Department of History and American Studies
University of Mary Washington

Mary Washington Healthcare Oral History Project

Bob Lively

Interview conducted by
Hannah Laughlin and Josephine Appiah
in 2013

The Mary Washington Healthcare (MWHC) Oral History Project began in 2013 and recorded 100 hours of interviews over the next two years. The project was designed to document the history of MWHC's expansion and record the recollections of people involved with its transformation. The oral history interviews were with board members, administrators, physicians, nurses, social workers, and community members. Beyond a story of expansion or a single organization, the interviews record successes and ongoing challenges with the transformations in health care and hospital-based medicine over the last thirty years.

Oral history is a method of documenting the past through recorded interviews. The interview is between a narrator with firsthand knowledge of significant historical events and an informed interviewer. The goal is to expand the historical record, record firsthand accounts of social, cultural, and political changes, and preserve the recorded interview. The recording is transcribed, lightly edited for clarity, and reviewed by the interviewee. The final transcripts are archived in Special Collections in Simpson Library at the University of Mary Washington. The interview transcripts are available to researchers through the library and the project website, mwhchistory.com.

Oral history is a primary source and is not intended to provide the final, verified, or complete history of events. It is a spoken account, often recorded in a single interview. It records and preserves an interviewee's memories and narration in response to questions by an interviewer. The interview is reflective and irreplaceable.

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00:00:02
Laughlin:
What is your name?

00:00:03
Lively:
My name is Bob Lively.

00:00:05
Laughlin:
How long have you been working here at Mary Washington Hospital?

00:00:08
Lively:
I came in April of 1990. So, around twenty-three years.

00:00:15
Laughlin:
How did you end up here?

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Lively:
I worked for Fairfax Hospital in the Inova health system for about ten years and had a friend that came down here to work. He told me about this sleepy little town, very quiet, no traffic, immune from all the big city frustrations and troubles. I was lucky enough to be able to apply and get a job.

00:00:43
Laughlin:
What was your first experience like at the hospital?

00:00:47
Lively:
I came as the administrator of the Ambulatory Surgery Center. That was owned eighty percent by physicians and twenty percent by the health care system.

00:01:00
Laughlin:
Describe your overall experience, being here for twenty-three years.

0001:05
Lively:
I think seeing the sleepy little town where—when we first moved here my wife and I were astounded at how people complained about traffic and we had lived in Fairfax for the last ten years. We couldn't find any of that traffic they were complaining about. There was no Wal-Mart. There was no Central Park. There wasn't Sheetz and there weren't Wawa's.

00:01:29
Laughlin:
How did you end up as Executive Director in Physician Relations?

00:01:33
Lively:
I worked for a number of different roles throughout the years. I went from being administrator of the Surgery Center to Vice President of Managed Care to Executive Vice President of the Integration and Network Development. Then, around 2005, I decided to slow down and do different things. I moved into the area of physician relations and have been there since then, and I enjoy it very much.

00:01:59
Laughlin:
Why did you choose this role?

00:02:02
Lively:
I like working with physicians. I like to feel like that what I'm doing in my team and all of our efforts are benefitting our physicians, who have very hectic, very crazy lives. They are trying to manage their practices, take care of their patients, and also run their practices like a business.

00:02:23
Laughlin:
Could you describe what you do in physician relations? What it does, exactly?

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Lively:
We are involved in everything that impacts a physician's day in the routine of working with the health care system. Whether its issues they have in getting information from the health care system, negotiating contracts, determining how to set up an electronic medical record, how to have all those things work effectively, how to get lab results, and things along those lines; also, recruiting. Understanding what their needs are and what the community needs as well are important parts of my job. [03:00]

00:03:01
Laughlin:
How would you describe your role in making the hospital function better?

00:03:09
Lively:
I think the role I've had over the years has been to facilitate growth in the areas that we've determined strategically were important to the community. Whether it be a different physician specialty that we haven't had before or whether it be a new service. Building the new hospital in Stafford was an example of that. We determined that patients could not get to Mary Washington Hospital from Stafford in rush hour traffic. We began to really work hard to try to understand what would meet the needs of the folks to the north of here and as a result of that we had Stafford Hospital come alive in 2009.

00:03:52
Laughlin:
How would you describe your relationship with the physicians?

00:03:57
Lively:
I feel like they know that they're always going to get a straight answer from me. That it may not always be the answer they want, but I'll be very responsive to whatever their questions and issues are. They know that I'm going to be a straight shooter and I believe that probably reflects most of us that work very closely with physicians. We try to feel their pain, feel what their frustrations and troubles are, and know that it's not always easy to work with a very complex system like we have. We have ambulatory surgery and the emergency department; you have various levels of care throughout the community. It's sometimes very difficult for physicians to negotiate that maze. We try to help them in every way possible to make their life easier and make their day easier.

00:04:49
Laughlin:
What kind of difficulties do these physicians have?

00:04:54
Lively:
I think most physicians started out thirty years ago working inside the hospital. I mean it was very customary to see their patients during the day and then close their office and see their patients in the hospital either at lunchtime, in the evening after their office hours are over, or in the early mornings. They managed that life for a number of years. It became more and more difficult for physicians to manage an outpatient practice and take care of the needs of their patients inside the hospital. It is

almost impossible in most situations. I think the physicians have looked to us to find ways to help. We have hospitalist medicine now that takes care of all the adult patients, as well as the pediatric patients. We have OB (obstetrics) hospitalists. We have a number of services that recognize that physicians can't be everywhere at the same time. They have to spend their time growing their practices in their office first and foremost.

00:05:57
Laughlin:
What is your primary goal for Physician Relations? [06:00]

00:06:02
Lively:
I think the primary goal is to be sure physicians can trust us, know that they're going to be able to get an answer, and that they're going to be able to work with us; that we are responsive, care about their issues, their needs, and their concerns.

00:06:17
Laughlin:
What is the thing you find most difficult?

00:06:22
Lively:
I think the most difficult thing is the change in times that our physicians are going through in health care, specifically health care reform. The reduction in payments and the push from managed care plans to focus more on volume of patients being seen by physicians, rather than the quality of care. It's sad when you look at a physician—from a managed care perspective, the complaint on the physician is that they take too much time with a patient. I don't think any physician wanted this to be the way their career was directed when they went into medical school, decided they wanted to work with people, save lives, and make lives better.

00:07:07
Laughlin:
Can you describe some of the changes that the physicians are going through right now?

00:07:12
Lively:
Most physicians now are very electronic in their offices. Very rarely do you see the physician that relies on a typewriter and a fax machine to communicate. Almost all physicians are connected to the Internet. Most physicians now, by requirements of health care reform, have to have an electronic medical record in their office. It manages their billing, their practice management focus, as well all other clinical information. This has been a real challenge in a lot of practices; to set the systems up,

to pay for the systems, to understand them, and reach that learning curve where they really know how to continue to see their patients. And yet, they also learn how to use a very complex practice management system that's electronic.

00:08:08
Laughlin:
What were some big changes over the years that you've been here that have affected physicians in the hospital?

00:08:15
Lively:
I think some of the biggest changes we've seen—when I came in 1990 we didn't have neonatal intensive care. We didn't have a cardiac surgery program. We didn't have a neurosurgery program. We didn't have a trauma program and we didn't have hospitalist medicine. Most of the time patients needing those services had to go out of town to Richmond or Northern Virginia. The physicians had to spend a lot of time coming into the hospital taking care of their patients and trying to manage their practice. Those were the biggest changes. When I came to Fredericksburg in 1990 there was no such thing in Fredericksburg as managed care. We were very familiar with it in Fairfax, but it was a new concept here. Physicians had to get their arms around it. [09:00] Along with it was the new hospital system in which payers would not be paying the health care rates and payments that they had in the past, which is a big change in a sole community like Fredericksburg. You had to negotiate. Sometimes we got rates that we weren't used to getting, and that was a real challenge for physicians, as well as for the health care system.

00:09:30
Laughlin:
What would you say the biggest change for the hospital itself has been in the community?

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Lively:
I think about ten years ago the leadership of the organization and the board decided that one of our major driving goals was that we were going to provide all of the services here in this community so that no one would have to leave; except for maybe high-level pediatric care, burns, and transplants. Our focus on clinically developing the services and the programs to support them has really driven the organization. That's why now you see thoracic surgery, vascular surgery, cardiac surgery, neurosurgery, neo-natal intensive care—things we didn't have in 1990. You see so many levels of care that it's very rare that a citizen has to leave this community for services any longer, other than pediatric or transplant or burn type services. That's something to really be proud of in this community.

00:10:40
Laughlin:
How would you describe the hospital's role in the community when you got here in 1990?

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Lively:
The things that struck me about this hospital when I came from Fairfax were its commitment and its closeness; its close ties to the community. That has grown every year since I've been here. It's what drew me here, but being a part of it I have watched it grow even more. This hospital system really cares about this community. It's the fiber of everything that we do from all the programs in the community that we support. You can see it in almost everything that we do. The charity care we provide: the support of the Moss Free Clinic and the Fredericksburg Christian Health Center. It just runs throughout every fiber of this community. You'll see some form of Mary Washington Healthcare helping improve the health of the people in this community through those venues.

00:11:42
Laughlin:
Do you feel like those values still drive the hospital today?

00:11:45
Lively:
Very much so. I think when the times really get tough—leadership as well as all of the associates in the organization and the physicians—this is one thing we can look to and be proud of. [12:00] We've never wavered on our commitment to the community.

00:12:09
Laughlin:
What are some changes in health care over time that you've seen that have affected physicians and staff?

00:12:23
Lively:
The pressure that physicians have to see a certain number of patients every day in their office so they can make ends meet with the reduced payments they get from health plans; the managed care plans have made it more difficult. It's put more pressure on physicians. Every physician will tell you that it's diminished, in their eyes, the quality of care they're able to provide. They can't spend as much time with their patients as they used to. It was their dream to be able to make the difference in that patient's life, to be able to sit down and listen to that patient. But now you see—and this is not a bad thing—there is the use of what we call extenders or mid level providers that are working with physicians. These are nurse practitioners, midwives, and physician assistants. They do a lot of things in a physician's office that you probably wouldn't have dreamed of twenty or thirty years ago.

00:13:22
Laughlin:
What is the most beneficial part of the hospital would you say for patients?

00:13:30
Lively:
There is a strong commitment to patient care. There's a strong commitment to the community. The patients feel it when they come through the front door. They feel it when they're in their rooms being taken care of by the nursing staff, by housekeeping—the whole range of staff that will touch a patient while they're here. They feel it. They know they're being cared for. They know we care about them and that's something you don't always see. But you can feel it here in this organization.

00:14:03
Laughlin:
What do you love most about your job and most about the hospital?

00:14:08
Lively:
It's the growth and knowing that anytime somebody comes through those front doors, there are going to be people ready to take care of that person, take care of their family, and make sure that their experience here is a great experience. It doesn't just begin and end when they come through the front door. It means making sure they're in the right situation when they leave, whether it's a nursing home, assisted living, or going back home. It means that we surround them with the care and the love they need to get better.

00:14:42
Laughlin:
How would you say things like the Affordable Care Act have impacted the hospital?

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Lively:
Well we're still trying to figure it out. For the most part I don't think the blueprint is complete. I think people are still trying to understand how part A connects with B, C, and D, and all those areas. [15:00] It's very complex. If anybody tells you they understand every aspect of health care reform, you better run as fast as you can to get away from them because nobody can understand it. It's still a work in progress, but there are many aspects of it that are very beneficial to the health care user. Just the fact as I look at both of you. You're young students, and you're probably on your families' health care plan and that was actually extended to the age of twenty-six, which was one of the first enactments of health care reform. As a parent of a twenty-five year old at the time, I thought that was wonderful. There are really good parts. The elimination of pre-existing conditions means that no

longer can a person be turned away from health insurance because of something they've had in the past. Those are really, really good changes. There are other changes that I think we've yet to get our arms around. There's more pressure in hospitals to reduce re-admissions by certain diagnoses and it requires us to work very closely with physicians. It also requires work with nursing homes within the area to be sure we're all moving in the same direction. We can't do it by ourselves. I think that's what we're finding. It takes all of us working together to be effective in these changes.

00:16:32
Appiah:
How do you think those changes will influence how patients view doctors? Like with re-admissions?

00:16:39
Lively:
I think there's always a challenge for a patient. Let's say a patient in the nursing home. In the past the easiest thing to do was to send that patient to the hospital. We're rethinking all of that now. We're understanding that's not always the best place for an elderly patient to go. If you can keep them in the nursing home they're going to be better off. The health system isn't penalized for the readmission and the family doesn't have to move their family member and get them readjusted to a whole different environment. It's a matter of educating. They don't always understand when a physician says you don't need to go to the hospital because the old way was always the answer. The new paradigm is, let's keep you where you are. You can get the care you need in the nursing home and not have to be sent to the hospital. That requires education because the families of the patients; that's what they expect as well.

00:17:43
Appiah:
Does it cost the insurance any different price if they stay in the nursing home? Like is it covered under their health plan?

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Lively:
That's one of the biggest misnomers in health care is that nursing home care is covered by your health plan. [18:00] Nursing home care is covered under Medicare only if it's skilled nursing. A lot people we know and love are in nursing homes under what's called custodial care. For many, many years they may finish their lives in a nursing home and that there is no coverage under traditional health care. If they don't have long-term care insurance then the family is going to have to bare the brunt of that, which is very costly. A lot of Americans don't realize that. I think there's a misnomer that Medicare covers everything, and that simply is not the case.

00:18:36
Appiah:
How about life insurance? Does life insurance cover that as well, or does that only cover in case of a person dying?

00:18:42
Lively:
That's generally the case with life insurance. You either have long-term care insurance, which is a very specific insurance policy. Or you rely on your Medicare for the skilled nursing. Or you have to use your own resources.

00:19:01
Appiah:
What's the most difficult aspect of reform that you're seeing on the ground?

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Lively:
The biggest challenge that I think we're seeing now, at least with our physicians, is the whole idea of understanding the electronic medical record and how that's a requirement. It's not easy. They're so many vendors out there selling electronic medical records. It's very hard for physicians to know which vendor to go to. Some vendors don't stand behind their product. Physicians have had to transform their entire office, their entire hard medical record, into an electronic version. It's a challenge. Their productivity drops when they're going through this conversion because they cannot see as many patients. They're still learning a new system. Many times there are patients who complain that when they were seen by the physician, the physician had their back to them because they were typing on a keyboard entering something into a computer. The physician was not touching them, looking them in the eye, and caring about them.

00:20:06
Appiah:
What about the emergence of tablets? Like I know at my doctor's office at home they use a tablet to be able to input all that information in and it integrates everything. Is that really expensive or is it not feasible in every place?

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Lively:
It's expensive first and foremost. For some physicians, it's a struggle for them to be able to afford that, all the software, and the other hard equipment that goes along with that. Sometimes the software and the systems don't work as well as they should. It takes a while to get the bugs worked out. All the while, the physicians are trying to take care of the patients and they can't really miss a beat. Yet, they have to implement this new technology, and it's a challenge; it's not easy.

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Laughlin:
In the long run, do you feel like the electronic system is more beneficial or hurtful?

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Lively:
It will be more beneficial once all of the parts are talking to each other. Once all of the data can be shared. [21:00] For a patient it's going to mean you don't have to keep giving the same information over and over again. When you go from one point to another in the system it all transfers. When someone comes into the emergency department, the physicians there will know what medications that patient is taking, when they were last seen by their physician, and what their physician episode was. The physician that takes care of that patient in that office will know what the hospital did. They'll know what the medications were. First and foremost, what the treatments were and what the plan of treatment is going to be moving forward. All in all, theoretically, it's the best of all worlds. It's getting into the details, getting into the weeds, making all these things work systematically with varying systems that don't always talk to each other, and synchronizing with the hospital systems to be sure all the information is getting to where it needs to go.

00:22:00
Appiah:
What about integrating with smart phones? Do you find that to be useful? I know that in some medical facilities the employees who have smartphones are able to connect. The program and the software, so that they can spend more time with the patients and input information later. Do you find that to be useful?

00:22:18
Lively:
Very much so. That technology—the regular technology that we're all used to as consumers—will probably go leaps and bounds ahead of what we're seeing now, if we're able to compliment what the physicians and health care physicians are doing.

00:22:35
Appiah:
Do you find it easier for physicians who have smartphones to get the work done that way versus those who have to do all of it at the computer at the station during the day?

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Lively:
I think it varies. There are physicians that are still somewhat not quite up to speed with that. They would tell you that they're going to resist it as long as they can and hold out, and maybe retire before

they have to learn the new technology. There are other physicians that have grasped the new technology and seem to be moving along quite well. I have a physician and they send a timesheet once a month to account for their hours of work. They don't have a scanner in their office, so I ask him to take a picture on their iPhone and email the picture to me. That works just as well. It's like, wow! This is another tool we have. We didn't even know we had it. A very simple solution, but something they probably hadn't thought of.

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Laughlin:
What are some of the big changes in technology that you've seen since you've been here?

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Lively:
The minimally invasive procedures that physicians can do now. That recovery time is so much different that what we saw ten, fifteen, or twenty years ago. Eye surgery is a great example. Many years ago when someone had cataracts surgery they were immobilized for a week or two, and could not even move. And now you know that's something where you walk out of the surgery center and you're ready to function almost the next day. [24:00] The way the surgeon can enter the body in a very, very minimally invasive way, without having to make the big cut and crack the ribs and do things like that; it is making a huge difference in the recovery time of the patients.

00:24:23
Laughlin:
Does this also change patient care in the hospital, as in they're in the hospital a less amount of time?

00:24:32
Lively:
Correct. Very much so. The sooner you can get a patient recovering, get them home into their environment they're familiar with; it's better for the patient, for the family, and everybody involved. You reduce the chance of any kind of hospital born infections, which you always want to avoid.

00:24:58
Appiah:
Do you offer a lot of continuing education classes? Like for instance, the staff who have trouble with computers. Do you have any classes for them to take to help the process?

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Lively:
We do. We have a lot of education along those things or various programs with the computer. That's continuing to grow and develop daily.

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Appiah:
And are those classes at a discount rate for them or is it free?

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Lively:
Generally it's free. I mean if it has cost us something to go outside and bring it in, I think we pass some of that along to the associates. But most of the time we do this internally with our own staff.

00:25:34
Laughlin:
Talking about education in the hospital, what kind of programs do you have here to educate physicians and the future generations?

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Lively:
We're not a teaching hospital. We don't have some of the resources that you would see at a UVA [University of Virginia] or MCV [Medical College of Virginia/Virginia Commonwealth University]. What we have is a lot of physicians that provide mentorship for PAs [physician's assistants], nurse practitioners, and physicians that are in residency. On occasion residents will come through the system—that's where physicians are being trained and mid-level providers are being trained. They are learning from well-respected physicians in the community. We all work together to be sure we make that accessible to them when we have someone like that. They can go into the ORs and observe operations, and things along those lines.

00:26:42
Appiah:
How do you educate the community about different resources that are available here?

00:26:48
Lively:
We have a website now. I think a lot of community members are Internet savvy. That's the first place they'll go. We have to be sure we're tied in with the right search engines. I mean that's one of the most important ways of communicating. [27:00] When most people have a health care issue now, the first thing they do is Google it and try to understand more about it. At least from a lay perspective, they're very knowledgeable. We try to use those tools—we use all the social media that we can because that's the way of the times right now. That is the way that most people learn about the health care system, their disease, their ailment, or whatever they're going through.

00:27:31
Appiah:
Do you find that things like WebMD undermine the role of the physician?

00:27:38
Lively:
What I've heard physicians say to families is you've got to be very careful when you go to WebMD or any of the search engines and look up a disease. It's probably going to scare you because of what you are going to read; you're probably going to read the worst. You have got to be very careful and very selective. I think that's a great caution. Because if you've ever done that you will know that you'll come away terrified. You'll think all the worst things in the world. It's almost like when you read the contra-indication of a medication; why would anybody want to take this medication? A little bit too much knowledge can be scary when it's not used in the right way.

00:28:27
Appiah:
Do you think that the medical knowledge that physicians get from med school allows them to use that knowledge in a more effective way? In a way that can explain to patients with more perspective?

00:28:41
Lively:
I think that's still a work in progress. I think some physicians are better at that than others. Nurse practitioners and PAs can spend a little bit more time with their patients explaining those things. Many times the patients have a very positive experience when they are seen by a PA or a nurse practitioner because they can do those things. Whereas a physician may not have the time they would like to have to be able to just really explain that.

00:29:12
Appiah:
Can you clarify, what is a PA?

00:29:14
Lively:
Physician's Assistant.

00:29:16
Appiah:
Are they similar to like an LPN for the nurses? Is that what it is?

00:29:21
Lively:
That's a pretty good analogy. An LPN [Licensed Practical Nurse] for a nurse is sort of like a mid-level nurse to help the RN. That's a great analogy! The mid-level is what we call it because it's between the nursing level and the physician. A PA is a step higher and can enable the physician to do other more critical thinking kinds of things. The nurse practitioner and the PA can do the routine kinds of things that the physicians would normally have to do.

00:29:57
Appiah:
Routine things? Are you meaning things similar to those, like when you're in the doctor's office- the person who does your vitals and everything before the doctor comes in? [30:00]

00:30:04
Lively:
That's even taking it to a different level. That can be a medical assistant, which is like a certified nursing assistant you see in hospitals; but medical assistants are the ones that you'll actually see in the physician's office more than you will CNAs. CNAs are certified medical assistants. They do the blood pressure, all the vitals, and they can do a history of important pieces of the history and pass it on the physician or nurse practitioner.

00:30:37
Appiah:
What is the most difficult part of getting people's histories? Because it's very similar to a lot of what we've done in our oral history— getting people's life history, but you're getting their medical history. How do you do that and put it in perspective of medicine instead of just them telling you stories?

00:30:54
Lively:
I really don't know how to answer that. I'm not a physician. It's hard to say exactly how. Most systems are structured to get to the heart of what the issues are when you're getting a history and physical on somebody, so you can determine what the issues are. It's kind of guided; it has its parameters so that it's controlled to a certain extent.

00:31:16
Appiah:
Does more than one person get the history? Does only the physician get the history, or a little bit of everybody? Like the nurse gets a little one and the doctor gets one.

00:31:25
Lively:
It's kind of a building process, at least from my experiences. It'll keep being added onto. I mean if you've ever been to a doctor's office and the person gets a very detailed, "Why are you here? Tell me about this and that." And the physician walks in and says, "Why are you here?" [laughs] You think, "Wait a minute, I just told you that." It's just how well they can execute that whole interchange that is critical. Some do it better than others.

00:31:51
Appiah:
As someone in charge of Physician Relations, do you have a lot of interaction between administration and physicians and communicating issues? Or is it more just inner position politics?

00:32:04
Lively:
It's really a little bit of everything. It's anything that can help make that physician's day easier. It's very complex to get a patient into our system because we're a complex health care system. Physicians have to run their own office. What we try to do is understand where the difficulties lie and make things smoother and easier for them. Examples are getting appointments scheduled for MRIs or having somebody scheduled for surgery and all of those things. If we don't pay attention to them it can be very frustrating for the physician's office. There are a lot of different hands that have to touch that and a lot of different people that get involved in it. It's really anything we can do to remove some of those headaches and those burdens throughout their day and make their day run smoother. That means the patient is getting better and smoother care.

00:33:04
Appiah:
What are some of the difficulties as medical practices have become more like a business? Like you mentioned earlier that in a lot of ways they're running their own business.

00:33:12
Lively:
They are. If you look at physicians that have an office, they're paying their own employees. They have pension plans for their own employees. They have to buy health insurance for own employees. They have to hire and fire. They have to pay rent. They have to do all the things that any businessperson would have to do. They also have to manage the patients that come see them, make sure they're taking care of their patients, and they are communicating with a lot of different areas that also touch their patients, like the hospital, the imaging, and the lab. They manage every bit of that and every aspect of that. It's a very daunting task when you think about it. Unlike in dental school, they didn't get a lot of training on how to run a business. Dentists seem to have a very clear

career track in dental school on: "This is how you set up appointments. This is how you call patients two days before to be sure they come in." That never made it to the medical schools in the past.

00:34:17
Appiah:
How do you, as someone in charge of physician relations improve that process? You talked about making their day easier. Do you also help on the business end? Do you help with training them about appointment times and those type of things?

00:34:28
Lively:
We do. We've actually had people go in and sit in physician's offices and try to understand what wasn't working. Why they were turning patients away and they had fifteen open slots every day? We try to help them understand how you make that phone call to the patient; it is the most important thing anybody does that day, which is to get that patient in. That's why you're all there. If you have a receptionist that doesn't understand that and doesn't care about that, then significant re-training with the receptionist should occur. They have to live every moment of the day they're in your office to make sure that they take care of the needs of those people calling on the phone; you have to make them feel special, feel wanted, and cared for. That's just an example. I mean there are so many aspects of that.

00:35:18
Appiah:
Have you found that over the years that the business model has become easier? You talked about you've in this field for the last ten years, you said right? Have you noticed that the business model has become more clear over time or has it become more and more of a complex process?

00:35:36
Lively:
It's more complex. Almost every year physicians wait to see where the federal government is going to cut their payments again, on the Medicare or Medicaid. Once that happens they are trying to understand how they can make ends meet. From a monetary perspective, it is a challenge every day. How are they going to survive, continue to pay their expenses, and pay all of their overhead? [36:00] Their revenues are decreasing because someone that has control over how much is going to be paid for a certain office visit or certain procedure is deciding that they are going to be cut that every year.

00:36:15
Appiah:
How do you deal with medicine shortages? I know that's a huge problem across the country. How do you deal with a physician who says, "I have a prescription, but I realize there's a shortage and I need it." How do you guys improve that process?

00:36:28
Lively:
I don't know. I don't see that much. We have that maybe once a year with the flu vaccine. We don't see a lot of that.

00:36:39
Appiah:
What's the most difficult part in physician relations in terms of communication, the most difficult aspect?

00:36:45
Lively:
I think every physician is their own advocate for what they see and it's almost like you're looking at a beach ball. If we're all three lying looking up at one, we'll all see the different colors because of our perspective and how we're seeing it. They look at everything from their practice perspective or their specialty. I think that sometimes you have to get everyone to understand that there's involvement of everybody in this, and it's not just one perspective. That takes patience, it takes education, and it's very trying sometimes to say, "Well, I understand you look at the patient from this way and these are the body parts or the organs that really are important to you, but that's not the whole. There are other pieces that are involved and other people that are involved, and we have to get their input."

00:37:35
Appiah:
Do you get a lot of interaction with nurses as well? I know there's a lot of hierarchical conflict between nurses and doctors because they perceive things differently. Do you see a lot of that in your field?

00:37:45
Lively:
I am probably not involved as much. I know the doctors look to the nurse very much, at least in the hospital setting. Most times, doctors in office practices will hire LPNs or medical assistants because they can't afford to hire RNs- to be in their office. There's a varying degree there. They all rely on those professionals to help them run their day-to-day practice.

00:38:11
Appiah:
Do you notice a generational difference in physicians? Like, since you've been in there for ten years, have you seen a generational difference in how the physicians approach your office in terms of issues?

00:38:25
Lively:
The biggest difference is the technology. The physicians that have been in practice many, many years have the bigger struggle in grasping the new technology; the office based technology for the most part. The newer physicians—I mean you look at them and they're so young—they don't generally want to work the hours that the older physicians have worked. A lot of physicians now are coming out and they want to work a 9:00 to 5:00 day, five days a week. That was unheard of fifteen, twenty, or thirty years ago. [39:00] Physicians didn't have the luxury of just being able to work those kinds of schedules because they didn't have hospitalists to see the patients in the hospital. They didn't have plans like Kaiser, where that's what's promoted to the physicians joining Kaiser. You work a five-day week and you work 9:00 to 5:00. You don't have any call. Those were things that were just part of medicine for many, many years. Those were the big struggles. Who is going to take your call? Who is going to take care of your patients after hours? Who is going to see them in the hospital when they come in on a weekend? Those things have gotten a lot easier for physicians in the last fifteen years or so.

00:39:43
Appiah:
Do you have a lot of interaction with future doctors? Like fellows or residents? Do they also fall into your field? Because they're not necessarily- they're the weird middle ground where not physicians, but they're becoming physicians.

00:39:54
Lively:
In recruitment, typically we will be contacting physicians that are still in residency. Once they finish they're going to have offers. The average physician probably has five to ten offers from around country. Those offers are there before they're ever out of their residency. We've got to be very quick and be sure we're in that ball game and having dialogue with them then. Sometimes they're not really clear on what they want to do in a year or two years when they get out. So it involves creating that relationship and building that trust with them. It's a lot like recruiting college athletes and building the trust. When you're talking an athlete that maybe has another year to go in high school, they're not sure exactly. It's building the relationship so when they do make a decision you are there.

00:40:46
Appiah:
Do you find that in some ways it's easier to interact with them because they're not doctors yet and they don't have the same perspective as doctors? Or is it just different?

00:40:55
Lively:
It's different. I think they're so overwhelmed with what they're doing, that it's a challenge for them to really focus on what they're going to be doing in a year or two. They've still got some huge hurdles to get through in residency or fellowship. Or whatever they're encountering.

00:41:16
Laughlin:
Would you like to cover anything that we might have missed?

00:41:20
Lively:
I think we've covered a lot. I really do.

[End of Interview]