

PHYSICIAN PRACTICE OPTIONS™

September 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Physician Finds Extenders Increase Efficiency, But Bring Criticism as Well

In a decade when some physicians have been forced to become creative to survive competitive pressures, one could say David Giammittorio, MD, an obstetrician-gynecologist in Alexandria, Va., is a survivor. "It's not the strong who survive; it's the adaptable," he says.

Long before *The Wall Street Journal* asked in a 1996 headline, "Is the Male Gynecologist Vanishing?," Dr. G, as he is known, had already mitigated the effects of the shift toward female practitioners by hiring four female certified nurse midwives (CNMs). He was among the first physicians in the 1990s to develop a site on the World Wide Web promoting his office, called Physicians and Midwives. Now he has a new business idea involving midwives that may catch on as well.

Dr. G has experienced so much success with CNMs, he is introducing their services to other practices and this introduction has led him to acquire practices as well. The process begins when he leases a midwife to another practice. In 1997, he merged with one practice that had leased a midwife, and this summer Dr. G plans to merge with another such practice.

Before he started employing midwives in 1991, Dr. G worked as a solo practitioner and delivered about 100 babies annually. With the use of midwives, he found he could deliver twice that number. "In our area, a single obstetrician delivers 100 babies a year," he says. "Matched with midwives, it doubles our effectiveness." Today his group of two board-certified ob-gyns and six CNMs deliver more babies at Inova Alexandria Hospital than any other group.

In the practice, 70% of the revenue comes from obstetrics and 30% is from gynecology.

Physician Complaints

Dr. G's use of midwives has not endeared him to his obstetrician colleagues. Several answered "no comment" when asked about Dr. G's practice. Two who agreed to speak if their names were not used said that because Dr. G uses CNM-physician extenders, he can have a high-volume practice that accepts the lowest fees from managed care companies. His practice thereby undercuts the practices of other obstetricians who can't afford to take on a low-risk obstetrician case for a global rate of \$1,500, when \$2,000 is common in the region. "He is not a team player," said one.

In a health care climate increasingly shaped by health care costs, CNMs, who earn about \$70,000 annually, are seen as an effective way to provide high-quality maternity care for half the cost of a physician. "We made a positive change in the way we practice because we were spurred on in part by the changes in the medical care system," Dr. G says. Craig Winkel, MD, chairman of the ob-gyn department at Georgetown University Medical School, adds, "Economically it makes sense."

More than economics, though, Dr. G argues midwives deliver better patient care. "They are very good at handholding, and that's no skill to be scoffed at," he says. In his practice, midwives are booked at a more leisurely pace than are physicians, allowing the CNMs to spend more time with jittery patients, listening to

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To Serve the Uninsured, Physician Suggests a Simple Plan

What can physicians do to solve the problem of providing care for 43 million uninsured Americans? These 43 million represent 17.6% of the population and most are not the poorest of the poor, who tend to be covered by Medicaid. Approximately 75% work part-time, but are not offered insurance through their employer. If insurance is offered, it may come at a cost they choose not to pay, according to *The New York Times*. As the cost of health care rises sharply this year, more Americans will be left without health insurance.

Seeking to address this abysmal situation, David McDonald, MD, a family practitioner in a three-physician primary care group in Renton, Wash., formed the American Association of Patients and Providers (AAPP), which has developed a solution of its own. Three years ago, the group launched a plan called SimpleCare.

The AAPP says as much as one-third of the high cost of health care can be attributed to the overhead required for billing insurers, a problem managed care has exacerbated. Under the SimpleCare program, participating physicians would give participating patients a lower price in return for a cash payment at the time of service.

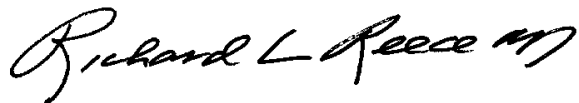
"Many patients would pay 30% to 50% less when the administrative burden is removed from the equation," according to the SimpleCare plan. "Without the administrative red tape, providers have more quality time to spend on each patient's health care needs."

For a family practice in Renton, for example, a typical insurance charge of \$79 would include the cost of billing, rebilling, and complying with regulatory requirements. This charge can be cut to \$35 to \$45 when a patient pays for the service at the time of service, according to the SimpleCare plan. Physicians would charge \$35 for a short visit of no more than 10 minutes, \$65 for a visit of as much as 20 minutes, and \$95 for visit of an hour. The program would work best for those people who have catastrophic health insurance coverage or who are in a medical savings account, the AAPP says.

While few patients without insurance can afford individual policies or high monthly premiums, many can afford to pay a discounted fee for a valued service. The benefits for patients are many. They are free to choose their own physicians, they don't have to worry about paying more for pre-existing conditions, and all services are covered.

Physicians would realize increased cash flow and expenses would fall as a result of fewer administrative requirements, AAPP says. What's more, the plan puts health care providers back in charge of the care delivery system by allowing them to set a reasonable fee for professional services and to get paid quickly and without the administrative hassles of billing insurers, many of which are notoriously slow to pay.

SimpleCare is not a universal answer for the problems of the working uninsured, but it's a start, and the benefits for physicians are difficult to ignore. In addition to improving cash flow, physicians experience less trouble with insurers, and they are back in charge of the health care system. For physicians, this last benefit may be the most appealing of all. To learn more, visit www.aapp.net or www.simplecare.com.



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

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Groups Find New Value in Administrators

Many medical groups hire office managers or practice administrators to free physicians from having to manage administrative and other business tasks necessary to run a practice successfully. By handling nearly all nonclinical activities, a good office manager or practice administrator can give physicians the time needed to concentrate on clinical issues, see more patients, and generate more revenue.

As physicians sign complicated prepaid managed care contracts and physician practice management companies have failed or downsized in the last year, the demand for talented office managers and practice administrators with strong management and financial skills is growing, experts say. Given that nearly 87% of the nation's employees are enrolled in some form of managed care plan, physicians need to be able to predict expenditures accurately and often handle a significant amount of preauthorization and reimbursement-related paperwork that comes with contracting with managed care plans. "Office managers and practice administrators who can handle these problems are in demand, and their pay is increasing," explains Cheryl Toth, a practice management consultant with Karen Zupko & Associates, health care management consultants in Chicago.

To be effective, an office manager or practice administrator also must be able to manage the physicians he or she works for, and doing so successfully requires diplomacy, says William Tetreault, MD, a member of the board of directors of CapitalCare Medical Group in Colonie, N.Y., a group that has a practice administrator to manage its 15 locations and 197 employees. "It takes talent to work with respected, intelligent doctors, who are not trained to be managers but are used to being their own bosses," Tetreault says. "You have to try to explain to them that they might not be the best person to run their business."

Experts familiar with the work of practice administrators and office managers make a distinction between the two. They say practice administrators need an additional set of skills beyond those needed by office managers: the ability to negotiate with health care payers.

tasks are different from that of office managers. In addition to being involved in contract negotiations, Enos also is involved in the planning, development, and implementation of new methods of practice, rather than simply handling day-to-day operations. While an office manager takes direc-

Average Compensation by Region for Health Care Office Managers

Year	Northeast	Southeast	Midwest	West	Overall
1994	\$45,691	\$42,433	\$43,608	\$44,353	\$44,162
1997	53,392	49,065	49,702	50,484	50,660
1998	55,128	50,809	54,293	50,500	52,682

Source: 1998 Professional Association of Health Care Office Managers Office Manager Salary and Benefits Survey, Pensacola, Fla.

Solo practitioners and groups of two to four physicians will hire office managers to manage the business details of their practices. Conversely, larger groups will hire practice administrators to have someone who is both a manager and a negotiator. Commensurate with the added responsibilities is higher pay for practice administrators over that of office managers, experts say.

"In a group of any size, the administrator or manager is a conduit to get things done," says Dorothy Sweeney, vice president of The Health Care Group, health care consultants in Plymouth Meeting, Pa. "In larger practices, however, an administrator—as opposed to an office manager—will meet with hospital administrators and health care payers to negotiate contracts, providing the business expertise many doctors lack. In smaller practices, the office manager can handle personnel issues, pay bills, and deal with nearly all the paperwork, freeing physicians to practice medicine."

Edward Enos is the practice administrator for Latham Medical Group, a practice of nine physicians and about 100 employees in Albany, N.Y. His

tion from the physician owners, a practice administrator sets the direction. "Office managers work with the tools they're given," Enos explains. "I decide what the best tools are."

Responsibilities

An office manager's responsibilities usually include financial management, such as supervising billing, accounts receivable and payable, and preparing monthly financial statements. They also may prepare annual budgets, negotiate prices for supplies and equipment, and interview, train, and supervise nonclinical staff.

In comparison, practice administrators generally work for larger practices of five or more physicians. Their responsibilities go beyond staff and collections management and often can include managed care contract negotiating, marketing, helping determine physician compensation and reimbursement methodologies, managing medical and business information systems, planning, and business development.

While office managers do not negotiate managed care contracts, they often

(Continued on page 4)

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administer the contracts. Negotiating responsibility in smaller practices generally falls to the group's physician leaders, who may hire outside consultants to evaluate the terms of a contract, says consultant Toth.

Earnings and Responsibilities

While increased responsibility requires increased pay, it is also true that the bigger the practice, the more administrative talent is needed, experts say. Therefore, an office manager's or administrator's responsibilities and compensation are usually related to the size and revenue of a medical group. "In the age of managed care, the complexity of running a medical office suggests that experienced managers may be

cian practice management operation in the Sacramento area.

Total compensation in 1998 for a health care office manager was \$52,682, according to the 1998 Professional Association of Health Care Office Managers (PAHCOM) Office Manager Salary and Benefits Survey, an increase of 4% over the average of \$50,660 earned in 1997. PAHCOM, in Pensacola, Fla., is a professional association of about 3,200 office managers. Based on responses from about 300 members, the survey shows the highest paid office managers work in cardiology practices, at an average compensation of \$59,774. The lowest average compensation is in general surgery practices, at \$41,294. Office manager salaries are

enue of \$2 million to \$5 million was \$68,688, according to the MGMA. In groups with revenue of \$50 million or more, the average salary for administrators was \$124,111. The MGMA survey reflected responses from 572 administrators.

Groups with fewer than 12 physicians can expect to pay a starting salary of about \$40,000 for an experienced office manager, says consultant Sweeney. Larger practices can expect to pay about \$50,000 for an experienced office manager, she says. Offices in urban areas pay more than offices in rural areas. "Starting salary decisions should be based on what other practices in an area are paying, and the manager's experience," Sweeney explains. "We recommend starting managers get a straight salary to start, possibly with a bonus at the end, and salary plus incentive pay after the first year."

Second-year incentive pay should be related to specific goals, says Sweeney. "We recommend increasing the salary slightly, say 2% to 4%, then giving up to an additional 8% to 10% raise contingent on whether a handful of larger, more specific goals are met," she says. "For example, the physicians can determine individual goals related to productivity or marketing, with a 2% raise for each one that's reached."

Experience and Education

Educational level also affects compensation, but advanced degrees aren't valued as highly as experience, says Sweeney. Administrators in large practices of 15 or more physicians often hold a master's degree in a subject related to medical management, but may not necessarily have an MBA, she says. "In my experience, most of these master's programs are geared toward hospital administrators," notes Sweeney. "If I had to choose between an MBA with little or no experience and only a moderate vision for the business, and a non-MBA who has good vision, common sense, and executive ability, I'd go for the ability," Sweeney says.

Also, an MBA may demand more

Average Compensation for Practice Administrators

(By net medical revenue)

Net revenue (in millions)	Practice administrators for 7 or more physicians	Practice administrators for 6 or fewer physicians
\$2 or less	N/A	\$52,658
\$2 to \$5	\$68,688	63,311
\$5 to \$10	84,563	72,315
\$10 to \$20	97,133	N/A
\$20 to \$50	117,526	N/A
\$50 or more	124,111	N/A

Source: *Management Compensation Survey: 1998 Report Based on 1997 Data* by the Medical Group Management Association, Englewood, Colo.

hard to find—and are therefore being paid more," says Kathy Palmerton, a consultant in the health care services group of Gordon, Odom & Davis Inc., accountants in Sacramento.

This year in the Sacramento area, for example, practice administrators are getting an average pay increase of 15% and office managers an average raise of 12%, according to a survey by Gordon, Odom & Davis. Such hefty increases were needed because FPA, a large physician practice management company in San Diego, filed for bankruptcy protection in July 1998, Palmerton explains. "The demand for talent grew when FPA went under," she says. FPA had an extensive physi-

highest in the Northeast and lowest in the West.

The average practice administrator's compensation for a group of seven or more physicians was \$84,233, according to *The Management Compensation Survey: 1998 Report Based on 1997 Data* by the Medical Group Management Association (MGMA), in Englewood, Colo.

Just as pay for practice administrators increases with responsibility, it also rises with practice revenue because larger groups have more employees to manage and more managed care contracts to negotiate and maintain. The average salary for a practice administrator in a group of seven or more physicians with net rev-

responsibility than a medical group's physicians may wish to delegate. "MBAs want the authority to make strategic decisions," notes Rose Chambers, executive director PAHCOM. "Physicians have been very reluctant to delegate that."

Some physicians have a difficult time relinquishing authority to any manager or administrator, Sweeney says. "Some physicians find it unnerving to relinquish control of some of the business of a practice, especially at first," she says. "But they should remember that a good practice administrator has the time and expertise necessary to analyze data, strategize, and implement policies."

For both managers and administrators, maintaining trust means maintaining communication, says PAHCOM's Chambers. That time commitment can be as little as an hour a week. "With a really good manager or administrator, that's all it should require for the physician to go over routine reports and give strategic direction," she says. "The time spent with an office manager or administrator can mean money saved."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

Total Compensation by Medical Specialty (For health care office managers, 1998)

Specialty	Total Compensation (Salary and benefits)
Cardiology	\$59,774
Dermatology	47,200
ENT	46,832
Family practice	46,093
Gastroenterology	49,533
General surgery	41,294
Internal medicine	46,475
Neurology	58,786
Ob-gyn	53,391
Ophthalmology	58,918
Orthopedics	53,956
Pediatrics	51,291
Physical medicine	53,591
Plastic surgery	50,198
Psychiatry	47,129
Urology	50,352

Source: 1998 Professional Association of Health Care Office Managers Office Manager Salary and Benefits Survey, Pensacola, Fla.

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Physicians Examine Their Options

By Thomas M. Gorey, JD

We frequently receive requests for advice from physicians considering making changes in their practice structure. Recently, I received the following letter, which illustrates the type of situations our readers are confronting.

"I am a gastroenterologist in a two-physician practice in an affluent suburban community on the East Coast where there is a heavy penetration of managed care," said the letter writer. "My partner and I have been seriously considering merging with an eight-physician GE practice in an adjacent town (soon to be 10 as another two-physician practice is intending to join), which would make a total of 12 if we joined. Since there is only a small area overlap in regard to the areas we service, our respective markets are largely separate. I believe the eight-physician practice is compatible with ours, and I have a sense the operation is run well by two business-oriented physicians who head the practice. The group operates an outpatient endoscopy suite, and it plans to expand geographically.

"Over the past six months," the letter continued, "our own practice has grown due to local changes in the community. For example, a GE doc from a busy internal medicine group left, and our business has grown directly and indirectly as a result of his leaving. Also, we have captured some of the business left behind when a local managed care organization downscaled its in-house GE staff. Initially, we did not believe either of these sources of new business would continue over the long-term, but we are beginning to work on agreements to make these new sources more formal.

"Given our initial uncertainty that we would retain this increased business, we have been slow to hire a third physician," the physician wrote. "We also have been

slow to hire a third physician because of the possibility that we might consummate the merger, and that move would help us meet our manpower needs. In addition, factors such as the volatile and uncertain referral base and decreasing reimbursement for GE services have stalled our hiring a third physician and encouraged our thoughts for this merger. In any case, we desperately need help to handle this increased workload.

"As a result of all of these factors, I now believe our market is expanding and that we have no need to merge," the physician wrote. "In a merger, we would give our excess business to the new entity instead of holding onto it and hiring our own third physician and growing our own practice in a more traditional manner. Yet I have read

business to support our new physician? Your opinions regarding our situation would be most appreciated."

Objectivity Needed

It is difficult—and perhaps hazardous—to render advice of the type the physician is seeking based on the limited information available in a letter. Nevertheless, I offer some thoughts all physicians may wish to keep in mind as they sort through their options. This advice should not, however, be construed to be legal or practice advice.

My first suggestion would be to retain a consultant and an attorney who can help think through the various issues involved. There is no substitute for a consultant or attorney with experience in these issues. Not only will a consultant or attorney

Following a physician practice merger, there usually is an attempt to achieve a certain level of standardization, both in business practices and clinical practices. Are you prepared to give up some measure of autonomy in these areas in the event of a merger?

that there is a strong trend in areas like ours to form single-specialty groups.

"Your article, 'Lessons to be Learned from Group Mergers' (at www.mdoptions.com) was most informative," the physician concluded. "In it you state, 'Physicians merge their practices to improve their position in a market that is changing or that they anticipate will continue to change.' Am I being shortsighted (because of our recent increase in business) in concluding that we have no need to merge because we have the market in our local community? Or is health care generally so volatile that the events that led to our recent business surge could end tomorrow, leaving us with having hired a third GE for our two-physician group but not enough

provide expert advice, but he or she also will provide a needed measure of objectivity. The consultant can help assess the dynamics of the market and evaluate the various options. A good attorney can help evaluate the proposed merger from a legal perspective, including addressing antitrust issues, and, if you decide to proceed with a merger, can help ensure that the arrangement is legally structured in the best possible way.

You may not be able to find the expertise you need within your suburban community, but you certainly should be able to find qualified health care attorneys and consultants in a city within about 50 miles. It is important to get advice from knowledgeable professionals who have experience with physician practice mergers and who

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are familiar with your particular market.

Regarding the merits of merging with the neighboring practice, there appear to be some positive aspects to the idea. Evaluating any actual deal, however, would involve analyzing the details of the agreement. The recent growth in business in your community and the prospects for continued expansion in your market are promising. How to take advantage of those opportunities is the question.

To Merge or Not

In trying to decide between two or more alternative practice options, it is important to emphasize that there often are no right or wrong answers. Just as in the clinical side of medicine, where there may be two or more possible therapeutic options for a particular diagnosis, in the business side there also may be two equally plausible strategies. Both may be viable and neither is risk-free.

For these reasons, selecting between the two in the abstract makes little sense. Rather, you need first to identify your goals and objectives and then measure the likely risks and rewards of each option against each of those goals. Your letter only hints at what your long-range goals may be. Working with your consultant to articulate clear goals will provide the perspective you need to plan an effective strategy.

Obviously, if you simply want to be able to handle the increased business in your community, there are many easier ways to do so than to merge with the larger neighboring group. Growing your practice in the traditional manner, by bringing a new gastroenterologist into your practice, would allow you to maintain maximum control and to continue to focus your efforts locally. Although, as you recognize, this approach is not without risk, as is the case with any strategy, including merging with another group. Carefully structuring the employment or partnership agreement, however, can mitigate some of risk, should the recent upturn in business prove to be short-lived.

Physicians tend to merge their practices for one of two reasons: either as a defensive strategy in response to a perceived threat or as a proactive strategy to take advantage of potential opportunities in the market. It does not sound as if you are in a defensive

It is important to get advice from knowledgeable professionals who have experience with physician practice mergers and who are familiar with your particular market.

posture. If anything, it appears the level of competition in your community has decreased, rather than increased, over the past year or more. In a sense, these changes have created a dilemma of a different sort: how to handle the increased patient flow coming your way.

Obviously, the question of how to expand your practice locally to take advantage of current and anticipated practice growth opportunities is a much better position to be in than having to respond to an imminent threat caused by the entrance of a competitor into the market or the loss of a major managed care contract. In either case, time is on your side because you may not have to act on the option to merge with another practice immediately. Other than developing a strategy for dealing with the increased business, for example, by hiring a third gastroenterologist, you should not feel pressured to consider other major practice changes.

Business Savvy

If merging your practice makes sense for multiple reasons—not simply as a response to the recent growth in business—the option deserves consideration. From your description of the other group, it sounds as if the larger group has considerable business savvy and the eight physicians are planning an ambitious expansion that would enable them to become a major player in the market. Since there is a strong penetration of managed care in your market, the size of the proposed merged group and prospects for future growth would position you well for favorable managed care contracts as part of a larger, merged group.

One of the questions you need to ask yourself is whether you have the same aggressive practice expansion goals as your prospective partners. If you do, the merger may make sense. If you don't, even though the deal may make sense on paper, the changes that would result may detract from

what has been your focus over the years—working in a small practice environment to provide care in your community. Following a physician practice merger, there usually is an attempt to achieve a certain level of standardization, both in business and clinical practices. Are you prepared to give up some measure of autonomy in the event of a merger?

Although you believe your practice and the eight-physician practice are compatible, there sometimes are surprises when mergers take place. If you go ahead with a merger, do all you can before to get a sense of how your prospective partners handle cases. To do so, you may want to share cases, if possible, before the merger is final.

If you are leaning toward participating in a merger, another issue to address is the method of revenue distribution. This method is often a stumbling block when groups plan mergers and has caused newly merged groups to fall apart. Related to this issue is accounting for overhead. Would being part of a larger group entail increased administrative expenses, for example, for new information systems or central administrative staff? What will be the effect on your staff? Will you be allowed to maintain current staff with present responsibilities or will certain functions, such as billing, shift to the other office, thereby requiring you to let a staff member go?

Most important, do not go forward with a merger—or any other practice development strategy—simply because it appears to be a trend. No single practice organizational model is correct. There is a place for groups of all sizes, just as there is a need for solo practices and two- and three-physician partnerships. Physicians have seen enough practice organization fads in the past five years to realize that some healthy skepticism is needed whenever one model is touted as the one true answer. ■

(Continued from page 1)

their concerns, and educating them about expectations, breast-feeding, and other issues. "They (CNMs) get mothers-to-be to become more relaxed and confident and that makes labor easier," he says.

Several academic studies published in recent years support Dr. G's contention. They conclude the use of midwives lowers rates of Cesarean sections, use of medication during childbirth, and episiotomies. Despite the studies showing positive outcomes from midwives, the use of these physician extenders remains controversial. "There is still some animosity between midwives and traditional obstetricians," Dr. G says. "The truth of it seems to be that patients prefer midwives and that insults obstetricians."

Barry Rothman, MD, the chairman of the Inova Alexandria Hospital's ob-gyn department, agrees that some obstetricians see CNMs as rivals. "It's less so than five years ago, but there is some jealousy on the part of some obstetricians toward midwives," he says. "They are jealous of Dr. Giammittorio because he is able to do it."

James Scroggs, director of practice management at the American College of Obstetricians and Gynecologists, in Washington, D.C., says he is aware of other obstetricians being resistant to allowing CNMs to assist in hospital deliveries. "It's a competition issue," he says. "CNMs are probably doing some things obstetricians do."

Midwives have not wholly gained uniform acceptance by patients either, some of whom fear CNMs may not have the training to recognize dangerous situations. "Some patients object," says Dr. G. "They are apprehensive. But I explain that I will be there for them."

Patient Choice

Global rates for maternity care typically cover about 12 patient visits and a delivery. Depending on patient preference, a midwife in Dr. G's practice may perform more than half of those visits. "For a low-risk case, the doctors may have seen the patient three times and the midwife nine times," he says. "For a disease-oriented case, the patient may see a midwife only two of those 12 visits."

Even among practices that employ

In 1991, the merit of using midwives became apparent. "We had more deliveries than we could handle but not enough to hire a third practitioner."

—David Giammittorio, MD, Physicians and Midwives

midwives, Dr. G's arrangement is unusual. "In other practices that have midwives, patients sign up to be a midwife patient or an MD patient," explains Dr. G. "If you're a midwife patient, you stay that way unless you have a complication. We think this way is inefficient. Patient trust in the caregiver is important to the success or failure of her treatment. Therefore, we take the team approach to each case."

Colleagues also have criticized Dr. G for his published cesarean-section rates. The numbers, reported by Virginia Health Information, a nonprofit health data organization in Richmond, Va., show Dr. G and his partner, ob-gyn Mary Cutting, MD, have dramatically lower rates of C-sections when compared with C-section rates for the region. VHI project director, Debbie Brockwell, says the regional C-section rate is 15.5% of all births from a single provider. Dr. G's rate is 7.14%; Cutting's rate is 5.85%.

"Very quickly through word of mouth, it got out into the community that increased human support led to less drug support which led to a lower C-section rate," Dr. G says.

Inova Alexandria Hospital ob-gyns claim Dr. G and his partner have low C-section rates because they accept only low-risk pregnancy cases and refer to other physicians more risky patients, such as those who are insulin-dependent diabetics or who are hypertensive as a result of being pregnant. Dr. G refutes this claim. "That happens to be not true," he says.

In Dr. G's practice, midwives handle routine after-hours calls from pregnant women calling to report minor problems. Consequently, physicians are not awakened in the middle of the night when a patient has vaginitis, spotting in early pregnancy, pregnancy headache, colds, or flu. "I am disturbed much less than other obstetricians," he says. "So I get more rest."

Midwives in Dr. G's practice also triage patients by taking the first calls from pregnant women in labor. They determine if there is a genuine need to go to the hospital and they meet the patient at the delivery suite. "In a traditional setting, a patient calls the doctor in the middle of the night, the patient is greeted by a strange hospital delivery nurse, the doctor comes while the patient is in active labor, and catches the baby," Dr. G says. "In our system, the patient calls in the middle of the night and gets the midwife. She and the midwife decide if she should go to the hospital. The patient meets the midwife at the hospital, someone she knows and has seen throughout her pregnancy." CNMs encourage women to stay home as long as possible once contractions start. When the expectant mother arrives at the hospital, the midwife is there for the duration, usually with several strategies designed to ease the stress and pain of labor.

Some CNMs use warm packs and oil to stretch the perineum and help reduce tearing of tissue during birth. They also use a combination of massage, position changes, breathing exercises, and moral support. In most cases, drugs are not used to speed labor, and anesthetics are avoided as much as possible. Most women are offered a long, warm shower or bath to reduce pain and relax muscles. They walk around instead of lying in bed.

"Every one of our birthing rooms has a shower," Dr. G says. "If the patient is up and mobile and has human support, the biologic unit has better functioning. It keeps drugs to a minimum and enhances vaginal delivery."

If and when the patient is in active labor, the midwife advises the doctor that it is time to come in. "We assign a doctor and midwife to the hospital every day so there are no office responsibilities that day," he says. "This is something we dreamed up

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ourselves, but others may be doing it.”

Rules about midwives and doctors vary from state to state and hospital to hospital. As required by the Inova Alexandria Hospital, Dr. G or his associate must be in the hospital when a patient gives birth. Other area hospitals say physicians need only to be available. Emergencies that require him to assume the case from a midwife include pre-eclampsia, placenta previa, and diabetes. “Midwifery is focused on the normal pregnancies and most pregnancies are normal,” he says. “Doctors are focused on the abnormal. We’re trained to be disease fighters. While the midwife sees a normal obstetrical case, I see a sick ob or gyn case. It is a more efficient use of my time.”

Dr. G insists his group’s patients give birth in a hospital and not at home. It’s too risky, he says. The group also does not do births in bathtubs or hot tubs, as some facilities do.

In 1991, just as managed care was growing in suburban Washington, D.C., where he practices, Dr. G began to see the merit of using midwives. “We had more deliveries than we could handle but not enough to hire a third practitioner,” he says. “When I saw the virtues of the CNM, the collaborative practice unfolded.”

At the time, his male partner left to pursue more education, leaving Dr. G with the choice of hiring more doctors or more midwives. “Our sense of what the patients wanted was that half the patients were happy with just the doctor, half were happy with just the midwife, so we started offering both,” he explains. “We changed the practice so that every patient had a midwife and a doctor involved in their pregnancy and labor. As the practice became more dominated by midwifery, people who respond to that have come to us.”

Patients come from as far as Annapolis, Md., and Fredericksburg, Va., each about 50 miles away. Sometimes, patients come from even farther away—from China and the Middle East. Americans living abroad who plan to be in the Washington area when they deliver have found Physicians and Midwives on the World Wide Web at www.erols.com/midwife. “At least a dozen patients each year come to us from the Internet,” says Dr. G.

Interest in Midwives Grows Steadily

A certified nurse midwife is a registered nurse who has completed a master’s degree in a special midwifery program and passed a national exam. CNMs can legally practice and write prescriptions in every state. Almost all deliver babies in hospitals. Other kinds of midwives are certified midwives who are certified by a state or midwifery organization. Lay midwives have simply served an apprenticeship with another midwife and traditionally focus on home births.

Midwifery was brought to the United States from England in 1925. It took 40 years before the concept was widely recognized here. By the 1950s, most births in the United States were taking place in hospitals. Cesarean sections, epidurals, and heavy doses of pain medication became the norm. When the women’s movement began to flourish in the 1960s and 1970s, women began to challenge the way obstetricians were treating them. As they took a more active role in their health, women moved toward more natural, low-tech delivery methods, and toward female practitioners.

The word “midwife” means “with woman.” In a modern world that offers the best state-of-the-art pregnancy treatment money can buy, more women started returning to a centuries-old tradition that in prior decades was followed by women who

could not afford a physician.

By the 1970s, an interest in midwifery was rekindled and, simultaneously, the number of female ob-gyns started to grow. “I’ve always supported CNMs,” says Craig Winkel, MD, chairman of the ob-gyn department at Georgetown University Medical School. “But if you mentioned adding CNMs to your practice back in the early 1970s, people thought you were nuts. Now because of economic pressures, I’m not considered so nuts.”

In 1970, only 7% of all ob-gyns were women, according to the annual AMA survey, “Physician Characteristics and Distribution in the US.” The long and erratic hours were thought inappropriate for female doctors. But by 1996, that figure had risen to 31%. Also in 1996, 60.5% of ob-gyn residents were women.

At the same time, the number of CNMs grew from 1,700 in 1976, the first year their numbers were tracked, to 7,000 last year, according to the American College of Nurse-Midwives, in Washington, D.C.

In 1975, the first year records on births involving midwives were kept, there were 19,686 infants born in the United States with the help of midwives or 1% of American babies. By 1996, the most current data available from the National Center for Health Statistics, there were 239,090 CNM-attended births in the United States, or 6% of all births. —MG

Dr. G offers his own childbirth classes that differ from classes offered at Inova Alexandria Hospital. “We didn’t care for the slant of the hospital classes,” Dr. G says. “The hospital has to teach to the average patient and the average doctor. They depend too heavily on drugs. We depend on personal empowerment.” His classes focus on nutrition, exercise, relaxation, breast-feeding, and postpartum support.

Economically, the use of midwives is making progress. A study of 1,000 patients published in the November 1996

issue of the *Journal of Obstetrics and Gynecology* showed that hospital charges for midwife births were 21% lower than those for doctors. The reason for the lower charges is that CNMs are less likely to use interventions that cost money.

For the future, Dr. G intends to continue to “lease” his practice midwives to other practices so doctors and patients can see the benefits firsthand. And he intends to grow his practice in this way. —Reported and written by Maureen Glabman, in Miami.

Public Markets Punish PPMCs

By W.L. Douglas Townsend Jr. and Jill S. Frew

Physician practice management company stocks continue to languish in the public markets along with other health care services stocks. Since July 1998, an index of health care services stocks that included HMOs, hospitals, PPMCs, and assisted-living and post-acute-care companies declined 28% while the S&P 500 index increased 22% (Table 1).

Also, price-to-projected earnings estimates have dropped for the entire health care services sector and for PPMCs. In July 1998, health care services companies were trading at 19.8 times projected 1998 earnings. By July of this year, the same index of health care services companies was trading at 14 times estimated 1999 earnings, a decline of 29%. During the same period, PPMC price-to-forward

earnings multiples dropped from 14.7 to 11.3, a 23% decline. This drop indicates investors' concern over future growth rates in the sector as well as earnings stability (Table 2).

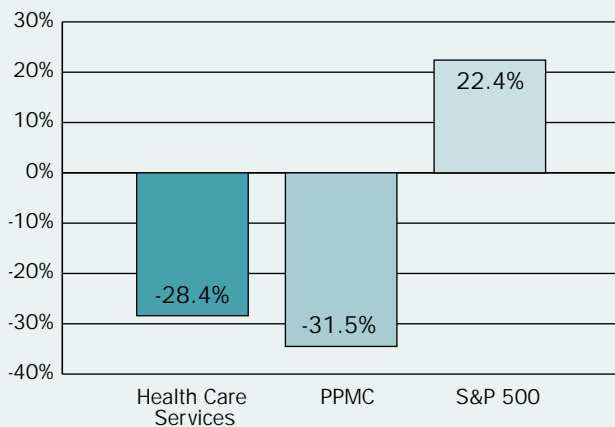
In response to the unrelenting market conditions, some public PPMCs have pursued different options to remain viable (Table 3). On June 14, Physicians' Specialty Corp., in Atlanta, agreed to sell to TA Associates, in Boston, in a transaction that will take the company private. Physicians' Specialty Corp. is just one of several PPMCs that announced this year that it will exit the public market. Others include Sheridan Healthcare, in Hollywood, Fla., and Concentra Managed Care, in Boston.

On June 15, PhyCor Inc., in Nashville, said Warburg, Pincus & Co., investment

bankers in New York, would invest \$200 million in the company. The investment will be in the form of \$127.5 million of PhyCor convertible subordinated notes and as much as \$72.5 million of PhyCor common stock purchased in the open market or in other transactions. PhyCor had seriously considered going private but decided that the Warburg investment would be a better deal for shareholders, PhyCor said.

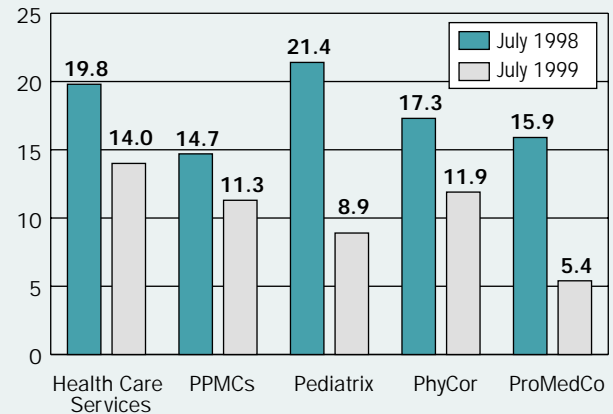
Also on June 15, American Oncology Resources Inc., in Houston, completed its acquisition of Physician Reliance Network Inc., in Dallas, another PPMC focusing on oncology. The combined company changed its name to US Oncology Inc. The companies said the merger would give them an opportunity to generate faster revenue growth. ■

Table 1: Health Care Services, PPMC, and S&P 500 Indices



Source: Townsend Frew & Co., Durham, N.C., 1999.

Table 2: Price-to-Projected Earnings



Source: Townsend Frew & Co., Durham, N.C., 1999.

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

Table 3: Three PPMCs Strategies

Practice Management Company	Strategy
Physicians' Specialty Corp.	Sell to a venture capital firm
PhyCor Inc.	Secure investment by a venture capital firm
American Oncology Resources Inc.	Merge with a competitor

Source: Townsend Frew & Co., Durham, N.C., 1999.

Small Group Succeeds Despite Increased Complexity and Rising Costs



This interview is the first in an occasional series of articles about physicians in practice. In this interview, Richard L. Reece, MD, editor-in-chief, discusses the practice of medicine with Joseph E. Fuller Jr., MD, a family practitioner in Old Saybrook, Conn. This series will profile real physicians and the issues they face in delivering medicine today.

Q: Can you please tell us a little about your background?

A: I grew up in Lynn, Mass., which is a working class seacoast community north of Boston. After high school I went to American University in Washington, D.C., and then graduated from the University of Massachusetts Medical School in Worcester in 1980. I did my residency from 1980 to 1983 in Middlesex Hospital in Middletown, Conn., in the family practice residency program.

Q: Why did you choose the residency program at Middlesex Hospital?

A: At 150 beds, Middlesex Hospital is a good-sized community hospital in which to practice. It's small enough so it's homey, but it's large enough to attract enough subspecialists so that we family practitioners have a lot of support. For example, we have an unusual number of cardiologists and gastroenterologists for a community our size. I suspect that we have so many subspecialists because of the good quality of life in Middlesex County.

Q: Why did you settle in the town of Old Saybrook?

A: For a brief period of time after I finished my residency, I served as a physician in the U.S. Public Health Service in Newmarket, N.H. When my service was completed I was looking for a place to practice. At that time, my practice included obstetrics services, which I

enjoyed. I wanted to practice in a coastal town and looked into practicing in several New England states. I found that it would have been difficult to get privileges to do obstetrics in Massachusetts, which was my first preference, and Rhode Island is much the same.

So I called the president of Middlesex Hospital; he was very welcoming and helped me find a place to locate my practice, in Old Saybrook. Old Saybrook is a community of about 9,000 full-time residents. It's right on the coast, and as a small town it is safe and represents a high quality of life. Although there were a few physicians in town, not one of them was making rounds at the hospital, and none was doing obstetrics. There really was sort of a void in family practice. So I started in solo practice here, borrowed a pile of money, opened my doors, and started seeing patients in 1985, when I was 31 years old.

Q: What are the characteristics of your current practice?

A: Currently, I have two partners, both of whom are female. We're all in our mid-forties. They have active family practices but do not offer obstetrics care. In fact, I stopped doing deliveries when it came time to find a partner—I honestly couldn't attract a partner who wanted to

radiology practice occupies an additional 2,000 square feet on the second floor. This arrangement is convenient for our patients, who can go upstairs for mammography, ultrasound services, x-rays, and other routine radiology diagnostic services.

Q: Do you think small group practices are better than larger ones?

A: A small group practice is the best model. When your patients have to be treated in your absence it's best that they see somebody they've at least seen around the office; in large groups, the patients can feel that they are being treated by strangers. Also, in a small group, the practice's policies and procedures can be more easily negotiated and accepted by all the physicians. In larger groups, the physicians differ in the way they like to do things and as a consequence it's harder to reach a consensus.

Q: How difficult is it to earn a living in family practice?

A: Basically, primary care physicians are underpaid. Overhead is a huge and necessary expense of the practice. When I opened my practice, all my bookkeeping was done by hand. I had one employee. I spent most of my time seeing patients and little time fretting about billing. Today I have a huge staff,

"Despite the fact that our charges are up substantially, our real income has fallen even more substantially."

do deliveries, since we are a 35-minute drive away from the nearest hospital.

We've been together for about eight years. They are skilled physicians, and I think we work very, very well together. And female physicians are a big draw for female patients.

We practice out of a quaint New England house, built in 1803. Our practice occupies about 4,000 square feet, and a

which is expensive to keep. I have eight full-time and four part-time staff members. These staff members include nurses and others who perform reception, billing, collections, filing, and transcription duties. About 70% of our income goes to overhead.

Also, three significant activities in our practice are money losers: house calls, hospital visits, and nursing home visits.

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Because of the reimbursement policies of third-party payers and Medicare, these services are grossly undervalued. We still do them out of a sense of professional necessity, but we definitely lose money on every single visit in these areas. For example, if I visit a Medicare inpatient at the hospital, which is a 70-minute round trip, I am reimbursed approximately \$31, or some such ridiculous sum.

Residents in medical school don't understand the realities of private practice. Somehow they expect to earn piles of money, which, in reality, will be paid only by an HMO or an emergency room. You can't come into private practice and expect to earn anything like what people think doctors earn.

Q. *What do you think is the optimal structure of physician compensation?*

A. I had never thought about it much, but when we wrote our practice contract we decided that compensation would be based on charges generated to

reimbursement. Otherwise, there is no point in doing our work.

In addition, the physicians should contribute to the group's reputation and visibility in the community and work to help their community, their hospital, and their neighbors. We sponsor a little league team and a girls' softball team, we've coached the hockey team, we contribute to the plays that are put on at the school. I think every professional group has this responsibility.

Q. *What strategies have you adopted to keep your practice profitable?*

A. My most profitable activity comes from treating walk-in patients. Because of low reimbursement from Medicare and managed care, I keep the office open for walk-ins on weekdays from 8 a.m. to 7 p.m. and on Saturdays from 8 a.m. to 4 p.m. without lunch breaks. We see call-ins, we see walk-ins, and we encourage office care rather than telephone contact. In fact, a walk-in center

address these questions. We also benefit because we use the hospital's management services organization.

Q. *What is your involvement in inpatient care?*

A. We admit patients and perform rounds at the hospital. But we certainly feel the effects of managed care. Often we get questions about why we bothered to admit a patient instead of offering another service, such as home IV infusion. The threshold for hospital admission is so high that we rarely admit patients anymore. Hospitalists often care for our patients in the hospital.

Those I do admit are often quite ill or elderly. When I first started in practice most of the hospital patients were distributed over a much larger age group, so that many cases were quite interesting and patients were interested in their conditions and wanted a lot of counseling and guidance.

Now, for the most part, there are two types of patients. The first type of inpatient has an acute condition requiring care from multiple specialists; the primary care physician functions as kind of a glorified social worker, trying to keep all of the caretakers organized and focused on the problem. The other type of patient is so frail and elderly that he or she often can't even remember my visits; in fact, I've had many complaints from families that I didn't go to the hospital, because the patient didn't even remember I was there.

As a result, some of these visits are not terribly gratifying. In addition, the reimbursement is negligible. I would like to continue hospital work, but I'm not being paid appropriately for my time and my training. Furthermore, there are many hassles associated with closed formularies, utilization review, quality review, and managed care administrators questioning our practice patterns, all of which increase our administrative burden on a daily basis. These superfluous administrative details result in a major financial loss for the practice, while diminishing and disrupting the time we can spend on patient care.

Q. *Is the need to focus on administrative matters a significant frustration in family practice?*

“Three significant activities in our practice are money losers: house calls, hospital visits, and nursing home visits.”

reflect the individual doctor's contribution to the practice. This encourages physicians to work as hard as they like and at the same time allows them to take some time off without having to restructure the contract or renegotiate the relationship. They simply generate less income and take less home.

Q. *Should compensation incorporate measures such as patient satisfaction?*

A. It's hard to incorporate qualities like patient satisfaction overtly into a contract. It should go without saying that every physician who participates in a group needs to enhance the appeal of the practice by being affable and available to patients. Customer service is really our top priority. That is why we're here, to take care of patients. No matter how the world interferes with us, and no matter how much of a headache we get from the administrative hassles imposed upon us by HMOs, the patient has to come first, regardless of compensation structure or

moved into town about 10 years ago and left two months later, and I think the reason was that our patients didn't need a walk-in center, since we were it.

In addition, Old Saybrook triples in population in the summer because it's a seaside resort town. We're always willing to see our summer visitors on a walk-in basis. We have a separate chart folder system for summer patients; it is a cart on wheels that we call the "one-time chart." Instead of creating complicated manila folders for each new patient, we wait until the second visit to create a full chart.

Q. *What is your relationship with the local hospital?*

A. Our close working relationship with Middlesex Hospital is vital to our success. First, we want to have influence in what kinds of services the hospital offers. Also, if we have questions about certain services, then it's best to have a relationship where we can comfortably

A. Yes. I think in the United States generally, physicians are constantly impeded from practicing their profession by the need to pay attention to administrative matters. In frustration, I often complain that I wish I could practice medicine for five minutes uninterrupted. I spend so much time fretting about the business aspects of my practice and the administrative procedures required by an HMO or the hospital.

But truthfully, I recognize that it is in my best interest to focus on the administrative side of medical practice. It's a necessity and doctors that ignore the necessity to function as an administrator or as a chief executive cannot practice medicine successfully.

Q. Does your practice employ an administrative manager?

A. In effect, I serve as the practice manager. But we all try to work together in managing the practice, and this helps us keep our overhead down. Also, when we delegated that responsibility to an office manager, it didn't work out well. We felt more comfortable when the physicians reclaimed the responsibility for office management. Of course, that requires that the doctors learn how to be effective administrators, and not treat administrative issues as an imposition on their time. The administrative decisions made by physicians can have a huge impact on the efficiency of the practice.

Q. Do you think using mid-level providers is beneficial?

A. Yes. Practicing with nurse practitioners and physician assistants can be quite beneficial. We had a nurse practitioner for about five years before she joined the hospital, where they paid her a higher salary than we could afford. But she performed extremely well, and was well accepted by our patients. Patients should be allowed to choose to see the physician assistant and that person should build up his or her own practice. If the mid-level providers are closely supervised so that their care is reviewed daily by a physician, then that strategy can enhance practice revenue and efficiency.

Q. Do you have a telephone triage system?

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Physician Compares Free Market to Socialized Medicine

Joseph E. Fuller Jr., MD, a family practitioner in Old Saybrook, Conn., is familiar with the Canadian and Scottish health care systems. In an interview with Richard L. Reece, MD, editor-in-chief, Fuller says he has found that each system has certain strengths when compared with the U.S. health care system.

Q. What was your experience in geriatric care in the United States, and how does this experience compare with your experience in Scotland?

A. From 1993 to 1995, I served as a medical director of a nursing home in Old Lyme, Conn. This position became intolerable because of the frequent phone calls and the paperwork required as part of practicing in today's managed care environment. The practice of geriatrics in the United States generally is hamstrung by social attitudes and our lack of understanding. We have a certificate of added qualifications in geriatric medicine, but we don't have enough training programs in geriatrics. Elderly people do not receive appropriate funding for their care; physicians are not allowed to admit elderly patients for long enough to do an appropriate assessment.

This is in stark contrast to the experience I've had with medical practice in Scotland. The summer following my residency, I spent a three-month geriatrics fellowship in the Aberdeen Geriatric Clinic in the northeast section of Scotland. At Aberdeen, the routine geriatric admission was a six-week acute assessment that was performed within the confines of the general hospital, so that all radiological and laboratory services of the general hospital were available on site. The plan was to evaluate and treat these patients for six weeks to determine whether they could go home. Often they did go home substantially improved. When they required long-term care placement, you had the time and the social work support to arrange for those services properly.

Q. In your experience, are administrative burdens more onerous for

physicians in the United States?

A. In terms of the actual practice of medicine, I found myself much freer to practice in Scotland as well as in Canada, where I practiced for two months in July and August 1982 at Gander General Hospital in Gander, Newfoundland. Without so many administrative burdens, I had more time to see patients and my practice was much more enjoyable.

Q. What is your opinion of the system of health care in the United Kingdom in comparison to the U.S. system?

A. Americans missed a great opportunity to adopt a national health system after World War II. As president, Harry Truman introduced a plan for national health insurance at that time, but he failed to get it passed. To this day, by law and practice and ethics, health care in this country is a business. Services are controlled by the free market, with no central planning body. Health care is also a privilege. We allow patients to go without adequate health coverage. We have more than 43 million uninsured Americans, yet many vendors, managed care companies, and their executives reap huge profits out of the practice of medicine.

In contrast, the National Health Insurance Act of 1947 in the United Kingdom established health care as a parliamentary or constitutional right. Every citizen of the United Kingdom has health insurance from birth until death, and the services are complete and controlled by central and regional health planning bodies. I would advocate a national health system in the United States; it's the basic system of care for most civilized countries.

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A. Yes, all practices should incorporate a telephone triage system for the benefit of both the patients and the physicians. In our practice the physicians rarely take phone calls. The physicians only take calls from other caregivers, such as radiologists, social workers, and physiologists. Even at that, almost every office visit is interrupted at least once. If we accepted phone calls directly from patients, we couldn't get anything done. The phone triage system is managed by our nurses and medical assistants, who can address most patient needs themselves much more quickly.

However, the physicians like to review significant lab test and radiological test results in person. First of all, if the physician relays this information to a patient over the telephone,

eral, the system has served our needs well and handles all of our scheduling and financial matters. However, I'm always startled at how expensive it is to maintain software and hardware contracts. Over time, our information system, as simple as it is, has cost us quite a bit. Our contract runs us about \$6,000 per year.

Q. How important is it for a small practice to have a procedure room?

A. A procedure room is very important, because it enables us to treat injuries and handle office surgeries and emergencies. We have a procedure room that includes emergency equipment. We have a Banyan kit, an emergency resuscitation kit (which is capable of doing full cardiac resuscitation), oxygen tanks, and cardiac drugs. We have the ability

that, or dispense our own pharmaceuticals to our patients.

Q. How has managed care influenced your practice?

A. Managed care has influenced our practice substantially. Again, when I started in practice I had one employee, all of my forms were manually completed, I had very little overhead and I could make a living as a solo practitioner in a 900-square-foot office. In contrast, many years later, when about 30% of my patients were involved in HMOs, I found myself standing in the hallway holding a clipboard, looking at long lists of diagnosis codes and procedure codes. I realized that I had just spent only five minutes talking with the patient, but was spending 10 minutes trying to figure out how to code the patient's chart using the information on the clipboard.

That's when several realizations hit me. Number one, I needed to get a computer, because I couldn't process all of the data myself anymore. Number two, I needed to get a partner, because I did not have enough time to see patients and handle all the administrative details on my own. And that's when everything ballooned. My expenses went crazy, my staff increased significantly, and I have spent \$100,000 to \$200,000 on computers over the years. With managed care, it's an entirely different world. Despite the fact that our charges are up substantially, our real income has fallen even more substantially. In fact, we've had to let a partner go, partly because we are unable to generate enough income due to the discounts associated with HMO contracts and continuing reductions in Medicare reimbursement.

Q. How do your children view the profession of medicine?

A. My children are 12 years old and 16 years old. I don't think either one of them is considering medicine as a profession. Every once in a while my daughter asks my wife if daddy is going out of business, because I moan and groan so much when I get home about trying to collect from our institutional deadbeats. ■

"The patient has to come first, regardless of compensation structure or reimbursement. Otherwise, there is no point in doing our work."

he or she can't see the patient's body language, which can reveal the response to the information or the level of comprehension. Second, the physician can't draw diagrams to help facilitate patient understanding, or hand them educational materials if need be. Third, sometimes the news is bad, and I think it's one of the worst professional practices to call a patient at home or at work with very bad news.

Q. Do you believe that an information system is crucial for a physician group of your size?

A. Yes. Computers are the wave of the future. Even in a group as small as ours, if we don't create a paper-free office, my file room will be in serious danger of falling into the basement. It's ridiculous to have two-inch thick charts when we can store all the information on computers and produce paper documents only when absolutely necessary for legal reasons or for communication.

We have had a patient management system for about six years now. In gen-

to do most of the routine procedures an emergency center can do, although of course we don't advertise ourselves as an emergency center.

Q. Are you able to generate any revenue from ancillary services?

A. No. Stark laws basically prohibit physician ownership of x-ray machines and in-house laboratories, which are the most likely ancillary services a practice like ours might offer. When I started out in practice, physicians were actually encouraged by professional associations and business groups to have their own laboratories and pharmacies. These strategies were promoted as a way to enhance patient service, increase revenue, and improve the overall appeal of the practice. But since that time, for some reason, physicians have been targeted as the only professionals who can't profit from the tools available to them. Imagine a plumber being unable to own his own wrench! It would be helpful to family physicians if we could perform more testing in our offices and charge for

Referral Problems Undermine Patient-Doctor Relationship

Patients value their primary care physician's (PCP's) role as the coordinator of their health care, but problems with gaining referrals to specialists diminish their trust and confidence, according to a report in JAMA, July 21.

Kevin Grumbach, MD, of the University of California, San Francisco, and colleagues used a cross-sectional survey to assess the attitudes of patients toward their physicians' involvement in directing access to medical specialists.

The 7,718 patients surveyed averaged 66.7 years of age and had been diagnosed with benign prostatic hyperplasia (40%), congestive heart failure (29%), or peptic ulcer disease (31%). Thirty percent rated their health status as fair or poor.

While 75% to 91% preferred to see their primary care physician before consulting a specialist, the researchers report that

nearly a quarter of patients surveyed "agreed with the statement, 'My primary care physician or medical group interferes with my ability to see specialists.'"

Similarly, more than 80% of patients rated their PCPs highly on a range of measures of satisfaction, the researchers indicate, but perceptions or experiences of referral barriers strongly predicted low ratings in the team's multivariate regression analyses.

Low ratings were especially true for patients most desirous of specialty referrals, who were 3.2 times as likely to express low trust, 2.5 times as likely to manifest low confidence, and 1.6 times as likely to voice dissatisfaction compared with those with the lowest referral propensity.

Source: Reuters Health

HHS Calls for Changes in Hospital Oversight

The U.S. system of ensuring patient safety and quality of care in hospitals is fraught with "major deficiencies," according to a two-year study by the federal Department of Health and Human Services' Office of Inspector General.

"Overall, the hospital review system is moving toward a collegial mode of oversight and away from a regulatory mode," the report said. "The emerging dominance of the collegial mode may undermine the existing system of patient protection afforded by accreditation and certification practices."

The current oversight system consists of external reviews conducted by the Joint Commission on the Accreditation of Healthcare Organizations, in Oak Brook Terrace, Ill., and certifications conducted by state agencies. The IG said the Joint Commission accredits 80% of the 6,200 hospitals certified for participation in Medicare.

The report reveals that state agencies responsible for hospital oversight are not surveying hospitals on a timely basis.

Approximately 50% of nonaccredited hospitals in the United States in 1997 had not been surveyed within three years by the state, and some rural hospitals had not been surveyed in as much as eight years, the report said.

The report blamed the federal Health Care Financing Administration (HCFA) for not holding the Joint Commission or state agencies accountable. The public receives little information on performance of hospitals or the external reviewers, the report said.

Just hours after the study's release, HCFA Administrator Nancy-Ann DeParle announced that her agency has incorporated the IG's recommendations into HCFA's new Hospital Quality Oversight Plan. "This plan will ensure that hospitals deliver the high quality of care patients deserve through better oversight and performance monitoring," DeParle said in a prepared statement.

Source: Reuters Health

NCI to Fund Cancer Research Network of MCOs

The National Cancer Institute (NCI) has announced that it would award funding to the HMO Research Network to establish a project known as the Cancer Research Network.

The NCI awarded \$16 million for the four-year project, to be based at Group Health Cooperative's Center for Health Studies in Seattle. The Cancer Research Network plans to establish a "population laboratory" by combining a large number of enrollees from different sites, databases, and research resources.

According to a press release from NCI, "By combining the data capacities of these large integrated health systems, researchers will be able to study health care patterns among millions of patients who mirror the diversity of the nation in terms of age, gender, income, education, cultural background, and location."

The first three studies planned are an evaluation of the effectiveness of smoking cessation programs conducted by HMOs, an examination of key factors that prevent late-stage breast and cervical cancer, and a study of whether mastectomy or early screening mammography prevent breast cancer in women at high risk.

Barbara K. Rimer, MD, director of the NCI Division of Cancer Control and Population Sciences, commented in the NCI statement, "The collaborative spirit represented by the commitment of the HMOs exemplifies a new paradigm for cancer research that will pave the way for greater progress in preventing disease."

Source: Reuters Health

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September 15, 1999



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