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The Building of a Doctor and a Medical Practice

Brandon Hopkins

COLLEGE SCHOLARS PROJECT ~~PROPOSAL~~ Approval APPROVAL

Brandon Hopkins — Scholar

Dr. Geoghegan — Mentor

The Building of a Doctor and a Medical Practice

Proposed Project Title and Completion Date (semester & year)

COMMITTEE MEMBERS' SIGNATURES

(Minimum 3 Required)

Ellen B. Anderson — Acctg. & Bus. Law

Galen Georgiades — Physics Department

[signature] — BCMB

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DATE APPROVED _____

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by: Brandon Hopkins
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Table of Contents

Table of Contents

Introduction

My goal has always been to be an innovative and knowledgeable leader in the medical field, and this project has helped to further that goal. The culmination of ideas and building blocks contained within these pages is my plan for establishing the framework of my future. It is a work that will grow as my opinions become more defined and my knowledge expands. By the time I am ready to open a practice of my own, the insight contained within these and the pages to follow will allow me to make a smooth transition into the practice of real world medicine.

This framework is built around my goal of having an ethically run medical practice focused on the health of my patients. I see this as an important area of study because so many doctors are great at the art of medicine and dismal in the field of business. This is by no means a fault of their own except that they have never exposed themselves to the ins and outs of the business world. A doctor's paramount goal should be the care of his patients, but it would be naïve to think that one could care for patients without a smoothly running practice. To achieve this goal, I have learned a good deal in many areas of business. Some of these areas include Management, Hiring, Accounting, Finance, Tax, and Law. The business design outlined here will guide me through many of these fields, and it has also given me a chance to specify how I will cope with many of the roadblocks faced by today's medical practices. This is by no means a complete guide to all business workings, but it is a beginning from which I can continue the learning process.

In conjunction with this goal of being fluent in the business world, I have looked at many other aspects that must come together to be a great physician. Three of these areas include the importance of communication, having well formulated opinions, and being knowledgeable in one's field. The significance of communication skills is spread throughout this entire work because it can singly determine how accomplished a physician can become. It is also intricately tied to each skill in the field of business. One cannot hire or manage people, collect on Accounts Receivable, or deal with sales people without communicating well. This skill of interpersonal communication encircles ones family, friends, coworkers, patients, and many others. In relation to my second topic, having excellent communication skills also lend themselves to use when expressing one's opinions. I feel that physicians need to have well-articulated opinions because many medical options such as abortion and end-of-life care can be so controversial. Several of these topics are covered in this work. The last area touched on in this culmination of ideas is medical microbiology. I include it to demonstrate how one must be aware of the changing face of medicine in today's society, and to show a small fraction of the material that must be understood by a good physician. There are many medical specialties that are challenging, but the ability of microorganisms to change and adapt has many medical implications and offers many problems. Many of these benefit the world, but some can lend themselves to misuse as in the case of Bioterrorism. With a firm grip on these and other areas of focus, I will be able to express my views and treatment suggestions to patients while being fully assured of my medical knowledge.

I feel more confident about entering the medical field than I ever have after the beginning of this project. I say the beginning of this project because it is something that I will build upon in the years to come. The format of this work allows me to add other sections much like the addition of chapters to a book. By recording the flux of my opinions and working to expand my knowledge in all fields, I will become a doctor never satisfied with being average. Despite all this work and planning, a physician must follow his heart. The ability to care with one's heart heals patients and makes and excellent physician, but being efficient at these other aspects will let me sleep a little easier at night.

The Human Doctor

A basic thing one must come to understand is that a doctor is human, and that he must face the day to day hardships of life in the same way as any other person. When looking at a doctor's life from the outside, it could be easy to see them as above others in society. This pedestal that doctors are often placed upon is only a place to hide from the actual difficulties they must endure. Their life may look enviable on the outside, but often it can be a hectic road filled with tough decisions and hardships involving ones family, one's work, and one's self. Because of this, a doctor must be ready to deal with tough situations and be ready to make tough decisions. As in any other profession family and friends provide the support needed to live a good life because few can do it on their own. The following interview stories illustrate some of these pressures in life that many doctors face, and how they must face the reality of their responsibilities to themselves, their patients, and their families. The interviews in this section are important in my medical future in the sense that as a doctor one often forgets to plan other important aspects of life. It is these other aspects of life that make a doctor as normal as anyone else.

The first two interviews are ones that illustrate a common theme in the life of many doctors. This is the desire to raise a family and have a spouse to love. These interviews show the magnified difficulty posed in this pursuit when the complicated life of a doctor is intermixed with the demands of a spouse and child. The first couple, Ben and Janice met on a stint in the Peace Corps in West Africa, and their romance eventually led to marriage in 1993. They went to medical school together, and then they had a daughter named Madison. The juggling of school and a child has posed many difficulties for the two. An average resident after medical school must work more than 86 hours per week, and this often involves 48 out of 72 hour stints on float weeks. Laws are being passed that will limit these hours, but their implementation is some time off. These long work hours for each of the parents requires much planning and sacrifice in order to balance the responsibilities of being a doctor, parent, and spouse. Janice says, "Even when I'm away, I'm still thinking about what needs to be done." When she is at work there are things to think about for home, and when she is at home there are things to think about for work. They find that by making vacations a priority and by having specific time set aside for family they can make their hectic schedules doable. Their situation shows how a family must be intricately woven into the framework of a doctor's life. The second interview focusing on family life is the one of Dr. Savita Collins. She was an otolaryngologist on the fast track to tenure until her son Alex was born. She worked through her pregnancy not slowing down until around the sixth month when sickness and aches were too much to bear. She left practice only days before she gave birth. In this time she started making arrangements for her return, and she started setting goals to put her back on track when she did. After she had Alex her work related goals that once took priority now took a backseat to her son. She says, "I need to concentrate on what's important. The research, the patient care and getting tenure, while having more time with my family." The common theme seems to be that no matter the hardships involved in having a family while being a doctor, they are definitely worth the sacrifice. There is no secret setup or trick that can be done to make situations like these work. A doctor must understand that in order to have a family he or she must be willing to make the sacrifices and put in the effort necessary while still serving the needs of ones patients. This effort involves open communication between the doctor, his child, his colleagues at work, and especially his spouse.

Obstacles must be overcome in the life of doctors, much as they must be overcome by others in society. The difference is that the nature of medicine involves maintaining an

environment of respect and trust in order to make your patients feel confident in your abilities. Thus, when a doctor loses control of the direction of his or her life it can often be a hard journey to regain one's self-confidence. The two following interviews illustrate two very different and unexpected tribulations that have befallen two doctors. Nina Sanchez, MD, had a family, a busy practice, and was involved in many leadership positions. She did not think that an act of random violence would turn her world on its end. She was at work one day while her colleagues were out to lunch. A stranger found his way into her office and smilingly beat her to the edge of life. She said, "I thought I was going to die. I thought one thing. I had left home early for a doctor's appointment and didn't say goodbye to my kids." She was left beaten, bruised, and severely psychologically damaged. She became a woman trapped by fear. It was only by relying on her family and friends that Nina was finally able to put this experience behind her. This act removed the confidence and strength that Dr. Sanchez normally conveyed, and it took her a long time to reestablish those abilities. The second doctor interviewed is Dr. Michael Spuza who is now serving an eighteen-month sentence in a federal prison. He traded his clothes for a pair of khaki pants and camp shirt and his shoes for a pair of prison issue work boots. He thought the of going to jail would never come when he was sentenced for Medicare fraud. It was surreal. He and several other doctors ended up being the scapegoats in a scandal involving medical labs that did testing for patients. These labs were knowingly defrauding the government while the doctors believed that the business deals they had set up fell well within legal boundaries. The doctors got the jail time while the owners of the labs got off free. After being indicted he lost all control of what happened in his life. Dr. Spuza takes responsibility for his trusting in the laboratories lawyers and now anxiously awaits getting back to his practice. His mother who is also a doctor is maintaining his practice, but when he returns he will have to work very hard to regain the trust of his patients and colleagues. The experiences of Dr. Sanchez and Dr. Spuza show how fast the life of a doctor can be thrown completely out of sink. The only thing that has gotten both of these people through these hard times is their friends and family. Things such as these are unfortunate, but a doctor must understand that good as well as bad things are bound to happen in their lives. A doctor must be ready to deal with both.

A very personal story is one of a doctor I have worked with for quite some time. Dr. Bennett is an Emergency Room physician who I have come to respect for his coolness under pressure during difficult circumstances. In late January, he and another colleague from Morristown Hamblen Hospital were in a car accident on their way back from skiing in North Carolina. Dr. Bennett was severely injured and his passenger, Candi, died at the scene. Here is a man who more often than not is on the giving end of treatment, but that day was on the edge of life. He could no longer use the vast amount of knowledge he had acquired; not even to save his own life. He is making a very slow recovery, and may never practice again. It makes one see how doctors are just as frail as the rest of society, and tragic events involving injury can befall them as easily as anyone else. I think many doctors forget this truth, but this experience has engraved that idea into my mind. As a doctor or a person, one should value each day they have as if it is their last.

The final hardship that faces every doctor at one point or another is when to turn in the stethoscope. After putting so much of one's self into a job it can be quite a daunting experience to decide what if anything to do next. Just such a decision was on the mind of two doctors interviewed while nearing the end of their careers. The first involves Dr. Daryll Eggers. He was an OB/GYN doctor who has taken up a second career as the owner and operator of a restaurant. This restaurant is a restored flour-mill in his home town where he and his wife have previously dabbled in the restaurant business. The trouble with the retirement of a doctor is the void created in his life. This void is usually

filled with his service to people and the vast amount of time being a doctor requires. This restaurant has given Dr. Eggers another way to both fill his time and serve people. He has immersed himself in something that makes him happy and gives him time to spend with his family, and this is what every doctor if not person needs out of retirement. The second interview is one with Dr. Muscari age 65. Fast approaching the age when most doctors retire, his hometown suffered a major tragedy. A flood destroyed much of the business district in town including his practice. He had to make a decision as whether this was the end of his practice or if he owed the public something more. He said,"I thought this is the end of the practice, but no, you don't quit that easily. These people depend on me, and I wasn't going to let them down." This is the essence of what being a doctor is about. It embodies making the tough decisions even when they don't always favor what would be best for you. Dr. Muscari reopened his practice with new and better equipment, and he also enticed many of the former business owners back into town. Unlike other professions being a medical doctor brings with it the burden of people. So even when retiring the people involved must be considered. Dr. Eggers and Dr. Muscari each considered all aspects and people in their lives before deciding to retire or not.

Several lessons should be drawn from the personal stories of the preceding doctor's interviews. These lessons revolve around the fact that no doctor has the perfect storybook life. There are pitfalls to overcome and tragedies to bear. This by no means indicates that being a doctor does not provide many joys and amazing experiences. It simply means that a balancing act must constantly be performed in order to keep the semblance of a normal life intact. Above all, the lesson that can be drawn from most of the doctors interviewed is that no matter how difficult it may be, it is worth having a family and a set of close friends to love and to count on in your times of need. Even doctors need someone to take care of them from time to time.

Communication in the Medical Field

Communication is the tie that binds the human race together, and it is essential in one form or another. The tone of a word or something as simple as a smile can change the entire meaning of a conversation. It is because of this that a doctor must be able to communicate his ideas appropriately, especially in interpersonal situations. This is the sole determinant of what makes the difference between a good doctor and an amazing physician. This art of communication must be adaptable depending with whom you are interacting. A relationship between friends is different from a relationship between coworkers, and the doctor-patient relationship is also distinct. These differences cause the personal interactions of these parties to in turn be different. It is triumph in these many different arenas of communication that builds the framework for a successful physician.

The history of medicine follows an evolution of the doctor role. This change has mimicked the way in which doctors relate to people. Before modern medicine most of the treatment was done in a patient's house, and frequently the doctor had a personal relationship with the patient. This personal connection has been degraded over time by a societal move towards individualism and a more widespread need for medical care. It is no longer possible for a doctor to know every patient in the in depth sort of way that was common in years gone by. Doctors today are more distant and many times a more introverted group. This causes many issues involving communication with nurses in the hospital, other doctors, and even the patients physicians are sworn to protect. Serious lapses in this skill of communication have created large problems in our healthcare establishment. With adequate re-investment into this area, this situation can be turned around.

The doctor-nurse relationship in the hospital setting is an area that needs to be looked at in depth in order to fix some serious problems. I conducted a survey focusing on hospital nurses in order to help understand this very relationship. Nurses have been chosen instead of doctors to analyze this relationship because of the relationship hierarchy. Nurses are generally subordinates of doctors, and when there is a problem, they feel restricted in their ability to confront it and make it better. This gives them a reason to help find solutions to any underlying problems in the relationship. Nurses have also been surveyed because the majority of doctors confronted on the issue assume that the doctor-nurse relationship is intact and working well. The survey results paint a very different picture.

The survey is simple in layout but complex enough to let nurses express their true opinions. In order to do this a qualitative survey was conducted as opposed to a quantitative one. Because of this, I have introduced the factor of subjective analyzation, but I feel the survey outcomes have been so overwhelming that there is no ambiguity in my conclusions. I started with the hypothesis that nurses feel under appreciated and that they had ideas on how to improve their situation. The goals of my questions, which can be seen on the next page, were threefold. First, I wanted to see the problems associated with the doctor-nurse relationship. Second, I wanted to get a second hand opinion of how doctors treat patients, and the results of those comments will be analyzed more thoroughly in the later section on the doctor-patient relationship. The last focus of the survey is on opinions geared towards fixing some of the problems identified in doctor relationships. This is the most important part of the study because anyone can complain about a problem, but without looking for ways to make things better; nothing can ever be accomplished.

The results of this survey have been very enlightening. First, I wanted nurses to give me their gut reaction toward what the word "doctor" means to them. Out of 22

Brandon Hopkins
Phlebotomist and UT senior
Survey

These questions are private and will only be used in conjunction with my senior research thesis. As nurses and other day to day providers you are an under appreciated and essential part of what makes this hospital run, and your viewpoints are priceless. I appreciate the few minutes it takes to fill this out. Your statements will shape my senior thesis and hopefully the way I relate to hospital personnel and patients as I travel through medical school and thereafter. I will be around to pick these up throughout the day, or you can just drop them off in the main lab. Thank you

- Are you a Nurse, CNA, LPN, or Other and if other please give me your title?
- How long have you been in this field?

- If you had to describe doctors in one word what would it be?

- Would you say most doctors grasp the concept of interpersonal communication (why or why not)?

- How do you feel doctor's treat and relate to you as a nurse? Does this relationship create the most productive work environment?

- What could a doctor do to improve this relationship?

- Do you feel doctors communicate well with patients (yes/no)?

- Explain to me the way a doctor relates to a typical patient?

- Are there differences in how a doctor relates to a dying patient (what are they)?

- Describe how patients normally feel about how their doctors treat them. (in context to the time and quality of time spent with them)

- What are at least three ways a doctor could improve the way his patients feel about him?

  1.

  2.

  3.

  4.

- Are there any other suggestions that you would give a future doctor?

different surveys 19 of the responses were negative. These responses ranged from seemingly irritated with moody and impatient and ended with angry comments such as "self-declared omnipotent" and "asshole." These opinions demonstrate a major conflict between doctors and nurses. To call someone you work with on a day to day basis, who could be considered your boss an "asshole" shows some major resentment. To understand this better I asked how nurses felt doctors treated them on a day-to-day basis. The results of this question allowed nurses much freedom in response, but the same answer kept coming up. As can be seen on my data pages, I included several of the response, and many of them focus on the concept of respect. Many nurses feel disrespected in the workplace by certain doctors, and because of this they harbor negative feelings toward those physicians. The opposite is also true. It was said that when treated with respect, "the ones who do that, we will bend over backwards for to help." This attitude is consistent throughout every survey. Other statements are that doctors feel nurses are put on earth to serve them, "it is hard for me to go the extra yard for a rude doctor, some doctors get annoyed when we voice our opinions." These statements all focus on power and who is in charge. Being in charge and rude runs in opposition to teamwork and patient care. The following nurse comment elaborates on this idea, "Ninety percent of the day patient responsibility falls on the shoulders of nurses, and then doctors show up and treat this person who is caring for their patient as second hand help." While looking at it from this perspective it is easy to see how a nurse could be critical of how a doctor treats her. A nurse said, "most doctors don't even understand what my job entails." Doctors need to respect and understand the roles of the nurses who help care for their patients. Without this respect how can a hospital environment ever be productive?

In conjunction with how nurses feel doctors treat them, I wanted to know a nurses opinion of how doctors handle interpersonal communication in a general sense. For a professional group of people whose soul purpose is to serve and care for patients the survey results are quite dismal. Only four hospital personnel out of almost thirty surveyed thought that doctors possess good interpersonal communication skills. The time aspect is a major contributor to this problem. It is felt that physicians seem too busy to actually get to know individual patients, and this creates the appearance that doctors don't typically care about specific patients. Even when they take the time to communicate it is either over the head of the patient or it is only a one way conversation. The problem with being too busy is stated by many of the nurses as a source of communication problems. Nurses feel the burden created by time stressed doctors because the extra responsibility of patient care is placed on their shoulders. They say doctors only speak long enough to get the job done, and they always seem too busy to talk. However, the most frightening statement was that doctors are more concerned with patient turnover and money than with spending time helping patients. I hope this is not the case, but sometimes it may be. I can understand the frustration nurses feel when dealing with the constant complaints from patients about lack of doctor care, especially when nurses are not even thanked by doctors for their effort.

Another statement that can be heard throughout the survey is that doctors act superior. Nurses say that many doctors truly believe that without them everyone would be dead. This pedestal doctors often place themselves on makes it hard to communicate with a nurse or a patient. It also acts as a barrier that doesn't allow true feelings to pass through. The communication problem created involves speaking on a level above others, and it often leads to doctors talking down to people. It is easy to see how such an environment where one feels unappreciated and looked down upon can lead to the preceding descriptions of doctors that before seemed so harsh. Now that so many problems have been uncovered in the nurse doctor relationship one must find hope for improvement.

The answers to this relationship strife must be found within the conflicting parties. However, since most doctors see no problem the only place to look for advice is from nurses. The survey asked nurses how they should be treated, and it asked how a doctor could improve the nurse-doctor relationship. These statements benefit in how I, as a future doctor, should relate to nurses and patients. The nurse responses offer solutions that I find very pleasing because they involve common sense approaches. I put much faith in the honesty of these responses because it truly seems that nurses would like a better working environment. It only makes sense that a person would enjoy a working environment where stress is low and coworkers can be regarded as friends.

I have been offered many interesting pieces of advice, but the concept of listening shouts through. More than fifteen different statements made by nurses focused on listening to the advice of patients, nurses, doctors, and other health care personnel. This advice seems so simple, but it can be easily overlooked in one's personal or professional lives. How often does one say, "I wish I had listened to the advice of my parents. I would never be in this mess if I had." As individualistic as modern society has become with constant outside stimuli it has become a natural defense to block out what is going on around oneself. This creates problems because situations arise when one truly has to focus, listen, and understand what is going on. A doctor may be able to care for a patient without listening to what they have to say with the aid of test results and experience, but a major role of the doctor is being neglected. This role is to care for the whole person. In order to do that he must listen to the patient and the nurse. Doctors must make it a habit to make eye contact, speak and write clearly, and let the person know you are listening to them. It is not the material that took so many years of schooling to learn that is being criticized by society, but instead it is the skills learned in the first three years of life that have become rusty without use. Listening to what others have to say is the first step to improving relationships for doctors.

As mentioned before respect also falls into this equation as well. Several nurse statements summed up the solution to this conflict quite nicely. First, one nurse said, "Remember who trained you in medical school--the nurses," and another said, "walk a day in a nurses shoes and you will remember to be humble." These statements seem to ring true to the fact that much of what doctors learn is from their direct experience with nurses. I am not sure when a doctor wakes up one morning and decides to feel superior to other hospital personnel, but I regret that it happens. I fully understand that doctors have more knowledge about medicine and the workings of the human body, but the nurse knows more about the patient in Room 113. Nurses spend more time with each patient, and doctors must base many of their decisions on nurse observations. Doctors often forget this intricate tri-connection between doctors, nurses, and patients. It was said by a nurse that, "Remember we are all on the same team." Remembering this will be the centerpoint of my working with nurses in the hospital. I believe that if one listens and treats other health care workers as teammates, much more can be done to help a patient. In connection with this, doctors need to place themselves in the trenches with nurses more often. Doing this to become grounded should be a paramount goal because without it becoming a master physician will be impossible.

Description of Doctors	Nurse opinions of whether Doctors grasp interpersonal Communication	
immature	no-	they don't feel anymore
demanding-2	no-	lack of communication skills
spoiled	few-	they don't see patient as a person only an sickness to be cured
dedicated	no-	doctors only speak long enough to get the job done
puberty	no-	they believe everyone would be dead without them the longer they practice
babies	no-	they don't feel anymore or care what others have to say
asshole -3	yes -	but there are the superiors who deal with others as beneath them
detached	no-	they refuse to get on the patients level to help them understand
egotistical-2	no-	they don't see patient as a person only an sickness to be cured
intelligent	few-	most physicians don't see nurses as part of the team and treat them accordingly
impatient	yes -	physicians she works with do, but others seem to busy too talk
self declared omnipotent	no-	they refuse to get on the patients level to help them understand
unpredictable	no-	concerned with patient turnover and money rather than spending time with patients
odd	no-	communication implies 2-way information Exchange, doctors want one way; them to you
moody	no-	they don't see importance in it, or are too busy, don't think it is important to care
driven	yes -	it comes with experience she knows few who do not have it
non-caring	no-	interpersonal comm. Involves listening most docs fail at this
	no-	don't spend any Time with Patients, rush in and out

Way Nurses Feel Doctors Treat them (personal statements)

Doctors feel nurses were put on earth to serve them and don't treat them with respect
very disrespectful not a productive work environment
doctors' patients are in hands of nurses and it would be better if they respected them for what they did and not just for following orders
don't appreciate nurses and want everyone to know that they are in charge
not many treat nurses with respect, but the ones who do, we will bend over backwards for to help
doctors can be friends with me, they are best with their patients, the second kind treat me and the patients badly, they go hand in hand
disrespectful doctors have it harder because it is hard for me to help a rude doctor
treat nurses as if their opinions are irrelevant compared to theirs superior attitude
most treat me with respect and see us as a team, they create a good work environment
some listen and treat with respect, but most do not. Some doctors get annoyed when nurses voice opinions on pt care this increaes stress envir.
Respectfully and it creates a good environment (she is a neonatal nurse practitioner)
not as a partner, but more as a busy body to do their bidding
treat us well and respect our opinions
most doctors don't even understand what my job entails
due to my advanced NNP training I feel I am listened to more than other nurses, I think I get a little more respect
I feel respected, but a few doctors make others look bad by treating nurses as second hand help and as if we knew nothing
treated as glorified flunkies,expected to do a little of everything from making coffee to making phone calls for them
doctors can be very condescending, and they don't always treat you as if you are a real person

Way a Doctor Relates to a Typical Patient and if it is done Well From a Nurses Standpoint

no-average time spent is < 3 minutes, I just asked me their name before he went in the room."
no-most are short in explanation and not compassionate at all
no-condescending but patient doesn't normally realize "They think the doctor was up last night awaiting their arrival when the doctor actually just asked the nurse their name
yes-doctors tell patients what they need to do to imprve their health in a nice tone
varies-I see you're here for? How are you feeling. I'm going to order some tests/labs. I'll see you in the morning less than 3 minutes total
no-how are you doing? Doesn't listen to the answer, flips the chart, mumbles a few words and leaves
no-don't take time to listen to what patient has to say and they speak above patients
no-tend to use medical terms that are non-understandable and they mumble and write illegibly
no-come in room explain whats going on and show a little concern for the patient
no-talks at them not to them and doesn't listen to them always seems in a rush
no-"superior" talks quickly too many "medical" jargon not in a way patients can understand
no-to much medical jargon and they are impatient
yes-treat children well and relate to parents well
no-I am the boss you do what I say, mumble and use medical jargon
yes-they relate well when they have something to tell, but when they are busy they may be impatient
yes-knowledge barriers cancause problems like speaking above patient, hard due to lack of personal knowledge of the patient
no- get to know pt. By reading the chart and by what nurse tells them, they don't take time to learn on their own
no- takes 2 minutes to explain what they are doing

What Nurses Hear Patients Saying About Their Doctors

If the doctor spends time with them the love them, if not the patients are indifferent and they tell nurses they don't like their doctors
not enough time with little explanation
patients think the doctor will stay around the hospital, but they are only there once or twice
could explain things in more depth about procedures, prognosis, and pretend that they are interested in the patient
some take time to listen and touch, hug a family member, but some just zoom in and out always making pts feel non-important
frequently hear the patients say the nurses do all the work and the doctors get paid
feel they are herded in and out like cattle
patients want to see more of them
doctors who act like they care and spend time get a much better response
rushed
patients say the doctors act like they are not "all there" like they have something better or more important to do
most feel not enough time given
they feel they are well treated
most feel hurried and that doctors don't respect the time with them, quality time is what is important
patients don't feel listened to
well he didn't stay long

Ways to Improve the Way a Doctor Relates to Nurses and Patients and ways to Become a Better Doctor

Treat Everyone with Respect	8
Care more	8
Listen to what is being said	15
Spend more time with patients	7
don't talk down to patients	7
treat everyone equally	
support patients wishes	
Be on time	
take less patients	2
smile and maintain eye contact	2

Treat Each Patient as if they are the only one you have
Remember who trained them in medical school...the nurses
Remember where you have come from be humble
Remember Everyone is on the same team
At least to pretend to enjoy being with patient, don't watch TV or be pre-occupied
Don't ignore patient while talking with family about something trivial
Befriend nurses they will have more respect for you and they will often know more about a particular patient than you will
Find ways to deal with stress
Keep a professional attitude, but get to know patients on a more personal level
Don't look at each patient as a case look at them as an individual
Don't question or tell a nurse she is stupid in front of a patient
Patients families do notice when doctors are not nice to nurses and other staff
Be knowledgeable
Be self confident
Always think before you speak, no temper tantrums
Everyone is scared even the best doctor
Treat each patient as if they are your mother
Nurses can be your best friends...treat them well and help teach them the way you like things done without being demeaning
Walk a day in a nurses and a patients shoes and remember to be humble
Hold their hand, cry and laugh with them
Sit down and listen to the patient, call them by name, and touching the patient can be soothing to them
Don't make them wait to hours to see you then spend two minutes with them
Watch the movie "The Doctor" base relationship skills on that
nurses spend the most time with the patients so they probably know them best
Always read and educate yourself to continue to improvee knowledge base
Be more self reliant never ask a nurse to do something you could do yourself
Be compassionate about what you are doing and not so much about the money

The next logical step going from nurse-doctor interactions would be to explore the way doctors relate to patients. I for one believe this relationship has deteriorated over time, and much is needed to improve it. Being a doctor like being a plumber is a way to support one's family and one's lifestyle, but more than that it is pledge to hold patient rights in utmost regard. This pledge has been broken. Problems arise for one simple reason. A balance must be struck between two opposing goals. The goal of patient care and the goal of a successful practice constitute these two important weights. The scale for many years now has been shifted too far towards creating successful money oriented practices, and somewhere along the way patients were left out in the rain. This has created a mechanistic manner in which patients are treated in the medical field today. One can blame it on costs, HMO's, excess of patients, or one of a thousand other scapegoats, but the simple fact remains something must be fixed. The focus of medicine must be shifted away from business and back to helping the ill. A successful practice is an important goal, but it does not have to be at the expense of patient individuality. Ideas to avoid this might be to hire more medical personnel or to find more ways of cutting costs. These, solutions, however, only perpetuate the cycle of money oriented medical practices. The one true solution is the teaching and understanding of how to communicate with patients. Five extra minutes talking to the grandfather with a failing heart would not only make him feel better about his care, but it could also save the doctor future court costs. Doctors must once again become the friends of patients. By creating relationships such as these, we in the medical field can remove the stigma that people are looked at as dollar signs.

The communication and building of friendship has many facets and starts when a patient walks into the front office. When a person walks into a friend's house, does one want to see a sterile environment with uncomfortable chairs? No, a person wants a nice place where they feel comfortable and at ease, and this is also what is desired in physician's practice. The first step in this is having a receptionist who is friendly and as helpful as can be. Her desk should be clearly visible, especially to first time patients to avoid confusion. She must also be very alert to make sure no patient is missed or overlooked. When a patient arrives he or she will be placed on the waiting time tracking list. This list is a tool to help analyze patient wait times. It helps make sure that everything possible is done to decrease patient waits. An example of this can be seen on the next page. One must continually improve office functions such as this because they weigh heavily on return visits. Most doctors are capable of fixing common ailments, but only the best are able to sustain lasting relationships with their patients. While waiting, I will encourage conversation between my receptionist and other coworkers with my patients. I believe that this conversation can help establish a lasting relationship between my practice and my patients. The waiting environment is also important. The waiting area along with my exam rooms will be cozy and warm. Walking into a white sterile environment where everything is cold to the touch isn't my idea of a good time. Little things such as these may prove to raise up-front costs, but the potential benefits for patients will pay off in the long run.

Now that my patients are comfortable, I can focus on getting to see them promptly. Time management is a very tricky obstacle. There is only so much time to give. A physician must understand that his or her time is no more important than a patient's time. If a patient makes an appointment for 9 o'clock it should be assumed under normal circumstances that he will be seen relatively at that time. I understand that emergencies arise and backups can happen, but one must be able to handle them in a professional manner and not make them a routine practice. A common reason that back-ups happen is due to overbooking. Three people are often scheduled for the same time with the assumption that two of them will not show up. This type of setup needs to be fixed. It

WAIT TIME TRACKING

Patient Name	Arrival Time	Appointment Time	Time Seen by Doctor	Wait from Appointment Time to Time Seen
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				

Average number of early arrivals: _____ Longest wait of the day: _____

Average number of late arrivals: _____ Shortest wait of the day: _____

Daily average wait: _____

creates a problem for doctors and for patients. I propose to employ a missed appointment fee. Proper use of such a practice means that adequate attempts to inform patients of their appointment are made, and that this fee is clearly known by the patients. I will accomplish this task by having an employee call patients the day before an appointment to confirm the appointment and make note of the missed appointment charge. The employee will again call to confirm on the day of the appointment and again politely mention the importance of keeping the appointment. This in conjunction with a day after phone call thanking patients for visiting my practice and being prompt is one way I will combat long office waits. This alone would do wonders for the image of doctors.

I walk into medicine having an innate advantage. I am a morning person, and I will open my practice at approximately seven in the morning. This gives my patients the opportunity to arrange an appointment around their work schedules. I will work till eleven, and I will then proceed to eat lunch and visit my patients that have become hospitalized. I will return to my practice at two and take appointments until six. This will be my schedule for Monday, Wednesday and Friday. This schedule allows me to catch patients before and after work while at the same time visiting hospital patients at a time when they are awake. Many doctors do their hospital rounds in the morning, but I do not believe a true assessment of a patient can be accomplished when they are half-asleep. It is also a lot easier to be a patient's friend when they are awake and alert. This would be another step towards improving patient care and improving public perception of doctors. Although I will be scheduling patients before and after work, some patients will be inconvenienced by my absence during lunch hours. Because of this, I will have an alternate schedule on Tuesday and Thursday. During this schedule I will also begin work at seven, but I will not leave at eleven. I will take a fifteen to thirty minute bag lunch break. This will allow me to schedule patients during their lunch hours two out of five days a week. The following table outlines my weekly schedule.

Monday , Wednesday , and Friday			
7.00-11.00	11.00-2.00	2.00-6.00	2.00-6.00
Open practice and take appointments	Lunch and Hospital visits	Appointments and close practice	Have 15 minute meeting with Office Administrator

Tuesday, Thursday			
7.00-11.00	11.00-11.30	11.30-3.30	3.30-6.00
Open practice and take appointments	Lunch and 15 minute meeting with Office Administrator	Appointments and close practice	Visit with Hospital Patients and take care of unexpected situations

I understand that I cannot accommodate every person's schedule, but I do believe being flexible is important in a service business. There will be days that I have to work longer than my schedule dictates, but proper scheduling should be able to keep that at a minimum.

The topic of direct doctor to patient communication now takes place. The patient has been called the day of and day before the appointment, they were greeted by a friendly person upon entry into my practice, they waited in a warm caring environment for a short period of time, and now the ball is in my court. I hear patients talking about the quantity of care they have received from their doctors. What they really mean is quality of care. I do

think you can spend as little as three minutes with a patient and convey more warmth, love, and understanding than an emotionless doctor can give in an hour. Patients want doctors to become more connected with them as a person. Doctors spend years training to be objective in their craft, but by doing this they lose something that connects them to their patients. I propose to regain this connection. It was said by Hunter "Patch" Adams, "If you treat a disease you win you lose. You treat a person I guarantee you win, every time." This statement is a guiding light in my belief in medicine.

To treat a person one must care and become emotionally connected to the person. This entails being happy to see them when you meet, smiling, laughing, and even crying when the time is right. It is the little things like this that make such a difference in how a patient perceives his or her doctor. A nurse said that many doctors walk into the room and pay more attention to the television than they do the patients. I say that is ridiculous. A patient should feel like their welfare is the only thing on their doctor's mind. This is probably never the case, but make them believe it anyway. Action precedes attitude, and if you act like you care, you will begin to care. Make eye contact with a patient. This art of communication is not rocket science. It basically entails being considerate and treating others as you would be treated or as you would treat your own mother. This is a golden rule that will place patient care once again to the forefront of concern in the medical field.

The last area of conflict between the patient and the doctor is one of payment. A medical practice no matter how you slice it is still a business and patients must be charged. Unless a massive change in medical care takes place in the U.S. this will not be altered in the near future. Patients feel over-charged by their doctors. They feel the time devoted to their care is not adequate in terms of the price they pay. The thing many patients do not understand is that many other tasks related to their care are accomplished before or after they see their doctor. Patients must be helped to understand the make-up of how they are being charged. In analogy, would a person walk into a mechanics shop, have their car fixed, and then not ask what was done to it before they paid. I surely hope not, and the same should be true in the medical field. The following fee explanation sheet is an example of how I will communicate this. The doctor should go over many of these with the patient because a patient should understand that the doctor will be working for them even after they leave. This type of form shows that much outside work must be done to help heal a patient. It is not always just the few minutes in the exam room that one is being charged for. This belief is common and must be changed.

With the adjustments to a practice mentioned above, patient communication can be made much more effective. In conjunction with this improvement, I believe that patients should be routinely monitored as to how they feel I am running my practice. To do that I will have each patient fill out an Office Report Card similar to the one following this section before they leave the office if able. Questions involving courteousness and promptness are of my utmost concern. I also feel the open suggestion area will give patients an open forum to convey their opinions on improvement for my practice. Continuous monitoring and changes in how I relate with patients will make my practice stand out in the eyes of the public.

FEE EXPLANATION

Dear Patient:

Your fee for service includes your visit with the doctor based on the time and complexity of your condition and any treatment provided. In addition, proper attention to your case requires that the doctor spend more time working for you outside your direct visit with him or her. such time may include:

- Creation of a permanent medical record.
- Review of all laboratory blood test results (e.g., a biochemical survey and CBC contain 42 separate test to interpret and file in your chart).
- Review of prior and current x-ray or scan reports and personal review with the radiologist of abnormal studies.
- Preparation and mailing of consultation reports and follow-up visits letters and laboratory/scan results to referring physicians and any subsequent consulting.
- Follow-up phone call or letter regarding laboratory test results of patients and/or copies of test results when indicated or requested.
- Phone consultation with referring or consulting physicians and other health care providers about your case.
- Other phone calls to and from you and your family members for various reasons.
- Referral letters to any further specialists recommended by the doctor.
- Patient educational materials and medication samples when available.
- Any research done by the doctor about your case. The doctor used medical libraries and computerized medical search services.
- Staff assistance regarding your visit.
- Arranging and coordinating other tests and consultations.
- Calls to and from pharmacies.
- Insurance application forms: health insurance, disability insurance, life insurance.
- Insurance reports: health claims, disability claims to insurance and state, Medicare disability.
- Discussions (sometimes acrimonious) with hospitalization utilization review, insurance companies, or Medicar for ongoing hospitalization.
- Review and management of hospital records.
- Letters of necessity to obtain medical instruments or prescriptions.
- Letters of necessity for medical services to insurance companies.
- Arrangements for hospitalization with hospital admissions, house staff physicians and consulting physicians, and test/treating facilities.
- Communication daily during admission with nurses, house staff, and attending physicians.
- Tumor registry and other required reports.
- Home health care and nursing facility orders.
- Other reports and forms: jury duty, school, job, sick leave, back to work, communicable disease, etc.

In addition, the doctor participates extensively in continuing medical education, clinical research, teaching, and medical writing to keep up-to-date on the latest medical advances.

At our office, we feel a strong commitment to keep costs to our patients down. Even so, the cost of salaries, rent, taxes, insurance, billing, postage, photocopying, medical supplies, office supplies, medical journals and textbooks, and other materials keeps increasing. We charge only what we feel is necessary in order to maintain the highest standard of care. We look forward to a lasting and healthy relationship with you.

Sincerely,

OFFICE REPORT CARD

To help us serve you better, we would appreciate your filling in this report card on our office.

	LOW			HIGH
Did we greet you promptly and cheerfully? 1 2 3 4				
Was our office neat and clean?	1	2	3	4
How is our magazine selection?	1	2	3	4
How do you like our office décor?	1	2	3	4
Was there adequate parking?	1	2	3	4
Were you seen on time?	1	2	3	4
If we were late, was it explained?	1	2	3	4
Have your phone calls or lab results been returned promptly?	1	2	3	4
Do you like being called by your first name?	1	2	3	4
Were you comfortable during your treatment?	1	2	3	4
Was our staff courteous?	1	2	3	4
Have we answered your questions clearly?	1	2	3	4
Did you understand why particular care was recommended?	1	2	3	4
How well are we responding to your needs?	1	2	3	4
Would you recommend us to your family and friends?	1	2	3	4

As a patient of Dr. _____ I would like to tell him/her _____

_____

_____

Additional suggestions that might help us serve you better would be appreciated.

_____

_____

_____

_____

Thank you for your help and cooperation!

Your name below is optional. If you would like a response, please enter your name and phone number.

_____

Abortion

This is one of the most controversial debates of our time. Abortion is a topic that is deeply routed in the history of man, and it continues to be a subject of much medical and moral debate. It is important not only to have a stance on issues such as this, but a person especially a doctor must know the history of the debate and have ideas to make things better. With this in mind, it is important to know that the history of abortions spans the history of man, but with the technology of the last century it has become increasingly important to understand it better. In the time before 1973 having an abortion was an extremely horrifying experience. Though the process was extremely painful there was no anesthesia used, and many underhanded practitioners and con artists took advantage of women in desperate situations. Over 193 women died in 1965 alone. It was clear that something had to be done to stop this deficiency in society. The change began to start in 1962 when a patient by the name of Sherri Finkbine had to travel to Europe to have a severely deformed and inviable child aborted because a local district attorney in Arizona threatened to prosecute her if the abortion was performed in Texas. The publicity of this case pushed the subject of abortion to the forefront of public debate in American society. Five years later abortions were still illegal, but sensing a push towards legalization; the Catholic Church gave its opinion. They issued an encyclical called *Human Vitae* which stressed no use of any form of birth control. This statement inferred that having an abortion was also against church doctrine. This prompted as much as 90% of American Catholics to disagree with the churche's stance even when it contradicted with church doctrine. This type of social change and cases like Sherri Finkbine's in America finally led to societal acceptance of abortion. In the five years preceding the Roe vs. Wade decision 18 states legalized abortion. This means that the Supreme Court decision of Roe vs. Wade to legalize abortion was only a reflection of what was already happening in society at the time. The court decision established rules that are flexible. They say that an abortion is legal before the viability of the fetus is possible outside of the mother's body. This is a debatable statement especially in the ever-advancing technological society we live in, but the courts set it at 24 weeks. The provisions for having an abortion have to do with circumstances where the mothers life may be lost, and the provision, that many consider a loophole, that a woman may have an abortion when her health is at risk. This is a very blurry criterion because the concept of health can be shaped to fit almost any circumstances. It is due to this provision that a doctor must fully understand his view on abortion.

A doctor must realize that unlike the positions of many in society he cannot look at abortion as a black or white, wrong or right issue because many gray areas exist that must be addressed. As a man I do not feel I have the moral ability to try to control the reproductive life of a woman. The problem is that as a doctor I have to decide if abortion fits into something I am willing to support or something I am willing to perform. First of all, lets call a spade a spade. Abortion and fetus are medical terms, but clearly stated abortion is the killing of a child not an inanimate object called a fetus. It may seem that by calling it murder would make it a more clear cut topic, but it only makes the decision that much harder because there are instances when the life of the mother is at stake and for her to live the child cannot. Because of these exceptions to the rule, I must support the fact that abortions are medically necessary in certain circumstances, and that there is a clear responsibility that they need to be performed by a medical professional. Although I understand this need, I don't think I would be willing to perform an abortion under ordinary circumstances.

Situations where abortions should be allowed are few and far between, and the view that having an abortion is a way to fix an unwanted pregnancy must be changed. I will address this later. The situations that arise that must truly be addressed are those falling in three categories. The first category pertains to the circumstance when the child will be either nonviable upon birth or will have serious defects or malformations. This was the situation the before mentioned Sherri Finkbine had in 1962. She took thalidomide tranquilizers for medical purposes in her fifth month of pregnancy. This drug is now called the "monster former" often making children with missing arms or legs. After Sherri was alerted to this fact a "therapeutic abortion" was requested. This is obviously not something Sherri wanted to happen, but the fact is that having an abortion may be the best recourse under these conditions. The second situation would be when the process of having a baby would severely endanger the life of the mother. This is often the case in mothers who have cancers such as ovarian or cervical. In these cases a hysterectomy is often the only option, and it must be considered. There are many other medical conditions that might severely complicate a pregnancy, and all of the options must be weighed before a decision is made concerning the mother and the unborn child. The last situation that makes me angry and sad is when rape or incest are involved in the picture. This is a completely horrible situation that must be dealt with on a case by case basis, and it would be very insensitive and callous for me to tell a woman that she must bear the child of the man who raped her. This is something that must be decided by her. These are the situational circumstances that I would deem worthy of consideration when deciding on the appropriateness of an abortion, but the timing of the abortion also should weigh heavily on the decision. Abortions performed less than 8 weeks of gestation are 7 times safer than pregnancy. The earlier an abortion is performed the better because the longer the child lives the more moral and legal consideration it must be given. My opinion is that for most situations, if an abortion is being considered, it should be performed in the first 12 weeks of gestation. For 1998 the National Center of Health Statistics says that 56% of abortions are before 8 weeks and 88% are before 13 weeks. No matter what situation a woman is in, the option of abortion should only be considered after thorough counseling with a doctor to look at all options because it may not be the best course of action. The doctor and the mother must understand that they will be killing a child when they perform the abortion.

The topic that gets many people and even myself up in arms is the use of Late Term Abortions, which are now banned in many states. The medical term for this procedure is Intact Dilation and Extraction, and it is a very gruesome procedure. This type of abortion is only a very small but significant fraction of abortions. It ranges somewhere around 1.4% and consists of abortions after 21 weeks of gestation. This age is approaching the time when the child (fetus) could be viable outside of the mother's womb, and there are only a few situations that I would agree with a decision as monument as abortion. I say this because when a child is viable I believe its rights must also be heavily considered in all decisions. As can be seen throughout my discussion on this topic I try not to take an absolutist position on every topic because no situation or person can claim absolute moral authority in all circumstances. A balance including the welfare of the mother and child must be looked at before deciding on decisions such as late term abortions, but it is fair to say that almost every time I will opt out of recommending or even supporting a late term abortion.

I have spoke of the history of the debate and my views on when and how I believe abortions are suitable. I have explained that I would normally not feel comfortable performing one, but to complete this topic I must explain how I would and will help to fix the high percentage of abortions that are currently being performed. This is necessary because without a plan of action nothing every changes and people get stuck in the same

circular debates. In 1998 eight hundred-eighty four thousand-two hundred and seventy three abortions were legally performed in the United States. This is more than 20% of all pregnancies. This number is so high that one is not even able to comprehend its magnitude. Consider that more than 290 times as many children are aborted each year than people were killed in the attack on the World Trade Center. This number must be lowered in some way. We must change the meaning of an abortion, educate people on their options, improve adoption services, and mainly preventing unwanted pregnancies from happening in the first place. It must be conveyed to society that having an abortion is not a societally acceptable way of dealing with a simply unwanted pregnancy. This opinion does not apply to the criteria listed before where abortions should be considered. Today, when a woman accidentally gets pregnant the idea of abortion immediately jumps into their head. The word abortion must be replaced in this rationale. One is not having an abortion, but instead they are killing their unborn child. Changing the concept and the magnitude of what is being done would help change the number of abortions. This combined with the adequate availability of professional counseling would help curb the rate of abortions. With counseling a mother could be informed of her options and the emotional turmoil involved in all of her decisions. This combined with improved adoption programs would give many women a better option than basically killing a child for an unacceptable reason. All of these ideas consist of ways to lower abortion rates after the women are already pregnant, but the best way to handle this problem is to lower the rate of unwanted pregnancy. Prevention is normally the best way to handle most medical situations. The numbers show that 63% of abortions are by women 15-24 years of age and 80% of the women are unmarried. This implies that targeting these young women with sexual education and lowering their sexual activity before marriage would be a logical step towards the betterment of the problem. I recommend more sexual education at younger ages for men and women, and I especially support access to contraceptives and birth control for adolescents. It is simply a shame that so many teenagers bear such a high rate of abortions because their parents are too ashamed or naïve to admit that their children are having sex. As a doctor I support most things that could lower this rate of abortion and improves the health of my patients.

Doctors and all medical professionals have a responsibility to consider the medical and ethical issues involved when the issue of abortion is presented to them. These have been my views on this topic and I admit that I do not have all the answers, but I will stand for the rights of all my patients. This includes the mother and the unborn child. The lot of doctor is that he must make decisions that often result in undesirable outcomes. This makes the idea of the Hippocratic Oath to do no harm something that sits in the gray area between right and wrong. When talking about the bioethical issue of abortion, it must be understood that it is a topic that many spend a lifetime arguing against on a platform their entire life while others spend a lifetime fighting the exact opposite battle with fire and commitment for what they believe. Right or wrong it is here to stay, the decision is how to deal with the law and situations with which we are presented.

End of Life Care

There is a common issue that arises at the end of many people's lives in a society that can prolong life for so many years. Physicians must deal with this issue, and it is how to adequately care for terminally ill patients. The role of a physician should not be to make decisions involving the welfare of his patients, but instead the role should be as a guide who informs the patient of all of his options. When a patient is informed he is able to decide how his life will come to end. I am a firm believer in the important role a doctor plays in end of life care. This care can be in the form of hospice care, and it can also include a role in helping a patient end their life with dignity. I believe patients have the right to know when I believe nothing more can be done to make them physically well again. This does not mean giving up on a patient or letting them lose hope, but it does mean the focus of life should be changed from length of life to quality of life. Hospice care and physician assisted suicide are two issues that I have thought long and hard about that deal with this issue of quality of life.

I have seen one too many patients spend the last month of their life semi-conscious in a hospital room because a doctor doesn't know when to stop with the aggressive therapy and life prolonging measures. This includes all the invasive blood draws, body taxing drug combinations, and other treatments that put a heavy toll on the body. I don't know if these unrealistic efforts are done because of training or because of fears of lawsuits, but I believe a common theme is that most doctors don't know how to accept that one of their patients will die. I do not want to save every patient that is in my care because that is not the role of the doctor. Yes, doctors save lives and heal the sick, but what is a doctor's role when a patient can no longer be made well. You then become a friend and an advisor on how to savor the last days, weeks, or months of one's life. This is why I am such a firm believer in the concept of hospice care.

The movement towards this idea of hospice care started in the 1960's by two foreign physicians practicing in the United States. These women were Elisabeth Kübler Ross and Cicely Saunders. The idea behind this movement is to not try and fight or delay the onset of death but instead to make it as comfortable an experience as possible. At the end of life there are two things that a person needs most. The first is the relief of physical pain, and the second is the relief of psychological pain. The latter I will deal with more thoroughly at a later time. These goals often revolve around the patients desire to die in a dignified manner and have the maximum amount of control over death. The idea of hospice care has led to the concept of palliative care. This is a goal to reduce the painful and undignified symptoms of the dying patient. There are two types. The first which is active palliative therapy involves trying to prolong survival and achieve remission of the disease. This active form was born out of the way many patients feel they are treated by the medical field today. Instead of a number or simply a person with a disease they wanted to have a name and be treated as a friend again, and this is a concept I will practice in my day to day medical life. The second form which is symptomatic palliative care therapy involves maximizing the quality of life during the remaining weeks or months of a persons life. This goal of respecting autonomy and letting patients make their own decisions is what I believe is important about end of life care. This discussion naturally leads into the next more debatable option many physicians must deal with at the end of a patient's life.

My background and faith give me the ability to firmly take a stand on the issue of physician assisted suicide. It is one thing to say it is right or it is wrong strictly on first reactions, but when situations are looked at in real life on a case by case basis things become more complicated and the strengths of it can be seen. I stand firm that a patient has the right to decide when medical treatment should stop, and this in itself is not even a

controversial issue. The controversy arises when a patient is in such unbearable pain that they decide they want their life to end. Sometimes the only other option to relieving pain is to give high doses of drugs that place the person in a semi-state of drooling consciousness. These strong painkillers often place the patient in a dream world till their death, and this is no life to live. I find it hard to make the decision as to when a person's life should end, but I do not find it hard to accept when the person makes the decision on their own. A physician is present during a person's entry into this world as well as a person's departure. A patient's manner and choice of departure from this world in terminally ill cases shouldn't even be up for debate, but it constantly is. In order to make my stance clear, I will discuss the issue in an ethical manner.

Should physician assisted suicide be allowed in these cases in a moral and ethical society? The first step to answering such a question is to define exactly what is meant by physician assisted suicide because there are many different definitions for very similar words. There are currently three methods of hastening the death of terminally ill and suffering patients. These are by removing life sustaining treatment, assisted suicide, and euthanasia. The removal of life sustaining treatment is currently accepted with the consent of the patient or legal caretaker. Euthanasia is an active form of ending a patient's life by the direct injection of a lethal drug, and because of this active role it should be kept from use in practice. The role of patient assisted suicide however is a more widely debatable issue.

This concept is not an issue of moral disagreement, but it is rather an issue of moral pluralism. The basic fact that people have different backgrounds for forming opinions leads to the conclusion that the answer to moral problems will sometimes if not usually be different. This comprehensive concept of looking at life can be referred to as a person's worldview, and this view is unique to each individual person. Although there are many different types of worldviews a person may have, the concept of patient assisted suicide is supported by many of them with the use of two premises. The first premise is that one of the most important ethical principals in medicine is a patients rational autonomy, and this principle should be most important in almost all conflicts that arise with others (Levine, pg. 67). The second premise is that the role of a doctor is to provide the best care for his patient and to do the least amount of harm. John Stewart Mill's model of utilitarianism and principle of harm, Greek and Virtue Ethics, and Kantian Ethics are all worldviews that support physician assisted suicide, although all three doing it in a different manner. Physician assisted suicide should not be forced on either patients or doctors, but it should be a choice for patients who need its benefits.

The essential idea of utilitarianism is that right acts should produce the greatest amount of good for the greatest number of people, which is called "utility" (Pence, pg. 18) The benefit of society as a whole must be looked at in order to fullfill the definitions of this worldview. The person involved in this from an emotional utility standpoint is the patient, so maximizing his utility in this respect would maximize the overall societal utility. The theory of value is defined by pleasure or doing what people would prefer, and if an autonomous person with no want and desire or even hope of recovery wishes to die then patient assisted suicide would alleviate this need. The second utilitarian argument is the financial benefit of such actions. A rational autonomous person would be given the choice of having to be kept alive while being in such pain and humiliation. The choice of a quicker and more efficient means for a person to die with dignity and without pain would benefit society in many ways. The money saved on futile life sustaining treatments could be used to further benefit the elderly populations instead of being wasted on avoidable and unwanted treatments. The principle of harm also reaffirms that this case is purely personal and does not put other people at risk, and because of this should be allowed. The fact that

the greatest harm that can be done to a desperate patient is to force them to endure unbearable suffering is cause alone for utilitarianism's greatest good principle to apply in the case of terminally ill patients opting for physician assisted suicide.

Greek and virtue ethics looks at the issue from a second worldview standpoint. The standpoint focuses on performing a role well. The traits of a good physician would develop toward a natural goal. This goal is the premise that the role of a doctor is to provide the best care for his patient and to do the least amount of harm. The virtues that are needed for this include compassion, knowledge of healing, skill in human relations, respect of a patients autonomy, and knowing when no more can be done. This wolrdview asks what virtues are necessary in a good person to be a good physician, and what should this physician do? The answers to these questions lie in the virtues of a good doctor. Knowledge of healing would implore the doctor to help the person to the best of his ability, compassion would be found in the form of the doctor wanting to alleviate this patients harm, people skills would be found in communicating with the patient and the patients family, and respecting the patients autonomy would be found in the doctor respecting the terminally ill patients right to end his own suffering. These virtues all support the option of physician assisted suicide. Physicians should be oriented to helping patients in the here-and-now, and this includes helping terminally ill patients to die, believing that it is futile to maintain a life of pain and suffering that had little chance of amelioration (Pence, pg. 11).

The last worldview deals with intentions of a person instead of a person's consequences. This is a Kantian viewpoint. This means that acting properly is a matter of duty and not of consequences. The right of a rational terminally ill patient to make an autonomous decision about ending his life is a maxim that can be ruled universal. This concept also requires that the patient is and end and not only a means. This means that each individual patient has infinite moral worth, and these patients desires cannot be compromised for someone else's. In accordance with Kantianism a person is only free when they act rationally. With this in mind, in a free society a rational person should be allowed to make such a decision in regard to their own life. The moral pluralism regarding the issue of physician assisted suicide for terminally ill patients is supported by utilitarianism, virtue ethics, and kantianism. All of which look at the issue from extremely different world viewpoints. Because of this, it is irrational to remove the right of physician assisted suicide for suffering terminally ill patients who have autonomous rights.

Medical Overconfidence and Prejudice

Prejudice and overconfidence are two words that cannot be part of a physician's life. In order for a doctor to best serve his patients he must treat all of them equally, and always understand that he does not have all of the answers. The history and events surrounding the AIDS (Acquired Immunodeficiency Syndrome) illustrate both of these points quite well.

The outbreak of this deadly disease started in the U.S. in the early 1980's. The first instances of the disease were isolated in the homosexual community. The CBC reported the disease as a mysterious "gay cancer" and the name GRID (gay-related immune disorder) was given to this sickness. It was this disillusion that the disease was only transmissible by homosexuals that was so out of touch with what medicine is all about. This idea was not born out of scientific evidence but instead it was born out of fear and hope that the "normal" people would not get the disease. Instead of looking at the problem with one's brain and love of people, it was looked at with fear and hatred. It wasn't until a year later that the disease was renamed AIDS after babies of drug addicted mothers were found to have the disease. In the 1980's the medical community harbored much prejudice towards the carriers of this disease. This prejudice mirrored the prejudice of others in society. This is exactly the type of thing that doctors and other health care workers must shield themselves from. They must subscribe to the truth that all people deserve adequate healthcare no matter what one's individual prejudices may be.

During the early days of the AIDS outbreak the blood supply of America was not tested for AIDS because there was no test for it, but it was not tested for Hepatitis do to cost cutting measures. The testing for Hepatitis would have eliminated somewhere in the range of 80% of HIV infected blood. The reasoning for no testing had to do with costs, but it also had to do with the overconfidence by the blood-banks that their blood supply was not infected. In 1983 the Health and Human Services Director Secretary Margaret Heckler said," I want to assure the American people that the blood supply is 100 percent safe.....The blood supply is safe both for the hemophiliacs and for the average citizen who might need it for surgery." She also predicted a vaccine for AIDS would be available in 2 years. After that, more than 8,000 hemophiliacs were given a life sentence because of overconfidence and unwillingness to accept a deficiency in the system, and to this day there is still not a cure or a vaccine for this horrible disease.

A person is first of all human and vulnerable to all human weaknesses, and this includes doctors. They are susceptible to the fears of prejudice and the overconfidence gained with experience and lack of change. A doctor must care for each and every patient with the same dedication. This means that sometimes you must treat a person who you know will not be able to pay you back. It means that you must provide care for all races, creeds, faiths, and backgrounds, and a good doctor will draw enjoyment from each of these experiences. This can happen when a doctor realizes that he doesn't have all the answers, and he can learn something from each of his patients. It is when overconfidence in one's abilities becomes apparent that life decides to throw you a curve ball. It does not matter how much about medicine you know, nature is an ever-changing kaleidoscope and you can never view it all. Although this is true, once realized, a doctor can make the effort to learn as much as he can to help his patients and the people in his life. This is a motto that should be followed by doctors and all others around the world.

Medical Microbiology

It is important for a doctor to know the current developments and pitfalls found in the field of microbiology. The microbes that make up this field are marvels of nature. They react and change with every step we take. It is important for a doctor to understand them because they are a major cause of death in the United States. The scope of the microbial world covers the realms from emerging infectious diseases to the very real threat of bioterrorism. In order to be a good doctor, one must understand the threat of infectious diseases.

Microbiology is a field created by organisms that have been here longer and will be here long after we are gone. This field is of utmost importance to the medical practitioner because of the relationship it has with people. These and other microbes cause infectious diseases, and their threat was difficult to contain before the 1950's. Some control was found over them with proper use of handwashing and disinfectants at clinics and hospitals, and this combined with less crowded conditions and a cleaner water supply hindered the transmission of many diseases. The ability of people to resist the infection in the first place was improved with access to better nutrition and vaccination. Despite all of these strides in infectious disease control tuberculosis, pneumonia, syphilis, and other such diseases continued to kill many people. It was during widespread clinic use in the 1950's that the be-all-end-all for bacteria was thought to have been found. Antibiotics seemed to eradicate any and all forms of bacteria. This sense of conquest over bacterium however was short lived. Due to the rapid mutations and genomic changes of bacteria many strains have become resistant to some if not all antibiotics. In the 1980's a rise in infectious diseases was noted, and by 1995 it was one of the top five causes of death in the United States once again.

These changes in bacteria, viruses, and fungi along with the new environments for them, created by humans, have established an important niche that must be studied to understand medicine. This emphasis includes emerging infectious diseases, food borne and water borne diseases, hospital acquired (nosocomial) infections, antibiotic resistance, and the deadly realm of bioterrorism. All of these public health issues are equally important, but because of the current situation faced by the United States the focus of this discussion will be on Bioterrorism. I will however discuss some basics involved in the other fields.

After antibiotics new emerging infectious diseases and old diseases that were thought to be under control have wounded the ego of the medical community. There are several classifications for what level of emergence will be given to a bacteria, but by discussing individual bacteria one will be able to understand the general importance of study into this field. A bacterial disease that has previously been unidentified and has only recently entered the human population is Lyme Disease. This disease is caused by the spirochete Borrelia burgdorferi. The rise is in this disease relates to two factors. First, there is the deer tick, which is the disease vector. This vector grew enormously between 1980 and 1990 due to an explosion of deer populations caused by reforestation. Second, there has been an increased desire by humans to build houses in forested areas. This gives the abundant deer tick easy access to the human host. This disease can cause long term neurological damage, and like many other diseases it frightens the public. It is important for a doctor to understand the tests and risks involved in diseases such as this in order to deal with his frightened public. Diseases other than Lyme Disease that have recently been in the public sight are Legionnaires Disease caused by Legionella pneumophila and cat

scratch fever caused by Bartonella henselae. As long as the human race advances into new places and changes environmental conditions, there will always be new emerging diseases to handle.

A second area of focus in microbiology is Food Borne and Water Borne diseases. These diseases can also be considered emerging or re-emerging, but they hold a special place in science due to the importance place on them by the public. It is amazing the risks that people are willing to take. These range from driving in cars to sexual promiscuity, but society seems unwilling to budge on the purity and safety of its food and water supply. In the past, the focus on food and water cleanliness was focused on pesticides and residues, but the bacterium E. Coli O157:H7 has changed all of that. This strain of E. Coli causes bloody diarrhea, kidney failure, and possible death. Undercooked meat, non-pasteurized juices, and radish-sprouts have fueled the outbreaks of this disease. At one time outbreaks such as these would have been isolated, but with the advent of global trade and food being shipped throughout the world it is common to spread an outbreak like this to many places. In contrast, water borne outbreaks still tend to be a more localized occurrence. One of the major causes of water borne diseases are parasites, but the conditions favoring parasite growth offer a suitable environment for bacteria also. An often-overlooked aspect of infected water is that infected water can easily contaminate food. It is for these reasons that we closely monitor our food and water supply. Outbreaks spread by these vectors are not only dangerous, but if uncontrolled can cause the nation to panic. The food and water supply illnesses caused by microorganisms must be understood by physicians.

Of major interest to clinical practitioners are the subjects of nosocomial infections and how modern medicine can be a source for new diseases. Nosocomial infections are the enemy of all doctors, hospitals, and medical personnel because when a person is under medical care they do not expect to be infected with something else that may even be worse. This can be seen clearly when a patient enters the hospital with a minor injury or for minor surgery and ends up with a serious infection? It happens more than most institutions would like to admit, and consequently people who should live do not. Several factors contribute to this problem. These include accidental contamination, the lack of following hygiene protocol by the staff, and superfluously medicating with antibiotics. Accidental contamination is an inherent risk that goes along with hospital care, and it can be lessened but never eliminated. With this in mind, I will talk about lack of hygiene protocol now and speak of superfluously medicating patients later. Working in a hospital is like other jobs except for the simple fact that people's lives weigh in the balance of the decisions you make. Even when this in known, it is often easy to cut corners in patient care. For instance, it is easier if you don't wear gloves in every room, it is faster if you don't wear the droplet precaution mask, and washing your hands is not always on the top of the list. It is small things like these that are large contributors to nosocomial infections. Staff who visit multiple rooms need not only be aware of such dangers, but they need to have incentive to follow proper procedures. It is in the understanding of the importance of this that can remove a major contributor of nosocomial infections in hospitals and practices. A big source of nosocomial infections has been the influx of technology into the medical field. Because of this it is more likely for a person to die of their own flora than it would be to die of something like pneumonia or tuberculosis, which are the public's mental image of infectious diseases. This may seem strange, but surgeons today are transplanting hearts, saving people from cancer with chemotherapy, and other such amazing medical miracles. The only catch is that with more invasive procedures comes a higher risk of infection with bacteria that have never before been suspected of being able to cause disease. These bacteria are called opportunistics. The reason people in circumstances like this are susceptible is because of their weakened immune system. The risks involved in such

procedures must be carefully weighed and every safety and hygiene precaution followed in order to lower a patient's risk of acquiring a nosocomial infection.

Hand in hand fighting the threat of nosocomial infections are a doctor's antibiotic arsenal of weapons. The only problem with this arsenal is that it keeps becoming less effective than it was in the last battle. Bacteria keep adjusting their defenses and putting up more armour. An early example of this occurred in the 1980's when homelessness and drug abuse created an ideal environment for tuberculosis to flourish. These patients with M. Tuberculosis were given antibiotics and other medications, but because many of them were alcoholics and drug abusers, their compliance was very low. This allowed M. Tuberculosis time to adapt to the antibiotics, and multi-drug resistant tuberculosis was born. This is a case where a long known pathogen acquires one or more resistance traits that makes it non-susceptible to previous treatments. The abuse and overuse of antibiotics by patients and doctors is what has created this problem. A large percentage of blame lies on the doctors' shoulders because as treatment based approaches have begun to become ineffective many doctors turn to more advanced antibiotics. Instead, doctors should use front-line antibiotics if they must at first, but they should send samples to the lab to determine the antibiotic that is least expensive and not needed as much in the fight against multi-resistant bacteria. Many of the bacteria that have acquired this resistant traits are Streptococcus Pneumoniae (most common cause of pneumonia and sepsis), Staphylococcus Aureous, and Enterococcus species. Some of these bacteria are resistant to all known antibiotics, and pose a major threat to immuno-compromised patients as well as the general public. Eternal Vigilance and caution is the only true weapon we have keep the threat of infectious diseases at bay.

This day in age we have technology that can save millions of lives and help countless others. The price of this technology is that with its development, weapons have been created that can kill many more than could ever be saved. The field of microbiology is no less susceptible to such downfalls of science. These leaps in knowledge have created the very real threat of Bioterrorism. The history of biological warfare spans many centuries even before the vectors of sickness were known. One of the first known uses was in the 6th century B.C. when Assyrians poisoned wells with rye ergot and other such tactics. Dead bodies infected with plagued being thrown over walls and variola contaminated clothing given to Native Americans are two other such past uses of biological warfare. The fact is that the threats faced today are not new, but they could be epidemic in size due to the advances in technology. Over 140 countries have come to this conclusion and have signed the Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on the Their Destruction, commonly called the Biological Weapons Convention. The problem with this agreement is that many countries continue to add biological and chemical weapons to their arsenals.

The reason that a doctor must be up to date on such issues is the fact that not only are these weapons out there, but people are willing to use them. For example, the "yellow rain" incidents in Southeast Asia, the ricin assassination weapon in London in 1979, and supposed accidental release of anthrax spores in Sverdlovsk in 1979. The current political movement involving Iraq is also on the list of major current threats. After the Gulf War inspection into Iraq's biological capabilities was investigated. It was found that they were currently researching weaponinzing Bacillus anthracis, botulinum toxins, and Clostridium perfringens. Later in 1995 it was found that many of these weapons were even tested for delivery in rockets, aerial bombs, and spray tanks. Iraq had 100 R400 bombs filled with botulinum toxin, 50 with anthrax, and 16 with aflatoxin. This is only a small fraction of what was in store for attackers. Now several years later this same threat has re-emerged

and with it the fact remains that Iraq has the ability to produce biological weapons and they have the will to use them.

These threats combined with extremists groups makes the possibility of biological attack in the United States a real possibility. Because of that, it is important that doctors have a firm knowledge base in the symptoms and treatments of various Biological weapons. The first thing a doctor must be able to do is determine if a biological attack may have been initiated. The protocol followed can be vague. To detect outbreaks such as these a doctor must always be on alert. Epidemiological clues and indications that may signal a possible Biological or Chemical attack follow.

1. Large numbers of ill person with a similar disease or syndrome.
2. Large numbers of cases of unexplained diseases or deaths.
3. Unusual illness in a population (e.g., rennal disease in a large population may suggest exposure to a toxic agent such as mercury).
4. Higher morbidity and mrtality in association with a common disease or syndrome or failure o such patients to respond to usual therapy.
5. Single case of diesease caused by an uncommon agent (i.e., Burkholderia mallei or pseudomallei, smallpox, viral hemorrhagic feve, pulmonary anthrax).
6. Several unusual or unexplained diseases coexixting in the same patient without any other explanation.
7. Diseases with an unusual geographic distritubuiton (i.e., tularemia in a nonendemic area, influenza in the summertime).
8. Illness tha tis unusual for a given population or age gropu (i.e., outbreak of measleslike rash in adults).
9. Unusual disease presentation, (i.e., pulmonary instead of cutaneous anthrax).
10. Similar genetic type among agents isolated from distinct sources at different times or locations.
11. Unusual, atypical, genetically engineered, or antiquated strain of an agent.
12. Stable endemic disease with a na unexplained increase in incidence.
13. Simultaneous clusters of similar illness in noncontiguous areas, domestic or foreign.
14. Atypical disease transmission trhough aerosols, foor, water, which suggests deliberate sabotage.
15. Ill persons who seek treatment at about the same time (point source with compressed epidemic curve).
16. No illness in person who are not exposed to common ventilation systems (have separate closed ventilation systems) when illenss is seen in persons in close proximity who have a common ventilation system
17. Unusual jpatter of death or illness among animals, (which amay be unexplained or attributed to an agent of bioterrorism) that precedes or accompanies illness or death in humans. Sentinel dead animals.
18. Absence of a completely natural vector in the area of outbreak.
19. Large numbers of both military and civilian casualties when such populations inhabit the same area.

These clues tie together to create and indication of attack by biological or chemical weapons. The next step is to identify what type of agent is present and how to treat it or limit its spread. Some of the agents more commonly studied for use in attacks are Anthrax, Brucellosis, Cholera, Glanders, Plague, Q-fever, Tularemia, Smallpox, Venezuelan EE, Hemorrhagic fevers, Botulinum toxins, Ricin, Staph enterotoxin B, T-2 mycotoxins. Doctors should be familiar with each of these agents and should know the

steps taken to treat infected people. The second consideration that must be examined is the prevention of spread. Containment procedures must be used to stop wide spread infection. This can be done by treating hospital and first response staff with prophalactics or vaccines if possible. The vaccination of a certain percentage of the public creating herd immunity should also be considered. This and other such precautions must be taken to insure small numbers of casualties.

The threat of biological weapons being used against civilians and military is non-debatable. We are more vulnerable due to the access to such technology by terrorists and extremist groups than ever before. Because of that, awareness and constant education for the public and medical field is crucial to prevent the deadly possibility of a Bioterrorism attack.

Hiring and Managing

The hiring and managing of people is less of a science than it is an art form. One person can accomplish little, but a well-managed group of people can build cities and empires. I am not interested in building cities, but I am interested in running a well organized and efficient practice geared towards my patient's best interests. To do this I must have staff members that are excellent at their job, enjoy helping people, and truly enjoy the place they work. This may seem like a task that is impossible to perfect, and you may be right, but with the right plan; results that mimic the above goals can be obtained. Several aspects come into play when considering how this plan should be formulated. A doctor must know what the goals of his practice will be. A doctor must then hire the right people to accomplish those stated goals because employees will interact with patients first. Lastly, a doctor must be able to continually monitor and improve the efficiency of his practice because its dynamics change with time, and the continual improvement of patient care demands it.

The goals of my practice in terms of hiring and managing my employees will be simple. Treat everyone in the same manner, as you would like to be treated, and gear all ends towards patient health. This applies to the compensation I pay my employees, the way my employees treat patients, and to how they treat each other. No one wants to be in a bad work environment because the practice, the employees, and patients will inevitably suffer. Practices loose track of their goals by loosing a handle on their employees. An employee is the first and last thing a patient encounters when coming to a doctor's office, and these interactions must be improved upon. The key is to have the right people working for you while making sure they have the skills you desire.

In the paraphrased words of Donald Trump, "You do not have to be the smartest man to make it in this business, but you must be able to hire the smartest people." This is the key to a successful practice, and I believe the key to any business. This corresponds to managing of people because you must hire people well before you can manage them well. There are many steps involved in the hiring of employees. First, a doctor must determine what he is looking for in an employee along with a written job description for that position. In my practice I am looking for someone who can adequately handle the tasks assigned to them, but above all I need employees who love people, are willing to admit their faults, and will work hard to improve their understanding of patients. The second half of the puzzle is the job description because this gives an employee a list of the responsibilities he/she will be required to fulfill. When workers don't know who is required to perform a certain task lack of responsibility allows the task to be neglected. The form on the next two pages illustrates an example of a Task Analysis Checklist that can keep this from happening. This checklist covers many of the day to day operations involved in running a practice. These responsibilities can then be divided up among the correct personnel to comply with Internal Control measures, which are discussed in the Accounting Section.

I will specify the type of employees to be hired later, but for now I will discuss the beginning of a typical hiring process. To find the right employees, I will have to post ads in various places including: the paper, Internet job hunter sites, and various other outlets. The next step will be the receipt and processing of resumes. One usually cannot get to know a person's ability to relate with people by using a resume, which is my main goal, but it is the best way to sort people through a first round of screening. Eight areas are usually looked at while reviewing a resume. These include General Neatness, Completeness, Experience, Work History, Education, How They Sell Themselves, Initiative, and English Skills. The following guidelines that are after the Task Analysis Checklist further explain these categories.

TASK ANALYSIS CHECKLIST

Staff Name: _____ Date: _____						
Answer the telephone						
Schedule patient appointments						
Maintain listing of telephone callback						
Check for messages with the answering service						
Dial outgoing calls for doctor						
Telephone pharmacists						
Return nonemergency calls for doctors						
Receive patients						
Register patient arrival						
Communicate with "no-show" patients						
Schedule detail rep. appointments						
Schedule appointments with accounts						
Prepare "thank yous" to referring patients						
Maintain doctor's personal appointment log						
Verify new patient credit information						
Prepare a daily work schedule (patient appointments)						
Conduct daily work schedule staff meeting						
Maintain laundry supply records						
Maintain equipment maintenance schedule						
Maintain patient recall, reminder file						
Maintain "periodic" task reminder file						
Open the office						
Make coffee						
Open, sort, and distribute mail						
Order needed janitorial services						
Do office housekeeping chores						
Quiet noisy children						
Renew magazine subscriptions						
Pull records for tomorrow's patients						
Check lab cases for tomorrow's patients						
Confirm appointments for tomorrow						
Inventory and originate order for professional supplies						
Conduct office staff training in new procedures						
Schedule and conduct regular staff meetings						
Post charges and payments						
Post payments received in mail						
Prepare and mail monthly statements						
Follow up on delinquent accounts with doctor; take action						
Prepare management reports for doctor and accountant						
Review management reports with doctor						
Send necessary materials to accountant's office						

TASK ANALYSIS CHECKLIST

Staff name: _____ Date: _____						
Prepare and mail insurance claims on a daily basis						
File claim forms in suspense file until payment received						
Follow up control procedure on old claims						
Telephone insurance company about unpaid claims						
Post payments for insurance company to patient ledger						
Dispose difference between pt. bill and ins. co. reimbursement						
Endorse checks received from patients						
Handle disposition of patient "rubber checks"						
Prepare checks for overpayment to the order of patient						
Determine correcting entries needed in patient ledger						
Prepare patient ledger adjustment forms						
Maintain and replenish petty cash fund						
Check invoices from suppliers for discounts						
Prepare checks for doctor's signature						
Review and sign expense checks						
Record disbursement in daily journal						
Record all cash received in daily journal						
Prepare bank deposit						
Make bank deposit and obtain receipt						
Reconcile the bank balance						
Run a trial balance of accounts						
Prepare payroll checks						
Sign payroll checks						
Record payroll disbursement in ledger						
Deposit payroll withholding tax with bank						
Maintain a listing of office problems						
Schedule and assign unusual tasks						
Take corrective action on an employee problem						
Conduct a salary review						
Compose patient medical correspondence						
Medical—legal scheduling						
Medical—legal paperwork/requests for records						
Type and prepare correspondence						
Keep exam rooms stocked with supplies						
Distribute schedules to various locations						
Make sure instruments are sterilized and trays set up						
Charting procedures and treatment plans prepared						
Enter each procedure on superbill for front desk						
Give postop instructions						
Take x-rays						
Check patient's medical history for health problems						
Escort patient to exam room						

REVIEWING RÉSUMÉS

General Neatness

General neatness of the application or résumé: Is their handwriting readable (consider your records, etc.), résumé typed and error-free?—How is the applicant's spelling and grammar?

Completeness

Completeness on the résumé and application: Did they fill in all the blanks? Is the information on dates, etc., complete?

Experience

Length of experience, type, amount of demonstrated responsibility, types of positions held, etc.

Work History

Do they have a good work record? How long do they stay at each position? What were some of their reasons for leaving?

Education

Do they continue their professional growth through special classes, workshops, special on-the-job training, and evening college? Involvement in professional groups or clubs?

How Do They Sell Themselves?

Do they know how to amplify their skills and strengths? How do they demonstrate their level of self-confidence?

Initiative

Do they offer anything besides the basics?

English Skills

Do they use appropriate English in the interview and on the application or résumé?

Now that guidelines have been established for the sorting of resumes lets consider a specific hiring. Like I said before the hiring of intelligent people is key to the success of a practice, and this is of utmost importance when one is hiring an Office Administrator or Manager. This person will be the link between my clinical realm of medicine and the non-clinical day-to-day activities of the office. A large amount of time and effort must be placed into this hiring because this person will hereafter handle most of the burden of the hiring responsibilities. Because of this, it is important the Office Administrator clearly understand the goals of the practice, be fluent in interpersonal communication, be able to manage people, and possess the technical skills necessary to watch over the workings of the office. The following list of Interview questions can be used as a gauge to measure the knowledge and fit of the Administrative applicant. Along with the interview many tests will have to taken by the applicant to measure his or her skill level. An example of a Collections Written Test follows the interview questions.

ADMINISTRATOR INTERVIEW

Applicant Name Date Grade

To the Interviewer: Ask the applicant to respond to the following.

How do you feel about dealing with sick people.

Give me your thoughts on interpersonal communication and empathy in regards to a patient.

Tell me a way in which you related to people well in a non-business environment?

What type of volunteer activities do you participate in?

What is the best way to placate a patient who has become frustrated while waiting for service?

Would you describe yourself as a people person and if so why?

Give me an example of how you think some practices are run in a less efficient manner than possible. How would you fix this problem?

Quote the mission statement of a recent employer and tell us about one or more ways you helped fulfill it.

Describe a challenge you have faced in dealing with a physician governing board and how you dealt with it.

Tell us about the professional organizations in which you participate.

Describe your continuing education activities in the past year.

Given a budget for your own professional education, what areas would you seek education in to better be able to serve this practice?

Describe the professional achievement of which you are most proud.

What would your recommended budget ratios be, as a percentage of revenues, for labor, facilities and marketing, for a practice similar to the one you left, and why?

Describe how you believe a practice should optimally use its CPA and attorney.

Describe how you might correct an over-budget situation in any one fiscal quarter.

Describe the differences in cash and accrual accounting and why one or the other should be used.

What is meant by double-entry bookkeeping?

What types of activities outside the office are often tax deductible for physicians?

Give three examples of cost-saving methods in purchasing and ordering supplies.

A part-time temporary person wishes to be an independent contractor rather than an employee. Explain how you would determine if this were feasible and the risks to the practice.

List the regulatory issues/agencies a medical group needs to monitor compliance with.

Describe how you would choose your personal assistant(s) and what skills and qualities you would look for.

How often would you want to meet with which physicians and why?

Describe the leading health care organizations in this area and their apparent strengths and weaknesses.

Describe the computer programs in which you are proficient.

Name or describe any organizational tools you use to improve your own performance or keep track of issues and responsibilities.

Describe how you would handle a repetitively tardy staff person. Physician?

You suspect an employee of having a drinking problem. How would you handle it?

How would you handle an employee complaint of sexual harassment by a physician?

Describe how you would go about firing an employee who merited termination.

Describe how you would handle a disruptive physician in a meeting.

Describe how capitated reimbursement works.

Describe how capitated reimbursement changes the way physician compensation formulas should be structured.

Describe how you would market this practice in a capitated environment.

Describe the difference between internal and external marketing and how each is used.

What are your opinions about external marketing in our specialty?

COLLECTIONS WRITTEN TEST

Applicant Name Date Grade

For each of the following circle "True" or "False":

A patient who is not satisfied with treatment does not have to pay. *True/False*

If the divorce decree states the father is responsible for medical bills, you cannot pursue the mother if she brings the child in for treatment. *True/False*

You cannot call a patient after 8:00 pm. *True/False*

You must accept a $5.00 payment from a patient no matter how large the bill is. *True/False*

If you are a participating provider for an HMO or PPO, there is nothing you can do if you are not happy with their determination of payment. *True/False*

You cannot call patients at work. *True/False*

Checks that are postdated are illegal. *True/ False*

You must wait at least 30 days before turning past due accounts over to collection. *True/False*

You cannot turn a patient over for collection without first informing them. *True/False*

You cannot charge insurance companies for additional information. *True/False*

If the insurance company says you are charging more than is "usual & customary" there is nothing you can do. True/False

You cannot charge interest on medical bills. *True/False*

The only person you may speak to regarding the debt is the patient. *True/False*

If a patient owes you money, you can withhold transferring medical records until they pay you. *True/False*

You cannot run credit checks on your patients without their permission. *True/False*

It's illegal to sue on a medical debt. *True/False*

Aside from being proficient at the skill of Collections an efficient Administrator must understand the areas of Billing/Data Entry, Bookkeeping, Filing and Sorting, Insurance, Math/Calculator work, Medical Abbreviations, Spelling, Transcription, and Typing. The Administrator will not be handling all of these tasks every day, but he or she will be supervising the people that are. I expect my Administrator or Office Manager to encourage, guide, and pick up the excess workload of the other employees in my practice. With this in mind, people will have to be hired and responsibilities clearly assigned to divide up the work to be done in the office. Depending on the size of the practice many job titles and responsibilities can arise. Some of these include: Accounting Manager, Appointment Secretary, Billing Clerk, Bookkeeper, Cashier, Collections Agent, Clerk Typist, Coding Manager, Data Entry Operator, Secretary, File Clerk, Insurance Clerk, And Transcriptionists. Aside from the business end of the practice an array of other personnel will have to be at a medical practice's disposal. These positions include but are not limited to: Nurses, Phlebotomists, Physical Therapists, other Doctors, Nurse Practitioners, and Physician Assistants. For a small practice many of the business positions will be combined keeping in mind Internal Controls. As the practice grows more of the positions can be filled by redefining an employee's responsibility list. Another possibility that will be explained in more detail in the Accounting section is that of Independent Contractors. This is a legal tax definition that people can be placed under when doing certain jobs for the practice. This can save money in many ways, and one of them is the outsourcing of certain tasks. An example of this would be if an independent contractor in this case a physical therapist were to be hired. One would be a client of this physical therapist and he or she would provide the practice's patients with services. This is especially a good option for smaller practices because it limits the necessity of maintaining an in house physical therapist or other such personnel.

After spending so much time and effort in hiring the correct Office Administrator or Manager my focus on hiring personnel to fill the other positions changes. In a practice focused on improving the health-care of patients, I will need caring and personable staff to convey that message to my patients. They will be in charge of maintaining the sense of comfort and quality care that I demand. Because of this, one must focus less on the technical skills of the incoming applicant and more on their interpersonal skills, enthusiasm, love of people, and determination to be good at their job. The great thing about this is that it does not limit the people who can work for me. Age, sex, religion, background, etc. will not be factors because I will be hiring a person's potential. This does not mean I want people with no experience or knowledge, but it does mean I am willing to hire people who may not know every technical aspect of the job. This is one of the reasons such an efficient Administrator is needed. He or She will be in charge of taking this enthusiastic people person and bringing them up to speed on the technical requirements of their job.

Lack of certain skills can be overcome in a precise and calculated way. Guidelines will be set up that will close the gap in my employee's skill level. This can be done with the correct application of a Proficiency Schedule. This is something that can bring an employee up to speed, and it can also help to cross-train employees in the practice. Each employee will have a proficiency schedule that will list the areas that they will need to become more familiar with. A date for instruction will be laid out along with a later date for evaluation. This is a cyclical system that continues to keep one's employees up to date. Successful completion of training in a particular skill will earn an employee a Certificate of Achievement and a bonus. This type of personal achievement incentive tied to a tangible bonus is part of the management style that I will go through next.

I try to think like and idealist but allow my actions to be realistic. This approach is the same one I use when approaching the concept of management. There will always be problems and bumps in the road, but having a plan and continually working to get better is the only way to find some semblance of efficiency in a business.

The idea I want to create in my practice is that of a team. I do not want to be looked at as the sole provider of leadership and direction. Everyone has something different to offer, and I believe that many good ideas are stifled because employees don't feel like they are part of something worth working hard to better. I want everyone all the way down to the Appointment Secretary to feel like he or she is a pivotal part of the system. The truth is that no matter how high on the horse doctors get they cannot help heal people without the help of the Appointment Secretary and the other members of the team. The way I am going to do this has several parts. First, to get and keep good people you have to compensate them well. Secondly, one must continually encourage each member of the team and make him or her strive to work harder. Lastly and most vitally, in order to have people who give their all a workplace must be fun on uplifting.

High paying employee salaries are a thing that make most business owners cringe. That is why I am not a businessman first. I am a doctor whose goal is to treat patients to the best of my ability. The only problem is that I cannot do it alone. I must have the best employees who care for my patients and are willing to put in the extra effort. This may mean staying an extra hour here and there or it may just mean giving a smile to comfort the people waiting in the lobby. For the little things like that, I am willing to lose a little money out of my bank account. The highest paid office employee will be my Administrator because he or she will be my eyes and ears as to what needs to change in that outlet of my practice. All other employees will be paid a given rate above what the average employee in their position would normally make. I say this because I demand an above average practice, and that dictates above average employee wages. This payment will come in many shapes. First, I feel a professional employee earns a salary and is not paid by the hour. Along with this salary, I will employ a mixture of Fringe Benefits and Bonuses, which will be discussed in the next section. Fringe Benefits have advantages for the employee and employer. I will discuss the money saving value of this form of payment in the Tax section. Examples of these benefits include Retirement Plans, Medical Insurance, company sponsored Christmas parties or picnics, child-care, paid vacations, and many other perks. I will group these benefits in a certain manner under a Cafeteria Plan that lets my employees get the most from their individual compensation package. These forms of payments and incentives should be good for attracting and keeping some of the best employees. The next section focuses on how to best make use of these members of my team.

Now that there is a workforce paid well and not looking elsewhere for better pay one is able to concentrate on efficiently managing them. I want to run my office in a manner borrowed from other fields. Two fields that have much to give are Sales and Sports Management. Sales management centers around constant motivation and goal setting, and Sports Management normally focuses on a team effort and striving for a goal together. I believe these concepts transfer well to the management of employees in a medical practice. This means that my Administrator and I must play an active role in the functioning of the whole system. The plan involved in this will consist of daily, weekly, and monthly activities.

The daily activity will be made up of a checklist review in my office with the Administrator and me. An example of such a checklist is on the next page.

OFFICE MANAGER CHECKLIST

Person Responsible: Office Manager Date: _____	Daily	Weekly	Monthly	Quarterly	Semiannually	Annually
Account receivable—aging review (collections)						
Production goals set and monitored actively						
Billings/production/charges for the month reviewed						
Scheduling "working" and "not working" reviewed						
New patient count/flow						
Referral pattern or new patient source review						
Insurance billing report						
Over-the-counter collections	**Spot Check**					
Cash flow general						
Accounts to/at collection agency						
Day sheets balance to ledger cards monthly or	**Spot Check**					
computer balancing/reports run for month end						
Accounts payable reporting						
Balance checkbook/bank reconciliation						
No. patients on day sheet/computer = no. shown on schedule	**Spot Check**					
Profit and loss review						
Budget issues						
Auditing—accounting or billing procedures						
Payroll taxes paid/deposited						
Inventory—office supplies						
medical supplies/medical samples, etc.						
Special projects progress						
Personnel review/report						
Profit center review						
Chart audit	**As Needed**					
Recall system effectiveness review						
Marketing projects report—internal and external						
Cross-check receipt nos. with pts. shown on ledgers or computer						
Review of management reports from computer/bookkeeper						

After a few changes this checklist will be the master checklist over the day to day operations of the business. The key to this checklist is for it to be a spot check of other employees' checklists. This does mean that each employee will have a checklist. It makes forgetting to do something a lot harder if one must check off for it. It also gives me a good quantitative way to monitor my practice. I won't just be saying, "How are things going." I will be able to actually look and see if all of the duties are getting done.

The next section of my people management plan is what makes my system so much different than most that I have seen. I plan on meeting with all of my employees once every week for about thirty minutes to an hour. During this time, I will be Encouraging my employees to work harder, I will be discussing how the current week went, and I will be setting up a plan for the next week and beyond by improving the attitudes of my employees. These techniques are the ones used by successful sales companies throughout the country. They focus on keeping the moral of their employees up because of their constant emotionally draining contact with people. I see such a correlation due to the constant people interactions involved in the medical field, and thus the same motivational techniques should work. This idea of goal setting and coming together as a team reinforces my central theme, and it mimics the workings of a sports team. This is that as a united and unified group of people, my practice is better equipped to help patients even at the worst of times.

At the beginning of each meeting, I will discuss how my employees did throughout the week. This will open them up and allow them to be more conversational with me throughout the meeting. During this beginning, I will discuss the bonuses that will be awarded for the week. There are two types of bonuses that can be given. First, there are tangible awards that can be earned such as money, PTO time, office picnics, or Christmas parties. These types of rewards will be given for various accomplishments such as always filling out daily checklist accurately, keeping the petty cash box in order, and a big one is keeping the Uncollectible Accounts Receivable percentage below a certain level. Although my employees will be on salary I will still use a time clock to award bonuses for working extra or being consistently on time. The second type of bonus is honorary. These types of bonuses keep an employee's self-esteem and commitment to working hard at an optimum level. These awards include Personal Achievement Awards, Employee of the Month Awards, Patient Voted Most Friendly Employee Award, and others. No matter how much money an employee makes, eventually they will get unsatisfied if they do not feel they are appreciated. This appreciation for my employees is basically what the beginning of each meeting will be about.

After I have made sure every employee knows they are needed, I will now open the floor for discussion on how the week in a business sense went. This process includes going over patient complaints/praises and brainstorming on how to improve the process of people interaction. When there is a problem, fixing it must be approached in the correct way. It is said, "you can attract more bees with honey than you can with vinegar." With this in mind all of my criticism will be led and followed with a complement. This sandwich idea makes a person feel proud and responsible for fixing whatever problem is found. Part of discussing how the week went involves setting goals to improve. The following page will be analyzed and reformatted each week. This page will give my team reasonable goals to achieve in a set framework of time. Without goals it is very easy to become complacent with how well things are going, but my purpose as a doctor is to continually improve the process of patient care. To do this one must have goals.

GOAL SETTING

Purpose:				Date:	
Persons Present:				Page:	of:
Goal	**Task Involved**	**Target Date**	**Who Initials**	**Anticipated Results**	**Date Compl**

As the end of my meeting approaches I will end with another technique used in Sales and basketball. This is the use of motivation and encouragement to improve the moral of my employees. This will not only make them better able to deal with problems that arise in my office, but it will make them better able to deal with problems in their own lives. It is one thing to say that home life is home life and work is work, but they are intricately tied to one another. If one can teach people skills that benefit their complete outlook on life, it will be easier to help people enjoy their work. The goal of this encouragement focuses around the idea of constantly being in control of one's emotions. The positive outlook created by being in control of one's emotions benefits everyone. It will benefit the smoothness of my practice and it will benefit the patients who must interact with my employees. The key to controlling one's emotions is to realize that action precedes attitude. Acknowledging a bad attitude and making a conscious effort to correct it is the solution. Basically, when one feels sad one should smile.

At the end of every session I will read a quote that symbolizes facing fear, self - doubt, or the overcoming of an obstacle. This quote will be the theme of the week. I will encourage my employees to memorize it and I will quiz them on it throughout the week. The following are some of the quotes I find to be very inspiring. I will encourage my employees to help in this encouragement and motivation process by contributing quotes of their own.

By Michael Jordan

- "I never looked at the consequences of missing a big shot. Why? Because when you think about the consequences you always think of a negative result. If I'm going to jump into a pool of water, even though I can't swim, I'm thinking about being able to swim at least enough to survive. I'm not jumping in thinking to myself, "I think I can swim, but maybe I'll drown." If I'm jumping into any situation, I'm thinking I'm going to be successful. I'm not thinking about what happens if I fail."

By Anonymous

-

Success is failure turned inside out,
The silver lining to the clouds of doubt,
So stick to the fight when you're hardest hit,
It's when things seem worst that you mustn't quit.

By Anonymous

- This is the beginning of a new day. God has given me this day to use as I will. I can waste it or use it for good. What I do today is important because I'm exchanging a day of my life for it. When tomorrow comes, this day will be gone forever, leaving in its place something that I have traded for it. I want it to be gain, not loss; good, not evil; success, not failure; in order that I shall not regret the price I paid for it. May I have sufficient wisdom and courage that this shall be my record for today.

By Geoffrey Gaberino (Olympic gold Medalist, Swimming)

- "The real contest is always between what you've done and what you're capable of doing. You measure yourself against yourself and nobody else."

❖

By Helen Keller

❖ "Security is mostly a superstition....Avoiding danger is no safer in the long run than outright exposure. Life is either a daring adventure or nothing."

By Theodore Roosevelt

❖ "The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood...who knows the great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end of triumph of high achievement, and ...if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat."

These types of quotes are what I plan to pass on to the people that work for me, and the attitudes that they possess are how I live my life. This type of encouragement will be the foundation of running my business.

The final key to management is in understanding that it is not a closed system. The people you have as employees have as much insight into how they should be managed as the best boss has ever had. Because of this, I welcome open conversation during these meetings with my employees, and I also encourage them to approach me outside of the team meetings. In conjunction with the meetings I will ask that each employee fill out a Staff Survey evaluation each month that will give me a picture of how things are going. An example of such a survey is on the next page. This will allow me to see what aspects of the practice are running smoothly and which need to be adjusted.

I understand that things are complicated and management is not an easy task, but I think a plan makes it much easier. The plan I've laid out for acquiring, training, and keeping good people in my practice will be successful in the sense that my patients will be well cared for.

STAFF SURVEY

Name _____ Position _____ Years with Practice _____

Please circle as appropriate

Salary, for position	1. Below par	2. At par	3. Above par	4. Don't know
Fringe benefits, for position	1. Below par	2. At par	3. Above par	4. Don't know
Staff interrelationships	1. Below par	2. At par	3. Above par	4. Excellent except for 1 or 2 persons
Performance reviews	1. Never or almost never	2. Occasionally	3. Regular	
Duties	1. Not clearly defined	2. Some defined, some not	3. Clearly defined with job descriptions	
Communications	1. Poor—nonconstructive criticism	2. Occasional praise, some helpful criticism	3. Doctors often praise and constructively criticize when deserved; conversation is usually pleasant, two-way	
Workload	1. Way too much or too little!	2. Usually OK	3. Just right—interesting mix of duties	
Hours	1. Poor—too long, out too late	2. Usually OK	3. Fine	
Training	1. Almost nonexistent	2. Adequate	3. Great! Thorough in office training; attend seminars	
Physical environment	1. Poor—depressing	2. Adequate	3. Pleasant	

Comments/Additions/Explanation

_____

What three things need improving in this practice?

1. _____
2. _____
3. _____

Managed Care and the Future of Healthcare

Throughout time providing healthcare has been a service deserving some manner of reimbursement. The form of reimbursement has changed especially over the last century. In the past, healthcare was often provided on a fee-for-service basis. When one performed a procedure, the patient paid for it directly, but with the many advances in healthcare this has become impossible in today's society. The creation of insurance plans were meant to combat this inadequacy of resource distribution. The state of healthcare in the United States is a function of how well these healthcare plans work. Analyzing the history, the present state, and the possible future directions healthcare may lead, I hope to gain a grasp of how I can help to improve the care of patients throughout the country.

The first insurance plan was formed by a group of doctors. It was Blue Cross and later expanded to become Blue Cross/Blue Shield. This plan was operated under the historical fee-for-service concept. It is called an indemnity plan because it pays for reimbursement of losses or damages to a patient. This type of plan gave unethical doctors the ability to provide unnecessary services in order to increase their reimbursement. This practice of overuse of resources has created a second more common type of managed care. This managed care format is called capitated reimbursement, and it umbrellas a broad range of the many common health care plans of today.

There are both capitated and indemnity plans functioning in today's free market, and both of these forms of financing provide for two basic functions. First, they create an organization that is financially accountable for "needed health care services" for a specific group of people. Second, they are in charge of controlling and managing the costs and quality of the medical providers working for them. This change from independent practices to managed care can tend to create an adversarial relationship between the health care plan and the physician. The strengths and weaknesses of several different plans will be looked at next. These include the three types of HMO's, IPA's, PPO's, and POS plans.

Health Maintenance Organizations (HMO's) were the first form of capitated healthcare plan. This means that instead of being paid on a fee-for-service manner doctors were paid a predetermined monthly amount of money per individual. This has been a revolutionary concept because it switches physician's financial incentives from providing more health care to reducing expensive services to lower costs, and keeping the population healthy. The idea of keeping the population healthy by prevention is a very good idea and goal, but the reduction of costs is what can interfere with the traditional patient-doctor relationship. There are three types of HMO's today. The Staff Model is the first and functions as an in house clinic providing almost all services on sight. The staff, including physicians, are salaried, and the range of physicians covers many specialties. The physicians usually provide no fee-for-service work. The benefits of such a setup allow the physicians to function a little more independently because they are salaried and not trying to specifically lower costs with each patient. This has also been a criticism of this model because they are often less productive due to no financial incentive to increase productivity. The main patient criticism under this plan is lack of selection when choosing a physician. If the doctor does not work for the practice, you are not covered by the healthcare plan when being treated by that doctor. The second model is the Group Model. It is a multidisciplinary group practice contracted by the HMO. These groups may have existed prior to the HMO contract or they may have been created by the HMO. The main

differences are multiple sites for different specialties and that these groups still often provide fee-for-service billing. The weaknesses of this set-up are the same as Staff Model including lack choice of physician. The last form of HMO is the Network Model, and it is made up of a network of practices. It provides much more independence in physician selection, but its drawback is lack of uniformity. The more spread out these groups become the less able a HMO is able to assure procedures are being followed. The premiums of HMO's often increase when going from Staff to Group to Network Models because of more overhead and need for organization. These types of HMO models are what dominate the healthcare field today.

Although HMO's are very prevalent many other healthcare plans have been established to compete for a share of the market. IPA's are Independent Practice Associations. They are organizations of physicians in different practices. This allows a physician the ability to retain most of his autonomy while still taking advantage of capitation contracts. Managed Indemnity Plans are reviving the fee-for-service concept by imposing stricter restrictions on insured procedures and selectively choosing their customer base. Because of proper management this form of healthcare plan has made a comeback. Another form of indemnity plan is a Preferred Provider Organization (PPO's). It is an indemnity plan who contracts with insurance companies or employers to purchase health care services from selected providers. They choose providers on the basis of cost, reputation, quality positions, and willingness to participate. The key to this type of plan is the incentives for the beneficiaries. They often provide reduction in the deductible or the co-pay, and they often offer discounts to gain volume of patients. This high volume of patients is how they make money. The process of Utilization Management has begun to make many of these plans and HMO's look very similar, and a combination system is now very popular.

IPA's often utilize one form of this combination system. It is called a Point of Service (POS) plan. It combines an indemnity plan, a PPO, and an HMO. The cost range of services ranges from high with the indemnity plan to low with the HMO. This plan is very popular because it offers a wide range of flexibility for the patient. For minor ailments where a specific doctor is not important a patient can choose to use the less expensive HMO physician network. Alternatively when a specific problem arises where a specialist or out of network doctor is wanted, the indemnity plan allows one access although at a higher cost. This is the direction that many healthcare providers are going. By doing this, in the future, there will be less of a distinction in the different type of plans available.

Healthcare plans including HMO's, PPO's, or indemnity models are not inherently evil. They are only tools that have arisen to try and manage the resources available in society. The fundamental question is whether healthcare is a right or a privilege. As a future doctor, I must say that at least basic healthcare is right. Problems arise in trying to provide this basic healthcare, and in trying to figure out how to allocate the excess more advanced healthcare. Infinite healthcare needs have run headlong into finite healthcare resources.

Managed care has been the United States answer to how to allocate resources although its success is debatable. The idea of managed care is to save money by restricting often optional treatments to pay for treatments that provide more utility to the overall good. In theory this process should free up money to use for prevention and other health improving treatments. In deciding how to spend and where to put our healthcare dollars managed care uses Utilization Management which has been mentioned before. A specific goal of this management is to lower access to specialties, lower utilization of hospital services, and lower use of emergency rooms. They also try to change physician behavior

involving referrals, hospitalization, and costly medical procedures. In context with this management use of gatekeepers has become common. These people are often primary care physicians that regulate the flow of patients to specialists. This creates one of the major patient frustrations by making seeing a specialist a two-visit ordeal. This flow regulation is often exaggerated by lack of communication between the primary care provider and the specialist in context with patient evaluations. In providing for patients and controlling management utilization doctors can become involved in many conflicts. Does a doctor look out for the patient or does he look out for the HMO whom pays his bills. For instance, if a doctor prescribes a drug under his best judgment and it is not covered by a patient's healthcare plan, then the patient may forgo filling the prescription. This may cause the patient to become less healthy and increase healthcare costs further. Should the doctor have instead prescribed a different less effective treatment that is covered by insurance? For reasons like this I believe it is folly for doctors to act as if money is no object. A scale must be balanced on a case by case basis as to what is best for the patient in terms of healthcare and affordability. Rationing is inevitable in the system we have today, and without it the healthcare infrastructure would go bankrupt.

In realizing that healthcare rationing must be accomplished American society has created many forms of health management plans, but we have failed in the goal of providing everyone with a basic minimum of healthcare. There are over 39 million Americans without any healthcare coverage. This should be appalling to everyone not only me. As advanced and developed as our country has become it is pitiful how low a value we place on the healthcare of our people. The U.S. has created a very tiered medical system where the rich receive the best healthcare and others have none. I am not advocating removing all considerations of money from access to healthcare, but before money should be considered a bare minimum should be available. It is currently not, and we must find a way to correct this problem. Several models should be looked at for this purpose. These are the German healthcare system, the Canadian healthcare system, and the concept of expanding Medicare. None of these ideas are perfect, but they are a definite improvement on our current system.

Germany's cost of healthcare per person is $1,286 as compare to the U.S $3,500 per person in 1991. There are several reasons for this. First, Germany's government plays a much larger role in healthcare than it does in the United States. This more centralized role has helped to keep costs down. Second, there has been a ceiling placed on physician fees. I am not opposed to this as many doctors in the U.S adamantly are. The way they increase their salary is to increase the number of patients they see. This keeps productivity high while sacrificing part of the physician-patient relationship. While this is a disadvantage, the autonomy of the German physician is paramount. Their decisions are not second-guessed by third-party providers as they are here. As an up-in-coming physician this sounds like a great concept. As a physician who has been through years of schooling to perfect a very specialized skill, who would want to be told by a 23 year old HMO manager how many minutes he can spend with his patient.

Canada has a healthcare system that should be looked at for ideas. They have a fund similar to the U.S. Social Security Fund. This payment system covers all medically necessary services. The average cost is $2,000 when compared to America's $3,500 per person. A major source of funding for this system is "sin" taxes on cigarettes and alcohol. It only makes sense to have the largest contributors to preventable illness pay for a large portion of healthcare. No matter what direction America's healthcare system travels, a tax system like this would be very beneficial. Much like Germany Canada's government has a much larger role in the rationing process. A key to their system is the sacrifice of some extremely high-end technology. For instance, machines designed to break up kidney

stones are very expensive. Instead of every hospital having one, Canada's healthcare system may have only a few throughout the country. This rationing makes alternative cures more attractive, and because most kidney stones eventually pass naturally, this rationing system has worked well. The government makes rationing decisions by region, and they provide basic care to everyone in the system. Once again, physicians in the U.S. often balk at a system like this because the government sets their fees, but when looking at physician salaries it is clear to see that Canadian doctors are not starving martyrs of the community. The following average salaries illustrate: Cardiologists-$290,500, Opthanologists-$240,000, Dermatologists-$200,500, and General Practitioners-$128,000 in 1991. Strengths and weaknesses can be seen in both the Canadian and the German system. The future success of American healthcare will come from re-evaluating the importance of everyone attaining a basic level of health coverage.

A direction to look in that resembles the single payer system of Canada would be the expansion of Medicare. This combined with a fee-for-service reimbursement at set rates by the government would help the healthy subsidize healthcare for the less healthy. This would help blanket the 39 million Americans currently without healthcare. A major positive for the plan is that it is partially in place. Combined Medicare and Medicaid currently cover one fifth of the population. Expansion of this plan would remove the need for many of the 1500 private insurance plans that create their own rules, qualifications, reimbursement rates, forms for patients and physicians, and rationing practices. Much of the current money spent on overhead could then be used in the actual field of healthcare. This is in assuming that such a system would be run smoothly and efficiency promoted. Efficiency could be promoted by following practices as in Germany's system. There is no easy quick solution to improving the healthcare system, but people should begin to take a serious look at what is really important. Is healthcare and health coverage a right, or is it only a privilege provided for the rich and healthy. This must be decided in order to begin the long process of social change that must ensue.

Law in Medicine

Medical practice becomes more and more entangled in red tape as time passes. In order to focus on helping people, one must have a firm grasp on the requirements set forth by the law and other governing bodies. Without understanding all facets of medical law, a doctor leaves himself vulnerable to malpractice suits. This has become a major theme in American society, and it will be discussed to close this discussion of the law.

First, lets assume one is practicing medicine and new patients are taken. At the point you have begun the care of a patient, you have a law binding duty to that patient to provide treatment in guidelines with the current medical standards. There are two ways to begin the care of a patient. A new patient may be taken on an individual basis or one may be taken from a group contract. These contracts can include agreements with HMO's, being on call at an ER, agreements with companies, nursing homes, schools, or athletic teams. Various legal agreements can be drawn up specifying what type of care you are responsible for in regards to each group you work with. In the context of treatment the function of emergency care arises. As a doctor, one is legally bound to provide emergency care in a timely fashion to the patients you have agreed to provide care for. There are also many non-discrimination standards that must be upheld when admitting patients. No race, color, or national origin can be considered when taking on a new patient because of Title VI of the Civil Rights Act of 1964. This forbids anyone receiving federal or financial assistance (including Medicare and Medicaid) from using in the previous discriminatory practices. Other laws such as the Americans with Disabilities Act and the Rehabilitation Act further these anti-discriminatory laws. Provisions in these acts include wheelchair accessibility and the important requirement of having a sign-language interpreter working at one's practice.

In providing almost any type of care in today's world one must fulfill a multitude of consent forms. The informed consent forms must provide adequate quality information allowing a patient to make an informed choice. In context with this consent it is required that a doctor inform a patient of his or her alternatives. This should be done in a no pressure format and can be delegated to other employees if time is pressed. Implied consent is assumed for many of the standard procedures performed in a practice. For instance, if a physician is caring a needle for an injection and a person holds out their arm, it can be assumed that implied consent has been given. When dealing with children the rule of law becomes more complicated. This is especially true when dealing with STD's, substance abuse, and reproductive matters. In several situations such as this, a child's consent can be taken without his parents, but in most circumstances parents permission is required. Each patient should be analyzed on a case by case basis before determining what type of consent must be obtained.

In providing care it is important for a doctor to have staff performing appropriate duties. Professional and technical staff need to understand, to fulfill, and stay within the scope of their assigned duties, assuring that the physician become directly involved when needed. This working within the scope of one's job requirements in a medical practice includes:

1. Who may order procedures and medications
2. Who may accept such orders
3. Who may perform procedures or give medications
4. Whether procedures or medications must be supervised

5. Degree of supervision
6. Who may interpret results or diagnose a condition
7. Who may order, modify procedures and medications

In context with the personnel knowing their roles, a physician must also understand the limits of his knowledge and expertise. They have a duty to recognize their limits. For instance, not referring a patient when an inadequacy of skills is present can lead to malpractice claims. This is becoming a very important topic in today's healthcare society because of the increased tendency for managed care organizations to employ gatekeepers and practice utilization management in order to lower costs. By employing these cost control measures managed care organizations place a heavy burden of responsibility on the shoulders of primary care physicians. This conflict of interest may cause negative effects and lead to more malpractice claims.

The subject of law has gotten off to a fast start, but the physician above may have jumped the gun. Without the proper licensing all of the previous care given would have been illegal. A practice must ensure that the licensing of its employees is always up to date. Whether it be the physicians medical license or the nurses, a system should be in place to ensure proper renewal and adherence to continued education. Aside from professional licenses there are Organizational licenses required by law, building permits, and certificates of occupancy that must be obtained. Many different pieces of equipment will be used by a medical practice such as X-ray equipment, and permits and leases for this equipment must be obtained. In a medical office certain medications can be kept on sight. For this purpose, a doctor must have a certificate from the Drug Enforcement Agency (DEA) to possess and prescribe controlled substances of Levels I-IV. To assure proper internal controls of these drugs a substance drug inventory should be used. An example of this can be seen on the following page. The following safeguards should be employed along with the drug inventory.

1. Keep, careful required records
2. Control access to prescription
3. Lock places where drugs are stored
4. Assure proper storage conditions
5. Dispose of properly after expiration date

Legally required licensing is an important part of medical practice, but there are also accredidations and certifications that can be obtained that aren't required by the government. The may not be legally required, but the practicality of their acquisition may make obtaining them necessary. There are three separate reasons for obtaining these accredidations and certifications. First, in order to become a member of a hospital medical staff with the privilege of admitting patients, one must fulfill certain requirements. These requirements often are:

- ❖ Provide continuous care, respond promptly to calls from hospital staff
- ❖ Complete medical records promptly
- ❖ Attend meetings
- ❖ Demonstrate a level of hospital activity
- ❖ On call with ER when scheduled
- ❖ Inform hospital of licensure complaints or malpractice suits

A second reason to seek accredidation is in regards to one's specialty. Board Certificates are not required by one's specialty, but they look much better in the eyes of MCO's. These

DRUG INVENTORY LOG

Date	Drug Name	Amount Removed/Added	By	Confirmed

Managed Care Organizations are the third reason accredidation standards must be met. They have periodic reviews to assure a practice is in line with the MCO's goals.

In conjunction with this it is important that all office medical staff know all requirements and networks each MCO deals with. Under each type of plan whether it be an HMO, PPO, MCO, IPA, or PHO there are requirements that must be met for each patient. This makes it very important to acquire from the patient what type of plan they have and if they have recently changed plans. By following proper procedures on the plan the Managed Care Organizations also have requirements to uphold. These may be the assigning of a certain number of patients. Cooperation between a practice and third party providers can save everyone money especially the patient.

It seems as if each step a physician takes more and more paperwork and requirements pile up. The practice now has all the proper licensing and has treated the patient. Is the headache over? No, the billing of a patient must now ensue in a legal manner. There are important billing stages, which I outline in the financial section. Collections agencies may be used in some cases in order to shift some responsibility/liability, but their collection practices are governed by the Fair Debt Collection Practices Act. This ensures that harassment does not occur. Two important rules regarding collections must be followed.

1. If a patient files for bankruptcy one must immediately stop trying to collect directly from the party
2. If a patient dies, one must make a claim at the estate proceeding.

The issue of a patient under my care dying is very complicated. I do not know what the current accepted practices are in handling collection after death, but I would lean towards cutting my losses unless a major sum of money is in the balance. The key to collections is in the understanding that a doctor is there to heal people, but that idea must be balanced with the reality that one is running a business.

The patient doctor relationship is over for one reason or the other. There are several reasons for this relationship to be ended.

- ✓ Medical Care is no longer needed
- ✓ Patient ends relationship
- ✓ Another physician accepts transfer of care
- ✓ Termination of care with enough time to find another doctor. This requires the proper notice

It is important that the proper procedures be followed when ending the physician patient relationship. One cannot end the relationship on a basis of discrimination.

In this entire process from the beginning of care to the end of care appropriate and accurate record keeping has been essential. This is in order to provide excellent care in the future by using past information and to prevent malpractice claims. A system for ensuring accurate record keeping is useful. There are many new computer-based programs that can assure proper follow-ups and less human error. The only thing about computer charting is that it is less connected than a caring doctor writing on paper although it may reduce many errors. In relation to records, confidentiality is key. There should never be any access to records by unauthorized personnel. Even when disclosure of information is needed, proper procedure should be followed. There are special forms for HIV, drug abuse, and other such disclosures. It is also important for a physician to follow government requirements for disclosure. Some of these include births, deaths, contagious disease, child and elder abuse, domestic violence, gun shot wounds, other wounds of violence, industrial accidents, and radiation incidents. Some states require more and some states require less disclosure.

If all of the following procedures are followed, it lowers the incidence of malpractice suits and decreases liability, but this rate is still very high.

As in all businesses there are insurance needs that must be met by a medical practice, and some of these are unique to a medical practice. To help meet all of these needs it would be beneficial to have one person or company represent most if not all of one's insurance needs. The standard insurance is General Insurance or Building Liability. It covers features such as roof damage, vandalism, fire, or injuries inside the building not related to the reason for the patient's visit. This is a type of insurance carried by all businesses. A second mandatory form of insurance is Malpractice coverage. Premiums are paid to cover the risk of injury to an employee. An optional incentive for an employer is to provide employee insurance. This is considered a fringe benefit, which is an incentive for both the employee and the employer. This is talked about in more detail in the financial section. The last and type of insurance is Professional Liability Insurance. This insurance is obtained to defend oneself in a malpractice case.

This issue of liability has truly come into focus in today's current field of medicine. Doctors are constantly looking over their shoulders to prevent lawsuits. Nevertheless, there are thousands of malpractice claims in the United States every year. Doctor's must be very careful in understanding what may make them liable. There is a something called the Doctrine of "respondent superior" which makes the physician liable for mistakes of his staff. This again is why it is important for employees to stay within the scope of their responsibilities. Physicians must also be careful with what they tell patients. By giving concrete assurances of cures or timelines for death, a doctor can create problems for himself. When concrete timelines are given an imaginary legal contract can be created that can create patient dissatisfaction when broken. To avoid this a common practice many physicians use phrases such as: 90% of people with your condition recover after this amount of time. Terminal cases can be handled by saying things like 10% live one year 20% live 1-5 years and many live much longer, and we will do our best to make sure you are in the latter category. In addition to the obvious causes of liability such as medical mistakes, deaths, and displeasure with the outcome, there are several overlooked causes of liability. These include:

- Slippery floors, spills, make sure staff and patients are alert to these dangers
- Help patients who may not be able to walk well, dress themselves, or get onto the exam table
- Don't leave patients with special needs alone ex: very ill, infirm, infant, or young children,
- Keep equipment clean and safe, keep out of reach of children
- Avoid spread of transmissible diseases.

Filing a malpractice claim requires many steps by both parties. The person filing the claim obviously must take the first step. The following steps outline the general proceedings for a malpractice claim filed in Detroit which has one of the largest malpractice rates in the country.

1. Person filing claim files a Notice of Intent (NOI)-this must be filed before the statute of limitations (ex: which is 2 years or 6 months from claim discovery) and it contains a request for records that must be provided within 56 days
2. After 182 days the prosecuting party files a Summons and Complaint with the court-the 182 day period gives time for investigations and time to settle out of court-if a physician doesn't respond to the NOI a Summons can be filed after 154 days
3. Prosecuting party pays approximately $145 with the Summons and Complaint and the jury fees if needed

4. The Complaint also has a form called the Affidavit of Merit-this was created to avoid frivolous claims. It must be signed by a physician with credentials in the area of dispute, and if it is not signed a move for dismal may ensue. Although this was a good concept plaintiff firms have begun to hire physician who will sign anything for money. These physicians are often called "whores" by the law community
5. There are many things that must be filed by the defense also. An Affidavit of Meritorious Defense must be file within 91 days-This Affidavit has signatures saying the doctor be accused has not committed a breach of duty.

Basically there are four things the plaintiff must prove to establish liability. The first is Duty, and this involves the standard of care. The standard of care is the practices and guidelines followed by physicians in the same area of specialty as you. The second thing one must prove is that a breach of this duty has occurred. This is usually done with other doctor testimony. An injury or illness must next be proved, and this relates closely with the fourth part of liability. Causation of the injury must be linked to the breach of duty. This may seem very straightforward, but it is actually a complicated process. Much work is involved in proving all of these liability establishment factors. Depositions must be obtained, records obtained, interrogations or written questions, securing additional damage experts, and obtaining an economic damage amount all factor into the lengthy time involved in such claims. This process can easily take over two years, but after that a judge must explain to the District Attorney the reason for the hold-up and most judges are loath to do that.

The sheer number of unfounded malpractice claims lugging through the system is astounding, and some work has been done to improve this. This reform is called Tort Reform. It has created more hoops to jump through by the plaintiffs that make frivolous claims more trouble than they are worth. This may not be the best way to accomplish the goal, but something must be done. There have begun to be strikes throughout the country in relation to the effects of so many claims. With these claims malpractice insurance has shot through the roof. Many doctors have been forced out of business especially in high risk specialties by high malpractice premiums or have left due to being fed up with malpractice litigation. How many doctors can we afford to lose? An interesting statement by Charles Krauthammer sums it up, "doctors give up the best decade of their youth, their 20's, to treat the sick and learn their craft and society should let them practice it with autonomy, dignity, and freedom from capricious victimization." The many good doctors should not have to pay for the few.

How in fact do we lower this massive number of malpractice claims? I think it comes back to my central theme of patient physician communication. This belief is supported by a lawyer I interviewed named Lisa Anstess. She was a nurse who felt as if she always had to cover herself for fear of being sued. She feels this in no way to truly help people, so she went back to school to become a lawyer. She currently defends doctors in malpractice claims. She says that the prevalent motivating factor for being sued is having a poor outcome (even when a known risk was present). She agrees with me that this is tied to the poor communication/interaction present between the physician and patient. Lisa explains that patients feel that doctors are rushed and not giving them their full concentration. She has had several cases involving patients hearing conversations during surgery that were irrelevant to their care. Patients must feel the doctors care. This lowers patient anxiety and also makes it easier to accept mistakes or unexpected outcomes. "Doctors with good rapport are usually cut a little more slack by patients who wouldn't want to hurt 'such a nice person,'" says Lisa. Always remember that bedside manner is important and personal communication tied into general caring can save much time and money in relation to malpractice claims.

Business Aspects

There are many aspects of running a business, but most of them can be broken down into five basic categories. These are management of Accounts Receivables, Expense Management, Internal Controls, Budgeting, and Tax Considerations. Entering into the medical field is a daunting task, and it is only made worse by the thousands of rules and regulations that govern the business world. In order to run an efficient and people focused practice, a physician must be able to seamlessly go from physician to businessman. If one is able to accomplish this goal, the stress often caused by financial matters can be lifted. This benefits the physician and his ability to provide excellent patient care.

In a general business in which a service is provided, Accounts Receivable is the primary source of income. It would follow that the management of this account should be paramount in such a business. This is the very set-up the owners of a medical practice deal with on a day to day basis. They provide a service in turn for compensation. The difference is the profit motive must be balanced with being able to provide a premium service. One handles Accounts Receivable in an efficient manner by getting them back in a reasonable amount of time. This can be accomplished by the effective use of accounting methods combined with setting target dates and guidelines. Examples of these target dates and guidelines follow.

1. Balancing out the accounts receivable (either by computer or manually by adding up ledger cards to cross-check with day sheets) will take place monthly by the _____.
2. Patients with outstanding balances will have bills sent out to them by the _____ of each month.
3. All billings to patients will have "all bills due and payable in full by the _____ of the month."
4. Aging reports will be completed monthly. Breakdowns will include 30, 60, 90, and 120+ categories and will also be broken down by major type of category (M/Care, M/cal, HPR, privates, etc.). Accounts will be aged by computer by the _____of each month.
5. A comprehensive review of accounts receivable will be performed monthly with doctor and office manager between the _____ and the _____ of each calendar month. (Generally takes place at the monthly management meeting.)
6. Routine follow-up accounts receivable/collections or insurance follow-up will take place monthly between the _____ and _____ of each month.

Write-offs of over _____% will be reviewed with the doctor monthly. This is for monitoring, coding, strategy, and general assessment of carriers and payment levels.

To assist in the management of Accounts Receivable it can often be helpful to use ratios. The Accounts Receivable Turnover and the Number of Days' Sales in Receivable are two ratios designed specifically for this purpose. The Accounts Receivable Turnover measures how frequently during the year the Accounts Receivables are being converted to cash. The Number of Days' Sales in Receivables is an average estimate of the length of time the Accounts Receivables have been outstanding. This combined with an Accounts Receivable Aging Report similar to the one on the next page makes the keeping track of Accounts Receivable much easier to control. The two formulas for these ratios follow:

ACCOUNTS RECEIVABLE AGING REPORT

Month:______________________________________ Date Performed: ____________

Performed by: ______________

Payer	0-30	31-60	61-90	90+	Notes
Patient Portion Medicaid Medicare Worker's Comp					

Accounts Receivable Turnover	Number of Days' Sales in Receivable
= Net Sales on Accounts/ Average Accounts Receivable	= Accounts Receivable, end of year/ Average daily sales on account (The lower this number the better)

A very inventive way to help lower The Number of Day's Sales in Receivables is to include credit terms with a person bill. This financial tool gives a discount to a patient who pays their bill within a certain amount of time. This can lower the uncollectible amount of the Accounts Receivables. The following is the example of the use of credit terms of 2/10 n/30. This is not considering the interest the patient could have earned if they had kept their money in an interest bearing account.

←2/10	$1000 Bill	n/30→
Payment within 10 days		Payment within 30 days
$1000 original bill 5% of $1000; ($50 savings) $950 Reduced Bill		Bill is $1000

If the bill is paid within the first ten days a discount of fifty dollars can be obtained. If the bill is paid within 30 days no discount is issued, but after 30 days interest at a specified amount will begin to accrue. The use of credit terms employees aspects of both positive and negative reinforcement, and both can help to improve Account Receivables collection.

A physician's livelihood depends on being able to keep track of his Accounts Receivable, but ironically this is an area he will not deal with directly. Because of this, a physician must hire intelligent people who can be relied upon to handle such an important task. I outline hiring and management of people in an earlier section, but special care must be given to the training of employees in this area. These employees will be trained in people skills as well as accounting skills. To collect payment in a timely manner, they must be congenial and persistent. In a medical practice, as in any other workplace, people are not likely to do their best at this without an incentive. Aside from an employee's base pay, I plan on improving my Accounts Receivable collections by offering office bonuses for each month we break a set Accounts Receivable percentage. A worksheet for just such an occurrence can be seen on the next page. Person to person phone calls guided by a computer prompter telling which patients bills are past due will also help keep collections efficient. All steps taken to improve AR collections will eventually lower costs for patients, and thus improve total value of healthcare for them.

ACCOUNTS RECEIVABLE MANAGEMENT BONUS WORKSHEET

Collection Ratio

Determine the historical collection ratio for the practice. _____

___

Determine specialty comparable collection ratio. _____

___

Determine the target collection for the practice. _____

___

Bonus staff $X for each month they beat the target ratio. _____

___

AR Aging

Determine the historical AR aging. _____

___

Determine specialty comparable AR aging. _____

___

Determine the target AR aging. _____

___

Bonus staff $X for beating target or Y% of difference between target and actual total AR below target.

Example: $100,000 AR target
$90,000 actual AR with 1% of difference bonus
$10,000 difference x 1% = $100 bonus paid

or

Bonus staff similar to above but for AR over X days (60 or 90)

_____

or

Bonus staff X% of all collections

_____

No matter how hard a person works, there will always be situations that arise that make bill collections difficult. That is why a formal financial statement needs to be obtained at the office to specify the manner of payment. This includes cash, down payments, insurance payments, etc. This form also can help arrange a payment system. A good example of this form is on the following page. Although this form states the method of payment, a patient may not pay is his bill for one reason or another.

A physician must realize that in order to stay in business he must pursue collections persistently. There are several legitimate reasons a person has not paid their bill, and working with patients to help them pay their bill will be the goal of my practice. A process of phone call communication will be the benchmark for steps taken, and only after no progress is made in that department will the manner of acquisition change. At that point, three collection letters will be mailed out in a staggered format. Examples of these can be seen on the next several pages. The first letter that is mailed is a "soft" letter. This letter emphasizes understanding while stating the importance of getting in touch with us to work something out. The second letter is less personal, and it is a letter formatted for legal purposes. It verifies past phone conversations, the amount owed, and gives the option for a payment plan. This letter is tough, but it is no different from a letter that any other company would send to collect payment for a service. The last letter is the Final Notice. It gives deadlines and four separate options. The options are to settle the account, make monthly payments, send the account to collections, or move to legal action. I prefer not to have to send a letter such as this, but I will so as to not allow the delinquency of a few to raise prices for other patients.

After these three letters are sent, the use of a collections agency would be my next course of action. This is a good step because liability is transferred from the practice to the collections agency. This is helpful because a doctor's office does not want to build a reputation for harassing its patients for money. This burden is now placed on the shoulders of the agency. There is also a major negative to a collections agency. Their rates are very high, and they can often reach more than fifty percent of the bill. This may seem large, but as opposed to taking a complete loss. Having something is better than having nothing. It is also useful to keep track of accounts being pursued by collections agencies. This can be done by computer or by a Collection Agency Account Tracking form like the one following the sample letters.

On occasion collections agencies will not be able to collect on an account. At this point two options can follow. Either a suit can be filed or a loss can be taken. Pursuing action in small claims court is not an action I would normally take. I would instead take the loss and inform the patient that they are being removed from my care. Court action can do more damage in the form of reputation that the proceeds obtained. Do to the business status of my practice the loss of would take would be in the from of a direct write-off from the expense account.

As can be seen there are many nooks and crannies of the Accounts Receivable process that must be monitored. This can be accomplished through proper record keeping and proper following of procedures. It is important that no matter what happens, a doctor's first goal is to provide excellent healthcare. In order to do this he must be able to run his practice successfully, and this correlates with maintaining one's Accounts Receivable. No one will benefit in the long run from patients getting away without paying for the services of a doctor.

FINANCIAL AGREEMENT

For professional services rendered.

Patient, or parent of patient if patient is a minor: _____

1. Cash professional fee for services $ _____
2. Cash down payment (incl. deductible) $ _____
3. Estimated insurance payment $ _____
4. Uninsured balance $ _____
5. Amount financed $ _____
   (the amount of credit provided to you)
6. Finance charges $ _____
   (the dollar amount the credit will cost you)
7. Annual percentage rate $ _____
8. Total of payments $ _____
9. Total of amount $ _____
   (1 + 6 above; sum of cash amount, financing charge, and any amounts financed by creditor)

Total payments (8 above) is payable to Dr. _____ in _____monthly installments of $ _____ each and _____ installments of $ _____ each. The first installment is due on _____, and following installments on the same day of each consecutive month until paid in full.

NOTICE TO PATIENT/GUARDIAN

Do not sign this agreement if it contains any blank spaces. You are entitled to an exact copy of any agreement you sign. You have the right at any time to pay the unpaid balance due under this penalty without penalty. You have a right at this time to receive an itemization of the amount financed.

I want an itemization I do not want an itemization

I have read, understood, and agreed to the above financial agreement, terms and conditions, and schedule of payments.

_____

Signature of responsible party Date

_____

Doctor's signature Date

SCHEDULE OF PAYMENTS

Pmt No.	Due Date	Amount of Installment		Date Paid	Follow Up
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					

FORM F-17

FORM S

COLLECTION LETTER 1 (SOFT)

Dear Patient:

It is the policy of this office to contact patients who have received two billing statements but have not replied. We are certainly aware of the difficult financial times in which we are now living, and because of this we think communication between our office and patients regarding past-due bills is most important.

We ask that you cooperate in calling our office to communicate with us about your outstanding balance. We are certain we can work out a suitable written payment arrangement with due dates, amounts, etc., to the benefit of all. Keep in mind that we accept VISA/MasterCard for payment in full on accounts.

We thank you for your cooperation and look forward to assisting you.

Sincerely,

Bookkeeper

COLLECTION LETTER 2

To:

From:

Date:

Re: Payment Arrangements

This is to verify our telephone conversation of _____.

We agreed that you will be paying $_____ by the _____ of each month to complete payment of your professional fees. The total balance owing is $_____. You will be paying _____ payments, with the final payment being made on the _____of _____.

Please sign below for our records and return one copy of this letter to our office in the enclosed envelope. We have also enclosed a copy for you to keep for your records. We appreciate the opportunity to provide you with the medical care you need.

Approved:

_____ _____

Patient Date Date

_____ _____

Office Representative Date

COLLECTION LETTER 3

To:

Date:
Balance Due:

Final Notice

Because your account is long past due, we would normally turn it over to a collection agency. We would, however, prefer dealing directly with you since a collection agency action would affect your overall credit rating. Please read and check one of the options below and return this signed form to us by _____.

_____ 1. I would prefer to settle this account. Please find full payment enclosed.

_____ 2. I would prefer to make monthly payments. Please see attached for my payment commitment.

_____ 3. I prefer to have this balance paid in full by my:
VISA/MasterCard (circle one)
Exact name on account: _____ Exp. date _____
Total amount authorized _____

_____ 4. I would prefer that you send my account to collections or move to legal action.

OFFICE USE ONLY:	Voucher prep'd. _____	Verif no. _____
Date verif _____	**Copy to chart** _____	**Copy to pt** _____

IF FULL PAYMENT OR REGULAR PAYMENTS ARE NOT MADE, FURTHER ACTION WILL BE TAKEN BY _____.

If you have any questions, call the office at _____.

COLLECTION AGENCY ACCOUNT TRACKING

Agency name _____

Contact person _____ Phone _____

Patient Name	Date Sent	Date Paid	Amount

The second aspect of a successful business is in the maintaining of one's expenses. A practice must maintain the proper balance of providing necessary comforts without creating frivolous expenses. This is easier said than done. The solution to keeping expenses as their optimum level is by periodically reviewing the office's current practices each week or month. This will be one of the objectives of the meetings mentioned in the communications section. This open communication between all employees will allow the cutting of unneeded expenses in order to streamline the practice to meet it's vision and goals. It is mind numbing to try and realize how many different expenses make up a practice. The following is a typical list of expenses for a practice.

Fixed Expenses Occurring Monthly

- Accounting
  - Bookkeeping
  - Patient Billing
  - Payroll Service
- Auto Expense
  - Auto Lease
  - Gas, Oil, Maintenance
  - Insurance
- Contributions
- Equipment Leases (lease vs. own)
  - Computer
  - Copier Exp
    - -purchase
    - -paper
    - -supplies
    - -repair/maintenance
  - Postage Meter Costs
  - Clinical Equipment
  - Telephone
  - Typewriter
    - -supplies
    - -repair/maintenance
- Insurance
  - Major Medical
  - Individual (doctors)
- Management Consultants
  - Initial
  - Ongoing Maintenance
- Marketing
  - Telephone Book
  - Incentive Thank You gifts
  - Practice prom. (entertainment)
- Parking
  - Doctor and Staff
  - Shared Staff
- Pension/Profit Sharing Contr.
  - Doctor
  - Staff
- Plant Maintenance
  - Office clearning
    - Windows
    - Plant Care
  - Building Exterior
- Rent
- Subscriptions (Recept. Rm.)
  - Professional
- Merchant Disc. Fees
- Taxes
  - City Business Tax
    - City Pers. Prop. Tax
  - City Unsec. Pers. Prop. Tax
  - Federal Income Tax
  - State Franchise Tax
  - Other
- Temporary Help—Doctor
  - Staff
  - Answering Service
- Equipment Repair
- Auto
- Continuing Education
  - Doctor (spouse)
  - Managerial (?)
  - Clinical
  - Staff—Managerial
  - Clinical
- Hiring
  - Advertising
  - Agency Fees
  - Outside Prof. Serv.
  - Temp. Help—emergency
  - Other
- Signage
- Petty Cash/Change

Expenses That Can Increase with Production

- Collection Expenses
  - Small Claims Court

Clinical Supplies
Back Off/Clinical
Table Paper
Toilet Paper
Lab Fees
Office Supplies
Stationery
Practice Brochure
Misc. Supplies and Charts

Salaries
Doctors (draw)
Staff
Shared Staff
Taxes—Payroll
Uniforms
Utilities—Water, Gas
Elec. Refuse (in rent)
Postage
Telephone
Dictation

Fixed Expenses Occurring Regularly but not Monthly

Accounting
Tax Preparation—bus.
Tax Preparation—pers.
Conventions
State—Regis. Fees
Hotel and Travel
National—Regis. Fees
Hotel and Travel
Regional—Regis. Fees
Dues
National, State, and Local
Other
Insurance (overhead)
Profess. Property—Comp.
Fire
Liab
Theft/Damage
Profess. Liability
Disability—Doctor
Office Overhead
Worker's Comp.
Worker's Comp. Audit
Life/Disab. Ins. on Debt
Practice Preservation?
Licenses
Clinical
City, State, and Local
Marketing
Quarterly Communications
Newsletters (Quarterly)

Other/Miscellaneous Expenses

As can be seen there are quite a few things that must be maintained in order to keep a practice running smoothly. It is important to enter into the medical field knowing that all of these different expenses exist. Imagine how daunting it would be to begin a practice only understanding the workings of the human body.

A second consideration that must be worked out in conjunction with expenses is how to divide them up in a multi-doctor practice. There are several ways that this can be done. A practice can allocate expenses in terms of collections, charges/production, equally dividing between doctors, divided by a formula, or divided upon another sharing arrangement. The proper allocation of expenses will help to lower them in the future. Expenses cannot be lowered if the practice doesn't know who is creating them. A monthly group sharing expense accounting report should be filed each month. This allows the allocation of expenses to being divided up among several doctors. An example of such a form follows. Although it does not contain every expense listed above it covers the many of them. A more in depth report can be obtained less frequently. As opposed to Accounts Receivable every aspect of a physician's practice has expenses related to it. Because of this, the proper understanding of where money goes is very important to understand.

EXPENSE-SHARING GROUP ACCOUNTING REPORT

for the month of _____ 20___

Expenses
Divided by Productivity

Physician Extended Wages	$ _____			
Physician Extended Benefits	$ _____			
Staff Wages	$ _____			
Clinical Supplies	$ _____			
Office Supplies	$ _____			
Repairs	$ _____			
_____	$ _____	Dr. A _____%	Dr. B _____%	Dr. C _____%
Subtotal	$ _____	$ _____	$ _____	$ _____

Divided Equally 3 Ways				
Legal and Accounting	$ _____			
Outside Services	$ _____			
Marketing	$ _____			
_____	$ _____	Dr. A 1/3	Dr. B 1/3	Dr. C 1/3
Subtotal	$ _____	$ _____	$ _____	$ _____

Divided Equally 4 ways (C=2)				
Janitorial/Maintenance	$ _____			
Rent and Utilities	$ _____			
Telephone	$ _____			
Business Insurance	$ _____			
Waiting Room Magazines	$ _____			
_____	$ _____	Dr. A ¼	Dr. B ¼	Dr. C ½
Subtotal	$ _____	$ _____	$ _____	$ _____

Other/Miscellaneous				
_____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____
Subtotal	$ _____	$ _____	$ _____	$ _____

Expenses per Physician Total	$ _____	$ _____	$ _____	$ _____
Expenses Paid by Tenants	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ _____

Internal Controls serve the purpose of preventing abuses of the system. This is the third category that is important in running a business. The major abuse of the system prevented by internal controls is embezzlement, and the major factor contributing to this is the lack of business experience of physicians.

There are three things that internal controls help to assure. They help to ensure that drugs and supplies are used for medical purposes only, they help to ensure that patient information is accurate and private, and the help to ensure that all laws and regulations related to the practice are followed. There are several steps that can be taken to make the previous goals become common practice.

1. A physician must create an environment where following controls is expected by creating personnel policies for proper hiring and training. This includes making people fully aware of their individual roles and responsibilities. This also includes evaluating ongoing performance, fair promotions, and good management (This is discussed in more detail in the hiring and management section).
2. This step involves always being aware of the risks associated with a medical practice. This includes being up to date on the changing laws and regulations (make it mandatory that staff be up to date with events in the medical field). This also involves understanding the societal view or community view towards one's medical practice. Steps must be taken to identify all of the risks found.
3. The third and arguably most important involves control procedures geared for eliminating fraud and embezzlement. Examples of this include filing false insurance claims or Medicare fraud. Four steps can be taken to combat these risks
   A) Initial hiring of personnel who are competent and have a good work history
   B) Crosstraining of personnel which is training one person to do another's job as part of continued education. This serves two distinct purposes. It gives an employee a break from the monotony of their job, and it enables someone else to do their job (possibly to detect errors or fraud).
   C) Mandatory Vacations accomplish the same thing as crosstraining, and if it is tied into a incentive package can have tax benefits.
   D) Separate responsibilities for related Operations-Very important Ex. Don't have same person sending bills, collecting money, and accounting for the transactions. It would create an opportunity ripe for not only embezzlement and fraud, but also for accidental errors. Everyone needs someone to check up on them every once in awhile.

In relation to the steps above target dates and guidelines will need to be created. Examples of these include:

1. Deposits will be made at least _____ times per week and/or made daily if more than $_____ in receipts exists.
2. The bank statement will be mailed to the doctor's house and reviewed. The statement will be brought into the office by the doctor within _____working days of receiving it.
3. Checks written will be accompanied by the stub, payment coupon, or some type of documentation for doctor review when signing the check. No check will be approved by doctor without some type of verification. A copy of the verification will be maintained with the payment date, amount, and check number on the paperwork.
4. A running balance will be kept in the check register at all times.
5. A petty cash journal will be kept and balanced monthly. A fund of $ _____ will be kept (locked). When the fund gets below $25, the officer manager will replenish it.
   When paying cash, a patient will receive a receipt with notation on the account.

A monthly Checklist like the one on the next page will also be used.

INTERNAL FINANCIAL CONTROL CHECKLIST

By: _____ Date: _____

Cash Collections and Receipts	Yes	N
Is a change fund being maintained?		
Are receipts issued for cash payments		
Are receipts prenumbered?		
Are carbon copies of receipts kept?		
Are payments received indicated as check or cash on the receipts and daysheets/computer?		
Is cash totaled daily to agree with daysheets/computer?		
If a receipt is spoiled, is it voided and left in the book attached to daysheet?		
Are employees who handle cash bonded?		
Deposits		
Is deposit prepared daily?		
Are deposits held overnight stored safely?		
Are the carbon copy deposit slips attached to the daysheet/computer run?		
Is the bank statement opened only by the doctor or accountant?		
Is the bank statement mailed to the doctor's home?		
Does amount deposited to business account from receipts balance with month-end totals?		
Daysheets and Financial Cards		
If on a manual/pegboard system, is it used correctly?		
Is there an individual daysheet/computer run for each day?		
Does the doctor review and initial the daysheets/computer run?		
Are daysheets/daily computer runs compared with appointment book and financial records monthly?		
If manual:		
-Are daysheets and financial cards prepared in ink?		
-Is a tape of accounts receivable cards run at the end of each month and balanced with A/R on daysheets?		
-Are financial cards stored safely?		
-Are all financial cards returned to card files nightly?		
Are all accounts with balances billed? Even those pending insurance?		
If computerized, where possible, are billing and collection duties done by separate persons?		
Is backup on the computer performed daily?		
Are disks stored off site in a safe place?		
Petty Cash		
Do you itemize cash expenditures?		
Are receipts kept for petty cash expenditures?		
Do you keep a running balance of petty cash?		
Does the cash balance agree with the records? Is it balanced monthly?		
Are employees' purses and personal belongings kept in a separate location away from front office area?		
Employees		
Are employees required to rotate duties and responsibilities where possible?		
Are refund checks approved by the doctor?		
Are "write-offs" and adjustments reviewed by the doctor monthly?		
Are accounts in internal collection contacted at least monthly?		
Accounts Payable and Miscellaneous		
Does doctor sign all checks?		
Do you refuse to keep a signature stamp in the office?		
Does the doctor refrain from "skimming" or "dipping" into the petty cash?		
Do you have your CPA or an outside person perform periodic reviews?		

(We recommend monthly internal cross checks; this takes only about 20 minutes a month.)

The reason for this checklist is to make the job of keeping track of Internal Controls a relatively easy process. There six areas this checklist covers. Cash Collections and Receipts, Deposits, Daysheets and Financial Cards, Petty Cash, Employees, and Accounts Payable make up these areas. This sheet is actually a very thorough representation of what areas need to be watched over. Each area has its own checks and balances that go along with it. For instance, the petty cash fund is an area that might entice stealing from the practice. It is human nature to want what one doesn't have, but controls must be set up to deter such a theft. The petty cash balance must be kept accurate with use of a Petty Cash Reconciliation. An example is on the next page. It gives the date money was taken or deposited, the voucher number, who deposited or took from the fund, who approved the transaction, and the ending balance. It is important for the doctor and other employees to follow procedures involving this fund. Another area that must be monitored closely is the cash receipt from patients. A division of responsibilities must be maintained that separates the person collecting the cash from the person recording the receipt. Receipts from such transaction, like the one following the Petty Cash Reconciliation example, must be examined each day to insure that the receipts match the cash inflow. A final reminder is that physicians should sign all checks. This keeps the practice purse strings firmly in the hands of the physician. Many more examples of such controls can be given, but the Financial Control Checklist gives a broad overview of what controls are needed.

The final aspect of Internal Controls is the monitoring of the system. A major part of this is periodic review of the Financial Control Checklists to see what changes need to be made, but there are also three other areas to be conscious of. The first are is that there are signs to look for that may indicate fraud or otherwise underhanded activity are going on with respect to the employees of one's practice. These are:

- Large lifestyle changes without an employee winning the lottery
- An employee refusing to take vacations or strong reluctance to participate in cross-training especially if someone else must do their job
- Noticeable increase in the use of alcohol or signs of drug abuse

The second area that must be monitored is the accounting of one's firm. This includes the basic accounting that is done in house, and the accounting that is done by outside firms. Examples of fraud include:

- Missing Documents ex: prescription pads, claims forms etc. (how common in today's society is it for a person to write illegal prescriptions in order to illegally sell the drugs at a later date)
- Unusual change (drop) in Accounts Receivable collections
- Difference in cash receipts and bank deposits

The last area is the accounting done by outside firms. External audits should be performed in order to assure internal compliance. Different firms should be used also in order to assure that the firms are following generally accepted accounting procedures. As can be seen there are many areas of a business that a physician can be taken advantage in. It is the responsibility of the physician to have maximum oversight in his practice to assure that such incidents are uncommon. Constant vigilance is the price that must be paid in every area of a practice in order to ensure all patients get the maximum benefit for the money they pay.

PETTY CASH RECONCILIATION

Period from: _____ to: _____ Department _____

STARTING BALANCE:

_____

Date	Petty Cash Voucher No.	Paid to	Charge to	Approved by	Total	Balance

TOTAL VOUCHERS | | |

Auditor: _____
Date: _____
Over/Short: _____

Approval: _____
Date: _____

PETTY CASH REIMBURSEMENT | |

BALANCE BROUGHT FORWARD | |

RECEIPT

RECEIPT_____

Receipt Number: _____

Received from:_____
from:_____
Address: _____
For: _____
_____
_____ Dollars_____
Dollars_____

Date: _____ **Check** **Cash**
Cash

Rec'd by:_____ Credit Card

RECEIPT_____

Receipt Number: _____

Received

Address: _____
For:

_____

Date: _____ **Check**

Rec'd by:_____ Credit Card

RECEIPT_____

Receipt Number: _____

Received from:_____
from:_____
Address: _____
For: _____
_____
_____ Dollars_____
Dollars_____

Date: _____ **Check** **Cash**
Cash

Rec'd by:_____ Credit Card

RECEIPT_____

Receipt Number: _____

Received

Address: _____
For:

_____

Date: _____ **Check**

Rec'd by:_____ Credit Card

RECEIPT_____

Receipt Number: _____

Received from:_____
from:_____
Address: _____
For: _____
_____
_____ Dollars_____
Dollars_____

Date: _____ **Check** **Cash**

Rec'd by:_____ Credit Card

RECEIPT_____

Receipt Number: _____

Received

Address: _____
For:

_____

Date: _____ **Check** **Cash**

Rec'd by:_____ Credit Card

The next are of a business that must be designed and managed properly is in budgeting. The key to designing a budget relies on the specific goals of the business. An owner must determine the sacrifices or expenses that are necessary to achieve those goals. For example, if money/profits are the specific goal then lower quality at a higher turnover would be a way to achieve the goal. However, the goal of my practice, as stated throughout this design, is to provide excellent healthcare in a patient centered environment. There are three parts to achieving this goal.

1. Purpose-This is the reason the practice exists. The reason the practice exists is that I feel confident that I can provide excellent patient care. This patient care will benefit the patient in terms of health and it will also benefit the practice in terms of profit as a secondary driving force.
2. Vision-These are the steps that will be taken to achieve this purpose. These steps are outlined through this business design. The basic concept is to design a patient oriented business that is run very smoothly. This efficiency will reduce overhead and lower costs. Lower costs combined with more time with patients will reduce malpractice claims and enable myself as a physician to provide the best care possible
3. Mission-This is the specific manner in which the company plans to achieve its purpose and manner. I would like to say that it would be done on my own, but that would be pompous and incorrect. In the paraphrased words of Donald Trump, "you don't have to be the smartest man at everything, but you must hire the smartest people to work for you." This is also how I will achieve my purpose and vision. I will hire the best people including staff, a Financial Advisor, a law firm, insurance agent, etc. People are the key to success and nothing can be done alone.

Another important aspect of my business is the goal of staying patient oriented. I am running a business but I am a doctor first. This is a constant balance that must be maintained because in reality if my practice is in the red, I can provide healthcare to none. Another aspect of creating my budget will be patient and employee driven. I want to include their thoughts on how things should work. This interaction will give my practice a better chance at reaching its goals quickly. While setting the goals remember to not set them too high or too low. Very high goals often seem unattainable and people don't work hard to reach them. Similarly, very low goals are so easy to reach that employees are not challenged to achieve. For these reasons goals must be properly balanced.

The actual financial budget for my medical practice will be based on five areas. These revenue projections will determine how much money a practice has to work with.

1. Number of days a week the physician works
2. Number of weeks worked per year
3. # of patients per day
4. anticipated hospital admissions
5. anticipated procedure volume

This information is taken and a fee analysis is performed. This fee analysis can be done in several ways, but a common measurement tool is a *Relative Values for Physicians or a Physician Fee Analyzer.* Using this tool allows a physician to set his fees in accordance with the relative values of other physicians in his same field. This is one way, but I don't know if there is a better one out there or not. With this information and the information from the revenue projections an estimated number for cash collections can be obtained.

The next step in the designing of the budget is expenses. These expenses should be matched with the goals (purpose, vision, mission) of the practice. Expenses provide flexibility in both directions. Is it worth it to have nice pictures in the waiting room or should that money be used somewhere else. These decisions will decide the success of the practice. There are two separate types of decisions that must be considered. The first concerns budget-operating expenses and the second involves physician related expenses. The budget-operation expenses can be broken down into four areas covered in more detail in the expense section

1. Staff Salaries and Benefits
2. Clinical Expenses
3. Office, Rent, Furniture and expenses
4. Legal and accounting services

The Physician related expenses include five separate areas

1. Physician salaries
2. Malpractice premiums
3. Dues, memberships
4. Travel
5. Automobile Allowance (unlikely in my case)

As can be seen a budget is a very fluid thing that changes when the goals of a practice change. When designing a budget for my practice I will work with several professionals to ensure its sound framework. I choose not to present numbers now because there are so many variables to consider without the hiring of an actual financial planner specializing in medical practice budgets. However, the concepts presented in this budget planner can be utilized in my future plans.

The area that must be analyzed in context with the opening of a medical practice is the many business decisions that are related to tax. Taxes in the American society are unavoidable, but the goal is to pay the minimum amount permitted by law. These taxes paid are an expense much like the lighting bill. In order to lower the lighting bill one should turn the lights off when he leaves the room, and to lower taxes a knowledgeable businessman uses the tax code itself. There are several types of taxes including: Sales, Income including federal and state, property taxes, self-employment taxes, other many others. It is important to understand the relationship each type of tax has with one's practice, and it is also important to have an accountant with much experience in the medical field.

Before a practice can be taxed a decision must be made as to how the business entity will be classified. Different classifications offer different benefits. Some allow salaries to be paid and others are simply flow-through entities. The choices range from Corporations, S-corporations, and Partnerships. Careful consideration must be taken before deciding what type of entity a practice will be classified under. Once a decision has been made it can be very expensive and time consuming to change things in the future.

Corporations are normally businesses that are large and a portion of them can be publicly owned. For a medical practice the corporation would be specifically a Personal Service Corporation. This division applies to medical, legal, and accounting firms. The major benefit of this is that the corporation can still use the cash method of accounting even when more than five million a year is being made. A second advantage is that a shareholder is only liable for his personal stake in the corporation. A disadvantage of this set-up is the use of a flat tax rate of 35%. A system of double taxation is also currently in place although rumors of its change circle throughout government. This means that the corporation is taxed for its profits and when payments are made to shareholders, the money is taxed again. Such tax rates can combine to produce over a 60% tax rate. This prompts many corporations to harbor money without paying it to shareholders. Laws ensuring that any money over $150,000 can only be held for a reasonable business need have also curbed this practice. Without this need the corporation would have to pay dividends out to shareholders. These faults combined with high start-up cost make the forming a corporation business entity for my medical practice very unlikely without major changes in the law.

The second business entity to be considered is the S-corporation. This is a business entity that was created to help alleviate the problem of double taxation specifically. A positive seen in this form as in a normal corporation is that a person is only liable for the % of debt up to the amount of stock that they own in the S-corporation. Many other aspects are appealing to a medical practice, but not everything is ideal. Many idiosyncrasies of an S-corporation include:

- Buy-sell agreements that force a leaving physician to sell stock back to practice before he leaves
- The fact that they must file a subchapter S election with the IRS and the fact that an S-corp may be more expensive to operate than a partnership due to state taxes.
- In Tennessee S-corporations are taxable by state income tax or franchise tax unlike partnerships
- A large benefit is that there are no self employment taxes
- Another benefit is that S-corps can pay salaries

Partnerships are the final category of business entity that may be a possibility for my future medical practice. Partnerships are much more flexible in area of income, gain

deduction, and loss ration allocation than any form of corporations. Partnerships are flow-through entities that use form 1065 and form K-1 to show each partner's individual earnings on each persons 1040. The only disadvantage of a traditional partnership is that each general partner has the responsibility of unlimited liability with respect to the business unlike corporate forms. A new hybrid partnership has filled this gap. It can be compared to an S-corporation with greater flexibility. It is a Limited Liability Corporation LLP. They are very attractive to medical professionals in a business entity sense because they make malpractice of individual doctors not detrimental to the practice as a whole. This is possible because LLP partners are only liable for their portion of the practice as a business such as debts, but they are fully reliable for the services they perform. Any example of this follows.

Three doctors are members of an LLP. These doctors are general partners, and they are defendants in two separate lawsuits.

Lawsuit 1- Employee age-discrimination lawsuit for $600,000
Lawsuit 2- Malpractice suit filed for mistakes performed during surgery by doctor number one for $1,000,000

Lawsuit 1 results- Each partner is liable for $200,000 worth of damages related to age discrimination suit
Lawsuit 2 results- Doctor number one is liable for the entire $1,000.000 not covered by malpractice insurance

Other benefits of LLP's include the ability to make guaranteed payments, the ability to negotiate contracts every year, and the fact that start-up costs are low which generates immediate tax savings for the company. This can be seen in the following example. Assume that a medical practice operates its first two years with a $100,000 net loss each year, but on the third year a net gain of $500,000 is produced. At a hypothetical 35% rate and a 9% discount rate the following graph compares a flow through entity such as an LLP to a corporate form.

Tax Savings and Costs		Passthrough Entity		
Year	(Deduction) or Taxable Income	Tax Savings or (Cost)	Discount Factor	Present Value of Tax Savings or Cost
1	$(100,000)	$35,000		$35,000
2	$(100,000)	$35,000	.917	$32,095
3	$500,000	$(175,000)	.842	$(147,350)
Total=		$(105,000)		$(80,255)

Tax Savings and Costs		Passthrough Entity		
Year	(Deduction) or Taxable Income	Tax Savings or (Cost)	Discount Factor	Present Value of Tax Savings or Cost
1	$(100,000)	0		0
2	$(100,000)	0	.917	0
3	$300,000	$(105,000)	.842	$(88,410)
Total=		$(105,000)		$(88,410)

As can be seen from the results the actual dollar amount of tax savings in both cases is $105,000. The difference is that the deduction in the corporate form cannot be taken until a profit is realized by the practice. This time delay cost the practice over $8,000 dollars in tax savings. As can be seen this start-up tax savings is a very big incentive in favor of becoming an LLP. The only disadvantage is the fact the self-employment tax must still be paid. LLP combine flexibility found in a pass-through entity with the legal protection found in the corporate form. Before a decision is made however a tax expert should be consulted.

As can be seen from the above tax savings example, when savings happens can save or cost a practice a large amount of money. A system called Arbitrage is formulated to take advantage the effects of time. It's goal is to increase after tax-wealth by combing tax-favored investments and financing strategies such as the tax saving choice of an LLP over a corporation. A businessman must always consider the time value of money when making financial choices. A dollar today is worth much less ten years from now. In conjunction with this a lower tax rate may also imply implicit taxes that are found in the form of lower after tax rates of returns on investments. One must be careful when taking out loans or investing in other corporations because tax rates and structures can often dictate whom comes out ahead and who is left in the red.

Another interesting tax benefit is found in the form of Tax Credits. These credits are direct reductions in tax liability. This means that a credit is worth much more than a deduction of the same amount. In relation to a medical practice there is a general business credit that combines 13 individual credits. At least four of these may be applicable to a medical practice.

1. Research Credit- in my belief that research is important, this credi would help to fund any plans I may have in the future related to that goal.
2. Disabled Access Credit- this nonrefundable credit pays for expenses to provide access to persons with disabilities. An obvious benefit for a medical practice
3. Orphan Drug Credit- Testing for Rare Diseases (This may or may not be part of my practice, but it is a definite credit to be aware of.)
4. Rehabilitation Credit- I am a big fan of this credit because the more comfortable a patient can be made the easier it is to make them well again. This credit is for the rehabilitation or buildings placed in service before 1936 or listed as historic structures by the U.S. Department of the Interior. It equals 10% of the rehabilitation costs for qualifying commercial buildings and 20% of rehabilitation costs for certified historic structures.

Various other tax facts to be aware of do not fall into a specific category, but they will be listed here. Key person life insurance can be very beneficial in smoothing a transition after an accident or death has befallen a member of the practice. The thing to remember is that the premiums are not tax deductible, but any pay-off would not be taxable. A second miscellaneous item is the use of independent contractors. This can be a very beneficial practice when used within the law. An example of this is when a person is needed in the office to do lab work. It would be better to have them classified as an independent contractor as opposed to an employee. A practice would not have to pay taxes for services or provide fringe benefits if this person is an independent contractor. Their payment would be strictly an expense

The last area of tax that has major implications for a medical practice or any other business is the use of fringe benefits. These benefits can provide huge incentives for employees while providing tax savings to an employer. The reason this works is because

the law allows employees to exclude benefits from income tax. Employers benefit by being able to escape paying payroll tax. The cost of a fringe benefit is deductible in the same manner as any other compensation paid to employees. There are several examples of fringe benefits, and many of them can be grouped in a cafeteria plan. This is an incentive that allows employees to choose the benefits he or she want to receive. Examples included may be

- Employer provided medical insurance-This is not taxed and is one of the most important fringe benefits desired by employees
- Group Term Life Insurance-can be provided and is not taxed until the amount exceeds $50,000
- Dependent Care Assistance Programs-On site day care or a set amount can be given for off site care
- Company sponsored picnics are also tax deductible incentives used by companies
- Company car use
- Retirement plan contributions- The assortment of retirement plans is very large and companies can contribute to them. With the effect of time-value of money this can be a major incentive to ensure one's future livelihood.

An employers cost of providing plans like the one's listed above are usually less than the benefits would cost the employees if they had to provide them for themselves. This is attributable to the employer's economy of scale. The cost of providing health care to a large group (per person) is cheaper than insurance for a single individual. This along with all of the other tax laws are fluid. It is important for a good business owner to keep track of such changes. The best way to do this is to make sure good people work in one's accounting department.

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