Practice Traits, Office Problems, and Management Education Needs of Family Physicians

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A survey of family physicians in Ohio and North Carolina was undertaken to characterize business and management features of office practice and to assess attitudes towards practice management training. There were 255 respondents, a 64 percent response rate. Findings indicated that older physicians in smaller communities, with a preference for a solo practice, were seeing the largest number of patients per week. Younger physicians are more evenly distributed by community size, with a preference for group practices. Financial problems were mentioned most frequently. Both young and older physicians assume leadership responsibilities and strongly endorse management training as a part of medical education.

The business functions and management responsibilities of medical office practice have received little curriculum emphasis in relation to the organic and behavioral subjects. Perhaps this has been considered nonacademic or something which is best learned when a physician enters practice. However, the medical profession is now faced with the high costs of health care and a discouraging rate of physician morbidity. It is doubtful that practice management knowledge and skills will be a cure-all, but they do offer a practical approach to this dilemma.

There is very little conclusive information available to substantiate the value of business and practice management training. This study is an initial step in the collection of management information from practicing physicians. There are interesting differences between younger and older physicians, which may or may not be attributed to the existence of practice management preparations.

There were four objectives for this study: (1) to obtain data from family physicians for numbers of families in their practices, patient visits, after-hours calls, nights on call, and leadership roles; (2)

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Table 1. Respondents
N=255

State	%	Community Size	%
Ohio	60	0-10,000	33
North Carolina	32	10,001-25,000	21
Other	8	25,001-100,000	25
	100	100,001+	21
			100

Years in Practice	%	Practice Type	%
0-2	28	Solo	47
3-5	13	Partnership	23
6-10	7	Group	19
11-20	16	Other	11
21+	36		100
	100		

to determine both general and specific problems faced by physicians in business management; (3) to compare practice characteristics of recent graduates with those of experienced practitioners; and (4) to determine the interest in practice management training for practicing physicians, residents, medical students, and office staff.

Methods

A survey of 400 family physicians was conducted in 1977. There were 255 respondents, a 64 percent response rate. Two hundred fifty physicians were surveyed in Ohio, 120 in North Carolina, and 30 in other states. The 30 in other states were family practice residents from Ohio and North Carolina who are in practice outside these states.

Table 1 presents classifications of respondents by state, type of practice, years in practice, and size of community.

Results

There were no appreciable differences between responses from Ohio and North Carolina regarding practice traits, office problems, and educational needs.

Practice Traits

Community Size

Older physicians tend to be located in smaller communities. Forty percent of the physicians surveyed who have been in practice more than ten years are located in communities of less than 10,000 people. Younger physicians are more evenly distributed across all sizes of communities. Physicians who have been in practice for five years or less are distributed as follows: 24 percent in communities of less than 10,000 people; 24 percent in communities of 10,001 to 25,000; 22 percent in communities of 25,001 to 100,000; and 30 percent in communities with a population over 100,000 (Table 2).

Practice Type

Partnership and group practice are much more characteristic of young physicians than of the older group. Two thirds of physicians who have been in practice less than six years are in partnership or group settings. Only 31 percent of physicians in practice more than ten years are in partnership or group practice (Table 3). By way of comparison, Wasserman[1] reports that the average

Table 2. Community Size			
	Years in Practice		
Community Size	5 Years or Less %	6 to 20 Years %	21 Years or Over %
10,000 or less	24	47	33
10,001-25,000	25	14	21
25,001-100,000	22	27	16
100,001 plus	29	12	30
Totals	100	100	100
N=	105	59	91

size of general practice groups is 3.5 physicians. According to their 1969 survey, the most prevalent form of organization was partnership. Professional corporations showed the most significant growth of any organizational form.

Number of Families

The number of families being cared for by the respondents was not influenced by practice type or years in practice. The average panel of patient families was approximately 2,000 per family physician surveyed.

Patients Per Week

Solo physicians tended to see more patients per week than did those in partnership or group practice. The average number of office visits per physician was 170 per week. Physicians in solo practice averaged over 200 patients per week. Physicians in partnership averaged nearly 160, and those in groups averaged slightly less than 150 per week. Older physicians tended to see more patients per week than did younger ones. Fifty-one percent of physicians in practice more than six years saw over 175 patients per week, while only 27 percent of those in practice less than five years reported that number (Table 4).

After-Hours Calls

Solo physicians were on-call more nights than those physicians in partnerships and groups. Most solo physicians were on-call five or more times per week, those in partnership averaged three to four times per week, while members of groups took call once or twice weekly. There was an average of 18 after-hours calls per week reported by physicians. Group practices tended to have fewer calls than did solo practices or partnerships.

Computer Systems

Computerized systems were more characteristic of group practices than of solo practices or partnerships. Thirty-three percent of groups surveyed were using a computer for billing, while only three percent and seven precent of solo practices and partnerships, respectively, use such systems. Physicians in practice ten years or less tended to be greater users of computers than physicians with more than ten years experience.

Leadership Responsibilities

Respondents noted a high incidence of leadership responsibilities in hospital and community organizations, and in medical education. Physicians in practice six years or more indicated major leadership roles in hospital and community activities, while younger physicians were as much involved in medical education, but not as active in other organizations (Table 5).

Office Management Problems

Financial

Financial issues were considered either a major or minor problem in 53 percent of the responses. Specific financial matters which ranked highest as

Table 3. Practice Type

Practice Type	Years in Practice 5 Years or Less %	6 to 20 Years %	21 Years or Over %
Solo	34	56	72
Partnership	37	20	17
Group	29	24	11
Totals	100	100	100
N=	92	54	82

Table 4. Patients Seen per Week

Patients/Week	Years in Practice 5 Years or Less %	6-20 Years %	21+Years %	Practice Type Solo %	Partnership %	Group %
0-125	47	27	29	30	34	33
126-175	26	22	19	17	36	27
176-225	17	24	23	26	14	24
226+	10	27	29	27	16	16
Totals	100	100	100	100	100	100
N=	105	59	91	120	59	49

problem areas were third party procedures and accounts receivable. Other financial problems, in order of importance, were money management, accounts payable, and daily cash flow.

Organizational

Organizational features of the practice were considered a major or minor problem in 44 percent of the responses. The appointment and telephone system and medical records were reported as the leading office problems.

Communications

Communications was rated as a major or minor problem in 36 percent of the responses. Office staff communications was rated as a problem more so than were patient or colleague communications.

Educational Needs

Practice management training was strongly endorsed. Over two thirds of respondents considered leadership and management skills very important for physicians, and at least moderately important for residents and medical students.

Office staff were also considered an important group for management skill development. Over 50 percent of physicians stated they would probably attend a yearly practice management seminar, with an even higher percent endorsing a yearly program for office staff.

Table 5. Leadership Roles

Leadership	Hospital Responsibilities Years in Practice		Medical Education Responsibilities Years in Practice		Community Responsibilities Years in Practice	
	5 Years or Less %	6 Years Plus %	5 Years or Less %	6 Years Plus %	5 Years or Less %	6 Years Plus %
Major Role	16	44	21	16	9	34
Minor Role	61	37	43	53	41	36
No Role	23	19	36	31	50	30
Totals	100	100	100	100	100	100
N=	88	131	94	129	88	124

Recommendations

Based upon the high rate of response and the survey results, the following recommendations have been formulated for educators who have responsibility for preparing future physicians for office practice. In addition, many of these recommendations have application for continuing education for physicians and their office staff.

Practice Traits

Physicians who are considering forming a group, or who are entertaining the idea of joining an established group, will wish to thoroughly appraise all factors involved.[2] Training must be geared to practices in all sizes of communities, with particular emphasis upon legal structure, organization, and dynamics. This preparation will be necessary when assuming managerial responsibilities of partnerships and group practices.

Individual residents should have primary responsibility for a panel of 150 to 200 families by the third year, with access to a larger number of families as a member of a team of physicians. This larger base of comprehensive and continuing family health care will provide more extensive exposure to the realities of practice.

Toward the conclusion of their training, residents should be scheduling either half-days or complete days of patient visits similar to private practice. This would amount to 15 to 20 patients per 3 1/2 hrs (half day) or 30 to 40 for seven hours (full day). This will enable residents to experience the volume and mix of patients of a typical workday.

Residency training should provide opportunities for residents to take night call for family practice patients at least once or twice weekly as a means to better prepare for the after-hours calls in community practices.

The residency program should have a data processing system available for analysis of financial, diagnostic, and demographic data. The purposes of such a system are to enable the resident to obtain a profile of his/her practice and understand computer applications in office practice. A computerized system will also provide data for validation of ambulatory practice experiences.

Leadership development should be an integral part of residency training to prepare graduates to assume major roles in health care and community organizations. Leadership skills can be developed through experiential activities, such as assisting in supervision of the practice, conducting group meetings, participating in hospital committees, and assisting in program development. Didactic programs could focus upon leadership styles,

motivation and learning theory, and group process.

Office Management Problems

Despite the obvious financial aspect of medicine, many private physicians give little attention to the financial functions of their practices. Financial authority cannot be entrusted to an accountant or office manager.[3] Residency training should address financial management as a major responsibility of office practice. Financial understanding may be facilitated by providing residents with (1) financial data from their practices, (2) direct involvement in daily cash flow, billing, and third-party procedures, and (3) exposure to financial consultants and institutions.

A second management dilemma is the organization of the office practice. Residents require a thorough understanding of both patient and paper flow systems. Firsthand knowledge of these systems can be gained by a "behind-the-scenes" view of each office staff member's function and by working with practice supervisors in the design and implementation of office procedures and protocols.

Educational Needs

Management skills in the practice setting are of special value because of the complexities of practice organizations and the sophistication of office staff.[4] Such subjects as personnel supervision, financial management, communication and office systems, professional incorporation, and facility design and renovation should be included in all aspects of medical education. This will better prepare physicians to recognize potential office problems and either develop management strategies or seek appropriate consultation. Management advisors also advocate increased physician awareness and knowledge as a means to effective client relationships.

Comment

Conclusions from this study appear quite evident. The business and practice management dimensions of office practice are a challenge to both medical educators and physicians. Subject matter is fundamental and the necessary skills are attainable. The implementing components are curriculum, programing time, and resources.

Practice management training has been instituted in many family practice residencies, and faculty are encouraged to vigorously pursue this education in their respective programs. The Task Force on Practice Management of the Society of Teachers of Family Medicine has recently published a Medical Practice Management Curriculum and Institutional Guide.[5] This document is recommended for all medical educators whose objective is preparing physicians for office practice.

As a continuation of this study into the practices of family physicians, the authors are researching the graduates of Akron City Hospital's Family Practice Residency, where practice management training has been in the curriculum since 1973.[6] This investigation will provide the all important feedback loop to educators from the learners, who are now practicing physicians. This is perhaps the most critical evaluation of residency training. Research parameters will involve practice characteristics and statistics, professional development, and personal and family growth. Specific information which will be obtained includes outpatient and inpatient volume and mix, diagnostic and demographic data, organizational structure, number and type of support staff, budgets and costs, patient and staff education, hospital and community activities, and other features and innovations. Results from this further look into practice realities may provide the impetus for a relevant practice preparation curriculum.

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