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## ReMARKS

# Physician Centered; Patient Focused

By designing the practice around the physician's needs, you can focus on the patient.

BY ROBERT F. PRIDDY AND T. ROBERT MESTAS, MD [Published May/June 2006](#)

The idea of a physician-centered practice is stirring a lot of controversy. Many physicians are embracing this practice development method that places physicians squarely at the center of the medical practice. However others, mostly non-physicians, see this as flying in the face of so-called "patient-centered" care. After all, the sales pitch from managed care plans and health systems is rooted in their "patient-centric" focus. The problem is, without physicians, who is going to "focus" on the patients?

The concept of the physician-centered practice is actually pretty simple. Without a physician you don't have a medical practice. Therefore, first defining the basic work style and needs of the physician is elemental to making the practice work and being able to serve your patients well. It's putting the concept into operation that can be a challenge.

An analogy to this situation would be a factory that relied heavily on one very expensive piece of machinery to produce its products. The factory workers would probably take very good care of that machine and they would learn to use it well. And although they know they need to produce quality products, they realize that without the machine, they can't. They understand the importance of keeping the machine running well.

Once physician work styles and needs are defined (the machine is understood), the practice, from staff responsibilities and work processes to managing the patient interaction, is built around those defined needs. Simple, right?

Well, if you're a physician, you may be asking, what needs? I'd like a cup of coffee on my desk when I walk in, is that a need? You know better. Needs are hardwired behaviors that often can be accurately determined only with deep introspection, professional assistance, or an objective assessment. We have assessed more than 400 physicians to precisely determine their work needs and how to make those needs fundamental to the operation of their practices.

Some of us can get an idea of our "needs" if we take a giant step back and look at those work patterns that we've exhibited most of our lives. For example, is there "a place for everything and everything is in its place?" Are you most comfortable making snap decisions or do you prefer to ponder and research an issue first? Do you shoulder all responsibilities or do you see system issues as the source of problems? Answers to those questions can reveal some of your needs, but 'yes' and 'no' responses are too simplistic to be valid.

If you're a physician, snap decisions probably aren't an option, but a necessity, and although

you like orderliness, there just aren't enough hours in the day to devote to a tidy desk. That's the complexity of defining your needs. You may want to respond or act a certain way, but circumstances may not allow it. Daily routines become habits, and it's difficult to separate habit from need.

However, assume you have defined a list of your most important needs through introspection, outside counsel, or a work-assessment like the [Birkman Method®](#). You know your needs; what do you do with them?

You turn them into the business and operational plan for your practice.

Let's use the example that is not uncommon among physicians we've assessed: You need a high degree of order or structure. A look at many physicians' desks or ink-stained shirt pockets may not seem to support that notion, but again, it's the difference between usual behaviors, habits, or circumstance, and needs behaviors.

If the staff sees the cluttered desk and other indicators that this is a pretty loose ship, they'll likely respond in kind. A lax attitude towards scheduling, record keeping, financial reporting or performance is likely if staff believes structure isn't important to the physician.

Inserting order and structure into business and operational plans is sometimes most easily achieved by following the money. The money starts at the front desk when patients are scheduled or registered. What system or process does the physician need to create the required level of order and structure? It's defined individually, but it is defined.

In an office-based practice, the money, via a superbill, then accompanies the patient to the exam room. Who is responsible for this? How are patients roomed? How is the physician informed of the roomed patients? What has occurred prior to the physician's arrival? As you can see, it's an exercise of mapping both operational processes and individual staff responsibilities. If you pursue this exercise, you'll find it isn't always a straight-line process; it will have offshoots and parallel lines. But in creating this map, order will follow. Staff duties and responsibilities will become better defined and more logical, and policies and procedures will emerge as effective and intuitive to the needs of the practice.

The usual result of this process is staff members with better understanding of their responsibilities, less ambiguity towards procedures, and greater flexibility in dealing with situational changes. They understand how to use and interact with the "machine" more effectively.

How does this attitude affect patients? Patients benefit from a better running office, as well as a more satisfied and effective physician.

Keeping with the example of order and structure, patients will likely perceive a higher level of focus on themselves and their needs when the physician has her needs met. Patients know when offices are out of synch. They'll make comments about hoping their records aren't lost or express concerns that the doctor seems unhappy or is not attuned to them.

Considering other elemental needs that are usually measured and incorporated into physician-centered practice development, patient communications may be improved and staff may find structure helps them be more responsive to patient needs.

Patient advocates need not worry. The physician-centered practice doesn't turn patients into second-class citizens. It allows and encourages physicians and their staffs to better focus on patient needs because their own needs are being met. In the machine analogy we used earlier, if the machine isn't handled properly and maintained appropriately, as hard as it may run, it won't produce quality products. For a physician practice to operate like a well-oiled machine, the physician's needs must be known and met. ■



[Robert F. Priddy](#) is the executive director of [Physicians Career Practice, LLC](#), a physician career management consulting firm based in Westminster, Colorado. T. Robert Mestas, MD is the company's medical director.

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