



# The Sweet Spot

Decide for yourself what comprises the right patient volume in your practice. Part one of two ■ By John Nelson, MD.



*Editors' note: This month we begin a new bimonthly column authored by John Nelson, MD. Dr. Nelson will cover practical, real-life topics and ideas for improving your practice in this space during the coming months.*

**A**re you pretty sure your workload is in the sweet spot? That is, do you think you're seeing the "right" number of patients? For most of us this isn't an easy question to answer. My wife figured this out a long time ago. When she asked me "So how was it today?" at the end of the work day, I would nearly always answer "Too busy" or "Too slow." On the rare occasion I enthusiastically said the day's workload was "just right" she would nearly fall out of her chair. (*Disclosure:* Now the way I really answer her question most often is to say, "It was OK. How was your day?" I learned that the constant too busy/too slow answers are a downer and marital accord is served by other responses. I share this hoping you can benefit from my experience, but marital advice isn't the point of this column.)

How you feel about your workload from day to day is terribly significant, but just how do you decide what the *right* workload is? More importantly, what can be done if you're convinced you're constantly working too hard or at an unsustainable pace?

This month I'll offer thoughts for those who feel they're seeing too many patients. In future installments of "Practice Management," I'll address those seemingly rare people who think their patient volume is too low.

## COMPARING APPLES WITH APPLES

If you think you're seeing too many patients, you probably want to know the typical patient volume for hospitalists in practices similar to yours. So it is natural to turn to survey data, such as the SHM Compensation and Productivity Survey, which is published about every two years (results of the 2005-2006 are available to SHM members at [www.hospitalmedicine.org](http://www.hospitalmedicine.org)).

You might think about how your practice differs from the average practice in the survey to explain why your volume *should* be higher or lower. Then you might talk with individual hospitalists from other practices, and even the colleagues in your own practice. What is their patient volume and do they think it is too high, too low, or the elusive just right?

So by comparing your workload with external benchmarks, you know the real answer to whether your patient volume is too high or not. Right? Not so fast. Who says you are average and should feel comfortable working at the average pace? Isn't it possible that the *right* patient volume for you is different than for others? I think data from other hospitalists serve only as a rough guideline and starting point for deciding about your own volume. Ideally you should have significant latitude to decide where the sweet spot is for yourself. Kudos if you're in that situation now.

Unfortunately, instead of having a lot of latitude to decide for themselves, many hospitalists complain that their hospital executive/employer insists that they see at least X wRVUs/visits/new encounters (where X is usually heavily influenced by the SHM survey or other database). And it is especially frustrating to have an executive who doesn't know what it is like to work as a hospitalist decide about the right workload for you.

If you are in a practice where you have little say about how many patients you see, here is a strategy to secure a much greater degree of control over this decision: Offer to decide for yourself and accept the change in your salary that will occur as a result of your patient volume changes. For this to work you will need to have a compensation scheme that has a connection between your production and your income. (Details of such a salary are beyond the scope of this column, but let me assure you it isn't as complicated or risky as you might fear.)

## CASE IN POINT

Let me briefly illustrate with a hypothetical example from an outpatient primary care practice. Doctor A opens a solo office and decides to work 4.5 days a week and see 22 patients each day (11 on the half day). He's chosen this workload because it seems reasonable, safe for patient care, and rewards him with what he regards as a reasonable salary. In other

words, he feels like he has found the sweet spot for workload and income (productivity and compensation).

Dr. A then recruits a partner, Doctor B, whom he pays the same salary as himself and tells Dr. B he must work 4.5 days a week and see the same patient volume as he does. Dr. B is able to conform to this, but isn't so sure he's working in his own productivity and compensation sweet spot. Over the next few years the group grows to 10 doctors, all making the same salary, working 4.5 days a week, and seeing the same number of patients each day.

Are all 10 doctors in this practice likely to be happy with their workload? I don't think so. I'd recommend they look for a way to let each individual doctor decide independently (within some broad boundaries) to work different amounts, varying the number of days worked, or daily patient workload.

A single parent might work only three days a week when childcare is available; an energetic doctor might decide to work five full days a week, and so on. In fact, this is how most private primary care practices operate. And they do this despite complicated decisions about how to allocate overhead between doctors with different levels of productivity, an issue that is usually much less difficult for hospitalists than primary care offices.

But a significant number of hospitalists are in a practice that looks like Dr. A's. They're hired at a predetermined salary and then are urged, or required, to see a specified number of patients and work a specified number of days or shifts. A great deal of effort often goes into getting each doctor to handle a workload that is similar to others in the practice. This patient volume/workload target is usually vague until the hospitalists want to add a new doctor and the employer must be convinced the doctors are working very hard. At this point the SHM survey data and other tools often come into play, and patient volume expectations become much clearer through what is often a somewhat unpleasant negotiation.

So if you're in a situation where a hospital executive or other employer decides the appropriate patient volume for you, think about changing to a compensation system that enables you to decide for yourself the sweet spot between patient volume, days or shifts worked (time off), and income. Most employers—especially hospital executives—are delighted to switch to production-based compensation and let you decide for yourself how many patients you see.

Switching to a salary based significantly—or entirely—on production often raises a number of questions that, again, I'll address in a future column. But my point here is that it can be quite liberating because it lets you make your own decisions about productivity. It might be the thing that allows each member of your group to decide, within some generous boundaries, just how hard he or she wants to work. And the group as a whole can decide more independently when additional doctors should be added.

I encourage each group to operate in a way that maximizes individual doctors' ability to decide where the patient volume sweet spot is—whether through a production-based salary or other methods. Don't let this decision be based too heavily on things such as survey data and the decisions of hospital executives.

## CLOSING THOUGHTS

My goal in writing this column is to stimulate your thinking about your own practice—not to provide a prescription for the one right way to operate a practice. After all, the best way to operate a practice varies from one place to the next.

I plan to address controversial topics regularly, hoping to achieve two objectives. The first is that some of my ramblings help you think about the best way to operate your own practice. The second is that some of you might decide to e-mail us (at [ldionne@wiley.com](mailto:ldionne@wiley.com)) your point of view—some of which can be printed here so that we can learn from each other about the options for operating a successful practice. **TH**

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