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Module 10:

Evaluating Practice Opportunities:
Family Medicine



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cma.ca/pmresources

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Key Learning Points

- *Evaluating short- and long- term practice options*
- *Lifestyle and personal issues Trends in medicine and their potential impact on you*
- *Where to look for practice opportunities*
- *Costs and benefits of different medical practice models*
- *Remuneration options*
- *Primary care renewal initiatives*
- *Getting started in your chosen practice*
- *Useful resources*

Key Message

When evaluating a practice opportunity, remember that you may be able to negotiate income, service obligations, financial obligations and benefits. Ask questions, do your research and be knowledgeable about the market value of the compensation, as well as the obligations of any position you consider.

Introduction

Whether you are a second-year resident dreaming about your short- or long-term practice options or a practising physician looking for a change, there are many things to consider when evaluating any practice opportunity. Personal aspirations, lifestyle and location may be at the top of your list, but other factors that will influence your decision include provincial and national medico-political issues, healthcare trends, professional issues and the different kinds of medical practices and payment models that are available to you.

After years of structure and discipline, you may need some encouragement to break out of “resident” thinking and take ownership of your future. Throughout medical school and residency, you have had minimal control over the many variables that have had a direct impact on your personal and professional satisfaction, including: where and how much you worked; when you worked; physicians you worked with and for; staff you worked with; patients you served; the physical environment of the hospital, office or clinic where you worked; practice policies and protocols; tools and equipment.

Undoubtedly, many experiences were good, but some may have been less to your liking. Personality conflicts—whether with physicians, nurses or administrative staff members—are inevitable when many healthcare professionals come together to work and learn in busy training hospitals. Even though you had little influence over your training circumstances, at least you knew that there was light at the end of the tunnel, because you knew you needed to put up with a challenging situation only until your rotation or residency was done.

Now that you are looking at life beyond residency, take stock of your present practice environment to ensure that your future circumstances are positive and rewarding. Imagine joining a group, and then having to work with staff and colleagues who are very similar to your old antagonists—for the next 10 years. The reality is that not everyone escapes difficult working circumstances. The likelihood of this scenario is greatly reduced, however, when you develop a detailed approach toward evaluating your future practice opportunities. Now is the time to be proactive. Critically appraise what contributes to the effective, efficient and rewarding work environment in which you envision yourself. This module provides an overview of the many important issues that you should assess to ensure that the practice you join or start will be personally, professionally and vocationally rewarding. Whether you are evaluating a one-week locum or the option of joining a group for the long term, advice about the evaluation process is essentially the same.

Evaluating Short-Term Practice Options

Locums

Many family medicine residents initially choose to do locums when they finish residency. This is an excellent way to experience a variety of clinical practice styles and formats, as well as different communities. In fact, one should ideally test-drive a potential long-term practice opportunity by doing a locum there first. Locum opportunities abound, but don't expect that all will satisfy your professional and personal aspirations. As in all contractual arrangements, it is important that both parties—in this case, the locum and the host doctor, clinic or institution—have fair and realistic expectations of each other. Module 11. Locums: Negotiating A Fair And Mutually Beneficial Locum Contract details the steps to take in evaluating a locum. This module also includes a Locum Evaluation Checklist appendix.

Short-Term Salaried Positions

Some new entrants accept short-term employment that is remunerated by salary or sessional fees. This option is especially attractive to physicians whose significant other still has a year or more of professional training to complete.

Examples of term positions include:

- a term position in a community health clinic, health service organization or academic centre, such as covering for a physician on maternity leave or on sabbatical;
- a salaried position sponsored by a Ministry of Health or Regional Health Authority;
- a term position as a hospitalist or clinical associate in an outpatient setting, such as a cancer clinic;
- a sessional position for which you are paid a fixed hourly rate to work in student health or an STD clinic.

| Advantages of short-term salaried positions | Disadvantages of short-term salaried positions |
|---|---|
| Guaranteed income | No professional tax deductions |
| No long-term commitment | No long-term security |
| Ability to assess salaried practice as a long-term option | Earning potential capped |
| Little or no management responsibility | Minimal or no control of the working environment, such as patient volume, staffing, practice demographics or policies |
| Medical and/or dental benefits may be included | |
| Hours/Days of work may be fixed | |

Key Message

Appraise short-term employment opportunities as critically as you would long-term practice options. Have your lawyer and accountant review the legal and financial terms of a contract before you sign it.

Evaluate Contract Offers In Detail.

Medical residents, as salaried employees, are familiar with having their tax, EI, CPP and benefit contributions deducted at source by their employer. In practice, however, the term “salary” may not equate to the same terms as the salary contract offered to residents. There may or may not be benefits. Never assume anything; ask questions about all terms, obligations and benefits in the contract.

Remember that, if you receive all of your income from practising medicine as a salaried employee, you will not be deemed by the Canada Revenue Agency to be a self-employed professional. This means that, potentially, you will have no tax deductions for professional expenses, as well as professional dues and Canadian Medical Protective Association (CMPA) malpractice insurance. Before you sign a contract, you are strongly encouraged to have your accountant and legal advisor evaluate the contract in detail, as well as the potential tax implications. We also recommend Tax Tips For The Physician And Physician In Training, an excellent income tax resource that is updated annually and posted on cma.ca.

Term Position Checklist

What salary will you be paid?

- What benefits, if any, will you receive?
- If there are benefits, then...
 - What are the terms and definitions of sick leave?
 - What are the terms of disability coverage and will the payouts be tax free or taxable?
 - What are the terms for holiday and CME leave?
 - Are there medical and dental benefits?
- What are your service obligations (e.g., regular hours and on-call work, patient volume and complexity)?
- Will you be obliged to work at more than one location, and will parking be available?
- Will your employer pay for your CMPA coverage and professional dues?
- Are you allowed to do some fee-for-service work to maintain your self-employed professional status?
- Do you have the option to work extra hours, or to refuse overtime? How would you be paid for overtime?
- What if it doesn't work out? Is a termination clause provided for both parties?
- It is very important to critically appraise any contract you are offered. If the offer is suboptimal, negotiate for a better deal. All contracts essentially address three issues:
 - What you give
 - What you get
 - The “what ifs”: What transpires if something does or does not happen?

Always have your professional advisors review any contract before you sign it. Your accountant and contract specialty lawyer will provide valuable counsel about the financial arrangements and terms of the contract. In addition, other PMC modules are dedicated to the discussion of legal issues and negotiation; see *Module 5. Legal Issues For Physicians and Module 9. Principles of Negotiation*.

EVALUATING LONG-TERM PRACTICE OPTIONS

There are many questions to answer when you are evaluating long-term practice opportunities.

- Do you want to practice in an urban, rural or remote area?
- Will you be a traditional, comprehensive family practitioner?
- Will you do obstetrics? Will you provide ER, hospital or nursing home care?
- Do you want your own patient roster, or do you prefer to offer shared care in a clinical team?
- Do you prefer to primarily offer periodic or sessional care?
- Do you have special interests, such as sports medicine, ER, student health, industrial medicine, occupational health, or consultative work for insurance companies or the Workers' Compensation Board, and can they be accommodated in your overall practice profile?
- Will you work full-time or part-time? Do you prefer solo or group practice? What are your income aspirations?
- Do you prefer an associated or partnership group arrangement?
- What remuneration model do you prefer: fee-for-service? salary? blended format? an alternative payment plan?
- What is your comfort level with billing for non-insured services?
- To what degree do you want management responsibilities?
- Is it important for you to have input into how your staff members are hired, their job descriptions, their performance evaluation?
- Is it important for you to have input into and control of the volume and manner in which reception books your appointments and manages your day?
- Do you want to teach?

While these are some of the important issues to address, first and foremost, you must ensure that your personal wellness will be fostered rather than potentially compromised with your long-term commitment.

Lifestyle And Personal Issues

Always address your non-professional needs first. Professional satisfaction will be difficult, if not impossible, without lifestyle satisfaction and fulfillment. Ensure that you consider your own non-professional needs and desires, as well as those of the people close to you.

- Will you and your family be happy living in a particular community for a long period of time?
- Are affordable, quality housing and good schools available?
- Can your significant other find satisfactory employment?
- Does the area offer the cultural, religious, shopping, recreational and sports activities that are important to you and your family?
- Will you easily be able to visit family, as well as host your family and friends?

Remember: If you are unhappy at home, it is very likely you will be unhappy at work.

Supply Versus Demand

In the late 1980s, several reports suggested that Canada had an oversupply of physicians. The response of many medical schools was to significantly reduce class sizes. Attrition of the physician population because of retirement, however, coupled with the reduced number of new trainees, changed expectations of desired hours in a work week, and the ever-growing population have combined to prove these oversupply reports wrong. In fact, the end result has been an increasing shortage of family physicians and some specialties.

The consequences for the senior family medicine resident are both significant and beneficial. The considerable demand for family doctors has created a job market that is more inviting, receptive and rewarding than in recent memory. Opportunities abound in family medicine and for some specialties. Even in a job market governed by the Canada Health Act and, more significantly, by provincial governments, the supply/demand imbalance has recently encouraged governments to increase the remuneration options and benefits offered to most, if not all, physicians. The economic realities of 2012 will likely oblige provincial governments to re-evaluate physician payment, though the significant gains made over the past several years are unlikely to be lost.

Before beginning the quest for a practice opportunity, the prudent resident will consider how current national trends may affect their job search and prospects. Research the variety of remuneration packages and incentives offered in smaller cities and rural centres, as well as those sponsored by the provincial ministries of health. Even some large Canadian cities are undersupplied for family doctors.

Established physicians also now realize that they have a vested interest in assisting any potential new associate as much as possible.

Provincially Regulated Practice Restrictions

In addition to supply, demand and price, other trends in medicine may impact your future career choices. Although restrictions on where a physician may practise are now uncommon, some regulations still exist. Quebec, for instance, still requires an additional qualifying exam, and imposes billing restrictions in selected larger centres. The billing restrictions will often be removed if a physician who is new to the area meets certain underserved area requirements, such as hospital work, for a predetermined amount of time.

To learn more about regional incentives and restrictions, contact your provincial medical association and provincial ministry of health.

Key Message

Consider yourself and your family first when making decisions about your medical practice. Only when you have addressed those needs should you evaluate the financial and clinical aspects of a longterm practice opportunity.

Hospital Restructuring And Regional Health Initiatives

Hospital downsizing, healthcare restructuring and the centralization of medical services may have considerable impact on those who practise in the respective institutions or areas. Investigate whether hospital restructuring is pending or has already occurred in all of the locations that you may be considering for long-term practice. It would be regrettable to set up your office across the street from a hospital, only to have it close in three years and relocate five miles away.

Many provinces are establishing regional health organizations to oversee the care needs of the population in their catchment area. These organizations will, for example, encourage and reward doctors to establish collaborative healthcare teams to serve special needs groups. The team may consist of physicians, nurses, nurse practitioners, physiotherapists, pharmacists and social workers. Fee-for-service enhancements and additional block funding may be provided to the team to cover the expenses and salaries that would otherwise be outside the realm of the traditional ministry of health payment models. Additional funding for linking all team members via electronic medical records is sometimes available as well. If you intend to practise within such a system, it will be very important to know where and how you will fit in.

Professional Issues

It is prudent to research all potential practice opportunities to verify that your professional needs will be met before you commit to a long-term contractual relationship. Is there sufficient demand for your services to guarantee an adequate income, as well as vocational satisfaction? Or will the demand be so onerous as to threaten your quality of life?

Be sure to evaluate office space, hospital facilities, laboratory access and ambulance services. Will the institution meet your personal standards of practice? Is there a group practice or association you may join? What are the personalities and qualities of the members of the group? Will you be able to work well with them? Are quality consultants and the other allied healthcare professionals that you will require be readily available?

As you are the new kid on the block, will your potential colleagues expect you to “pay your dues” as they had to? Is ‘call’ shared equally, or will you be expected to accept a disproportionate share?

If you anticipate a widely diverse patient base, will they have easy access to your office and laboratory facilities? Will parking be available for you and your patients, and at what cost?

Research all aspects of the practices you are considering. A well-done study will help you to accurately evaluate your suitability to the practices and may uncover any deficiencies. No one likes surprises after starting practice. Not only will good research help you plan for your future, it may well demonstrate your interest, initiative and enthusiasm to the parties with whom you are negotiating.

Key Message

Use the many resources available to help you find and explore practice options.

Where To Look For Practice Opportunities

Residents approaching their final year are often overwhelmed by clinical, teaching and research responsibilities, added to the ongoing commitment of studying for fast-approaching qualifying examinations. It may be daunting to also embark on the task of identifying short-term or long-term opportunities for the years ahead. Numerous resources are available, however, to start you on your quest.

On the cma.ca website, you will find links to the most effective and efficient resources for practice opportunities.

- **Classified ads online.** Find the online listings of classified ads, published every two weeks in CMAJ.
- **Residents' association lists.** Provincial and national residents' associations compile practice opportunities and lists of locums.
- **Recruitment organizations.** The Canadian Association of Interns and Residents (CAIR) provides links to all provincial-specific recruitment organizations. Some of these organizations provide staff who will help you to write a résumé and prepare for interviews.
- **Job fairs.** In some parts of Canada, provincial and faculty-sponsored job fairs cater to family physicians and specialists; these are often held in the fall. The venue typically includes representatives from the many towns and regions that are looking for new doctors, nurses and other allied healthcare professionals. In other words, they come to entice you to practise in their area. Many also may have additional financial incentives available.
- **Provincial medical associations (PMAs).** PMAs also keep lists of the specialties that are in demand in their province, along with contact names and numbers. Most PMAs have easy-to-search websites, which include practice opportunities that are regionally and specialty specific.
- **Medical journals.** The print edition of CMAJ has the most extensive listing of positions for physicians of any Canadian medical publication. These same ads are posted online at cma.ca. Other medical journals, particularly Canadian Family Physician, which is published by the College of Family Physicians of Canada, may also be helpful.
- **Word of mouth.** Simple, but invaluable. Talk to your instructors and colleagues who are now in practice. A former colleague who has recently started practice can often provide useful, timely and unbiased advice. Tap into the wisdom of your program director, department head or staff physicians whose opinions you respect. As well as knowing about practice opportunities in your field, these individuals will probably be contacted by prospective employers who want personal references for you.

Practice Options

Researching a potential opportunity also means evaluating the mode or structure of the practice. Whereas, in the past, the vast majority of physicians were solo practitioners, today there are many different forms of practice: associations, partnerships, salaried positions and alternative payment plans, to name a few. If you learn about these different models, you will appreciate the obligations, costs and benefits associated with each.

Solo Practice

Some physicians today are solo practitioners, but their numbers are in decline. The vast majority of new family physicians prefer to enter group practice to capitalize on economies of scale and save considerably on overhead. If planned and negotiated properly, a well-organized group practice can incorporate all of the benefits of a solo practice.

| Advantages Of Solo Practice | Disadvantages Of Solo Practice |
|---|--|
| Complete autonomy for the physician | Complete responsibility for practice set-up, overhead, staffing and practice management |
| Control of all aspects of the practice and work environment | Initial start-up costs are much greater than for a group practice |
| Dedicated staff and resources | No economies of scale possible by sharing costly overhead with partner or associate (e.g., rent, utilities, staff) |
| Freedom to set working schedules, patient volume and practice style | No coverage when you are away Difficult to qualify for alternative funding models |
| Quieter office, with fewer distractions | No on-site peer support Isolation |

Group Practice

A group practice is defined as two or more professionals who are practising in the same office. The professionals do not need to be associates, or of the same discipline (e.g., a GP specializing in sports medicine, an orthopedic specialist and a physiotherapist who share an office). The key advantage of a group practice is sharing the costs of office space, medical equipment, supplies and staff. Once a group exceeds seven or eight doctors, however, the economies of scale often plateau. Bigger is not always better.

Key Message

Preparation is the most important step of any negotiation.

Group Practice Formats

There are three primary formats of group practice: associations, partnerships and professional services agreements.

An **association** is an expense-sharing agreement. It can range from sharing only the rent and waiting-room costs to sharing everything, including staff, equipment, all medical supplies, communication systems, electronic medical records (EMR) and office resources. Associates do not share income, nor do they specifically share professional or legal responsibilities for others in the group.

The expenses can be separated into two categories: **capital expenses**, which include the initial renovation of the office, installation of communications systems (phone, intercom, fax, etc.), the purchase of computer systems and EMR, and all other major medical or office equipment that the group members require in order to run an office and practise. Capital expenses are often shared equally because, regardless of the amount of time one member will be in the office, he or she will still need this essential structure and equipment to practise.

After the office is set up, there will be **ongoing expenses**, which include office and medical supplies, staffing costs, rent, utilities, insurance, etc. These expenses are generally shared proportionately to use, unless all group members are in the office the same amount of time. For example, four doctors share an office in which only three can work at the same time. Dr. A works eight half days, Drs. B and C work seven half days and Dr. D works six half days. The office is utilized for 28 half days per month. Dr. A pays 28.57% (8/28) of the total shared expenses, Drs. B and C pay 25% each (7/28) and Dr. D pays 21.43% (6/28) of the shared expenses. The degree to which expenses are shared must be clearly specified in a legally binding association agreement.

A **partnership** group practice shares not only expenses, but also income, personal liability and medical liability. The contractual obligations and benefits of this complex arrangement must be evaluated in detail. A formula for each partner's share of income and expenditures must be specified within a legally binding partnership agreement, which is generally much more complicated than an association contract.

A **professional services agreement** is essentially an extension of the fee-sharing agreement commonly used for locums. It applies when a physician or group of physicians form or join an existing group practice that is managed by a third party. The third party provides and pays for a fully outfitted clinic and staff. The third party also manages most, if not all, of the practice management issues. The physicians establish their practices and have patients rostered to them rather than to the clinic, as in the case of a walk-in clinic or community health centre. The physicians establish a fee-sharing agreement, or "split", with the third party instead of negotiating an overhead sharing agreement with each other. A 70/30 split is frequently used, for example. Therefore, the physician remits 30% of all

income generated through the clinic to the third party. Income generated elsewhere is not impacted.

Advantages:

- You will have minimal practice management duties or obligations.
- Staffing and ongoing clinic management is done by the third party.
- When you don't work, you have no overhead costs, unless you are in an alternative payment model.

Potential Disadvantages:

- If you are remunerated in an alternative payment model, you would most likely be obliged to remit 30% of all indirect clinic practice generated income, as seen in a capitated model or if there are monthly bonuses and management fees paid for your rostered patients. This additional fee-sharing obligation can be significant and, when added to the other fees shared, your actual overhead costs can often be more expensive than if you managed your expenses directly.
- With minimal practice management obligation comes minimal control—and this is, potentially, a major disadvantage.
- The largest overhead cost is staffing. For the third party to maximize income, they will often try to minimize staffing costs—and you may have little or no control over this. A minimum-wage approach will not draw or keep quality staff. Poor staff or frequent staff turnover will have a major impact on one's daily practice effectiveness, efficiency and enjoyment.
- As in a locum or salaried format, the physician may have little or no say regarding office policies, procedures, staff hiring and management.
- Each physician signs a fee-sharing contract with the third party. It will also be essential for each physician to arrange a group practice contract with each other, as if they were associated or in a partnership. If not, mutual best interests cannot be assured.

A professional services agreement can look quite attractive on the surface. Remember that your obligations to your patients are the same as when you are associated or in a partnership. Your patients are assigned to you, and thus you must meet all obligations to your patients as per the provincial payment model in which you are participating. If you move or close your practice, you are responsible for all medical records issues, as is any other GP in private practice.

Whether you are considering an associated, partnership group practice or professional services agreement, have your lawyer and accountant review the contract agreement to ensure that your interests are protected now and into the future.

| Advantages Of Group Practice | Disadvantages Of Group Practice |
|--|---|
| Economies of scale for expenses (e.g., office space, medical equipment, supplies and staff) | Potential loss of autonomy. This can be avoided with a comprehensive group contract |
| Minimal or no start-up costs, if joining an existing practice | Daily practice routines and schedules must be coordinated with other physicians and staff |
| Resources and staff are often shared equitably. | Complex personnel structure means greater possibility of personality conflicts. Excellent and ongoing communication are essential to maintain a comfortable work environment. |
| Convenient consultations on difficult cases | Greater possibility for disagreement over capital purchases. What voting structure will the group use to make decisions? |
| Cost effective to hire a dedicated office manager to hire staff and run the practice efficiently | May be difficult to find a group practice that is a good fit, personally and professionally |
| More financially practical to have sophisticated medical and computer equipment | |
| Physicians can make best use of their time: seeing patients. | |
| Better positioned to qualify for alternative funding models | |

Finally, some group practices may be organized as a combination of association and partnership. Academic group practices and some capitated alternative payment group practices fall into this category. Module 8. Physician Remuneration Options addresses this in more detail.

Key Contract Points

The contract agreement is of paramount importance to anyone who is considering group practice. The contract should outline the responsibilities of each member of the group, as well as the benefits to be enjoyed by each participant. In the case of a professional services agreement, the contract should clarify exactly what the third party will provide the physician.

The detailed contract should address all existing issues and potential problems, outlining courses of action on the “what ifs”. Ultimately, this will save you time, stress and money. Some specific issues that a contract should address include:

Term of agreement and notice of termination. These clauses address the duration of the agreement and what procedures will be followed if a partner or associate wishes to leave the group. They also outline the obligations of the outgoing member and may include restrictions to future activities (a non-competition clause, for example).

Individual obligations. This outlines the responsibilities (clinical, on-call, financial, administrative) of each member.

The group's obligations. This specifies the benefits each member is to receive; for example, clinical coverage, expense sharing, shared staffing, administrative support.

Office lease. Is this a sublet or a new lease? Are there negotiated options to renew? How do you get your name on the lease? Do you want your name on the lease? Have your lawyer review the lease to verify that existing group members have negotiated the best deal possible and have anticipated all obligations.

Billing and expense responsibility. Who does the billing? Who is responsible for administration? How will shared expenses be allocated?

Authority regarding business decisions. This determines how decisions will be made; for example, majority vote, two-thirds or unanimous. This is particularly important when major capital expenditures are being considered.

Staffing issues. When you join a group, interview the shared staff as if you were hiring them in the first place. Negotiate to have the ability to replace staff if existing personnel do not work out. Negotiate to have an equal say in performance evaluations, office policies and staffing plans.

Basis for profit-sharing. The formula for distributing revenues among the members of a partnership must be detailed in the agreement.

Financing the practice. The financial responsibilities of each partner or associate regarding expenses and capital purchases (e.g., building and expensive equipment) must be detailed.

Liabilities and debt. The potential debt responsibilities, shared expenses and personal expenses assumed by each member individually, as well as the group as whole, must be delineated.

Insurance. The contract should specify how much disability, practice overhead and life insurance each member of the association or partnership requires to cover potential financial obligations in the event of disability or death. Will members be required to insure each other?

Potential buyouts. Can an individual member be bought out? How will the value and security of a share or “partnership interest” be calculated?

Key Message

There are advantages and disadvantages to all modes of medical practice. Your lawyer, accountant and financial consultant will be invaluable as you explore your options.

These are just some of the issues to address in the association or partnership agreement. It is essential to seek the expertise of a lawyer who has experience in contract law and who has worked with physician groups in the past. You and your lawyer should work closely to anticipate all of the “what ifs” that you and your potential associates or partners have not experienced to date. Detailed information is available in *Module 5. Legal Issues For Physicians* and in *Module 9. Principles Of Negotiation*.

Remuneration Options

Author’s note: An overview of remuneration options follows. Also see *Module 8. Physician Remuneration Options*, which addresses this topic in much greater detail

Fee-For-Service, Salary And Blended Arrangements: Pros And Cons

Most family physicians in Canada are self-employed professionals whose income is still generated, directly or indirectly, by fee-for-service billing. An increasing number of physicians, however, now derive a portion or all of their income in the form of a salary. Salaried physicians are, in effect, the employees or contractors of their hospitals or organizations.

Short-term salaried positions were discussed earlier. The same issues apply when evaluating the pros and cons of a long-term salaried position. As stressed earlier, the term “salaried” must be used with caution in reference to physicians working within an academic or health care institution. The benefits enjoyed by other employees (e.g., pensions, sick leave, holidays, medical and dental insurance, disability insurance) may not apply to salaried physicians. If you are negotiating

a salaried position, determine what benefits are included and ensure that they are documented in your employment contract. Like any partnership or association contract, your employment agreement should be reviewed and approved by qualified legal counsel before you agree to the terms. Have your accountant review the agreement as well—there may be tax complications if your employer pays for certain benefits (e.g., disability insurance premiums) rather than you.

Examples Of Salaried Positions

In academic institutions, physicians commonly derive their income in the form of a salary, or through some pre-determined mix of salary and fee-for-service income. Outside of academic institutions, the most common example of a salaried physician is within a community health centre that hires doctors to provide care for the population served by the clinic. These physicians are paid a salary, have benefits, paid vacation, CME and paid sick leave. They may or may not have pension benefits and disability insurance coverage. Professional dues, such as CMPA, CMA, College and Provincial Medical Association dues, may or may not be paid for by the employer.

Large private-sector companies also employ physicians on a contract basis. The federal government—particularly such departments as Health, National Defence and Veterans Affairs—and other government bodies employ physicians on both salary and contract bases. In addition, many provincial governments employ salaried physicians for under-served areas.

Clinical Associates And Hospitalists

An increasing number of hospitals now offer clinical associate positions to family doctors. These physicians are hired by the hospital to work in specialty clinics and cancer clinics, plus serve as surgical assistants. Depending on the employer, a clinical associate may or may not be a fully salaried employee with benefits, etc. Some (as in the case of surgical assistants) actually continue to bill on a fee-for-service basis.

There is a significant decline in the number of family doctors who wish to do, or are allowed by their hospital to do, in-patient care. As a result, an increasing number of both academic and community hospitals are hiring family doctors to be “hospitalists”. These physicians are contracted to assume the inpatient care of patients admitted to medical services. They are typically paid by a guaranteed hourly rate to determine their ‘salary’. Shadow billing fee-for-service for the hospitalist’s clinical activities is generally required by the institution to justify the funding they receive to pay the hospitalist. In many cases, such a salary is, in fact, a gross income payment, and the individual doctor is then responsible for paying his or her own taxes and expenses, and has no employee benefits. Many ‘contract’ their services as self-employed professionals to still qualify for professional deductions. Again, contract review by one’s lawyer and accountant is essential.

A guaranteed income, unaffected by the volume of procedures and services performed, is one of many advantages enjoyed by salaried physicians. But, unlike their fee-for-service colleagues who earn business income, employee-physicians can claim very few expenditures as tax deductions. A physician whose entire income is paid as a salary can generally not deduct association dues or malpractice insurance premiums. Under such circumstances, physicians should negotiate to have the employer pay these expenses.

Salaried physicians should always consider negotiating for the ability to do additional fee-for-service work to earn supplementary professional income. For example, the physician could negotiate for regular time—perhaps one day a week—to work as a fee-for-service provider, independent of the contractual obligations to the employer. Under this scenario, expenses such as malpractice insurance premiums, convention costs, automobile expenses and association dues would be tax deductible against this revenue, if they are incurred to earn business income, are reasonable in amount, and are allowed under the Income Tax Act. Seek the advice of an accountant who specializes in taxation before making any commitment to an employer.

| Advantages of salaried positions | Disadvantages of salaried positions |
|---|---|
| A secure, agreed-upon income, received every pay period | Limited ability to earn more, except by renegotiating contract, even though workload could increase without a parallel increase in earnings |
| No requirement to manage the practice | Limited control over working environment |
| No responsibility for overhead costs | Employer makes decisions about staff, working conditions, patients and overall operation of the clinic |
| Benefits may include guaranteed paid vacation, CME time, sick leave, medical/dental benefits, life and disability insurance | No guarantee of employment beyond the term of the contract |
| | Limited ability to claim expenses, such as CMPA fees or association dues, as tax deductible |

Hospital-Based Academic Positions

While the majority of physicians in academic institutions receive 100% of their income as a salary, some academic positions offer a combination of salary and fee-for-service income.

Some jurisdictions have a ceiling that limits the amount of fee-for-service income that each academic physician may earn and retain. Income generated by physicians in excess of the limit may be paid, in whole or in part, to the general operations and benefit of their department. The specific arrangement can be complicated; academic physicians may need to address the issues of association or partnership arrangements, as well as the issues of “blended” income. In addition, academics often have no autonomy regarding practice management decisions, unlike their self-employed community-based counterparts.

Because contractual and professional arrangements are likely to blend, academic opportunities represent, potentially, the most complicated form of practice.

Academic physicians must learn to negotiate contracts with the institution, university, their clinical group members and department chair. When negotiating in an academic setting, don’t make the mistake of assuming that there will be no latitude or flexibility with your institution. Module 9. Principles Of Negotiation addresses this issue in detail.

The academic physician needs expert personal and professional advice. Contact your lawyer, accountant and financial consultant prior to signing any contract.

Key Message

Direct or shadow fee-for-service billing continues to be a significant component of physician remuneration. A fundamental knowledge of fee-for-service billing is essential—regardless of the payment model. Alternative payment models, however, continue to evolve quickly and vary significantly across Canada.

Alternative Payment Plans

The terms vary from province to province, but, in essence, alternative payment plans (APPs) offer various new methods of remunerating physicians for clinical work. Alternative funding plans (AFPs) address alternative methods of paying physicians for clinical and academic work. Both APPs and AFPs are compensation models for medical practice that have come into vogue over the past decade. AFPs are typically implemented in academic centres where a significant part of the physician's work and time is not remunerated by fee-for-service payment. For instance, academic physicians often devote a lot of time to teaching, research and administration, yet none of these services or duties are billable under the fee-for-service model.

An APP or AFP is created through a mutual agreement between a group of physicians and the province or territory. The agreement is documented in a binding contract, signed by the province and the physicians, and often as well by the provincial medical association and, for academic positions, the university. The province/territory agrees to provide a set amount of remuneration per physician or full-time equivalent, and the physicians agree to provide set levels of clinical, teaching, research, administrative and other activities. The parties agree on a mechanism to account for these defined deliverables and compare them with budgeted amounts on a periodic basis. As part of this process, APPs and AFPs generally require physicians to submit billings as if they were earning income as fee-for-service doctors, even though their remuneration is set and guaranteed by the contract (i.e., shadow billing). Governments often compare the amount of shadow billing with the remuneration received by the same physicians, to ensure that the public has received value for their money.

A more detailed review is offered in Module 8. Physician Remuneration Options.

Primary Care Reform

Provincial ministries of health continue to evaluate how best to offer cost-effective primary care. A decade ago, many provinces were actively evaluating alternative payment plans for physicians, with particular attention paid to patient-enrolled models, with physician payment being based on enhanced fee-for-service, a "capitated model" or both (a blended model). Family physicians were encouraged to form group practices, offering patients easier access to comprehensive, seven-day-per-week outpatient care; in exchange, the physicians generally agree to provide a predetermined "basket" of common services. There may be additional incentives for after-hours outpatient care, home care, obstetrics, palliative care, preventative care, complex care and hospital care. These models require physicians to enrol and roster their patients into their practice, and are referred to as patient enrolled models (PEMs). Services rendered under such APP contracts may be remunerated in several ways, including but not limited to the following:

- A percentage bonus is applied to the fee-for-service billings for existing comprehensive services. Performance incentives and bonuses are given for after-hours care and for meeting predetermined special service delivery targets. These are components of existing plans, such as Ontario's Family Health Group (FHG) program. This model enhances the traditional fee-for-service model, in which the physician is remunerated for seeing the patient.

Key Message

After you do a detailed appraisal of remuneration models, get professional advice from accountants and lawyers who specialize in contract law before you make any decisions. They will help you to maximize your income and deductions, and minimize your risk.

- A capitation format guarantees an annual basic fee, paid for each rostered patient (factoring in age and gender), for the delivery of a predetermined basket of common primary care services. For example, the annual payment for providing outpatient non-emergent primary care services for a 20-year-old male may be approximately \$50, compared with \$350 for an 85-year-old female. The physician receives this base payment in 12 equal instalments over the year, regardless of whether or not he or she has seen the patient. There are incentive bonuses for preventative care targets and for shadow billing for all services and procedures that would have been covered under fee-for-service. Services not in the basket of services are billed under fee-for-service. In Ontario, for example, this is called a family health network (FHN) or organization (FHO).
- As of 2012, the majority of provinces have chosen to enhance the traditional fee-for-service model with percentage-based bonuses, age-based modifiers and bonuses for chronic disease management, rather than offer capitated models.
- A “blended” model is common in rural and remote areas, where the population base is too small to guarantee the volume of fee-for-service billings that would generate an appropriate income for a physician. In these scenarios, the Ministry of Health guarantees the physician an annual gross income for provision of common medical services in the office. The physician must provide shadow billing records for office-based services. Fee-for-service still applies for obstetrical and emergency care, as well as medical services provided after hours or in hospital. Retention incentives and bonuses are offered annually to physicians who stay in the under-serviced area. This model is common to rural areas of Ontario and in Newfoundland and Labrador.

Non-Insured Services

Provincial ministries of health sometimes reduce or delist the number of services they pay physicians to provide, and these services become non-insured. It is now essential for all physicians to be familiar with existing guidelines, recommended fee schedules, and the mechanics of billing patients directly for non-insured services.

Non-insured services now contribute a greater portion of the family physician’s income than ever before. Consequently, point-of-service payment machines (i.e., debit and credit cards) are being introduced to the physician’s office—a trend unheard of just a decade ago. In addition, because of computerization, some provinces accept nothing but electronic data transfer (EDT) billing from physicians, leaving doctors who have minimal computer skills scrambling. *Module 8. Physician Remuneration Options addresses direct-to-patient billing in greater detail.*

Seek Professional Advice.

Alternative payment plans are diverse and can be complicated. It is extremely important to critically appraise the pros and cons of every option. In all cases, you will find that an AFP results in more administrative obligations and accountability.

Association or partnership contracts require even more intense scrutiny. The practice management issues can be more complicated than in the fee-for-service model. Do a detailed appraisal and get professional advice from qualified accounts and lawyers who specialize in contract law before you decide on any remuneration model.

Getting Started

Once you have educated yourself about all of the above issues, you will be more prepared to decide how to establish your practice. Your options include:

- Assuming a practice: solo or group
- Buying into a practice: solo or group
- Starting your own practice: solo or group

Assuming a practice

A lot of work and extra time is required to effectively and efficiently start up your own practice. Then it takes up to two years for everything to settle down— especially if you need to hire new staff and outfit the office. From this perspective, assuming the practice of a physician who is retiring or leaving may look attractive, but it only makes sense if you have evaluated the practice in detail and, ideally, have test-driven the practice before committing, by doing a locum there. Furthermore, in some provinces, assuming a practice will disqualify you for some very attractive bonuses in terms of accepting new patients in the first year of your practice.

In some cases, it is not to your advantage to assume a practice.

| ASSUMING AN EXISTING PRACTICE | |
|--|--|
| Advantages | Potential Disadvantages To Watch Out For |
| Instant full practice, with a steady income stream | Inheriting someone else’s problems and mistakes |
| Office and staff are in place | Potential attrition of staff, which could be very costly |
| Office policies and procedures are established and accepted by patients and staff | Sufficient difference in practice styles and policies, requiring staff and patients to be “re-educated” |
| Medical records and cumulative patient profiles are already prepared | More work and stress in the first few years compared with starting your own practice |
| EMR is already set up | |
| New patients can be accepted with discretion | A patient roster that is too large to manage |
| Less need for meet-and-greet visit with all patients | A disproportionate number of seniors, with multiple complex medical problems, and the inability to accept new patients |
| Existing patient roster puts you in a good position to consider AFP or other remuneration format | |

Buying into a practice

In Canada, there is a physician shortage and no lack of patients who are seeking your services. Therefore, paying an outgoing physician a 'goodwill' payment for their patient roster and an assured income stream no longer applies. A physician's practice does not have a market value—unless it is a specialized practice, offering very specialized services, in which the physician supply exceeds the demand or provides non-insured services, such as a cosmetic surgery clinic. This may apply to a few specialists, but is unlikely for family physicians.

Capital start-up costs: As discussed earlier, joining a group practice may require you to buy existing equipment from the departing doctor. You may incur additional start-up fees if the capital expenditures of the outgoing physician's associates or partners are not fully depreciated. Such costs are typically not significant and can be easily financed.

Starting your own practice

Today, many family doctors establish their own practices rather than assume one from a physician who is retiring or leaving. This enables you to determine the philosophy, demographics and style of your own practice. When starting out, copy the best practices that you observed during your residency and locum experiences. More important, avoid the pitfalls and mistakes that you have seen other physicians make!

It is very important to get started on the right foot, as your first visit with each patient will set the stage for every future encounter. Have a standard "meet and greet" protocol, so that patients will have realistic expectations of what medical services you can and cannot provide for them.

You also will need to invest a lot of time in getting to know your patients: registration, setting up their medical records, compiling their medical profiles and establishing your professional relationship will often take three or four visits. It typically takes up to two years before your practice roster is established and you are familiar with your patients. A good source of advice is Module 12. Starting Your Family Practice On The Right Foot.

Few of you will choose to go solo. If you do, you will need to equip and staff the office. See Module 16. Staffing And Human Resources. Also refer to Module 15. Setting up your office, which, in addition to exploring issues related to practice start-up, offers a case example of setting up a solo practice and details the costs of the first year of operation. The appendix in Module 15 will also help those who are joining or forming a group practice to compile an inventory of what is being provided and what is missing.

Most of you will start your own practice as a new member of a pre-existing group. Make sure that your new colleagues have the same approach to office policies, practice style, prescribing methods and non-insured service billing as you wish to have. This is particularly important if you will be sharing staff and covering each other's patients. Any divergence in style or attitude can lead to conflicts among physicians, staff and patients.

First and foremost, evaluate your potential long-term colleagues: Whenever you are evaluating the pros and cons of joining a group, make sure that your future colleagues have a vested interest in your long-term success and are prepared to accommodate you. Also be sure your expectations and requests are realistic.

To this end, we suggest that you proactively decide on the general and specific questions and issues you want to review with all of your potential new group members. They may at first be uncomfortable to participate, but if you frame your request in a manner that demonstrates that you want to assure them that you can meet their expectations and needs, then they should be more receptive.

Furthermore, when a new member joins a group, the group should update and, when appropriate, renegotiate their various agreements. Issues you raise may not have been anticipated before, and may enhance their existing contract. Don't be surprised if the group does not have a written contract. Sadly, many have not thought this process through—and if not, it is essential that a written contract be agreed upon before you commit.

The getting-to-know-you interview

The following questions and issues may be applicable to most scenarios and are offered for your consideration. Select the issues that you believe are most relevant to your situation.

General Questions:

- What is the practice philosophy, profile and style of each member?
 - Is it compatible with yours?
- Does the group practise comprehensive or selective care?
 - If selective care, this can impact cross-coverage.
- Do they have special interests or skills?
 - This allows for referrals within the group.
- Do they have clinical teaching commitments? And, if so, are you obliged to participate?
- What is their approach to referrals? To what degree do they work up their patients?
 - This question must be addressed tactfully. If a member is fast to refer problems that most GPs can handle, then staff will need to spend a disproportionate amount of time closing the loop on these referrals. Staffing is a group's greatest expense.
 - Furthermore, to what degree will this colleague be able to cross-cover you if you are more comprehensive and thorough?
- What are their attitudes regarding evidenced-based medicine, up-to-date treatment guidelines and preventative care?
 - Remember, you will cross-cover each other. Are they good doctors that you will be entrusting your patients to? Will they be a potential liability?

Practice Style:

- Paper or EMR?
 - Approximately 60% of GP groups have EMR. If not, ensure that they are keen to upgrade, and clarify when.
 - If an EMR exists, is it a good EMR system?
- Prescribing policies:
 - As with locums, do all of your potential colleagues use discretion and follow EBM guidelines when prescribing antibiotics, benzos and controlled substances? Do chronic pain patients sign a contract if on narcotics? If not, then there will be conflict when cross-covering.
 - Do they keep an up-to-date cumulative medication profile, and is it easily accessible?
- Phone prescription renewal policies
 - Do they charge? If not, volume will be high, staff will be disproportionately involved and you will meet resistance if you decide to charge.

Practice Management:

- Is the group associated or in partnership?
- Will you have any capital cost buy-in obligations?
- Are shared expenses proportionately shared? If so, what is the formula?
- Is the office owned or rented? If rented, is there a guaranteed option to renew the lease?
- Does the group schedule regular meetings and share responsibilities and tasks?
- Do major decisions require a majority or a unanimous decision?

Physician Remuneration:

- Do all the group members bill fee-for-service?
- Or do they participate in an alternative funding plan (AFP)?
 - If so, what does it involve?
 - There will be provincial variations here, as discussed above.
 - Will participating in this payment model be in your best interest?

Gender Considerations:

- Is the group composed of both female and male physicians?
- Do all physicians provide women's and men's health care, prenatal care, newborn and pediatric care?
- Are the patients of all members comfortable to be seen by their trusted colleague, regardless of gender, for urgent care, or do they expect to be seen by a gender-specific doc?
- If so, this makes cross-coverage more onerous for a subset of colleagues—especially when covering for holidays.
- Assess the interest in a group practice policy to avoid genderization and segregation of the group practice, if appropriate.
- For example, is there a group policy that all patients must be accepting of urgent coverage by any colleague when their primary doctor is unavailable?

Medical Records: Format And Documentation:

- How easy is it to use your colleague's medical records—paper or EMR?
- Do their records meet college requirements? (see Module 6. Medical Records Management and Module 7. EMR)
 - For example, do their SOAP progress notes stand alone without their interpretation?
- Has the group standardized their CPP, medication records and patient information handouts?
- If still using paper charts, are they receptive to you doing a chart review?
- Have any of them been peer reviewed by the college for their records? How did they do?

Staffing Preferences And Policies:

- Do they have shared staff and/or dedicated staff?
- If dedicated staff, do these staff members cross-cover for each other?
- Is there a nurse on staff?
- Are staff all full-time, or is there job-sharing?
 - Job-sharing fosters easy cross-coverage and succession planning.
- Are there written and up-to-date job descriptions for each staff member, and a global staffing plan?
- Is there a written and up-to-date policy and procedural manual?
 - This is essential for training new staff members and doctors!
 - Most practices do not have these—so be prepared to assist in preparing one.
- Have they standardized procedures and policies?
 - Appointment scheduling
 - Phone management and triage
 - Patient reception, prep and discharge
- Is the office staffed during evening hours?
- Do any of the associates have their significant other working in the practice?
 - If so, in what capacity? If managerial, this could be a potential source of polarization.
 - Meeting associates' significant others before you commit is a good idea.

Office Design And Utilization:

- Do the doctors have dedicated offices, or shared modules?
- Are there customized or common exam room set-ups?
- Is the equipment up to date and well maintained?
- Are all of your equipment requirements met?
- Does the office follow best practices in infection control, and is autoclaving done properly?
- Is there a centralized nursing/procedure/supply area?
 - Weight, BP, shots, N , spirometry
 - Private bathroom and staff lounge
- How effectively and efficiently designed are the physician/admin/patient common areas?
- Have the ergonomic and comfort needs of both staff and physicians been addressed?
 - Design, colour, furnishings, decoration, background music, etc.
 - Module 15. Setting Up Your Office addresses this in more detail.

Emergency And Same-Day Patients:

- Do any or all of the members see walk-in patients?
 - Walk-ins are discouraged, unless you dedicate a doctor for this contingency on a rotational basis.
- Do all members set aside dedicated time in their schedules to see same- day patients?
 - Many doctors state that they do avail time for same-day urgent visits, but a review of their appointment schedule, as discussed in the locum module, often reveals that they do not. If so, what is the potential impact on their ability to cross-cover for you when you are away?
- Will all doctors agree to proactively set aside more dedicated same-day appointment slots to cover each other when on holiday?
 - Locums are hard to find!
- Does the group prefer to have a rotational approach, wherein one doc sees the majority of same-day patients? If so, then again, the gender-neutral policy is important.

Policies For Non-Insured Services:

- What are the present policies and practices of each member regarding billing for non-insured services?
 - Extent, rates, reconciliation, arbitration
- Do they actually follow through with their policy?
- Will they agree to a group standardized fee schedule?
- Solidarity:
 - Will they agree to update patient information on their website and in the office?
 - Will they require patients to acknowledge agreement of such policies?
- See Module 12. Starting Your Practice On The Right Foot.
- Who deals with confrontation?
 - Will all doctors agree that they will always back up staff and personally deal with confrontation when staff members carry out their policies?

Key Message

Be thorough when evaluating long-term practice options. Always have a written group practice contract reviewed by your accountant and lawyer.

Vacation, Half-Days Off And Cme Coverage:

- Does the group offer each other daytime coverage for half or full days away from the office?
 - This is essential for part-time physicians.
- After-hours coverage: Is there a call group, and a dedicated site for seeing after-hours patients?
- Does each doctor work a regular evening office shift?
 - This is important if the group participates in a patient-enrolled model or an AFP.
- Holidays and CME:
 - Does the group cover each other for holidays?
 - How does each member negotiate for holiday time?
 - Under what circumstances does a member need to arrange for a locum?
- Do some or all members do OB and/or hospital coverage?
- If so, are you obliged to participate?
- Do they participate in an expanded coverage group to reduce the call roster?

Professional And Liability Issues:

- Do all members maintain their CCFP accreditation?
- Do they have an up-to-date college licence, CMPA, and adequate disability and practice overhead insurance?
- Have any members had or are they presently involved in a malpractice suit?
 - This is important to know because, if they lose their licence, they will not be able to meet their group obligations.
- Do they have life insurance to cover contractual obligations for the remaining term of the association agreement?
- Is there an adequate group office insurance policy to cover personal liability?
- How do you get your name on the coverage policy?
- Will all members agree to a proof requirement, whereby they annually show each other that all coverage is up to date?

Due Diligence:

- Review existing contracts, and have your lawyer and accountant review the group's financial statements.
- Review the lease and staff contracts, as well as contracts to major suppliers, such as computer hardware and software providers.
- Sign all contracts at the same time.

Bottom Line:

- Do your associates/partners have a vested interest in your success?
- Additional issues and questions to consider are listed in Appendix 1: Sample Practice Evaluation Checklist.

Summary

Planning your future takes a lot of time and effort. But the more time and money you invest in your practice, the more you will benefit, both vocationally and professionally. Take ownership of your future: You have a vested interest in your own success.

There are many things to consider when evaluating medical practice opportunities, including your lifestyle, national issues and trends, location, professional issues, modes of practice—and especially the quality and compatibility of potential

long-term associates. Address your personal long-term aspirations and needs, and those of your family, before you look at the financial and clinical aspects of a long-term practice opportunity. Then, before you make a commitment, evaluate all aspects of your opportunities thoroughly, and seek professional advice about all financial and legal matters.

ACTION PLAN

- Gather as much information as you can. Take advantage of the many clinical as well as professional learning opportunities you will be exposed to during the rest of your residency.
- Copy best practices from successful clinicians you respect.
- Research as many office policy and procedure manuals as possible. Copy those you like and note the policies, procedures and issues that you don't want to copy or adopt when you set up practice.
- Stay up to date with the medical/political issues of the day—they may affect the decisions you make about your future medical practice.
- Talk with as many physicians as you can to learn what they have done right and, more important, what they have done wrong or wish they had done better.
- Ask questions until you get all of the answers you need.
- Explore all available resources to help you make beneficial decisions about your future.

Resources And References

Practice management education modules:

- **Module 6:** Medical Records Management
- **Module 7:** Electronic Medical Records
- **Module 8:** Physician Remuneration Options
- **Module 9:** Principles Of Negotiation
- **Module 11:** Locums: Negotiating A Fair And Mutually Beneficial Locum Contract
- **Module 12:** Starting Your Practice On The Right Foot
- **Module 15:** Setting Up Your Office

MD Financial Management website: cma.ca/pmresources

New in Practice Guide: Available on cma.ca

Appendix 1: Sample Practice Evaluation Checklist

First And Foremost: Lifestyle

- Will you and your family be happy living in the community for several years?
- Is affordable, quality housing available in the community?
- Are schools, shopping, recreational, cultural and religious facilities readily available and accessible?
- Can you, your family and friends visit each other easily?
- Are there employment opportunities for your significant other and family?

When Evaluating A Salaried Position

- Have you addressed what you are to give, what you are to receive, and all of the “what ifs” with your lawyer and accountant?

When Assuming A Practice And/Or Joining A Group

- Does the practice have a specialty interest or special needs population?
- Does the practice follow current guidelines and evidence-based medicine?
- What are the policies regarding antibiotic, narcotic and anxiolytic medications?
- Are patients charged for non-insured services? If so, for what services?
- What are the office policies for phone-call prescription renewals and missed appointments?
- How are requests for sick-leave notes handled?
- Does the practice offer obstetrics or minor surgical procedures?
- What are the regular office hours? Is there flexibility for your schedule?
- What are the on-call obligations for the hospital, nursing home or emergency department?
- Do the doctors share the on-call obligations equally?
- What are the arrangements with other physicians for after-hours, weekend and holiday coverage?
- Does the practice have a comprehensive list of specialists for referrals?
- Are there teaching opportunities or obligations?
- Is the practice in an area where hospital restructuring has happened or is pending?

Appointment Scheduling

- What is the average number of patients seen per day?
- How much time is allocated for the average patient visit?
- Are time slots reserved for check-ups and counselling?
- How many time slots are allocated for same-day call-ins? How are these patients accommodated in the schedule?
- How many periodic health examinations are scheduled each day? How much time is allocated for these appointments? When during the day are they scheduled?
- When are procedures done? How much time is allocated for procedures?
- Does the practice offer variety (e.g., pediatrics, geriatrics, adolescents, women's health)?
- Is the reason for the patient visit recorded on the appointment schedule?
- Does the practice have an extensive list of contacts (e.g., call group members, consultants, labs, diagnostic services and pharmacies)?
- Can you customize your appointment schedule?

For more details, see Module 12. Starting Your Practice On The Right Foot.

Medical Records

- Are the medical records comprehensive, well organized and legible?
- Do the physicians dictate or write progress notes?
- Are progress notes done in a SOAP format (symptoms, observations, assessment and plan)?
- Do the physicians keep up-to-date cumulative patient profiles and such records as cumulative medication sheets, diabetic, INR and lipid flow sheets?
- Are allergies and immunization records clearly marked?
- Do the records indicate compliance with evidence-based practice guidelines for preventative care and screening?
- Do the records indicate the office's prescribing habits for controlled drugs, anxiolytics and antibiotics?
- Do the records raise any concerns regarding medical competence?
- Will the group members welcome standardization of medical records?
- Does the practice have, or intend to have, an electronic medical records and chartless office?

For more details, see *Module 6. Medical Records and Module 7. Electronic Medical Records.*

The Medical Office

- Do the physicians own, lease or sublet office space?
- Which office functions are computerized? Which are still done manually?
- What communications equipment does the office use?
- Is the office accessible, modern, comfortable, clean and pleasant for patients, staff and physicians?
- Are the exam rooms and common areas well designed for function and comfort?
- Is the office and medical equipment up to date?
- Will your personal needs for equipment and office space be met?

- What are the present and proposed staffing arrangements?
- Will you have shared or dedicated staff?
- What responsibility will you have for hiring and evaluating staff?

For more details, see *Module 16. Staffing And Human Resources and Module 15. Setting Up Your Office.*

Finances And Billing

- Does the group have an association or partnership agreement?
- Are shared and individual expenses clearly delineated in the agreement?
- Will expenses be shared equally, or will they be proportionate to each physician's utilization?
- Have you reviewed the agreement in detail with your lawyer and accountant? Are you happy with the financial terms of the partnership or associateship? Are any health, dental or other benefits available through the practice?
- How are the physicians remunerated? Fee-for-service? Alternative payment plan? Blended format? Salary?
- Who submits and reconciles the billings?
- Are there clear policies for the billing and collection of fees for non-insured and third-party services?
- Is there a clear policy regarding patients who have overdue accounts?
- Does the practice post its office policies and distribute patient information sheets to clearly inform patients that they will be billed directly for non-insured services?

For more details, see *Module 8. Physician Remuneration Options.*

Accounting

- Has your accountant reviewed the bookkeeping and accounting practices in detail?
- Are expense and income records readily available for your review and approval?

For more details, see *Module 4. Personal And Professional Accounting And Taxation.*

Insurance And Legal Issues

- Do all group members have adequate professional and personal liability insurance, life insurance, office insurance, disability insurance and practice overhead insurance to cover any losses or obligations for the term of the group practice agreement?
- Has your lawyer reviewed and approved the office lease?
- Have your lawyer and accountant reviewed and verified that your best interests are covered in the association or partnership agreement?
- For more details, see *Module 3. Personal And Professional Insurance and*
- *Module 5. Legal Issues For Physicians.*

Bottom Line

- Do your future associates have a vested interest in your success?