Evidence and Innovation in Private Practice: An Evolving Paradigm

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With all the talk about “transformation” in medicine, there are challenges ahead for each of us, no matter what our current practice status is. The impending change makes the need to remain current with medical knowledge and technological advances all the more crucial. Medicine has always been a lifelong learning experience over a 3- to 4-decade career. Private practitioners, by virtue of their experience, have traditionally been well placed to contribute to the advance of medical innovation. To do so responsibly and effectively in today’s “best-practice” environment, however, may require an ongoing level of cooperation with medical organizations and academic institutions not previously considered.

It is always desirable to have the reputation in one’s professional and social marketplace as a physician and surgeon who is current with their knowledge and skill. A worthwhile philosophy to maintain is to not rush introduction of new ideas or technology without testing, preassessment, and being sufficiently assured as to the benefits. In his book, *The Tipping Point*, Malcolm Gladwell provides a good presentation of the 5 lifecycle stages in the application of new ideas: innovators, early adopters, early majority, late majority, and laggards. In regards to medicine, there will always be those who desire to be first, even though there is the danger of also being among the first to make the early mistakes from which the rest of us will learn. When evaluating new ideas and introducing new technology, we need to remain cautious and deliberate thinkers. It is important to not become a “laggard” when a true innovation or technological benefit is recognized. It is equally important not to be perceived as “experimental” or “cavalier.”

To try and better standardize care, our American Academy of Otolaryngology—Head and Neck Surgery Foundation has worked diligently to create a process to continuously update an expanding list of clinical practice guidelines, indicators, and consensus statements. It is understandably argued that these documents are designed to reduce bias and make it easier for all of us to consistently practice a uniformly high quality level of otolaryngologic medicine and surgery. This evidence-based initiative is a necessary and worthwhile endeavor with great intentions. However, despite the caveats, it is reasonable to counter that they may sometimes make it more difficult to adapt care to the specifics of an individual patient. There may also be restrictive financial impact based on insurance carriers’ different interpretations of the same documents. Further, most of the acceptable studies currently used in evidence-based medicine are generated by academic centers whose patient populations may not necessarily translate well to the patient population of our general membership in terms of various clinically relevant parameters.

The evidence-based medicine process of winnowing down sometimes hundreds of articles to analyze the relatively small number of “good” studies necessarily leaves out a potential wealth of experiential data with lower level “relevancy.” There is still value in the reporting of unusual case studies and “how I do it” articles, but they are now less desirable. The result of this process is that there will most likely be a greater incentive for developing and publishing more level I and II research, which is good, but such work takes time and a support system that is generally not available to the private practice physician. It has become more difficult, therefore, for the private practitioner to make a broader professional impact from his or her clinical experience.

The majority of our membership remain in some form of private practice, and we would be wise to try and prevent an increased separation between those who make decisions from those who have to implement those decisions. Without the balance of expertise and evidence from all of our specialty, medical progress slows down. Steven Johnson writes in his book, *Where Good Ideas Come from—The Natural History of Innovation*, “When one looks at innovation in nature and in culture, environments that build walls around good ideas tend to be less innovative in the long run than more open-ended environments.” It is a cautious reminder, and we would benefit from creating a decision-making model that encourages input from all of our physicians.

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throughout their careers. Perhaps one opportunity to promote is to robustly encourage wider participation during the open comment time period when preparing guidelines and consensus statements. Another idea would be to have our postgraduate training programs create a network of graduates, including those in private practice, and offer the opportunity to collaborate in random controlled clinical trials.

Morton Meyers, MD, describes in his book, Happy Accidents, that many of medicine’s great advances have come from the periphery or by the knowledgeable recognition of an unintended consequence. Will the current changes in medicine negatively affect the introduction of those serendipitous findings because they might appear too different, too specific, or too radical to obtain and commit the resources for a level I or II study? As a group, we are stronger when there is full inclusion and transparency in the evidence-based medicine process. The challenge, then, is to encourage more interactive clinical scholarship participation from our private sector and at the same time have our academic centers continue to keep an open mind to new ideas that may come from outside institutional medicine.

Coming out of residency, one presumably is fully trained in the “latest and greatest” techniques, but progress marches on. How each of us chooses to maintain our education and skills over a career is worth discussing. The current model may result in a lag in implementation of validated new ideas coming into the private sector. All states have general medical annual/biannual CME requirements, which may also include a minimum number of hours in non-specialty related matters, such as domestic violence or medical errors. For those who are not required to take American Board of Otolaryngology recertification, it is up to the individual to responsibly maintain a well-rounded specialty specific education. A fully balanced otolaryngology Grand Rounds and journal club experience may not be readily available or taken advantage of when in the private sector. There may be active subscriptions to our journals, with accompanying CME questionnaires, and opportunities to participate in our self-study courses, but that is time-delayed knowledge without the opportunity for the valuable interactive intellectual exchange that can take place when we gather together. Industry-sponsored educational dinners cannot be considered an adequate substitute. Unfortunately, in any 1 year perhaps only about one-third of private practitioners attend the AAO-HNSF Annual Meeting (36% in 2014), where new ideas are often introduced, and historically fewer regularly attend state society meetings.

Collectively, in theory, we are strongest when everyone contributes to the process of evidence and innovation. Individually, however, each of us has to decide how to best utilize the precious resource of time, and there are understandable differences in the relative priorities between academic and nonacademic physicians. On the positive side, of those of us who do attend national and state meetings, there are a good percentage of private practitioners who have chosen to sit on committees. At the national level, there is a genuine effort made to “rotate” academic and private practice leadership positions within our Academy on both the Board of Directors and Board of Governors. And, to be fair, there are many of us in private practice who choose to give of our time by serving on local hospital boards and committees. Further, every year there are a wide range of “current advances” CME programs along with a growing number of excellent hands-on technical skills CME training programs throughout the country that many private practitioners take advantage of.

There are appropriate questions to ask in every generation, including ours. Who can perform microflap surgery? Who can do endoscopic base-of-skull procedures? Who can use the robotic surgery equipment? When outside the academic setting, hospital policies and local politics make for inconsistent implementation of surgical privileges. On the other hand, introducing new technology and innovation in an office setting seems to have very few restrictions, particularly if you are in private practice. As long as you obtain consent from the patient, who presumes your safety and skill, you are relatively unencumbered. Perhaps the current transformation in the practice of medicine will result in the incorporation of minimum standards for both academic and private practice implementation of new technology and innovation. Perhaps the move to bundling of reimbursements will limit some private practitioners from becoming innovators without some form of active academic involvement.

The era of independent, nonacademic clinical research may be declining. Medicine, however, will continue to progress. We all must adjust to the evolving paradigm to validate standards and introduce new ideas with the acknowledgement that the methodology has the secondary potential to de-emphasize the private practice experience. If you are in private practice and want to remain a “best doctor” in your community, you can only benefit from being engaged in the new process of evaluating and implementing medical innovation and technological advances in our increasingly regulated profession. The opportunities are there, but we have to take a proactive approach. There is clinical scholarship in all of us worth sharing. In this time of transformation, one thing does seem more certain. We are stronger if all our parts are working together. It has never been more important for the private practitioner to become an active participant in organized medicine, personally and professionally, to continue learning, to benefit from the exchange of ideas, and to help determine and deliver the best practice parameters our specialty can provide.

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