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The Administrator
REVIEW



A NEW YEAR? A NEW BEGINNING

As the world starts a new year, PSAA starts a new beginning. Now that the holidays are over it is time to work diligently on our new beginning. As of March, Orla McClure will be managing PSAA. The American Society of Plastic Surgeons has agreed to provide us with a contract to manage our meeting. They will work closely with us to provide hotel accommodations and all the necessary meeting arrangements as well as providing us with

an 800 number for all incoming calls to PSAA. We are excited to embark on this new endeavor and hope that the members at large share in this excitement as well. The Web site will provide you with the new address and phone number once everything is finalized. We would like to thank Amy Vernon for a job well done. Amy has been a key component in the success of PSAA over the last few years. We would also like to wish Amy good luck as she welcomes a new member into her family around the end of March.

I hope everyone who was able to attend our meeting in San Antonio had a wonderful time. The Education Session was great, and our hats are off to

Charlotte for a job well done. The Tapestry Session on Saturday was a perfect way for everyone to get to know a little bit about each other. We only wish the weather had been a little more cooperative. The rain was relentless and the cold was bone chilling. Even so, I hope everyone went home with warm memories of a great meeting. The River Center Comedy Club provided us with a great show filled with laughter that could be heard all the way to Houston. Unbelievably, the river barge cruise was cancelled due to the rain. The only ones

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LORI CRUZ

MISSION STATEMENT

“To encourage and support the professional development of those who manage plastic surgery practices by providing the resources necessary to achieve the highest level of competency and to serve as the nation’s authoritative body on plastic surgery practice management and to be an advocate for the profession on issues that affect the delivery of plastic surgery care.”

VISION STATEMENT

“Promote a networking environment that will enrich the plastic surgery practice management experience and encourage growth.”

PSAA POSITION LOCATOR SERVICE

Announcements of 75 words or less, outlining a position’s qualifications, office location, and any other pertinent information will be listed in The Administrator Review for a nominal service fee of \$50. Each announcement will be coded and the PSAA Executive Office will mail or fax resumes directly to those placing announcements.

All announcements will run on a space available basis. Contact the PSAA Office (703) 820-7400 for additional information.

The Administrator REVIEW

PURPOSE

The Plastic Surgery Administrative Association, Inc., is a non-profit organization dedicated to increasing the management skills of our members through educational programs related to the unique specialty of plastic surgery.

To meet the needs of our members, the goals of PSAA are:

1. To further the efficiency of the professional offices where members are employed.
2. To manage a more professional office.
3. To better serve the plastic surgeons, supporting staff and patients for whom the members work.
4. To conduct educational and training programs and to assist and direct the plastic surgery community at large.
5. To encourage individual participation for personal and professional growth.

The views expressed in articles, editorials, letters and other communications published by *The Administrator Review* are those of the authors and do not necessarily reflect the opinions of the editors or the Plastic Surgery Administrative Association, Inc.

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HOW IS YOUR DECISION MAKING?

Leaders get paid to make decisions. How effective are yours? Are they accurate? Is your process efficient? To improve decision making, you need to learn how to avoid six common decision-making errors described here (see also table).

PREMATURE DECISION MAKING

A decision made before you know the underlying cause will not address the root of the problem.¹ One solution: Organize a team of people involved with the issue to construct a cause-and-effect diagram. This exercise will help the team identify the source of the problem.

A second method to address this error is to develop criteria must meet. Determine the objective you see, then develop—in writing—standards that constitute success. Review any decision against the criteria to ascertain that the selected course of action will meet the stated objective.

OVER-GENERALIZING

When we over-generalize, we use deductive reasoning instead of inductive reasoning. Deductive reasoning proceeds from a general observation to a specific situation; inductive reasoning proceeds from a specific observation to a general conclusion.²

The most common error when deciding whether to use inductive or deductive logic is to generalize from a small sample size. For example, “You never get a second chance to make a great first impression.” Are employees hired because of the first impression they give? Do employers really believe that an individual will be a great employee for the next 10 years because of his/her first impression? People sometimes take classes that teach them how to shine in the interview. Be cautious not to generalize from one incident.

Another example of this type of error is jumping to a conclusion based on personal bias. If you listen to one

6 COMMON DECISION-MAKING ERRORS AND HOW TO OVERCOME THEM	
Error	Remedy
Premature decision making	Use cause-and-effect diagrams
Over-generalizing	Use a large enough sample size
Failure to predict the impact of unplanned events	Plan for interruptions
Failure to predict human behavior	Use the “if then” method
Anchor and adjustment error in the future	Realize that what worked in the past may not work
Sunk-cost decision	Acknowledge mistakes, cut losses and move on

member of your staff frequently criticize a co-worker, you will learn much of the disapproval comes from a single observation. For example, Cindy was late for work today. Therefore, Cindy is probably late for work all the time. You can easily see the error in leaping to conclusions, but often the error is masked.

FAILURE TO PREDICT THE IMPACT OF UNPLANNED EVENTS

This error occurs most when an employer asks an employee, “How long will it take you to complete a task?” The employee answers, thinking only of the task in question, not of the rest of his/her responsibilities or the multiple interruptions that will occur.³

To prevent this decision-making error—failing to account for interruptions or unplanned events—follow two procedures. First, multiply the given time estimated by the employee by two and a half—a rule arising from analysis of construction projects.

FAILURE TO PREDICT HUMAN BEHAVIOR

Decisions fail when the decision-maker fails to consider the human behavior that will occur because of a judgment. To increase the probability of predicting behavior accurately, use the “if then” method. Consider what will happen and how people might behave, rather how you would like them to behave.

A classic example of this type of

error is Medicare’s decision to base skilled nursing facility reimbursement on resource utilization groups (RUGs). While relative value scales have served Medicare’s purpose in other programs, the Centers for Medicare and Medicaid Services (CMS) did not predict human behavior in the decision to implement RUGs, which determine reimbursement levels for skilled nursing facilities. The RUG level is determined in part by input from therapy staffs. The greater the RUG level, the greater the reimbursement.

Medicare, in effect, made a skilled nursing facility’s therapy staff the driver of reimbursement. The agency failed to consider that the therapists making these

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SHOW ME THE MONEY: ONE'S PRACTICE EXPERIENCE WITH EMPLOYEE BONUSES

The physicians in my small surgical practice are committed to rewarding staff members for their efforts. Historically, they distributed money at year-end, with little structure and much subjectivity. When the physicians decided to modify their approach, they had to overcome the history of the bonus plan and employee expectations. Little by little, however, they and I, the practice administrator, conquered resistance and turned the bonus plan into a combination bonus/incentive program. By involving staff, we improved the system and realized benefits beyond our expectations.

A BONUS PLAN THAT DIDN'T GROW WITH THE PRACTICE

Northwest Metropolitan Urology Associates, Chicago, has five physician/owners, three main practice sites and several satellite sites. Each main site employs a manager, receptionists, file clerks, office billers, surgery schedulers, billing employees and nurses.

The practice grew from one physician to two, then several years later to three, four and five physicians. When there were two partners, the physicians awarded a monetary bonus to staff at the end of the year, considering each employee, the length of time of employment and their perception of the value s/he added to the organization. Employees received an extra check at the beginning of December. This was the extent of the bonus plan for many years, during which the practice grew considerably.

Several problems became evident with the practice's bonus system:

- It was subjective;
- The cost increased significantly as the practice grew; and
- Employee expectations and rivalries played roles.

When the two original physicians began giving bonuses, they subjectively determined the amounts and didn't consider the consequences of practice

growth. Management next tried to structure the bonus amounts based on each employee's years of service and rate of pay. The physicians decided to give employees bonuses based on two weeks' pay—essentially an additional paycheck. While this was less subjective, it became costly as the practice grew to more than 40 employees.

Staff expectations and dissent grew. One year, the practice distributed bonuses on the day of the holiday party. Some employees disclosed their amounts to others, causing strife. Another year, the physicians delayed bonus decisions until early December; employees didn't receive checks until the end of the month. Several workers said they had counted on the money for shopping and expected it at the beginning of the month; others responded that the bonus was a gift and, as such, should not be counted on.

Needless to say, the physicians, too, had concerns over the bonus plan. As the practice grew and the cost of bonuses rose, subjective decisions about who should be rewarded what became increasingly difficult. Competition among staff members hurt morale. They physicians' initial intention of rewarding employees had backfired and created more harm than good.

WHAT TO DO?

We had three possible approaches to the bonus problem:

- Continue the status quo;
- Eliminate bonuses altogether; or
- Change the current method to combine monetary and nonmonetary rewards.

Continuing the status quo was not reasonable. The problems continued and, in fact, seemed to escalate each year.

Eliminating bonuses would be simple, but the physicians and I believed that this would create more controversy than continuing the current system. Regardless, the physicians were commit-

TIPS FOR OTHER PRACTICES

A practice that decides to implement a bonus or incentive plan needs to:

- Plan carefully;
- Communicate clearly;
- Ensure measurable objectives; and
- Involve staff in the planning process.

While they may seem simple and obvious, each one can be difficult to accomplish. The climate of the organization, the attitudes of the employees and the commitment of the physicians to reward staff play key roles.

Careful planning of the bonus program may prevent having to change it in the future. Better to implement a plan in slow, carefully developed steps, considering future growth of the practice, than to try to change what has already been established.

Clear communication with employees is essential. They need to understand how the plan works, when it becomes effective and what period of time it covers. Email is fine for brief, back-and-forth messages, but if significant concern arises, a group meeting is the most effective way to communicate and reach resolution.

Setting objectives was difficult; we worked hard to develop goals that involved every employee. We're considering separate goals per department for future quarters. Don't forget the need to measure progress towards goals—in hard numbers. Choose objective goals; subjective goals present measurement problems and can spark disagreements over whether they were accomplished.

We found great value in involving employees in the planning process for the bonus/incentive plan. Although we sought suggestions informally, other means, such as formal committees, could be established. Any plan is more likely to succeed when employees have a say.

And don't forget—a bonus/incentive plan can be an excellent recruiting tool.

ted to rewarding their employees in some fashion.

If the objective of an employee bonus is recognition or motivation,

nonmonetary rewards can be effective. In 1999, I began to look for ways to show appreciation for employees in place of or in addition to money.

MAKING A CHOICE

I suggested that the physician discuss, choose, implement and communicate changes to staff well before the end of the year, when they expected bonuses. This would give employees time to accept a new structure. I also suggested involving employees in the process. The physicians agreed.

The five physicians and I began discussing the bonus plan at our monthly practice management meetings. I shared bonus plan information I'd gathered from books, an article search by the Medical Group Management Association (MGMA) and an MGMA information exchange on employee incentive plans. I also helped develop and implement a survey of benefits for a local chapter of an office managers' organization.

The discussion at both the January and February meetings focused on nonmonetary staff rewards and setting goals to allow employees to earn a monetary bonus. We discussed the importance and ease of frequent verbal praise.

I got the mandate to implement two types of nonmonetary rewards: movie passes for employees who went an extra step in their jobs and an employee recognition program.

The physicians still wanted to reward staff monetarily but thought employees should accomplish something to receive it—turning a bonus into an incentive. They decided to set quarterly goals for the year and give quarterly monetary rewards for reaching the goals. I suggested we notify employees about changing the bonus structure and ask for their involvement in setting goals.

IMPLEMENTING A SOLUTION

We sent a letter to staff explaining the change in the bonus structure, describing the nonmonetary and monetary parts of the plan and inviting input. Most received the communications positively and began talking about goals and suggestions. We held a staff meeting on the rewards topic to resolve misunderstandings.

Nonmonetary rewards—The nonmonetary part of the bonus plan was

relatively easy to implement. I ordered 50 movie passes and asked managers to award one when an employee showed extra effort. As often as possible, managers presented the prizes at their individual office meetings to recognize workers in front of peers.

I awarded movie passes to managers, too, who went the extra mile.

With staff input, the managers and I developed an employee recognition program. Each office in the practice chose a specific quarterly criterion for these awards, such as:

- Number of compliments received from patients, physicians and other staff members;
- Written nominations from fellow staff members based on assistance to fellow employees; and
- Collection of staff thank-you tickets for assistance

Each quarter, we recognize winners from each office at staff meetings. We attribute the program's success to employee involvement in the planning process—they feel ownership of the program.

Monetary bonus—Using information from MGMA and an office managers' survey, our physicians established an annual monetary incentive: one week's pay, one fourth paid each quarter. With feedback from employees, they developed quarterly performance goals:

- Quarter 1 – A dollar amount for collections. We kept staff informed of progress toward this goal in percentages, via email;
- Quarter 2 – Accurate messages;
- Quarter 3 – Knowing the mission statement and wearing name tags regularly; and
- Quarter 4 – Combination of the first three goals.

At the end of each quarter, managers reported the results from their offices; I compiled them for the physicians. If the goals were achieved, we issued checks at the beginning of the next quarter. To date, the practice has reached all goals.

SUCCESS OF A NEW SYSTEM


The new bonus/incentive structure has worked for Northwest Metro Urology in several ways. We changed the long-standing plan with minimal dissension, timed the change appropriately and involved employees. Staff members make

excellent suggestions and discuss new goals among themselves in preparation for future quarters.

I talked with staff about the inappropriateness of discussing bonus amounts with fellow employees. But what eliminated much of the disgruntlement was standardizing the bonus amount and tying to each person's compensation level.

Employees have contributed to the nonmonetary part of the plan, too. Their suggestion led to a program to recognize workers with more than five years of service. Every summer we gather staff, ask designated employees to come forward, thank them for their service and give them a flower. It's simple and effective.

The physicians expressed satisfaction with the results of the established goals. In fact, they believe they received more benefit than anticipated. Just setting goals focuses employees' attention on critical areas of the practice and/or individual performance of job duties. Although goals change each quarter, employees continue to respond to previous quarters' goals.

The program has improved worker morale. It gives people something to focus on instead of grouching—people want to meet their goals and pull together. I believe that it has increased our teamwork, which in return has positively affected productivity and morale. 

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THE PSYCHOLOGY OF MEDICAL GROUPS FINANCIAL MANAGEMENT AND THE ROLE OF PHYSICIAN LEADERS

How does the financial management of medical practices affect the psychology of medical groups?

Physicians typically lack facility with financial statements, even those reflecting the performance of their own business. Doctors are, nevertheless, interested in their practice's success, so managers must interpret financial data for them.

Good practice leaders must understand the psychology of presenting and managing the financial performance of the medical group. Let's take well-known foundational psychological theories and apply them to financial analyses, interpretation and management of the medical organization. Let's guide medical group practice leaders—especially physician leaders—in financial management with time-tested understanding of human cognition and behavior.

ROLE OF PHYSICIAN LEADER

The financial performance of a medical group practice—and the management of that performance—affect the psychology of its physicians. Leaders, especially physician leaders, must strive to understand this psychology to shepherd the group through the full range of financial situations most effectively.

Doctors will take their cues about the financial state and future of the group from their physician-leader colleagues. Physician leaders who understand the financial state of the group are more likely to manage situational disorders or new opportunities effectively. Physician leaders are not in a position to defer understanding of the group's finances to the "numbers people." They are obligated to grasp the finances and understand how the numbers will affect the psychological state—and thereby, the future direction and performances—of the business, patients and staff.

CONTROL EXPECTATIONS

Many well-tested psychological theories and behavioral models demonstrate the relationship among humans' sense of control over their environment, their psychological and emotional states and probably behavior patterns. Remove control from people with high need for control and, generally, attitudes and behaviors turn negative. Resulting behavior can present problems for a medical group:

- Flight—The physician(s) leaves the group;
- Fight—The physician lashes out in an unhealthy and/or inappropriate manner; or
- Surrender—The physician gives up on any path that could impair personal or group financial performance because there is "no use."

Physicians must believe that their behavior connects with the behavior of support staff and the financial performance of the group: They need to feel a sense of control. Physicians need to understand the factors (behaviors) that affect financial performance coupled with regular, understanding reports of the group's financial state. These reports should include progress toward fiscal objectives and behaviors that affect financial performance. Whenever possible, reports should describe the contribution of individuals to demonstrate how the behavior of single members can and does affect the whole group.

AVOID LEARNED HELPLESSNESS

Learned helplessness represents the extreme of control expectations. Leaders who blame the financial condition of the medical group on the uncontrollable dynamics of the health care environment condemn their colleagues their plight. Animal behavior models demonstrate that without an expectation for escape from negative stimuli, a creature resigns itself to the punishment and eventually dies.

Physician leaders should not sign the death warrant for their enterprise by resigning their colleagues to expectations of declining financial performance due to health care's seemingly uncontrollable dynamics, such as shrinking reimbursement from payers, rising operating costs and expensive capitalization requirements. Every business faces such challenges. What will physician leaders do to propel the medical practice forward in spite of those pressures? What will leaders do to prevent a state of learned helplessness?

A large multisite, single-specialty group practice in a competitive metropolitan market has doubled the income of its physicians over four years—despite downward pressures from payers over rising costs related to expensive business strategies. How did it accomplish this feat? The practice:

- Added profitability to ancillary services;
- Used market power to negotiate better contracts with payers;
- Governed the practice to exploit scalable economics; and
- Pushed higher volumes through a fixed cost base.

To resign a medical group's economic performance to the uncertainties of the market will resign its physicians to a helpless state of mind. Negative behavior patterns usually follow.

REWARD VALUE OF BEHAVIORS

A reward of insufficient value will not typically motivate behavior. An example is dedicating countless extra hours to clinical documentation to enhance reimbursement by a few percentage points. The aggregate absolute effect may be positive for the group but marginally so for the individual and, hence, a poor motivator.

Consequently, leadership needs to focus on physician behavior change that produces the best results for the required

incremental effort or behavior change, i.e., optimal leverage of time and effort for the physicians. A focus on more efficient patient scheduling, seeing more patients or reducing staff and overtime may produce rewards worth the effort—with worth defined as gain available compared with the alternatives. Leaders earn appreciation for insights regarding personal rewards enhanced through reasonable behavior changes, i.e., high-return behavior change.

MINIMIZE COGNITIVE DISSONANCE

Cognitive dissonance is the mental conflict produced by an inconsistency between two beliefs or a belief and a behavior. It's generally produced from inconsistent information or the misalignment of apparent fact with observations of one's environment. For example, someone who believes smoking causes cancer and who continues to smoke probably experiences cognitive dissonance. In medical group practice, cognitive dissonance figures in these two examples.

- Physicians know that certain specialties receive reduced payment from major payer, such as Medicare, but incomes of physicians in those specialties are not, ostensibly, negatively affected. In larger medical groups this happens for a variety of reasons, e.g. higher levels of productivity for certain specialties, greater operating effectiveness, profitable ancillary services and better financial performance in other specialties shared through a collective compensation model. But if this phenomenon is not well explained, physicians may be confused. Thus, positive results can produce cognitive dissonance.

- Physicians' incomes are declining as the group invests in facilities, support systems, nonrevenue-producing technologies and program expansion. The group may be in a stage of a business cycle where it makes sense to invest at the expense of physicians' incomes. The physicians in the trenches, however, don't see a clear path to returns on lost income. Leaders need to provide reliable forecasts of when the picture turns positive.

In such situations, practice leader-

ship can minimize cognitive dissonance by clear, frequent communication in open forums that invite and encourage questions and debate.

ATTRIBUTION THEORY

Attribution theory suggests that absent an accurate understanding of an observed event, people will attribute meaning to their observations based on their own experiences. Two financially related examples are illustrative:

- A specialty department has difficulty retaining good support staff. Observers attribute the problem to wage scales and the value of benefit packages. Physicians and staff question the ability of the group to attract and retain "good people." The issue, in fact, is the behavior of one or several physicians. The wrong explanation is attributed to the right problem.

- Overall revenues of the group are deteriorating. Physicians' incomes suffer. Physicians determine that the root issues are downward pressure on reimbursements and "unfair" managed care contracts. The attribution here is partly accurate. A little digging reveals poor physician productivity, billing, coding and collections as principal contributors to the problem. Here, problem resolution is largely within the control of leadership.

The answer to the misplaced attributions is typically a simple financial and operating performance report—one that any physician can understand. Management's evaluation and reporting of the group's financial performance must jibe with the interpretation available from the performance report, or the group must ask appropriate questions that elicit explanations of organizational performance. Leaders responsible for shining that light to bring forth explanations to key financial problems.

THE SITUATIONAL PSYCHOPATHOLOGY OF THE FINANCIAL CRISIS

Medical groups in financial crisis are battlegrounds. They suffer the obvious and the not so obvious. And group crisis always affect patient care.

The psychology of the medical group in financial crisis is pathological:

- Fear for the future on a personal and collective level runs wild;

- Emotions become frayed, and people act out;
- Problem behaviors are magnified to the extreme;
- Mistrust is pervasive;
- Individuals tend to focus on self-preservation, sometimes at all costs;
- Some simply give up and give in; and
- The "right people" bail out.

Financial crisis is the group leader's "moment in the sun." The prescription for this financial "transient situational disorder" includes:

- Immediate announcement that leadership is addressing the problem;
- In-depth analysis of the situation with a determination of the root causes and key symptoms;
- Full disclosure of the organization's current state, with as many "all hands" meetings are required to inform employees;
- Inclusion of interested internal parties to devise and implement a plan to stem the problem. Broadening of the circle of decision makers sends an important message: "There's not attempt to cover mistakes by being exclusive;"
- Engagement of qualified and trusted outside advisers who deliver "plain talk" assessments;
- Presentation of short-term problem-resolution plans with an absolute deadline for decision, irrespective of whether all data are in. Usually, just about any decision is better than none at all;
- Action by leadership to review all disbursement requests, oversee all checks written, produce a thorough report on accounts receivable management, step up collections, push price where reasonable and freeze new hires; and
- Consultation with outside counsel after short-term problems are under control, the root causes of the problem identified and the group pulls together. Practice sets a new path to ensure the same mistakes are not made again.

Medical practice leaders must identify the psychopathology of the group and address attendant unproductive behaviors quickly. They must act as sympathetic counselors when required and judges and jury when appropriate.

Medical groups that survive financial crises are always stronger for it. The experience enriches the culture of the

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DEFER OR REFER? GIVING REFERENCES AND AVOIDING LEGAL LIABILITY

Today's tight labor market means that physicians and office managers often must deal with high rates of staff turnover. Reference requests from departing employees inevitably follow.

Certainly, we owe the medical community information about our former workers and hope that colleagues also will be forthcoming about potential hires. Such information can be critical for hiring decisions because some estimates state that 30 percent of people misrepresent or fabricate educational credentials on their resumes.^{1,2}

Other common types of resume fraud include inaccurate representation of prior job responsibilities, falsifying gaps in work history, falsifying job titles and inflating or deflating salary history. Can we tell others the truth about previous employees and not be sued? The answer is yes—but with caution and qualification.³

LIABILITY ISSUES

What is a practice's liability in giving references? There are two separate issues:

- The liability associated with giving information; and
- The liability associated with not giving information.³

Practices are reluctant to give information about an employee—particularly negative information, which has the potential for legal liability.⁴ This fear is justified: Organizations have been successfully sued for simply describing a past employee as “something of a character.”⁵ But you cannot run a practice and expect never to receive reference requests. In fact, some states have laws that require you to provide references on request by former employees.

A reference-giver does enjoy the right of “qualified privilege” when giving references to “interested parties.” This means the reference-giver may say

positive or negative things about the employee provided that s/he can substantiate the information and gives it without malice.⁶ But if you do make negative comments, you bear the burden of proof.

RULES CAN GUIDE, PROTECT YOU IN NEGATIVE REFERENCES

However, you can substantially reduce the risk of giving references by following these guidelines:⁷

- Determine if the job candidate has signed a release or waiver form allowing the prospective employer to contact previous employers or supervisors for references. By signing a release form, the candidate waives the right to privacy. If a release form has not been signed, the practice may be open to a charge of invasion of privacy;
- Never volunteer negative information. It can be interpreted to mean you are maliciously trying to harm another. This is not to say you cannot give negative information, just that you should not volunteer it. Instead, answer only the questions asked, and then only after careful consideration. Volunteering negative information provides a basis for questioning the motive of the reference-giver and has led to successful lawsuits based on retaliation;⁸
- Make sure all comments you make are strictly related to the job;⁹
- Do not make overall assessments of an employee's character or potential;
- To help reduce the possibility of a claim of bias, say something good about the person;
- Keep reference information factual and avoid opinions;
- Fully document all facts that you reference. Insufficient or missing documentation jeopardizes the claim of qualified privilege. To prove libel or slander, damage claims have to show false information was used as a basis for a reference. Documented facts provide valuable evidence in the case of a

lawsuit; opinions are much more difficult to defend and offer tempting targets for a plaintiff's attorney;

- Do not give references immediately. Tell the requester that you will first have to research his/her files. You can use this action in court to prove that you did not provide information without thoughtful consideration of its consequences;
- Obtain written consent from an employee prior to giving any information that will affect his/her job search;
- Inform a terminated employee that the practice will give the reason for termination if asked. Knowing this beforehand often will keep the employee from using the medical practice as a reference if s/he departed under less-than-friendly circumstances; and
- Give specific facts without labeling them as positive or negative. For example, rather than reporting an employee as having “poor attendance,” describe your office's attendance expectations and the employee's history of work attendance. Let the reference seeker draw his/her own conclusions.

TAKE CARE WHEN REFERRING THOSE WITH CRIMINAL BACK-GROUNDS

If you have doubts about giving references, confirm only employment and dates of employment. But failure to provide information also can lead to legal liability. This problem occurs if you know the former employee has a history of criminal or aggressive behavior on the job and subsequently does harm. It's particularly relevant in a medical practice, where staff may have access to sensitive medical records, drugs or medical supplies.

Under the legal doctrine of “negligent hiring,” an employer can be held liable for the actions of an employee if the employer knew, or should have known, that the former employee had a history that endangered others. This implies that if the employer had adequately checked references before making a hiring

decision, the employee would not have been hired and would not have had the opportunity to commit the injurious act.

Failing to provide negative information when requested may establish grounds for subrogating the hiring group's liability to your group. In essence, your group may bear some of the responsibility for the problem—as well as some of the liability and damages to the injured party or parties. If you have concerns about giving a negative reference for a former employee who had exhibited questionable behavior or was found to have a criminal record, consult your attorney.

HOW YOU SAY IT IS ALMOST AS IMPORTANT AS WHAT YOU SAY

While what you say or do not say in a reference is the most important issue, how you give a reference can also bear weight. Should you give the reference in writing or through a phone call? Writing is usually best because it serves two purposes: it allows you and your staff to review the information for accuracy and provides a record of the statements made.

Granted, giving references over the phone takes much less effort and often involves only contact with other colleagues. Orally communicated references can in theory also involve less liability because oral communication does not provide irrefutable evidence in a lawsuit. But on the negative side, people tend to be more candid in giving negative information over the phone, and your tone of voice may suggest your attitudes toward the former employee.

Another aspect to consider when granting phone interviews is that the conversation may be recorded. In many states, surreptitiously recording phone call is legal. A recorded conversation would reveal both the content of the reference and vocal intonation, which may be used to convey extra meaning. This, in turn, could increase the chances of a successful defamation lawsuit. Ask at the outset if the conversation is being recorded. If it is, request that the recorder be turned off or you will terminate the interview.

One last word of caution concerns the assumption that colleagues are in a better position to protect you when you give them information about former

employees. However, under oath they will be compelled to divulge their source of information and its content. The safest procedure is to provide yourself the same legal protection with a friend or colleague as with someone you do not know.

Reference-giving is usually a straightforward process that seldom results in problems for the reference-giver. But with any personnel action, do it systematically and professionally, keeping in mind any possibilities for legal liability. By following some guidelines, knowing state laws and being honest but cautious, a practice can protect itself from litigation and provide useful information to professional colleagues. **A**

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IF YOU CAN'T SAY SOMETHING GOOD...

The current state of litigation in the United States requires organizations to give references cautiously about previous employees. To reduce an organization's exposure to charges of libel or slander by former workers, supervisors are often limited by company policy to reporting only dates of employment. If negative information is given only to "get back" at an employee whom the reference-giver didn't like, the company may be exposed to liability.

Yet truthful reporting of negative information is justified in certain cases. An employer can give a negative reference with minimal liability. A reference-giver enjoys the right of "qualified privilege" when giving references to "interested parties." S/he may say negative things about a previous employee – provided the truth of the information can be documented and the information is given without malice.

In fact, it's sometimes in an organization's best interest to relay negative information. For example, if an applicant has a record of criminal behavior, the organization reduces its legal risk by full disclosure. A company hiring someone who later causes problems may subrogate some of its liability to the organization that refused fully to disclose negative information about an employee. If the applicant engages in illegal behavior on his or her next job, providing this information enables the organization to demonstrate in court that it was not negligent by withholding information.

To reduce liability further, a firm can request legal releases from its prior employees. It can include permission to report specific information in the release form. Employees refusing to sign the release can expect to have minimal references provided. Of course, negative information should be reported without the intent to defame the applicant, since reporting negative information for the purpose of harming another or "getting even"—even if true—produces legal liability.

Never volunteer negative information. Instead, answer only the questions asked. By keeping all comments strictly job-related—staying away from overall assessments of another's character or potential—liability is reduced. Finally, say something good about the person. This provides evidence that you were not biased in your report. We also suggest you put reference information in writing to provide a record.

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PATIENTS WANT IT... DOES YOUR PRACTICE HAVE IT?

It's no secret a healthier lifestyle including good nutrition and exercise enhances wellness and may increase longevity. In addition to seeking surgical solutions to combat visible signs of aging, patients are increasingly turning to their trusted physician for clinical expertise in providing a more complete age management program. Be at the forefront of this continually changing field by having the answers to patients' hardest questions.

Updated for 2003, join physicians and their staff at the PSEF/ASAPS Age Management Symposium, April 11-13, 2003 at the Omni Royal Orleans Hotel in New Orleans, Louisiana. Discover how to develop a wellness program for your practice and see the advantages of being able to offer this service to patients who are truly motivated in enhancing their well being. Program Chair Brian M. Kinney, MD, and Co-Chair James H.

Carraway, MD, along with an expert faculty will cover a wide range of topics. The program will meet these objectives:

- To provide a forum for interaction between teachers and researchers involved in biomedical aging research and practicing plastic surgeons
- To demonstrate the effectiveness of age management programs and extending life expectancy and wellness
- To discuss the role of hormone replacement treatment programs
- To explore biomedical concepts of the aging process and understand the demographics of aging
- To recognize how diet, culture and exercise affect health and aging
- To incorporate aging principles into a comprehensive plan for patient care in cosmetic surgery

An optional course entitled, "Innovations in Facial Shaping: Adjuncts to Cosmetic Surgery" will provide

participants with an in-depth review of the treatment rationale and clinical applications in the use of Botulinum Toxin Type A. Sponsors: ASPS, PSEF, ASAPS, and ASERF.

Take advantage of the early registration discount by March 14, 2003. For complete program brochure and registration information, go to the ASPS website at www.plasticsurgery.org and click on the Medical Professionals link, or type in <http://www.plasticsurgery.org/profinfo/agemgmt/intro.cfm>. Questions can be directed to the ASPS/PSEF Registrar at registration@plasticsurgery.org or call 1-800-766-4955, press 9 or 847-228-9900, ext. 472 (outside U.S.).

Hotel rooms are filling quickly; reserve one today by calling the hotel directly at 504-529-5333. Reservations made after March 14, 2003 or after the room block fills, are subject to space and rate availability. **A**

PRESIDENT'S MESSAGE

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cruising the river that night were the ducks!

We look forward to our meeting this year in San Diego. Richard Crici, our Education Chair for 2003, has some wonderful ideas for education and has also built in some time for fun.

PSAA is striving to make changes to make our organization bigger and better. PSAA has also started a Charity Fund. We would like to ask each member to donate \$10 or more this year. This information can be found on your dues notice or you may mail a check to our mailing address. With the money collected each year we will choose a charity in our host city in the field of Plastics to benefit a child. For 2003, we have chosen the San Diego Burn Center. Those who attended the luncheon in San Antonio with APSA will always remember the gratitude on the face of the child who

benefited from APSA's donation in 2002.

The luncheon with APSA was both wonderful and educational. New friendships formed and the hospitality was spectacular. It was from this luncheon that many new ideas for PSAA were born. ASPS has also taken over APSA's management. We thank those who made it possible for these two wonderful organizations to unite.

Our Web site is forever changing thanks to Dan Goldstein, who always has a positive attitude. Dan has graciously offered to donate \$500 for each PSAA member that uses his services to design a new web site. Our first one has already been contracted and we hope there are many more to come. Dan designed our Web site and provides his services at little or no charge. There are many people in our field of friends who work very hard behind the scene to strengthen our organization. We would like to take this opportunity to thank you. In our ever changing world people are not always recognized for their hard work.

I would also like to make sure that

each person sends in his or her correct email address. Dan sent out an email blast several weeks ago and over 50 came back as a bad address. If you did not get an email, please drop me a note at ljcruz@earthlink.net so we can update our files. The *Review* will be posted to the Web site in February and September of each year. The only hard copy you will receive in the mail will be in July with the entire meeting information and forms. With all the changes made this year in management and the *Review*, PSAA will be able to reduce our operational expenses this year alone, by \$30,000. We hope in the future to reduce them even more without compromising the integrity of our organization. If you have any comments or suggestions, please send me an email. I wish you great success in your personal and professional endeavors during this year and look forward to seeing you in San Diego.

Lori Cruz
PSAA President

DECISION MAKING

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recommendations work for the facility administrator or for a contract company whose objective is to maintain the contract. This has placed employed therapists in an untenable position of being the determiners of reimbursement, subjecting them to pressure from supervisors to increase the service level to support a higher RUG. If Medicare had done a simple “if then” assessment of the parties involved, it could have predicted this situation.

ANCHOR AND ADJUSTMENT ERROR

Medicare made another classic decision error—that of anchor and adjustment—in implementing RUGs in this skilled nursing facility environment.⁴ The mistaken thinking says if relative values worked in situation A, they will work in

situation B. Medicare is anchored in past decisions. CMS tried to apply the same method to a new and dissimilar environment.

To prevent similar mistakes in your practice, ask yourself if a decision is anchored in past experiences. If so, make the adjustments necessary for the new environment.

SUNK-COST DECISION

The sunk-cost decision-making error essentially states: “The decision has been made and we’re going to stick with it.”⁵ Many of us learn as children to hold fast to our beliefs. Parents often tell kids, “If you start something, finish it.” Persistence is admirable—unless it wastes resources.

Ego also drives sunk-cost decisions. It’s not easy to admit an error. However, managers who acknowledge their mistakes, cut their losses and move on will be more successful in the end.

Lastly, a decision maker should remember to use a team.⁶ It is the rare administrator who knows everything about any situation. A leader needs to assemble the right people and lead them with the decision tools described. **A**

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PHYSICIAN LEADERS

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organization, and the lessons are invaluable to its future.

The ability of a medical group to survive a severe financial crisis turns on its leadership, and the success of the leadership depends, in part, on its understanding and management of the situational disorder.

SO WHAT DOES A PHYSICIAN LEADER DO?

To manage the financial performance of the medical group practice effectively is to also manage the psychology of medical group practice finance.

Based on the psychological theories presented, the physician leader would:

- Understand that financial performance is affected by a related psychology. Because financial performance is a function of human behaviors, and these are a function of psychological states, financial performance of an organization is affected by the collective psychological state of the people who compose the

organization. Simple syllogistic logic? Perhaps, but it is frequently lost on physician leaders and financial managers who are trained in the “hard” sciences.

- Physicians are, by and large, empiricists; they need to see as much data as possible to draw conclusions. Further, they understand that direction is a product of the analyses, interpretative methods and models applied; i.e., the truth is not always obvious or available. So owners or medical practices need full disclosure of financial data, subjected to rigorous analyses by competent professionals providing interpretations of current and future direction.

- Pathways to change must be provided; i.e., options to move from where we are to where we want to be, with risk assessment equations for each. Physicians are accustomed to acting quickly with limited information within tolerable risk and reward boundaries.

- Leaders in a crisis should disclose everything and, if necessary, admit mistakes, misjudgments and miscalculations. The human condition is suspicious of secrecy and forgiving of admission of mistakes.

- Routinely deliver an easily under-

standable report of financial and operating performance. Provide the least number of indicators that tell the most about the overall performance of the business. This is as much art as science. With such a report, physician leaders provide their written, interpretive summary of the results, including the most likely effects of current performance on future states of the business.

- Leaders will help colleagues understand the full depth of the practice’s financial profile. A required understanding of financial performance of a medical group goes beyond awareness of top-, middle-, and bottom-line performance. Physicians need to understand something of the balance sheet of the organization.

The successful physician leader will pay as close attention to the psychological factors associated with the financial condition of the medical practice as s/he pays to routine accounting reports. **A**

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