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The precision medicine revolution

The dream of every physician is to personalize a care plan for each and every patient. But what does "personalization" actually mean? What if there was a way to investigate your patients genomic information in order to provide them with the treatment regimen that works best for them.

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But it’s one thing to talk about lofty ideas, and quite another to put them into practice. So how do we make precision medicine a reality for physicians to use in their practice every day? To answer these questions, Medical Economics turned to Joel Diamond, MD, an expert in precision medicine. His cover stories break down what precision medicine is, and explore the practical, financial and technological challenges physicians will experience embarking on that journey—and how to solve them.

Beyond precision medicine, we have tons of great content in this issue, including:

- Cyber insurance is sold as a way to protect your practice from hackers, but is it worth it?
- Tips for opening your own practice.
- Are you late all the time during your practice day? One doctor has an idea that might help.

However, the biggest story in the world right now—the outbreak of the novel coronavirus (COVID-19)—is one we can’t ignore. To that end, Medical Economics has editors working on this story day-in, day-out to provide our physician audience with what they need to know.

To read our news and useful information about this pandemic, please visit: MedicalEconomics.com/coronavirus.

As always, if you have feedback on our content, story ideas, or would like to contribute to Medical Economics, please reach out to our editors at medec@mjhlifesciences.com.

Mike Hennessy, Sr.
Chairman and Founder
of MJH Life Sciences
An epidemiologist discusses what physicians need to know about the novel coronavirus (COVID-19).

Medical Economics editors are covering what you need to know during the ongoing novel coronavirus (COVID-19) pandemic. Our ongoing coverage of COVID-19 includes:

- Breaking news on the latest development
- Tips for physicians to extend the life of N95 respirators
- Mental health tips for doctors and other care providers
- How physicians can protect themselves from the virus
- Strategies for using telehealth to connect with your patients

To read all of our ongoing coverage, go to: MedicalEconomics.com/coronavirus
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Always running late? This will help
A simple trick to keep yourself running on schedule, writes Rebekah Bernard, MD.

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CAREERS

Always running late? This will help
A simple trick to keep yourself running on schedule, writes Rebekah Bernard, MD.

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ohan Dua, MD, got the bad news in a phone call one morning in February 2017: His practice had been hacked.

The EHR system shared by Dua and his wife, Kiran Dua, MD, had been breached and hackers were holding their patient data for ransom. That attack sent the couple, who practice in Northridge, Calif., on a months-long ordeal that cost their separate practices time, money, and service interruption.

Dua, a nephrologist, never thought he and his wife, a primary care physician, would join the ranks of healthcare providers and organizations that have suffered crippling cyber attacks. Luckily, their losses were at least partially covered by the combined $100,000 cyber coverage they had through their medical malpractice insurance. The insurer also provided them with experts to help recover from the attack.

Even with that assistance, however, their practices were forced to shut down for several months while they dealt with the attack. “We still don’t know how much money we lost,” Dua says. “We lost patients, too.”

The growing threat of being hacked has more primary care physicians buying cyber insurance, according to experts. But what those policies cover, how they work, and how much they cost are mysteries to many healthcare providers, most of whom are only familiar with malpractice and business insurance.

WHAT CYBER INSURANCE DOES

Cyber insurance covers losses and damages resulting from patient data being stolen, exposed, held for ransom, or improperly shared. It covers deliberate actions, such as hacking or ransomware, as well as accidents, such as a lost laptop containing unencrypted patient information or a coding error that accidentally exposes patient data.

A comprehensive policy will cover paper records as well, since so much information is still stored in physical files.

Cyber insurance helps providers deal with the consequences of data breaches, which can range from relatively minor to catastrophic.

The assistance provided can include:

- paying regulatory fines and penalties;
- compensating for loss of income from downtime or lost patients;
- hiring IT experts to find and fix the breach;
- hiring a call center to handle inquiries from patients;
- hiring a public relations firm to deal with unwelcome publicity;
hiring attorneys to represent the practice in any lawsuits filed by patients (as well as any damages awarded); and

paying ransom to free hijacked data.

In short, it covers almost any loss or expense that can be attributed to the data breach.

For example, the Duas’ coverage helped them when they were forced to write off uncollected bills due to patient payment records that weren’t recovered, a loss that Dua estimates at $40,000 to $50,000.

Coverage typically applies only to the data itself and not the computer hardware a practice uses, such as laptops, smartphones, tablets, or servers, which often are covered under a general business insurance policy.

A complete policy includes first-party and third-party coverage, says Marcin Weryk, vice president of XL Catlin, a cyber insurance vendor. First-party coverage pays for damages suffered by the policy holder, such as lost revenue, business interruption, IT forensics and data restoration.

Third-party coverage compensates for damages caused to others by the data breach, such as the legal costs incurred from lawsuits filed by affected patients.

Practices that haven’t bought cyber insurance often have some coverage through their malpractice or general business policies, but it’s usually limited to about $30,000 in damages and contains exemptions, says Brandon Clarke, co-founder of Affenix, a brokerage specializing in cyber insurance.

Before deciding whether to purchase additional cyber insurance, physicians should know what coverage they already have, Clarke says. Though the Duas have separate practices, they were able to combine their separate $50,000 cyber insurance coverage in their malpractice policies to help compensate for the joint attack.

HOW MUCH DOES IT COST?
The cost of a cyber insurance policy varies, depending on the carrier, the size of the practice, and the extent and amount of the coverage, experts say. The larger the practice, the greater the risk and the more it can expect to pay.

The good news is that cyber insurance is less expensive than malpractice and liability coverage. A typical five-physician primary care practice should have at least a $1 million umbrella cyber policy, Clarke says. That coverage would cost anywhere from $1,200 to $5,000 a year, he estimates.

Christine Marciano, a certified information privacy professional (CIPP-US) and president of Cyber Data Risk Managers, a cyber insurance broker, recommends $1 million to $5 million in coverage for that same practice and says it would cost $1,500 to $8,000 a year. Coverage can be purchased from general insurers or companies that specialize in cyber insurance.

Some insurers will assess a practice’s cyber security practices before deciding whether to write a policy and recommend ways to decrease risk, such as encoding laptops and improving passwords.

A TEAM RESPONSE
When shopping for cyber insurance, practices

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**How to protect your data**

Here are best cyber security practices to follow, according to the AMA and cyber security experts:

1. **Review current practices and policies.** Protecting data is the responsibility of the practice, not the EHR provider or software designer. Identifying vulnerabilities before a hacker does is the goal. Some cyber insurance providers will conduct a safety audit for an additional fee.

2. **Encrypt and password-protect mobile devices, including laptops, tablets, and smartphones.** Set policies on who has access to the devices and who can remove them from the office.

3. **Install and update anti-virus software.** Keep software and operating systems up to date and patched.

4. **Create separate wi-fi networks for your practice and your patients, using different passwords for each.** Unauthorized access was the leading cause of security incidents in 2015, according to an IBM report.

5. **Enforce a workplace policy requiring strong passwords with a mixture of letters, numbers, and symbols.** Change passwords regularly.

6. **Limit levels of access to data.** Employees should have access only to the information they need to do their jobs.

7. **Train employees.** All staff should be taught to protect data and how to identify disguised attacks, such as phishing emails, which are disguised as legitimate communications, but can install malware if opened.

8. **Back up all data regularly.** Backups should be kept off site and off network.
Small does not equal safe

Healthcare data breaches are rampant. In a 2017 survey by the AMA and Accenture, 83 percent of physicians reported experiencing some sort of cyber attack, though not all resulted in breaches.

Cyber criminals target healthcare organizations because their data contain patient names, birth dates, addresses, social security numbers, credit card numbers, and health insurance information. Whether the hackers use the information themselves or sell it to others on the black market, it’s all that’s needed to steal identities and commit fraud. That’s why healthcare data is more valuable even than credit card records.

Physicians in small primary care practices who think they would not be a worthwhile target for hackers should look at the U.S. Department of Health and Human Services (HHS) list of reported breaches of healthcare information.

There, among the giant health insurers, government agencies, and large hospital systems, are medical practices that found out the hard way that they, too, can be targeted: an 11-doctor cardiology practice in Knoxville, Tenn.; a solo family physician in Weston, Fla.; a solo internist in Scottsdale, Ariz.; and many more.

In fact, a practice might be targeted specifically because it is small, says Christine Marciano, a certified information privacy professional (CIPP-US) and president of Cyber Data Risk Managers, a cyber insurance broker in the United States and Australia.

“I think it’s the smaller offices that are much more vulnerable,” she says. “They’re focused on treating patients, not on (encrypting) their laptops, and making sure they have the latest security measures.”

Lee Kim, JD, CIPP-US, director of privacy and security at the Healthcare Information and Management Systems Society, says attacks on small practices were uncommon five years ago, but no longer. In fact, some hackers will test and refine their methods on small practices before going on to attack larger targets, such as healthcare systems.

She is seeing more of a new kind of attack, which isn’t after a practice’s data or patient information, but its computing power to earn digital currency. Attackers have hijacked practice servers to mine for pseudocurrencies, like Bitcoin. Users might be unaware that the reason their computers are operating so slowly is that they’re running the complex calculations to reap the currency.

“Even though you’re a small practice, the motivation to attack is still there. People who say they haven’t been targeted simply haven’t been targeted yet,” Kim says.

should investigate exactly what help they will receive in case of a breach. Unlike a fire, managing a data breach often requires the help of a team of experts, not just a check to cover damages. Depending on the nature and size of the breach, that team can include lawyers, forensic accountants, IT experts, publicists and call center operators, among others.

Besides the coverage itself, the real benefit of cyber insurance is being able to turn over management of the crisis to a carrier with experience in data breaches. Most practices do not have the time or resources to handle it themselves, says Clarke.

Once an insurer learns of a breach, it assesses the situation and decides which corrective actions need to be taken to prevent further damage and deal with the aftermath.

The insurer hires vendors and contractors to provide the necessary services. For example, a lawyer will handle HIPAA notification, while IT specialists locate and fix the breach and a PR firm writes the notification to patients whose data has been affected.

The decision whether to pay ransomware is up to the practice, but the insurer typically recommends a course of action and handles any payment, if one is made. For example, XL Catlin has vendors with Bitcoin wallets, since that is the cryptocurrency usually demanded by ransomware hackers, Weryk says.

EHRS AND PARTNERS
Patient data is exchanged between practices, insurers, hospitals, and labs every day. The more places data is stored, the more vulnerable it is to attack and accidental disclosure. Even a practice not targeted directly can be liable for data lost by a partner or vendor.

For example, in April, the state of New Jersey levied a fine of nearly $418,000 against Virtua Medical Group, a physician network, after a vendor error left the records of more than 1,650 patients visible online.

Many data breaches are going to involve EHR systems, and while the system vendors usually work with IT experts to find and fix any payment, if one is made. For example, XL Catlin has vendors with Bitcoin wallets, since that is the cryptocurrency usually demanded by ransomware hackers, Weryk says.

Practices should investigate what sort of cyber protection and coverage their partners and vendors have, with an eye toward working together to keep data safe, says Lee Kim, JD, CIPP-US, director of privacy and security at the Healthcare Information and Management Systems Society.

“It’s really a shared responsibility between you and your vendors,” she says, “and you each have a responsibility to keep it secure.”
When patients hit ‘record’ at the doctor’s office

I was recently at my physician’s office and observed a patient recording himself and a family member in the waiting room. He continued recording as he walked down the practice hallway and entered the examination room. It was clear that the patient had not only recorded himself, but also had captured other patients in the room and patient names being called out. He even potentially captured conversation between patients and healthcare providers.

Yet, no one from the practice told him to stop filming, questioned his activities, or otherwise reacted. Has this happened in your practice?

If it did, how would you react?

The above scenario is hardly surprising in the age of social media, although it was a first for me. However, while most healthcare providers and medical practices are aware of the significant limitations HIPAA places on their activities, it is less clear how to react when it’s the patient who wants to record the physician and could potentially expose protected health information of other patients.

Practices should address the issue of patients recording themselves and others by planning ahead. A practice should develop a policy for handling such activity and prepare the necessary paperwork for patients to acknowledge the policy put in place. If a practice chooses to allow such recordings, then the policy must set the appropriate parameters for recording at the practice, such as where filming can occur, whether permission must be requested, and other necessary requirements.

Sometimes patients ask their physicians directly to record an encounter for arguably legitimate reasons, such as to help remember medical information or instructions or share the details of the visit with caregivers or loved ones. A practice should have a separate approach for physician recordings and should tailor it to physician preferences.

What happens if a patient does not ask permission and records the physician without his or her knowledge? While this may violate the practice’s policies, such activity can also expose the practice to liability and impact its reputation. What information was in plain sight and recorded that presented a HIPAA issue? Could the practice be liable for anything else related to the recording? How did its staff behave? Practices should be aware at all times that recordings may take place without their knowledge, so appropriate HIPAA precautions and patient interactions should be the norm through training and preparation.

Finally, practices should be aware that patients have the right in most states to record interactions with third parties where the law only requires one party to consent to the recording. This means a patient does not need to inform the physician that he or she is recording at all. Other states, such as Illinois, require that both parties are aware of the recording. In these states, this means that a patient who records a physician or staff interaction without permission has actually violated the law.

I recommend exploring these issues with legal counsel in order to assure that your practice is properly protected, and that any plan is tailored specifically to your practice’s needs. For example, the approach may be different for an internal medicine practice compared to one that focuses on cancer or communicable diseases. Knowledgeable legal counsel can assist in understanding your practice’s legal risks and potential vulnerabilities.

Ericka L. Adler has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@mjlifesciences.com.
Often times physicians approach me because they don’t think their practice has a winning strategy. Moreover, they tell me that they do not believe their practice has the right capabilities to execute their current strategy. Having capabilities is all well and good, but just because you are capable of doing something, does not mean you are going to be successful.

“Winning” practices often don’t follow prevailing trends, but instead follow five habits that contradict conventional wisdom to out-execute and out-compete their rivals.

Here is my personal take on the five strategy execution used by thriving practices:

1. **COMMIT TO AN IDENTITY**
   Thriving practices focus on a clear target market and on what makes them unique with that patient demographic. They avoid chasing growth by pursuing multiple markets in areas where they have no clear point of differentiation. They get very clear about their strategic position and build capabilities that will help to support that position over the long term.

2. **DO NOT GET CARRIED AWAY WITH BENCHMARKING**
   Practices that dominate the market keep an eye on what competitors are doing, of course, but they do not blindly follow the herd. In fact, they know that using the same technologies, following the same methodologies, and benchmarking the same key performance indicators as their competitors is just a recipe for mediocrity. The leading practices develop a winning strategy that will set them apart in their community (and perhaps in their specialty), and translate their long-term strategic moves into their current projects and performance metrics.

3. **PRUNE WHAT DOESN’T MATTER TO INVEST MORE IN WHAT DOES**
   There is a saying: “You have to keep pruning the rosebush if you want to create beautiful blooms.” It’s easy to keep adding new features (e.g. services, technologies) to your practice, and adding new projects by Nick Hernandez, MBA Contributing author
Testing your strategic choices

Many of the practices I work with think they have strategy, but a test shows they haven’t made any strategic choices at all. Consider these steps to quickly determine whether your practice understands what a real strategy is and whether your strategy can actually be successful.

**Step 1: Identify your long-term strategic moves**

I often challenge physicians by asking, “Do you have a real strategy for long-term success?” Strategy requires disciplined analysis and a deep understanding of how not only the healthcare industry but also how your specialty is likely to play out in the coming years. Then you need to get very clear on the few, key strategic moves your practice needs to make in order to position yourself for future success.

Strategy requires tradeoffs. You cannot be everything to everybody; you cannot just blindly copy the moves of your competitors and hope to win. You have to figure out what to say “yes” to, and what to say “no” to. You make clear-cut choices about how you will compete in the future, then allocate your time and resources accordingly. Keep in mind that less is more when it comes to strategy execution. I recommend that you whittle your wish list down to only a few strategic moves that will have the greatest impact, and say “No” to everything else.

**Step 2: Question the validity**

Take a look at each strategic move in isolation, and ask yourself, “Could we do the exact opposite, and would that also be a valid strategy?” If doing the opposite of your stated strategic move would be stupid or nonsensical, then it is not really a strategic move at all. It is simply a “table stakes” requirement for doing business in your specialty. It is likely to be something that many of your competitors will also be doing.

Your strategic move should be something that will help you to establish a competitive advantage. A strategic move should help you to create a category or a niche in your catchment area (and perhaps more broadly in your specialty) where you can genuinely claim a position of leadership or a meaningful point of difference. A strategic move should make it very clear what are going to say “yes” to, and by association what you are saying “no” to, and what you are NOT going to do.

This is where I have seen many practices fail. Their stated strategies often include generic fluff like, “provide a world-class patient experience.” Well duh, really? So the opposite of that would be to provide a lousy patient experience, and that would also be a valid strategy? I don’t think so. You haven’t actually made a strategic choice at all.

Take a look at your long-term strategic moves now, and question viability of those courses of action. I’m betting a few of you will realize there’s still quite a lot of work to be done.

---

**5 IT IS NOT ABOUT AGILITY**

Practices that dominate the market are not “agile” in the sense that they respond to external change as rapidly as possible. Rather, they are “smart agile.” Physician leadership needs to be agile enough to address threats, or pursue promising opportunities that support their plan, but remain disciplined and focused enough so as not to end up “chasing squirrels,” lurching from one idea to the next while losing sight of their original strategic intentions. Successful physicians shape their future by creating the change they want to see.

Nick Hernandez, MBA, FACHE, is the CEO and founder of ABISA, a consultancy specializing in strategic healthcare initiatives for physician practices. His firm helps devise and implement strategies that will allow practices to remain competitive and solvent.
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When my BPH symptoms became unbearable I really didn’t want to undergo invasive surgery and I’m not a personal fan of BPH medications. Relief can be inadequate and temporary and they have a whole host of side effects.1

Peter J. Walter, M.D., F.A.C.S. Western New York Urology Associates and UROLIFT® SYSTEM PATIENT

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Countless physician groups are grappling with how best to introduce and leverage genomics in their practices.

With good reason. Precision medicine appears to be an unstoppable force that could revolutionize how physicians diagnose and treat patients.

The science of genomics has advanced at a rapid pace, and new discoveries about how these insights impact clinical decision-making are circulated almost weekly. Consumer demand is rising, thanks to regulatory approval for direct-to-consumer genetic testing and resulting media coverage.

In my own practice, more and more patients come to office visits with questions about how genomics could help identify their risk for disease, how this data could guide wellness, prevention and screening activities, and if we should adjust medications and other therapies based on their genomic profile.

So, how do you get started?

A BUSINESS CASE FOR PRECISION MEDICINE

The most critical step is understanding what value precision medicine brings to your practice, and where it can have greatest impact from both a clinical and business perspective.
Consider how genomics can improve patient care:

- When sharing family history during her initial visit, 34-year-old Emily reported incidents of breast cancer, colon cancer, high blood pressure and clinical depression within the past two generations. Genomic testing can help her physician identify which diseases pose a genuine risk for Emily – driving subsequent wellness activities and preventive care,

- An avid bicyclist, Carlos recently suffered multiple fractures to his left wrist after a fall. Pharmacogenomics (PGx) testing would enable his provider to identify pain killers that Carlos metabolizes well, avoiding trial-and-error prescription and dosing delays while accelerating physical therapy and rehabilitation.

6 steps to precision medicine

- Understand your patient population. Who can benefit most from genomic testing? Do you have a large number of polypharmacy patients? Individuals approaching the age where risk for certain conditions rises (coronary artery disease, cancer)? This information will help you understand if pharmacogenomics (how individual patients respond to specific medications) would deliver value, or if cancer genomics or germline testing for hereditable diseases is more appropriate (or both).

- Evaluate where specific populations fit into various payer contracts you have in place. Are most covered in traditional fee-for-service agreements, or are many included in ACO or shared savings plans? Consider not only if you can deliver ROI for the patient (lower personal costs, better care) but for the practice as well. Could precision medicine afford you the opportunity to take on more risk, because you can leverage genomics to better identify patients more likely to develop disease, intervene earlier and target therapies more effectively?

- Use the analysis generated by steps one and two to negotiate aggressively with payers.

Determine which populations you believe you can impact with precision medicine and work towards contracts that increase your revenue for effectively managing the patient population while reducing payer costs.

- Educate physicians and medical staff about precision medicine and about your strategy to integrate it as the standard of care for specific patient populations. Ensure they understand the clinical value, as well as the business value, that genomics can deliver. In addition, develop educational materials for your patients, to help them understand how they can benefit from precision medicine and what to expect from their caregiver.

- Begin your precision medicine program with the patients who were identified in step one as those where the greatest benefit can be realized. Integrate genomics testing with diagnostic and therapeutic care incrementally, so you can realize success before expanding into other patient groups.

- Take the time to evaluate and assess technologies and solutions that can bring genomics data directly into the EHR workflow, allowing providers to use it in real-time clinical decision-making (e.g., should I prescribe antidepressant A or antidepressant B?). Typically, genomics results are reported on paper or scanned PDFs that cannot be clinically integrated within the patient context. And, all too often, test results have not been translated into clinical vocabulary that is meaningful and actionable for providers. New platforms are emerging that bridge the gap between the science of genomics and making the data useful at the point of care.

Industry thought leaders agree that genomics holds great potential to transform healthcare – from prevention to diagnosis to treatment. Patients are often ahead of their providers in understanding how genomics can help them stay healthier – and in highly competitive healthcare markets, providers cannot afford to be late adopters. By thinking strategically and equipping providers with critical support tools, practices can leverage the promise of precision medicine to improve current clinical practice – and begin to reap the benefits of better care and outcomes.

MedicalEconomics.com
The medical benefits in both these examples are obvious. Emily’s physician can relieve her worries by learning which genetic variants she has inherited—and which she has not. Rather than conducting unnecessary or early screening for conditions for which she may not be at elevated risk, her physician reduces unnecessary costs and the possibility of associated side effects or complications.

Likewise, if his physician discovers the most effective drug immediately, Carlos has a shorter length of stay (if hospitalized) and fewer follow-up visits for medication adjustments. Plus, he feels less pain, heals faster and gets back to a higher quality of life sooner.

The net-net: lower cost of care and

Can precision medicine combat burnout?

by Joel Diamond, MD, FAAFP

I have been contemplating the concept of “empowerment” recently—a term bandied about as an antidote to physician burnout. I’ve found that, much like the timeless adage about weather, lots of people are talking about it…but no one is actually doing anything about it.

With one major exception: A growing number of organizations are adopting tools to bring the advances of genomic science into the physicians’ workflow. Providers fortunate enough to have access to this information tell me it makes practicing medicine fun again and helps them feel more “doctor-y.”

That sounds like a compelling cure for burnout to me.

How are genetics and genomics empowering? Briefly put, insights from molecular testing:

- give providers a focused view of individual patients’ heritable risk factors,
- facilitate highly accurate diagnoses,
- reveal how well the patient may or may not metabolize specific medications, and
- identify targeted therapies to deliver the safest, most effective results.

Knowledge is power

Precision medicine is a game changer for physicians—in large part because it gives them much more information to leverage when making critical care decisions. That’s key because, as we’ve all been told, knowledge is power.”

Here are several examples:

Consider 30-year-old Sara, who reports a significant familial history of breast, ovarian and colon cancer. Sara’s physician can order a molecular lab test to determine whether she exhibits genetic variations elevating her risk for one, any, or all of these diseases. If so, the physician and a genetics counselor can begin appropriate and aggressive screening and prevention. If not, Sara’s physician can alleviate her anxiety—and avoid putting her through early and frequent diagnostic studies (which also increase the lifetime cost of keeping her healthy).

Dr. Green, a psychiatrist, has treated Kevin for 14 months for depression. Green has tried several therapies, escalating dosages of each when Kevin didn’t respond. Finally, Green orders a pharmacogenomics panel to gain insight into which medications Kevin metabolizes well and which might cause undesirable
better outcomes faster. This translates not only into happy patients and higher satisfaction ratings, but also improved quality scores and a healthy bottom line for practices participating in accountable care organizations and shared savings programs. According to independent healthcare consultant Bryon Cipriani, one study of 1,000 subjects has shown that practices can save $1,100-1,600 per patient per year when genomic testing is done.

THE REIMBURSEMENT LANDSCAPE

Unless a practice has its own genetic testing lab, it will not bear the cost of processing and analyzing genomic tests physicians order. But even if they outsource side effects. With test results in hand, Green quickly can understand why previous drugs were ineffective and prescribe therapy that has a nearly immediate positive impact. Imagine how many months of frustration, office visits and trips to the pharmacy were wasted when pharmacogenomics testing could have enabled Green to arrive at the best drug and dosage as the first line of therapy?

Likewise, consider 4-year-old Carlos, who develops a seizure disorder. A genomics test helps the specialist precisely diagnose the cause and immediately begin the appropriate therapy. This prevents or greatly reduces ongoing seizure activity, developmental complications and undesirable side effects from trial-and-error treatments.

It also reduces the likelihood of costly hospitalizations and readmissions. These tests, if integrated within the clinical record, represent valuable information all of Carlos’s clinicians will need to consider as they make future diagnostic and therapeutic decisions.

Remove barriers to point-of-care genomics

It’s clear why this knowledge represents power in the physician’s hands. And therein lies the challenge: making sure it lands in their hands. It’s critical to ensure this vital information is readily and conveniently available to clinicians within their workflow.

Genetic and genomic testing is already being done in many healthcare organizations; some even have established their own molecular labs. Unfortunately, results are not saved as discrete data, nor are they integrated with the wider clinical record. To factor these insights into their clinical decision making, providers must:

- be aware that molecular tests have been ordered, received and saved (typically as a PDF) somewhere in the organization’s IT ecosystem
- understand how and where to find the results
- exit their workflow and open a lengthy scanned document (often dozens of pages)
- sort through the full lab report (typically not translated into familiar clinical terminology)
- synch what they are reading in the report with other information contained in the medical record
- decide how relevant the information is and add it to other considerations

For precision medicine to be truly empowering, healthcare organizations must overcome barriers to making the data meaningful to providers as they go about the day-to-day practice of medicine.

When embarking upon their precision medicine strategy, organizations need to consider the following:

- Who within their organization is already ordering genomic tests and from which labs?
- How are test results being received and stored within the organization’s IT system?
- Is the data easily available to all other clinicians across the enterprise? (Pharmacogenomic tests ordered by a psychiatrist, for example, are also valuable to a PCP, cardiologist, oncologist and others. Likewise, germline information about heritable disease risk and targeted therapies spans specialties.)
- Will providers—some of whom have had minimal training in genetics and genomics—be able to understand and make use of test results? How can they achieve a specified level of proficiency?
- As the volume of genetic and genomic data grows—as it surely will—how will the organization manage it?
- How will individual providers be able to keep up with the rapidly advancing field of genomic science and bring new discoveries to bear with previously diagnosed patients and as new conditions manifest?

Precision medicine is rapidly becoming recognized as the new standard of care. The potential for improving quality and safety of care—as well as patient loyalty—is tremendous. And because it empowers providers with new information and robust clinical decision support, it promises to enhance satisfaction as well.
genetic tests, most organizations are acutely aware of coverage because, if external labs are not reimbursed, they pass the cost on to the practice's patients. Unfortunately, reimbursement policy lags clinical practice when it comes to precision medicine - and payment varies wildly from state to state and test to test. Medicare coverage is advancing most rapidly, Cipriani says, with 80 percent of carriers covering specific pharmacogenomics testing such as behavioral health and pain panels (if appropriate ICD-10 codes are reported, supported by required documentation.) Likewise, genomics tests may be reimbursed to identify disease risk and hereditable conditions (e.g., BRCA 1

Financial implications for practices

Limiting the risks of ‘Failure to Treat’ and marginally effective treatments

Today, most physicians practice trial-and-error medicine. They evaluate symptoms, arrive at a diagnosis and proceed with the most likely or common treatment.

A prime example occurs in patients diagnosed with anxiety or depression. How often do we select an antidepressant, try it for a few weeks with little effect, increase the dose for another few weeks and, if that fails to produce the desired outcome, start the process all over again? Relief for the patient could take months, during which time resources are being consumed in the form of prescription costs, office visits and wasted time.

But a pharmacogenomics test can cost as little as $200, and the results can be made available within the clinical workflow. Those results could equip physicians with the information required to select the best medication for the individual patient, the first time around.

Using innovative or costly therapies wisely

Determining the best treatment for patients is tricky, but insight into genomic markers enables physicians to know when a novel therapy might be the best choice. Consider evolocumab (Repatha). It is costly but highly effective for patients with familial hypercholesteremia (FH), a genetic condition that drives up LDL cholesterol levels regardless of lifestyle. If patients undergo genomic testing to identify whether they carry this variant, practices could stratify their population to determine risk. Physicians could then appropriately prescribe evolocumab without wasting time on other treatments or prior authorization because they have scientific proof the drug is appropriate.

Finding greater success with ACOs and other risk-sharing models

The formula for value-based success aligns with the objectives of precision medicine: treating patients effectively, faster and without unnecessary cost. Genomic testing arms physicians with an unprecedented level of insight into a patient’s condition so they can determine the best individualized care plan - and sooner.

Let’s look at the patient with high LDL. Without genomic testing revealing the genetic variant for FH, physicians would follow a standard course of treatment: prescribing a statin. When the first medication does not work, physicians would work their way down the list of typical drugs. Costs mount, outcomes remain poor and the practice fails to meet quality measures for treatment of high cholesterol. A simple genomic test, on the other hand, would allow physicians to easily diagnose FH and deliver successful care sooner.

What the lack of knowledge can cost

Precision medicine and genomics are complex disciplines, and front-line physicians may understandably struggle with the learning curve. Which patients should we refer for genomic testing or counseling? And, of the vast array of genomic tests (carrying vastly different price tags) available through a plethora of molecular labs, which are the best tests to order for the patient sitting in the exam room?

Education and training are, of course, important components to helping physicians become comfortable with these new and exciting approaches to care. It is equally vital that practices seek point-of-care tools to guide physicians. Key considerations include the ability to gather a highly detailed family history.
and 2 or familial hypercholesterolemia). Medicaid plans also often provide coverage for specific tests, and may offer the best reimbursement, especially in areas where opioid addiction and behavioral health challenges are acute.

Commercial plans are less predictable, Cipriani adds. Some payers offer a flat fee, often a few hundred dollars, while others reimburse testing on a case-by-case basis—with payments for the same diagnostic codes ranging from just a few dollars to thousands. The advent and spread of Molecular Diagnostic Services (MolDX) is stabilizing payment in certain areas, although almost always at lower rates than what might have previously been paid.

Consumer-driven demand
Last but not least, practices must consider consumer demand. The general population is acutely aware of the potential of genomic information. Many patients are already trying direct-to-consumer (DTC) tests and challenging their physicians to incorporate those results into care plans. Practices must respond quickly to retain patients and remain competitive.

Practice leaders must likewise figure out how to handle the downstream effects of genomic demand: Patients might request additional tests, both necessary and unnecessary, based on their self test results. So it would be wise for practices to implement new policies and procedures to handle DTC tests and address the consumer movement.

Many variables factor into the financial implications of precision medicine and genomics. The ROI picture is not clear yet, although all indications point toward positive impacts on quality of care, patient satisfaction and the bottom line.

"Many variables factor into the financial implications of precision medicine and genomics. The ROI picture is not clear yet, although all indications point toward positive impacts on quality of care, patient satisfaction and the bottom line."

Financial implications for practices
Precision medicine is still in its early stages, but it already has the power to disrupt your practice. Here are five considerations for when and how to add genomics and precision medicine.

When healthcare leaders talk about the financial implications of care models like precision medicine, their thoughts often focus on the return on investment (ROI). How much will it cost to take this case to the precision medicine level? What are the potential downsides? What could it add to our bottom line?

Physicians who adopt precision medicine early should note: It’s often difficult to prove the ROI of new modalities immediately. Early adopters must consider the broader financial implications and factor qualitative value into the overall equation, especially as precision medicine evolves. Most physicians recognize the inherent benefits of diagnosing and treating patients more precisely, but it will take time to generate the necessary body of data to demonstrate the positive return for adding precision medicine to the mix.

Joel Diamond, MD, FAAFP is an adjunct associate professor of biomedical informatics at the University of Pittsburgh and chief medical officer for 2bPrecise, a business segment of Allscripts that helps providers leverage the value of genomic data at the point of care.
The relationship between a physician and patient can be deep and fulfilling, but sometimes it can turn sour quickly.

The years-long relationship between Ada D. Stewart, MD, a family physician with Cooperative Health in Columbia, South Carolina, and the incoming president of the American Academy of Family Physicians, her patient slipped into this category due to a denied request.

Stewart is and the incoming president of the American Academy of Family Physicians. The patient had been receiving prescriptions for chronic pain medications from Stewart and had been doing well with her pain management contract, but when the patient wanted something that would help her sleep, that fell apart.

The patient was seeking Lorazepam, a benzodiazepine that she had taken years before, but new guidelines discouraged prescribing with opioids due to the increase in the risk of death. When Stewart denied the patient’s request, the situation grew tense.

Stewart says the woman insisted this drug was the only thing that could help her and that she couldn’t take any other drugs. When Stewart held her ground on the issue, the woman accused the doctor of not caring.

“So, I had to kind of get myself together, because number one is as a physician, and one who has established a relationship with her over the years and knowing that I care, my first reaction was, how can you say that?” Stewart says. “You know, I definitely care. So, it was hurtful for me.”

EMPATHY
Most physicians who are in primary care have patients they find more challenging than others for a variety of reasons, according to Dennis L. Gingrich, MD, a Penn State College of Medicine professor with 40 years of clinical experience.

“Some [reasons are] unrelated to the patient’s interaction or personality and simply related to the complexity of their illnesses,” he says “But sometimes you can get that sinking feeling if you look at a patient coming up on the list and think...
either, ‘this is going to take a long time’ or ‘it’s likely to be a challenging conversation’ or ‘I may not be able to meet this patient needs today, based on past experience.”

In addition to these kinds of patients, some patients become rude, belligerent, or even violent. Gingrich says that situations with these patients can be a result of anything from them just having a bad day to almost psychopathic behavior. When dealing with these patients, he says three things need to be assessed: the situation, the patient, and the physician’s actions.

This is what Stewart did when dealing with her patient. Rather than express her immediate, internal reaction, Stewart calmed herself down and considered the patient’s mindset. She then explained the situation in a way so that the patient understood she was denying the drug in order to avoid possible deadly interactions.

“You have to kind of sit back and look at the patient and be empathetic to their particular issues and give them a balanced way,” she says. “Yes, recognizing their thoughts, but still making sure that you explain to them what’s actually going on and why you’re doing what you’re doing.”

Gingrich says that the alternative, getting angry at your patient and expressing it, almost never works, but often finding the cause of the patient’s frustration and doing what you can to try to alleviate the situation.

“If [the patient’s problem is] something like an office practice or a personal manner in which you work with patients, it might be something that can be adapted to this particular patient and there may be a flexible solution,” he says.

Another aspect is to communicate to the patient that they are a partner in solving the problem. Gingrich says that he tries to personalize communication with his patients by using their name, making eye contact, and using a measured, reassuring, calm voice. He says this usually calms the interaction.

“Angry patients [use] a lot of energy trying to maintain that anger and if you don’t...”

“The two things that are most commonly involved would be psychological illness such as personality disorder, or alcohol or drug overuse. Both of those situations will cause patients to blur behavioral boundaries.”

—DENNIS L. GINGRICH, MD, PROFESSOR, PENN STATE COLLEGE OF MEDICINE
feed the fire by getting angry back, it generally dissipates,” he says.

A SAFETY PLAN
But it’s still important to read the patient’s mood and other visual cues to ensure that the anger really has dissipated. If they’re not calming down, or if they are getting more belligerent and possibly even violent, then you need to try and focus on what is causing this increase in aggression, Gingrich says.

“The two things that are most commonly involved from a patient’s perspective would be psychological illness such as personality disorder, or alcohol or drug overuse,” he says. “Both of those situations will cause patients to blur behavioral boundaries. And that’s something that if you’re the primary care physician, such

Practical tips for dismissing a patient the correct way

The following strategies can help protect physicians from liability and accusations of patient abandonment:

**Provide written notice**
The physician should issue a written termination letter to the patient prior to the effective date of termination. The letter should clearly state a termination date (we suggest 30 days in advance) and the reason for termination.

**Include a list of suitable alternative providers**
We suggest that the letter also contain a list of alternative health-care providers in the area and if appropriate, referral to the patient’s insurance network.

In addition, physicians can provide the patient with contact information from the local and state medical societies, which can be resources for finding a provider that fits their needs.

**Time the termination properly**
Avoid withdrawing from treating the patient when the patient is in medical crisis, unless the patient requires the services of a different specialist and arrangements are made for transferring the patient’s care to such specialist.

Continue providing effective treatment during the intermediate period following issuance of the termination letter and prior to the effective date of termination. Advise your office staff members that the patient is still welcome to schedule an office visit and/or arrange for services before the effective date of termination.

**Examine managed care contracts and communicate with health plans**
If you are a participating provider in a managed care network in which the patient is covered, review the managed care agreement for specifications concerning termination of the physician-patient relationship. Some managed care contracts contain language requiring suitable justification for termination as well as specific notice requirements.

The best strategy is to contact the payer, explain the situation, and ensure everything is done properly per the contract to prevent problems later.

**Provide access to medical records**
Offer to send a copy of the discharged patient’s medical records to the patient’s new doctor. Numerous states have laws which require that records not be withheld solely because of a patient’s inability or refusal to pay.

**Communicate with everyone else in the practice**
Be sure to apprise all physicians and office staff members of the termination to avoid inadvertent re-establishment of the physician-patient relationship.

For example, a receptionist or appointment scheduler who is unaware that a patient has been issued a withdrawal letter might schedule a new appointment for that patient following the termination date. In some jurisdictions, this has been construed as renewing the physician-patient relationship, regardless of whether such a result was intended.

Finally, the treating physician should always be the one who makes the determination to terminate the physician-patient relationship rather than another staff member. By remaining personally involved, the physician can ensure that all of the above concerns are addressed appropriately.

Eve Green Koopersmith, JD, is a partner, and Samantha N. Tomey, JD, is an associate with Garfunkel Wild, PC, in Great Neck, New York.
as a family physician, that you would need to address medically anyway over the longer term.”

In extreme cases of dealing with a belligerent patient, a physician may need a safety plan not only for themselves, but for their staff and other patients as well.

“It can get scary,” Stewart says. “And there’ve been episodes within hospitals where physicians and nurses have been harmed and you have to recognize that is a real problem now.”

Stewart says that her first concern in those situations is to ensure that the patient is not between her and the door of the examination room. But still she tries to calm the patient down. If that fails, she’ll excuse herself from the room and contact the proper authorities.

If a physician works in a health system that provides security, they can be contacted for help, but local law enforcement is often amenable to offering security services in extreme cases when safety is a concern, Gingrich says.

The police or security have also been known to give preemptive protection in cases where violence is expected, he says. “That’s very rare, but it does occur occasionally.”

**DISCHARGING A PATIENT**

But once out of that situation, if a physician doesn’t feel safe caring for a patient or simply can no longer provide care, that patient must be discharged from the practice.

The first step is to explain to the patient what is and what is not an acceptable behavior in the practice and clearly define the consequences of unacceptable behavior and what will lead to a discharge from the practice, Gingrich says.

“That needs to be done usually in person with the patients and asking them if there are any questions and documenting that conversation in the record,” he says.

If they must be discharged, there are a number of rules that must be followed. First, they must be notified in writing, through a certified letter with a return signature, that they are being discharged and why.

“The statement should not say ‘we’re discharging you from the practice because you’re a miserable person;’ it should say something more like, we are sorry that we do not seem to be able to consistently meet your needs and still maintain our practice clinical rules,” Gingrich says.

“‘It can get scary. Physicians and nurses have been harmed and you have to recognize that is a real problem now.’”

—ADA D. STEWART, MD, COOPERATIVE HEALTH, COLUMBIA, S.C.

Then the patient should be given time to find another clinician who will assume their care, usually about 30 days. At the same time, the front-office staff should also be made aware of the discharge, so that if the patient calls seeking an appointment after the 30 days, they are not scheduled for one, Gingrich says.

If a physician works in a larger health system, they should check with the system to see if the patient’s discharge from the practice means the patient is discharged from the whole system, says Gingrich.

At Stewart’s health system, if a patient is being discharged from one physician, they will try to place them with another physician within the system. They also give the discharged patient a 30-day supply of whatever prescriptions they are on and offer to send the patient’s medical records to another physician free of charge.

“We’re not abandoning them and not just dumping them out without any follow up or without care,” she says.

Gingrich says that the key to these interactions, whether it is simply an uncomfortable interaction or a situation where a patient needs to be discharged, is just to be empathetic.

“Challenging patient situations are difficult for all physicians to deal with because we are trained to provide the best care possible for every patient,” he says. “And it’s difficult if there’s a barrier to doing it. I think it’s important for us all to know that utilizing empathetic, patient-centered communication skills and approaching these situations thoughtfully will, in general, provide the best overall patient care for our practices.”
Opening an independent practice

While more physicians are becoming employees, others who crave autonomy are going out on their own. Here’s how to succeed.

by CHRIS MAZZOLINI Editorial Director

Physicians crave autonomy. They are independent thinkers who wants to use their expertise to treat their patients the best way they know how, but this disposition often comes into conflict with today’s healthcare system, which favors large hospitals and corporations. The number of independent practices is dwindling.

But every year there are physicians who decide to work for themselves.

That’s exactly what James Underberg, MD, did. Underberg opened a concierge practice in 2009. But there is no roadmap for physicians like Underberg, so we sat down to discuss the benefits and challenges of opening a new practice.

Q: Medical Economics: Why did you decide to go out on your own to open a practice?

Underberg: I had been in a large multi-specialty group practice for many years, and that was the only type of practice I know. Our practice was being acquired by an even larger practice, and that was the only type of practice I know. We made the decision at that time that it wasn’t right for me. Everyone has different goals, desires and different ways that they see themselves in practice. And for me, I wanted more control over the way I did things. I explored a lot of different options and decided what made the most sense for me was to actually go in the opposite direction and open up my own independent practice. And much to everyone’s suggestion that it couldn’t be done, it can be done. It’s not simple. It’s not easy. Many physicians don’t like being their own boss anymore, although that was something and it was a reason a lot of people used to go into medical practice many years ago.

But there are lots of people available to help you in this process. And so, all you need to do is find the right people, get the right suggestions, research things very carefully. Spend some time learning and understanding it can be done. And nothing is simple, nothing is easy, but oftentimes taking control back and being more independent and the way you see and manage your own practice leads to more professional satisfaction if that’s what you’re looking for. And so I tell people don’t think that there’s only one way of doing things, because there are options. And you need to imagine them before they happen.

Q: ME: What are some of the major challenges that you experienced? And how did you go about solving them?

Underberg: I think the first and most important thing is making sure you explain to your patients what you’re doing. And so if you’re leaving a large group practice, you want to make sure that there’s a way you can communicate to your patients that you’re leaving. Often there are legal issues around that depending on what the structure is of the group you’re participating with, or a member of or a partner of and how you’re leaving. But, ultimately, the one thing you do have to remember is that patients can do whatever they like. If you do leave, patients often find you and if they have a good relationship with you, they will seek you out.

That’s the one thing I remind people is that it’s all about the relationships you have with your patients. That’s the strongest thing that ultimately leads to the development of independent practice. The next is that once you are an independent practice,
And so, I think it’s important to define those concerns and issues early and make sure that you’ve worked through all the kinks before you make the move.

Q: ME: You obviously learned a lot opening your new practice. Is there one thing you wish you knew then that you know now?

Underberg: I might start the process earlier. I think interacting with experts who have helped physicians do this is a key and important part of this process. And there are lots of people available who can help guide you and who have gotten through the process before, and connecting with them long before you actually think making the move is going to happen is probably the most important part of this process.

Underberg: For my transition, it was fairly easy for most of the patients to follow me. They had seen me for many years, and I was encouraged by how many wanted to continue to see me in my new practice. I think one of the most important parts of this process is to make that transition simple and easy for the patients. They should be able to reach your office. There should be lots of different ways to contact you. Your office should be very helpful in making sure that records can be transferred, and you want to make sure that you have a good transition and relationship with the practice you’re leaving, so that transfer of records is simple and easy for patients who want to make the move.

Ultimately, it all comes down to ease of communication. And if that process is simple for the patients, it’s very easy to make the transition. If the patients perceive barriers, whether it’s communicating with you, or getting records transferred, having things proceed as smoothly as they had in your old practice, then they might not come.

And so, I think it’s important to define those concerns and issues early and make sure that you’ve worked through all the kinks before you make the move.

Q: ME: You obviously learned a lot opening your new practice. Is there one thing you wish you knew then that you know now?

Underberg: I might start the process earlier. I think interacting with experts who have helped physicians do this is a key and important part of this process. And there are lots of people available who can help guide you and who have gotten through the process before, and connecting with them long before you actually think making the move is going to happen is probably the most important part of this process.

Underberg: For my transition, it was fairly easy for most of the patients to follow me. They had seen me for many years, and I was encouraged by how many wanted to continue to see me in my new practice. I think one of the most important parts of this process is to make that transition simple and easy for the patients. They should be able to reach your office. There should be lots of different ways to contact you. Your office should be very helpful in making sure that records can be transferred, and you want to make sure that you have a good transition and relationship with the practice you’re leaving, so that transfer of records is simple and easy for patients who want to make the move.

Ultimately, it all comes down to ease of communication. And if that process is simple for the patients, it’s very easy to make the transition. If the patients perceive barriers, whether it’s communicating with you, or getting records transferred, having things proceed as smoothly as they had in your old practice, then they might not come.
thing that I would have done differently. I waited, partially because I wasn’t sure what I was going to do. And then once I left, things took a little longer to be set in place. The other thing someone told me, which I thought was very wise, was that once you make the move, realize that it takes almost a year to have everything working the way you want it to.

So take a deep breath and realize that nothing is perfect right off the bat. You’re just going to have to live with that in the beginning, because you’ve been somewhere else where things are working relatively smoothly for a long time. Knowing and understanding that I think helps you get through those rough spots in the beginning because there’s always going to be something—the phone doesn’t get connected the way you thought it was, the electronic records don’t transfer over the way you would like to, or the internet isn’t working properly, the EHR doesn’t work properly. And so, you just have to give it time.

Q: ME: For the physician that’s watching this that’s thinking about opening their own practice, what advice do you have for them?

Underberg: If a physician was thinking of making a move from a large practice to solo or independent practice, the first thing I would advise them to do is to find or seek out someone else who has already done it, and talk to them in detail about all of the things that they thought went smoothly, and all the things they thought maybe didn’t go so smoothly and what their options were. I think the more people you talk to, the more you learn about the best way to make it happen. All that said and done, be flexible, because things don’t always work out the way you think they will. Perfect example is I chose an EHR system. And several weeks in realized it wasn’t right for me and stopped and moved to another one rather than continuing with one that I realized wasn’t right for me. So again, understanding that you may make a mistake, and it’s OK to backtrack, is another key and important factor.

Q: ME: In recent years, there’s been a huge growth convenient care clinics where patients can go and get treated for minor issues. What impact you think these convenient care clinics has had on the competitive landscape for practices?

Underberg: I think the emergence of urgent care facilities has benefits and also has some problems. For people who have an immediate urgent issue in an evening or weekend time, not having to sit in an emergency room for hours, I think is a good thing. My concern is that many people are starting to use urgent care facilities for their ongoing preventive or primary care. And there’s a lack of continuity if they go from one facility to another or see different providers all the time. I do think that it’s a tool that can be used wisely by patients; I think we can leverage urgent care to make patients’ immediate concerns more easily addressable. But I think it shouldn’t replace the ongoing role between a primary care physician and a patient with regards to their ongoing preventive medicine. My experience with patients who visit urgent care facilities is that they have to be very proactive in making sure records from that visit are forwarded to us. More often than not, we either need to spend time on our own getting those records or asking the patients to make sure they’re sent to us after the fact. Patients often are good about telling us they were at an urgent care facility. But making sure we get those records and a copy of what happened or the testing that was done is not always forthcoming. And so being proactive in that role, I think is key and important.
Doctors have long known that patients’ expectations have a significant impact on the effectiveness of treatments prescribed for them. But much less is known about the effect of providers’ expectations for those treatments.

Researchers at Dartmouth College recently devised an intriguing experiment to begin investigating these questions. They simulated clinical interactions in which “providers” (actually undergraduate students) administered what they’d been told were two different kinds of creams—one supposedly with analgesic properties, and one without—to “patients” (also students) who’d been subjected to mild thermal pain.

In reality, and unknown to the providers or patients, the creams were identical. The goal was to see how the doctors’ expectations of the effectiveness of both kinds of creams affected the level of pain relief patients experienced, and how those expectations were transmitted between doctor and patient.

Results of the study were published in 2019 in *Nature Human Behaviour*. Senior author Luke J. Chang, Ph.D., assistant professor of psychological and brain sciences at Dartmouth, spoke recently with *Medical Economics* about the study and what its results mean for primary care doctors.

**Q:** Medical Economics: What was the purpose of your study?

**Luke Chang:** We’ve known for a long time that expectations matter in treatment effects. And to-date, most of the studies have been on the patient side, about how their beliefs influence their own outcomes. But we’ve known that the doctors’ expectations also really matter. And so basically we were interested in trying to figure out how strong these effects were. And there hadn’t really been any studies that have tried to causally manipulate doctors’ expectations.

**Q:** ME: Describe the methods you used.

**LC:** We randomly assigned participants to play the role of “doctor” or “patient.” Some of the participants were students at the...
“Importantly, the patients perceived the doctors to be more empathetic when the doctors believed the treatment to be true.”

Chronic Conditions

Treatment outcomes

college who were getting research credit and some were just people around town, and they got paid.

Then we explained to the doctors that we were interested in studying simulated clinical interactions, and that they’d be administering a treatment to the patients. We showed them what looked like a real sort of medical-grade cream that we called Thermedol and it came out of tubes. And then we showed them another cream that came out of like a Vaseline jar, and we mixed it with food colorings so they could tell which was which.

We administered both of the creams to the doctors, and then we applied thermal heat pain to the doctor’s arm on top of each of the creams, and when we applied the heat to the Thermedol, we lowered the temperature, which made it seem like the treatment was working from their perspective.

Then, after we’d manipulated their beliefs, we had them administer the creams to the patient. So they had to introduce themselves and then explain what the study was about with the treatment, and how the treatment works. Then they applied the creams and administered the thermal stimulation to the patient. But the key part was they couldn’t tell the patient which treatment was which.

The temperature was, on average, 47 degrees Celsius, which is about 112 degrees Fahrenheit. It feels basically like if you pour hot coffee on yourself. So it would turn your skin red afterwards but it wouldn’t blister or actually leave any permanent damage.

And we found that when the doctors believed that they were giving the real treatment, the patient reported experiencing less pain. And we did a couple of different versions, but it seemed in all of them the patients reported somewhere between a 15 to 30 percent decrease in the amount of pain they were experiencing.

Now, one kind of problem in the pain world is that we don’t really have good ways to measure how much pain someone’s experiencing outside of just them self-reporting it. So we also tried to use a couple other objective measures of pain. One is just overall physiological arousal, and for that we measured skin conductance while they were receiving the pain and found that the patient had lower arousal levels when the doctors believed the treatment was real.

The other way is to try to see if there’s any evidence of their behavior changes based on the manipulation. And what we did for that is, while they were undergoing this procedure, both the doctor and the patient wore video cameras.

They were basically just GoPros that were placed on this thing we developed that mounts on their heads so that we can record their expressions but not disrupt their interactions. Then we used computer vision techniques that turned the video feeds into predictions for which facial muscles were being expressed.

And then we tried to figure out, is there any combination of facial expressions that predicted how much pain people felt? We did this by training the model on the doctors when they were receiving the pain. And basically it was if you showed more eyes widening and clenching of your jaw, Importantly, the patients perceived the doctors to be more empathetic when the doctors believed the treatment to be true.”
things like that, then that meant you were experiencing more pain.

And then we applied the model to the patients’ data while they were receiving the pain and found that the model thought that they were experiencing less pain when the doctors believed the treatment to be valid.

Q: ME: How did you explain the use of the cameras to the doctors and the patients?

LC: They were told that we were interested in studying how the dynamics of clinical interactions between people affected one another.

Q: ME: What was your reaction to the findings?

LC: It seemed like too good to be true in the beginning, how robust the findings were. But we did a bunch of different manipulations to rule out other hypotheses like habituation, or maybe it’s because of the cameras, or maybe because there was also an experimenter in the room to make sure that the pain was being delivered safely. All of it basically to make sure it was the doctors’ beliefs that were being transmitted.

Importantly, the patients perceived the doctors to be more empathetic when the doctors believed the treatment to be true. We don’t know exactly what they were doing differently. They could have been paying more attention to the patients, they could have been more caring, more eye contact, those are things we’re exploring more.

Q: ME: What is the main takeaway of your study for primary care doctors? How can they use what you found to improve outcomes in their patients and their connections with patients?

LC: There’s not a ton of research on this, at least that I’m aware of, and the research findings are intriguing, but not fully compelling. There was some work by David Rakel showing that for the common cold when patients perceive their primary care providers to be more empathic, they had a slightly lower duration in their cold and slight changes in their white blood cell counts and other biological indicators.

So I think what that tells me, along with our results, is that finding ways in which you can show compassion and being empathetic are probably going to help, although we haven’t actually done those manipulations yet to see if that’s the mechanism for how these beliefs are being transmitted.

And then I think in general—and this is a bit speculative—but trying to instill hope and things like that, which would be trying to maximize these expectancy effects, could also be ways to augment treatments.
Physician interest in supplementary work outside of the primary practice setting is nothing new. But the industry of medicine is becoming increasingly regulated and constrained. The widely lamented lack of physician autonomy in patient care is mirrored by a lack of physician autonomy in pursuing work alongside patient care.

It is important that practicing physicians understand restrictions regarding side work to avoid unexpected financial penalties—or even grounds for termination. The process of blending a patient care practice with supplementary work can be successful, but it requires strategic planning.

COMMUNICATION
Physicians who want to pursue side work while maintaining a clinical partnership or remaining employed in clinical practice need to understand the importance of creating an accurate account of the independent side project. Partners and employers may have questions, and providing them with well thought out answers can help facilitate effective communication.

Phil Boucher, MD, is a pediatrician in Lincoln, Neb., who practices at Lincoln Pediatric Group, a group of 11 physicians. Boucher creates the podcasts Parenting Matters and Private Practice Matters. He also runs a Facebook group for parents called Present and Productive Parents.

He discussed his plan with his partners so they would know what he was planning before he started. “I didn’t want them to be surprised or be caught off guard to see my information online,” Boucher says.

PRACTICE CONCERNS
One of the most important strategies for successfully blending patient care with side work involves careful consideration of the concerns of physician partners and employers. Clinical partners may have apprehensions about the possibility of taking time and attention away from shared responsibilities, such as on-call duties and last-minute patient needs.

As with any skill, knowing the priorities and personalities of colleagues and supervisors can help a physician home in on the specific issues that may present a conflict.

Peter Valenzuela, MD, MBA, is a family
physician in Santa Rosa, Calif. and the chief medical officer for Sutter Medical Group of the Redwoods. Valenzuela runs a side business creating comics about the healthcare industry, which he posts on social media and on his website (www.doc-related.com).

Valenzuela says that his practice has restrictions about what physicians can do outside the medical group. “I make comic strips, which do not directly compete with anything our health system provides,” he says.

Physician partners or employers may be worried about how side work could impact the values and reputation of the practice. Valenzuela points out that employers may be concerned that a physician’s side work could put the employer at risk. He says that, in his case, the question regarding whether his comics would paint a dark picture of how physicians are treated in the practice was raised. “I was able to successfully argue that my comics target what’s wrong with healthcare across the United States, not just in our neck of the woods,” he says.

PROFIT INCOME SHARING

Financial matters can be complex, and can vary with each practice setting. Nana Korsah, MD, is a primary care physician and owner of MD Worklife Balance, a financial coaching business for physicians. Korsah says that the contracts of some employed physicians state that the employer or practice group owns anything the physician does for profit.

On the same note, Valenzuela explains that his group requires physicians who have administrative side gigs, such as medical directorships outside of business hours, to pass funds through the medical group to be taxed.

NEGOTIATION

If a doctor is dedicated to pursuing a side project, a discussion—and possibly a new contract—can help work out the process out. A negotiation can be more successful if the physician explicitly addresses the concerns of the practice or employer.

Boucher suggests that doctors tackle employer concerns and work towards mutual benefit. “I see hospitals that worry that the physician’s brand will eclipse its own, but this has never actually been the case in practice. If the hospital promotes their own staff, then the outcome helps both the physician and the hospital to have more reach,” Boucher explains.

MEDICAL LIABILITY

Before starting any side project, a physician must consider liability issues. Typically, medical malpractice insurance coverage is specific to a defined professional setting and scope of practice. Additional patient care or other work that is not clearly mentioned in a contract may not be covered.

Doctors who take on patient care outside their primary practice setting must ensure that all patient care is covered by a malpractice insurance policy.

But that doesn’t necessarily mean the physician has to purchase an additional medical malpractice policy. Boucher, who provides information to parents through his podcasts, took steps to ensure that his online presence wouldn’t put him at legal liability for topics discussed.

Projects such as writing or editing health content for a professional website or blog may include disclaimers or built-in liability coverage that protects all team members who work for the publication.

Some types of side projects—such as product promotion—may incur a risk of litigation. The manufacturer of the product may be fully responsible for the effects of the product but it is important for a physician to define liability and legal responsibilities rather than make assumptions.

CUTTING TIES

Physicians who have professional interests outside the primary practice setting can usually achieve a balance. But when a compromise can’t be reached, a physician may be faced with a difficult career choice—a choice that depends on long term professional goals and priorities.

Disputes over intellectual property rights may be an area where neither party is willing to compromise. “We actually had a physician leave our group because he wanted to patent a device, but his agreement would not grant him intellectual property rights,” Valenzuela says.

The key to having a successful side project as a practicing physician lies in good planning before getting started. “Go slowly and look at it is a long game that requires patience, time, and financial risk. Don’t do anything that could jeopardize your license, your current gig, or that makes you look sleazy or sales-y in the eyes of your colleagues or patients,” Boucher says.

— PHIL BOUCHER, MD, LINCOLN, NEB.
Always running late? This simple tip can help

In my previous practice, I routinely ran an hour or more behind schedule. It seemed like no matter how carefully I tried to schedule patients and manage my time, I would inevitably find myself falling behind.

Running late was a huge source of stress and anxiety for me. In my rush to move on to the next patient, I would often delay finishing my notes until the end of the day, at which time I would be faced with an hour or more of charting, which created even more discontent.

The reasons for running late were legion—sick patients being crowbarred into the schedule, people showing up for their appointment late, technology problems slowing down the system. But more often, the reason I ran behind was because patients just seemed to need a little more time than my schedule allowed.

This could be because a patient had multiple concerns, was recently diagnosed with a very serious disease, or because they needed longer to explain their medical history. Sometimes it was because the patient was lonely and wanted to chat. Occasionally, it was my own fault when I allowed small talk to devolve into a discussion.

As I discussed my dilemma of always running late with psychologist Steven Cohen, he suggested something that I had never considered: “Try starting your visit by telling your patient how much time you have scheduled for them.”

Cohen pointed out that most patients have no idea how much time they have scheduled with the doctor, which makes it harder for them to manage their time in the exam room. By telling the patient upfront how much time they have, the patient is now empowered to control the narrative. They are better able to prioritize their concerns.

Telling a patient how much time you have scheduled for them may seem strange or even a bit rude at first. But if done with empathy, most patients are happy to have this additional insight.

**HOW TO TELL PATIENTS**

After entering the exam room and greeting the patient, smile and say warmly, “We have fifteen minutes together, and I’m really looking forward to hearing about how you are doing.”

Simply stating the amount of time you have scheduled for them may seem strange or even a bit rude at first. But if done with empathy, most patients are happy to have this additional insight.

This technique works particularly well with patients who are very talkative and helps them to minimize tangents or small talk.

It is useful to keep a clock in sight of both the doctor and patient, since not everyone is good at self-assessing time. By displaying a clock, patients are better able to manage their visit time, presenting important info early in the visit and winding up their concerns as the end of the visit approaches.

You may need to update the patient with the amount of time remaining. “We have about five minutes left. Is there anything important we haven’t covered yet?”

At the end of the visit, say, “I really want to hear more about your other symptoms, but unfortunately, we are out of time for today. Let’s schedule another appointment so that we can give your concerns the time they deserve.”

The key is that patients know that they will be able to pick up the dialogue at the next visit—which is sure to be on time.

As physicians, we need to accept that we simply can’t accomplish everything in one visit. Primary care is about building relationships and developing long-term strategies for health over time—and it’s good for patients, with studies showing that continuity of care reduces mortality.

We must remind patients that just because today’s visit is up doesn’t mean their care is over. There is always next time to continue the discussion.

Rebekah Bernard MD is a family physician in Fort Myers, Florida and the co-author of Physician Wellness: The Rock Star Doctor’s Guide.
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Coronavirus practice survival guide

The ongoing outbreak of the COVID-19 virus is going to test and strain the entire economy—including physician practices. This package of articles will discuss how physicians can take on these challenges, including: building a financial action plan to weather a downturn in revenue; how to mobilize virtual care capabilities, including telemedicine, patient portals and secure texting; and dealing with staffing challenges, infection control and safety, patient flow and scheduling concerns, and crisis leadership tips.

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