

Creating a VITAL BURNOUT-PROOF Practice

If you're feeling disillusioned and burned-out in your current mode of practice, why not start over? Here's how to build a strong foundation.

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Our profession is ripe to the point of rotting with burnout. Consider the case of one family physician who, two weeks after starting in her first post-residency practice, was so disillusioned that she quit. She didn't just quit the practice; she quit being a doctor. While her response may seem extreme, we see the evidence of disillusionment and burnout all around us: early retirement, physicians scrambling to take on administrative and other non-patient-care roles, as well as widespread grumpiness.

Physicians burn out for a number of reasons, but perhaps the most common is a lack of balance in our work life. We work hard to get into medical school. We work hard to get through medical school. And we work hard in residency. When we finally enter practice, we expect to find – in addition to a better income – a work environment with more reasonable hours and a stable patient population with whom we can build long-lasting relationships. But the reality is often far different.

As new physicians, some of us had to build patient populations from scratch, but most of us were dropped into offices bursting at the seams with patient demand, finding schedules flooded with the overflow. In short order, we found ourselves in the typical mode of running from room to room, starting encounters with “Sorry I'm late,” and

jumping in all too soon with “I'm sorry, but we can't get into all that now. You'll have to make another appointment.” At the end of the day, we would go back to the stacks of charts and drudgingly sift through the lab work, imaging reports, consult notes and (shudder) all those nasty forms.

That is certainly where I was in 1998, five years out of residency. My reality consisted of hours of paperwork at the end of the day, coming in early to try to catch up, never having enough time and always running behind. This was not what I had hoped for when I decided to become a family physician.

I described in previous *FPM* articles my switch to solo practice (see “Going Solo: Making the Leap,” February 2002, page 29; “Going Solo: One Doc, One Room, One Year Later,” March 2002, page 25; and “Answers to Your Questions on Solo, Ideal-

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ized Practice,” May 2002, page 39) and have since spoken to many physicians about how they too can make the transition. In this article, I'm going to describe the essential foundation for creating a healthy balance in

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Disillusionment and burnout are not uncommon in the medical profession today, due in part to a lack of balance in physicians' work lives.



The current mode of practice, which tends to over-emphasize productivity and profits, may be doable in the short term but not in the long term.



To begin laying the foundation for a vital, well-balanced practice, you have to do some soul searching.



Both full-time and part-time practice are doable but require the ongoing balance between demand (total work) and capacity (the number of hours you are willing to devote to work in the average week).

practice. While I chose the solo model, these points apply to the creation of any practice: employed, solo, group or academic.

The foundation

A vital practice is one that can be sustained over time. The current mode of practice, which tends to overemphasize productivity and profits, may be doable in the short term but not in the long term. It inevitably leads to disillusionment and burnout.

Burnout often has its origin in a lack of balance. To find the balance that is right for you and begin laying the foundation for a vital practice, you have to do some soul searching. Begin by answering these essential but seldom-pondered questions:

1. How much would you like to work?

Keep money out of the discussion for the moment – we'll get to that later. Quite simply, how many hours per week are you willing to devote to work?

Some folks are willing to work full time; others prefer a part-time schedule. While both are doable, part-time practice can be trickier. It works best if you can manage some physical presence in the practice Monday through Friday. Each day you're out of the office adds extra work to you and your office staff. This comes from the need to deflect your patients either to others in the practice or to your schedule on another day. Deflection is uncompensated work. As opposed to "Sure, your doctor can see you today. How about 11 a.m.?" patients are

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told, "Gee, she's not here today. What are you calling about? Can it wait until tomorrow? Would you prefer to see the physician assistant? Let me get the triage nurse." (For those of you who really want to get a handle on your demand and reduce the amount of uncompensated work in the office, read up on Murray and Tantau's principles for same-day access; see "Same-Day Appointments: Exploding the Access Paradigm," *FPM*, September 2000, p. 45.)

Ultimately, whether full time or part time, a vital practice is one that keeps

KEY POINTS

- The desire to increase revenue drives a lot of dysfunctional behavior in health care and leads to unbalanced practices and burned-out physicians.
- Physicians can start over and create well-balanced practices based on four essential but seldom-pondered questions, such as "How much would you like to work?"
- Family physicians have options regarding where and how they work, so don't settle for a less-than-ideal practice.

demand and capacity in balance. Your demand is made up of the sum total of your work-related paperwork, phone calls, e-mail, travel, patient care and more. A reasonable proxy for total demand might be the total number of requests for office visits in a week, which of course will vary by season. Your capacity equals the time you are willing to devote to work in the average week. You will need to create flexibility in your capacity to deal with variation in demand, but you do not have to make yourself a target for all demand. I am willing to see patients between the hours of 9 a.m. and 5 p.m., Monday through Friday. There are those who would rather be seen at other times, and I will occasionally flex my schedule to see them (e.g., a sick kid on Saturday morning), but this is infrequent. On the other hand, I have enough capacity and flexibility in my daily schedule that I am able to offer appointments "today" to every caller.

2. What is your ideal scope of practice?

For a patient population that doesn't change, the total amount of work you do increases as you widen your scope of practice. Given relatively predictable demand for acute and planned care (planned care includes management of chronic disease as well as preventive care), each time you add something to the scope of practice, you do more for the same people.

I am not advocating for any particular scope of practice, but I urge you to spend some time reflecting on what excites you in your practice. For instance, do you delight in skin procedures? Do you enjoy delivering babies? Do you want to perform colposcopy or other more involved procedures? All too often the decision to do procedures comes from the need to improve revenue. Let the desire to perform procedures or offer other

services be based on your personal interests and your population's needs, not solely on income.

Once you have made a list of those things you very much want to have in your scope of practice, add that which you must do and cannot avoid. This list might include vaccinations, phlebotomy, EKGs and other testing. The driver for these things is based on the needs of your community. If these are things you would rather not do and others in the community are willing and able to do them, then outsource the work if possible. For example, my community has freestanding phlebotomy/lab stations, so I have the luxury of sending patients down the street for blood work, and I don't have to deal with centrifuge, purple top tubes, etc.

3. Where would you like to work? In the ideal world, you could work near your home so that travel time would be cut to almost nothing. I'm lucky enough to practice within a half-mile of my home, so the quick office visit on a weekend is no big deal. (I've had three or four in the past year.) If you're thinking of starting a new practice and want to keep expenses down, consider subleasing a room from an existing specialty practice that has too much space. I'm still doing that after two years and see no reason to change. My rent is less than \$500 per month.

The point here is to realize that, as a family physician, you have options about where you work. Explore those options, be creative and you'll find a location that will suit not only your patients but also your family and yourself.

4. How would you like to work? Would you like to be in an office with other physicians? Would you like clinical and clerical support? Do you want a fancy office? Each time you answer "yes," your overhead goes up and you will need to increase revenue, requiring a larger patient base.

The desire to increase revenue – or, more accurately, to increase the profit margin (the money left over after expenses) – drives a lot of dysfunctional behavior in health care. Much of the pressure to improve margin comes from the extremely high expenses under which most offices labor. Rather than drive up revenue, try operating with low expenses. It will have the same net effect.

As you begin to think about how you would like your office processes to work, consider starting very small and building

over time. Take the model from pre-1960. Hang out a shingle, do all the work yourself and as the volume picks up, hire someone to help. If you are working within a larger office, negotiate a "pay as you go" strategy so that you are charged for those things you use and not being used to support a bloated practice.

Let me give you an example: Practice Gordo has been around for 20 years. They have hired you as a new potential partner. You're coming on with a nice guaranteed salary for the first two years and then will

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move to compensation based on a percent of revenue if you are accepted as a partner. All of the partners profess to love this plan as "they eat what they kill" – and they all look very well fed. There are lots of late-model cars with MD plates in the parking lot.

Doing some digging, you find out that "compensation based on a percent of revenue" actually means "after we take 50 percent for office overhead." Suggesting that you don't need to work with a full-time secretary, medical assistant and nurse and that you'd like to try it another (more efficient) way, you hear, "That's fine, but we all work under the same agreement: 50 percent for overhead." I'd walk away from the deal.

Getting the word out

If you are starting a practice with no or few patients, you will want to grow quickly. I've worked with a number of new practices and have found four themes extremely pleasing to the public and able to give you a sustainable competitive advantage:

1. "I will see you today, regardless of whether you have an urgent problem."
2. "I will see you on time: 3 p.m. means I'll be walking in the room at 3 p.m."
3. "We will have all the time you and I need. No rushing."
4. "No bait and switch. When you sign up with my practice, you will get me and no one else."

I've worked with practices that opened their doors in very competitive locations, where previous physician tenants had failed due to an inability to garner new patients. ➤

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Before you decide on a particular scope of practice, spend some time reflecting on what excites you in your practice, not merely on how you can make more money.



As a family physician, you have options about where you work and, with some creativity, should be able to find a location that suits the needs of your patients, your family and yourself.



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To grow your practice quickly, promise your patients four things: "I will see you today," "I will see you on time," "We will have all the time we need" and "You will see me and no one else."



These four principles aren't compatible with a practice that doesn't have a handle on demand, doesn't give its physicians an incentive to practice efficiently and lets revenue drive its behavior.

Using the aforementioned rules, they filled their practices in record time; sustaining the rules, they've built unsurpassed patient loyalty. The growth is built on word of mouth and, therefore, costs nothing. You may want or need to make some initial investment in publicizing your new practice. Or you might invest your time in building rapport with nearby practices that are closed to new

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patients. If the practices are willing, bring lunch for their secretaries and schedulers, talk about your new practice down the street and invite them to steer new patients your way.

If you think these four principles would be impossible to live out in your current practice, you're probably right. They're not compatible with a practice that doesn't have a handle on demand, doesn't give its physi-

cians incentives to practice efficiently and lets revenue drive its behavior. To create a vital, well-balanced practice, you can't simply try harder at the current mode of practice; you must practice differently.

First things first

Starting up a practice from scratch involves many other steps: obtaining business insurance, securing a business loan, ordering telephone service, finding the right practice management software, obtaining a lease, ordering supplies, getting credentialed with HMOs and more. (For help with those steps, see the AAFP publication *On Your Own: Starting a Medical Practice From the Ground Up*; for ordering information visit www.aafp.org/x19744.xml.) Each of these steps is associated with its own timeline, paperwork and expense, and each looks more daunting before you get going. But do yourself a lifelong favor and look to basic values and balance in your life before getting bogged down in the details of the start-up. **FPM**

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