# New Practice Options

Physicians who are satisfied in medicine seem to have found a practice setting or style that fits their personality, temperament, lifestyle, risk tolerance—and their unique approach to patient care. In this chapter we present stories of physicians who have figured out how to design demanding full-time practices that work for them.

## *Fast* Facts

- *Physicians who have a clear idea what they are looking for are more likely to find the right practice on the first try, avoiding the stress and headaches associated with a poor work environment. Page 54*
- *The hospitalist movement is offering new opportunities for physicians. According to a recent* Washington Post *article, there were roughly 100 doctors who called themselves "hospitalists" in 1997; today there are more than 20,000. Page 57*
- *Some physicians have found contentment in their practice by opting out of or reducing reliance on third-party payers. There are several ways to do this. Page 60*

The hard truth is that practicing medicine is becoming more and more complex. This should not come as a surprise to any physician working today.

"There are two ways to look at it," says Patrick C. Alguire, MD, FACP, Director of Education and Career Development at the American College of Physicians (ACP). "You can throw your hands in the air and give up, or learn how to develop systems to handle the new requirements in a way that reduces the work and

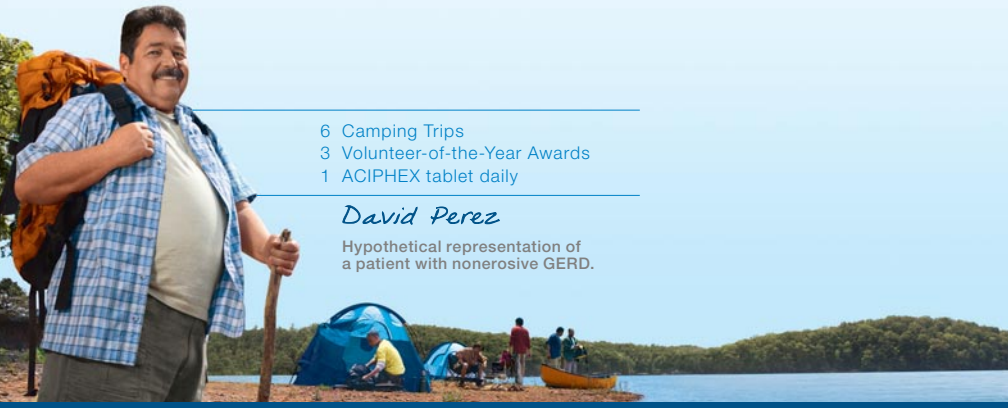
# There's more to GERD than heartburn…

**…other symptoms include regurgitation, belching & early satiety.**

**Recent research supports an association between BMI and GERD symptoms**[1-4]

- Being overweight or obese is a risk factor for GERD symptoms[1]
- The risk doubles for patients who are overweight (BMI 25 to 30)[2]
- The risk triples for patients who are obese (BMI>30 to 35)[2]

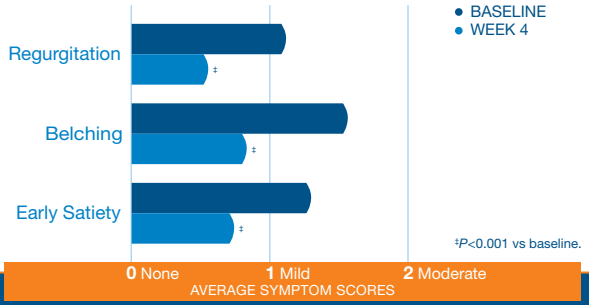
GERD=gastroesophageal reflux disease




# Write ACIPHEX to treat heartburn and beyond

**Study design:**
A combined analysis of 2 placebo-controlled studies (N=261) in nonerosive GERD patients with moderate to very severe heartburn who received ACIPHEX 20 mg once a day or placebo for 4 weeks (ITT: ACIPHEX, n=126; placebo, n=126)[5,6]

**At 4 weeks, ACIPHEX significantly reduced severity of regurgitation, belching and early satiety*†[5]**




*Symptom severity scores were recorded daily (0=none; 1=mild; 2=moderate; 3=severe; 4=very severe).
†Compared with placebo, at week 4 ACIPHEX significantly reduced severity of regurgitation ($P$=0.006),belching ($P$=0.007) and early satiety ($P$=0.04).

- Placebo: Regurgitation was reduced from 1.05 at baseline to 0.72 at week 4; belching was reduced from 1.47 at baseline to 1.06 at week 4; and early satiety was reduced from 1.28 at baseline to 0.91 at week 4. All $P$ values were <0.001[5]

**INDICATION**
ACIPHEX 20 mg is indicated for the treatment of daytime and nighttime heartburn and other symptoms of GERD.

**IMPORTANT SAFETY INFORMATION**
In clinical trials the most common side effect assessed as possibly or probably related to ACIPHEX with a frequency greater than placebo was headache (2.4% vs 1.6% for placebo).

Symptomatic response to therapy does not preclude the presence of gastric malignancy. ACIPHEX is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles, or to any component of the formulation. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

**PLEASE SEE BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION FOR ACIPHEX 20 MG TABLETS ON FOLLOWING PAGE.**

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Eisai
Woodcliff Lake, NJ 07677

Marketed by
PriCara™
Unit of Ortho-McNeil, Inc.
Raritan, NJ 08869-0602

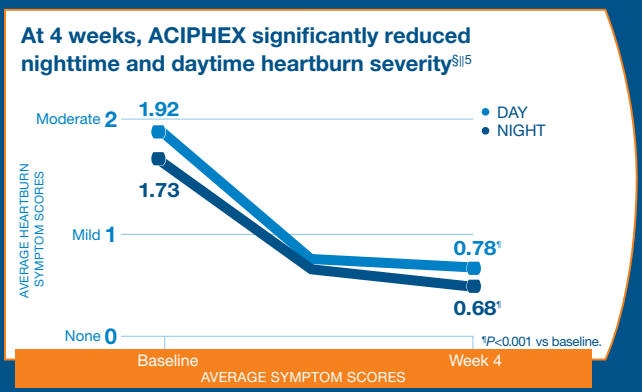

01AX1603D Sept. 2007

# “There’s more to my life than GERD”

**78%**

of patients in these studies were overweight or obese (BMI≥25); however, BMI was not an enrollment criteria[5]

## At 4 weeks, ACIPHEX significantly reduced nighttime and daytime heartburn severity[§‖5]




[§]Symptom severity scores were recorded daily (0=none; 1=mild; 2=moderate; 3=severe; 4=very severe).
[‖]Compared with placebo, at week 4 ACIPHEX significantly reduced severity of nighttime heartburn ($P$=0.006) and daytime heartburn ($P$<0.001).

- Placebo: Nighttime heartburn was reduced from 1.82 at baseline to 1.12 at week 4 and daytime heartburn was reduced from 2.01 at baseline to 1.33 at week 4. All $P$ values were <0.001[5]

USA

PROUD PARTNER

TREAT HEARTBURN AND BEYOND

AcipHex®
rabeprazole sodium

**References: 1.** El-Serag HB, Graham DY, Satia JA, Rabeneck L. Obesity is an independent risk factor for GERD symptoms and erosive esophagitis. *Am J Gastroenterol*. 2005;100:1243-1250. **2.** Nilsson M, Johnsen R, Ye W, Hveem K, Lagergren J. Obesity and estrogen as risk factors for gastroesophageal reflux symptoms. *JAMA*. 2003;290:66-72. **3.** Hampel H, Abraham NS, El-Serag HB. Meta-analysis: obesity and the risk for gastroesophageal reflux disease and its complications. *Ann Intern Med*. 2005;143:199-211. **4.** Murray L, Johnston B, Lane A, et al. Relationship between body mass and gastro-oesophageal reflux symptoms: The Bristol Helicobacter Project. *Int J Epidemiol*. 2003;32:645-650. **5.** Data on file, Eisai, Inc. **6.** ACIPHEX full prescribing information.

AcipHex®
rabeprazole sodium
DELAYED-RELEASE TABLETS
\ˈa-sə¸feks\

**BRIEF SUMMARY**
Before prescribing ACIPHEX®, please see full prescribing information.

**INDICATIONS AND USAGE**
**Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)**
ACIPHEX® is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX® may be considered.

**Maintenance of Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)**
ACIPHEX® is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

**Treatment of Symptomatic Gastroesophageal Reflux Disease (GERD)**
ACIPHEX® is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD.

**Healing of Duodenal Ulcers**
ACIPHEX® is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

***Helicobacter pylori* Eradication to Reduce the Risk of Duodenal Ulcer Recurrence**
ACIPHEX® in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate *H. pylori*. Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence. (See **CLINICAL STUDIES** and **DOSAGE AND ADMINISTRATION** in full prescribing information.)

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. (See **CLINICAL PHARMACOLOGY, Microbiology** in full prescribing information and the clarithromycin package insert, **CLINICAL PHARMACOLOGY, Microbiology**.)

**Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome**
ACIPHEX® is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

**CONTRAINDICATIONS**
Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles or to any component of the formulation.

Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

**WARNINGS**
**CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE.** If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See **WARNINGS** in prescribing information for clarithromycin.)

**Amoxicillin:** Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, cephalosporin, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See **WARNINGS** in prescribing information for amoxicillin.)

**SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.**

**Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.**

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile colitis*.

**PRECAUTIONS**
**General**
Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without *H. pylori* infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with *H. pylori* infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

**Information for Patients**
Patients should be cautioned that ACIPHEX® delayed-release tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX® can be taken with or without food.

Please see FDA-approved patient labeling in the full prescribing information.

**Drug Interactions**
Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients. There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death.

*In vitro* incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an $IC_{50}$ of 62 micromolar, a concentration that is over 50 times higher than the $C_{max}$ in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption may occur due to the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole 20 mg QD resulted in an approximately 30% decrease in the bioavailability of ketoconazole and increases in the AUC and $C_{max}$ for digoxin of 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

**Combined Administration with Clarithromycin**
Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxyclarithromycin. (See **CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials** in full prescribing information.)

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. (See **PRECAUTIONS** in prescribing information for clarithromycin.) (See **PRECAUTIONS** in prescribing information for amoxicillin.)

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

In a 88/104-week carcinogenicity study in CD-1 mice, rabeprazole at oral doses up to 100 mg/kg/day did not produce any increased tumor occurrence. The highest tested dose produced a systemic exposure to rabeprazole (AUC) of 1.40 µg•hr/mL which is 1.6 times the human exposure (plasma $AUC_{0-\infty}$ = 0.88 µg•hr/mL) at the recommended dose for GERD (20 mg/day). In a 104-week carcinogenicity study in Sprague-Dawley rats, males were treated with oral doses of 5, 15, 30 and 60 mg/kg/day and females with 5, 15, 30, 60 and 120 mg/kg/day. Rabeprazole produced gastric enterochromaffin-like (ECL) cell hyperplasia in male and female rats and ECL cell carcinoid tumors in female rats at all doses including the lowest tested dose. The lowest dose (5 mg/kg/day) produced a systemic exposure to rabeprazole (AUC) of about 0.1 µg•hr/mL which is about 0.1 times the human exposure at the recommended dose for GERD. In male rats, no treatment related tumors were observed at doses up to 60 mg/kg/day producing a rabeprazole plasma exposure (AUC) of about 0.2 µg•hr/mL (0.2 times the human exposure at the recommended dose for GERD).

Rabeprazole was positive in the Ames test, the Chinese hamster ovary cell (CHO/HGPRT) forward gene mutation test and the mouse lymphoma cell (L5178Y/TK+/-) forward gene mutation test. Its demethylated-metabolite was also positive in the Ames test. Rabeprazole was negative in the *in vitro* Chinese hamster lung cell chromosome aberration test, the *in vivo* mouse micronucleus test, and the *in vivo* and *ex vivo* rat hepatocyte unscheduled DNA synthesis (UDS) tests.

Rabeprazole at intravenous doses up to 30 mg/kg/day (plasma AUC of 8.8 µg•hr/mL, about 10 times the human exposure at the recommended dose for GERD) was found to have no effect on fertility and reproductive performance of male and female rats.

**Pregnancy**

**Teratogenic Effects. Pregnancy Category B:** Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8 µg•hr/mL, about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3 µg•hr/mL, about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers**

Following intravenous administration of $^{14}C$-labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on $mg/m^2$) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**

The safety and effectiveness of rabeprazole in pediatric patients have not been established.

**Use in Women**

Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse events and laboratory test abnormalities in women occurred at rates similar to those in men.

**Geriatric Use**

Of the total number of subjects in clinical studies of ACIPHEX®, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

**ADVERSE REACTIONS**

Worldwide, over 2900 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment. In general, rabeprazole treatment has been well-tolerated in both short-term and long-term trials. The adverse events rates were generally similar between the 10 and 20 mg doses.

**Incidence in Controlled North American and European Clinical Trials**

In an analysis of adverse events assessed as possibly or probably related to treatment appearing in greater than 1% of ACIPHEX® patients and appearing with greater frequency than placebo in controlled North American and European trials, the incidence of headache was 2.4% (n=1552) for ACIPHEX® versus 1.6% (n=258) for placebo.

In short and long-term studies, the following adverse events, regardless of causality, were reported in ACIPHEX®-treated patients. Rare events are those reported in ≤1/1000 patients.

*Body as a Whole:* asthenia, fever, allergic reaction, chills, malaise, chest pain substernal, neck rigidity, photosensitivity reaction. Rare: abdomen enlarged, face edema, hangover effect. *Cardiovascular System:* hypertension, myocardial infarct, electrocardiogram abnormal, migraine, syncope, angina pectoris, bundle branch block, palpitation, sinus bradycardia, tachycardia. Rare: bradycardia, pulmonary embolus, supraventricular tachycardia, thrombophlebitis, vasodilation, QTC prolongation and ventricular tachycardia. *Digestive System:* diarrhea, nausea, abdominal pain, vomiting, dyspepsia, flatulence, constipation, dry mouth, eructation, gastroenteritis, rectal hemorrhage, melena, anorexia, cholelithiasis, mouth ulceration, stomatitis, dysphagia, gingivitis, cholecystitis, increased appetite, abnormal stools, colitis, esophagitis, glossitis, pancreatitis, proctitis. Rare: bloody diarrhea, cholangitis, duodenitis, gastrointestinal hemorrhage, hepatic encephalopathy, hepatitis, hepatoma, liver fatty deposit, salivary gland enlargement, thirst. *Endocrine System:* hyperthyroidism, hypothyroidism. *Hemic & Lymphatic System:* anemia, ecchymosis, lymphadenopathy, hypochromic anemia. *Metabolic & Nutritional Disorders:* peripheral edema, edema, weight gain, gout, dehydration, weight loss. *Musculo-Skeletal System:* myalgia, arthritis, leg cramps, bone pain, arthrosis, bursitis. Rare: twitching. *Nervous System:* insomnia, anxiety, dizziness, depression, nervousness, somnolence, hypertonia, neuralgia, vertigo, convulsion, abnormal dreams, libido decreased, neuropathy, paresthesia, tremor. Rare: agitation, amnesia, confusion, extrapyramidal syndrome, hyperkinesia. *Respiratory System:* dyspnea, asthma, epistaxis, laryngitis, hiccup, hyperventilation. Rare: apnea, hypoventilation. *Skin and Appendages:* rash, pruritus, sweating, urticaria, alopecia. Rare: dry skin, herpes zoster, psoriasis, skin discoloration. *Special Senses:* cataract, amblyopia, glaucoma, dry eyes, abnormal vision, tinnitus, otitis media. Rare: corneal opacity, blurry vision, diplopia, deafness, eye pain, retinal degeneration, strabismus. *Urogenital System:* cystitis, urinary frequency, dysmenorrhea, dysuria, kidney calculus, metrorrhagia, polyuria. Rare: breast enlargement, hematuria, impotence, leukorrhea, menorrhagia, orchitis, urinary incontinence.

*Laboratory Values:* The following changes in laboratory parameters were reported as adverse events: abnormal platelets, albuminuria, creatine phosphokinase increased, erythrocytes abnormal, hypercholesteremia, hyperglycemia, hyperlipemia, hypokalemia, hyponatremia, leukocytosis, leukorrhea, liver function tests abnormal, prostatic specific antigen increase, SGPT increased, urine abnormality, WBC abnormal.

In controlled clinical studies, 3/1456 (0.2%) patients treated with rabeprazole and 2/237 (0.8%) patients treated with placebo developed treatment-emergent abnormalities (which were either new on study or present at study entry with an increase of 1.25 x baseline value) in SGOT (AST), SGPT (ALT), or both. None of the three rabeprazole patients experienced chills, fever, right upper quadrant pain, nausea or jaundice.

*Combination Treatment with Amoxicillin and Clarithromycin:* In clinical trials using combination therapy with rabeprazole plus amoxicillin and clarithromycin (RAC), no adverse events unique to this drug combination were observed. In the U.S. multicenter study, the most frequently reported drug related adverse events for patients who received RAC therapy for 7 or 10 days were diarrhea (8% and 7%) and taste perversion (6% and 10%), respectively.

No clinically significant laboratory abnormalities particular to the drug combinations were observed.

For more information on adverse events or laboratory changes with amoxicillin or clarithromycin, refer to their respective package prescribing information, **ADVERSE REACTIONS** section.

*Post-Marketing Adverse Events:* Additional adverse events reported from worldwide marketing experience with rabeprazole sodium are: sudden death; coma and hyperammonemia; jaundice; rhabdomyolysis; disorientation and delirium; anaphylaxis; angioedema; bullous and other drug eruptions of the skin; severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; interstitial pneumonia; interstitial nephritis; and TSH elevations. In most instances, the relationship to rabeprazole sodium was unclear. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported. Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

**OVERDOSAGE**

**Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug.** There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdosage with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoactivity, labored respiration, lateral or prone position and convulsion in mice and rats and watery diarrhea, tremor, convulsion and coma in dogs.

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the headaches, and also meets the end objective of delivering quality care." Dr. Alguire says that professional societies—the ACP among them—are offering help to their physician members in looking at systems-based practice management, division-of-labor issues, and the team approach to health care. "That's the next big change in the private practice area. Physicians will need these new skills in order to be successful," says Dr. Alguire.

What is it that makes practicing medicine work so well for some physicians, while others struggle year after year to find even a glimmer of satisfaction in the field they once thought would bring them meaning, happiness, and financial reward? In addition to being clear about their values, purpose, strengths, and work-life balance, physicians who are satisfied in medicine seem to have found a practice setting or style that fits their personality, temperament, lifestyle, risk tolerance, and unique approach to patient care.

Timothy McNichols, MD, has practiced internal medicine at Ferrell-Duncan Clinic in Springfield, Mo., for seven years. This was his first job out of residency; and looking back, he realizes he chose well. He interviewed at several practices before landing in Missouri. He knew what he wanted, and he was on the lookout for "big red flags," such as overworked physicians and signs of poor management decisions.

"I knew I didn't want to go into solo practice," says Dr. McNichols. "I wanted someone else to take care of the business end, and this clinic was obviously very successful. They had an established administrative team that wasn't top-heavy."

Dr. McNichols was also attracted to the fact that physicians were partners, not salaried employees, and that the structure was such that he could practice on his own terms. "You can work as hard as you want and make as much as you want," says Dr. McNichols. However, he adds, "if [time off] is more important, there's no one saying you have to work harder." Ferrell-Duncan Clinic, part of the CoxHealth system, was founded by two surgeons in 1945 and now has more than 100 physicians.

Finding this kind of fit sometimes requires effort. It's not uncommon, especially for new physicians just out of training, to take a job only to discover it's not at all what they'd expected, and to leave within a year or two for greener pastures. Identify-

ing individual strengths and limitations, likes and dislikes, preferences and "deal breakers" before even going into a new practice can save a lot of stress and headache down the road.

## The Business of Medicine

Physicians in practice by themselves or with a few other physicians know all too well that there is more to practicing medicine than simply practicing medicine. The decisions made day to day, month to month, and year to year can significantly impact how the practice works for you—or against you. One trend that appears to be gaining momentum among primary care and specialty physicians alike is that of becoming more entrepreneurial within the traditional medical practice. With reimbursement dropping lower and lower, physicians are looking for ways to increase their income without necessarily seeing more patients each day.

**One trend that appears** to be gaining momentum among primary care and specialty physicians alike is that of becoming more entrepreneurial within the traditional medical practice. With reimbursement dropping lower and lower, physicians are looking for ways to increase their income without necessarily seeing more patients each day.

Taking an entrepreneurial approach to medical practice can bring the spark back to medicine. "Being an entrepreneur is a radical act of creativity," says Philippa Kennealy, MD, MPH, CPCC, PCC, President of The Entrepreneurial MD (www.entrepreneurialmd.com). Dr. Kennealy originally trained as a family physician but left private practice in 1996. She obtained a master's degree in public health from the University of California at Los Angeles, and became Medical Director and CEO of the Santa Monica-UCLA Medical Center. She was also executive vice president of two Internet start-ups before becoming a certified coach. Now she works almost exclusively with other physicians, helping them develop their entrepreneurial skills.

Accordingly to Dr. Kennealy, bringing an entrepreneurial mindset to even the most traditional practices can help physicians gain a greater sense of control. "You don't have to do a lot of things; you just need to start thinking more like a businessper-

son," says Dr. Kennealy. "Where are you losing time? What's inefficient? Where could technology help you?"

Dr. Kennealy's clients typically fall into one of three groups:

- Physicians who want to stay in medicine but who also have a business idea they want to explore—sometimes related to medicine, sometimes not.
- Physicians who are tired of practicing medicine and who have an incipient business idea, but don't know if it's realistic or how to flesh it out.
- Physicians who plan to stay in medicine but realize they need to practice differently, more efficiently, or in a more businesslike fashion.

There are any number of options for physicians who want to create additional revenue streams for their practices. A few of these include offering cosmetic procedures (within the scope of one's training, of course), skin care products, supervised and comprehensive weight loss programs, or information products, or adding well-trained staff who can offer services such as massage therapy, acupuncture, nutritional consultation, counseling, or life coaching.

Be careful, however, if you decide to offer new products and services through your practice. Most physicians don't want to be viewed as "selling their wares," and how you present your offerings can make all the difference. It's important to do it ethically and tastefully and to put the needs of patients first. For example, dermatologist Rick Noodleman, MD, of Campbell, Calif., offers his own line of skin-care products. The extension of his dermatology practice made sense to him—and his patients. "Patients like to get skin-care advice from their doctor," says Dr. Noodleman. "They assume correctly that, while we benefit monetarily, we have their best interest in mind. If three things will do the job, we're not going to sell them ten."

Dr. Kennealy suggests surveying patients to gauge interest beforehand. "Don't assume or presume what they'll find valuable," she says. "Do proper market research to find out what people value and what they are willing to pay for."

## Enough is Enough

But it's not necessary to add services in order to make med-

ical practice more satisfying. Physicians may find that simply changing the way they deliver services or structure their businesses can make a huge difference in professional satisfaction.

## The Hospitalist Movement

It wasn't long ago that when patients were hospitalized, their own doctor—family physician, internist, or specialist—managed their care from admission to discharge. Sure, a few consulting physicians were called in, and residents would often help take care of the patient; but for the most part, the patient's "main doctor" called the shots. Today patients will very likely make the acquaintance of a brand new doctor—or several of them—in the course of a hospital visit. According to a recent *Washington Post* article, there were roughly 100 doctors who called themselves "hospitalists" in 1997; today there are more than 20,000.

Patrick C. Alguire, MD, FACP, Director of Education and Career Development at the American College of Physicians, says that the advent of the hospitalist reminds him of how emergency medicine developed as a specialty 30 years ago. At one time, family physicians or internists who had a special interest in the ER simply gravitated toward working in that arena—often in addition to their regular practice. Today most emergency departments are staffed by board-certified emergency medicine physicians. The trend may be going the same direction with hospital medicine. "They have their own journals, textbooks, and organizations," says Dr. Alguire. "It's a bona fide career choice for individuals."

Physicians are attracted to a hospital-only practice for a variety of reasons. For young physicians emerging from residency, it provides a full-time or part-time way to practice medicine without having to make a large investment in a practice. Many residents find positions in the cities where they did their training and don't have to uproot their families after only three or four years in one spot. And then there is the beauty of shift work: When you're on, you work hard; but when you're off, you're really off.

Physicians interested in this type of work may investigate the following resources:

Society of Hospital Medicine: *www.hospitalmedicine.org*

American College of Physicians *ACP Hospitalist* publication: *www.acponline.org/hospitalist*

*Today's Hospitalist* magazine: *www.todayshospitalist.com*

Opting out of or dramatically reducing reliance on third-party payors is one way to make practice less complex, reduce overhead, and regain control of how care is delivered to patients.

This approach has worked well for Audrey Corson, MD, and her colleagues. The idea came as a way to rescue her practice and her patients.

When Dr. Corson and a colleague originally joined a group practice in Bethesda, Md., more than a decade ago, she says they were naïve. "Like all large groups, they took all insurance," says Dr. Corson. "We were two women, and our panels filled up extremely quickly." Soon they were not only booked, but overbooked. The paperwork was a burden, and it was becoming financially infeasible to offer patients basic services such as immunizations. Dealing with patients' ever-changing insurance was one headache after another.

Dr. Corson recalls an experience with an insurance company that implemented a "pay for performance" system. "For three months they audited our charts, checked prevention benchmarks, and surveyed our patients. We got terrific grades. For this my partner and I shared a bonus check for $6.98."

"As our days got tighter and tighter, we asked ourselves if we were giving the quality of care we thought the patients required." For Dr. Corson and her associate, the answer ultimately was no. And they did something about it.

Now partners in Bethesda Physicians, they work with two other female physicians. The group takes no insurance but does accept Medicare (in the non-participating category) as its patients age into eligibility. The office collects fees at the time of service and prints a form for patients to submit to their insurance companies. The practice enjoys a collection rate in the range of 95 to 98 percent.

When they started out with this new model, Dr. Corson says a few patients left immediately, but most stayed. The physicians kept their fees reasonable; and when patients called the office, they were told what their charges would be. "In a full, busy day I see 15 patients," says Dr. Corson. Patients get an annual physical; and when they're sick, they receive same-day care. The group offers some dermatological services and travel medicine.

Because they aren't bogged down with insurance filing,

patient billing, and collections, the group is able to function effectively with a small staff: two medical assistants, one full-time receptionist, and one part-time receptionist. The office has only four exam rooms, and the doctors juggle schedules so that they are not all there at the same time. "We run a lean operation," says Dr. Corson, "and we pay our staff well." Dr. Corson herself stays on top of the business aspects of the practice, paying all the bills and even doing payroll. She doesn't hesitate to negotiate for the best deals on supplies and services. According to Dr. Corson, "You have to run a good business in order to provide good care."

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When Dr. Corson goes to local medical meetings, she admits she's often the center of attention. Other doctors want to know how the new model is working. Dr. Corson contends that if more physicians were willing to take back their practices, they'd not only have more fun but would also be more intellectually stimulated. "Doctors need to stop feeling as if they are beholden to insurance companies. Be beholden to your medical principles," she says. Dr. Corson advises physicians who are burned out on their current style of practice to step back, take a deep breath, ask themselves why they went to medical school and residency, and decide what kind of care they want to provide to their patients.

"If you interviewed any of the four of us in our practice, you'd find that we're all very happy," says Dr. Corson. "We love coming to work, and our patients love coming to see us. There's no downside. Our patients are receiving old-fashioned, total quality care that we think is so important," she adds.

## An Old Style of Practice—in New Clothing

Alan Sheff, MD, had been practicing internal medicine for more than 20 years when he really began to feel the stress. In

addition to the usual long hours, worrying that something might be slipping through the cracks, and the ever-present professional anxiety of "am I doing a good enough job?" he also noticed feeling slightly bitter about practicing medicine.

Following his residency at New York University, Dr. Sheff practiced in rural upstate New York for five years before moving to the Washington, D.C., area, where he joined a group practice. Later he tried solo practice. Unfortunately, he says, it was right at the time that managed care was becoming a driving force in health care.

"The slippery slope began," says Dr. Sheff. "All these different forms, contracts, insurance that no longer paid for physicals." He began to feel like a cog in a wheel.

"I was resentful that patients expected a lot of care with no reimbursement, resentful that they'd complain about the phones not being answered fast enough," says Dr. Sheff. "This needling kind of resentment impairs the physician's ability to be fully present. It's poison to the doctor-patient relationship."

Around this time, he turned 50; he wasn't planning to retire any time soon, and he wondered if he could keep up the pace for another 15 years. Dr. Sheff says he asked himself, "Will you even live another 15 years if you keep at this stress level?"

Primary care, contends Dr. Sheff, is at a crisis point nationally. "Well-meaning, well-trained, capable physicians are stretched too thin. They're being asked to do too much with too few resources."

After six years as a soloist, Dr. Sheff and nine colleagues formed Potomac Physician Associates, a practice that has grown to 18 primary care physicians. A year after starting the group practice, Dr. Sheff embarked on an entirely new kind of practice, with the help of a Florida-based company called MDVIP. Whereas he once had a roster of about 3,000 patients, he now has 550. His practice is closed to new patients, and there is a waiting list. No, he's not working part-time or living below the poverty line. Each of Dr. Sheff's patients pays an annual fee of $1,650 to receive a detailed, prevention-oriented physical examination and wellness plan as well as 24-hour access to their physician through a beeper or cellphone. The practice continues to bill Medicare and other third-party payors for covered ser-vices. Dr.

Sheff calls it "personalized and preventive health care."

Dr. Sheff spends one to two hours conducting a complete annual physical examination on each of his patients. These encounters go far beyond simply reporting findings and suggesting lifestyle changes that a patient may or may not follow. With far fewer patients and more time to spend with them, Dr. Sheff coaches his patients on behavior modification and discusses how they can reduce disease risk factors. This, he says, keeps them healthier. He even talks to patients about how they can realistically fit regular exercise into their busy schedules. "We now have the data in the last year or two. This care really is better and more cost effective," says Dr. Sheff.

**Dr. Sheff says he** was pleased with the enthusiastic response he received from his patients when he transitioned to a membership-based practice. "[MDVIP] told me I'd be surprised by who signed up and who didn't," says Dr. Sheff, "and they were right."

Since Dr. Sheff took the plunge, three other physicians in his practice have transitioned to the MDVIP model. They took a space adjacent to their main office that features a separate entrance, a cozy waiting room with coffee, a dedicated staff, and "real people" answering the phones. They cross-train staff to work both sides of the practice, which has improved customer service overall. The per-physician cost to operate Potomac Physician Associates has remained relatively stable since part of the group adopted the MDVIP model of practice.

Dr. Sheff says he was pleased with the enthusiastic response he received from his patients when he transitioned to a membership-based practice. "[MDVIP] told me I'd be surprised by who signed up and who didn't," says Dr. Sheff, "and they were right." He recounts calling one of his very wealthy patients early on to tell him about his plans. That patient didn't sign up. Other less affluent patients were happy to pay an annual fee for comprehensive, preventive health care. "It's not how much money you have, it's the value you place on prevention," notes Dr. Sheff.

"This model is simple and innovative, and it says, 'Slow down' . . . I explain it to patients as taking a giant leap back in time," says Dr. Sheff.

He has no regrets about converting to his new style of practice. When asked what advice he'd offer other physicians who might consider this path, he says, "Seriously and carefully consider it as an option, and get professional advice. If it doesn't work, you're out of a practice and your patients are out of a doctor. All the tumblers have to line up right for it to work. You have to have a genuine philosophy toward prevention and wellness. Examine your motives. Don't do it for the money. It's about the patients," he adds.

This type of practice is not right for every physician or every location. And there are a number of legal and ethical issues that must be addressed before embarking on this practice model. Physicians would be well advised to speak with their accountant, attorney, and practice management consultant before making the switch.

## Mixing Medicine and Business

Creating a practice that works is, in no small measure, an exercise in self-awareness. This involves recognizing your own natural talents and abilities, tapping into what genuinely interests you, and identifying the type of work that is most likely to keep you engaged and satisfied over the long term.

For Arlene Noodleman, MD, MPH, of Campbell, Calif., this kind of self-knowledge about her role as a physician developed over time. A preventive medicine and occupational health specialist, she has seen her career take several interesting twists and turns over the course of more than two decades. She worked at the San Francisco Department of Public Health in the early days of the AIDS crisis; at IBM in San Jose, where she oversaw the worksite health of more than 13,000 employees; as an occupational medicine consultant for Silicon Valley-based companies; and in the biotech and pharmaceutical industries, where she spent more than 10 years.

Her business acumen paid off when she made the decision to work with her husband, Dr. Rick Noodleman, in his growing medical center. Rick sees patients and Arlene runs the business side. With more than 40 employees and more than 7,500 square feet of office space, it is the largest accredited facility of its kind in San Francisco's South Bay area. The couple has also launched

a line of clinical skin-care products, which they make available to their patients and to the public online.

Rick Noodleman says doctors should do things that intrigue them as well as things that are good for their patients. "Stay excited, innovate, think outside the box. Just do what keeps your brain working," he says.

Arlene Noodleman acknowledges that it's not always easy to shift careers. "When you get to mid-life, it's hard to make a change because you have so many responsibilities," she says. "Physicians are trained to be risk averse, to create homeostasis. It's important to do the internal work necessary to discover your passions. Do a self-assessment, on your own or with a coach. A lot of people are so busy climbing the tree that they don't realize until they get to the top that they're in the wrong forest."

## Quality Care + Efficiency = Happy Surgeons

For an orthopedic surgeon, the operating room is the center of everything. The ability—or inability—to schedule cases and operate productively and efficiently in the OR can make or break an orthopedic practice, not to mention creating either a very happy or very grumpy surgeon. Paul Dvirnak, MD, of Durango, Colo., is one happy surgeon, and you have to wonder if that's at least partly because he owns his operating room.

"General hospitals are important to a community," says Dr. Dvirnak, "but for a specialty surgeon who wants to provide state-of-the-art care to his patients, sometimes it's hard to do [in the general hospital]." Dr. Dvirnak and eighteen other surgeons are partners in Animas Surgical Hospital, a Medicare-accredited, state-licensed hospital that boasts a 24/7 emergency room; the latest in CT, MRI, and ultrasound; and a staff that Dr. Dvirnak says is second to none. The facility overlooks the Animas River, and patients who stay beyond day surgery enjoy meals catered from one of the top local restaurants.

Dr. Dvirnak now does surgery just a few steps from his office. "I do all my total joints here, plus ACL [Anterior Cruciate Ligament] reconstructions and all of my shoulder cases," he says. Patients get plenty of personalized attention; a nurse at Animas Surgical Hospital never has more than three patients to care for at any given time. Dr. Dvirnak says studies have shown that mor-

bidity and mortality rates are lower at surgical hospitals like the one he works in than at general hospitals.

One of the many advantages of surgeons' having their own facility, says Dr. Dvirnak, is that they can get what they need when they need it. "We used to schedule ACLs months in advance because the hospital had only one ACL set. Here, if we need another ACL set or whatever, if we have the patients to justify it, we get it immediately," he says. The administrators at general hospitals, posits Dr. Dvirnak, have so much to think about that it's hard for them to give ample attention to individual physicians.

**One of the many advantages** of surgeons' having their own facility, says Dr. Dvirnak, is that they can get the equipment they need when they need it. "We used to schedule ACLs months in advance because the hospital had only one ACL set. Here, if we need another ACL set or whatever, if we have the patients to justify it, we get it immediately," he says.

The setup allows Dr. Dvirnak to be highly efficient. "I did five cases today, three of them big," he says. With the ER across the hall and physicians and staff working there as team players, Dr. Dvirnak can set a wrist fracture or take care of a broken ankle with only a short interruption in his office schedule. Prior to his current setup, even a minor emergency could take him away from his office—and his regular patients—for several hours.

Developing Animas Surgical Hospital was a huge project, and it didn't happen overnight. The idea had been floating around the community for a number of years. It was originally an ambulatory surgical center where patients had only outpatient procedures, and was one of several thousand like it nationwide. The facility Dr. Dvirnak and his partners operate is the only one of its kind in Colorado and one of only about 100 surgical hospitals in the country.

"The only downside," Dr. Dvirnak says, "was the political discomfort, especially in a small town." There is strength in numbers, however. Dr. Dvirnak advises physicians considering such an undertaking to find and work with like-minded colleagues. "The biggest plus is having a vested interest, feeling that you're in control of your own destiny. We regularly remark to each

other how fun it is to go to work," says Dr. Dvirnak.

## Country Living: A Fresh Option

Place can encompass many elements—climate; proximity to family and friends; neighbors; educational options; access to cultural, religious, or recreational activities; the nearness of nature; or even the availability of great shopping and restaurants. No doubt, a significant part of making a practice work is making sure that the practice is situated in a location that works for you and your family.

Eugene M.R. "Rich" Charlebois, DO, had some life experience under his belt by the time he entered medical school at age 31. He had worked as a plumber and a policeman and had supported himself during college working as a private investigator. Upon finishing his residency in family medicine in Downey, Calif., he had offers to stay and practice in the area; but he and his wife felt drawn to a smaller community and wanted to own a piece of land.

They also wanted to experience real winter (not an option in the Los Angeles area) and to enjoy the change of seasons, which, says Dr. Charlebois, "makes it harder for the years to run into each other."

The couple settled in China, Me., and Dr. Charlebois joined a small practice in nearby Waterville. Getting there required tenacity. "Every time I followed up on an open position, they wanted to know about my connections [to the area]. It wasn't until we started telling people that my wife was originally from Rhode Island and about my connections in Montreal that suddenly I had three interviews," recalls Dr. Charlebois.

Family life is important to Dr. Charlebois, and he's surrounded at his office with people who hold similar values. "I'm the only man in the practice," he says. "The other two doctors are female, we have a dozen female staff, and the fourth doctor we're trying to woo is also a woman. We all have kids."

Rural life suits the Charlebois family. They live lakeside on four acres where the children, now 8 and 7, play outside with the dogs and build snow tunnels in the winter. The family enjoys boating and fishing in the warmer months. "In some ways it's Norman Rockwell," says Dr. Charlebois. "On the downside, the

nearest neighbor with kids is a half-mile away. We have to make arrangements and schedule play dates."

Practicing medicine in Maine has required adjustments on Dr. Charlebois's part. "Mainers are an interesting breed, and I say that with respect. They're rugged individualists," says Dr. Charlebois. "[In California] I used to say to patients, 'You can't do that anymore, it's not good for you.' Now, I have to go the extra mile to let them know [a recommendation] is in their best interest. Otherwise, they'll dismiss the advice, dismiss me, and miss their next appointment."

For physicians who feel the need for a change, Dr. Charlebois offers some philosophical advice. "Carefully think about what you're considering to be a limitation. We limit ourselves in huge ways that are not real; they are presumed, or have the weight of belief," he says. "Nothing says you have to stay anywhere you don't want to be." Dr. Charlebois says that although it's not as financially lucrative practicing in rural Maine as it would have been had he stayed in a large metropolitan area, the cost of living is not as high, and the return is well worth it. If practicing in a rural area sounds good to you, Dr. Charlebois says there is a demand for primary care physicians in his area.

## Locum Tenens Options

Locum tenens is Latin for "to hold the place." Although the term refers to holding the place for another physician who is on leave or until a permanent employee can be found for the position, for many who work "locums," the job serves as a placeholder position while they determine the direction they want their career to take. Anywhere there is a doctor shortage, the demand will be high for physicians who want to work on a locum tenens basis. Work is available for primary care, specialty, and sub-specialty physicians.

According to Lorna Lindsey, director of academic affairs for CompHealth, a Salt Lake City-based staffing firm that helps physicians, nurses, and allied health professionals find both permanent and temporary jobs, physicians do locum work for a variety of reasons. Sometimes, she says, "they'll have more than one profession. One physician who worked with us for years was an award-winning wildlife photographer." This doctor, Ms. Lind-

# When these radio hosts say
# "this one is for the ladies"
# it takes on a whole new meaning.

**Dr. Mazzullo**

Lisa Mazzullo, MD, OB/GYN,
Feinberg School of Medicine,
Northwestern Memorial Hospital

**&**

**Dr. Streicher**

Lauren Streicher, MD, OB/GYN,
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### Resource for Locum Tenens Opportunities

Physicians interested in locum tenens work can visit the Website of the National Association of Locum Tenens Organizations (*www.nalto.org*) to access a list of companies that place physicians in locum positions. *LocumLife*, a magazine about locum tenens work, offers a free subscription. For more information, visit *www.locumlife.com*.

sey recalls, was delighted to take assignments in places like Alaska, Montana, and Colorado, where he could practice medicine and take photographs in beautiful, natural settings. Other CompHealth physicians who have enjoyed locum work include one who played the cello with the Cleveland Symphony for part of the year and worked locums in the "off season," another who ran a scuba diving school in the Bahamas half the year, and a physician couple who did a cross-country bicycle trip. "They pedaled over a few states, stopped to do locums, and kept going," says Ms. Lindsey.

For family physician Erin Dawson, MD, doing locums is the right work at the right time. Dr. Dawson attended medical school in Wisconsin and completed residency in Pittsburgh in 2006, but she wasn't sure where she wanted to settle. Locum tenens work is giving her the opportunity to explore not only different areas of the country, but also a variety of practice settings. Her first assignment was with the Indian Health Service on a reservation in Southern Arizona. At the time she was interviewed for this article, she was at a VA Clinic in Washington State and was about to wrap up there to go fill in at a private practice in Wisconsin for the summer. "It's nice because in residency, you see one way of doing things," says Dr. Dawson. She says she's learned how valuable a good computerized medical record system is, and that when she eventually looks for a permanent position, negotiating for protected administrative time will also be on her criteria list.

Physicians may opt for this type of arrangement, like Dr. Dawson, in order to test-drive different practice settings before settling down, to augment a full-time job in order to pay off medical school debt more quickly, or to generate income while

pursuing another graduate degree, perhaps an MBA or MPH. "[Doing locums] buys doctors additional time to look for the right job. It's a great networking tool," says Ms. Lindsey. Traveling around doing locums can pay off socially as well. "We've had physicians meet their future spouses on locum assignments," remarks Ms. Lindsey.

Mid-career physicians or those nearing retirement are also candidates for locum tenens work. Physicians teetering on burnout, frustrated with paperwork and politics, or in need of a fresh perspective can take a break from their normal routine and still earn an income by filling in for other physicians. Twenty years ago, voluntarily stepping away from a successful practice might have been seen as a career-limiting decision. But changing jobs—even several times over the course of a career—is no longer considered unusual.

Locum assignments may be as short as a single day or as long as a year or more. Physicians are often covering for someone who is on medical or maternity leave or on sabbatical, or when there is an open position in a practice. Seasonal work is common. "A practice may be located where there's a higher demand during certain times of the year. Rather than hire another full-time associate, they'll bring someone in for the busy season," says Ms. Lindsey.

Most often, physicians who provide patient care in a locum tenens capacity are affiliated with a staffing firm like CompMed. These firms typically take care of getting physicians the necessary state medical licenses and hospital privileges they need, as well as travel costs and housing (usually a corporate apartment or, for shorter assignments, a hotel or B&B). In addition, she says, "a good locum organization will take care of malpractice insurance, and the physician should never have to worry about purchasing tail coverage," she says.

The locum life is not for everyone; but when it's a fit, it can be a nice way to practice medicine. "I can see myself doing this for at least another year," says Dr. Dawson. "There are places I still want to check out." She's even considering doing locums internationally at some point.

Dr. Dawson advises physicians considering this career path to be flexible and open-minded. "Be willing to accept different