



DELEGATE YOUR WAY TO SUCCESS

Personality and training often leave physicians with the misperception that they must do everything themselves. Why overcoming that thinking is critical to your practice's survival.

By Barbara Alden Wilson

FAMILY practice physician Timothy Pursley is like most doctors—he prefers to spend his time on patient care rather than with the business of running an office.

“We want to practice medicine—not deal with insurance paperwork, not balance the books, not hire and fire,” says Pursley, one of three physicians at Maitland Family Practice in Maitland, Florida. To that end, the physicians in the practice delegate nearly all work outside

of patient care—and even some patient care itself—to their staff of 22 support people and one nurse practitioner. It’s a system that Pursley says is vital to the success of their practice, which operates on a mostly fee-for-service basis and steers clear of HMO plans.

Physicians in small group or solo practice cannot expect to control every aspect of the office, experts agree. Effective delegation of responsibilities is essential to today’s medical practices, which, un-

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like Maitland Family Practice, usually rely heavily on reimbursement from managed-care insurance plans.

“The days of being able to handle a relatively small corps of patients, to know them all personally and to know every detail of the [financial] books are over,” says Darrell Schryver, a principal consultant with the Medical Group Management Association.



Schryver

“Insurance reimbursement is decreasing, so seeing more patients is necessary to increase practice income—not necessarily to raise physician income, but merely to pay the bills.”

This increased patient flow necessitates the use of RNs and other providers such as nurse practitioners and physician assistants to carry some of the patient care load. Bookkeepers or accountants may need to be brought on board to handle finances. And front desk staff may need to be increased just to keep scheduling and check-in processes on track.

Common sense? Certainly. But delegating tasks may not come easily to you once you find yourself in the position of “boss.” In order to survive the tight economics of medicine in the 21st century, it’s necessary to avoid or overcome the following misperceptions about delegating.

Misperception #1 “I can do it myself.”

“Physicians are trained to be lonely gunfighters fighting illness,” says Robert Hogan, PhD, a professor of psychology at the University of Tulsa and the president of Hogan Assessment Systems, a leadership and management consulting firm. “They are very smart, sometimes arrogant, and they may think they know more than anyone else. This makes for lousy leadership capabilities.”

Part of being a good leader, Hogan

points out, is realizing that you are not the best at carrying out every aspect of an office’s operation. Staff members must be trained and then trusted to do their jobs.

“It’s all about team,” says Hogan. “A physician’s practice must be a team effort with competent people.”

The first step, according to Schryver, is to assess how much you’re doing that someone else could do. A nurse, for example, could see patients for problems such as stitches removal or follow-up appointments after certain procedures.

(Each state has authority over the licensing of allied health professionals. Legal counsel may be appropriate before delegating certain aspects of patient care. See sidebar, “Legal Resources,” for written materials that may be helpful.)

When hiring clinical support staff, it’s important to be realistic about the amount of help you need. Charles E. Cornett, MD notes that each of the four physicians with whom he practices at Internal Medicine Associates in Indianapolis has an LPN and a medical assistant.

“In my last practice opportunity, there was one medical assistant for each physician,” Cornett says. “Looking back, we were very understaffed.” He notes that his current practice runs smoothly, thanks to adequate staffing with highly competent individuals.

The “I-can-do-it-myself” attitude should never extend to the business end of the practice, both Schryver and Hogan note. Fears over letting others handle money can stand in the way of delegating the books, but trying to be your own accountant will eventually become overwhelming when your practice grows. It is essential to take the steps to hire bookkeepers and/or accountants you can trust.

“I’ve attended several seminars with

legal experts on the financial management of a practice,” says Pursley. “I learn something new every time. It’s amazing how easy it is for doctors to get taken advantage of by employees, especially those who handle the money.”

Pursley, whose undergraduate major was accounting, says that while it is easy for him to review his practice’s books, personnel and management issues don’t come naturally to him. His only “training” in management issues during medical school was a short rotation in practice management and a two-day seminar on the subject.

“I’ve had seven years of schooling on how to practice medicine, and I still know essentially nothing about practice management,” he says.

In addition to the seminars like those that Pursley advocates, there are other resources for helping physicians find the right staff and delegate effectively.

“We recommend using psychological assessments when deciding whether to hire someone,” says Hogan. “You can tell who won’t steal, can handle pressure, and will be loyal to your practice by administering these tests much better than you can with just an interview and background checks. No one is as good a judge of character as he thinks he is.”

Of course, checking references, licensure, and certification is vital to finding good support staff, Schryver points out. “You should even check with the school or schools a potential employee went to about their grades,” he says. “You can see a potential pattern of sloppiness at work if their work at school was less than great.”

Misperception #2

“Patients will leave if I DON’T do it myself.”

Could shifting certain elements of patient care to a nurse or midlevel

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Timothy Pursley, a family practitioner, says the NP in his office is an asset with patients. "Our nurse practitioner is very knowledgeable and a good conversationalist who puts people at ease," he says.

provider such as an NP or PA leave a bad impression with patients?

"No," insists Schryver. "Patients WANT extenders in a practice, because the extenders usually can take more time with them than a physician can."

Pursley's experience has borne this out. "Our nurse practitioner is very knowledgeable and a good conversationalist who puts people at ease," Pursley says. "She generally sees our overflow patients on Mondays—lots of colds and bronchitis. In my almost three years here, I've had only one patient complain about having to see her instead of a doctor. She does all of our diabetic



PHOTO / DOUG DIKANE

Legal Resources

✓ *Medical Group Practice Legal and Administrative Guide*. Billed as an all-in-one resource on the legal and administrative aspects of practice management, this book explains how to form a group practice, design a physician compensation system, manage personnel, start a credentialing and peer review program, build an efficient billing and collections system, and insure and avoid liability, among other issues. It can be updated with annual supplements covering legal developments and topics of emerging importance. Published by the MGMA in

conjunction with Aspen Publishers, Inc., 1998 (includes 1999 update). ISBN 0-8342-1100-9.

✓ *Operating Policies and Procedures for Medical Practices*, by Betty Warn, CMPE, and Elizabeth Woodcock, FACMPE. This guide covers policy development and maintenance, appointment scheduling, registration, medical records and transcription, referrals, prescription management, ancillary test reporting, information systems, materials management, and central billing office procedures. Includes a disk with sample policies and procedures that you can put to use in your office. MGMA, 1999, 376 pp, ISBN 1-56829-092-6.

✓ *Governing Policies Manual for Medical Practices*, by Courtney Price, PhD and Alys Novak, MBA. This manual serves as a tool for developing policies to make a physician's group run smoothly. Features detailed information and advice about:

- * BOARD ISSUES: strategic planning, officers, and committees
- * PHYSICIAN ISSUES: bioethics, compensation, disability, intellectual property, licensing, medical records, patient relations, physician evaluation, and recruitment
- * BUSINESS ISSUES: bad debt and collections, business ethics, charitable contributions, employee discounts, harassment, political contributions, and unfunded patients.

Includes sample policies and a disk of generic policies to customize for your practice. MGMA, 1996, 464 pp, ISBN 1-56829-079-9.

✓ *Job Description Manual for Medical Practices*, by Courtney Price, PhD and Alys Novak, MBA. This manual contains hundreds of job descriptions for positions found within group practices. It is designed as a tool to help you develop an effective job description implementation strategy, conduct appropriate job analyses, and understand legal issues. Includes a disk of generic job descriptions that can be used as is or modified for your practice. MGMA, 1999, 612 pp. ISBN 1-56829-095-0. ■

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teaching as well, and our diabetic patients love her.”

Both Schryver and Pursley note, however, that patients should be aware that they can see a physician in the practice any time they feel the need. And in Cornett’s practice, the physicians make sure their patients have no more than two or three visits with their nurse practitioner between doctor visits.

Certain aspects of telephone work in a practice can also be delegated. Patients don’t generally care who calls them with test results, as long as the call comes in promptly. At Maitland Family Practice, most patients receive calls regarding routine test results from the floor nurse. Likewise, prescription refill calls are handled by the practice’s desk nurse. For each of the two physicians in the office each day, there is a floor nurse and a desk nurse. “I couldn’t get through the day without them handling all that they do,” says Pursley.

Misperception #3 “As long as I practice good medicine, the business will take care of itself.”

On the flip side of the attitude that the physician must do everything him- or herself, some doctors like to think that as long as they offer quality care and have set up a “good” staff, they need not worry about the business side of the practice. That’s a foolish mindset, Schryver says.

“ALWAYS do regular internal audits, regular chart reviews and regular checks of anything your extenders and staff do,” he says. “Some practices review certain systems daily, others quarterly. In a small practice, for example, you may want to review your charts often and look at the books monthly or quarterly. A physician extender who sees 10 to 15 patients a day should have 3 to 5 charts reviewed each day.”

Cornett notes that charts from Internal Medicine Associates’ nurse practitioner are reviewed by the treating physician the same day the NP sees the patient.

Regular staff meetings are also essential to keeping the business end of a practice running smoothly. Although these meetings often are run by the office manager (sometimes as often as daily), it’s a good idea for at least one physician to sit in on a meeting once a month or so, Schryver says. This is not only to keep staffers on their toes, but also to stay in touch with them, learning their names and who does what.

Protocols for staffing are available from the MGMA and the AMA and can be adjusted to fit the needs of your practice. (See sidebar for offerings on computer disk.)

Misperception #4 “I’m not here to win a popularity contest. Whether people like me doesn’t matter.”

No one will argue that a physician’s first obligation is to practice good medicine. But completely ignoring the importance of getting along with your staff and your patients will cost you a great deal. Poor relationships between physicians and staff often lead to high turnover, which in turn leads to the expense of finding and hiring new employees. And even the best staffers find little incentive to do their best work for a jerk. A physician’s unpleasant demeanor will reverberate with patients as well. Hogan’s studies have revealed that physicians who score low on the likeability scale of normal personality are the physicians most likely to be sued.

“Unfortunately, personality can’t be taught,” Hogan says. But it can, believe it or not, be delegated.

“If you don’t have the interpersonal skills to put people at ease, hire a number two person who does,” he asserts.

One pediatric practice in Florida did just that. The physician who founded the practice, while highly competent and well-regarded in the field, was viewed by some parents as too formal and businesslike. He hired a gregarious partner who was also very capable, but related to patients and their parents in a more folksy way. He was put in charge of all informational interviews with parents of prospective patients. The practice has since added two physician partners and a nurse practitioner to handle the high patient volume.

As for a less than charismatic physician’s relationship with the staff, a competent and caring office manager can act as a “personality buffer” between the doctor and support employees. “As long as there is SOMEONE personable who is dealing with the patients and dealing with the employees, the overall morale will be pretty good,” Hogan notes. “But sometimes we see doctors who have to fail—go bankrupt—before they are willing to change or admit they need a ‘people person’ as their number two.”

Physicians can’t—indeed shouldn’t try—to be all things to their practice. Hiring and training qualified people, and then delegating them tasks appropriately is imperative in today’s medical environment. ■

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