and potential interactions. In addition, some physicians use the Internet to send prescriptions to a pharmacy for fulfillment. The survey shows that the proportion of physicians writing prescriptions electronically rose from 11% in 2001 to 16% in 2002, and 21% of responding

As e-health continues to evolve, it is gradually but fundamentally changing the economics, interrelationships, and competitive landscape in health care, the report says.

physicians said they plan to implement e-prescribing by next year.

Many physicians using e-prescribing said it improves their compliance with drug formularies (82%) and the quality of care they deliver (79%). E-prescriptions help physicians reduce the number of queries from pharmacies about prescriptions that are illegible, were accidentally written for inappropriate or nonexistent dosages, threaten to interact with a patient's other medications, or are not covered by a health plan's formulary, the report says.

Electronic Medical Records

EMRs that capture patient medical histories, prescribing information, x-rays, and other data for physicians are the most widely used of all the patient-care tools. Among responding physicians using the Internet, 30% currently use EMRs, up from 22% in 2001. Moreover, 24% said they plan to adopt this tool by the middle of next year.

More than half of surveyed physicians (58%) use EMRs for the efficiencies that paperless systems offer, according to the report. "But efficiency has declined in comparison with physicians' other goals," say the authors. A high percentage of physicians reported they equipped their offices with EMRs primarily to meet mandates from managed care companies and group practices (89%), and to improve the quality of care (87%).

"By ensuring that the most complete patient-health information is instantly accessible, the tools enable physicians to treat patients more comprehensively by integrating care across illnesses and coordinating treatments and medications," says the report. Most physi-

cians who switched to EMRs have converted at least three quarters of their documents to EMRs.

Many physicians consider the cost of EMR systems to be prohibitive, however, and that perception remains a leading impediment to more widespread adoption of these programs. Among physician respondents, 44% of those who do not use EMRs cited cost as a factor. "For that reason, the tools tend to be used by physicians in practices with higher revenues, namely, specialists and larger practices," says the report.

Also hindering the adoption of widespread use of EMRs is uncertainty about regulations for the Health Insurance Portability and Accountability Act. "It remains to be seen how the regulations will affect the collection, sharing, and storage of medical data as well as how compliance with the federal rules will affect the delivery of patient care," says the report.

Disease Monitoring

Remote disease monitoring (RDM) uses technology to capture, report, and analyze patients' health data so that physicians and patients can have an active role in managing chronic conditions between office visits. Typically, physicians use these systems with patients whose symptoms require frequent monitoring, such as those with diabetes. Specifically, among the small percentage (7%) of responding physicians who were using RDM tools, most use them to monitor blood glucose levels. Blood pressure and pulse rate monitoring were the next most common uses.

Generally, patients report self-test-

ing results to their physicians. Among physicians using this tool, 93% said that it enables them to deliver better care, and 96% said that it improves patient satisfaction. "We expect RDM's exemplary performance to generate a buzz among physicians in the near future, which will in turn encourage more of them to adopt the tools," the report says.

Online Communication

The proportion of doctors currently communicating with patients over the Internet held steady at about 25%, from 2001 to 2002. "Growth has stalled because there are more physicians who are afraid of getting bogged down in Web communication than who view themselves as liberated by its enhanced reach and connectivity," the report says. "This fear has kept many from embracing or even experimenting with handling requests for drug refills, addressing queries about minor ailments, and providing other, less critical consultations online.

"To remain competitive, physicians must adjust their strategies as e-health evolves," says the report. "They must understand that e-health poses different kinds of opportunities and challenges to different types of organizations. We believe that as the influence of the online channel increases among doctors and patients, physicians should continue to add the Internet and Web-based technologies to their strategic and operational initiatives."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on physician practice strategies is available on our Web site (see page 16).

"By ensuring that the most complete patient-health information is instantly accessible, the tools enable physicians to treat patients more comprehensively by integrating care across illnesses and coordinating treatments and medications," says the report.

Hepatitis C Patients Can Benefit From Provider Education Efforts

Almost all patients require—and benefit from—some form of education about their medical condition, experts say; this is especially true for patients with hepatitis C.

Physicians who treat patients with hepatitis C must provide high-quality education so that newly diagnosed patients understand the nature and course of the disease, which can be complex and unpredictable. Educating patients about the disease can facilitate informed decisionmaking regarding whether therapy can help them manage the condition. The patients who are candidates for treatment also need to be educated about the risks and benefits of particular medications, and they may need assistance in learning how to use and become comfortable using injectable drugs.

The hepatitis C virus is the most common chronic blood-borne infection in the United States, according to the American Liver Foundation (ALF), in New York. Approximately four million Americans have the hepatitis C virus, and experts estimate that as much as 85% of those who are infected with the virus each year will develop chronic hepatitis C.

Risks and Benefits

“Patients with hepatitis C must clearly understand the risks and the potential benefits of treatment so that they can make informed deci-

sions about whether to pursue drug therapy,” says Robert Coli, MD. Coli is a gastroenterologist who practices in a two-physician, single-specialty practice; he is also a staff member of Kent County Hospital in Warwick, R.I.

The primary role of patient education about hepatitis C is to address the nature of the disease, says Howard J. Worman, MD, associate professor of medicine and anatomy and cell biology at Columbia University in New York. Worman is the author of *The Hepatitis C Sourcebook* (McGraw Hill/Contemporary Books, New York, 2002).

“Hepatitis C is not a death sentence,” Worman asserts. “Rather, it is a chronic disease that must be monitored and managed. Patients who are newly diagnosed with the condition have to realize that most people with hepatitis C do not suffer complications and do not die from the condition. For most people, the prognosis is good. Gastroenterologists and other physicians should emphasize this point during patient education efforts in order to provide the correct context in which patients should view their diagnosis.”

When explaining the disease to patients, physicians should help them understand how having chronic hepatitis C will affect them. “Because most patients will not develop cirrhosis or other complications of the disease, physicians should give patients a somewhat positive message

about the disease before they start talking about treatment,” Worman advises. “Patients have to understand that having chronic hepatitis C should not be affecting their day-to-day life, whether or not they are taking drugs for the condition.”

Being Realistic

Still, physicians need to be realistic when talking about the condition, especially since the course of the disease for each individual is often unpredictable. “A physician cannot predict that one patient will be fine in 80 years while another will have cirrhosis in 10 years,” Worman notes. Patients need to understand that the course of the disease in any individual patient will be uncertain, he adds.

What’s more, the toxicity of hepatitis C drugs can be a concern, Coli adds. “Potential side effects can be serious; they include bone marrow suppression, hemolytic anemia, depression, and hypothyroidism,” he says. “Because the drugs will not eradicate the virus in many patients, managing patient expectations for the outcome of drug therapy is crucial.”

Providing such a nuanced message can be time-consuming. “Physicians are very busy, and they do not always have time to educate their patients adequately,” states Worman. To address this situation, Worman suggests that physicians who treat many

(Continued on page 9)

For most patients with hepatitis C, the prognosis is good, a point that gastroenterologists and other physicians should emphasize during patient education efforts to help patients view their diagnosis in the correct context, says Howard J. Worman, MD, of Columbia University.

(Continued from page 8)

patients with hepatitis C may want to dedicate a nurse or a nurse practitioner to providing patient education and becoming familiar with the needs of individual patients.

Coli has found that community resources often may be available for patients who need education about the condition. “The nursing staff at the local hospital or a community health center, for example, can be an invaluable resource for patient education, particularly in training patients for the self-injection of interferon,” Coli explains. “In my practice, we also take advantage of the resources provided by the pharmaceutical companies, such as patient-friendly literature and toll-free telephone lines staffed by nurses.”

Maximizing Efficiency

Identifying reliable external resources is important in helping gastroenterologists—especially those in solo practices—to maximize their efficiency in providing patient education while ensuring that each patient receives the information he or she needs. “In an academic setting or in a large gastroenterology practice, the physician can handle the basic history and physical, order laboratory tests, review the lab tests, and discuss the condition with the patient,” Coli explains. “He or she can then turn the patient over to a physician assistant or a nurse practitioner, who can spend more time with the patient and explain in detail the condition and the potential side effects of therapy. For patients on drug therapy, the physician assistant or nurse practitioner can help ensure compliance

with therapy and monitor the patient for side effects. Unfortunately, the gastroenterologist in solo practice does not have this luxury.”

Patients who are candidates for drug therapy must be educated thoroughly so that they can make an informed decision about whether or not to begin therapy. “The treatments available today are suboptimal in that they work only about half the time, and they often cause unpleasant or dangerous side effects,” says Worman. “Patients must understand this fact before embarking on treatment. Some patients may decide to forgo treatment, based on the relative risks and benefits and on the speed of progression of their disease. The results of a liver biopsy can be helpful in deciding the need for early treatment. Educating patients about the treatments will facilitate discussion between them and their physicians concerning whether and when they should start drug therapy.”

Determining whether a patient is a good candidate for medication therapy is a complex decision and requires gathering and interpreting clinical, biochemical, and pathological data, Coli explains. “Therefore, patients need to be adequately educated, especially in the emerging era of consumer-driven health plans, so that they can become informed participants in the decisionmaking process,” he adds.

In fact, effective patient education can be especially important for those hepatitis C sufferers who decide to pursue drug therapy. Today, almost all doctors prescribe combination therapy with a peginterferon alfa and a rib-

avirin as the first-line treatment for hepatitis C, unless there is a contraindication, Worman explains.

The peginterferon alfas approved by the federal Food and Drug Administration include peginterferon alfa-2a (Pegasys) and peginterferon alfa-2b (Peg-Intron). Oral ribavirin for hepatitis C is sold under two brand names (Copegus and Rebetol). “Typically, peginterferon alfa-2a and Copegus are used together, while peginterferon alfa-2b and Rebetol are used together,” Worman explains.

In general, patients will administer weekly injections of the peginterferon alfas subcutaneously (accompanied by a dose of oral ribavirin). Peginterferon alfa-2a is available as a premixed solution for subcutaneous injection, while peginterferon alfa-2b must be reconstituted prior to injection.

Improving Compliance

Patients who decide to begin a drug regimen will need significant education about the particular drug’s risks, benefits, side effects, method of administration, and dosage. Studies have shown that patients who maintain a good understanding of these issues will be more likely to comply with therapy and thereby achieve better outcomes.

“While not all patients with hepatitis C need drug therapy, those who do must be compliant with their drug regimen in order to maximize the chances that the medication will improve their health,” Worman says.

Coli agrees, saying, “Patient education increases compliance because it

(Continued on page 12)

The nursing staff at a local hospital or a community health center, for example, can be an invaluable resource for educating patients with hepatitis C, particularly in training them for the self-injection of interferon, says gastroenterologist Robert Coli, MD.

(Continued from page 1)

bidding for a limited pool of available candidates, and hospitals, particularly nonprofit facilities, usually lose out of necessity to avoid conflicts with federal regulators. "The richer incentive packages are coming from group prac-

than men, according to well-publicized, peer-reviewed studies. Moreover, the schools produced only 1% more graduates from 1992 to 2001, while the U.S. population grew by 13% during that period.

U.S. residency or fellowship programs. Though other parts of the exam may be taken in foreign countries, the clinical skills portion requires IMGs to pay a \$1,200 fee and travel to Philadelphia or Atlanta

Almost 90% of U.S. hospitals are recruiting physicians, according to a 2002 survey by Merritt Hawkins & Associates.

tices," says Stewart.

One anecdotal report among physician recruiters involves a neurosurgeon in the Southeast who, with only five years of experience, obtained a guaranteed starting salary of \$800,000, nearly double the top starting salary for neurosurgeons nationally five years ago.

"A radiologist in the Midwest received an irresistible recruitment benefit of a \$3,000 monthly stipend, paid continuing medical education, and paid vacation time for 19 months during training in exchange for an employment commitment to work for a large practice," says Stewart. "A West Virginia group hired a gastroenterology fellow by offering him a yearly salary of \$350,000 plus a \$50,000 signing bonus."

Demographic Factors

Such offers are surprising considering the state of the economy. "The jump in physician salaries is somewhat unexpected with the recession, cost containment by Medicare and Medicaid, and private insurance cut-backs," observes Edward Salsberg, director of the Center for Health Work force Studies at the State University of New York at Albany.

In addition to disgruntled doctors, academic and demographic factors are also affecting the deficits of physicians. Currently, nearly 50% of medical school graduating classes are women, compared with rates of a decade ago when only 36% were women. Women work fewer hours

The shortage of residency candidates is exemplified by a 2002 survey conducted by the Society of Thoracic Surgeons (STS) in Chicago. Of 144 residency positions available for heart surgeons, 21 were unfilled early this year. Previously, there were several applicants for each slot. The number of applicants for general surgery residency programs also has slipped, by about 30% over the last nine years, according to studies published in the March 2002 issue of the *Archives of Surgery*.

Residency candidates are disinterested in general surgery because it requires years of training and long work hours that cut into personal time, research shows. Trainees are reluctant to join heart surgery programs because of reductions in reimbursement from Medicare, the cost of nurses and physician assistants, the rising cost of liability insurance, the need to repay steep tuition loans, and 60- to 80-hour workweeks, according to STS analyses. The society estimates that 50% of its heart surgeons will retire by 2010, while the numbers of those entering training are too low to replace them.

Filling the Gaps

International medical school graduates (IMGs) often fill gaps in physician supply, especially in rural communities. But that pipeline has dried up since the 1998 addition of a mandatory face-to-face clinical skills assessment portion to an exam required for certification to enter

to demonstrate English proficiency.

Before the clinical skills portion was added, 10,297 foreign graduates were certified in 1997 compared with an estimated 5,429 in 2002. "Changes in the number and characteristics of those seeking certification directly affect the graduate medical education population and the future physician work force in the United States," wrote authors of a report on the problem that appeared in the Sept. 4 issue of JAMA. Foreign medical school graduates make up one quarter of U.S. physicians.

Military doctors who complete obligations also helped to fill vacancies. But after the terrorist attacks of Sept. 11, 2001, their tours of duty were lengthened, says Kurt Mosley, MHA's vice president, business development. "A lot of doctors who were coming to us from the military had their commitment or separation dates extended after 9-11," he says.

Besides the lack of trainees and military candidates, the nation's population is aging, potentially requiring more medical care. Recruiters, such as MHA's Merritt, say the conditions involving physician supply and demand is akin to the perfect storm. In the past, shortages often were confined to rural areas. "Now hospitals in cities from Boston to Boise are looking for physicians," he comments. In 1998, the majority of MHA searches were for small communities. That trend reversed in 2002 when the largest number of searches involved organizations in communities of more than 100,000 residents.

Most striking is a recent survey by the San Diego County Medical Society, reported in the Feb. 3 issue of *AM News*. Recruiters say San Diego is one of the most desirable areas in the country because of its mild climate, and it has been largely immune to shortages. Yet, that city will soon experience a deficit of doctors as well. According to the survey, 35% of San Diego area doctors plan to stop practicing in the next three to five years. One third of those who plan to stay are cutting patient care hours. Among physicians who responded to the survey, 71% said recruiting new doctors was difficult; 26% of San Diego respondents aged 36 to 45 and 29% of those 45 to 55 said they would relocate, retire, or change professions in the next five years.

Last year, Richard Cooper, MD, and a team of researchers at the Health Policy Institute at the Medical College of Wisconsin in Milwaukee, predicted a dramatic shortage of 200,000 physicians by 2020. Officials at state medical associations and specialty societies have expressed similar alarm. "There's more water going out of the bathtub, than going in," comments MHA's Mosley.

A Glut or a Shortage?

Still, the AMA officials hold that there is no physician shortage. "From a national perspective, a shortage does not appear to exist," says an AMA spokesperson. "Between 1990 and 2001, the supply of physicians in the United States grew 35.9%, more than twice the growth rate for the U.S. population. During those years, only four specialties saw a drop in physician supply: general practice, general surgery, public health, and aerospace medicine."

And, as late as January 1996, the National Academy of Sciences was urging the United States to take immediate steps to cut residency funding and freeze medical school class sizes in fear of a glut. NAS has not produced a report on the subject since. However, one academy researcher, Ann Greiner, says predicting physician supply and demand is difficult. "There are too many factors involved, such as practice climate, the supply of foreign medical school graduates, federal policies, and the use of physician extenders," she notes.

Some analysts claim the United States has an insatiable desire for medical talent. The more abundance of physicians, the more citizens find a need for them. If the need for physicians can be filled, then experts raise the issue of distribution, and the question of true shortage versus maldistribution has always been controversial. "It's true more doctors live in desirable metropolitan areas but we also have an increased need for services all over," says Westfall. Recruiters, who used to accept physician shortages as being cyclical, are not so quick to call the current climate a passing phase.

CompHealth's Stewart says, "The specialties are growing astronomically and unpredictably."

And, adds Westfall, "Everyone wants to know if this is temporary. I don't see it going away in the short term, in the next three to five years. Training programs have not expanded their capacity to match the demand for specialists. Even when they do, it will take years to train a new crop of doctors."

Moreover, an exodus out of practice could continue. One in six physicians is somewhat or very

unsatisfied with his or her career, reported researchers of a study released in January by the Harvard Medical School and the Center for Studying Health System Change in Washington, D.C.

For the moment, recruiters scramble to fill jobs that go wanting, some 18 months and longer. "I wish the AMA would tell us where the oversupply is," Stewart says. Search specialists at Cejka & Co. are making a lot more cold calls, even to retired doctors. One Southwest surgeon contacted by the firm had been retired for three years. He missed medicine but didn't know how to get back in. The surgeon wound up accepting a \$200,000 position with a two-man group that ideally wanted a resident.

In 1998, MHA's top request was for family practitioners and internists. By 2002, it became radiology, cardiology, orthopedic surgery, and internal medicine. "The situation is pretty dire in states where malpractice is a serious issue, such as New Jersey, Nevada, West Virginia, and Pennsylvania," says Mosley. "In the last six months in West Virginia, one hospital paid an orthopedic surgeon a \$50,000 signing bonus and \$50,000 for loan forgiveness," he relates. "Five or ten years ago, a top signing bonus would have been \$15,000."

Groups or hospitals offering doctors below-market rates will not fill their positions, says Michael Lindsey, senior vice president, permanent placement, Medical Doctor Associates, in Norcross, Ga. "Residents get 40 calls daily from recruiters," he says. "They can pick and choose their situation."

—Reported and written by Maureen Glabman, in Miami. More information on physician practice strategies is available on our Web site (see page 16).

"I wish the AMA would tell us where the oversupply is," says Larry Stewart of CompHealth.

Patient Education Resources

For many physicians seeking to educate their patients with hepatitis C about their condition, using published materials can be helpful, as is referring patients to reliable Internet sites, say gastroenterologists Robert Coli, MD, and Howard J. Worman, MD.

"I give patients with hepatitis C literature that is written at the patient level," Coli explains. "I even give them medical literature after they have read the preliminary literature."

Information from reliable sources, such as the American Liver Foundation (ALF), in New York, and Hepatitis Foundation International, in Silver Spring, Md., can provide patients with excellent general education about hepatitis C, thereby reducing the time physicians would otherwise need to spend educating them about their condition.

The ALF, for example, is a reputable source of information for patients with hepatitis C. The foundation's Web site (at www.liverfoundation.org) provides patient-friendly articles about the disease, information about clinical trials, interviews with expert physicians, success stories from patients, and links to other reliable sites.

Similarly, the National Center for Infectious Diseases, a division of the federal Centers for Disease Control and Prevention, in Atlanta, provides patient educational materials about hepatitis C on its Web site (at www.cdc.gov). The site also provides other materials, such as brochures, slide sets, and posters, for physicians to use in their education efforts.

Coli recommends *Hepatitis Magazine* (at www.hepatitismag.com). The online version of the magazine offers articles, news briefs, book reviews, links to support groups, and stories about people (including celebrities) who have been coping with hepatitis C effectively.

Other sources of information for patients with hepatitis include the Hepatitis Information Network, or HepNet (at www.hepnet.com), the federal Department of Veterans Affairs (at www.va.gov/hepatitisc/), the Hepatitis Foundation International (at www.hepfi.org/), and the National Institute of Diabetes & Digestive & Kidney Diseases (at www.niddk.nih.gov/). As with all Web sites, physicians are advised to review these and other sites prior to making recommendations to patients.

—DJN

(Continued from page 9)

leads to a more informed and cooperative patient."

Patients who must self-administer injectable drugs need to be thoroughly educated about their treatment. "Having a nurse dedicated to teaching patients how to inject themselves with medication and who is available to address their concerns can help them become more comfortable with these drugs," Worman says. "Physicians who treat only small numbers of patients with hepatitis C can fill this role them-

selves. Either way, there must be thoughtful interaction between a health care professional and a patient who will be using these drugs."

It may be somewhat easier for patients to comply with injectable drug regimens when they can use a drug solution rather than a drug that must be reconstituted. "However, most patients are intelligent enough to learn how to reconstitute and draw up the drug, if they are properly educated," Worman says.

Coli believes that it is easier for patients to comply with drug therapy when they can use an injectable solution rather than an injectable that must be reconstituted. "Injectable solutions are also easier to administer than drugs administered via IV infusion, which is inconvenient and costly," he says. "A single dose in a single injectable device is the ideal way to maximize compliance."

Some specialty drug distributors (which receive faxed prescriptions from physicians and then mail patients their drugs) have toll-free help lines to assist patients who have questions about using injectable medications. Manufacturers of hepatitis C drugs also have patient help lines. Such assistance can relieve pressure on busy physicians by providing medical professionals who can educate patients about their medication or make referrals for patients who need further assistance.

The Internet is also a significant resource for patients with hepatitis C, Coli asserts. "Patients can learn as much as they want to about their condition just by sitting in front of their computer," he says. "Patients who are bright and motivated can learn to understand their condition in detail, and generate questions to bring to their physicians. Physicians who welcome these questions are more likely to build rapport with patients, who are then able to better manage their condition."

While many sources are available to help physicians become more efficient by providing basic information for patients, patients still are likely to rely on their doctors to provide education that is more complex and individualized. "Only the physician can answer questions about a patient's specific situation and prognosis," Worman notes.

—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).

Strategic Changes Can Help Boost Entrepreneur's Job Performance



Michael E. Gerber is the founder and CEO of E-Myth Worldwide, a business consultancy in Santa Rosa, Calif., and the author of *The E-Myth Physician: Why Most Medical Practices*

Don't Work and What to Do About It (New York: HarperBusiness, 2003). He has worked with many small business owners, including many medical professionals, to help them improve the productivity and success of their businesses. Gerber discussed his ideas for physicians with Richard L. Reece, MD, editor in chief.

Q: Let's begin by clarifying that the "e" in the title of your new book, *The E-Myth Physician*, stands for entrepreneurial, not electronic.

A: That is correct. I am referring to the entrepreneurial myth, which is essentially the myth that most people who start small businesses are entrepreneurs. In fact, an individual may understand the technical work of a business—such as a doctor understanding how to practice medicine—but may not automatically be able to run that business successfully.

Most medical practices today are not necessarily going out of business, but many are failing to fulfill the potential that the physicians had envisioned as students in medical

school. In fact, most doctors who own their own practices don't really own a business. Instead, they have created a job at which they are working constantly, hoping to be able to take some time off. But, they don't know how their practice would run without them.

Q: In your book, you identify two kinds of doctors: those who own their practices and those who work for HMOs or insurance companies. Is the book directed at the first group?

A: Yes. My book is directed toward physicians who are small business owners. Most of these physicians are either in solo practice or in small medical groups. These physicians are like members of every profession: They believe their profession is unique; they believe the circumstances their profession faces are unique; and they believe their problems are unique.

Doctors do not tend to think of themselves as business owners. They think of themselves as medical professionals, which is obviously what they are. The problem they encounter in thinking of themselves as medical professionals and not as small business owners is that they suffer from many frustrations related to their lack of business knowledge. They don't want to run a business; they want to treat people. But, they are, after all, in the *business* of treating people.

The purpose of *The E-Myth Physician* is to help doctors under-

stand that the main obstacle to their having a successful medical practice is that they were never taught the business skills necessary to run their practices well. Medical schools teach doctors to become great medical practitioners but offer little or no guidance on the multiple nonmedical proficiencies required to build a thriving medical enterprise.

Compounding the problem is that many physicians have made a fatal assumption; they think: "If I know how to provide medical care, I can practice medicine and live a successful life forever after." But there are many critical roles that must be learned in order to have a successful medical practice. Physicians must be business managers, not just clinical technicians.

Q: Do most doctors practice medicine simply as technicians?

A: Many doctors say, "I'm not going to work in the hospital anymore; I'm not going to work in this group anymore; I'm going to go out and start my own practice. I will do things my way." But they may not understand how a practice must become an emerging business in order to flourish.

Basically, a medical practice can be viewed in three ways. First it is a practice. Second, it must become a business. Third, it has the potential to become an enterprise. For the practice to become an enterprise, the physician must have a business

(Continued on page 14)

"There are many critical roles that physicians must learn in order to have a successful medical practice. Physicians must be business managers, not just clinical technicians."

(Continued from page 13)

model that will allow it to flourish.

As more medical practitioners become entrepreneurial, the health care industry will become more competitive. This trend will lead to improvements not only in how physicians do business, but also in the medical services they provide.

In fact, as the world of medicine changes, it will become more difficult for doctors to continue to run their businesses the way they have been and not lose market share.

Q: So, doctors need to change their business model and their way of thinking?

A: Yes. Until doctors change the way they think, they will never change what they do. Successful business owners must have clarity of vision. Most medical practices have no vision, and without vision, the overwhelming experience of everyone in that medical practice is what I call the “tyranny of routine”: “Doing it, doing it, doing it.”

Q: Can you give an example of a physician who developed a vision and implemented it?

A: In my book, I describe a physician who thought about what he wanted his practice to be, and he stated his vision in his mission statement, which was this: “We will be on time every time exactly as promised or we will pay for your visit.” He went about fulfilling that mission and that vision, and he enlisted the help of his staff to be on time every time.

This physician’s vision is stunningly original. Given the reality of a medical practice, most patients know they have to wait to see the doctor. In my book, I talk about the phe-

Asking Key Questions Helps to Improve Results

Great managers ask key questions that help to define the results they intend to achieve with the support of their staff, says author Michael E. Gerber of E-Myth Worldwide, a consulting firm in Santa Rosa, Calif. The questions are:

- What is the result we intend to produce?
- Are we looking to produce that result every time?
- How can we produce even better results?
- Do we lack systems in certain areas of our business?
- If we lack certain systems, what would those systems look like if we were to create them?
- If we have a system, why aren’t we using it?

—DJN

nomenon of the waiting room experience, which is about as dehumanizing as any experience can be. Patients make an appointment to see the doctor, knowing that it isn’t a real appointment because, in many cases, the doctor doesn’t see the patients until the doctor is ready. Essentially, this says to the doctor’s patients, “You don’t matter. I do.”

If I were an entrepreneur who wanted to create medical practices, I would examine solo medical practices and look for key opportunities to differentiate my practice from everyone else’s practice. The first promise I would make is to be on time. In essence, physicians should look for patient-friendly ways to practice the business of medicine.

Q: Is boutique medicine an example of this type of differentiation?

A: Absolutely. Physicians who are offering this type of care are dropping out completely of typi-

cal organizations. They are promising their patients that they will be available 24 hours a day and that they will navigate their patients through the complicated maze of health care.

Although boutique medicine is an example of entrepreneurial differentiation, it is not necessarily an efficient or effective model. Although the physicians may promise to be available 24 hours a day, they still have to figure out how to deliver the services to their patients. Boutique medicine may be better than the typical dehumanizing health care experience, but it’s still not good enough.

Q: To be successful in any entrepreneurial venture, entrepreneurs must first develop a business plan. And yet, doctors often don’t do so, do they?

A: No. They hire a consultant to do that for them. Physicians will abdicate—rather than delegate—accountability for developing such a plan.

“As more medical practitioners become entrepreneurial, the health care industry will become more competitive. This trend will lead to improvements not only in how physicians do business, but also in the medical services they provide.”

How to Improve Physician-Patient Communication

One step physicians can take to help eliminate patient dissatisfaction is to always listen to—and never interrupt—their patients, says Michael E. Gerber of E-Myth Worldwide, a consulting firm in Santa Rosa, Calif. He also suggests that physicians ask themselves the following questions in order to improve their communication with patients:

- How do I greet my patients?
- Do I know my patients' names?
- Do I know what the experiences of my patients are?
- How do I interact with my patients?
- Can I improve this interaction?
- Have I organized my practice around health awareness and development?

These types of questions can help physicians focus on how they interact with their patients, which can improve patient satisfaction and help eliminate patient dissatisfaction, Gerber says.

—DJN

The problem with professionals is that they believe in professionals, so they go out and hire professionals to help them do something that is distasteful to them or uncomfortable for them. This way, they never learn anything about what they are hiring the professionals to do. They never, in fact, believe that it is truly important for them to understand what strategy is, what tactics are, what systems are, how marketing works, how management works, how increased productivity works, how people work, and how people can be inspired so that they are engaged in a productive way.

Basically, strategic planning in a medical practice has three core components that comprise, what I call “the planning triangle.” These are the business plan, the practice plan, and the completion plan. The business plan determines who you are, the practice plan determines what you do, and the completion plan determines how you do it.

Q: What advice can you give physicians regarding how to manage their staff?

A: As businesspeople, physicians need to both train and inspire their staff. To accomplish this goal, physicians need to build systems that not only support their staff, but also empower the staff to develop in such a way that they can produce significantly better results than their own personal skills and experience would enable them to do on their own.

Great personnel management involves a great management system. Management isn't about controlling people. It's about managing a system through which results are achieved. Systems allow the physician's staff to know what results they are accountable for achieving; they don't have to guess.

Q: How should physicians, as businesspeople, handle patient dissatisfaction?

A: The best way to deal with patient dissatisfaction is to avoid it in the first place—if at all possible. The key to doing so is simple: Just keep promises that have been made. What's more, physicians should try to make certain

every step of the way that their patients know that they have kept their promises.

Q: Your book also offers a section on the fundamental processes that occur in a medical practice. How can these processes be improved?

A: These processes, such as on-time scheduling, are fundamental, but they are often forgotten. Or, they become too mechanical. Physicians need to focus on finding extraordinary ways to do all of these things. For example, when was the last time patients walked into their doctor's office and saw a vase of fresh flowers? Physicians are not focused on the effect of such heartening things that help enliven the experience for patients.

Q: How can physicians take charge of their businesses?

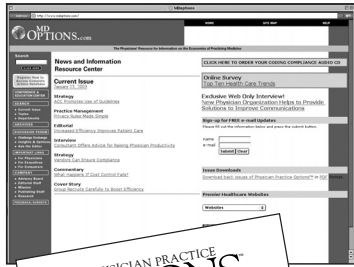
A: There are many things that they can do; here are a few. Independent physicians must recognize that they aren't simply working for their own personal income. They are also working for the equity and value of their business as a whole. Physicians must simply become more entrepreneurial about their practices.

Instead of keeping a distance between themselves and the work of the office manager, doctors should continually keep the manager well informed of their vision and ideas so that the manager can innovate, quantify, orchestrate, and monitor all systems through which the practice produces results.

Most important, physicians must develop a plan. I can't stress this enough. Without a plan, without a charted route, doctors won't be able to implement their vision with any clarity. The vision defines the plan, and the plan defines the steps involved in achieving that goal.

—Edited by Deborah J. Neveleff, in *North Potomac, Md.* Gerber can be contacted at www.e-myth.com/physician. More information on physician practice strategies is available on our Web site (see page 16).

MD
OPTIONS.com



Our FREE online resource includes:

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as group purchasing, practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™


E-MAIL UPDATES

Let MDOPTIONS.com come to you! MDOPTIONS.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

Name: _____

E-mail: _____

PHYSICIAN PRACTICE OPTIONS™

 Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PRSR STD
U.S. POSTAGE
PAID
Permit No. 664
S.HACKENSACK,NJ