After Residency, Then What?

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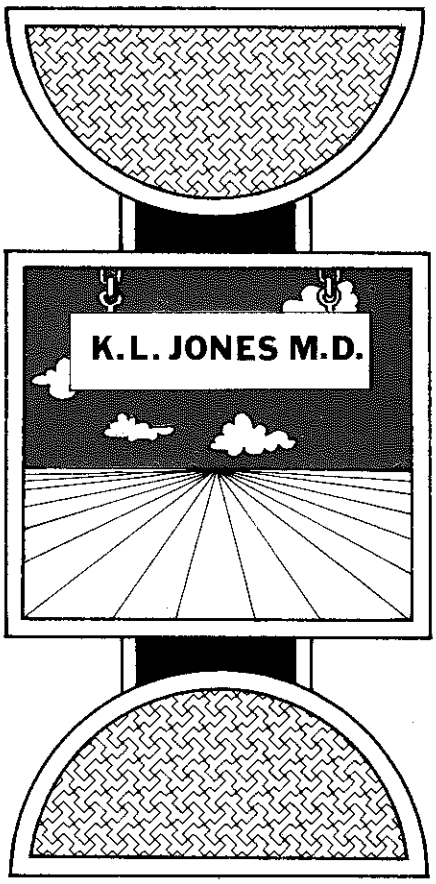

The first two years of solo private practice following a family practice residency are described. Most proposed goals were achieved. The practice had to be limited after ten months to maintain standards set during residency, and "adequate data base" was redefined because of poor patient acceptance. Residency training must stress office management, and it would be advisable to devise a formula for how and when to limit a practice. Family practice residency training is invaluable in setting up a new practice.

Two short years ago, I sat in the Family Practice Residency office wondering what I would encounter when my family practice residency training ended and my life as a practicing family physician began. Now, after 24 months of solo practice, I am in a position to reflect on what has happened to my practice, to my family, and to me, and to try to assess what role my residency training played in those events.

Current information on the circumstances of starting practice – especially out of a family practice residency – was not available when I finished my residency. I did not know what to expect as a new family physician. All those who taught me said there would be no major obstacles, but they all had begun their practices in a different era and with different training. Those few teachers who were residency trained had gone directly to teaching positions or had joined group practices. What would happen to me, with my perhaps different goals, as I set up my practice in a community where my type of training and I were both strangers?

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Background

After medical school and a rotating internship, I spent two years as a general medical officer in the Indian Health Service. I then completed the last two years of a family practice residency in a large community hospital in Wichita, Kansas. Immediately after training, I set up a solo practice in a western Colorado community where I had no personal contacts beyond those made while looking for a practice location. This community of 28,000 people was centered in a medical referral area of 150,000 people and had a total of 84 practicing physicians. Most of these were in the more restricted specialties, however, with only nine MD general practitioners, ten other MD primary care physicians, and 16 osteopathic primary care physicians. The community had a well-equipped 220-bed hospital, consultants in most clinical areas, and a group of four general practitioners who offered to share weekend call with me.

Goals

When I hung out my shingle, I had some very specific goals in mind. I wanted a controlled practice with a schedule that would allow adequate time for care of my family and enjoyment of the outdoor recreation

of the area. I wanted to practice at a pace that I could continue *and* enjoy indefinitely.

Professionally, I desired a small practice so I could be thorough with those families I agreed to care for, and could "keep up" technically. I planned to use a problem-oriented record and a nurse practitioner. I had no interest and minimal training in major surgery. For the business side, I wanted a very tight bookkeeping system with minimal insurance done by office personnel and minimal credit (maximum time-of-visit collection). Within these bounds, I felt entitled to an adequate income, anticipating less than the national average for family physicians because of my reduced schedule.

Achievements

When all the idealistic planning ended, I was confronted with an open front door and a ringing telephone. I rented a 1,000-sq ft office with three examination rooms, and I hired one nurse-receptionist thinking things would be slow for a while. To my amazement, a new family physician in town turned out to be like an inventory sale in a department store. The schedule was full from the first day, and countless families wanted to "get on the list" before I discontinued taking new patients. It was an impossible situation with one staff member, so I hurriedly hired a second.

The practice grew rapidly and I was confronted with the decision of how to limit it. Unfortunately, at the end of my training, I had no formula in mind for how or when to do this, so I devised my own under fire. After ten months of taking all comers, accumulating 1,500 charts, getting home at 7 PM for two consecutive weeks, and disregarding all the local practicing physicians' advice, I "temporarily" stopped taking new *families.* I have never resumed. I still see other family members and take some physician referrals for an average of two new patients each day.

During residency I devised a problem-oriented chart folder and record system and have continued to use it. Notes are dictated and typed, copies of all prescriptions and refills are kept, all telephone messages (both for my patients and patients of other physicians in the call group) are filed in my charts *or* are on record. Certain diseases are cross-indexed, and to date I have had one disease audit by a local internist. Consultation sheets are sent with every consultation or referral.

I am on call three nights of every week and work every sixth weekend. Appointments are scheduled four days a week, five hours a day, and I make hospital rounds once a day, six days a week. One day a week is spent managing business affairs. I am not in the office six weeks each year (meeting time included).

With this schedule, I see 25 to 30 patients in the office each day, including two complete physical examinations. I have an average of two inpatients, varying from zero to six, and have had an average of two deliveries per month.

The office runs smoothly at this pace. Patients rarely wait more than 30 minutes (confirmed by a mailed, anonymous patient poll). I am usually able to see patients with acute illnesses on the day of their choice.

I hired a nurse practitioner when the office opened. She functioned as an office nurse and then went away for three months' training. I theorized that patients would understand the relationship from their initial contact with the practice so there would be no major adjustment later. In reality it did not work. I was unable to relinquish much responsibility early in my practice, and I could not spend the money necessary to keep a competent registered nurse. When the practice was in its infancy, I did not have a large number of functions that lend themselves best to a nurse practitioner's services, such as nursing home calls, obstetrics, newborn care, house calls, or established chronic diseases.

When I opened my practice, I felt the product I offered would be very attractive to my patients, my family, and to me. I was not so certain the other physicians would react similarly. Now that the practice is a 24-month-old reality, it is interesting to reflect on whether this indeed is the case, although my conclusions are certainly not scientifically documented.

Patient reception has been excellent. Patients appreciate being seen near their appointed time, and having some time to chat. I am frequently asked by them to "please don't get too busy." Whether this response reflects the fact that I am new, young, and enthusiastic or indicates their support of my attempt to run a controlled practice is uncertain. Only more experience will tell. The way my patient load has leveled off leads me to believe that it will be more satisfactory to patients than the standard open-door policy. My call schedule makes me less available than the average general practitioner in the area, but it has been consistent since the practice started. So far, my availability has been no problem. I partially attribute the minimal number of evening and night calls to the fact that patients are seen during the day if ill, and phone calls are returned reliably.

Patients seem convinced that I am looking after their health, because my record system allows me to easily see when they are overdue for a physical examination, or to recall other problems that should have follow-up. I have received the impression that this is an unaccustomed service.

I tried using a mailed patient questionnaire to assess office function on one occasion and feel it was a useful tool. The procedure did create some apprehension on the part of my office employees. Both had worked in several other physicians' offices and were not convinced of a need for systematic anonymous consumer input. Patients were cooperative: 23 of 25 questionnaires were completed and returned.

Opening a new office, even after a very practical residency, had a profound effect on me. I was initially uncertain whether the community would support me, in spite of everyone's predictions of instant business. The first three months were engrossing physiologically, even after it became obvious even to me that my services were definitely in demand. The particular bodily function that accurately reflects my catecholamine level stabilized at about three months (just after my indebtedness reached its maximum) and was back to normal by six months. The most trying circumstances were not in the area of clinical medicine. Apparently my training had me well prepared for the vicissitudes of the medical aspect of my practice. The real adrenalin stimulants were problems related to office management. Such things as employee problems, accounts receivable management, and third-party antagonisms seemed to go home with me after the office was

closed. All this occurred in spite of the fact that my residency included much more practice management than most.

The reaction of my family to the practice followed about the same pattern. The actual planning and setting up of the office was the first time my wife had had much input into the technical aspect of my medical career, and it proved to be a delightful experience. But after the office opened and I became engrossed in the management problems at work, I became poor company at home. Even though my body was on the best schedule it had had in years, my mind stayed at the office long after hours. But since those first three months, and with a very adequate schedule, my family agrees that we can continue at this pace indefinitely.

It is difficult to assess whether or how one really affects one's peers. I was the first residency trained family physician in town, but the other physicians were not (and for the most part are still not) aware of the kind of training I had. So that fact generated no interest per se. A few things have been obvious. Consultants delight in knowing in advance what I want them to do. Members of my call group appreciate (and some have adopted) a system for recording phone messages. Several physicians in the more narrow specialties have been interested in my records system and the business aspect of my practice.

I am satisfied with the professional quality of my practice, which would probably not be the case if it were not a limited practice. The needs of this community are such that I would already be hopelessly swamped with work and looking for a narrow specialty to take refuge in if I had continued to take all new patients that wanted to enter my practice. At the pace of my present practice I can spend the time with outpatients that I consider essential for comprehensive care. I can read about involved cases and arrange complex laboratory evaluations without feeling that I am ordering unnecessary examinations or omitting essential ones. Occasional lengthy counseling sessions can be scheduled without sacrificing my personal time. I have adequate time to communicate with consultants both before and after they see my patients.

My concept of an appropriate data base has been jarred by reality. A substantial segment of my practice has no desire to give of their blood or their dollars to accumulate the data base that I feel is academically adequate; and the attitude towards this varies among family members. So I am left with the option of driving these families from my practice or offering a complete data base as a recommended but optional plan. I have chosen the latter course and find that it wears well. I find just as many patients who want more laboratory work or procedures than I feel are justified, and I have approached that problem the same way. I have had little success encouraging well-child care between the ages of 18 months and 5 years.

The financial progress of my practice was the greatest unknown – or at least the greatest uncertainty – when the practice began. Such information would have been invaluable when I was deciding where to go and trying to figure out whether offers to join groups were really financially advantageous or not.

I tried to purchase used equipment from older physicians and all I acquired was ill will. It seems that antique equipment increases in value directly proportional to the number of years they used it, and any discussion of a price takes on a personal quality. So I purchased new equipment. During the first six months I spent $6,000 on medical equipment (no hospital surgical instruments) and $4,000 on office business equipment (including transcribing/dictating equipment).

The office broke even after the first six months. Collections equaled expenses. After that, for the seventh through the 18th months, the office ran expenses at 50 percent and collections at 90 percent. The maximum indebtedness was $18,000. While living at a comfortable level, I have been able to pay off my business indebtedness in 24 months.

Several valuable lessons came out of those first months. Hiring cheap help was the most expensive thing I did. All help must be trained to fit a practice, but people who will adapt to the job quickly and not let essential matters get out of hand are either already employed or know what they are worth.

During the early lonely hours of a solo practice my management consultant's advice was a tremendous help. The expense seemed great when income was zero, but I never regretted money spent there.

No amount of training is adequate to prepare one for the vagaries of the third parties. Until I awakened to the fact that they thrive on mistakes, misunderstandings, and delays, I kept looking for a flawless approach and found mainly frustration. My training was invaluable but incredibly inadequate. And I doubt I would have listened had the course been taught.

Finally, the total investment in starting a medical practice is minimal in comparison to income potential even after the first few months. I wasted a lot of time and energy trying to save money on my initial investment.

Conclusion

Two years later, I have a very good feeling about my decision to establish my own practice; and I think that feeling is not an accident. I could have started a practice without a residency background, but I am convinced that my relative ease in doing so was enhanced by the opportunity to practice in a realistic outpatient setting for two years. Clinical skills are essential, and in clinical areas I was prepared. The problems were in areas of personnel management and office management.

A critical feature of any practice, whether solo or group, is how and when to limit it. This topic should be dealt with in depth during residency training so that the resident has his plan firmly in mind when he sets up practice. This would convince the young physician that limiting a practice is indeed professional, for this is not a universally accepted concept among practicing general practitioners. Limiting a practice is essential if a young physician is to provide continuing care of high quality to his patients and, at the same time, maintain any sort of satisfying family life.

When I began the final two years of my family practice residency, I doubted that the training would be worth the time and expense it required. After two years of private practice all of those doubts are gone. The family practice residency enabled me to cope with most aspects of the business and personal life of a family physician.