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Doctors in Transition

Medicine outside of clinical practice

Nebraska Medical Association

Advocating for Physicians and the Health of all Nebraskans

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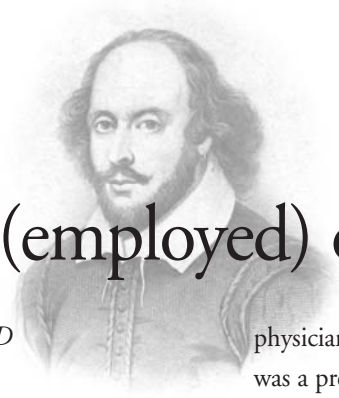

"To be (employed) or not to be (employed)"

by Jason Bespalec, MD
Geneva

"To be or not to be, that is the question" is one of William Shakespeare's most famous quotes from Act 3, Scene 1 of Hamlet. However, I propose that if Shakespeare were a family physician today, the quote would be, "To be employed or not to be employed, that is the question." I myself have been both. Therefore, in the rest of this article, I will relate to you my story of transitioning from being an employed physician to now being an independent physician owner.

I grew up in Crete, Neb., and when I decided that I wanted to become a family physician there was no doubt that I wanted to practice in a rural community. I graduated from the University of Nebraska Medical Center in 1995 and entered the Accelerated Rural Family Practice residency. During my second and third years I started to look for rural employment options. During residency, I received very little training on what to look for in a practice. Certainly, nothing was ever said to me about the benefits of being employed vs. independent. I had four goals back then. 1) I wanted to be in a rural community, 2) The town had to have its own hospital, 3) I did not want to be the only physician there, and 4) It had to be a good place to raise my family. I found that place in Geneva, Neb., and I started my practice there in June 1998.

The practice, at that time, consisted of one physician and one PA. A residency buddy of mine went with me to Geneva and we became a group of three physicians and one PA. I thought this was a pretty sweet deal. The practice was owned by the St. Elizabeth Physician Network. I really didn't know anything about this network or what it did. I was assured by the people there that it was a good deal. The contract I signed had everything I thought I wanted. I got the salary I wanted. It had a production bonus if I worked really hard and time off in the form of a 4 1/2 day work week and three weeks of vacation. Then something happened the first week that I was there that, to this day, I still find very peculiar.

The Network did not want the practice anymore and sold it back to Fillmore County Hospital. However, it wanted to keep the doctors as employees. I now had two bosses. This was very confusing to us and our patients, but we were able to make it work. This was the status quo for the next six years. In that time, my buddy left the practice and moved back to Omaha. We did replace him with another physician. In 2004, we lost our PA. We were a rural health clinic at the time and we needed to have a mid-level to keep our qualifications. So, we borrowed one from the other practice in town. This was the start of my transition from employed to independent.

The other practice in town was owned by a physician in his early 80s. He had one employed physician and the PA we borrowed. It was that other employed physician who approached us and wanted to merge the two practices into one and wanted us to be the owners. Fortunately, he was a banker for 10 years prior to him becoming a doctor. He was able to take the numbers from both clinics and show us that the Network was taking a large percentage. We decided that we would leave the Network and merge the two clinics. We were told by the Network we would starve and that we would be back. In 2004, we formed Fillmore County Medical Center. We are still going strong today.

Initially, three of the five physicians bought in as owners. The other two stayed on as employed physicians. We have gone through other changes over the years. One of our employed partners died and one of the owners left the practice. We have since added three more PAs and have hired another physician that will start in July. There are only two owners now; I am one of them. I don't think I work any harder today then I did as an employed physician, but the benefits have been great. Let me tell you some of them.

First and foremost, the biggest benefit I see is now I have control over my practice. In the Network, I had control over nothing. I couldn't make employment decisions. I could not do anything to control the costs of the practice. Now, that has changed. My partner and I make all the decisions now. We share all the ownership responsibilities. We control our staff. We control our overhead. We decide how we want to practice. The first thing we did was change the attitude. We believe that health care is a customer service business. The hospital and the Network were only concerned with the bottom line. We

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From clinician to administrator

by David H. Filipi MD, MB, FAAFP
Chief Medical Officer,
Blue Cross Blue Shield of Nebraska
Omaha

"So, don't you really miss seeing patients?" It's a question I've been asked many times having left clinical practice to become part of medical administration. I give most a short answer, but will give you a longer one, tracing my pathway from clinician to administrator.

Ironically, I became a physician because I loved the idea of a simple doctor patient relationship, working for myself with all that independence, and expecting patients to pay me for my outstanding service. How did I get from there to here?

My first step away from the dream and into the world of government rules and payer demands occurred when I ran for office in the Nebraska Academy of Family Physicians. As a director, I became aware of problems in the health care payment system and in government oversight which our medical societies sought to solve. "If only payers and government bureaucrats knew what they were doing to practicing physicians, they'd certainly change," we said. We wrote letters, we testified, we tried to see their perspective, but change was glacially slow.

I was then fortunate to be appointed to the Academy of Family Physicians Commission on Health Care Service. I was a practicing family physician among 11 of my colleagues from across the nation who met with national experts on health care delivery. From them, I learned the details of problems facing American health care. "How could I become a more potent advocate for American physicians?" I asked. They answered that I should obtain a stronger grounding in the business of medicine in order to be a credible voice in a room of suits. So, I began an evening course of study for an MBA at the University of Nebraska Omaha. I spent two evenings each week for nearly six years learning economics, modern management techniques, business law, and accounting. I actually found this fun and intellectually challenging. I had picked up the basics "on the fly," serving as managing partner of my group practice, but now I learned the rationale and deeper analysis of these exercises. Importantly, I already had a well-paying job as a physician and didn't have to worry about class ranking (though I graduated in the top 5 percent of my class).

During this time, I felt strong s upport from my partners. They were pleased that my business and management skills could be used to advocate for physicians when meeting with non-physician managers.

One of my mentors, a respected medical director, warned me that I was treading on thin professional ice. The further I ventured into management, the more I would be excluded from the physician community. At the same time, I would be treated with suspicion among non-physician management. With that, I committed myself to remain firmly within the physician community. I would always be a physician first and an administrator second. At first, I tried to split time between my family medicine practice and administration. It didn't work. I was insufficiently available for patients who needed a primary care physician and not available for important meetings when my office hours were scheduled. So, with the encouragement of my practice partners, I left clinical practice to enter the world of medical administration.

Initially, I was offered medical directorship of my large multi-specialty group practice. I enjoyed the challenge of growing the 50 person group to a well-functioning group of 150. I enjoyed the strategy, the improvement of clinical practices, the integration of former rivals, and serving the general needs of my practice partners. Later, I was recruited to my present job, medical director of Blue Cross Blue Shield of Nebraska. Here, I could influence a payer to reduce unnecessary barriers to practices and initiate cost saving and value added practices learned from my prior experience.

I learned that most problems erupted when well-meaning parties failed to adequately communicate. In prior physician leadership roles I developed trusted relationships through which I could describe payer initiatives which in the long run would better health care delivery, improve outcomes, and control cost. Instead of having responsibility for one medical practice I now shared responsibility for the health of nearly a third of Nebraskans.

Along the way, I said "no" to a cou-

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"Life is a journey." "Nothing is constant but change."

by Kathy Leeper, MD, IBCLC, FABM
Medical Director & Breastfeeding Medicine Specialist, Milkworks Lincoln

The longer I live the more I realize these familiar sayings are very true, and my life is a fairly good example. As a medical student, I felt I had control over my life. I met my husband, Scott Rasmussen, got married, and earned my MD right on schedule. We went through the "couples match" and ended up in Minneapolis for three years. Those years are a blur. I carefully planned to have our first child in May as we finished, and I planned to take a full year to enjoy our baby. She was stillborn at 21 weeks, and life started to teach me it does not always go as planned.

I joined a private pediatric practice a little over one year later when our next baby girl was three-months-old. I tried to work "part time," and life seemed doable until I became pregnant again and our in-home babysitter became ill. I then had to take our kids to a daycare after our son was born. That was harder for me. When I was at work I felt like I should be at home, and when I was at home I felt like I should be at work. I did not feel like I was the best physician or the best mother I could be, but I told myself it was the "hormones" and forced myself to wait a year.

Then one January morning I had to drag my kids out of bed with colds and drop them off at the sitter at 6:30 a.m. so I could go stand at the C-section delivery of healthy twins. I cried the entire drive there. I called a good friend that evening and shared my dismay. She suggested I could quit my job. I just laughed. *"The student loans have not yet been paid. I have a practice full of patients and two wonderful partners counting on me. I trained for seven years to do this."* But, she had planted the seed and after three sleepless nights and discussing it thoroughly with my husband, I told my partners I couldn't do it anymore. I left practice when I was 34.

I have to say that for me the biggest barrier to making a change was even considering it as a possibility. But, from the moment the decision was made, I felt that a huge weight had been lifted from my shoulders. The first year was difficult, adjusting to staying at home. But, Scott was very supportive, relieved of the pressure to be home in time to make dinner and care for our two young children. I had no intention of returning to medicine. Many people had trouble understanding that, but I suspect many of you understand. I really feel that becoming a physician is a part of "who I am," whether I am practicing medicine or not.

I made some friends and joined a book club. A couple years into my retirement, one of the members in my book club asked me if I would be interested in exploring the idea of opening a breastfeeding support center. Over the next three years, this dedicated group of women worked to develop a free-standing, non-profit breastfeeding support center. We divided up the work and made plans with our toddlers playing under the table. MilkWorks opened for business February 2, 2001. My son entered kindergarten that fall.

My main role was to see mothers with breastfeeding difficulties, but in the beginning I also retrieved mail, helped answer the phone, and helped with insurance filing issues. I had taken a week-long course in Chicago on lactation, but truthfully I learned a lot more practical information from the seasoned Internationally Board Certified (IBCLC) lactation consultants I was working with and from a worldwide network on the Internet. Breastfeeding has become such a mystery to modern medicine, and I have had to learn a lot on my own. Thankfully, I am very intuitive and I am not too proud to tell a mom when I am not sure about something. I have met many other physicians knowledgeable about breastfeeding through the Academy of Breastfeeding Medicine (ABM) and am thankful to have them an email or phone call away when a particularly difficult situation comes along.

We deliberately chose to only work with out-patient moms because there was already lactation assistance in the hospitals. But, this has contributed to a definite feeling of isolation for me. I cannot completely relate to "lactation consultants" because most of them are RNs. I realize that many physicians cannot fathom what I actually DO all day. I am not on hospital committees, and I do not see anyone in the halls. I

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Teach a doctor to fish

by Karla Lester, MD
Executive Director, Teach a Kid to Fish Lincoln

Life declares itself. Moments of clarity are not singular. All good comes from listening.

I left my pediatric practice in May of 2008 to start Teach a Kid to Fish, a nonprofit with a mission to prevent and reduce childhood obesity by empowering families to eat healthy and be active. I loved my practice, my patients, and most of all practicing pediatrics. I felt called to do something different. The 2007 Expert Committee Recommendations on the prevention, assessment, and treatment of childhood obesity were a call to action for me. I had seen the obesity epidemic evolve in my patients. I started a Healthy Living Clinic where families would come for 12 weeks to learn about nutrition and participate in physical activity and work with a behavior specialist. The problem wasn't that the program wasn't effective or wasn't needed. The problem was that as soon as families walked out the clinic doors, healthy behavior change wasn't supported in the community. In our community, like almost every community across the country, the healthy choice isn't the easy choice.

I remember sitting in a conference in Omaha listening to Dr. William Dietz of the CDC say, "To solve the epidemic of childhood obesity it will take a social revolution, each community finding its own solution." To hear that was transforming. That statement was the ripple in the tide moment of clarity, when I decided to start Teach a Kid to Fish.

I'm a huge dreamer for kids. My husband, Darek, knows this best of all. So much so that after I told him I was going to start a nonprofit organization to address the epidemic of childhood obesity and it would be called Teach a Kid to Fish, he asked me, "How's it going to be funded and why would you call it Teach a Kid to Fish? Fishing isn't even that active of a sport." I informed him that it would run on vision, we would be giving seed funds, and, that the name is not about fishing but about empowering children. "Give a man a fish, feed him for a day. Teach a man to fish, feed him for life." All he said was, "Well, I'm certainly not going to get in your way. We all know who would get hurt in that scenario."

Starting Teach a Kid to Fish has been the most difficult and challenging thing I will ever do in my professional career. Starting a nonprofit organization with such an overwhelming mission is a daunting task, especially without any funding! There are other community models like Teach a Kid to Fish, but they all have started and are sustained with seed funds from endowments or health care systems. I didn't have funds to pay myself or anyone else for that matter, let alone any funding to actually address the issue. It has been pretty overwhelming at times, and at times it has been the most rewarding experience. Teach a Kid to Fish now has an over $300,000 annual budget with a diversity of leveraged resources from local, state, and national funders. If you know the nonprofit world, you understand that almost all of those funds go into programming and are not spent on salaries. We have built such amazing partnerships. People are amazed at what we accomplish on such a budget.

I've learned so much over the last five years. Much of what I've learned also applies to the health care sector. Vision is everything. Creating community solutions for children's health is the vision of Teach a Kid to Fish. With all of the ups and downs in the public health and nonprofit worlds, staying the course with a strong vision as your guide is critical. The mission of the organization has to be clear, leading you to your vision, and bought into by key stakeholders. Strategic planning has been a vital part of carrying out our mission and moving the organization toward our vision. Partnerships are what make Teach a Kid to Fish programs sustainable.

For me personally, I am proud that I have stayed the course through all of the ups and downs. I am so grateful to Darek for not derailing me and for being that behind the scenes, stay the course advocate for children by letting me do whatever it is I feel like I need to be doing.

Recently, I was giving a talk at UNL to hundreds of dietitians and students from across the state. I was asked afterwards what I think my biggest success has been. First I said, "That I'm still standing." But then, said, "The greatest success for me now is that there are so many gifted individuals who have taken on the mission and vision of Teach a Kid to Fish. I am so proud that Teach a Kid to Fish has served as a platform for them and their gifts. To sit in a meeting and have a roomful of people advocat-

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Transition

by Geoffrey McCullen, MD, MS
Lincoln

The title of this column is "transition." That title implies moving from one venue to another. Perhaps, a better title is "evolution," or growing/changing for the better.

Just like other physicians, I entered medicine with high hopes. As physicians, I believe we share common traits: 1. We are committed to providing excellent, personalized care for our patients; 2. We are very busy and focused on our work leaving little time to examine system-level issues. Today, the U.S. medical marketplace has a health care cost/quality conundrum that must be addressed.

Two years ago, I was serving as president of our surgical group. We were seeing a higher cost associated with running the practice and shrinking revenues. Concurrently, the national debate was raging with passionate discussions regarding the problems and solutions in health care. In the ensuing months, we heard how the high cost of health care is affecting our nation's prosperity and competitiveness. Multiple stakeholders have been active in proposing solutions. Yet, the optimal path remains murky. As Louis Brandeis (former Supreme Court justice) once said: "the greatest dangers to liberty… lurk in the insidious encroachment by men of zeal, well-meaning, but without understanding."

In order to gain understanding of the issues and possibilities for solutions, I enrolled as a student in the inaugural class of the Dartmouth College Master of Healthcare Delivery Science (MHCDS) program. I started in June 2011 and recently finished. MHCDS is an 18-month program taught by faculty at the Tuck Business School and The Dartmouth Institute (the school of public health). Dr. Jim Kim, president of Dartmouth at the time and now serving as president of the World Bank, had a strong vision and conviction that transformation of the health care system was possible using scientific methodology and business operational capacity to affect change. The teaching venue included on campus sessions at Dartmouth along with online classes and assignments often utilizing illustrative case studies. The core courses included: finance essentials for leaders in health care; health economics and policy; clinical microsystems (designing, leading, and improving patient focused care); leveraging data to inform decision making; health care operations management; management and leadership of health care organizations; health communications (theory and skills); strategic marketing for health care organizations; population health and preventive care; management of organizational change; effective information technology for health care organizations; strategy for health care organizations; and personal leadership.

In addition, I was team member in an "action learning project" at Hartford Hospital (HH) in Connecticut. Like many large hospitals, HH is both the self-insured employer and the provider of medical care. In 2011, they faced a cost of $11,000/employee for low back pain. We worked with the clinicians and the administration to develop a clinical pathway and an injury prevention strategy that is now being implemented.

There was a significant price to the education. The direct tuition costs were $90,000. The indirect and opportunity costs are large: the reading, assignments, group meetings, online classes (10-15 hours/week); and the time away with travel to Hartford (three working visits) and Dartmouth (Hanover, NH) for four, 10 day on-campus sessions. I am a sports and exercise enthusiast and enjoy spending time with my family. I found it hard to keep fit and juggle the competing demands of work, family, and school. However, I believe it was worth the large commitment of time and resources.

As a result of the experience, I now see more clearly that there is truly an opportunity for physicians to be engaged in the health care solution. This will require collaboration, experimentation, measurement, analysis, and executing change. The conversation should begin at the local and personal level: 1. Why are health care costs high? 2. What can I do to affect positive change? 3. How can we develop our collective capabilities and evolve greater organizational ability that provides a market-based solution to the cost/quality conundrum? 4. How do we move from theory to action?

Charles Darwin once said: "It is not the strongest species that survives, nor the most intelligent. It is the one that is the most responsive to change." I would encourage my colleagues to engage and answer the questions posed above. Only then may we move forward together. □

Transitioning from practice to military medicine

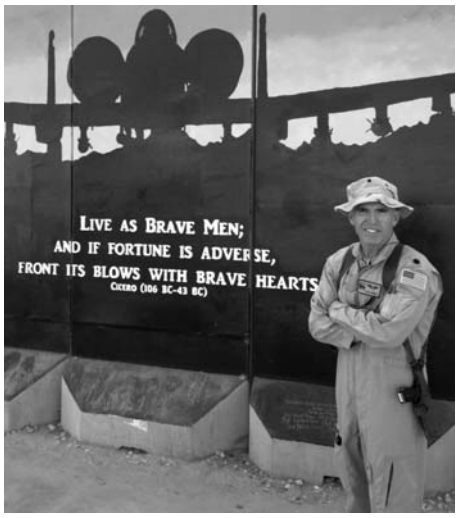
by Dan Noble, MD, Lt. Col., MC, FS
Chief of Aerospace Medicine,
155th MDG, NEANG
President, Nebraska Medical Association
Lincoln

0 Dark Thirty in Kandahar, Afghanistan……

After a three and a half-hour flight from Al Udeid Air Base in Qatar, I sit in a blackened cockpit of a C-17 during a combat descent with NVGs (night vision goggles), as surreal experience as any of the others I have had since arriving in Qatar on August 1, 2012. Just 24 hours earlier, my wife, Regina, had admirably filled in for me at the NMA's annual session where I was installed as president for 2012-2013. Just the year before when I was introduced as president-elect, I was off at combat survival school and resistance training in and around the mountains of Washington State.

It is eerily quiet on the tarmac after engine shutdown as we await our cargo for a low-level air drop in the mountainous region of northeastern Afghanistan. With the coming dawn, we fly along the infamous border of the Pakistan tribal areas to a remote FOB (forward operating base). As I have on many occasions since arriving in the Middle East, I found myself saying "we're a long ways from Kansas, Toto." The combat low-level air drop at 2000 ft. is the only way supplies make it to the remote FOBs. With uncanny precision between the air crew and ground troops, 20 pallets scream out the open aft ramp amid swirling gale force winds. It is all over in eight seconds. A second pass for the second 20 pallets and we can "relax" with a little open ramp surfing while we get ready for the flight home to our desert air base four plus hours away. With mission preparations, intelligence briefs, the sortie itself, downtime in Kandahar, and debrief, it becomes a 16 hour day. We have 24 hours off and then we are at it again.

Talk about transitions. I did not know exactly what was in store for me when I joined the Nebraska Air National Guard (NEANG) in 2009. I have been interested in the military since high school when I was recruited to the U.S. Naval Academy for wrestling. For family reasons, I chose to stay closer to home and, instead, attended the polar opposite, University of California at Berkeley. I never became a hippie but instead retained thoughts of somehow fitting in the military at some point in my life. I strongly believe in universal service of some type for everyone. Fast forward to 2008-09 to my flight training with a recently retired ANG pilot: he thought that I would enjoy some of the flying opportunities available as a flight surgeon. Nothing could have been further removed from my life as an orthopedic spine surgeon, but it sounded incredibly interesting. Besides, it is only one weekend a month and two weeks of annual training a year, right? Not quite. I found out that it would mean about two months out of the office a year along with those weekends and additional flying. But, I was all in. I found the majority of people with whom I worked to be highly motivated and stretching their time to maintain their commitment to the NEANG.



By fall of 2011, I was fully trained as a USAF flight surgeon and, a little too early by my reckoning, chief of aerospace medicine for the 155th Medical Group. I had a lot more to learn. It was like drinking from a fire hose as I sought to absorb as much knowledge as I could while learning the military acronyms and trying to avoid the quicksand of the USAF and DOD (Department of Defense) bureaucracy. I had survived RCOT (reserve commissioned officer training) which was a one-month course crammed into two weeks, akin to your worst internship nightmare rotation. Six weeks of onsite aerospace medicine training at Brooks City Base at the USAF School of Aerospace Medicine included a spin up to 5 Gs in the same centrifuge as the astronaut corps utilized, as well as two weeks of flying. There, I was lucky enough to score a sortie in a T-38 taking off with full after-burners as a flight of three, getting to 20,000 feet in what seemed like seconds, and subsequently pulling up to 7 Gs.

As a flight surgeon you have to complete the same training as any qualified

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USAF pilot, and I had to undergo additional water and combat survival training. Part of that training included a mock crash into the ocean, being engulfed in smoke and submerged in the dark in a fuselage under water, then forced to find the way out under conditions which seemed all too real. Being pulled out of the water and up 150 feet by a Blackhawk "penetrator" was another unique experience. That was far surpassed by being sleep deprived and starved, eating leaves (all the berries were long gone), and being chased through the mountains of Washington in the October rain. The resistance, or POW experience, was even more "interesting." I did survive but lost 14 lbs in 24 days. I would not recommend it as a weight loss program, but, luckily for me, it was reminiscent of my years as a college wrestler, surgical intern, and climber. Strangely, in retrospect, I actually enjoyed the experience.

I didn't realize that the past three years were actually building to a crescendo until the end of April 2012. I was working out at the base one afternoon when my commander, Col. Thompson, walked in my office with an unmistakable look on her face that clearly indicated bad news. The bad news couldn't be for me as life was as good as it had been in some time. "You're being deployed" took a little while for me to absorb. It was final. There was no changing it. That's a transition with a capital T. I would subsequently choose to close my spine practice which was no easy chore. My wife was as supportive as she has always been despite the fact that on short notice she would have to leave her practice as a radiologist, sell the house we had built 12 years earlier, and move to Phoenix with our three kids. All of this would occur within three months. I left Lincoln on July 30, 2012, and headed for Qatar.

Flight Docs: Petersen, Noble, Leinart, Jesus de Colon, and Sharma in front of the Special Ops V-27 VTOL Osprey.

When it was "0 Dark Thirty in Kandahar," I had been deployed for nearly two months with two more to go and realized you really don't understand the difficulty and scope of our operations until you are actually there. During my deployment, 150 degree heat indexes were common. I evaluated and treated over 400 coalition airmen and women, gave briefings, responded to flight-line emergencies, flew nearly 200 combat hours on 29 sorties into Afghanistan on a variety of airframes, and flew additional sorties into Baharain, Oman, and Kuwait. Through these experiences I gained even greater respect for the young men and women of our Armed Forces who fight, fly, and die for our country, as so many did while I was deployed. I feel privileged to have served with them.

What's next? With this type of life changing transition anything is possible. I will be gone five to six months this year with additional training and NMA responsibilities. It was good to return to Lincoln in January to get caught up at the base and fly some. During February and March, I undertook some trauma training at St. Louis University Hospital. A further centrifuge qualification follows in San Antonio to 7.5 Gs in preparation for F-16 training and flying in April. Our unit has a six day CERFP (urban search and rescue/disaster) exercise in May and I can't wait for a long vacation with my family in July. I will be deploying to Djibouti on the Horn of Africa in September and, again, my wife will be filling in for me at the annual session. It is probably a good thing as she is much better looking than me and certainly more articulate. It's all good!

Postscript: I have only described a few of my experiences as a NEANG/USAF flight surgeon. There is so much more. The complexity of our involvement in the Middle East and in Afghanistan has been questioned and debated by many for years. What can't be questioned is the dedication, hard work, and sacrifice of our troops and their families at home. Many have served multiple tours for a year or more at a time. After having been there for four months, future Veteran's and Memorial Days have been forever transformed. If you have ever thought about serving, I can tell you it is as rewarding as anything you have ever experienced in medicine, maybe even more so. We need docs in the Air National Guard and Air Force and if you think you may be interested now or in the future give me a call. □

"Ain't nothin' like the real thing….or is there?"

by Paul Paulman, MD
Professor and Predoctoral Director
Assistant Dean for Clinical Skills
and Quality,
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"Well, I guess we saved him this time!" These words reflected the feelings of the team of five senior medical students observing the video recording of their mannequin-based cardiac arrest team training simulation exercise. The training took place at the University of Nebraska Medical Center's new state of the art Sorrell Simulation Lab. The student team was able to administer lifesaving treatments to the mannequin which was simulating a patient in cardiac arrest. This team, like most of the student teams, was able to restore effective cardiac output by following known protocols. Perhaps as importantly, the students were able to learn and practice effective team communication skills during the simulation.

The use of simulation in medical education is growing rapidly across the United States. Simulation activities can be used to both educate and assess the skills of individuals and teams of learners. A growing body of literature links simulation training to improved patient outcomes, patient safety, and improved clinical skill performance. Most of us would not board a Boeing 737 for a commercial flight if we knew the flight crew had never flown the airplane in simulation. The same logic is increasingly being applied to medical procedures.

As assistant dean for clinical skills and quality for the College of Medicine at the University of Nebraska Medical Center, one of the jobs that I enjoy the most is to oversee operations of the Sorrell Simulation Lab. This 7750 square foot facility provides simulated clinical space featuring clinic rooms, "intensive care/emergency" rooms, and a soon to be completed operative care suite which will include pre and post op areas, and an operating room with the latest technology available for clinical simulation. Sim Lab staff also manage a cast of several dozen very talented individuals who serve as patient simulators for our learners. Our patient simulators can do everything from portraying a straightforward patient encounter to simulating someone who has just experienced the death of a family member.

The Simulation Lab is equipped with a multitude of simulation activities, ranging from very simple task trainers to very sophisticated mannequins which can blink, breathe, bleed, convulse, or deliver an infant. Activities in the various rooms in the lab can be recorded via unobtrusive ceiling cameras and audio pickups. I'm privileged to work with an exceptional staff including Patricia Carstens, Sim Lab director; Dan Brick, simulated patient coordinator; Dr. Tom Birk, IT director for the Sim Lab; and Jonathon Sample, director of room operations for the Sorrell building.

Since opening five years ago, there have been thousands of learner activities in the Lab ranging from straightforward procedure practice, such as suturing simulated wounds, to examinations involving live simulated patient interviews and physical examinations, to interprofessional teamwork activities involving learners from several colleges at the U of Nebr Med Center. Recently, Patricia Carstens and her staff have been able to reach out to rural critical access hospitals in Nebraska to provide the medical personnel in these communities with simulation activities by shipping mannequins for use on site. With all these activities we have only just begun to tap the potential of simulation for education and assessment of our learners.

Back to our student team, I've had the opportunity to work with this team during their pre exercise instruction, their hands on simulation, and review of their performance. "Dr. Paulman, this has been a great session, I think I'll be less nervous and better able to handle a cardiac arrest if I have to do that next year in residency!" This student just made my day. □

Reflections from the dark side

by Todd Sorensen, MD
President and CEO,
Regional West Medical Center
Scottsbluff

My career in medicine now spans about 36 years. For the first 20 of those, I practiced as a general internist with a mixed outpatient and inpatient practice. Near the end of that time, I earned a MS degree in administrative medicine, and subsequently became the medical director for a third-party administrator. As medical director, I was responsible for utilization management and was very involved in creating a provider network and joint-venture health plan. The health plan turned out to be dead on arrival (not all ideas are good ideas), though it took us a couple years to figure that out. After about five years as medical director, I was asked to become the CEO at Regional West Medical Center in Scottsbluff, and I have served in that role since.

Most of the people who occupy positions similar to mine have extensive backgrounds in management, having worked in various disciplines such as finance, nursing, human resources, or general business, and have had the opportunity to learn management techniques from a wide range of perspectives. Physicians coming to management almost always arrive later in their careers as a result of the extended time spent in training and practice prior to assuming management responsibilities. And new physician managers rarely begin their management careers in entry level positions, so many of the tasks and concepts considered routine by experienced managers can seem strange and uncomfortable to new physician managers. Among these are formal performance reviews, organizational dynamics, budgeting, and others. Achieving mastery over these tasks can be challenging, but is most certainly accessible to physicians determined to become adept at them.

On the other hand, physicians bring knowledge and skill sets to management positions that cannot be replicated by non-clinician managers under almost any circumstances. The understanding of such things as the rigors of medical training, the science and art of medicine, and the challenges faced by clinicians as they manage their practices, can be extremely valuable to physician executives, and can help them become very effective leaders in their organizations.

Many non-physician executives in health care have spent nearly as much time in formal education as their physician counterparts, earning master's and doctoral degrees in their chosen fields. Physicians tend to complete all of their medical training in a single block that may extend over a decade or more. For both physician and non-physician managers there are now many non-traditional educational opportunities that can lead to advanced degrees without the disruption that accompanies participation in more traditional programs.

Formal education can be a terrific boost to physicians interested in a career change. In addition to the knowledge gained, the introduction to the literature in the field is quite valuable since that is an important method for staying abreast of changes. The hours we spent poring over journal articles and trying to understand the nuances of study design and statistical analysis was preparation for a lifetime of continued learning.

Introduction and exposure to the literature in management is similarly important, but there are some fairly stark contrasts. The most obvious of these is that one rarely finds articles published in the management literature based on the scientific rigor routinely found in peer-reviewed medical journals. In addition, while it is possible to find medical journal articles covering almost any topic in medicine, the problems and the literature in management seem much less well-defined. As a result, researching a problem in the management literature can be substantially less rewarding.

Among the most remarkable changes I noticed in moving from clinical to administrative medicine has to do with schedules. In my practice, while my partners and I were always busy, the schedules were relatively simple. Essentially, I had only a couple things to remember: Is this a work day or an off day? And, if this is a work day, am I on call or not on call? So, keeping track of where I am supposed to be at any given point in time seems relatively simple. As an executive, the range of responsibilities and obligations seems wider, so keeping track of the schedule has become much less routine.

There are a few additional observations that are a little more personal. When I was in practice and when I was a medical director, I found it relatively easy to turn off the business mind and

(continued on Page 15)

"To be (employed) or not to be (employed)" *(continued)*

changed that attitude to one where the patient is the center. We went to an open schedule which allowed our providers to see their patients when they wanted to be seen. We came up with the motto "Believe or Leave." This meant that we were here for the patients and if you were not then it was time to leave. We did have a few employees that could not buy in to this new philosophy; they did leave. Today, we have an efficient and productive staff that truly believes in what we are doing.

The next thing we did was go through the business from top to bottom. We changed our fee schedule to make us competitive with the practices around us. This also ensured we were no longer leaving money on the table in regards to managed care organizations. We looked at all our buying and equipment. We started getting better and better deals. We were able to slash our overhead to one of the lowest around. Finally, we invested in an electronic medical record. We bought the system in 2004, and the system went live in 2006. It has done wonders for our coding and, as a result, our billings. We also have a certified coder on staff. It has made her job easier which has allowed her more time to focus on collections. Now, we have one of the highest collection rates around. Driving the overhead down and increasing the collections has put more money in our pockets.

Control and more money, that sounds pretty good. However, I could not have done it without the right people. Having the right people in place has made all the difference in our practice. If I did not have my partner's financial expertise this would not have happened. If we didn't have the right staff this would not have happened. If we did have the right lawyer, accountant, and hospital to work with this would not have happened. No one person could have done all this. That is why, I believe, that the single independent physician is a thing of the past. But, the independent practice, with hard work, can still be successful. I know that being an independent physician is not for everyone. Employment is still the way to go for some. But, I know I will never go back to being employed. □

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From clinician to administrator *(continued)*

ple opportunities. One tried to thrill me into a position where I was responsible for the careers of many other health professionals. "Think of the control you'll have over other people's lives." "No, thank you," I said. "Control is not why I became a physician." A recruiter for another position said, "Look how much you could add to the company's profit." Again, no thank you. That may interest someone else, but not me.

Before leaving direct patient care, someone should understand:

- You still have to work hard, but you won't have "call responsibilities"
- You most likely will have more evening meetings and professional travel
- You work as part of a team, not as an individual
- You will report to a boss who may see the world differently. You won't have the freedom of an independent physician. You can be fired.
- When you speak, you speak for both yourself and your company
- You need excellent communication skills
- You need to practice skills of conflict resolution
- You'll still be a physician, but your clinical skills may become rusty with time.
- Medical administration is no "bed of roses," but it is essential to a well-run organization.

And yes, I do miss seeing patients. But in my own mind, I continue to see them. I see patients when I make decisions that affect their continued care. In that sense, I am still their doctor.

There is no way for me to stop being a physician. □

"Life is a journey." "Nothing is constant but change." *(continued)*

have been asked on occasion to speak to local health care providers, and once a year I get to see my fellow physicians from around the world at the ABM conference. The Internet has also been a wonderful way for me to combat isolation. There are only a handful of other outpatient breastfeeding medicine specialists in the U.S., and it really helps to have such effortless access to them.

As MilkWorks has grown over the last 12 years, my practice has changed. The lactation consultants now see most babies under three weeks of age who tend to have more straightforward issues. I see babies older than that or with an identified medical issue such as cleft palate or tongue-tie. Two years ago, I acquired a wonderful nurse who has helped me see more moms each day. As we get ever busier, I envision restructuring our practice so I can see moms along with the lactation consultants and have them do more of the basic teaching. My "little boy" graduates from high school this spring, and I feel ready for more transitions of my own… □

Teach a doctor to fish *(continued)*

ing for children who wouldn't be there if Teach a Kid to Fish never existed is one of the greatest feelings in the world."

I started Teach a Kid to Fish for my patients. Selfishly, I did it for my three kids because I want them to grow up in a healthy community. I'm teaching them to fish.

Life declares itself. Listen up. □

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Reflections from the dark side *(continued)*

turn on the leisure mind when I was away from work. As the CEO, I seem to have lost that ability and tend to think about work-related problems all the time. It also seemed that by the time I had been in practice for three or four years, I had developed strategies for dealing with almost everything I saw. As a general internist, I found it necessary to refer patients occasionally, and when I did that, it seemed that I not only sent the patient to a specialist, but I sent all the related problems along as well. As CEO, we seek consultation sometimes to help us deal with challenges, but the problem, its "treatment" and its solution, can't be sent away. And in medical practice, one deals with patients one at a time. I found it greatly rewarding to work with my patients, helping most of them to improve their health, and helping some of them to deal with the inevitable reality of end of life. That kind of one-on-one closeness that characterizes a primary care practice is missing from a career in administration. Instead, there is the sense of trying to make things better for many, many people: patients, family members, staff and colleagues. There is great satisfaction in that, but it lives at a different level.

I feel fortunate to have had a career marked with a terrific variety of experiences. I am a firm believer in the value of professional leadership provided by experienced physicians, and I believe that now, more than ever, our health care system needs the insights, talents, and dedication that physicians can deliver. □

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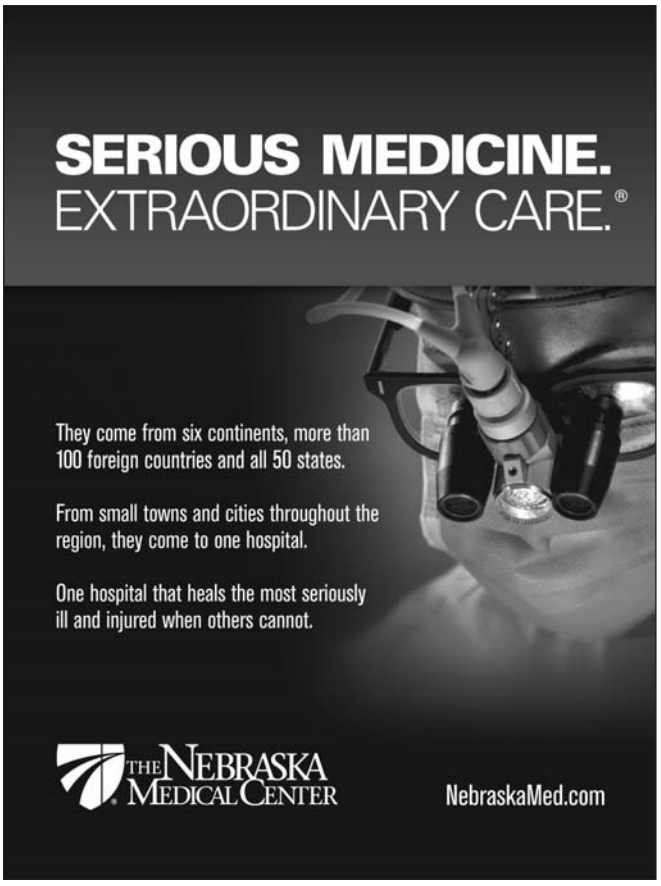

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