The Effect of Career Change from Private Practice to Full-Time Family Practice Faculty

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This study investigated the timing and extent of the emotional impact of the career change of 33 selected family physicians who, after at least 15 years in private practice, moved into full-time teaching and/or administration in a family practice residency program. Their intrinsic feelings of being enthusiastic, energetic, optimistic, and enjoying associates were all diminished during the first six months, dropped further in the second six months, but began to recover during the second year. Similarly the physicians' perception of their effectiveness in their new work – confident, competent, and fulfilled – was relatively low during the first six months, but began to rise during the second six months and again during the second year.

A comparison is made between the responses of those who held positions as directors and those who were non-directors. Changes reported were less marked in those who became directors than in those who did not. Possible causes of this phenomenon are explored. Methods to soften the impact of the career change are suggested.

The purpose for undertaking this study was threefold:

1. To reassure those who had experienced significant emotional disturbances in moving from long years in private practice to full-time family practice teaching that, with such a major career change, such emotional disturbances had occurred in others.

2. To offer information to those involved in or contemplating setting up family practice residencies that the most knowledgeable potential teachers are also the most vulnerable to the effects of career change and a variable period of lower productivity should be expected. The study, it was hoped, would also provide some analysis of the emotional or personality factors involved, and also the types of support which could best be provided.

3. To serve as available data to physicians who are contemplating moving from full-time practice into full-time academia.

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Methods

Pilot questionnaires were sent to two experienced family practice professors for their suggestions. Forty sets of six questionnaires (three for faculty and three for spouses) were then sent to family practice programs in the United States with the request that the questionnaires be filled out by faculty who had been in family practice for at least 15 years and had moved full time into a family practice training program.

Forty-nine faculty members and 43 spouses returned the questionnaires. Only those questionnaires of faculty members with all questions answered and meeting the above criteria, were used in the analyses.

The total number of usable responses of faculty members was 33. For comparison, these 33 were divided into two groups: one group consisted of 18 respondents who were not directors of programs, and the second group consisted of 15 program directors. However, personal opinions from any of the 49 were included in the commentary. The results from the spouses are not reported in this paper.

Background data on the two groups of directors and non-directors is al-

most identical. Mean year of birth in both is 1923, with the spread 1914 to 1928 for directors and 1913 to 1934 for non-directors. Average of years in practice is 20 for directors compared to 21 years for non-directors and mean year of change from practice to full-time teaching is 1972 for directors and 1971 for non-directors.

Thirty-one of the family practice centers to which the questionnaires were sent were university-based and nine were community programs. An attempt was made to achieve equitable geographic distribution.

The study is not a random sample, and therefore generalizations are of limited significance. This is not a statistical analysis and we do not know the significance of the differences. This study is retrospective in nature and therefore may be biased by the passage of time and limitations of memory.

Results

Summary of Replies

Findings of this study are reported separately for each of the major questions. (These are stated completely where required for clarity.)

How long have you considered the job change?

	Directors	Non-Directors
In general	3 yr, 9 mo	3 yr, 10 mo
Specifically	1 yr, 6 mo	9 mo

Which of the following would you say influenced your decision to change jobs? (answer as many as are appropriate):

	Directors	Non-Directors
Commitment to family practice training	15	16
Need for leisure	3	6
Health reasons	0	5
Personal or family life	4	10
Economic security	0	1

Which aspects of your job do you find most satisfying (in order of preference 1 to 6):

	Directors	Non-Directors
Teaching	1	1
Research	5	6
Patient care	2	2
Administration	3	4
Committee work	6	5
Curriculum planning	4	3

Was there a significant change in your income as a result of your new career?

	Directors	Non-Directors
Up	1	0
About the same	6	6
Down	8	12

Following your move from private practice to full-time teaching, how would you describe your feelings? Rate your feelings during three time periods – first six months, second six months, and second year.

My feelings during the first six months: (Please check on a 5-point scale, 3 is about average.)

Enthusiastic	_ _ _ _ _	Bored
Energetic	_ _ _ _ _	Tired
Optimistic	_ _ _ _ _	Pessimistic
Enjoys Associate	_ _ _ _ _	Lonely
Euphoric	_ _ _ _ _	Depressed
Insecure	_ _ _ _ _	Confident
Competent	_ _ _ _ _	Incompetent
Fulfilled	_ _ _ _ _	Unfulfilled
Relaxed	_ _ _ _ _	Overworked

The results of the 18 replies from *non-directors* (Figure 1) suggest that the eight intrinsic characteristics of personality listed – "enthusiastic vs bored," energetic vs tired," optimistic vs pessimistic," and "enjoys associates vs lonely" show a shift down in the second six months towards the negative side, but move up again in the second year.

The six characteristics – "confident vs insecure," "competent vs incompetent," and "fulfilled vs unfulfilled" are determined to quite an extent by environment and particularly by the job or task to be done. These are rated low in the first six months, but rise appreciably in the second year. This, of course, would be expected in any career change requiring new knowledge and skills.

The ninth graph in Figure 1, "relaxed vs overworked" summarizes a unanimous feeling of an excessively heavy workload. This "overwork" is presumably "qualitative" overload

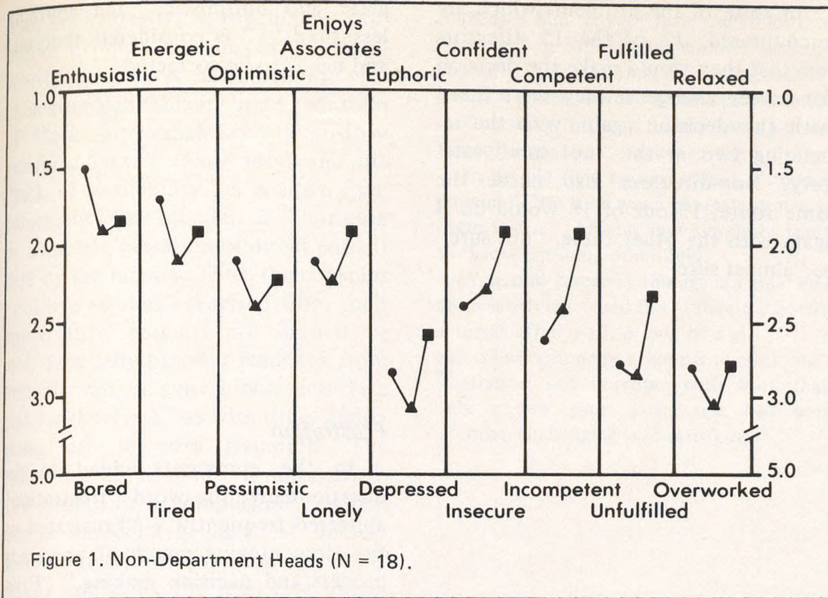

Figure 1. Non-Department Heads (N = 18).

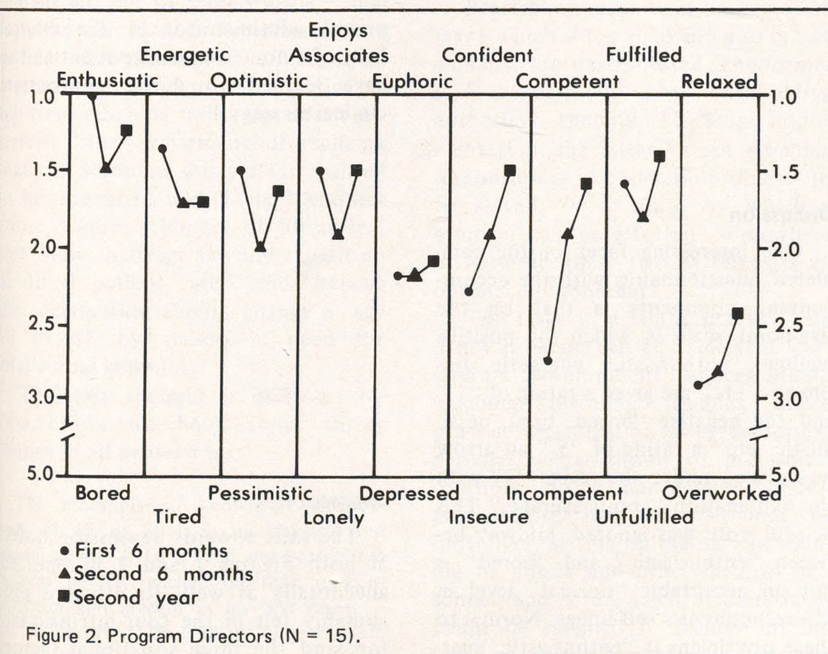

Figure 2. Program Directors (N = 15).

rather than "quantitative" overload. The actual work hours of a faculty member are usually less than those spent in private practice. The "qualitative" aspect of the work involving new skills, eg, trying to analyze the performance of a resident stumbling through a problem and devising a method of teaching a more effective manner of coping, all are more exhausting than providing the patient care, personally.

This phenomenon of qualitative overload has been researched recently in business administration studies. In one study it is reported that to a highly motivated, perfectionist type of person, qualitative overload is highly threatening and is detrimental to self-esteem. (French JR, Coplan RD: *Organizational Stress and Individual Strain,* unpublished paper, University of Michigan, Institute for Social Research, 1971) Diminished self-esteem is a component in the findings in almost all factors in Figures 1 and 2.

The middle graph in Figure 1 measures "euphoric vs depressed." ("Euphoric" was not an ideal choice as the opposite of depression; "cheerful" might have been a better choice.) However, the word "depression" occurs very frequently in the respondents' anecdotal descriptions of their feelings. As with the four "intrinsic" characteristics, the second six months prove generally to be the low point after the career change, and a definite move upward from the depression appears during the second year.

The description from the 15 *program directors* (Figure 2) of their intrinsic feelings following the change – "enthusiastic vs bored," "energetic vs tired," "optimistic vs pessimistic," and "enjoys associates vs lonely" – shows a negative shift in all four graphs, the lowest point occurring during the second six months and improvement in all but the second item in the second year.

As with the non-directors, the directors' feelings of functioning well in their new career in the sixth, seventh, and eighth graphs begin much below their intrinsic factors but move up rapidly during the second six months and the second year, except for a minor drop in "fulfilled vs unfulfilled" in the second six months.

In the "relaxed vs overworked" graph (9), again the phenomenon of overload appears, although some im-

provement is shown in the second six months and the second year. The level, however, is still far below that of the other factors.

Again, the "euphoric vs depressed" graph reveals a persistent negative level as compared with the other factors. Only a very slight rise occurs in the second year.

*How would you rate the following sources of support during your adjustment to your new career? (Most supportive is 1; * is a tie.)*

	Directors	Non-Directors
Senior faculty support	1*	6*
Junior faculty support	3	3*
Resident feedback	4*	5
Patient feedback	6	3*
Family support	4*	1
Religious support	7	6*
Increase in knowledge	1*	2

*Tie

One participant joined the faculty of a university only a few miles from where he had been in practice. Because he knew most of the consultants in the faculty well professionally and socially, and because he returned to his former hospital once a week for ward rounds and to maintain his ties to his former colleagues in the town, he felt that the personal support they all gave him prevented much of the distress encountered by some of his fellow family practice faculty members.

In general, if you had it to do again, would you still make this move?

	Directors	Non-Directors
Absolutely not	0	0
Not sure	2	3
Absolutely yes	13	15

In spite of the problems which are encountered, 13 of the 15 directors feel that they would make the decision for career change if they were faced with the decision again, with the remaining two in the "not sure" category. Non-directors also chose the same route, 15 out of 18 would do it again with the other three, "not sure" to "almost sure."

Change of Domicile

When the reactions of those who moved to a new location were compared with those who did not move, the scores of each are almost identical. Presumably, the problems delineated above are not dependent upon whether a physician is recruited from the place in which the program is situated or not.

Discussion

One interesting facet of the completed questionnaires with the accompanying comments is that on the five-point scale in which the positive feelings "enthusiastic, energetic, optimistic, etc" are given a rating of "1," and the negative "bored, tired, pessimistic, etc" a rating of "5," an arrow was placed under the rating "3" with the explanation "about average." This helpful note was ignored. Midway between "enthusiastic" and "bored" is not an acceptable "normal" level in the respondent's self-image. Normal to these physicians is "enthusiastic, energetic and optimistic," and anything less than "1" is considered abnormal and needs to be corrected.

Frustration

In the comments added to the questionnaire, the word "frustration" appeared frequently – "Frustrated by the slow moving march of university process and decision making," "Frustration over not being one's own boss" and "bureaucratic inertia." "I cannot do all the things I see that need doing."

The majority of physicians who moved into full-time teaching were solo private practitioners and in their own offices felt no restrictions (other than perhaps financial) on implementing any changes they felt necessary. In their own hospitals, over the years, each learned the skills of effecting change in that institution. In the university organization, however, the staff and protocol are new, and new skills must be learned if any changes are to be effected. One of the replying directors seems to be solving this problem – "Now able to see the incompetent administrator in the clinical light of a non-compliant patient and so have learned to devise appropriate clinical strategy."

Depression

The shift towards depression noted in both Figures 1 and 2 is reported anecdotally as well. Its effect is presumably felt in the four intrinsic factors and the three situational factors

also. Traditionally, in psychiatry, situational depression is linked to "loss." Another cause is described by psychologists MacPhillamy and Lewinsohn as "lack of availability of positive reinforcement."[1] The "loss" and the "lack of availability of positive reinforcement" are inherent in limitation or complete cessation of direct patient care by the faculty. Thus, the constant "positive strokes" received from their appreciative patients are limited or lost. This daily pleasant feedback from patients can become highly addictive and "withdrawal," as with other addictions, can be very traumatic. The "need to be needed" is unsatisfied. The feeling of accomplishment which occurs immediately in most doctor-patient relationships cannot be replaced easily by the relatively longer process of improvement in the competence of residents taught. Further, this improvement is the result of a group effort, not a personal achievement.

Positive Factors in Career Changes

Although having experienced the distress and diminished effectiveness of the move from private practice to full-time teaching, one respondent described "the excitement of realizing that the discipline was a desert waiting to be nourished with facts." Another wrote, "enjoy changes of life-style," and "new challenge beyond repetition of direct patient care," and "believe that occupation should change at age 50 to 55 by reason of need for intellectual stimulus."

This last thought is discussed by Drucker in his book about career change in all professions:[2]

> The accomplished knowledge journeyman, at 45 or 50 is in his physical and mental prime. If he is tired and bored, it is because he has reached the limit of contribution and growth in his first career – and he knows it. He is likely to deteriorate rapidly if left doing what no longer truly challenges him. It is of little use to look to "hobbies" or to "cultural interest" to keep him alive. Being an amateur does not satisfy a man who has learned to be a professional.
>
> One thing this man usually has is a desire to contribute . . . "wants to give" . . . .
>
> In his old field he has, indeed, "stopped growing". But if he was a competent man to begin with . . . he may now simply be ready to "grow" in some other field.
>
> A second career at this age is a great deal more satisfying – and fun – than the bottle, a torrid affair with a chit of a girl . . . . or any other customary attempts to mask one's frustration and boredom with work that, only a few short years ago, had been exciting, challenging, and satisfying.

Can These Problems be Prevented or Minimized?

In the questionnaire and accompanying comments, two reactions seem to underly most of the undesirable feelings expressed: (1) frustration with the administrative structure; and (2) insecurity of the new faculty about their effectiveness as teachers and acceptance as role models by their residents and students.

Frustration occurs in an establishment which is too rigid and also in one which is too unstructured. The former stifles creativity by withholding authority, thereby blocking implementation, the latter by not assigning responsibility for specific problems to be solved, or a route by which a solution can be effected. Somewhere in between these two extremes is an optimal environment.

The tasks in a family practice residency program can be delineated: curriculum development, undergraduate teaching, research, teaching office practice, organization of preceptor experience, organization of in-hospital rotations, office management, undergraduate teaching, development of objectives, setting up evaluation, training of nurses and other medical personnel, and so on. Each of these tasks could be assigned to faculty on the basis of their interest and capability. The objectives of each task can be arrived at. The responsibilities inherent in each task should be spelled out, and, most important, the extent to which each faculty member has full authority to act without prior consultation should be specified. The pathways by which a decision may be expedited should be clearly understood.

The overall organizational structure of the department should be free of ambiguity. For the areas of responsibility in which authority is not assigned, the route by which necessary permission may be obtained must be quite clear. In this way each faculty member understands what is expected of him without ambiguity. In a study at Goddard Space Flight Center "the more role ambiguity the person reported, the lower his utilization of intellectual skills and knowledge (r = –.48) and the lower was his utilization of his administrative and leadership skills." (French JR, Coplan RD: *Organizational Stress and Individual Strain,* unpublished paper, University of Michigan, Institute for Social Research, 1971.)

In this system of delineated responsibility and authority, the faculty members may be able to concentrate their efforts and imagination in a few pathways and be offered a challenge, plus the promise of reasonable expectation of seeing their efforts rewarded by accomplishment.

Teaching Teachers

The feeling of insecurity that underlies the recorded impression of ineffectiveness as a teacher can be prevented to a large extent by preparatory courses in teaching techniques. Well established programs which have developed effective teaching skills in certain facets of family practice must try to delineate these skills in a way which can be structured into a course for novice faculty. These courses could

be offered at specific times during each year. This is a high priority need in the discipline.

Patient Care

Continued involvement in direct patient care in the program's family practice center may help to prevent the depression described in this article and, in addition, help maintain the skills of the teaching physician and his credibility in the eyes of the residents. The feedback he receives through this direct patient care may partially fill the void produced by leaving his own practice.

Atmosphere

Finally, the stimulation of new ideas sparked from contact with others from different disciplines working in close proximity can be highly supportive. Discussion of a project with others trained in the behavioral sciences, education, or even as seemingly remote a discipline as business administration, often produces a wealth of new concepts that enriches both. In developing such a pioneer project as a family practice training program, care must be taken to limit the routine tasks of the faculty so that time and energy are left to think, to inquire, to discuss, to analyze and to experiment. The nurture of such an intellectually stimulating atmosphere will do much to offset the early negative effects of career change and at the same time help to develop a highly productive faculty team.

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