Succeeding in Urban and Rural Practice: An Interview With Marilou Terpenning, MD

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MD

At Santa Monica Hematology-Oncology Consultants in California, Dr Marilou Terpenning stays busy as managing partner of a thriving practice with four physicians and 20 employees. Yet she takes time to maintain another large practice in rural Owens Valley, east of the Sierra Nevada, and to serve as clinical associate professor at the David Geffen School of Medicine at the University of California at

Los Angeles. We asked Terpenning for insight into her success and found her eager to share. There was only one hitch: The interview had to take place at 6 a.m.—the calmest time of her day.

JOP: Good morning. Let's start with a little history. Did you originally intend to be a doctor?

I was a graduate student at Harvard in the School of Education when I was in one of those fluke accidents where a car crossed the median and hit me head-on. This accident made me realize that life wasn't a dress rehearsal, and I went to medical school instead.

Two factors led me to choose oncology. One of my best friends had died of leukemia when I was 6. That was back in the '50s, when children with cancer just disappeared, and it made me mad. Also, the first woman doctor that I ever met was a female hematologist when I was a first-year medical student. She was a professor, quite poised and well-educated, and a lovely role model.

I did my first 2 years of medical school at what was then the University of Medicine and Dentistry of New Jersey. Since it was then a two-year school, I transferred to Washington University School of Medicine and graduated in 1976. For internship and residency, I went to the University of Michigan at Ann Arbor.

I'd always planned an academic career doing research because I like basic science very much, and I came out to UCLA in 1979 for a fellowship. Oncology was an emerging field, and only a few centers offered both clinical work and basic science research. I chose to remain at UCLA for exposure to the broader fields of hematology and oncology as well as transplantation, and I did a basic science research fellowship in immunology. In 1982, I joined the full-time faculty, had a research laboratory, and taught at the Veteran's Administration Hospital and at the county hospital-based teaching program in the San Fernando Valley.

JOP: Why leave that for private practice?

In 1988, my son's father unexpectedly became ill and, ultimately, passed away. In order to provide for my family without excessive travel, I entered private practice.

I didn't know a thing about practicing medicine in the private setting. I set up a shingle in my hometown of Santa Monica. However, I knew many people from being on the faculty at UCLA, and they began to refer patients. The fellows I'd trained had relocated to locations all over the state, and they referred as well. St. John's Health Center, where I practice predominantly, was also very welcoming.

JOP: Was it a challenge to run your own business?

I found that I had administrative skills from running regional clinical programs in oncology when I was on the UCLA faculty. My work in the Midwest in the '70s had given me experience in caring for patients who lived at a distance because, at that time, there were no oncologists in rural areas. So I just continued having a well-run office designed to deliver expeditious and efficient health care, and set up systems to monitor patients long-distance.

Administratively, I've always had a strategic plan guided by the mission of making sure we could take excellent care of our patients and provide them an environment in which they can integrate cancer into their life, as opposed to having it become the dominant force in their life. With that guiding principle, things fell into place quite well.

To provide care economically has become much more challenging in the last five years, as our specialty has been under siege. With the number of cancer cases increasing rapidly, due to our colleagues in cardiology making it impossible to die of a heart attack anymore, the incidence of cancer is booming. The economics have been difficult. We try to help our patients have realistic expectations.

In the past five years, a great deal of practice energy has been expended working with insurance carriers and [Centers for Medicare & Medicaid Services]. Every year, there have been new hurdles to jump. Changing the oncology coding serially for the past three years has required intensive staff training, and this has been a major drain on practice time and energy, although this has led to some improvement in the level of reimbursement for treatment procedures. The extremely high cost of newer drugs, coupled with the marginal reimbursements that are barely break-even, requires you to run an office that's like a Navy bed—you must be able to bounce a quarter off it.

So, we do. Our staff is efficient and very computer-savvy. We are deeply committed to minimizing internal staff strife and building a collaborative relationship where there's trust and interdependency. Trust leads to speed because you can count on programs and people. We have evolved healthy means of settling differences, such as having section meetings or interstaff meetings when difficulties arise. I am not an adversarial person—I think it wastes energy, time, and takes away from patient care.

We have an exceptional staff, many of whom have been with us for many years. I have two younger partners, both of whom joined me about seven and a half years ago. There's an age gap between us of about 15 years. It's unusual to bring in two young doctors at the same time, and it was very challenging to say the least. But it's also very rare to find two people with similar value systems, practice styles, and consistency. That's the main thing that's important in a medical marriage—making sure that you have some shared values and vision of what medicine should be.

As a practice, we keep reinventing ourselves. When you've been together for a long time, you can get old and out of date and miss the benefit of changing times. We have managed to survive and do well in a very competitive environment with a high cost of living. Our staff is carefully selected, and we try to make sure they are well taken care of. I am cognizant of how difficult it is for people not making extremely high incomes to buy homes here in Southern California and have a decent quality of life.

JOP: How do you make decisions on capital investments?
Collaboratively. I'm the managing partner of the practice, but I have included my fellow partners from the beginning in understanding business, and how to run a practice. A good example is the practice conversion we are now doing, going into EMR [electronic medical record] over the next year. It's a lot of work, and we've spent two years studying it. We have an EMR committee in the practice, so there's buy-in from all of our staff, everyone from the front-office staff to medical assistants, to nurses and billers—including the physicians.

I do budget projections and cost impact for everything. We take a look at every business proposition, from a [photocopier] to a scanner. I have an excellent administrator who assists me with this.

JOP: And how did you pick the EMR product?
A number of years ago, I joined Medical Group Management Association, which is dominated by practice administrators. I have learned a lot from them. I've taken courses, we've had Web casts in the office . . . we've had demos of the number of different types of EMRs. I've gone to shows looking at

different practice-management systems. I've included my partners in all of this. It's definitely joint decision-making, because this is their financial future as well as my own. We have been studying the issue for three and a half years.

We chose to go with a nononcology product for durability. In the climate of increasing medical regulation, the oncology products' durability wasn't clear to me, whereas generic products can be modified to suit the needs of an oncology practice, and they will be go-ahead products for the next 15 to 20 years.

JOP: Your practice is unusual, with patients from rural areas as well as from Los Angeles.

We have a lot of patients who live on the more affluent west side of urban West Los Angeles, and St. John's Health Center tends to attract many people who are very successful in the world in a variety of ways. But this is not a concierge practice. We take insurance. We just don't participate in any HMO plans. Our office is sensitive and comfortable and focused on giving efficient, thoughtful care. It's important to treat each person in the way in which they are comfortable to be treated. We don't have a cookie-cutter approach, and instead attempt to give individualized care to assist our patients in using socially comfortable methods to adjust to their diagnosis and treatment.

JOP: And your remote practice?

I maintain a large practice in the Owens Valley, east of the Sierras, because there's no oncologist there. In the snow, it's very tough to get through the passes.

JOP: Is there a milestone in your career, in the development of your practice?

The field has changed greatly. I think the biggest challenge is to maintain the single purpose, the focus of why one becomes an oncologist: to help people in difficult circumstances deal as best as they can with challenging diseases . . . to help them find the strength to help themselves. The external pressures of health economics have made it increasingly difficult to do that, so one must constantly reevaluate goals and make sure that one's mission is in line with what's accomplishable. Remarkably, it remains so—always to my surprise. So the biggest milestone in my career is that I'm still an oncologist and enjoying being one after 30 years.

(Note: Terpenning's former professor, Parvin Saidi, MD, is now chief of Hematology-Oncology at the Robert Wood Johnson School of Medicine at the University of Medicine and Dentistry of New Jersey at Newark.)

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