

Practice Smarter . . . Not Harder!

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The American College of Obstetricians and Gynecologists (ACOG) Presidential Task Force on Changing Practice in the 21st Century developed a list of practical goals or recommendations that ACOG or our members can implement, to improve practice satisfaction and ensure survival in the twenty-first century. Three areas of focus were 1) Patient Safety and Risk Management; 2) Practice Economics and Efficiencies; and 3) Workforce Changes. Recommendations in each area were subdivided into what ACOG might implement and what members can do themselves.

Recommendations for ACOG to consider include enhancing the ACOG Web site; developing model protocols, informed consents, and electronic medical records templates; continue lobbying for tort reform, but also work on alternative concepts; help develop "reentry" guidelines; expand the Practice Management division to provide more tools for practices; and help de-

velop models to allow more practice style diversity.

Recommendations for ACOG members were to reduce variation in practice patterns, using standard tools; automate routine tasks with electronic tools; work cooperatively with other providers and practices; participate in emergency drills, "time-outs," and other risk reduction training; mentor new associates; and learn from them too.

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In his inaugural address,¹ American College of Obstetricians and Gynecologists (ACOG) President Kenneth Noller addressed probably the most critical issue facing the specialty of obstetrics and gynecology:

I believe that it is possible to have regular hours, and a family, and still practice obstetrics. What we need to do is to reevaluate how we practice our specialty . . . We need to learn how to practice smarter, not harder. We need to learn how to get more out of each hour, not simply to add more hours.

As ACOG president, I will appoint a task force with the charge to examine current practice models and to make suggestions for innovative changes. Such changes will hopefully reduce the number of our Fellows who leave the practice of obstetrics after only a few years . . .

The task force will also be asked to develop guidelines for improving practice efficiency. Medicine has lagged far behind industry in developing tools that both save time and produce a superior product . . .

In three short paragraphs, President Noller succinctly focused on both the problems faced by so many in our practice today and the

critical need for us to find the solutions to these problems. His charge to the task force was simple. We were asked to help improve the way that obstetricians and gynecologists practice medicine to make working within the specialty more attractive and satisfying, which will help attract and retain the best candidates.

I had the distinct honor and pleasure of serving as the Chair of this Task Force. It included some of the brightest and most creative thinkers who spent some significant time opining on the nature of the practice of our specialty and the changing environment.

Realistic limitations on the Task Force's activities and scope militated against our report being the final comprehensive overhaul of the specialty that would solve all our problems in one fell swoop. However, it is our hope that the Task Force at the very least identified the key problems of our day and has suggested ways that we can begin to address them.

This Current Commentary will limit itself first to presenting the scenario that set the stage for the Task Force's work and then discuss a brief synopsis of areas of concern and general recommendations.

Before getting into the specifics of our Task Force's work, let's first look at a brief scenario of two alternative practice models. The first is a more "traditional" model that most obstetrics and gynecology practices follow today, and the second is what practice can be

See related editorial on page 7.

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like, using some of the very tools we have at our disposal or what will be available in the very near future if we drive the market in that direction.

“TWENTIETH CENTURY OBSTETRICS & GYNECOLOGY, PC”

A patient in need of an annual examination calls this practice to make an appointment. She is put on hold for a minute and listens to a brief series of announcements about the practice, then a person picks up (or she pushes a menu button to be directed to the scheduler). After a 2–3 minute negotiation, she is given an appointment time and date, and if she is a new patient, she might be mailed some forms to fill out and bring to the office when she comes in.

One or 2 days before the appointment, the patient may get a phone call reminder about her appointment from the office staff. (They may leave this on her answering machine, which her 6-year-old may or may not remember to save when he plays with the machine.)

Let’s be optimistic and assume she gets (or does not need) the reminder. She gets to the office, and if she remembers to bring her forms with her, she turns them in and provides the front office staff with her insurance card for copying. If she’s forgotten the forms, she’s given another set to complete. She then finds out that her physician of choice was just called to the hospital for an emergency delivery, but she’s welcome to wait or reschedule.

She’s finally seen, 90 minutes later than scheduled, and is asked by a medical assistant a 10-minute series of questions about her current complaints and her medical history, as well as other questions about her family history, as more of

the chart is prepared for the doctor to review.

The doctor then comes in, reviews the chart, spends a few more minutes talking with the patient, performs an examination and cervical cancer screening test, and sends the patient out with a requisition for a mammogram that she may or may not ever go for. She’s given a written prescription for her routine medications and is told to come back in a year for her next examination.

She gets home and remembers a question she forgot to ask the doctor, calls the practice and plays “phone tag” with the triage nurse for the rest of the day. By the time they connect, she’s forgotten her

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question. Then she cannot find her prescription and must call the office again for another copy to be mailed to her, because she needs to send it into a mail order pharmacy. Sounds pretty routine, and maybe even familiar. However, this situation has much room for improvement.

“TWENTY-FIRST CENTURY OBSTETRICS & GYNECOLOGY, LLC”

A patient in need of an annual examination calls the office and is given an option of not waiting on hold but going online to the practice Web site. Here she can find out more about the practice and its providers. For a nonurgent appointment, she can actually sched-

ule her appointment herself, much as she can choose her own seat when she makes her airline reservations for travel.

Once her appointment type is scheduled, she is directed to a series of forms she can complete online and submit directly to the practice (which seamlessly integrates the information into a newly created electronic medical record it starts to build for this patient if she is new or into her already established e-chart).

Two days before the visit, the patient receives a secure message through e-mail (or if she chooses, a text message to her personal cell phone) that reminds her of her visit. She is asked to reply to verify her receipt of the reminder.

She then comes to the office and checks in at the front desk. Her insurance information has already been electronically verified, and she sits and waits only a few minutes, because her doctor is on time. The doctor was not only not on call the night before, but is not the practice’s “laborist” today, so there is no chance she will be called out of the office for an emergency delivery.

Because she is well-rested and not stressed out by the prospect of having two patients in labor while trying to work the office practice too, the doctor reviews the information provided electronically by the patient, is reminded by the electronic medical records’ (EMR) alert system of the patient’s possible increased risk factors of heart disease because of family history red flags, and ensures that before the patient leaves the office she not only has her mammogram appointment scheduled (again, electronically), but is also sent to the laboratory for an appropriate lipid profile. Her prescriptions are sent in electronically and immediately, so there is no chance they will be



misplaced (or misinterpreted due to less than pristine penmanship).

Incidentally, the brief transvaginal ultrasound that was done as part of the routine annual examination did discover a small amount of free fluid and a questionable mass on one ovary that the doctor did not feel on her bimanual examination, so a follow-up repeat ultrasonography was also scheduled.

The patient leaves the office quite satisfied with the personalized and focused attention she received. She remembers a question she forgot to ask the doctor, gets home and e-mails that question to her. By the end of the day, she receives a return e-mail with an answer to her question, and is very happy she did not have to make multiple calls and wait at home for a return call from the office.

Two days later, when her lipid profile returns “within normal limits,” she is notified by secure message and is happy to get this good news. She is reminded to return after her next menses for a repeat ultrasound examination to be sure the mass has resolved.

Which practice do you think more patients would prefer? In which would you prefer to work?

PROCESS AND RECOMMENDATIONS

The task force developed three “buckets” into which we categorized all the identified challenges that we face in the profession: Patient Safety/Professional Liability, Practice Economics, and Workforce Changes.

In considering the first area, we discussed both the increasing risk of litigation and the economic effect of the ever-increasing professional liability premiums as two factors that have contributed very heavily to the decreasing satisfaction with practice and to increasing

physician burnout. We also have seen the increasing complexity of the administrative side of practice result in larger office staffs and more inefficiencies overall in how we practice.

Finally, we looked at workforce changes and recognized the challenges we face are not due to *gender* changes in the workforce but *generational* changes! It has to do with a whole new generation of doctors for whom “practice” means something different from what it meant for the earlier generations. We have seen that the newer generation of doctors is more specialized in its knowledge and in its approach to practice. More of the newer doctors are interested in joining group practices (larger groups especially) and are shying away from the challenges of running the business of their own practice. They are less interested in partnership and more interested in being employed. The important thing to realize, however, is they are no less professional than their predecessors, but their approach is different.

To attract the new generation of physicians, the Task Force agreed we must be able to help our current practicing members adapt their practices to the new environment, allowing for the increased diversity in the workforce. Again, we are not referring to gender or racial diversity, but to lifestyle diversity. Some doctors want to work part-time, some want to limit their practice to obstetrics only, gynecology only, or office only. We must help our practices provide those opportunities in such a way that the practice as a whole may become “all things to all people,” in a sense assuming the role that individual doctors played in the past.

Ultimately, we developed a series of recommendations. These included several that we encourage

ACOG to accomplish and some that were aimed at our members directly to adopt in their practices. Recommendations specific to ACOG included

1. The ACOG Web site should be reengineered so that it may become the “go to” site for women’s health care, for both obstetrician–gynecologists and their patients.
2. Help develop models for protocols for the safe performance of in-office procedures, electronic medical record documentation templates, and algorithms for clinical decision-making, telephone triage guidelines, standardized informed consent and refusal forms, and other tools that can help ensure patient safety, reduce liability exposure, and in general decrease the variation in practice patterns.
3. Continue advocacy for liability reform and offer members information about options such as Alternative Dispute Resolution (arbitration/mediation, health courts), the “3 Rs”: A program encouraging the Recognition of patient injury, appropriate Responding to the situation, and Resolving the problems the injury has caused.
4. Help develop materials and guidelines to help with obstetrician–gynecologist reentry.
5. Expand the Practice Management division to provide even more useful information to members to help in their practices.
6. Help develop new practice models like the “laborist/hospitalist” and other new ways to approach the division of labor in a practice.

In addition, several areas were identified that could be implemented directly by our members,



without waiting for ACOG to develop them. They included

1. Adopt office protocols for in-office procedures, phone triage, emergencies that may arise, and also informed consent and refusal documentation for the many services we offer to help reduce practice pattern variation.
2. Automate routine functions by the use of electronic tools. An electronic medical record should provide efficient access to a more legible medical record, simultaneous access to that record by multiple users, and remote access to that record during nonoffice hours, as well as from the Labor and Delivery or the Emergency Room when needed in a hurry. No doubt a fully functional electronic medical record is in fact the "holy grail" that seems to be ever elusive. But we should not let "perfect" be the enemy of "good." While we are seeking the ultimate product (and figuring out how to pay for it) we can at least consider using the many electronic tools that are already in existence, albeit not yet perfected, that can help

us run much more efficient and even safer office practices. These include e-prescribing programs and Web-based functionalities that provide access to patient medical information on a real-time basis. In addition, a patient portal on a robust Web site could allow patients to make their own routine appointments, update their medical history, insurance, or demographic information online before coming to the office, and even provide secure communication on nonurgent clinical questions, facilitating more timely patient communication and improved patient satisfaction. At the same time, this could allow us to decrease total number of office staff or use them for more important functions.

3. Explore new practice models, including larger group formation, development of the laborist or hospitalist model in your practice or hospital, and generally seek cooperative relationships with other professionals or area practices to work together and more efficiently. Cross-covering with other high-quality providers in your area, for instance, and the

judicious use of collaborative providers might improve the quality of life of the physician and at the same time ensure a safer experience for the patient.

4. Participate in electronic fetal monitoring courses, "time-outs" before any procedures or operations are begun, and Operating Room or Labor and Delivery emergency drills.
5. Mentor new associates and learn from them.

The Task Force was an ambitious undertaking, and implementing all of its recommendations will be very daunting, to say the least. It will not take place overnight, and a timetable has not been established yet. It is the sincere hope of the Task Force that the recommended tools will enable ACOG to better serve our members and help their practices survive in the twenty-first century.

I would like to thank again Dr. Noller for creating the Task Force and giving it such a far-reaching charge.

REFERENCE

1. Noller KL. We are the champions (of women's health). *Obstet Gynecol* 2007; 109:1268-9.

