The Complete Business Guide for a Successful Medical Practice

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Foreword

If you are like most physicians, you will spend only a few hours in training learning about business and a lifetime learning the hard way. During my MBA training at the Tuck School, my classmates joked when we reviewed a bad investment term sheet, "Leave that one for the doctors and dentists." Because few medical schools offer courses on the business of medicine, few physicians receive training on investment asset diversification, financial risk management, return on investment (ROI), and the time value of money/net present value (NPV).

Imagine what it would be like for physicians entering practice if a book were written that was easy for non-MBA physicians to read and implement. Most physicians spend over 30,000 h and on average 12 years of schooling after high school to become trained doctors. According to Malcolm Gladwell, the author of *Outliers, The Story of Success*, it takes approximately 10,000 h of training to become an Olympic champion. Thus, a physician trains nearly three times more hours than an Olympian. We start working for a living around age 30 and generate an income that results in our paying relatively high taxes, rarely receiving financial aid for our children's education, and having fewer years for our savings and investments to grow prior to retirement.

For physicians who may be vulnerable to sales people offering investments that double our money in a short period of time, schemes to avoid paying taxes, and artificially low life and disability insurance premiums, this book focuses on creating steady, methodical, risk-appropriate, legal methods of creating wealth for you and your family.

Most physicians, who work for 30 years, can earn in excess of $10,000,000, but end their careers without creating personal wealth. The process of financial management is less complex than the healthcare delivery environment in which we find ourselves currently. With chapters on job searching, compensation, insurance, coding, accounting, law, marketing, revenue generation, and avoiding burnout, this book will give you the foundation you need to manage your finances and become a more knowledgeable healthcare professional.

If physicians average 60 plus hours a week in their practices caring for patients, plus attending meetings, reading journals, and attending courses, they have little

spare time to attend educational courses on finance and practice management. Most physicians don't plan to fail, but fail to plan. This book provides an action plan that can result in a successful financial and medical career.

In closing, I offer a confession based on insights learned through experience. As a 16-year-old, I asked my father, a practicing neurosurgeon at a community teaching hospital, "Who do the residents learn from, you or the nurses?" He told me, "Mainly from me. Only those who are smart enough learn from the nurses" [1]. As an Associate Professor of Surgery, I asked surgical residents, attending surgeons, and nurses what should be the aim of our residency program. The residents replied to learn how to do cases. The attending surgeons said it was to learn surgical technique and judgment. The nurses told me it was to *learn communication skills* [2]. Decades later, a physician CEO from New Jersey dismissed my insights as "soft skills." That prompted a physician CEO from Ohio to retort, "Communication, win–win negotiation, and conflict management constitute the hard skills because they are so difficult to do well and so difficult to perform daily." I wish you the best on your lifetime journey and hope that you will keep me posted on your progress.

Sincerely,
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Preface

Being a part of the healthcare profession still remains one of the most noble and gratifying professions. In spite of decreasing reimbursements, rising overhead costs, increasing debt of young doctors, and working long hours, more young men and women are applying to medical schools in record numbers. We belong to a very elite profession consisting of the brightest minds and very hard working men and women. In spite of all these positives, there we are experiencing a loss of control by doctors, by our professional organizations and by hospitals and other healthcare institutions. One of the reasons that we are losing control is our lack of understanding of business aspect of medical practice. We are all trained to diagnose and treat medical diseases. However, very few of us understand the business end of the practice of medicine. Very few medical schools address the business side of medicine. As a result, most doctors go to work for a hospital, a large group practice, an academic practice, to a government run medical facility, a small group practice, or even a few consider starting a solo practice. It is a rare doctor who knows how to understand a quarterly report listing the assets and liabilities of the practice, how to review an account receivable report, how to submit a request to a bank for loan, how to look at an explanation of benefits report (EOB), or how to evaluate the economics of investing in a new piece of equipment.

With the Affordable Care Act about to be fully implemented, doctors are discovering what this means for them. For many, it means they better understand the business component of their practice if the practice is going to thrive and even survive.

Many doctors likely weren't thinking about business skills when they got into the field of medicine, nor did they have time to take business courses. However, with decreasing reimbursements and rising overhead costs, the profit margins are going to be very small and it will be imperative for physicians to acquire stronger business skills.

This book is intended to give doctors the minimum business information that they need to know. They will learn the metrics to monitor on a regular basis to compare the practice to the previous month, to compare physicians within the practice, and to compare the practice to other similar practices in similar geographic areas of the country.

Physicians also have to worry about marketing more than ever before—both to potential patients and to other physicians, particularly primary-care physicians, who provide crucial referral business and also to potential new patients. Specialists need to spend more time nurturing relationships with primary-care physicians to make sure they are appropriately referring patients for care. This book will discuss how to market on the Internet and use social media to connect with existing patients and how to attract new patients to the practice.

It is imperative that doctors know how to speak the language of business when communicating with insurance companies, hospital administrators, bankers, accountants, and other advisors. Like any business, practices are going to need to collect the data to back up your strategies and communications with other bean counters. Doctors will need to have marketing and branding strategies that will create advantages and differentiation as the practice of medicine becomes more competitive. This book will provide those suggestions for branding your practice and making your practice stand out as unique and make your practice attractive to patients, other providers, and continue to endear your practice to your existing patients. We will give you the skills and examples from practicing physicians to identify your practice's strengths and come up with a strategy to showcase your areas of expertise making your practice stand out and become attractive to new patients. We will provide you with the Present this information in a way that's easy for other busy doctors and patients to understand.

An article in the Washington Post summed it up: "The reality is if you don't understand business practices, you can't survive in today's market—and if you don't survive, you won't do anyone any good. You will no longer be practicing medicine and providing the much-needed care to the patient that you went to medical school to treat" [1].

Let us begin this book with a discussion of two types of doctors. (1) those that just want to be an employee, accept less control, "just let me practice medicine." There is a price to pay for this approach and that is a trade-off of stability and a monthly check but with less pay and (2) physician entrepreneurs who want to own and to control their own business. The trade-off for the entrepreneur is less security and stability but with a potential for more control of your practice and more pay. We believe that the employed physician will also need to have a basic understanding of the business of medicine. The employed physician still needs to understand several metrics of the business of medicine he/she will also need to know how to read a balance sheet, how to calculate the RVUs for each physician, and how to become efficient as well as productive. However, those physician entrepreneurs in the second category must understand that medicine is also a business, and that the entrepreneur will succeed when he/she can speak the language of business, who can adapt, who are flexible as they be the doctors who will succeed and who will do well. So our

message is that all physicians need to understand the business of medicine. Our future and our control of our practices depend on it. We hope this book will give you the basics and will help to make you better business men and women which is also part of being a good doctor.

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Chapter 1
The Basics of the Business of Medicine

Neil Baum and Raju Thomas

Physicians who aren't good at business won't survive [1]

1.1 Introduction

Our purpose is to provide the graduating and practicing physician with an understanding of the business of a medical practice. All doctors leave medical school and their postgraduate training with excellent skills for diagnosing and treating medical illnesses. However, nearly every new doctor leaves his or her training with little to no skills to become successful businessmen and businesswomen. In fact, most physicians are now stereotyped as poor business people. Doctors have a reputation for being good at caring for their patients, but poor at managing the business aspect their of practices.

Currently, few medical schools offer any courses or advice on the business of medicine [2]. There are now 65 medical schools that offer a combined M.D./M.B.A. program. This is an increase from 39 schools offering a combined degree in 2003 [3]. However, you do not have to have an M.B.A. to be able to grasp the basic concepts of business that will affect your practice.

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Why are physicians such poor businessmen and women? Certainly the answer to that question comes from our training as physicians. Certainly, the fact is that most medical school curricula do not include any training that focuses on business of healthcare. Few physicians know how to read a profit and loss statement, how to review an employment contract, or how to create a business plan. Certainly, physicians are some of the brightest men and women in the nation. No one achieves a medical degree by being average. Our profession attracts the brightest and hardest working men and women in the nation. Certainly, we have a background in mathematics and know how to be comfortable with numbers and formulas. However, the nature of our training is learn by rote memorization based on repetition and doing tasks and cognitive thinking based on doing it over and over again until the task becomes natural and automatic. Doctors are admonished for thinking "outside of the box." Very few patients would feel comfortable with doctors performing a new procedure for the first time. Doctors are taught algorithmic thinking by professors who learned the same thought processes from their predecessors.

Doctors are taught to adhere to the "standard of care" and acceptable community standards. Unfortunately, healthcare does not tolerate failure. Patients do not want to hear that the success rate of any procedure or treatment is 50 %. They want reassurance that they will be in the 50 % that will have a successful outcome. Again, this takes us back to the art of medicine that only physicians understand. The problem today is that change in healthcare is being conducted by non-clinicians and leaders in business who may not have a medical background. We have to recognize that we are at a cross roads in the future of American healthcare. We can become involved in the business of medicine, understand the role of technology, recognize that computers are part and parcel of the contemporary medical practice, and that applied mathematics and business will be necessary to succeed in the near future. Failure to learn these basic principles will certainly leave the control and future to others who do not understand the mindset of doctors providing care for patients.

The practice of medicine is an art based on science. A physician is educated to rely on both objective and subjective understanding of disease pathophysiology, which then determines the treatment selected by the doctor in managing the medical problem. Business on the other hand is more objective than subjective. It is based on data collection, numbers, and interpretation of the information gleaned from collecting the data. The business of medicine requires the understanding of supply and demand, of assets and liabilities, of controlling spiraling healthcare costs.

The American healthcare budget is $2.6 trillion dollars with only 5 % of the patients who account for 50 % of the cost of medical care [4]. Our healthcare costs are nearly 17 % of gross domestic product (GDP) and we spend more per capita than another other country in the world. Yet we are not the healthiest nation in the world.

What is behind the spiraling healthcare costs? Most physicians have no idea what are the costs of providing care. If a doctor is asked how much is an office visit, how much is procedure, or what is the cost of a lab test or a more expensive imaging study, very few physicians can provide an answer. Compare that to a receptionist working in a hotel, a stock broker, an attorney, or a salesman at a car dealership who

is asked what is the cost of the service or the product, and nearly everyone from the entry level employee to the CEO can provide an answer. There really is no business in the world that works without knowing the cost of the service or the product except healthcare.

In the past, doctors have been paid for each service that was rendered. The more patients you saw, the more procedures you did, the more tests that you ordered, the more you could charge and if you were able to control your overhead costs, the more profit you were able to receive. There is going to be paradigm shift and the previous pay for procedures is going to be changed to payment for performance which means payment based on outcomes, hospital readmission rates, and even patient satisfaction.

Many of the bean counters think that the cost of healthcare is rising only because of the aging of the baby boomers. It is just not Medicare recipients who are responsible for rising healthcare costs. Per capita health spending among people under 65 is growing moderately, up 3.3 % from the previous year but still nearly three times the rate of general inflation. Higher spending was mostly due to price increases, rather than changes in the use of healthcare services: Prices for hospital admissions and expensive readmissions, outpatient care and prescription drugs all grew at a much faster rate than general inflation in 2010. Health care spending grew fastest among those who are 18 and younger [5].

Other issues and concerns that affect costs include government regulation, rising overhead costs, and concerns about malpractice and litigation.

If you do not understand the business component of your practice you may not be able to survive in today's marketplace where profit margins are going to be razor thin. You will no longer be practicing medicine and providing the care to the patient that you went to medical school for in the first place [1].

Doctors will need to learn about the business of healthcare. Those that do will be invaluable to the practice and those that do will have successful and profitable practices. Failure to become involved in the business of medicine will result in others, non-physician leaders, M.B.A.s, office managers, and office administrators taking over control. If there is going to be reform in the healthcare system, it has to come from physicians and those physicians who lead the change will have to be knowledgeable about the business of medicine.

1.2 How to Use This Book

We hope that there will be a few medical students, residents, and fellows who will read this book in its entirety in order to enhance their knowledge about the business of healthcare. Others will probably be interested in only specific chapters that will apply to certain business aspects of their practices. We want you to be comfortable with both approaches to using this book. For those who select to use individual chapters, this may provide you with an overview of each chapter.

Chapter 2: Transitioning from Training to Practice

This chapter will help you find a geographic area to practice. This chapter will also discuss the different options from hospital employment, small group practice, large group practice, academic medicine, multispecialty group practices, and even solo practice.

Chapter 3: Job Search

This chapter will focus on finding job opportunities that may be attractive to your search process. We will include how to use the Internet to find job openings, use of journals, and how to use your training program and the medical school to find options. We will also discuss the use of headhunters and how to help with the process. We will provide web addresses of effective sites that you can use as well as the names and numbers of search firms that can be used in finding a practice that meets your needs and geography. This chapter also contains a suggested process that all physicians need to use when applying for a position in a medical practice. This includes the resume, the curriculum vitae, the cover letter, letters of recommendation, and contract negotiations. We will provide templates and examples of effective resumes and cover letters to help guide you through the process. Most doctors, especially recent graduates, do not have the skills to navigate the negotiation process and reviewing contracts that will certainly impact their future for years to come. We will also include a contract check list to ensure that the necessary inclusions and what are the important exclusions that need to be included/excluded in the contract.

Chapter 4: Compensation Models, Patient Volume, & the Pro Forma

This chapter will discuss the various compensation formulas that are commonly used to compensate physicians. This chapter will also review the relative value unit (RVU) that is becoming more popular as means to measure a physician's productivity. This chapter will discuss the various distribution formulas as well as a discussion of the older fee-for-service model that will probably not apply to most contracts and compensation formals in the future.

Chapter 5: Insurances and Essential Fringe Benefits

Every doctor will need to have various insurance cover ages for both personal and professional purposes. This chapter will explain the two types of malpractice, occurrence and claims-made, and will explain the difference and the function of the tail

policy or what insurance you need upon retirement for coverage after you leave the practice of medicine but to cover actions taken while you were in practice. This chapter will also discuss your own health insurance, disability insurance, and a brief overview of life insurance.

Chapter 6: The Coding Aspect of the Business of Medicine

This chapter is designed to provide accurate and authoritative information on proper coding of medical services. This chapter will explain why is Coding Important and describe coding systems and how diagnostic coding and procedure coding work. This chapter will also explain the proper use of modifiers. This will be the bare basics of coding that every doctor will need to know to be able to bill and collects for his/her services.

Chapter 7: Understanding Financial Statements

This chapter will discuss the use of balance sheets, the income statement, and the cash flow statement. These are the minimum metrics that need to be reviewed on a regular level in order to understand the business of the medical practice.

Chapter 8: Numbers You Need to Know

Doctors need to have a greater understanding of the financial aspects of the practice. Knowing the collections and the expenses is not going to be adequate for be a part of the modern medical practice. The doctor will need to know about fixed and variable costs, the understanding of the net present value (NPV) of money, the internal rate of return (IRR), and the difference between cash basis vs. accrual basis accounting. This chapter will also cover the payback period of a project, which is vital to understanding the return on the investment (ROI) of any investment to be made by the practice.

Chapter 9: The Revenue Cycle

This is a vital metric for gaining an understanding of the financial health of any medical practice. This chapter will discuss the aging of the accounts and the monies due to the practice. This chapter will also discuss claims submissions, the scrubbing of claims to ensure that the claims are clean when they are sent to the payor, the use of clearinghouses, and the importance of upfront collections

Chapter 10: Stark Law Impact on Medical Practice

This chapter will provide the minimum of background information that all physicians must understand regarding the legal consequences of a medical practice. This chapter is written by a national expert in healthcare law and will include non-compete agreements, conflicts of interest, and Stark Law guidelines and what is necessary to avoid Stark Law violations.

Chapter 11: Restrictive Covenants

A restricted covenant or a non-compete clause in a new doctor's contract can be a very onerous point of contention. This chapter covers the legal aspect of restricted covenants and what every doctor needs to know before accepting such a clause in his/her contract.

Chapter 12: Medical Equipment: Leasing vs. Buying

This chapter will discuss how to create a business plan and how to prepare a financial analysis for new capital equipment.

Chapter 13: Ancillary Income

Doctors are forever looking for alternate streams of income. Opportunities for ancillary income include ambulatory surgery centers, imaging centers, pathology labs, and serving as an expert witness in the legal arena. This chapter will discuss the methodology of adding ancillary income to any medical practice.

Chapter 14: Selecting Advisors

Every physician, regardless where he/she practices or the size of his/her group, needs professional advisors. These include an accountant, a lawyer, an insurance agent, a financial planner, and a banker. This chapter will discuss suggestions for finding these advisors and resources for finding those advisors who have experience with physicians and other healthcare providers.

Chapter 15: Debt Reduction

Most physicians have significant debt when they finish their education. This chapter will provide suggestions for reducing that debt and ideas for making debt payback tolerable.

Chapter 16: Becoming Financially Savvy

A doctor's finances are not something that can be entirely relegated to an office manager, a family friend, or even to a financial advisor. It does require oversight by the doctor and his family and his/her advisor. This chapter will deal with issues that range from investment guidance, retirement planning, insurance needs, and a few vignettes that should help with your day-to-day financial navigation.

Chapter 17: Practice Buy-In Options—The Road to Partnership

Physicians usually begin as an employee of a larger practice. Eventually those physicians in group practices will want to become a full partner of the practice. This chapter will provide a road map for partnership and how to structure a buy-in, and how to determine the fixed value and fixed assets of the practice. This chapter will also discuss how older physicians can leave the practice and be bought out of their partnership.

Chapter 18: Marketing: Understanding the Modern Patient and Customer

All doctors need to understand the importance of marketing and practice promotion. This chapter will discuss how to ethically and effectively market your skills and expertise to other physicians and to potential patients.

Chapter 19: Building Your Career, Your Reputation, and Your Personal Brand

Most practices use marketing and promotion to explain what you do and how you do it. This chapter will discuss the why you are in practice and how to use the why to differentiate your practice from all others in the community, region, and even the nation.

Chapter 20: The Business Side of Developing a Social Media Presence into Your Medical Practice

The Internet and social media will be part and parcel of any future medical practice. This chapter will discuss how to harness this technology to keep existing patients and to attract new patients.

Chapter 21: Burnout Prevention for Practicing Physicians

As physicians are confronted with patients demanding more time from their physicians and doctors forced to see more patients in the same amount of time leaving less time to spend with patients, doctor stress and burnout will be a bigger problem for physicians in the near future. This chapter will discuss stress and burnout and suggestions for managing these problems that are going to confront nearly every physician.

Chapter 22: Future of Medicine

The authors certainly do not have a crystal ball to predict the future but this chapter will discuss what the outlook for healthcare will be in years ahead.

Chapter 23: Conclusion—Our Very Last Bottom Line

Physicians trained to measure rising and falling hematocrits, changes in pO_2 concentrations, and comparing chest x-rays and EKG with ease. Today, we need to be able to measure the cost of care not just for one patient but for large populations of patients. We need to know the outcomes of the care we provide and what is the cost of providing those outcomes. We need to know how many patients and what are the added costs of caring for patients with chronic conditions such as diabetes and congestive heart failure who are readmitted less than 30 days after discharge from the hospital. Physicians have to be cognizant of the cost and consequences of using brand name drugs versus generic medications. We must understand the time value of money and how investments in new technology have to make business sense as well as clinical sense. These are the issues that every doctor will be facing in the years to come. These are the issues that we must understand and that becoming a good doctor will require one eye on the patient and the other eye on the cost of care. The effective doctor of the future will be able to do both.

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Chapter 2
Transitioning from Training to Practice

Koushik Shaw, Thomas F. Stringer, and Roger G. Bonds

2.1 Transition to Medical Practice

The transition from the relative protection of resident training to medical practice can be understandably daunting. Are you prepared as a medical practitioner at completion of residency? This core question applies to skill and confidence as it relates to both clinical and business practice.

2.2 Clinical Preparedness

The residency training process is progressive with assignment of graded responsibilities and growing expectations as the resident matriculates. The Milestone Accreditation System assigns a score across six competencies with expectations adjusted by level of training. Core competencies include the assessment of professionalism, communication skills, patient care, medical knowledge, system-based practice, and practice-based learning and improvement.

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All training programs have been impacted by the institution of limited duty hours in 2003. According to an article in the September 2013, American College of Surgeons Bulletin, duty hour restrictions have resulted in the effective removal of 1 year of training [1]. Eighty-hour work week restrictions were instituted as a perceived benefit to patient safety. Challenges to education in a reduced work week include less time for development of clinical competencies with competing priorities for education focus. Clinical pressures and emphasis leaves little time for business skill development in this challenging time squeeze.

Duty hour restrictions may negatively impact continuity of care and impede the resident maturation process. However, maturation is also affected by the limited autonomy in resident training programs. The days of resident run services are historical. The independence to formulate and act on treatment decisions is limited by a combination of factors. They include hospital concerns, the medico-legal environment, billing pressures requiring supervision, legitimate ethical issues, and the patient safety movement itself. In response to these concerns, at least as they relate to general surgery, the ACS has instituted a Transition to Practice program that utilizes mentorship to provide opportunities for development of autonomy.

Over 10 years ago, the American Urologic Association considered the development of a two-tier system to better consolidate and focus training. This was, in part, a response to a changing practice pattern demonstrated by recertification surgical logs as well as limited clinical hours to provide training. However, a task force formed in 2006 dismissed the concept of a two-track specialty and in turn developed more focused training tied to internship assignments and to facilitated pathways to fellowship if additional training was desired.

The concern of teaching institutions for adequate clinical maturation of finishing residents is understandably shared by the residents themselves. At least in general surgery, confidence appears to play a role in the newly trained resident's lack of interest in solo or rural practice. A 2012 survey of practicing surgeons revealed that 37 % disagreed with a statement that current graduates are prepared to enter into the clinical practice of surgery. Eighty percent of general surgery graduates now pursue fellowships. This appears, in part, secondary to a sense of unpreparedness for general clinical practice [1].

2.3 Business Skill Development

What about skill and confidence as it relates to the business side of medicine? A Merritt Hawkins survey of graduating residents in 2011 revealed that 91 % felt insufficiently prepared to deal with and understand common business transactions including employment contracts and compensation arrangements [2]. Three of the most common business transactions are (1) employment with a physician practice group or hospital, (2) buy-in/ownership in physician practice group, and (3) sale of ownership interest in physician practice group.

Employment is governed by the employment agreement that will contain certain business terms including a statement of representations, warranties and covenants, a termination of employment clause and restrictive covenants. Business terms may include language on compensation, expense reimbursement or allocation, term of employment, and duties and responsibilities including call coverage. A covenant is a promise to the employer and if breached may be grounds for termination. Termination may occur "at will" (for no particular reason), automatically upon expiration of term (i.e. 1–3 years), or for cause (specific reason(s), usually outlined in the contract). Restrictive covenants seek confidentiality and protection from competition and often include a non-solicitation clause to prevent the terminated physician from recruiting the practice's employees and patients. Remember that every contract provision has a special meaning that assigns certain obligations and risk.

Ownership is governed by the purchase agreement and may or may not be outlined within the initial employment contract. There are three common physician practice entities governed by different documents. A partnership is guided by the partnership agreement. A limited liability company is guided by the articles of organization and the operating agreement. A professional corporation is guided by the articles of incorporation, the bylaws, and the shareholders agreement. The practice entities each provide a different level of favorable taxation, governance, liability protection, and ownership interest. Ownership requires an understanding of management and control, valuation mechanism, voting rights and protections, and financial obligations including the potential for additional capital contributions.

The sale of ownership interest is governed by the purchase and sale agreement and the owner's agreement. Considerations for sale should include valuation of ownership interest, liability release, indemnification, and review of restrictive covenant language. Buy-Sell provisions should provide a procedure for valuing and transferring ownership rights and include terms and time limits.

Before executing any document related to employment or purchase or sale of an ownership interest, competent legal review and opinion is highly recommended. According to a 2006 AMGA survey, 12 % of physicians leave a medical practice within the first 12 months and 46 % within 3 years. Eighty-three percent leave because of a compensation dispute or poor cultural fit [3]. These contractual nuances are usually well defined in the employment agreement.

Contractual issues represent just a small part of the business realities of medical practice. Understanding the basics of coding, revenue cycle management, variable and fixed overhead and practice accounting including financial statement analysis will be addressed in subsequent chapters.

2.4 Physician/Hospital Covenant

The world of medical practice usually requires credentialing with one or more hospitals and exposes newly trained physicians to medical staff issues and responsibilities. As a hospital staff member you will be expected to fulfill certain requirements

including attendance of staff meetings, provision of ED call coverage for unassigned patients, which may be with or without call pay, participation in committee functions and adherence to hospital bylaws. Failure to do so can result in termination of privileges which will impact future job opportunities.

The physician/hospital relationship is a changing and dynamic partnership. In an effort to manage service line development and corral favorable insurance contracts, hospitals are increasingly seeking to employ both specialists and subspecialists. A report from Accenture projected that the share of physicians with a practice ownership position would fall to 36 % in 2013 compared to 57 % in 2000 [4]. Data from the Medical Group Management Association (MGMA) Physician Compensation and Production Surveys suggest that the percentage of physicians working in practices owned by the hospital or integrated delivery system increased from 24 % in 2004 to 49 % in 2011 [5, 6]. However, MGMA data may not appropriately be extrapolated to all physicians because MGMA practices are disproportionately large. In contrast, a 2012 survey of physicians by the American Medical Association showed while there has been a shift toward hospital employment, 53.2 % of physicians were self-employed. According to the survey, only 23 % of physicians worked in practices that were at least partly owned by a hospital and another 5.6 % were directly employed by a hospital [7]. Certain specialties may experience a higher hospital employment rate. For instance, over half of finishing urology residents will sign hospital employment contracts. However, some of these practitioners will be set to transition to private practice after the initial hospital contract which assisted the establishment of the new practice.

Despite the wide range of practice types, hospital staff membership remains a necessity for many physicians although to a varying degree. Physicians that care for acute and seriously ill patients are critically interdependent with the hospital while other physicians may have little need. Additionally, physicians may potentially benefit from an enhanced hospital relationship in regards to improved access to IT, recruitment assistance, access to capital, and access to sovereign immunity. On the other hand, hospitals uniformly depend on physicians. From the hospital perspective, balanced accountability, cost, quality and appropriateness of care and patient outcomes are all dependent on the physician. The CEO may be in charge but he/she is not in control.

It is not only the opposing needs of the physician and the hospital but also the opposing cultures that challenge the relationship. The hospital functions in and understands a collective culture while the physician functions in an expert culture. In the business world, culture prevails over strategy.

A collective culture is motivated by recognition and relationships. Teamwork prevails, emotions are respected, and process is often more important than outcome. Time perception is now or soon such as in the next budget cycle. The thought process is a systemic with a common mission. Vision and values are shared based on successful results.

In contrast, the physician or expert culture is motivated by accomplishment, power, respect, and recognition. Rewards are based on individual performance. Physicians covet autonomy and time perception is STAT. Physicians, in general, think linear, manage by consensus, and view the hospital as a workplace. Traditional organizations are defined by mission, vision, and values. The medical staff mission,

on paper, is to be responsible for the improvement of patient care. The real mission may translate to preservation of individual needs and freedoms. The opposing cultures often lack a shared vision.

The historical covenant between the hospital and the medical staff was that the physician would take care of patients, abide by the bylaws and participate in governance as required. In return, the hospital would provide all the necessary resources at no cost to the physician. Economic pressures have altered the old covenant. The physician is squeezed by rising overhead costs, falling revenue, longer hours, and increased competition for profitable services. As a result, physicians are less motivated to volunteer their services. Physicians collectively are demanding pay for ED call and coverage, committee work, and as medical staff officers. Meanwhile the hospital is squeezed by rising infrastructure costs, declining reimbursement, increased demands for services, the growth of unfunded federal mandates, and patient and payer demands for increased quality and safety.

The shared challenges to the bottom line have altered the traditional service covenant between physicians and the hospital. Physicians and hospitals are part of a co-evolutionary process within an increasingly complex health care system. That being said, the successful delivery of health care will require partnerships and a joint commitment between the experts, the physician, and the collectives, the hospital.

2.5 Medical Practice Success

Parameters for a successful practice will certainly include a state of clinical and business preparedness that is ongoing and requires lifelong revitalization. As a vital member of your hospital staff and community, active participation contributes to success as well. The medical practice of the future will require improved quality outcomes, lower utilization with achievement of economies of scale, better patient satisfaction scores, competitive advantage cost to the insurers, and an understanding that payment will evolve to more value-based instead of volume-based.

2.6 Finding a Place to Practice

For most physicians looking for the right type of practice, there will be a particular style, or type of practice that will suit your personality, financial needs, leadership style, career goals and perhaps most importantly, geographic needs. It is also important to realize that the pros and cons of the various practice types will not only change with time (i.e. healthcare legislation) but along with your changing needs over the course of your career, and it is wise to periodically re-assess your career satisfaction and goals as your career progresses. Regardless of the practice type chosen, the overall direction of all practices has favored the drive toward better quality outcomes, lower utilization and economies of scale, an emphasis on patient satisfaction scores, lower costs to insurers, and payments in the future tied to value provided (outcomes, etc.) versus volume (fee for service). Although there is an