Module 1:
Getting Started As A Professional

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

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Key Learning Points

- *Establishing your professional advisory team*
- *The roles of your professional advisors*

Key Message

- *Practice management addresses the planning, financing and management of our personal and professional affairs.*
- *Whether you are a new medical student or a senior resident, you should seek professional advice now to manage your financial and legal affairs.*

ESTABLISHING YOUR PROFESSIONAL ADVISORY TEAM

Physicians are trained to be medical experts, and most medical training programs still lack formal training in business and practice management. Subsequently, many doctors fail to seek advice from business professionals to help them make important personal and practice decisions until *after* they have committed to what too often proves to be a suboptimal decision.

We encourage a more proactive, "primary care" approach to practice management decision-making. Just as family physicians offer preventative care to their patients and seek the expert advice of specialist colleagues to complement the care of their patients, all physicians should seek the expert advice of professional advisors to best address their personal and professional affairs.

We also recommend a more holistic and comprehensive definition of 'practice management'. Practice management should encompass the planning, financing and managing of our personal and professional affairs. Therefore, attention to comprehensive practice management principles caters to our personal and professional wellness.

To get started, it is essential to do a detailed personal and professional self-audit to address such important questions as: Where am I now? Where do I want to be in the short, medium and long term? How do I get there? What professional advice should I obtain to help me make the best decisions? An example of a self-audit tool is appended to this module.

Regardless of whether you are a medical student, PGY-1, a senior resident or new to practice, you should seek professional advice *now*, not later.

Your professional advisory team will include a financial consultant, an accountant, insurance advisors, lawyers who specialize in personal, family and contract law, and a bank manager. This module will provide an overview of the roles and responsibilities of each of these professionals.

THE ROLES OF YOUR PROFESSIONAL ADVISORS

Your financial consultant and accountant are probably the most important members of your advisory team. You will want to establish a long-term, trusting relationship with these two professionals, who should be very knowledgeable of physician needs and are committed to always act in your best interest.

Even though your interaction with lawyers, insurance advisors and bankers may be less frequent, it is equally important to choose professionals in those spheres who are competent and with whom you feel comfortable.

Financial Consultant

In many ways, the financial consultant is the "quarterback" of your advisory team. This professional should be much more than just an investment advisor to consult when you have disposable income to invest. In fact, your financial consultant is even more important to you when you are in debt. A comprehensive financial consultant will work with you to address several essential financial matters:

- **Cash flow and budget.** Understanding your cash flow is the cornerstone of your present and future financial health. You need your cash flow statement in order to develop a reasonable budget. Your financial consultant can teach you how to assess your cash flow and prepare an effective and efficient budget.

- **Net worth statement.** Most residents carry significant debt and therefore feel that a net worth statement is of no real value because it is depressingly negative, and in the red. Not so! Your net worth statement becomes a benchmark for future comparison and is essential for effective financial planning.
- **Debt status.** Debt is rated as good, acceptable and bad—for example, tax-deductible debt arising from business loans is good debt; low-interest mortgages and personal lines of credit are acceptable debt; and high-interest credit card debt is bad debt. By analyzing your debt status, a financial consultant can recommend efficient debt load reduction measures. The analysis will include weighing the pros and cons of consolidating student loans and other debts, such as credit cards carrying high interest rates.
- **Personal line of credit and interest rates.** Your financial consultant will also help you to negotiate with your banker for the best interest rates for your personal line of credit during medical school or residency. A concise and well-organized cash flow statement, net worth statement and business plan will be of great assistance when you are negotiating with any financial institution. Upon completing residency you will need to renegotiate your personal line of credit and establish a professional line of credit.
- **Life insurance decision.** Your financial consultant can assist you to project your life insurance requirements and help you decide how much life insurance you should buy. This is done by conducting an objective and unbiased review of your present and potential future liabilities, which also takes into account your aspirations for your family.
- **Financial plan and investment strategy.** Once your financial counsellor has gathered and analyzed all of the above information, he/she can help you to develop a financial plan that addresses your current debt load management, as well as an investment strategy that addresses your short-, intermediate- and long-term goals.

The principles of financial planning are examined in more detail in *Module 2. Financial Planning.*

Accountant

It is never too early to talk to an accountant. Medical students and residents at all levels of training can benefit from the sound advice offered by a tax specialist. Accountants can provide advice regarding the tax deductions and credits that you can claim now, as well as the expenditures made during medical school and residency that may be carried forward and deducted once you enter practice. Setting up personal and professional financial books and bank accounts before you start practice will save you a lot of time and money in the long run. Your accountant's advice is also essential when you look at the potential advantages of incorporation.

The CMA annually prepares an excellent tax planning resource called "Tax Tips for the Physician and Physican-in-Training", which addresses the latest changes in tax laws, credits and deductions. Tax Tips focuses on the special circumstances of medical students, residents and doctors in practice; it can be downloaded from cma.ca/pmcresources.

The principles of taxation and accounting are examined in more detail in *Module 4. Personal And Professional Accounting And Taxation.*

Insurance Advisor

Medical trainees are notorious for under-insuring themselves, wrongly assuming that they can defer buying insurance until they are earning more money in practice. The opposite is true. You should consider buying insurance as soon as you are accepted into medical school, then review your insurance needs again when you start residency.

Insurance—the cornerstone of your financial plan—is most important when you are in debt and have family and financial responsibilities.

All medical students and residents should conduct a detailed, objective review of their present and future insurance needs. This will include an evaluation of different insurance packages, including:

- **Disability insurance.** For income replacement. If possible, disability insurance should be purchased during medical school and re-evaluated annually during residency.
- **Life insurance.** Even if you presently have no dependants, you should buy as much life insurance as you can now. Your future liabilities will be greater than they are currently, and you may not be as insurable tomorrow as you are today. Your health, good lifestyle and youth enable you to buy insurance at preferential rates today.
- **Property insurance.** For your home/apartment and personal goods
- **Automobile insurance**
- **Personal liability insurance**

Personal and professional insurance issues are examined in more detail in *Module 3. Personal And Professional Insurance.*

Legal Advisor

Physicians' exposure to lawyers during medical training is often restricted to malpractice issues. Legal issues, however, touch every aspect of our personal and professional lives. It is extremely important to seek professional legal advice before signing any contract. Doctors are often reluctant to seek and pay for a lawyer's advice—even though that advice is much cheaper than a lawsuit!

Medical students and residents will discover that legal advice is very important for:

- Wills
- Powers of attorney for personal care and property, to grant authority for another person to act on your behalf
- Personal and professional contracts
- Home purchase agreements
- Creditor protection
- Incorporation

Never sign a contract without first seeking legal advice! Legal concerns will be examined in more detail in *Module 5. Legal Issues For Physicians.*

Banker

Banking issues are extremely important to all medical students and residents. The average debt load of a PGY-1 in Canada now averages approximately $175,000—and the interest liabilities on this debt are significant. For physicians who are considering the purchase of a home shortly after completing residency, the subsequent debt load can easily exceed $400,000. Even a reduction of 0.25% in one's personal line of credit can make a big difference over a span of five years.

Before approaching a bank manager, review the pros and cons of student loan consolidation with your financial consultant. Your objective will be to obtain prime rates for your personal line of credit and, when in practice, your professional line of credit.

Your financial consultant will be of great assistance to you as you prepare for your negotiation with a financial institution. Remember:

- Always negotiate with someone at the bank (such as the branch or loans manager) who can finalize any decisions.
- Banking institutions will favour applicants who have the 'three Cs':
  - **Character.** An organized and well-prepared individual knows where they are financially and where they are going. A current curriculum vitae, a business plan and an income/employment projection will make a positive impression.
  - **Cash flow.** Along with net worth statements that are comprehensive and current
  - **Credit rating.** Banks value your credit rating more than your future income-generating potential—so having an excellent credit rating is crucial. You can check your credit rating by contacting Canada's major credit bureaus: Equifax (www.equifax.com/EFX_Canada), TransUnion (www.transunion.ca) or Northern Credit Bureaus (www.creditbureau.ca). Credit ratings work on a seven-year cycle, so any late interest payments or failures to pay bills will negatively affect your rating for some time. Because errors are not uncommon, verify that any claim against you is legitimate. If you discover an error, you should apply, with documentation, for an appropriate correction.
- Negotiate with two or three banking institutions at the same time. You may not have money now, but you will in the future and, historically, physicians have been excellent credit risks. As such, the banks should treat you as a valued customer right from the start. They want your business—let them earn it!
- Negotiate service charges. These are not set in stone.

Key Message

Work with trusted professional advisors with whom you are comfortable.

RESOURCES

The indicated Practice Management Education Modules offer more detailed information about the above topics, including how to choose the right professionals to work with.

You are also encouraged to explore the web resources that are dedicated to medical students, residents and CMA members at cma.ca/pmcresources.

ACTION PLAN

- Establish a relationship with a financial consultant and other professional advisors.
- Assess your disability and life insurance requirements and purchase the best coverage you can now.
- Get a will and appropriate powers of attorney.
- Review existing and any forthcoming contracts with a lawyer.
- Talk to an accountant.
- Negotiate with your banker.

APPENDIX 1: PROFESSIONAL AND PERSONAL WELLNESS SELF-AUDIT

Financial Health			
In the past 12 months, have you... (Circle the "?" if you don't know.)			
Analyzed your cash flow (income and expenses) in detail?	Y	N	?
Is your cash flow: ❑ Positive ❑ Neutral ❑ Negative ❑ Don't know			
Updated your net worth (assets and liabilities)?	Y	N	?
Reconciled bank and credit card statements (monthly)?	Y	N	?
Always paid off all credit card balances on time?	Y	N	?
Verified that your credit rating is accurate?	Y	N	?
Negotiated prime rates for your personal line of credit (PLC)?	Y	N	?
Asked how your PLC will be renegotiated after residency?	Y	N	?
Established objectives for paying off this debt?	Y	N	?
Aware of the administrative, licensing and other requirements before beginning practice? (i.e., I have read "So you are finishing residency")?	Y	N	?
Personal And Professional Risk Management And Liability			
Upon making the transition to practice, have you considered...			
Your present and future life insurance requirements?	Y	N	?
Your post-residency disability insurance requirements?	Y	N	?
What riders are crucial to include in your disability insurance?	Y	N	?
Your professional office overhead protection requirements?	Y	N	?
Your present and future critical illness insurance requirements?	Y	N	?
Your future long-term care insurance requirements?	Y	N	?
Creating a foundation of financial security for your family?	Y	N	?
Creating/updating your will and assigned powers of attorney for both personal care and property?	Y	N	?
Verifying that your parents have up-to-date wills, powers of attorney and advanced life directives?	Y	N	?
Obtaining independent legal and accounting advice before signing any personal or professional contracts or leases?	Y	N	?
Tax Planning ("It's not what your EARN... it's what you KEEP.")			
Have you reviewed the latest "Tax Tips" on cma.ca?	Y	N	?
Will you meet with an accountant before finishing residency to address tax planning, available tax deductions and obligations of transition from residency to practice?	Y	N	?
Do you know if the academic APP you are considering joining allows you to be a self-employed proprietor or obliges you to be a salaried employee?	Y	N	?
Do you understand the importance of tax instalments and the implications if such payments are inadequate or missed completely?	Y	N	?
Do you understand how RRSPs reduce your taxes?	Y	N	?
Have you started an RRSP savings plan yet?	Y	N	?
Do you know what your RRSP contribution room is?	Y	N	?
Do you understand the pros and cons of incorporation?	Y	N	?

ACTION PLAN

If you answered No or "?" to any of the above questions, you should address these outstanding issues as soon as possible. Your financial consultant at MD Management is an excellent source to help you address all of these issues.

Module 2:
Financial Planning

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MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plans to best fit their personal and professional aspirations. You are advised to consult with professional advisors to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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Key learning points

- *The components and benefits of a comprehensive financial plan*
- *Managing different types of debt*
- *The benefits and pitfalls of loan consolidation*
- *RRSPs, debt repayment and combination strategies*
- *The benefits of incorporation*
- *Your credit rating*
- *Saving for the future: Understanding key investment strategies, including RRSPs, TFSAs, RESPs and incorporation*

INTRODUCTION

Financial planning is an evaluation of current and potential financial resources that leads to the development of step-by-step recommendations to help individuals achieve their goals and objectives, both personal and financial.

When you began your residency, you were provided with a schedule of rotations for the upcoming year. In every subsequent year of your residency, your program director produced a similar schedule for you. The reason that your time and resources were so comprehensively allocated was to ensure that you would be provided with sufficient quality education and clinical experience to fulfill your training requirements, pass the qualifying examinations and practise quality medicine.

Financial planning is a similar process. A qualified financial planning professional, such as a Certified Financial Planner (CFP), studies your current financial situation, reviews your goals and objectives, and recommends a course of action that will meet your short-term, mid-term and long-term goals.

Just as a family physician acts as the coordinator or "quarterback" for a patient's medical care, your financial planner acts as the quarterback of your professional advisory team. The ideal consultant will not only assess your situation and recommend the best course of action, but will also identify when you need the professional advice and assistance of others—such as an accountant, lawyer or insurance expert—then coordinate the necessary consultations.

THE COMPONENTS AND BENEFITS OF A COMPREHENSIVE FINANCIAL PLAN

During the financial planning process, you and your consultant will work together on the six major steps of comprehensive financial planning:

1. Gathering information
2. Establishing goals and objectives
3. Analyzing your current financial situation
4. Formulating recommendations
5. Implementing a financial plan
6. Periodically reviewing and evaluating your progress

Ideally, every recommendation made by your financial consultant will be based on an agreed-upon long-term plan. Consider the following as you prepare for your first meeting so that the financial consultant can immediately begin to construct an optimal financial strategy for you.

1. Current Situation

You will be asked for certain personal information (e.g., name, address, date of birth, spouse or common-law partner, children), as well as such relevant information as your banking institution and the name of your lawyer and accountant. Then the financial consultant will delve into your finances, current and future, to prepare the relevant documents and financial statements that will serve as the foundation of your financial planning.

Personal financial information: This statement details the pertinent financial information that will permit more specific analysis and recommendations. This will include salary, rent/mortgage, education and other living costs for yourself and, if appropriate, a significant other. The ages, desires and associated costs of any children will also be pertinent to the financial planning process.

Statement of net worth: This is a compilation of your present assets (the things you own) and liabilities (the things you owe), with the difference representing your equity or *net worth*. The net worth for most medical students and residents is negative because of the significant debt load incurred during training. This is the norm—not the exception—but the purpose of the net worth statement is to take a snapshot of your financial position at a single point in time to provide a starting point for subsequent planning. A comprehensive review of the terms and conditions associated with all of your financial obligations can often identify effective strategies that will help you to realize your goals earlier.

Dr. Smith, PGY-2 **Statement of Net Worth** **As at December 31**	
Assets ($)	
Cash	0
Medical library	1,000
Computer	3,000
Used vehicle	5,000
Total Assets	9,000
Liabilities ($)	
Credit cards	(1,600)
Line of credit	(180,000)
Total Liabilities	(181,600)
Net Worth	(172,600)

Factors To Consider When Evaluating Net Worth

Examples Of Assets	Examples Of Liabilities
▸ Cash in bank accounts ▸ Canada Savings Bonds ▸ Stocks, bonds and mutual funds ▸ Medical library and equipment ▸ Jewellery, valuable coins, etc. ▸ Home furnishings and personal property ▸ Market value of your car ▸ Registered education savings plan (RESP) ▸ Registered retirement savings plan (RRSP) ▸ Cash surrender value of life insurance ▸ Market value of your home (if owned)	▸ Credit card balance ▸ Personal line of credit ▸ Bank and other loans ▸ Income taxes owed ▸ Car loans ▸ Government student loans ▸ Loans from family members ▸ Other debts

Key Message

Copy the best practices you have experienced as a resident and during locums. Establish workable policies and procedures for your practice well before you start seeing patients.

Cash flow statement: A cash flow statement documents your cash inflows (i.e., your sources of money) and outflows (i.e., where you spend it). Such an analysis identifies potential resources and details your spending habits. Having an analysis of your resources and discretionary spending may highlight ways to improve your financial position, both in the short and long term.

Dr. LeBlanc, PGY-1
Cash Flow Statement
For the month of June

Cash inflow		
Salary, net of withholding taxes, CPP, EI and other incidentals		$2,800
Cash outflow		
Rent and utilities	$980	
Loan repayment (interest only)	500	
Food (includes entertainment, restaurants)	450	
Automobile, parking and travel	700	
Miscellaneous (e.g., gym, exam fees)	300	(2,930)
Net cash inflow (outflow)		$130

In this example, Dr. LeBlanc has a negative cash flow of $130 per month, which is quite common as a PGY-1. The objective is to reach a positive cash flow as soon as possible by budgeting and reducing discretionary spending.

Examples of what might appear on a cash flow statement:

Cash Inflow	Cash Outflow
▸ Salary (less deductions at source) ▸ Scholarships and bursaries ▸ Other income (e.g., remuneration for teaching (ACLS/ATLS courses) ▸ Locum income (e.g., covering ICU shifts for additional income) ▸ Interest earned on investments ▸ Income tax refunds ▸ Tax-free savings account (TFSA) ▸ Corporate investments	▸ Food/Housing (food, rent, cable, cell phone) ▸ Transportation (gas, parking, insurance) ▸ Tuition, medical books, equipment ▸ Loan interest and repayment ▸ Interest and principal repayment on other indebtedness (credit cards, loans, line of credit) ▸ Travel and vacation, CME courses ▸ Lifestyle (clothes, prescriptions, disability insurance) ▸ Other lifestyle (gym, travel, entertainment, gifts, hobbies)

Statement of insurance requirements: Life insurance provides a secure source of income replacement for your loved ones in the event of your death. Disability insurance, on the other hand, provides income replacement in the event that an accident or illness prevents you from working as a physician.
One needs to consider anticipated one-time costs (i.e., capital requirements), as well as ongoing periodic payments (i.e., income requirements) when calculating the most appropriate level of life insurance coverage.

Some Factors To Consider In A Life Insurance Needs Analysis

Capital Requirements	Income Requirements
▸ Funeral expenses ▸ Payout of outstanding student and personal loans ▸ Payout of outstanding mortgage balance ▸ Settlement of outstanding balance on credit cards ▸ Payment of any and all outstanding income taxes	▸ Periodic payments for surviving family members ▸ Periodic utility, property taxes and other costs inherent in home ownership/upkeep ▸ Periodic mortgage payments, if not paid in full ▸ University/College education for children/spouse ▸ Contingency funds for unforeseen expenses (e.g., income taxes, medical expenses, daycare costs)

Even if you currently have no dependants, life and disability insurance are necessary components of every physician's financial plan. *Module 3. Personal And Professional Insurance* explains the insurance needs for physicians in detail—but this should not substitute for professional advice for your own situation. Your financial planner will recommend a consultation with an insurance specialist to ensure that you have adequate coverage.

2. Goals And Objectives

Your financial planner will help you to formulate goals and objectives in financial terms, combined with a measurable time frame. Some examples of reasonable financial goals for those early years of medical practice include:

Mary's goal:	To save $ 10,000 in five years for a down payment on a house (5% of $200,000)
Rakesh's goal:	To be free of all indebtedness within 10 years of completion of residency
Adrian's goal:	To begin the investment process required to retire by age 55
Dan and Cindy's goal:	To take a full year off to travel around the world with their family within the first 10 years of practice
John's goal:	To repay all student loans ($75,000) within five years of completing residency
Katie's goal:	To purchase a desirable home within the first year of completion of residency
Win and Akshay's goal:	To set aside equal amounts in the next five years to pay down student loans and begin building retirement funds
Jane's goal:	To begin to save sufficient funds to finance her children's post-secondary education

3. Analysis And Obstacles

It is impossible to create an effective financial plan without having a concise and frank analysis of the existing restrictions on your cash flow and/or financial position. One might ask, *"What impacts your ability to attain your goals or objectives?"*. Although your perspective may be that you are making lifestyle

choices that are important to you, the financial consultant may observe that your current spending habits are working against your long-term goals. Together, however, you will find ways to improve your cash flow and make appropriate decisions about all of the things that are important to you. The objective, after all, is to find a balance between your finances today and your future objectives.

What You Might Observe:

- I enjoy travelling and want to spend money on trips while I am young.
- I enjoy dressing fashionably and am willing to incur any inherent cost.
- I prefer to lease an expensive sports car rather than a less expensive one.
- I would prefer to work less and enjoy more free time.
- I don't enjoy budgeting, bookkeeping or keeping track of my finances.
- I enjoy the neighbourhood I live in and am prepared to pay more rent to do so.
- I detest paperwork and would be willing to hire qualified personnel to perform such tasks.
- Electronic gadgetry appeals to me and I wish to utilize this in my personal and professional life when and where possible (e.g., latest phone and computer technology or voice-to-print dictation).
- Although I understand the importance of investing for the future, I have little interest or aptitude for the business world.
- I know nothing about accounting and taxes.

What Your Consultant Might Observe:

- Regular reviews of your financial situation can highlight opportunities and identify actions that can help you to reach your objectives more efficiently.
- Regular reviews of your practice's financial statements can identify problem areas that, once corrected, can be financially and personally beneficial.
- Tax planning with a qualified accountant can increase the after-tax take-home pay for you and your family.
- There are opportunities for tax savings and tax deferral through your RRSP and tax-free savings account that you could use to your advantage.
- Taking a holistic approach to your financial situation by looking at both assets and liabilities is more effective than looking at savings in isolation from your debts. A good financial advisor will look at the whole picture and generate savings.
- A Certified Financial Planner can not only assist you in reaching your financial and personal goals, but can also explain and educate you regarding the process.
- Although you hope that your young children will attend college or university, you haven't started to make contributions to a registered education savings plan (RESP).
- Income splitting with family members via salaries and other methods can increase after-tax take-home income for the family.
- There would be benefits to incorporating your practice.
- Adequate disability insurance protects you in the event that you are partially or entirely unable to work in the future.
- Appropriate life insurance protects your loved ones in the event of your death.
- Having a lawyer review important documents—such as home and equipment purchases, professional contracts with associates or partners, office leases and other contracts—is both important and beneficial.
- It is necessary and beneficial to complete and regularly update your will and power of attorney.

Key Message

Because of the need to simultaneously manage debt, create cash flow and prepare for the future, professional financial planning is absolutely essential for physicians, especially in the early years of practice. Establish yourself with a financial consultant before you finish residency to ensure that you start off on the right foot.

4. Written Recommendations

After appropriate analysis and consideration of your particular situation, you and your financial consultant will reach agreement on short- and long-term financial goals. The next task is to establish concrete steps and recommendations for you to follow.

When your financial consultant documents this strategy, make sure that the rationale behind each decision is included. Because most people are more likely to follow and fulfill a written commitment, you should sign the recommendations. This will help you take ownership of your financial goals and obligations.

5. Implementation

The financial plan will consist of a number of steps and activities. Make sure these steps are described and prioritized, to make it easy for you to follow.

6. Periodic Follow-Up

Financial planning is dynamic. Your long-term success is contingent upon a regular review of each of the first five steps. We recommend that this be done annually, or whenever your personal, professional or financial situation changes—whichever comes first. A regular appointment with your financial planner is an excellent reminder to evaluate your situation and identify continuing, or other, activities that could help you to attain your short- and long-term objectives.

The Financial Planning Process

There are many components to a good financial planning process. Ask your financial consultant to provide you with sample worksheets prior to your meeting, so that you can become familiar with the kinds of questions you will be asked.

MANAGING DEBT: THE GOOD, THE BAD AND THE UGLY

With increasing tuition costs, debt has become necessary for most people who pursue a career in medicine. Not all debt is the same, however, and proper debt management can lower overall carrying charges (i.e., interest) and expedite repayment.

The following sections refer to the *prime lending rate*, which is the interest rate reserved for a bank's best customers. It generally represents the bank's lowest available rate.

Canada And Provincial Student Loans

Most residents have some form of government indebtedness, such as loans negotiated with federal and/or provincial student loan authorities. This debt tends to be the most favourable in terms of after-tax interest rates and repayment options. Nevertheless, interest on Canada student loans begins accruing immediately upon completion of medical school.

Although interest rates on Canada and provincial student loans may reach prime + 2% or prime + 3%, interest paid on such indebtedness receives a federal tax credit of 15%. Most provinces and territories provide a similar tax credit of approximately 7%–8%. Accordingly, the after-tax interest rate tends to be very favourable. Your financial consultant can help you to weigh the value of these tax credits versus the benefit of loan consolidation, and determine how you can meet your financial goals more quickly.

Unsecured Liability

Unsecured indebtedness includes your line of credit from a bank or other financial institution. The interest rate on unsecured loans offered to medical students and residents can be as low as prime, provided you have a good credit rating. Your financial consultant can recommend ways for you to obtain and maintain a positive credit rating.

Car Loans

Secured liabilities, such as a car loan on 'moveable items' or 'chattels' (as opposed to fixed items, like a house) tend to entail a higher interest rate, unless special incentives have been offered by the vendor or car dealership. Interest rates of prime + 2% or prime + 3% are not uncommon.

Consumer Or Credit Card Debt

Consumer indebtedness via credit card use is the most expensive debt. Interest rates can range from 9% to more than 29%, depending on the individual's credit rating and the credit card. Carrying sizable balances on credit cards is both unwise and expensive. Wise medical students and residents who are unable to pay the balance on their credit card will do so by using their personal line of credit, which carries a much lower interest rate. The immediate savings can be 6%–26% per year.

Use a credit card that has terms and conditions that are advantageous to you. Medical students and residents often have access to cards that offer reward points and valuable insurance coverage for travel and purchases at no cost.

Other Debt

Other indebtedness, such as loans from friends or family members, can be a welcome and fortunate respite for a cash-strapped medical student or resident. The interest incurred and the priority of repayment, however, depends on the specifics of the individual situation and must be evaluated on a case-by-case basis.

PROS AND CONS OF STUDENT LOAN CONSOLIDATION

At the end of medical school, having to repay Canada and provincial student loans in addition to paying down the interest and principal of other liabilities can be quite onerous on new residents. Good debt management suggests that you evaluate all liabilities with respect to type, amount, interest and conditions of repayment. Many individuals wisely approach their lending institutions to *consolidate* their loans into a line of credit or term loan. Residents with good credit ratings can negotiate a personal line of credit at interest rates that are as low as prime, with very favourable repayment terms. Although overall debt will be unchanged, the related financing charges can be reduced. The physician not only saves money, but also may apply these savings to reduce indebtedness and expedite repayment.

You should exercise caution, however, and assess both sides of the equation when considering consolidating your Canada or provincial/territorial student loans. Interest paid on these debts qualifies for a 16% federal tax credit, as well as a provincial tax credit of roughly one-third or one-half of this amount on your tax return. Work with a financial consultant to compare after-tax cost interest rates under each scenario.

Consider the following example: A bank offers a resident the prime interest rate (e.g., 3%) on a line of credit to consolidate all indebtedness, including Canada student loans that are charging 5.5% per annum (prime +2.55%). At first glance, the bank's offer looks significantly better. In consolidating the debt to the loan authority, however, the resident will forfeit both the federal and provincial tax credits. Family medicine in under-serviced areas can realize a forgiveness on Canada student loans of up to $40,000 over five years, as outlined in Canada's recent budget announcement. Payment and interest will be required in residency, however. Note that different rules pertain in each province as well.

Consolidating your Canada and/or provincial student loans can be a tricky decision, one that depends on the particulars of your own situation. If you are considering this option, be sure to see your financial consultant.

RRSP CONTRIBUTION versus DEBT REPAYMENT versus COMBINATION STRATEGY

Residents should be aware of the importance of retirement planning and the advantages of starting early. Some contribute to registered retirement savings plans (RRSPs) and enjoy both tax savings and tax-deferred growth within this investment vehicle. When faced with a limited cash flow and significant debt, however, many ask: "Should I pay down my debts or contribute to an RRSP?".

Case Example: Jack and Jill

Jack and Jill are married and are residents in the same program. In addition to their Canada and provincial student loans, Jack and Jill have accumulated bank loans of $35,000 and $37,000, respectively. Their MD Management Financial Consultant has evaluated three alternatives for them to consider.

- **Focus on savings.** After five years, the couple could have $130,000 in RRSP assets but still have $72,000 of indebtedness—a net worth of $58,000 at the end of year five.
- **Focus on reducing debt.** After only four years, the entire $72,000 of debt would be eliminated, but no RRSP assets would accumulate—a net worth of zero ($0).
- **Combine strategies.** Extend the plan to seven years and eliminate the debt, but accumulate RRSP assets of only $60,000—a net worth of $60,000 at the end of year seven.

The tax deduction for the RRSP can be claimed in a future year (in the first year of practice, for example). This will yield a tax return of approximately $23,000–$32,500, which can then immediately be deployed to reduce debt in one large chunk.

With minimal RRSP contributions in years six and seven, the net worth of the first alternative ($58,000) would certainly exceed the value of the third alternative ($60,000). Nevertheless, Jack and Jill opted for the third strategy. It alleviated their discomfort with carrying a large debt, and recognized that, in the short term, they were less anxious about their retirement savings.

This example, of course, will not apply to everyone's situation. Each case needs to be be evaluated individually. A good financial consultant can calculate the value of each alternative, and help you to decide on a course of action that respects your particular attitude and preferences.

Your financial consultant will also review the potential benefits of investing some of your after-tax savings in a tax-free savings account (TFSA).

NEGOTIATING WITH BANKS

Physicians will obtain lower rates and optimal payment terms by establishing a sound credit rating. Some financial planning organizations offer their "select clients" good pre-negotiated terms for savings and loan products. You can save substantial processing time by working with a financier who is familiar with physicians, understands their current and future income potential, and is able to structure products for individuals. As a group, physicians can take advantage of better terms than those normally negotiated by individuals, and avoid the often intimidating and uncomfortable need to "haggle". A financial consultant can offer useful advice that will prepare you to meet with your lending institution.

Deal with an institution that understands your unique situation: the steps in medical training, the significant debt load, the salary increments during residency, and physicians' eventual earning potential. Most recognize the business sense of making loans to medical professionals, and quickly approve the maximum limits for a credit application in the hope of winning a long-term client. But ask yourself whether the institution wants you to take on more debt than you need, which might encourage you to overspend and delay the achievement of your financial goals. Work with an institution that respects the objectives that you have established with your financial planner.

A critical factor in any loan application is adequate preparation. Work with your financial consultant to prepare appropriate financial statements, such as a statement of net worth and cash flow statement. If you are adequately prepared, it will demonstrate that you are not only proactive but also in control of your personal and financial affairs. Apply for a line of credit that reflects your spending needs over the next year, plus a reasonable cushion—not the maximum amount available to you. This will help you to maintain spending within your budget—and next year you can apply for an increase on your line of credit, if necessary. Your financial consultant can help you to determine how much you need to borrow and ensure that you are prepared for a loan application.

YOUR CREDIT RATING

Banks often value your credit rating more than your future income-generating potential, so having an excellent credit rating is crucial. You can check your credit rating by contacting one of Canada's major credit bureaus: Equifax (www.equifax.ca), TransUnion (www.transunion.ca) or Northern Credit Bureaus (www.creditbureau.ca).

Credit ratings work on a seven-year cycle, so any late interest payments or failures to pay bills will negatively affect your rating for some time. Because errors are not uncommon, verify that any claim against you is legitimate. If you discover an error, you should apply, with support documentation, for an immediate and appropriate correction.

Proper use of a credit card can help you to establish a positive credit rating. Buy only what you need and can afford, and pay off the balances by the due date, using available cash or your line of credit. Always pay your bills on time, as delinquencies will negatively affect your credit bureau rating. Your financial consultant can offer more ideas aout how to maintain a good credit rating.

SAVING FOR THE FUTURE: UNDERSTANDING KEY INVESTMENT STRATEGIES

Once you start earning an income, it is possible to begin increasing your net worth, even by putting aside as little as $25 per week to reduce your liabilities (what you owe) and/or increase your assets (what you own). A financial consultant can work closely with you to develop the optimal financial plan that reflects your personal tolerance for risk and need for security. Your overall plan will include renewing RRSPs, TFSAs, incorporation and RESPs if you have children.

Short-term investments can help you to achieve short-term goals, like saving for a down payment on a home, planning for your first tax instalment, or saving for a winter holiday—without having to reach for your line of credit.

The effects of compound interest can boost long-term investments, as shown in the following example, which indicates how a smaller amount of money, invested early, can grow over time.

Physician A	Physician B
Invests $12,000 at a rate of $100/month for 10 years, then lets the investment sit for 10 years without further deposits	Invests $24,000 at a rate of $200/month for 20 years
Investment value at the end of year 20: $37,530	Investment value at the end of year 20: $34,770

A financial consultant can help you find the investment solution that is best for you, which will include such considerations as mutual funds, individual stocks, fixed-income products like guaranteed income certificates (GICs), or a combination.

ACTION PLAN

- Book an appointment with a certified financial consultant and start your financial planning process.
- Contact one of Canada's major credit bureaus and evaluate your credit rating.
- List your assets and liabilities in a statement of net worth.
- Develop a cash flow statement.
- Determine if loan consolidation is to your advantage.
- Talk to your financial consultant about the best options for banking.

RESOURCES

MD Management Limited

- MD Management Limited, a subsidiary of the Canadian Medical Association, provides comprehensive financial consulting services to physicians and their families. Employing more than 160 financial consultants in 47 centres across Canada, MD Management is the only financial services organization dedicated to understanding and meeting the financial needs of Canadian physicians and their families. Contact Member Service Centre at 1 888 855-2555.
- Resources available at cma.ca/pmcresources:
  - *Tax Tips For The Physician And Physician In Training*
  - *So You Are Finishing Residency*
  - *CaRMS Match Travel Costs*

Module 3:
Personal And Professional Insurance

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plan to best fit their personal and professional aspirations. You are advised to consult with a professional advisor to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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CMA National Practice Management Curriculum

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Key Learning Points

- *The importance of having personal and professional insurance*
- *Before you apply for insurance*
- *Your personal insurance requirements*
- *Disability insurance*
- *Life insurance*
- *Liability, household and other personal insurance*
- *Insurance requirements once you are in practice*
- *Taking ownership for protecting yourself and your significant others*

INTRODUCTION

No one likes to talk about insurance. Who wants to think of such depressing scenarios as loss, liability, disability or death? Many young professionals believe that the likelihood of personal or professional calamity befalling them is remote, and for that reason they do not place a high priority on insurance. A common assumption is that the cost of insurance outweighs the risk that a young person might need its benefits in the foreseeable future. So, is it okay for medical students or residents to defer buying insurance until they can more easily afford the premiums? Absolutely not!

The truth is that your insurance portfolio is the foundation upon which your financial plan is built. We need insurance most when we are deepest in debt, even though it may appear to be difficult to pay for it. Insurance provides financial protection for what we need, when we need it.

This discussion will examine the insurance application process, the personal insurance requirements that you should address now, and insurance requirements once you are in practice. Ask your financial consultant for objective advice about your insurance needs.

BEFORE YOU APPLY FOR INSURANCE

In the course of reading and completing any application for insurance, you may wonder how much detail to disclose about your medical history, health and lifestyle.

Insurance companies are extremely diligent when it comes to verifying the legitimacy of claims, especially those relating to disability and life insurance. There are many examples of claims not paid because further investigation by the insurer revealed that the insured did not completely disclose certain aspects of his/her past medical or personal history.

Suppose you have a medical condition or personal habit that would be of potential concern to the insurer. If you fail to disclose it to your physician and in an application for insurance, in effect, you are trying to defraud the insurance provider.

Case Example: A Social Smoker

The insurance application asks if you have ever used, or when you last used, tobacco products, including smoking cessation products, such as the patch or nicotine gum. You don't smoke regularly, but do sometimes have a social cigarette or cigar. The last occasion was three months ago.

Even if you smoke very infrequently, you should answer yes to using tobacco and identify when you last had a cigarette. The insurer may invite you to reapply in one or two years to have the smoker's status removed. Remember that, during the application process, urine and blood samples are tested for tobacco byproducts.

If you answer no to the use of cigarettes or tobacco byproducts in this scenario, you have misrepresented the facts according to the insurance industry's definition of tobacco use. When the insurance company discovers this fact, your contract might be rescinded, even if you are claiming for a totally unrelated condition.

Note that some insurers now permit non-smoker rates even in the case of occasional cigar use (one per month). If applicable, verify this in the contract.

Case Example: Medications Not On The Medical Record

During the fall and winter of your PGY-1 year you experienced significant anxiety and insomnia. You did not disclose this fact or seek counselling with your physician because you did not want the condition recorded in the physician's medical report that was part of your disability insurance application. Instead, you used samples of lorazepam for insomnia and an SSRI for six months to help you deal with the stresses of your first year. You now feel much more confident and are handling the rigours of residency better.

Any use of medications should be answered honestly, regardless of whether you used samples or had a prescription from your physician.

Even if you struggled through your first year without any professional help, you still suffered the symptoms and self-medicated to cope with anxiety and insomnia. Disclosing this information when applying for insurance is important.

It is, of course, professionally inappropriate to self-prescribe or use samples for personal purposes. You should always seek appropriate counselling and treatment for any and all medical conditions. Failing to do so makes you an increased liability to the insurer and, more important, to yourself.

Key Message

When applying for insurance coverage, be honest. Disclose all information about your health, lifestyle, behaviours and any known medical conditions.

Full disclosure and honesty are essential. The law is absolutely clear that the insured is obliged to disclose all information that may be material in allowing the insurer to assess the risk they are being asked to cover. The insurer determines what is material. Don't gamble with your insurance coverage by failing to disclose relevant information to your insurer, and don't risk your health by not seeking professional help for any and all medical conditions.

APPLYING FOR INSURANCE WHEN PREGNANT

If a physician is not adequately insured before becoming pregnant, she should still apply as soon as possible and not delay.

Insurance may be applied for during uncomplicated pregnancy, but disability insurers will accept applications only during the first two trimesters. An exclusion for "complications of pregnancy" will be applied and can be reconsidered for removal after return to work, provided that the pregnancy continued its course as "uncomplicated".

PERSONAL INSURANCE REQUIREMENTS

Regardless of profession, everyone should review the need for the following personal insurance protection against potential losses or liabilities:

- Disability or income replacement insurance
- Term life insurance
- Mortgage insurance
- Universal or whole life insurance
- Home and property insurance
- Automobile insurance
- Personal liability insurance
- Critical illness insurance

Assessing Your Personal Insurance Requirements

Insurance forms the foundation of your overall financial plan. Therefore, the first step in assessing how much personal insurance you need now and in the future is to seek objective advice from your financial consultant. The consultant will

conduct a detailed and unbiased evaluation of the types and amount of insurance you should purchase, which will prepare you to contact insurance providers.

It is critical that you also learn and understand the basic definitions and conditions of the various insurance products. Once you have assessed your needs and understand the coverage that is available, the insurance product should sell itself. Then you can critically appraise various insurance packages and providers, based on quality, detail of coverage and cost.

Who To Talk To About Insurance Products

Anyone can buy insurance directly from an insurance agent or broker. Physicians can also buy insurance from their provincial medical association and MD Management.

Insurance agents. Agents are generally restricted to selling only one insurance company's products. Because agents are paid by salary and/or commission, it is not realistic to expect completely unbiased and objective advice.

Insurance brokers. Brokers, on the other hand, can represent more than one insurance company. Insurance brokers are paid a commission for both the initial sale of the policy and for the ongoing premiums you pay to maintain your coverage. Although insurance brokers can sell the products of several companies, they tend to favour one or two companies that are most likely to accept their recommendation to underwrite the policy. The broker will not, however, be able to negotiate the insurance premium.

Medical associations. Some medical associations do not have brokers or agents. This means that physicians must review the product information themselves and apply directly for coverage. Administrative personnel in the association's insurance department can generally offer information and clarification. In addition, most associations have a customer services representative who can respond to questions and inquiries. Keep in mind here that these representatives may not be licensed and, if not, cannot provide specific advice.

Manitoba and Alberta have licensed insurance advisors. The Ontario Medical Association (OMA) offers the services of licensed salaried insurance advisors to members in the four Atlantic provinces and Ontario. OMA Insurance has an alliance with MD Management and works closely with MD financial and insurance consultants to provide seamless insurance advice to members.

MD Management Insurance Consultants. These experts are an excellent option for physicians who want comprehensive insurance advice. The Canadian Medical Association created MD Management for the sole purpose of serving physicians and their families, and its insurance advisors, like its financial consultants, are in a unique position to offer completely objective and unbiased advice. Because these consultants are salaried, their recommendations are not driven by commission or premium volumes, but are customized for each physician. They will refer you to the insurance provider—whether affiliated with provincial association group plans, private insurance brokers or a combination of both—who will best meet your personal needs.

Who Underwrites And Sells Personal Insurance

Private insurance companies. Anyone can purchase insurance from a private insurer. Each company, traditionally, specializes in certain products, such as life insurance and disability insurance. A contract is made between the individual and the insurance company. Once a policy is established, it should be non-cancellable (by the insurance company) and fully portable, as long as the client continues to pay premiums.

Medical associations, through group insurance plans. Professional associations, such as provincial medical societies, often negotiate with private insurance companies to provide their members with a selection of insurance products. These products are generally available to members only. Exceptions are major medical and dental coverage, which will normally include the spouse and dependants, and life insurance, which is typically available to spouses. With medical association group plans, the insurance contract is between the association and the insurer. An insured member receives a certificate of insurance, verifying his/her coverage.

Portability

Portability of personal insurance is critical for physicians, who may move many times during their medical training and careers. Most provincial association group plans offer very affordable "associate memberships", so that coverage is portable to wherever a physician moves, in or outside of Canada. For example, if a physician in Halifax is covered by the group plan offered by Doctors Nova Scotia (OMA Insurance), the physician can maintain coverage if he/she moves to British Columbia, or even outside of Canada, by continuing to pay "associate level" dues to Doctors Nova Scotia.

When considering association group coverage, confirm that the insurance is portable, and ascertain the cost of maintaining associate status with the provincial medical association. Deal directly with the medical association to learn the facts about portability of insurance. Don't rely on a private insurance broker to give you correct information about association plans.

Not all medical association group insurance plans are the same. When physicians apply for association insurance, they are restricted by their province of work or current training. Therefore, medical students and residents in some provinces may not have the same options available to them as their colleagues in other provinces. Each provincial medical association's (PMA) website provides easily accessable information to assist here.

But don't wait until you move to a "more favourable" province to insure yourself. Research and critically appraise your insurance provider options, based entirely on the province in which you are now living and working. Your provincial residents' association, provincial medical association, brokers for major private insurance companies and MD Management's financial and insurance consultants can help.

Insurance products are designed by the association to be as cost effective as possible. For this reason, the insurance premiums for an association plan are often less expensive than those for a similar plan offered by a private insurance company. The potential downside is that these premiums are not guaranteed; they are set annually and could increase if there is a bad claims experience. It is advisable to research the past history of the plan's performance and premium increases.

Regardless of who ultimately provides the insurance, you need objective, unbiased advice to ensure that the policy you buy offers you the most cost-effective coverage possible.

Key Message

Insurance is the foundation of your financial plan. Get objective advice to establish your personal insurance needs and identify the most appropriate products.

DISABILITY INSURANCE

Disability insurance should be thought of as income replacement insurance. Physicians should insure their income in the event they suffer a short- or long-term illness or disability.

Case Example: No Income For A Year

A 33-year-old self-employed physician is diagnosed with aplastic anemia and, fortunately, can benefit from a bone marrow transplant. The physician is unable to work for nine months, then returns to half-time work for three months before being able to handle full-time duties. This physician has to make do without any income for the better part of one year. Still, she must meet her financial obligations.

Residents have some disability coverage included as part of their employee contract with their teaching institution, although it ends at the conclusion of residency. Upon completion of training, students and residents are offered guaranteed access to the PMA plans for a limited time (without requirement for evidence of good health).

Medical schools should be advising all trainees that it is never too early to obtain disability insurance. Statistics indicate that, during the course of their professional careers, physicians have a 30% chance of being disabled for at least three months. If, like most physicians, you are self-employed, you will have no paid sick leave. Consequently, you should ensure that you have alternative financial resources to replace lost income. If you are a salaried physician, it is still important to review the disability insurance coverage in your employment contract.

Addressing one's disability and life insurance needs is the first step in the overall financial planning process. Because disability insurance contracts are very complicated, it is essential to obtain expert advice from a financial consultant, as well as objective advice from insurance experts. Consult both advisors together, not independently.

This discussion will review the basics of a disability insurance policy and identify what questions to ask your advisors, so that disability insurance coverage can be customized for your individual needs.

I Plan To Work In An Institution That Offers Me A Salary And Benefits. Do I Need Disability Insurance?

All residents are advised to obtain personal disability insurance (DI) coverage, regardless of future practice prospects. Should you secure a long-term position that guarantees comprehensive short- and long-term disability benefits, you will be able to cancel your personal coverage. Before doing so, however, have an independent expert review the details of the employee benefits plan—especially sick leave and disability insurance—to ensure that your coverage is optimal and meets any eventual need. The option of providing your own DI should be looked at because, in the event you leave the salaried position, you will still have DI in effect. Tax issues of both options should also be reviewed with your accountant.

When Should I Apply For Personal Disability Insurance?

Medical trainees should purchase personal disability insurance coverage before they complete their residency—ideally, during medical school. There are three key reasons for making disability insurance coverage your top priority.

- The application process takes time. You need time to review options and obtain unbiased advice. The insurance provider also needs time to process and approve an application.
- Your health risk is better now than it will be in the future. Disability insurance policies are approved based on past medical history and the individual's current risk of becoming disabled (and you are therefore a financial liability to the insurer). You cannot guarantee that you will be as healthy in one year as you are today.
- Your health today can also secure you a guarantee that you will be able to purchase more insurance in the future with no further medical evidence.

What If I Have A Policy, But It Isn't Ideal For My Needs?

Even if you determine that your current disability insurance is inadequate, the policy should be secure. Applying for an upgraded policy will not negate or jeopardize your existing coverage, whether your application is accepted or turned down.

What If My Application For Disability Insurance Is Turned Down Or Modified?

Approximately 40% of disability insurance applications are initially turned down or modified by the insurer. If you are turned down, have an expert help you to reapply. MD Management's insurance consultants, your provincial medical association insurance department or an experienced insurance broker can assist you.

A modification is an 'exclusion' for coverage. For example, a resident who has had appropriate treatment for seasonal affective disorder may be accepted for disability insurance coverage for all medical conditions except those related to depression. Some residents may be restricted to obtaining coverage that has exclusions or modifications. This is better than no coverage at all, however. Depending on the medical exclusion, there may be a time limit after which you can apply to have the exclusion removed.

In some provinces, the medical associations are now partnering with the residents' association to offer disability insurance to all residents, regardless of health status. For example, the Ontario Medical Association has partnered with the Professional Association of Internes and Residents of Ontario (PAIRO) to create the Essentials disability and life insurance offer, which is available to graduating members of PAIRO, PARI-MP or PAIRN. These plans are precedent-setting because all residents can be guaranteed of being accepted, regardless of whether they have existing health issues. Medical clearance would be required if one wanted to upgrade the "Essentials plan", but the basic plan is guaranteed. Refer to your provincial medical association's or residents' organization website for more information.

Where Do I Buy Disability Insurance?

While the resources for personal disability insurance for residents will vary from province to province, physicians generally choose between two types of professional disability insurance.

Private disability insurance. A few major insurance companies across the country offer individual plans for physicians. The policy is sold by insurance brokers, who are paid a commission by the insurance company for the initial sale and your ongoing premium payments. The policy is portable wherever you go, as long as you maintain the payments. The premium structure can be a fixed rate, determined at the time of purchase, or a stepped rate that increases every five to 10 years. Disability insurance premium rates are determined by age, gender, smoking status and health risk at the time of application. You should review the short- and long-term financial implications of the premium rate structure with your financial consultant.

Medical association group disability insurance. All provincial medical associations offer a group disability insurance plan to physicians who are working in the province, although the coverage and cost can differ across the country. Generally, you need to live and work in the province, and be a member of the provincial medical association, to qualify for coverage. The exception is in the Atlantic provinces, where the Ontario Medical Association's disability insurance plan is made available through the provincial medical societies. Some physician associations also offer disability insurance for medical students.

The medical association group plan is portable if you move from the province or the country, as long as you pay the premiums and provincial association "associate member" dues, which are significantly lower than the full membership fee. The premiums for the medical association group plans are generally less expensive than private policies, and the rates increase only every five to 10 years.

One significant concern is that trainees do not have the same access to medical association group plans in every province. Residents and medical students should investigate their options, based on where they are training at the time of their application. Your financial consultant will be able to tell you what is available in your province.

What Determines The Premium Cost Of Disability Insurance?

Premium rates are based on age, gender, occupation, smoking status, and past and present medical history. Annual premiums can be either fixed to age 65 or increased every 10 years at regular intervals, such as at 35, 45 and 55 years of age. The latter, known as "stepped rates", vary by company and plan.

Initially, it may seem advantageous to have fixed rates for life. Fixed premiums, however, are typically higher than stepped rates at the outset, which is when young physicians have more debt load and monthly expenses. Have your financial consultant project the long-term costs of higher rates now versus later, when the dollar value has deflated and you can afford to pay more. The cost of your disability insurance premiums is not deductible, and should be included in present and future cash flow calculations.

How Much Income Can I Insure?

It is wise to insure as much of your present and future after-tax income as possible. Insurance companies generally insure only 70%, or less, of your net take-home pay, because they want you to have a vested interest to return to work. When you want to increase your monthly benefits, you will need to justify that request based on net income, and apply for the increase or, better yet, exercise a future purchase option.

Although medical residents have limited monthly after-tax income, you can apply for entry-level disability insurance that will offer more after-tax coverage than your resident's salary would otherwise justify.

What Does "Totally Disabled" Mean?

It is important to clarify how your insurer defines "disabled" before you sign a disability insurance contract. Three general definitions exist.

- **Any occupation.** To meet the terms of this definition, you would be:
  - unable to perform the duties of any occupation for which you are reasonably suited by means of education, training or experience;
  - not employed elsewhere; and
  - under the care of a physician.

Physicians do not want this level of coverage, because it implies that one is not disabled unless one is unable to do any remunerative work. Residents should be aware that their present disability insurance coverage, in most institutional employment contracts, will revert to "any occupation" after one or two years of being disabled.

- **Regular occupation.** To meet the terms of this definition, you would be:
  - unable to perform the important duties of your regular occupation;
  - not employed elsewhere; and
  - under the care of a physician.

This is the definition that most physicians obtain. In this situation, you are not obliged to do non-medical work if you are not capable of practising medicine anymore. If you decide to do some remunerative work, your benefits will be reduced in proportion to the income you receive from the non-medical income. This is the standard definition under most association and private plans offered to professionals.

- **Own occupation.** To meet the terms of this definition, you would be:
  - unable to perform the important duties of your regular occupation; and
  - under the care of a physician.

Surgeons and sub-specialists often consider this coverage, but it is debatable whether it is worthwhile for a family physician. For example, if a plastic surgeon lost the use of a hand, "own occupation" could insure full benefits without penalty or reduction if the surgeon started another remunerative profession. Insurance companies review these cases in great detail, and the premiums for "own occupation" are significantly more than for "regular occupation" coverage. To determine whether the ongoing payment of the extra premiums is worth it, do a detailed projection of the cost/benefit and your risk of being totally disabled.

What If I Am Not Totally Disabled?

Most contracts contain clauses that address how your insurance company approaches disability. Insurers use either or both of the following:

Partial disability. This term generally refers to either one's inability to perform some of the duties of the job, or one's inability to perform normal duties for as much time as is normally required. Of the two key measures in defining disability, partial/residual disability will focus on either duties or time, or both. Every insurer will have a specific definition of partial disability.

Residual disability. This is based on the proportion of income that you have lost because of disability. You will receive a similar proportion of monthly disability insurance benefits. For example, if you suffer a 50% loss of income, you will receive a 50% benefit.

You may not need to be totally disabled before you can receive partial disability insurance benefits. It is important to clarify this before you sign a policy.

How Long Do I Need To Be Off On Sick Leave Before I Start To Receive Benefits?

The "elimination period" defines the number of days you must be disabled before you may submit your claim. Your claim must then be adjudicated and accepted, and the initial payout will be made at the end of the first eligible period. The longer the elimination period, the more time you will need to cover your expenses until your benefits start. Common elimination period options include:

- **30-day elimination period.** You will not receive any income or benefits for the first 30 days of disability. If you are unable to practise for 90 days, and you cannot submit your claim until after 30 days, you will not receive your first benefit payment until 60 days after you stop work. In total, you will receive 60 days of benefits. To prevent additional debt, you would need to set aside 30 days of after-tax income in a dedicated savings plan to self-insure (finance) the elimination period.
- **60-day elimination period.** Your first 60 days of disability are not covered, and you may receive your first benefit payment at 90 days. For a 90-day disability, you will receive only 30 days of coverage and will need to finance the first 60 days of your illness.
- **90-day elimination period.** Historically, most residents have chosen a 90-day elimination period, the term most often sold by insurance brokers and agents. In this scenario, you have no coverage for the first 90 days of disability and will receive your first cheque at 120 days. You are obliged to finance your ongoing expenses for 90 days, and hope that the cheque you receive at 120 days will cover your last 30 days of expenses.

There appear to be three reasons why most residents choose the 90-day elimination period. First, the premiums are cheaper, which the resident may feel is more affordable when the application is made. Second, most medical students and residents do not understand the significance of "self-insuring" their elimination period. And third, most medical students and residents have not sought the advice of an expert to help them make informed decisions about their individual insurance needs.

An informal survey of 500 medical residents during the 2001–02 Practice Management Curriculum seminars indicated that:

- Approximately 85% of respondents chose a 90-day elimination period for disability insurance.
- 80% had not sought any objective advice before buying their coverage.
- Approximately 70% did not understand the concept and importance of self-insuring their elimination period. Most respondents assumed that they would simply be able to increase their personal line of credit.
- Most of the respondents failed to project that their cash flow requirements in two or three years would be significantly greater than their present monthly expense obligations as a resident.
- Most residents did not consider that their income would increase in the next few years, making the payment of the premiums for the shorter elimination period more affordable.

What Does Self-Insuring Mean?

Self-insuring means setting aside adequate and accessible funds to replace your lost income until the terms of the elimination period have been met. Generally, one is encouraged to set aside at least 90 days of projected take-home income as a contingency. Obviously, this is not possible for the vast majority of medical students and residents—which is all the more reason to apply for an elimination period that meets your projected financial needs in the event you are disabled.

Reasons to consider a 30-day elimination period:

- You need the most insurance when you have the most debt.
- If you want a shorter elimination period later on, you will need to reapply and medically requalify for the coverage.
- If you have a shorter elimination period now and, in a few years, can afford to finance a longer term off work, all it takes is a phone call to your provider to go from a 30-day to a 60- or 90-day elimination period.
- You can also split the elimination period coverage (e.g., 50% of coverage starting at 30 days and 50% at 60 days.)

Young physicians, residents and medical students need the most comprehensive disability insurance coverage, with the shortest elimination period possible, when they are young and carry significant debt. Your financial consultant should do a detailed projection of several "what if" scenarios to determine the most appropriate coverage for you.

Note that the guaranteed PMA DI plans, such as the Ontario Medical Association's "Essentials" DI plan have a 90-day elimination period. To upgrade this to a 30-day elimination period, one needs to apply with a medical history review.

What Other Important Disability Benefits Should I Consider?

Additional benefits are often referred to as "riders". Choosing the appropriate rider is part of your overall financial and insurance planning. While the following are important to consider, this is not a comprehensive list of the benefits and conditions that may be available. Seek expert advice on the current terms of disability insurance plans that you are considering.

FUTURE INSURANCE OPTION (FIO)/ GUARANTEED INSURABILITY BENEFIT (GIB)

The future insurance option/guaranteed insurability benefit (FIO/GIB) feature enables you to increase the amount of monthly benefit, without having to reapply and medically qualify for more coverage. FIO/GIBs are typically structured in fixed increments and are available on a predetermined schedule (e.g., every year). You should ask for the maximum benefit with the shortest time frame. When you apply to exercise your FIO/GIB, your income has to justify the request for increased coverage. You will need to submit tax summary statements, along with your request to exercise the FIO option.

Case Example: Future Insurance Option

Before completing residency, a dermatology resident obtains a disability insurance plan with a $4,000 monthly benefit and a future insurance option/guaranteed insurability benefit (FIO/GIB) that allows for a $2,500 additional benefit every year to age 55. After two years in practice, the physician's gross professional income is $325,000. The overhead is 35% ($113,750), which leaves the resident with $211,250 net before-tax income.

Using the Income Ratio Guide from one of the provincial associations, this doctor could have a total of $8,500 of monthly benefit from all sources. He already has $4,000. He can financially justify an additional $4,500. The FIO/GIB allows the doctor to purchase $2,500 of the $4,500 with no medical questions asked. For the remaining $2,000, he either submits medical evidence now, or waits until the next option can be exercised.

In this example, the FIO/GIB provides part of the increase in income replacement coverage that the dermatologist requires without the insurer reassessing the doctor's medical risk. At any time, the doctor can apply for upgraded disability insurance income coverage that requires a medical risk reassessment. In the meantime, the existing FIO/GIB allows for increases in income replacement without medical evaluation.

Cost-Of-Living Adjustment

Ensure that your disability insurance coverage factors in a cost-of-living adjustment (COLA). If you have $6,000 per month coverage and become disabled in three years, your benefits will be $6,000 per month, then increase annually by a multiplier that factors in COLA adjustments. Note that, if you bought the $6,000 coverage in 2012 and do not suffer a disability until 2015, your base rate does not automatically reflect a cost-of-living increase; the COLA clause kicks in only when the benefits start.

Retirement Protection

When you are disabled, you do not have any earned income—so you cannot contribute to your registered retirement savings plan. A retirement protector clause will add, for example, up to an additional $1,500 per month over and above your monthly income replacement benefit. This particular benefit is invested in a non-registered fund on your behalf to help in retirement.

Remember that, unless other terms have been negotiated, many disability insurance plans terminate when the insured reaches the age of 65 years, so the retirement protector clause is very important.

Special Consideration

Suppose your significant other is a legitimate employee of your medical practice, and is put out of work when you become disabled. Your insurance policy may allow you to factor in the earnings your significant other would lose in such a scenario. Ask your insurance advisor whether you can include such a provision as part of your disability insurance coverage.

A Tax Caution

Never deduct your income replacement disability insurance premiums as a practice expense. If you do, your disability insurance benefits would become taxable earnings and be significantly reduced.

DISABILITY INSURANCE ACTION PLAN

- **Research and apply for personal disability insurance as soon as possible.**
- **Investigate what your provincial medical association can offer.**
- **If you already have personal coverage, review your policy with an objective advisor and, if necessary, reapply for better coverage.**
- **Get the shortest elimination policy and the best future insurance option you can.**
- **Remember the importance of a cost-of-living adjustment clause and a retirement protector clause.**
- **Analyze the pros and cons of "own occupation" versus "regular occupation" coverage, and verify that your contract clearly defines what they mean.**
- **If your significant other's employment depends on you, investigate whether his or her income would be covered by your disability insurance.**
- **Never deduct your income replacement disability insurance premiums.**
- **If you are salaried and your employer pays your disability premiums, have your accountant review whether it is in your best interest from a tax perspective. It may be preferable to pay for your own disability insurance.**

LIFE INSURANCE

Deciding how much life insurance to get is not simply a guess. Many factors, including your present and projected financial liabilities, family circumstances and dependants, savings and cash flow requirements, are part of a complex calculation that is best managed by sophisticated software and an expert advisor. Have your financial consultant analyze your situation, then calculate and customize your life insurance needs. MD Management, or your PTMA insurance advisor, can easily help you to calculate your life insurance needs—with no obligation to purchase their products.

Case Example: Providing For The Family

Beth is a 32-year-old female physician with children aged 1 and 3. Her significant other makes $50,000 per year. Her present family debt load (remaining student loan and mortgage) is $300,000. She wants to ensure that, in the event of her untimely death, her children will be provided for with the same standard of living,

Key Message

Calculating life insurance needs is complicated and requires expert advice from a financial consultant. Don't let the large sums scare you!

and will be able to obtain a postgraduate education. Beth plans for the probability that her significant other will be required to spend more time raising their children, that their family income will be significantly reduced, and that their child care expenses will increase. In the event of Beth's death, how much life insurance would she need to cover these costs?

Financial liabilities will include the immediate expenses related to Beth's death, funeral and legal activities, as well as all existing debt. Then the ongoing costs of daily living, housing, dental and medical expenses, extracurricular activities, leisure and travel must be projected, as well as the long-term costs of providing for university, and possibly postgraduate education, for the children. The possibility that her significant other's health may be compromised should also be considered.

What amount of money would be required to generate enough income, at conservative projections, to provide for all of these potential expenses? In this case example, Beth would be best served with a life insurance plan of well over $1 million. For example, $1.5 million, generating 5% per year, would provide the equivalent of about $75,000 income before taxes.

I Am Single, With No Dependants. Why Should I Get Life Insurance Now?

There are two ways to look at this question. If you are simply planning for the present, then the answer would be that you don't really need life insurance now, as long as your estate can cover the costs of your funeral and debt obligations. What is the likelihood, however, that you will have dependants or a significant other in the next two to five years? Then you will need life insurance. Can you guarantee that you will be as insurable then as you are now?

If you are single and want to defer buying life insurance, make sure you consider your future needs, and make an informed decision. Research the cost and re-evaluate your circumstances annually so that you can proactively purchase adequate coverage when your personal situation is about to change.

What Is The Difference Between Term Life Insurance, And Universal Or Whole Life Insurance?

Term life insurance. Term life is like your car or house insurance: You pay an annual premium for a guaranteed amount of coverage. The premiums are guaranteed for a specific period (or term) and the insurance policy should be guaranteed renewable, generally until you reach the age of 75 or 80 years. The premiums are based on age, sex, smoking status, and past and present health.

Term insurance is relatively inexpensive at the beginning of the plan, especially when you are young, because your risk of dying is very low. As you age, the risk of dying increases, and so does your premium. Only about 3% of term insurance policies are actually paid out, because most people choose to let their policies lapse rather than pay the renewal premiums when they get older.

There is no investment portion to term insurance. If you cancel the policy before you die, you do not get any money back. If you die after the term insurance coverage expires, or if you fail to renew and pay annually, there will be no paid death benefit.

Think of term life insurance as a relatively inexpensive disaster plan that will provide for your dependants in the event you die before you have accumulated an estate that can provide for them. As your net worth increases, your need for life insurance actually decreases, unless you want to guarantee provision for your children whenever you die.

Universal or whole life insurance. These policies guarantee a death benefit, as long as you continue to pay your premiums. If you pay more money than is required to meet your premiums, whole life policies can also provide you with an opportunity to invest in tax-sheltered investment vehicles. Extra money invested in whole life insurance may augment your death benefit, or become available to you later as tax-sheltered investment income to complement your retirement savings plan (RSP). Funds can also be withdrawn, tax free, if you or your significant other has a medical crisis or requires long-term care.

The appropriateness of these policies can be determined only after a consultation with a knowledgeable professional. As a general recommendation, however, medical residents and young practising physicians should buy as much term life insurance as they can reasonably afford. As your net worth increases, your need for life insurance to provide for dependants will decrease. Depending on your personal situation, in 10 to 20 years, you will aspire to be completely out of debt and continue to maximize your RSPs. At that time, you will have the option of reducing or maintaining your term life insurance.

Better still, when you are debt-free, consider a universal life plan as part of your financial and estate planning portfolio.

Where Do I Buy Life Insurance?

Private insurance and not-for-profit provincial medical association group plans (term life and disability income) are available to physicians and spouses (term life). Working closely with MD Management, provincial medical associations also offer a broad range of life plans (universal life, permanent and term plans), as well as private critical illness and disability income coverage to all CMA members and their families.

Mortgage Insurance

Mortgage insurance is a form of term life insurance in which the policy will cover remaining mortgage debt if you die. It is offered by the lending institution that holds your mortgage. The lender becomes the only beneficiary, and the coverage declines as you pay off the principal.

It is not mandatory for you to buy the mortgage insurance offered by the lending institution. In fact, it is often more cost effective to have a financial plan with adequate term life insurance to cover your mortgage and other capital needs (such as funeral expenses) that will arise at the time of your death. This way, the coverage does not decline and you have the option of keeping or ending the coverage.

LIABILITY, HOUSEHOLD AND OTHER PERSONAL INSURANCE

Personal Liability Insurance

Doctors are acutely aware of their need for medical malpractice insurance, but often neglect to adequately cover themselves from being sued for personal liability.

All household, automobile, cottage and office insurance policies will include a basic personal liability clause that covers you and your dependants for $1–$2 million. We strongly recommend, however, that you increase your personal liability coverage to at least $5 million or more, because settlements for loss or injury are much higher than they once were. One effective way to do this is to purchase an "umbrella personal liability plan" that can raise the limit on all of your personal insurance plans. All of your insurance—household, auto, cottage, office—would need to be with the same insurance company that provides the umbrella plan.

Even if it is more cost effective for you to use different providers for your home and automobile coverage, still, verify that you have adequate personal liability coverage for you and your present or future dependants.

Key Message

Personal liability coverage of $5 million or more is recommended, even for indebted medical residents. Future earnings are factored into increasingly higher settlements.

Case Examples: Personal Liability

A medical resident leaves the stove on in his rented apartment and a fire subsequently destroys the building and the possessions of his fellow tenants. A patient falls in your examination room and breaks her wrist. A mail carrier slips on the ice of your front stairs and breaks his leg. Your spouse is at fault in a car accident that injures the other driver. They all sue for damages.

In all of the above examples, the individuals will be protected if they have adequate personal liability coverage.

You may think that a medical resident with significant debt and little income would have no reason to have personal liability insurance of $5 million. Note that it is not what you make now, but what you will make later that counts. Future earnings are factored into settlements.

Household, Personal Property And Automobile Insurance

Are you a medical resident who rents an apartment? If yes, have you purchased apartment insurance for fire, theft, contents and personal liability? If not, why not?

It is common sense to adequately insure your home, automobile and personal property. Shop around the many private and group association policies to ensure that you get comprehensive, cost-effective coverage. Don't over-insure, however; the insurance company will not pay $500,000 to replace a $300,000 home. You should also evaluate the pros and cons of higher deductibles to reduce premium costs.

Critical Illness Insurance

Critical illness insurance provides a predetermined lump-sum benefit payment (tax free) if the insured experiences one of the listed critical illnesses (typically, up to 24 covered illnesses). A definite diagnosis is required before the benefit can be received. Examples include:

- ALS and other progressive motor neuron diseases
- Alzhiemer's disease
- Aortic aneurysm surgery
- Bacterial meningitis with permanent neurological deficit
- Blindness
- Cancer (some exclusions apply)
- Coma (greater than 96 hours)
- Deafness
- Myocardial infarction
- Heart valve replacement
- Paralysis
- Parkinson's disease
- Significant stroke
- Conditions may vary between policies.

When such an illness occurs, the insurance company will pay out a lump-sum one-time payment. Many policies, for example, offer $50,000.

The risk of critical illness increases with age. Therefore, the consideration of such insurance is often deferred until one gets older. The potential benefits of such coverage, however, should be reviewed every time one conducts an insurance portfolio review. Many young professionals, for example, choose to carry enough critical illness insurance to pay off debt. As is the case with life insurance, critical illness coverage can be purchased with a renewable (increasing) or level premium. It is generally advised to choose the lower-cost renewable premium initially, with conversion to a level cost plan at a later date, when cash flow improves.

LIFE AND PERSONAL INSURANCE ACTION PLAN

- **Buy as much term life insurance as you can reasonably afford.**
- **Have personal liability insurance of at least $5 million that covers you and your dependants.**
- **Have comprehensive insurance for your house, automobiles, future cottage, etc.**
- **Shop around for the most comprehensive, cost-effective coverage.**
- **Evaluate your coverage annually to make sure you are adequately insured.**

INSURANCE REQUIREMENTS ONCE YOU ARE IN PRACTICE

Once you start to practise, there are other insurance considerations that you should review regularly. Your professional insurance needs will depend on several variables, including where you work; with whom you work; and whether you are self-employed, in an alternative payment plan or fully salaried.

Self-employed physicians should consider *all* of the following insurance coverage provisions.

Practice Overhead Insurance

Any physician who is responsible for paying practice overhead expenses should apply for practice overhead insurance. This coverage complements your disability insurance and is often negotiated at the same time. Just as disability insurance is your income replacement, practice overhead insurance pays the rent, salaries and ongoing practice expenses when you are disabled. The coverage should have a short elimination period, such as two weeks, so that, even if you can manage with no income for a longer period, you won't need to pay practice expenses out of your personal savings for more than a short time. Coverage limits are based on actual practice costs, which you submit or project when you apply for the coverage.

You can insure for 100% of your average monthly practice overhead costs. If your overhead increases or decreases, apply for adjustments. Practice overhead insurance premiums are tax deductible; the benefit is taxable when received, but the expenses used to pay the premiums are deductible.

As with disability insurance, the practice overhead insurance plan has an elimination period. If you are a fee-for-service physician, directly responsible for all of your overhead costs, you should get a short elimination period. If you are part of an alternative funding plan (AFP), wherein you continue to receive capitation payments even when you are disabled, it may be in your best interest to have a longer elimination period for practice overhead insurance. Seek the advice of your financial consultant, accountant and insurance advisors before signing any contract under an AFP.

Office Insurance

While practice overhead insurance covers office operating costs if you are disabled, office insurance covers for fire, theft, loss of contents, and personal injury and liability. Physicians should have at least $5 million of personal liability as part of their office insurance package.

Medical office insurance entails special considerations that differ from your home insurance. For example, in the event of fire, it would cost much more than the expense of paper and files to re-create all of your medical records. You should insure for the total cost of re-establishing all of your data: materials, staff time, computer and communication systems. If you do not currently offer Workers' Compensation Board compensation coverage to your staff, make sure you have adequate personal liability coverage as part of your office insurance.

Office insurance premiums are tax deductible. As with other insurance policies, there are many private and medical association-sponsored plans to choose from.

Malpractice Insurance

Most Canadian physicians cover their medical malpractice needs with the Canadian Medical Protective Association (CMPA). Most provincial governments offer a significant premium reimbursement package that is specialty specific. If you provide non-clinical professional services that are not covered by the CMPA, you should look into additional professional liability insurance. Verify whether your CMPA malpractice insurance will cover all of your professional activities.

Group Practice Insurance Considerations

A group practice arrangement can be an association (in which expenses are shared), a partnership (in which expenses, income and financial liability are shared), or a combination of the two. Whatever the situation, it is important to ensure that no member of the group is a potential liability to the others in the event of death or disability, or because of personal or professional misbehaviour.

Case Example: Group Practice

The rent for a four-physician group is $50,000 per year and one member dies one year into a five-year lease. The three remaining associates are unable to find a locum or replacement associate for two years. The deceased's estate was liable for two years of rent and a pro-rated percentage of salary costs, which could be insured in a designated life insurance policy.

Follow these recommendations when negotiating your association or partnership agreement (more information is available in *Module 15. Setting Up Your Office*).

- Ensure that all group members have adequate and up-to-date disability and practice overhead insurance.
- Ensure that all members are co-insured and have adequate personal liability coverage in the office insurance policy.
- Ensure that all members are in good standing with all regulatory colleges and have up-to-date CMPA coverage.
- Ensure that all associates or partners have designated life insurance coverage to cover their present and future financial obligations to the group.

Key Message

Ask yourself this question: If I am not responsible for insuring these issues, who is?

CONSIDERATIONS FOR PHYSICIANS ON SALARY OR ALTERNATIVE PAYMENT PLANS

If you are not responsible or liable for overhead costs, insuring the physical plant or personal liability issues, then you will not require personal overhead or office insurance. You will require malpractice insurance, however.

It is wise to verify the insurance coverage that your employer or institution provides on your behalf. Have a contract lawyer clarify that your vested interests are covered, and that you have no direct or indirect liability for what happens in the workplace.

PRACTICE INSURANCE ACTION PLAN

- **Have your financial consultant and lawyer review your employment circumstances and relevant insurance needs.**
- **Have at least $5 million of personal liability as part of your office insurance package.**
- **Verify that your malpractice insurance will cover all of your professional activities.**
- **Review your insurance portfolio annually.**

Module 4:

Personal And Professional Accounting And Taxation

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

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KEY LEARNING POINTS

- *The basics of accounting*
- *The basics of the Canadian taxation system*
- *Tax deductions and tax credits of interest to physicians*
- *Tax instalments*
- *Incorporation*
- *Income splitting*
- *Goods and Services Tax (GST) and Harmonized Sales Tax (HST)*
- *The importance of professional accounting and tax advice*
- *Selecting an accountant*

INTRODUCTION

With residency behind you, it is important that you are introduced to the world of accounting, tax and financial management before you embark on a lifetime of medical practice. There are many stories of hard-working and talented physicians whose disposable income and net worth were greatly diminished by poor financial management and sub-optimal business decisions. By taking a vested interest in your personal and professional success, you can avoid the pitfalls that result from poor financial management.

All physicians have the aptitude to understand not only accounting and financial issues, but also many of the complexities inherent within the Canadian taxation system. What most physicians lack, however, is the experience and opportunity to learn the financial management skills that will help them to maximize their earned income and net worth. This module will explore the financial, accounting and tax concepts that physicians need to apply to their personal and professional practices to both promote efficiency and attempt to maximize after-tax income and net worth.

PHYSICIANS AS EMPLOYEES AND/OR SOLE PROPRIETORS

The vast majority of residents are employees of their hospitals and, as such, receive a salary based upon negotiations between their employer and their respective provincial association of interns and residents. If you are considered an employee, your employer is required to withhold from your salary specific amounts for income taxes, Canada Pension Plan (CPP), employment insurance (EI) and other incidentals; the remaining or net amount is provided to you each pay period, generally every two weeks. This employee status may change when you complete your training.

Once you have completed your residency, you might decide to operate your own medical practice. If so, practising medicine will also mean managing the medical practice. You will be responsible for the collection of all revenues (such as billings to the provincial Ministry of Health or Workers' Compensation Board) and payment of a portion or all of the expenses related to your practice. You will probably no longer be in an employer-employee relationship, in which someone remits source deductions (e.g., income tax, CPP and EI) on your behalf; instead, your status will be self-employed, or sole proprietor. As a sole proprietor, you will be responsible for remitting any personal income tax instalments to government authorities, and you will pay income tax on the excess of revenues over tax-deductible expenses—in other words, you will pay income tax on your business income.

Some physicians will remain employees of hospitals, governments and other regulatory authorities, and they will still be in an employer-employee relationship. Other physicians may be employees, but will also earn business income, which enables them to function as both employees and sole proprietors.

The deductibility of many expenses and the availability of tax credits are quite limited for employees, compared with physicians who are self-employed. The Canada Revenue Agency (CRA) and the Income Tax Act have criteria in place to determine the appropriate classification. It is wise to seek professional advice about your particular position—determination of your self-employed status can be complex and will vary according to your specific situation.

ACCOUNTING BASICS

Accounting—the process of analyzing and systematically recording business transactions and events in financial terms—relies on principles and practices that have existed for thousands of years. In Canada, accounting long predates the practice of income taxation, which was introduced during the First World War as a temporary measure to finance government activities, but which has persisted to the present day.

Accounting results are expressed in such financial statements as the income statement, balance sheet and cash flow statement. In addition to providing a sound basis to evaluate the past activities of an individual, organization or other entity, these reports provide a framework to make sound financial decisions regarding future actions. Governments, businesses, individuals, organizations and other entities, such as partnerships, have many uses for financial statements.

Balance Sheet

The balance sheet provides a snapshot of an individual's or organization's assets, liabilities and net worth at a single moment in time. It provides a baseline that can be compared with past and future financial positions, and it allows for evaluation of past performance and planning for future activity.

Dr. Smith, Medical Practitioner	
Balance Sheet	
As at December 31	
Cash and investments	$50,000
Total assets	$50,000
Liabilities	$28,000
Net worth	$22,000
Total liabilities and net worth	$50,000

Income Statement

An income statement is a detailed account of one's revenue and expenses for a period of time. The difference between revenue and expenses is the net income or net loss—the so-called bottom line.

Dr. Smith, Medical Practitioner	
Income Statement	
For the year ended December 31	
Revenue	
Provincial Health Plan	$200,000
Uninsured services	$15,000
Total revenue	$215,000
Expenses	
Staff	$35,000
Office rent	$15,000
Other expenses	$15,000
Total expenses	$65,000
Net income (loss)	$150,000

Because the income statement shown above does not consider income taxes, *net income* represents *net income before taxes*. Although the net income figure of $150,000 may be considered the bottom line, it does not necessarily represent the individual's after-tax take-home pay. For example, if Dr. Smith is a resident of Alberta, and makes the maximum registered retirement savings plan (RRSP) contribution of $22,450 in 2011, her federal and provincial income taxes will be approximately $36,500. This results in Dr. Smith having a net income before tax of $150,000 and a take-home pay of $91,050 (taxable income of $127,550 [$150,000 less $22,450 RRSP contribution] less $36,500 of income taxes).[1]

Cash Flow Statement

A cash flow statement is a listing of cash inflows and cash outflows, with the result being a net cash inflow or outflow. A surgeon may earn $20,000 in procedures during July and bill the provincial health plan accordingly. If the funds are not received until August, however, the surgeon's cash inflow for July will be nil ($0). This financial statement is intended to aid the analysis of the individual's or entity's short-term or cash position. It can also be useful in long-term financial management planning.

Dr. LeBlanc, Resident		
Cash Flow Statement		
For the month of June		
Items	Cash outflow	Cash inflow
Salary, net of withholding taxes, CPP, EI and other incidentals		$3,000
Rent	$900	
Loan repayment (interest only)	$800	
Food (includes entertainment, restaurants)	$400	
Automobile, parking and travel	$600	
Miscellaneous (e.g., gym, exam fees)	$200	($2,900)
Net cash inflow (outflow)		$100

[1] Income statements may be drawn up for either accounting or tax purposes. Although an expenditure may be an eligible expense for accounting purposes, it may not be an allowable expense for income tax purposes, as defined by the *Income Tax Act*. Therefore, some reconciling adjustments may be required to your accounting financial statements in order to make them appropriate for income tax purposes.

Budget

While the balance sheet, income statement and cash flow statement all deal with historical data, the *budget* refers to projected or estimated data. Although the estimated data may not prove to be entirely accurate, a budget enables an organization or individual to project and plan for future activities. The federal and provincial ministers of finance annually table a budget as their plan concerning how their respective governments will use financial resources in the upcoming year. At the end of the time period, the *actual* revenues and expenditures are compared against the *budgeted* ones, and the individuals and organizations responsible for financial management are evaluated. Business organizations and many individuals do the same thing. For example, financial institutions use budgets to evaluate a loan applicant's potential future activities and his/her ability to repay the loan.

In the same way that the figures within budgets are projected, one can also prepare estimates of cash flow, income statements and balance sheets to help evaluate and plan future activities. Accounting software programs, such as Quicken, Quickbooks and Simply Accounting, can be helpful. Spreadsheet programs, such as Excel and Lotus, can also be used for personal and professional budgeting.

Accrual Versus Cash Accounting

1. **Cash accounting** records transactions once cash is actually paid or received. The cash method of computing income is, strictly speaking, what its name suggests: income (or loss) for a fiscal period is computed by measuring cash or current cheques received, less expenses actually paid in that year. In cash accounting, the income statement and cash flow statement for a particular period will be identical. For tax purposes, only farmers and fishermen are permitted to use a cash method of accounting. Professionals who earn business income are generally mandated to use the accrual method of accounting.
2. **Accrual accounting** more accurately reflects business activity for a particular period. Under the accrual method of accounting, income is generally computed for the period during which it has been earned—in other words, when goods or services have been rendered—even though the billings for such activities may not have been collected by the end of that respective period. Similarly, expenses incurred to earn that income are deducted, whether or not they have been paid by the end of the fiscal period.

For example, billings for medical services provided in December would be counted as revenue in an accrual income statement ended December 31, even though such funds would not actually be received until January of the following year. Revenue would be recorded and an *account receivable* for the same amount would be seen on the balance sheet. Similarly, a physician may utilize a telephone in the office in December, but not pay for the service until January, when the bill is received. Although cash accounting will show no cash outflow for December, the accrual accounting method will record a telephone expense on the December income statement, along with an *account payable* to the telephone company for the same amount on the balance sheet.

Accrual accounting better matches revenues and expenses to the period in which they were earned or incurred. Finally, please note that certain professionals, including medical doctors, may elect to exclude from their income (for the current fiscal year) any work in process at the end of the year. Be sure to discuss this option with your tax advisor.

Accounts Payable

These are the amounts owed by you for products or services you have enjoyed or received. For example, at the end of the month, you would have an *account payable* to the telephone company for telephone service already received during the month.

Accounts Receivable

Amounts owed to you for services or products that you have provided are called receivables. For example, a doctor may bill the provincial medical plan for all services he/she has provided during the month of May, but, because the payment will not be made until the following month (June), the physician will have an *account receivable* from the provincial health authority as at May 31.

Accounting Or Fiscal Period

Any period in which income, cash flow and other transactions are measured is called an *accounting* or *fiscal period*. For tax purposes, self-employed physicians must follow a calendar accounting period (January 1 to December 31).

Expenses And Deductible Expenses

An expense is any expenditure incurred in a period to earn income. Although expenses may be deductible for accounting purposes, they will be *deductible for tax purposes* only if they are incurred to earn income from your medical practice, are reasonable, and are allowed by the *Income Tax Act*. Other restrictions may also apply. Furthermore, you should retain all supporting receipts and invoices related to these expenses, in case the Canada Revenue Agency requests them.

Inventory

Supplies stored and used in a business—such as tongue depressors or the paper examination table sheets in a doctor's office—represent *inventory*.

Reconciliation

Reconciliation is a process of accounting for the differences between two related accounts or balances. A pertinent example is the periodic or monthly reconciliation of a physician's billing records and Ministry of Health payments. As these two records very seldom agree, physicians should reconcile these two records on a regular and recurring basis, identifying what has not been paid, clarifying any discrepancies, and resubmitting any disputed claims to ensure payment is received for all services rendered.

Gross Income And Net Income

Gross income is a misnomer; people generally mean *gross revenues* or total earnings before expenses. *Net income* is gross income less expenses.

Interest Expense

Interest expense is interest paid on money borrowed to earn income. Interest expense, such as interest paid on money borrowed to earn investment income or to purchase medical equipment, may be deductible for tax purposes. However, interest paid on loans used to finance your medical school education is not deductible for tax purposes. (Note that the interest paid on loans to the Canada or provincial student loan programs generally qualifies for a tuition interest tax credit.) The rules surrounding interest deductibility can be quite complex. Contact your tax advisor to determine whether any interest expenses you pay are deductible.

Capital Expenditure

Businesses make *capital expenditures* when they purchase large and expensive pieces of equipment that will be utilized over several periods of time. Otolaryngologists, for example, may pay $150,000 for specialized equipment before they begin practice. For accounting purposes, the cost of such equipment cannot be *expensed* in a single year because it will be used over many years.

Instead, the otolaryngologist will expense some of the total cost each year over the entire period the equipment will be used in the practice. Apportioning the cost over a number of years is called *depreciation*.

The Canada Revenue Agency treats capital expenditures similarly. For tax purposes, however, each asset depreciates at specific rates (and by very specific rules), referred to as a *capital cost allowance*.

Net Worth

Net worth, also known as *owner's equity* or *residual earnings*, is essentially the balance of the proprietor's capital invested in the practice, plus any current-year net income (or loss), less any income drawn out of the practice as the physician's take-home pay. Overall, the total assets of the practice need to be equal to total liabilities and net worth. In the following example, Dr. Smith's net worth is $22,000 (and total assets are equal to liabilities and net worth).

Dr. Smith	
Balance Sheet	
As at December 31	
Cash and investments	$50,000
Total assets	$50,000
Liabilities	$28,000
Net worth	$22,000
Total liabilities and net worth	$50,000

Many physicians, including residents and medical students, find that their liabilities far exceed their assets and that their net worth is, in fact, a negative number. An admirable objective of effective financial planning is to incorporate practices and behaviours that serve to maximize one's net worth.

Key Message

An understanding of the basics of accounting is essential for every physician. In addition to having more control over your practice and personal life, you will be able to utilize the resources and skills of your accountant to best advantage.

TAXATION BASICS

Canada's income tax system is a relatively new phenomenon that dates back to the First World War. Ironically, attempts in the late 1980s to simplify the tax system further increased the size and complexity of the *Income Tax Act*. In the 1990s the provincial and territorial governments waded in to provide their own definitions of provincial/territorial taxable income and provincial/territorial income tax rates, so understanding the tax system has become more challenging.

The following section will explain basic terminology and outline available tax credits and deductions. This knowledge, along with tax and accounting advice from a qualified professional, will help you to minimize your income tax bills and maximize take-home income for you and your family.

Marginal Tax Rates

The concept of marginal tax rates is centred on the fact that Canadians are not taxed at the same rate for every dollar earned; the tax rate becomes progressively higher for increasing income ranges. Quite simply, your marginal tax rate is the amount of tax that you would pay on your last dollar of taxable income. If you were living in Ontario in 2012 and earned $69,000 of salary, the additional taxes you would pay on your last dollar of income would be 32.98 cents (see Table 2: 2012 Combined Federal Provincial Marginal Tax Rates: Province of Ontario in the next section) and you would keep 67.02 cents for yourself. In other words, your marginal tax rate would be 32.98%. If your marginal tax rate is 47.97% (the top

Key Message

Any physician can understand the basics of the tax system. This knowledge will help you work with your accountant to properly meet all filing requirements, minimize your income tax payable and maximize the after-tax income for your family.

marginal tax rate in Ontario for 2012), 47.97 cents of the next dollar earned would be taken for federal and provincial income taxes.

The concept of marginal tax rates generally depends on three things: your province or territory of residence, your level of income, and the type of income earned (i.e., capital gains, dividends and interest and other income). Basically, the higher your level of income, the higher the percentage of that income that will be claimed by the Canada Revenue Agency. Capital gains and dividends are traditionally taxed at lower rates than interest, business income, salaries and other income (see definitions below).

Federal And Provincial Income Tax Brackets

The federal personal income tax brackets and rates for 2011 and 2012 are outlined in the following table.

Table 1. Federal personal income tax brackets

2011 Taxable Income	2012 Taxable Income	Federal Tax Rate
$0–$41,544	$0–$42,707	15%
$41,545–$83,088	$42,708–$85,414	22%
$83,089–$128,800	$85,415–$132,406	26%
$128,801 and up	$132,407 and up	29%

The income tax brackets, as well as the rates imposed at each bracket, will vary between provinces and territories. Furthermore, certain provinces will also impose a surtax. As mentioned earlier, the combined federal-provincial tax rate is dependent upon the level of taxable income, the province or territory of residence, as well as the type of income earned (interest and ordinary income, capital gains or dividends). Identification of marginal rates becomes more complex when the combined federal-provincial rates are considered, as in this example for the province of Ontario.

Table 2. 2012 Combined Federal-Provincial Marginal Tax Rates: Province of Ontario

2012 Taxable Income Brackets	Interest And Ordinary Income	Capital Gains	Canadian Dividends	Canadian Dividends
			Eligible	Non-eligible
$0–$9,405	0.00%	0.00%	0.00%	0.00%
$9,406–$39,020	20.05%	10.03%	1.89%	2.77%
$39,021–$42,707	24.15%	12.08%	3.77%	7.90%
$42,708–$68,719	31.15%	15.58%	13.43%	16.65%
$68,720–$78,043	32.98%	16.49%	14.19%	17.81%
$78,044–$80,963	35.39%	17.70%	17.52%	20.82%
$80,964–$85,414	39.41%	19.70%	19.88%	23.82%
$85,415–$132,406	43.41%	21.70%	25.40%	28.82%
$132,407–$500,000	46.41%	23.20%	29.54%	32.57%
$500,001 and above	47.97%	23.98%	31.69%	34.52%

Earned Income

Earned income incorporates various types of income, including employment income, rental income (less any losses), self-employment income (less any losses), royalties from publications, and any alimony or separation payments received (less any such payments made by you). The calculation of earned income is often complex and may even require adjustments for certain items, such as professional dues or employment expenses. Furthermore, many sources of income are not covered by the definition of earned income, including investment income, pension income and RRSP or RRIF income.

The importance of *earned income* rests with its impact on RRSP contribution limits. For 2012, the maximum amount you can contribute to your RRSP is equal to 18% of your previous year's earned income (up to a maximum contribution limit of $22,970), plus any unused contribution room from prior years, less any pension adjustments (if applicable). Your 2012 RRSP contribution limit is indicated on your 2011 Notice of Assessment from the Canada Revenue Agency. Finally, please note that, if you are unable to maximize your RRSP contributions in the current year, you may carry forward any unused contribution room to future taxation years.

Employment Income

As employees of a hospital and/or provincial health department, medical residents earn income in the form of *employment income* (i.e., a salary). The employer calculates the deductions owed by the employee (such as income tax, CPP and EI contributions), withholds this amount from each pay, and provides the employee with a cheque for the net amount on a periodic basis. Salaried physicians are paid the same way by their employers.

Self-Employed Income

Most physicians are self-employed; the term *sole proprietor* is also used for independent contractors who have a business relationship with a customer but who also have the right to determine where, when and how their work is done. The proprietor, who must collect revenues and pay expenses, prepares a Statement of Professional Activities (Form T2032) and files this with his/her tax return. In addition, the proprietor will often be required to make regular *tax instalments* to the Canada Revenue Agency for taxes owing.

Although self-employed individuals may not be required to submit EI contributions, special note must be made of the physician's responsibility under the Canada Pension Plan. All self-employed individuals must make CPP contributions up to a maximum annual amount. Because employers must match employees' contributions to the CPP, sole proprietors, including self-employed physicians, must contribute twice the normal share of CPP (i.e., both the employee and employer contributions). However, a deduction equal to one-half of the total CPP paid by the self-employed individual may be claimed as a deduction from net income on their personal income tax return, while the second half of the CPP should be claimed as a non-refundable tax credit.

Investment Income

Investment income is a catch-all term for those revenues (and losses) that arise from the purchase of some asset or financial instrument for purposes of income generation, speculation or realization of a profit. Notable examples include purchase of Canada Savings Bonds, acquisition of shares in a private or publicly traded company, or purchase and rental of a property. Nevertheless, the tax treatment of investment income is dependent on the exact nature of that income. Taxes on capital gains tend to be most favourable, followed by dividends and interest income.

Interest Income

This is interest earned from an investment, such as a guaranteed income certificate (GIC), Canada Savings Bond or short-term deposit. Generally, *interest income* is taxed at 100% of the individual's tax rate.

Capital Gains And Losses

Capital gains are profits realized upon selling certain assets, such as shares in a company. Capital gains are generally calculated as the excess of the proceeds from the sale of the asset, less the asset's adjusted cost base. Expenses incurred on the sale or purchase of the asset may also be factored into the capital gain calculation. In addition, capital gains are generally taxed at 50% of the individual's marginal tax rate. For example, if you purchased a number of shares of stock for $500 and subsequently sold those shares for $1,500, you would realize a capital gain of $1,000. The *taxable capital gain*, however, will be $500 ($1,000 at 50%), and this is the amount that would be included in your tax return.

One may also incur *capital losses*, which are calculated in a similar fashion. Although capital losses are not taxable, the allowable portion (50% of the loss incurred) may be applied against existing taxable capital gains in the current year and, when not fully utilized in the current year, applied against taxable capital gains incurred in any of the three preceding years or in any subsequent years.

Dividend Income

Dividends are income received by shareholders of a company when profits have been distributed to investors. Dividends are further classified as "eligible" and "non-eligible". "Eligible" Canadian dividends are those received by individuals from public corporations and Canadian-controlled private corporations (CCPCs) that have been paid out of business income taxed at the high corporate rate. Dividends received from CCPCs that pay tax at the "small business rate" are classified as "non-eligible" dividends and are treated differently. (Further discussion on these terms and their tax implications is beyond the scope of this text).

Non-eligible dividends from a Canadian company, paid to an individual in the top tax bracket in 2011, are preferentially taxed at a maximum federal-provincial combined rate that ranges from about 27.71% in Alberta to about 41.17% in Prince Edward Island. Eligible dividends attract a maximum federal-provincial combined rate that ranges from about 17.72% in Alberta and the Yukon to about 34.85% in Nova Scotia.

For example, in Ontario, the top marginal tax rate that may be imposed on individuals in 2012 is 47.97%, while the top marginal rate on dividend income is 31.69% and 34.52% for eligible and non-eligible dividends, respectively. This lower tax rate for either eligible or non-eligible dividends reflects the fact that the corporation has already paid tax on the income before distributing dividends to shareholders.

Other Income

Although not necessarily a catch-all for other types of income, the tax definition of *other income* includes certain monies, such as scholarships and bursaries. For 2006 and subsequent taxation years, all amounts received in the year on account of scholarships, fellowships and bursaries may be excluded from income if they are received in connection with the student's enrolment at a designated educational institution in a program to which he or she may claim the education tax credit. (Before the 2006 federal budget, only $3,000 of such income was eligible for this tax-exemption.)

Note: The provisions of the *Income Tax Act* regarding bursaries and scholarships—particularly for those in residency or completing a fellowship—can be confusing. If in doubt, your particular situation should be discussed with your tax accountant.

Tax Credit

A *tax credit*—such as a tuition tax credit, education tax credit or the basic personal exemption—applies a set percentage of the credit amount against an individual's tax liability, regardless of the individual's marginal tax rate. Tax credits are deducted from federal and provincial taxes payable and may save the individual approximately 20% to 27% of the credit amount (depending on their province/territory of residence). The majority of these credits, however, are non-refundable. That is, if the total credits exceed your tax payable, you will not get a refund for the difference.

For example, a taxpayer, resident in British Columbia, who pays $10,000 in eligible tuition fees could apply federal and provincial tax credits totalling approximately $2,200 against his or her current year tax liability.

Tax Deduction

A *tax deduction*, such as an RRSP contribution, reduces one's taxable income, and the actual savings related to this deduction will be at the individual's marginal tax bracket. The higher the individual's income, the more that deduction will save the taxpayer.

For example, a physician in Ontario who earns more than $132,406 but less than $500,000 is in a marginal tax bracket of 46.41%. A $10,000 contribution to an RRSP could see taxes payable drop by $4,641—the marginal tax rate, multiplied by the respective expenditure.

In most instances, a tax deduction is more valuable to the taxpayer than a tax credit for the same amount.

POTENTIAL TAX DEDUCTIONS AND TAX CREDITS

What qualifies as a *deductible expense for tax purposes*? The general rules for deductibility indicate that:

1. expenses have to be incurred to earn income;
2. expenses are reasonable in amount and under the circumstances, and;
3. expenses are allowed (and not specifically denied) by the *Income Tax Act.*

Generally, personal and living expenses, capital expenditures and certain expenses specified by the *Income Tax Act* (e.g., golf club dues) are not deductible for tax purposes. It is important to get professional advice to ensure that you avail yourself of all potential tax deductions and credits. Also, retain any documents (such as receipts and invoices) that support your expenditures, as they may be requested by the Canada Revenue Agency. As a resident or fellow, you will be particularly interested in how the following expenses are treated for tax purposes.

1. **Medical library and equipment.** These are generally not deductible while you are a resident, as you will be considered an employee. Once you begin practice and become self-employed, you may transfer these items to your business at their fair market value. Depending on the nature of each asset, these costs incurred by your practice may be deducted immediately, or will need to be depreciated at specified rates over a period of years.
2. **Personal computer.** Like your medical library and equipment, once you begin to practise and become self-employed, the remaining fair market value of your

computer may be transferred to your business. You will then be able to utilize CRA-prescribed rates to claim capital cost allowance (i.e., depreciation) on the computer for the proportion that relates to business use.

3. **Automobile and travel expenses.** A resident will typically be able to claim a deduction for automobile and related costs if he/she was ordinarily required to work away from the principal place of employment, and also if that resident did not receive a travel reimbursement or allowance. For example, family medicine residents who are required to use their vehicles for house calls should have their employer complete Tax Form T2200 (Conditions of Employment) before filing their tax returns. This form will allow these residents to claim a pro rata share of all eligible expenses related to the operation of the automobile, including depreciation. The pro rata share is essentially the number of kilometres utilized for employment (i.e., the respective house calls), divided by the total number of kilometres driven in the year for both personal and business use.

Note that costs associated with travel directly to and from your principal place of employment are deemed personal in nature and are not deductible for tax purposes. Furthermore, the CRA specifies that all motor vehicle expenses should be supportable by vouchers, and also recommends that taxpayers maintain a log of kilometres driven for business and personal use.

1. **Interest on student loans.** Since 1998, interest paid on negotiated and existing Canada and provincial student loans has qualified for a non-refundable tax credit. The federal Department of Finance confirms that, once such loans have been consolidated—moved to another debt instrument, such as a line of credit or bank loan—any future interest tax credit is not possible

   Students may be eligible to claim interest paid on loans received under the *Canada Student Loans Act*, the *Canada Student Financial Assistance Act*, or similar provincial or territorial government laws for post-secondary education

2. **LMCC Parts I and II.** The fees to write either Part I or Part II of the licensing examinations of the Medical Council of Canada are not deductible for tax purposes and do not qualify for either federal or provincial tax credits.

3. **Certification examinations.** Examinations at completion of a residency program (e.g., College of Family Physicians exams at the end of family medicine or Royal College of Physicians and Surgeons exams at the end of another specialty) are deemed to qualify an individual to practise in a particular specialty. The federal budget of June 6, 2011, effective for 2011, detailed that ancillary fees and charges (e.g., the cost of examination materials) and examination fees for examinations required for obtaining a professional status (e.g., law bar or Chartered Accountant exam) or to be licensed to practise a profession or a trade in Canada are now eligible expenses to claim a non-refundable tuition tax credit. In early 2012, the Royal College of Physicians and Surgeons of Canada (RCPSC) was contacted regarding tax credit eligibility for FRCPC/FRCSC examination fees and, at the time of publication of this document, the RCPSC has confirmed that such fees paid for examinations in 2011 and subsequently will qualify for a tuition tax credit.

   Taxation of CCFP and FRCPC/FRCSC examination fees is a controversial area and a tax specialist should be consulted.

4. **USMLE Parts I, II and III.** The fees to write the United States Medical Licensing Examinations are not deductible for Canadian tax purposes.

5. **Annual dues.** Annual dues paid to the provincial/territorial medical association, the Royal College of Physicians and Surgeons or the Canadian College of Family Physicians, or to the College of Physicians and Surgeons of a particular province or territory, and which are necessary to maintain professional status, are deductible in the current year.

6. **Travel costs for interviews.** You may not claim the cost of travelling to interviews for residency or fellowship positions.

7. **Moving expenses.** Certain moving costs may be deductible, if you have relocated more than 40 kilometres closer to your new place of business, employment or school. These expenses are deductible only against income earned at this new location. Eligible moving expenses that are not deducted may be carried forward to the following tax year. Although you are not required to file moving expense receipts with your income tax return, you must be able to provide them to the Canada Revenue Agency upon request.

8. **CMPA coverage.** The annual membership fee paid to the Canadian Medical Protective Association (less any reimbursement from a provincial or other program) is deductible as an expense against business income earned as a medical practitioner. However, for an employee (such as a resident or salaried fellow) to deduct CMPA fees or other professional dues, the *Income Tax Act* requires that payment of the dues be necessary to maintain a professional status recognized by statute.

Even though CMPA dues are generally required as a condition of employment, this requirement has no bearing on the deductibility of the fees. In provinces other than Quebec, Ontario, Manitoba, New Brunswick, Saskatchewan, Alberta, British Columbia and Newfoundland and Labrador, CMPA dues are not required to maintain a professional status and therefore do not appear to be deductible. (In 2009, the College of Physicians and Surgeons of British Columbia adopted a by-law making it mandatory for their physicians to be either a member of the CMPA or have professional liability insurance.)

For salaried physicians of Quebec, Ontario, Manitoba, New Brunswick, Saskatchewan, Alberta, British Columbia and Newfoundland and Labrador, however, CMPA fees (less any rebate from a provincial reimbursement or other program) should be deductible as professional dues on Line 212 of your federal income tax return. For salaried physicians of the remaining provinces and territories, the net fees paid may be deductible as an employment expense on Line 229 of the federal income tax return, if the physician obtains a completed form T2200 from their employer stipulating that CMPA membership is a condition of employment and the employee does not receive reimbursement for his or her expenses.

Although the deductibility of CMPA premiums for physician employees has been a contentious issue with the CRA in recent years, an April 6, 2006 External Technical Interpretation (2005-0163641E5, Hewlett, Randy), noted that an employee who is required by his employer to buy malpractice insurance may deduct those amounts as an allowable employment expense, provided that the employer certifies this on a valid Form T2200.

Be sure to discuss the deductibility of CMPA premiums with your tax advisor.

Child Care Expenses

With certain restrictions, the costs of day care, babysitters, boarding schools and camps are deductible to a maximum of $7,000 per year for children under seven, and $4,000 a year for kids aged 7–16. The deduction must be claimed from the income of the spouse or common-law partner who earns the least income (except when this individual is at school, disabled, separated from you or in prison) and cannot exceed two-thirds of the spouse's earned income.

Please note that payments for medical or hospital care do not qualify as eligible child care services. Instead, these payments may qualify as medical expenses (if eligible). In addition, as a general rule, you cannot claim fees related to educational or recreational activities (e.g., skating or music lessons). That being said, depending on the circumstances, certain educational or recreational activities may be accepted by the CRA if it can be demonstrated that the primary purpose of the activity is to provide child care, thereby enabling the parent to work. Be sure to speak with your tax advisor for further details.

Retain the proper receipts for child care expenses, or your claims may be denied. Income Tax Form T778 (Child Care Expenses Deduction) should be filed with your tax return.

Tuition Expenses

Tuition fees paid during medical school or a residency program are not deductible, but are generally eligible for the *tuition tax credit.* Obtain Income Tax Form T2202A (Tuition and Education Amounts Certificate) from your university to determine allowable tuition costs. Keep in mind that fees paid for admission, application, confirmation, use of library or laboratory facilities, examinations (including re-reading) and diplomas, as well as mandatory computer service fees and certain academic fees qualify as eligible tuition fees. Other tuition fees (such as for ATLS courses and certain LMCC preparation courses) may also qualify for the tax credit. Be sure to obtain appropriate documentation for these courses from the respective administrators.

In addition to the tuition tax credit, students may also claim an education tax credit. Although full-time medical students can generally claim a federal education tax credit of $400 per month ($120 per month for part-time students), this benefit has not always been available for residents, who were considered to be pursuing post-secondary education in relation to their current employment. The March 23, 2004 federal budget removed this employment restriction, so those residents in an otherwise qualifying educational program may be eligible for the education tax credit for the 2004 and subsequent taxation years, provided that no part of the education cost is borne by or reimbursed by their employer. Generally, you cannot claim the education amount if you:

- received a grant or were reimbursed for the cost of your courses from your employer or another person with whom you deal at arm's length, other than by award money received;
- received a benefit as part of a program (such as free meals and lodging from a nursing school); or
- received an allowance for a program, such as a training allowance.

For further details, please refer to the following link: http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/323/menu-eng.html, or consult your provincial house organization (e.g., PAR-A, PARI-MP, PAR-O, etc.) or tax advisor.

Students are entitled to carry forward indefinitely unused tuition and education tax credits. This will enable students to utilize the credit when they have sufficient income (i.e., during residency). Any amount not used in the current year by the student and not transferred to an eligible person will be automatically available to carry forward. Once income is sufficient to utilize the unused tax credits, however, they must be applied to reduce taxes payable.

Business Expense Summary

Should you become self-employed when you begin practice, you will qualify to deduct a variety of expenses against your business or self-employed income. It is important that you obtain professional advice to ensure that you avail yourself of all eligible expenditures to maximize your allowable deductions, and potentially minimize taxes payable. Expenses must be incurred for the purpose of earning income and must be reasonable. In addition, be sure to retain all vouchers and/or receipts that support these expenditures. Some deductible business expenses incurred by self-employed physicians include:

1. Accounting and legal fees
2. Advertising and promotion
3. Specified amounts for meals and entertainment (see below)
4. Annual medical licence fees and certain professional dues
5. Bank charges
6. Interest on office loans and lease payments on assets used for business purposes
7. Convention expenses (for tax purposes, you are generally allowed to deduct two conventions per year)
8. Maintenance and repairs for the office and equipment
9. Professional development
10. Capital cost allowance on your professional library
11. Office expenses
12. Capital cost allowance on specific capital expenditures (e.g., medical equipment or leasehold improvements on your office)
13. Salaries and employee benefits
14. Utilities: heat, lights, power and water related to the business
15. Insurance: malpractice, office and practice overhead
16. Certain travel expenses related to your practice
17. Home office, in certain circumstances (see below)

Travel Expenses

Self-employed physicians who use an automobile for business purposes may claim a deduction for a percentage of the operating costs related to the vehicle, including fuel, oil, maintenance and repairs, insurance, licence fees, registration and interest on a car loan. To do so, it is very important to keep a travel log, in which you record your use of the vehicle for business purposes.

To obtain the allowable business percentage of expenses, divide the total business kilometres by the total kilometres travelled in the year. Note that travel costs related to driving to and from your principal place of business (e.g., from your home to your office) are generally not deemed eligible expenses.

If you have purchased your vehicle, you can claim capital cost allowance within limits specified by the *Income Tax Act*. If the vehicle is leased, there will be limits on the deductible leasing costs.

If you use a vehicle for business purposes, you should review allowable expenditures for tax purposes with your accountant.

Home Office

A physician may deduct costs associated with a home office if it is his/her principal place of business, or if the space is used only to earn business income and it is used on a regular basis to see patients. This is a challenging area of tax law, and recent pronouncements in the tax literature have addressed this topic. Seek professional advice if you believe you may qualify to deduct a home office.

Meals, Entertainment And Promotion Expenses

Entertainment expenses, as defined by the *Income Tax Act*, are only 50% deductible—which means that those in the top marginal tax bracket could see a reduction in their tax liability equal to almost 25% of the total entertainment expenditures if these expenses are claimed on their income tax return. *Practice promotion expenses*, however, are 100% deductible, resulting in a potential reduction in tax equal to almost 50% of the expenditure made at your top marginal tax rate.

Taking an associate to dinner to discuss a particular case qualifies as an *entertainment expense*. Tax law does not consider that this warrants full deductibility and the tax deduction for such expenses is limited to 50%.

It is wise to consult a professional about how to claim such expenditures.

The Importance Of Professional Accounting Advice

Because doctors are among the top 10% of income earners in Canada and our income tax system is inherently complex, physicians are strongly advised to have a qualified tax accountant as a member of their professional advisory team. A qualified accountant should act in your best interest to ensure that your taxes owing are minimized and that your family's after-tax take-home pay is maximized.

Calculation Of Taxes Owing

Most physicians are sole proprietors, or self-employed professionals. For tax purposes, there is no distinction between a proprietor and an individual. Residents of Canada, for tax purposes, are taxed on their world income, and their taxable income includes not only business income but also income from all other sources (e.g., salary, interest or taxable portions of capital gains). For a simplified diagram, demonstrating how federal and provincial taxes payable are calculated, see Appendix 1.

Tax Instalments

Unlike employees, sole proprietors—which describes many physicians—do not have income tax taken off a paycheque and withheld at source by an employer. As such, the payment of instalments is the only method by which the Canada Revenue Agency can collect income taxes throughout the year. The payment of tax instalments for individuals must be made on March 15, June 15, September 15 and December 15 of each fiscal year.

Generally, the CRA requires instalment payments if the difference between a taxpayer's combined federal and provincial taxes payable (before applying any instalments) and total amounts withheld at source regularly exceed $3,000 year after year. More specifically, if you owed more than $3,000 on your federal return in either of the two preceding years, and you expect to owe more than $3,000 for the current year, you are technically required to make instalment payments for that current year. Also, if you are a resident of Quebec, the federal threshold of $3,000 is reduced to $1,200 in order to reflect the fact that the Ministry of Quebec will collect its own instalment payments. Generally, the CRA will send reminder notices to individuals who may be required to make instalment payments.

The *Income Tax Act* allows taxpayers to select one of three methods to calculate their required instalments.

Method 1 (Second Prior Year Method)

Each of the required March 15 and June 15 instalments is equal to one-quarter of your total tax liability two years ago. The September 15 and December 15 instalment amounts are calculated by reducing your total tax liability for the immediately preceding year by both the March 15 and June 15 instalments, and dividing this result by two. Confusing? Let's try an example (a table, explaining this case example, is available as Appendix 2).

Case Example: Second Prior Year Method

Dr. White, a vascular surgeon, completes his residency in 2010 and begins practice on July 1, 2010. His self-employed net income for the remainder of 2010 totals $100,000. Overall, his total federal and provincial tax liability for 2010 is approximately $35,000.

In 2011 Dr. White finds his net income increases to $200,000, with a federal and provincial tax liability of $76,000. In 2012 his net income reaches $250,000, which incurs a total tax liability of approximately $99,000, while professional income of $300,000 in 2013 results in a tax liability of approximately $122,000.

What will Dr. White's required tax instalments be for the 2010 to 2013 taxation years?

For the year 2010: Because Dr. White was still a resident in 2008 and 2009, it is very likely that sufficient income taxes were withheld from his paycheques in order to ensure that his yearly tax liabilities did not exceed $2,000. If we assume that Dr. White's tax liabilities in 2008 and 2009 were nil, he will not be required to make instalment payments for 2010. Instead, Dr. White dutifully remits $35,000 to the CRA in April 2011 when filing his tax return for 2010. Dr. White could have voluntarily made instalment payments throughout 2010 in order to reduce the need to make such a large lump-sum payment in April 2011.

For the year 2011: In 2009, we assumed that Dr. White's tax liability was nil; however, in 2010, Dr. White's tax liability was $35,000. As Dr. White owed more than $3,000 in one of the two prior years, and as he expects to owe well in excess of $3,000 for 2011, he will be required to make instalment payments. By using the second prior year method, the March 15 and June 15 instalment payments in 2011 will each be nil (equal to one-quarter of the 2009 tax liability of nil) while the September 15 and December 15 instalments would each be $17,500—equal to the 2009 tax liability of $35,000, less the two first instalments of the year [i.e., nil], divided by two). Because he paid instalments throughout the year, in April 2012, when filing his 2011 tax return, Dr. White will be required to pay the remaining tax liability of $41,000 ($76,000 of tax liability, less $35,000 of instalments).

For the year 2012: The 2012 instalment requirements will be calculated similarly to the calculations in 2011. For 2012, Dr. White's March 15 and June 15 tax instalments will be the amount of his tax liability for 2010 (second preceding year), divided by 4, or $8,750 ($35,000 ÷ 4). His September 15 and December 15 instalments, however, will be calculated at $29,250 each ($76,000 [his tax liability for 2011 before instalments], less the March 15 and June 15 instalments [$8,750 + $8,750], divided by 2). Overall, after having paid these instalments during 2012, Dr. White will be left with a tax liability of $23,000 payable (tax liability of $99,000 tax payable, less instalments of $76,000 [$8750 + $8750 + $29250 + $29,250]) in April 2013, when filing his 2012 tax return.

For the year 2013 and subsequent years: Dr. White's March 15 and June 15 instalments will be his tax liability before instalments for the second preceding year ($76,000 in 2012), divided by 4, or $19,000 each. His September 15 and December 15 instalments will be $30,500 each (the taxes payable for 2012 before instalments [$99,000], less his March and June 2013 instalment payments [$19,000 each], divided by 2).

Method 2 (Prior Year Method)

This method calculates each of your quarterly instalments as one-quarter of your total federal and provincial tax liability (before any tax instalments) for the immediately preceding year.

In Dr. White's case, this method would entail equal quarterly instalments of $8,750 for 2011 ($35,000 ÷ 4); $19,000 for 2012 ($76,000 ÷ 4); and $24,750 for 2008 ($99,000 ÷ 4).

Method 3 (Current Year Method)

This method lets taxpayers estimate their tax liability for the current year and submit equal quarterly payments accordingly.

You may choose the method that will result in the lowest quarterly instalment amount. If you choose Method 1 (second prior year) or Method 2 (prior year), you will avoid assessed interest and penalties, as long as your payments are properly calculated and are made on time. If you choose Method 3 (current year), however, be aware that deficient payments may result in interest and penalties—particularly if you underestimate your actual income and submit insufficient instalments.

These rules, particularly Method 1, will allow a newly graduated physician to delay payment of any tax related to self-employment income for nearly a year, and regular instalments may not start until the second full year of business. Many newly practising physicians commonly fail to save the money required for taxes, however, and once they are required to make instalments or a payment when filing a tax return, find their savings are insufficient to meet these obligations.

Many physicians wisely subscribe to the 40/30/30 rule. For every $100 earned, $40 stays in the business account to cover overhead costs, $30 is set aside in a bank account dedicated to fund income tax obligations, and $30 is kept by the physician as after-tax disposable income. You may want to consider adopting this prudent practice at the outset of your career and modify this general guideline as you see fit.

Calculating tax instalments can be complicated and many rules apply. Graduating residents should obtain the services of a tax advisor as soon as possible to ensure that they are maintaining all necessary records and satisfying all statutory requirements, including instalments.

Key Message

It is important to choose the best method of paying tax instalments, keep accurate financial records and set aside the appropriate funds each quarter to meet your tax obligations. The professional advice of a tax accountant is invaluable to a newly graduated physician setting up medical practice.

INCORPORATION

A corporation is a distinct legal entity. It is a separate taxpayer for purposes of the *Income Tax Act*, owned by shareholders and managed by directors. A corporation earns revenue from many sources, incurs expenses and can offer benefits to employees and shareholders.

In Canada, the taxation of a corporation is different from the taxation of an individual. The *Income Tax Act* allows certain types of income earned by a corporation to be taxed at a lower rate than the tax rate imposed on a physician who earns income from the same sources personally. Whereas, in 2012, the top marginal tax rate for an individual in Canada ranged from 39% in Alberta to almost 50% in Nova Scotia, the combined federal and provincial tax rate on the first $400,000 of active business income earned in Canada by a Canadian-controlled private corporation (CCPC) ranged from about 11% in Manitoba to 19% in Quebec. This lower corporate tax rate is commonly referred to as the *small business tax rate*. Although income earned by a corporation may be taxed at this lower rate, additional taxes are incurred at the level of the individual taxpayer once funds are withdrawn from the corporation (usually by way of salaries or dividends).

By the inherent concept of "integration", an individual who earns income within a corporation and pays tax at the small business tax rate but immediately withdraws all the net earnings directly as salary or dividends will generally incur about the same total taxes as if he or she had earned, declared and paid tax on this income as an individual. Although application of the concept of integration may suggest no advantage to incorporation, there may in fact be significant benefits for physicians, particularly through *tax deferral* and *income splitting.*

In simplistic terms, *tax deferral* may be achieved when corporate earnings, which are taxed at the small business tax rate, are retained within the professional corporation instead of being immediately distributed and likely taxed at a shareholder rate. Tax deferral essentially allows for the investment (and therefore growth) of funds that would otherwise have been paid to the taxation authorities. Furthermore, tax deferral can create significant tax savings if the funds are withdrawn from the professional corporation at a time when the shareholder is in a lower tax bracket, such as during retirement or a sabbatical. The following tax-deferral example is presented for illustrative purposes only.

Case Example: Tax Deferral
In 2012 Dr. Merry, a resident of Ontario, earns taxable income of $200,000 and pays approximately $73,000 in federal and provincial income taxes. However, Dr. Merry has identified that his current lifestyle needs require a yearly income of approximately $100,000.

If Dr. Merry decides to incorporate his medical practice, the corporation's net income would be approximately $100,000 (equal to the $200,000 professional income, less a $100,000 salary paid to Dr. Merry). Assuming that the corporation earns only active business income, it would pay approximately $15,500 ($100,000 times the 15.5% tax rate) in corporate income taxes, leaving $84,500 in the corporation. Dr. Merry, on the other hand, would be taxed on his $100,000 salary and would therefore be subject to a tax liability of approximately $27,000, assuming he earns no other income and has no other deductions.

The combined taxes paid by the corporation and by Dr. Merry would be approximately $42,500 ($15,500 + $27,000) in comparison with the $73,000

that Dr. Merry would have paid had he earned all income personally (without a corporation). Dr. Merry now has an additional $30,500 in savings within the corporation, which he can use to invest, or even to pay off business-related debt.

It is important to point out, however, that additional tax will be owing once the $84,500 retained in the corporation is distributed to Dr. Merry. Ideally, these future distributions will occur at a time when Dr. Merry is in a lower tax bracket than his current bracket, such as during a sabbatical or in retirement.

Incorporation is not for everyone, and several other factors must be considered when evaluating its benefits and consequences. For example, there could be additional costs related to incorporation that could reduce (or even eliminate) any tax-deferral advantage. It is important to discuss the incorporation decision with your financial consultant, as well as with your tax and legal advisors.

The potential income splitting benefits that are available through incorporation will vary between provinces, as allowed non-physician family member shareholders of a medical corporation vary between provinces and territories.

Case Example: Income Splitting
Dr. and Mr. Jones are residents of British Columbia. Dr. Jones has decided that her spouse, Ben, who has no other income, will own non-voting shares of her professional corporation. Although Dr. Jones is in the top marginal tax bracket of approximately 43.7% for British Columbia, Ben will not incur tax at this top marginal rate until he reports approximately $132,400 of taxable income. Dr. Jones currently earns professional income of $200,000 per year. As the Joneses have a large mortgage on their personal residence, they require as much income as possible to pay for personal expenses and also to maintain current lifestyle needs. Finally, for 2011, Dr. Jones must receive a salary of at least $124,700 ($22,450 RRSP maximum contribution limit for 2011, divided by 18%) in order to continue maximizing RRSP contributions for 2012.

Let's assume that the corporation pays Dr. Jones a salary of $125,000 and then distributes any surplus corporate earnings to Ben. Assuming the corporation qualifies for the small business tax rate, it would be subject to tax of approximately $10,125 ($75,000 times the 13.5% tax rate) on its taxable income of $75,000 ($200,000 taxable income, less $125,000 salary). The remaining corporate earnings available to be distributed as a dividend to Ben would be $64,875 ($75,000, less $10,125).

Depending on the province, by virtue of the dividend tax credit, a taxpayer with no other income may earn up to approximately $30,000 in dividends without incurring any tax. If taxed personally on the entire $200,000 of professional income, Dr. Jones would have incurred a tax liability of approximately $68,000. If the corporation instead pays Dr. Jones a salary of $125,000, however, and pays Ben a dividend of approximately $65,000, Dr. Jones would incur a personal tax liability of about $36,000, while Ben would pay tax of about $4,800, assuming he has no other income or deductions. Overall, this strategy would result in combined personal and corporate taxes of $50,925 ($4,800 paid by Ben, $36,000 paid by Dr. Jones, and $10,125 paid by the corporation). This results in tax savings of $17,075 ($68,000, less $50,925), in comparison with the $68,000 Dr. Jones would have paid had she earned all of the income personally.

This strategy is called *income splitting.* Dr. Jones has been able to split income that was subject to tax at her top marginal tax rate in order to have it taxed in the hands of her spouse at a lower tax rate. The ability to have family members as

shareholders in a physician's professional corporation is determined by the provincial/territorial legislation and, as such, opportunities vary depending on the province or territory of residence. Furthermore, there are rules in place to discourage the implementation of certain income splitting strategies with minor children. Consult your tax advisor in order to determine the appropriate salary/dividend mix for your family.

In addition to tax deferral and income splitting, other benefits may be available. Nevertheless, incorporation may not be to every physician's advantage. A thorough cost-benefit analysis is necessary to determine whether incorporation is worth considering. When this module was prepared, physicians were allowed to incorporate in all Canadian provinces and territories except Nunavut. Because legislation, legal requirements and the costs and benefits are specific to each province and territory, any physician who is considering incorporation is strongly advised to get professional advice from tax and legal advisors.

Goods And Services Tax (GST)/Harmonized Sales Tax (HST)

The Goods and Services Tax (GST) is a value-added tax, levied by the federal government. The combined Harmonized Sales Tax (HST), also a value-added tax, is a single, blended combination of the PST (provincial sales tax) and GST, which is used in British Columbia,[2] Ontario and the Atlantic provinces of New Brunswick, Newfoundland and Labrador, and Nova Scotia. The HST is then collected by the Canada Revenue Agency, which then remits the appropriate amounts to the participating provinces.

Insured services and many other medical services are GST-exempt. This precludes physicians from having to register for GST/HST or charge and collect GST/HST. This also means that any GST/HST a physician pays on expenses or supplies is not refundable as an input tax credit (or ITC). However, the GST is deductible from income for tax purposes. In order to treat GST properly, you must have good accounting and bookkeeping practices that keep track of all expenditures.

Some physicians, however, should be wary. Certain activities—such as witness fees for court appearances, or surgical procedures that alter or enhance a patient's appearance but have no medical or reconstructive purpose and are not covered by provincial/territorial health plans—are not GST/HST-exempt. If the revenues from such non-exempt activities exceed $30,000 in any 12-month period or in any single quarter, the physician would be required to register for a GST/HST number and collect and remit GST. If in doubt, review your particular circumstances with a qualified accountant.

Until a few years ago there were unusual GST/HST implications for physicians who performed locums. In November 2000, however, the tax rules were modified so that the host doctor no longer has to charge GST/HST to the doctor who is providing locum coverage. A properly worded locum contract may eliminate potential GST/HST liability; the key is to state that the locum doctor has entered into a fee-sharing agreement with the host doctor, rather than paying a percentage split for services provided by the host doctor. To minimize and potentially eliminate GST/HST liabilities, have your tax accountant and/or lawyer review any locum contract you are considering.

[2] It is noted that, as a result of a provincial referendum in 2011, the residents of British Columbia rejected the HST and voted to go back to the separate federal GST and old provincial sales tax; the structure of the tax and exact details of the implementation of the provincial sales tax are still unclear at the date of publication of this document.

Income Splitting

As discussed earlier, *income splitting* is the practice of shifting income subject to a high marginal tax bracket to family members who may be subject to lower marginal tax brackets. By splitting income in this manner, you can minimize the income tax paid by the family as a whole. While income splitting may be possible by way of family member shareholdings if you incorporate your medical practice, income splitting is also a possibility for non-incorporated physicians.

Example: If a doctor, resident in British Columbia, earns $200,000 and his/her spouse does not collect a salary for working at the medical office, this is what the tax liabilities will look like.

Tax Situation Without Income Splitting			
	Doctor	**Spouse**	**Total**
Income	$200,000	Nil	$200,000
Taxes	$68,000	Nil	$68,000

If the physician decides to pay the spouse a salary of $50,000 for working at the office, their tax liability will shift.

Tax Situation With Income Splitting			
	Doctor	**Spouse**	**Total**
Income	$150,000	$50,000	$200,000
Taxes	$46,000	$ 9,000	$55,000

By splitting income between the physician and spouse, the family has taken advantage of the spouse's lower tax bracket and saved $13,000 ($68,000, less $55,000) in income taxes. Note that when salaries are paid to family members, they must have actually done the work and received the remuneration. In addition, the remuneration must have been reasonable compensation for the services provided and the services must have been related to your practice.

There are other methods of split income, including:

1. **Higher-taxed spouse pays family bills.** Family bills are necessary and, unfortunately, are non-deductible expenses. If the higher-taxed spouse pays these bills, the lower-taxed spouse will retain the maximum amount of personal funds. Earnings on the subsequent investment of these funds will be in the hands of the lower-taxed spouse, reducing the overall tax cost for the family.

2. **Lower-taxed spouse invests his/her annual income.** Because income on investments outside an RRSP are generally taxable, having the obligation for the majority of these investments assumed by the lower-taxed spouse will ensure that subsequent earnings will be taxed in the hands of the lower-taxed spouse. This practice will minimize subsequent income taxes for the family as a whole.

3. **Bona fide loan to spouse.** A higher-taxed spouse may loan a lower-taxed spouse money as a bona fide loan. Then the lower-taxed spouse can invest the loan funds and earn income. If the loan is properly structured, the subsequent income will be taxed in the hands of the lower-taxed spouse and will not be attributed back to the higher-taxed spouse. The following conditions must be met, however:

- The loan is genuine and is documented by a written note.
- There is a documented schedule for loan interest repayment and a clearly defined term for the duration of the loan.
- The interest charged is reasonable and consistent with the market interest rate (see below).
- The interest charged is fully paid within 30 days of the end of the calendar year.

Please note that the market rate designated on bona fide loans to a spouse are set by the Canada Revenue Agency as a specific prescribed rate each quarter. If this strategy appears advantageous to you, ensure that you obtain the services of a qualified tax advisor prior to implementation.

Gifts to children under 18. If a physician makes a gift to a child under age 18, any interest or dividends the child earns on this gift will be attributed back to the physician, who will incur the tax at his or her marginal tax rate. If these funds are invested by the minor and subsequently sold, however, any resulting taxable capital gain will be taxed in the hands of the minor, and not attributed back to the higher-taxed physician.

Gifts to children over 18. If a physician makes a gift of money to a child over age 18, any interest or dividend earned by the adult child will be taxed in his or her hands and will not be attributed back to the parent.

4. **Spousal retirement savings plan.** There are two main tax advantages to spousal RRSPs. First, in the event that you can no longer contribute to an RRSP because of your age but you still have earned income or contribution room available and you have a younger spouse or common-law partner who is still eligible to have an RRSP, you can continue making RRSP contributions through a spousal plan.

   Second, you and your spouse or common-law partner will be able to split income upon your retirement and reduce the overall tax burden for the family unit secondary to marginal tax rates. For 2007 and subsequent years, however, a similar income splitting benefit can be achieved without a spousal RRSP; for 2007 and later years, you and your spouse or common-law partner can agree to split up to 50% of your spouse/partner's eligible pension income under certain restrictions and upon filing the appropriate elections with your tax returns.

Before You Begin Practice

Before you complete residency, you are strongly advised to find a qualified accountant to be a part of your professional advisory team. Meet with the accountant prior to beginning your medical practice to ensure:

1. You are implementing the appropriate books and records to keep track of your personal and professional finances.
2. Business bank accounts that are separate from your personal bank accounts are established.
3. You understand the accounting methods, and that you have trained staff who will keep track of all revenue and expenditures from the outset.
4. Practices are in place to ensure that appropriate money is set aside from all revenue to cover your overhead costs and tax obligations.

5. You have a schedule of the amounts and dates of any required instalment payments to the Canada Revenue Agency.

6. Regular meetings are set up with the accountant.

7. You have a detailed list of the documents you will need to provide to your accountant at specified times in the year: bank statements, cancelled cheques, computerized bookkeeping statements, paid and unpaid invoices, billing remittances and uninsured revenue listings, payroll journals, and copies of any and all leases.

8. Your accountant has reviewed and implemented all applicable tax planning strategies to enable you to minimize your tax paid and maximize after-tax take-home income for you and your family.

SELECTING AN ACCOUNTANT

Choosing the right accountant is one of the most important financial decisions that a physician will make. Although this professional may not be able to increase your total billings, a knowledgeable professional accountant will maximize the amount of income that ultimately remains in your hands. Establishing and maintaining a proper accounting system and effective tax planning are essential aspects of medical practice management, and are necessary components of personal financial planning. Although you may be familiar with some tax strategies, such as RRSPs, there are many other issues on which an accountant can provide invaluable expertise: incorporation, income splitting, tax planning and GST/HST requirements, to name a few.

Although every community has "tax specialists" and "accounting services providers", physicians should engage an accountant who has earned one of the professional designations—certified general accountant (CGA), certified management accountant (CMA) or chartered accountant (CA)—and who specializes in taxation.

Key Message

Seek advice from a professional accountant before you start medical practice to ensure that you implement the best practices for accounting, record keeping and financial management from the beginning of your career.

The best way to select an accountant is by recommendation from your peers. Talk to your colleagues. Would they recommend their accountants? Have their accountants saved them money? How much? Do their accountants seem to be up to date on the changing tax environment? Have they ever had problems with their accountants? A good accountant does not limit your interaction to having you sign your personal tax return in April of each year. A worthy accountant meets with you several times a year, optimizes any potential tax savings before December 31 of each year, and is always available to discuss concerns or opportunities.

In addition to word-of-mouth recommendations from colleagues, each MD Management office provides a list of local accountants who are recommended by other physicians. Once you have a few recommendations, it is wise to meet with the individuals. In the meetings, describe your financial situation, medical practice and objectives. Determine what each would propose to help you optimize your situation and increase your after-tax take-home income. Ask up front what the accounting services will cost and whether this accountant, or a junior or associate in the firm, will be doing most of the work.

ACTION PLAN

- **Learn and understand basic accounting terminology and concepts.**
- **Familiarize yourself with Canada's income tax system and how it applies to physicians.**
- **Obtain the professional services of a knowledgeable tax accountant.**
- **Set up appropriate record keeping for accounting and taxation purposes.**
- **Be diligent about setting aside money to pay income tax and overhead costs.**
- **Maximize your disposable income and personal net worth through good financial management and tax planning.**

RESOURCES

Resources online at cma.ca/pmcresources:

- Tax Tips For The Physician And Physician In Training

Resources available from MD Financial Management:

- A Guide to Incorporating Your Medical Practice

APPENDIX 1: HOW FEDERAL AND PROVINCIAL TAXES PAYABLE ARE CALCULATED

The following is a simplified demonstration of how federal and provincial taxes payable are calculated.

How Federal And Provincial Taxes Payable Are Calculated				
	Federal	**Provincial**	**Total**	**Notes**
	Total income			Includes income from all sources (e.g., salary, net business income, interest, dividends, taxable capital gains, pension income)
Less	Deductions			Examples include RRSP contributions, moving expenses, child care expenses, professional dues, etc. (See Note 3.)
Equals	Taxable income	Taxable income		See Note 1.
Multiplied by	Federal tax rates	Provincial tax rates		See Table 1 for federal tax rates. Provincial tax rates are set by each province and territory.
Equals	Federal taxes	Provincial taxes		
Reduced by	Federal tax credits	Provincial tax credits		Examples include basic personal tax credit, tuition, education, medical expenses, CPP and EI tax credits. (See Note 3.)
Equals	Federal taxes owing	Provincial taxes owing (Note 2)	Total federal and provincial taxes owing	

Note 1. All provinces and territories except Quebec use the federal definition of taxable income.

Note 2. Ontario, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, and the Yukon levy provincial surtaxes, which are added to provincial taxes owing.

Note 3. See the definitions of tax credit and tax deduction.

Note 4. This table is presented for illustrative purposes only and does not necessarily encompass all relevant and required calculations needed to complete an individual income tax return.

APPENDIX 2: THE SECOND PRIOR YEAR METHOD OF CALCULATING TAX INSTALMENTS

Case Example: Dr. White And The Second Prior Year Method Of Calculating Tax Instalments[3]				
	2010	**2011**	**2012**	**2013**
Self-employed net business income	$100,000	$200,000	$250,000	$300,000
Combined taxes payable	$35,000	$76,000	$99,000	$122,000
Instalments				
March 15 instalment	nil	nil	$8,750 ($35,000 ÷ 4)	$19,000 ($76,000 ÷ 4)
April 30 payment of previous year's taxes		$35,000 payable on 2010 personal tax return	$41,000 payable on 2011 personal tax return ($76,000 taxes payable, less instalments of $17,500 and $17,500)	$23,000 payable on 2012 personal tax return ($99,000 taxes payable, less instalments of $8,750; $8,750; $29,250; and $29,250)
June 15 instalment	nil	nil	$8,750 ($35,000 ÷ 4)	$19,000 ($76,000 ÷ 4)
September 15 instalment	nil	$17,500 ($35,000 ÷ 2)	$29,250 ($76,000 – [$8,750 + $8,750]) ÷ 2	$30,500 ($99,000, less [instalments of $19,000 + $19,000]) ÷ 2
December 15 instalment	nil	$17,500 ($35,000 ÷ 2)	$29,250 ($76,000 – [$8,750 + $8,750]) ÷ 2	$30,500 ($99,000, less [instalments of $19,000 + $19,000]) ÷ 2

[3] The "combined taxes payable" amounts are presented for illustrative purposes only. Actual amounts will vary between provinces and according to the taxpayer's specific facts and circumstances.

Module 5:
Legal Issues For Physicians

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

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Key Learning Points

- *Why you need legal advice*
- *Finding a good lawyer*
- *Contracts*
- *Wills, powers of attorney and healthcare directives*
- *Other personal legal issues*
- *Professional contracts*
- *Medico-legal Issues*

INTRODUCTION

During medical school and residency, some physicians develop an aversion to dealing with lawyers. The unfortunate reason may be that, in the isolated world of clinical training, most talk of medico-legal interaction involves the issue of malpractice. That first call or letter from a lawyer is likely to spark a sense of paranoia among medical students and residents!

The truth is that lawyers are much more than the agents of malpractice nightmares—they also play a very important role on your professional advisory team. Physicians are experts in medicine, not law. Just as a family physician seeks the expert advice of specialist colleagues to assist in patient care, all physicians should seek a lawyer's expert legal advice on personal and professional issues in order to protect themselves and their families.

This module will provide an overview of the essential legal services required by all physicians, and make suggestions for an action plan to address the legal issues you may face now and in the future.

FINDING A GOOD LAWYER

As in any professional or business sector, the recommendation of a satisfied client is the best source of referral. Ask colleagues, peers and trusted teachers for the name of a lawyer that they use and would recommend.

Another great resource is the MD Financial Management professional referral list, which is available to all students, residents and practising physicians in Canada. A subsidiary of the Canadian Medical Association, MD Financial Management has financial consultants across the country who routinely ask their physician clients for the names of local lawyers and accountants they would recommend to others. Before adding anyone to the referral list, the MD regional manager interviews the recommended professionals to ensure that they are suitable for physician clients. If you are new to a community, the professional referral list gives you a place to start. It is still your responsibility, however, to make contact and interview the prospective lawyer or accountant. You should interview a few professionals to ensure that you are comfortable with their approach and style. Many will not charge for a preliminary interview, but it is wise to ask about fees in advance.

Your provincial medical association will also have resources available to assist you with professional legal issues.

What You Should Expect To Pay

Like many professionals, lawyers charge an hourly fee or per diem based on the type and scope of work that they perform. It is important to ask the lawyer for a breakdown of his/her fees. Lawyers are accustomed to being asked for such details, and are generally very good about explaining their fee schedules. Do not be surprised to see charges for telephone conversations, emails, faxes and photocopying. The price of some legal services, however, such as the preparation of a will, may be based on a completed document.

Proactive legal advice is much cheaper than reactive legal representation—in other words, lawyers are much less expensive than lawsuits. And, like physicians, lawyers should be fairly remunerated for their training and expertise.

Don't be "penny conscious and dollar foolish". Having legal advice before you sign any contract can save you time, money, stress and the mental anguish you will suffer if you must settle unanticipated conflicts. An experienced lawyer can foresee pitfalls and recommend solutions to be included in the contract before problems ever occur.

Key Message

Seek the expertise of a lawyer for all of your professional and personal legal affairs. Proactive legal advice is less expensive than reactive legal representation.

Can One Lawyer Advise Me On All Of My Legal Issues?

Just like medicine, law has its generalists and specialists. It is advisable to establish yourself with a lawyer you trust and who will refer you to expert colleagues for complementary legal services as needed. For example, you may have one lawyer to complete a house closing, and another who specializes in employment and contract law to help you evaluate a practice opportunity.

Interview Your Prospective Lawyer

It is important to interview your prospective lawyer. Verify in advance if you will be charged for this interview. Although many lawyers do not bill for this initial meeting, don't let a professional fee keep you from finding the right lawyer. The objective of the interview is to discover how experienced the lawyer is with the personal and professional issues that physicians face. You also want to feel comfortable with your legal advisor, confident that he/she will act in your best interest.

Questions To Ask Your Prospective Lawyer:

- How many years have you been in practice?
- What areas of law do you specialize in?
- Do you have ready access to partners/colleagues who can complement your expertise to meet my requirements, such as a lawyer specializing in contract law?
- Do you have several physician clients? Are you familiar with the issues they face?
- What are key points to look for in contracts that physicians commonly need, such as group practice contracts, contracts with institutions and employment contracts?
- How quickly can I see you if an urgent matter arises?
- Can I consult you by email or telephone?
- Would I work with your partner if you are not available?

CONTRACTS

What Is A Contract?

A contract outlines, in writing, the terms and conditions of a contractual relationship between two or more parties. It should clarify what each party will give and receive from the contractual relationship. If there were never any conflicts, if all parties honoured their obligations and if new variables never occurred, then a detailed contract would be unnecessary—but this is rare! A comprehensive contract anticipates and addresses all of the "what ifs" of a contractual relationship. For example:

- What if my associate uses 50% of the medical supplies and staff resources but pays only 33% of the costs?
- What if I am not happy with sharing staff? Will my associates agree to allow for "dedicated" staff?
- What if a group member fails to honour his or her obligations? What are our options to resolve this issue?
- What if I decide to move in three years but our lease is for five years? What will my obligations be to the remaining group members?
- What if I want to upgrade our electronic medical records in one year? Will the group agree now regarding how we will proceed in the future?

Like a great physician, a great lawyer will have learned from past experience and will be better able to anticipate the "what ifs" that may arise in the contractual relationship. If the "what ifs" are anticipated, alternatives and solutions can be determined in advance, saving valuable time, money and stress. Experience and contingency planning will also reduce animosity if conflicts do materialize.

SCENARIOS

Personal Legal Scenario: Rick And Ann

Medical residents Rick and Ann plan to be married in two months and will complete their residencies in one year. Rick, a general surgeon, expects to join a four-member associated group practice. The practice is located in an office building two blocks from the community hospital in the small city where Rick and Ann want to live. Ann, a family medicine resident, plans to do locums and sessional work initially, because the couple plans to start a family soon. A group practice in the same city hopes that Ann will join them as an associate.

Personal Legal Scenario: Beth

Beth, a PGY-5 in obstetrics and gynecology, is single and plans to do locums and maternity leave coverage for two to three years until she finds the right location for her long-term practice.

What personal and professional legal issues should Rick, Ann and Beth address? Are Beth's requirements different from Rick's and Ann's? If so, how are they different?

In any situation involving a signed contract, one should consider obtaining professional legal advice. Why? Because physicians are notorious for not reading their contracts. You might not call your lawyer for small issues, but a contract is different: When you sign a contract, you are responsible to meet the obligations and accept the benefits as detailed in the document.

Every individual will potentially be dealing with the same personal legal issues:

- Wills, financial powers of attorney, and healthcare directives
- Cohabitation or marriage contracts and other family law issues
- Real estate transactions

WILLS, POWERS OF ATTORNEY AND HEALTHCARE DIRECTIVES

During our Practice Management Seminars, which we've conducted since 1997, we have informally surveyed more than 10,000 medical residents and have found that:

- The vast majority of single medical residents do not have a will, financial power of attorney or healthcare directive (sometimes called living wills, and, in various provinces, called powers of attorney for personal care; directives; representation agreements; or mandates).
- Of greater concern, 50% of married residents with children did not have an updated will.

Sadly, surveys as recent as the spring of 2012 indicate that this scenario has not changed.

Ask yourself this question: How many times has your care of a critically ill patient been compromised or complicated because the patient had not assigned a healthcare directive?

Rick and Ann definitely should update their wills, financial powers of attorney and healthcare directives. The cost is minimal. They should then cue themselves to review and update their wills upon any significant personal or financial change of circumstances—having children, for instance—or at least every five years afterwards.

Does Beth need a will if she has no dependants? Many residents who were polled in our seminars believed a will is unnecessary for single individuals with no dependants. Although there may be an argument for this view, it is shortsighted—there is a difference between *need* and *should have*. Everyone should consider the purpose of a will.

Why You Should Have A Will

The purpose of a will is to appoint an executor to administer one's estate, to direct the payment of debts and taxes, and to bequeath one's estate to loved ones. You may not think you have an estate today, but that will not always be true. Are you taking into consideration any life insurance or inheritance you might receive before you die?

A will acts as a directive to assist loved ones and dependants in carrying out one's wishes after death. A will can also protect loved ones and dependants from unnecessary financial liability or loss. If you die without a will, the province will appoint someone as your executor, and he/she will distribute your assets in accordance with a plan set out in provincial legislation—which may or may not reflect your wishes.

Being single with no dependants doesn't mean Beth is not concerned about how her affairs would be handled in the event of her death. It is advisable for her to get a will, financial power of attorney and healthcare directive now—but, should Beth defer this, she should reconsider the matter at least once each year.

When writing a will, you will need to appoint trusted executors to carry out your directives. Most people name a family member (typically a spouse) or close friend. You should also appoint alternates in the event that your first executor dies or is not competent at the time of your death.

In deciding on the terms of disposition of your estate, consider alternative gifts in case your primary beneficiary dies. If you have minor children, you may create trusts in your will to hold their assets until they reach the age of majority or older. As your estate grows, your lawyer can advise you about the benefits of "spousal trusts", other estate-planning vehicles and creditor protection mechanisms.

Also ensure that you purchase life insurance to provide for your spouse and children in the event of your untimely death. Your lawyer can review with you the best way to designate a beneficiary for the insurance.

Powers Of Attorney

If one has an up-to-date will, death is a somewhat straightforward scenario to address. One's burial wishes are honoured and the estate is managed by trusted executors in accordance with the will's provisions. But what would happen if you became mentally incompetent? A power of attorney for financial affairs and a power of attorney for personal care will provide for this scenario. In these documents, you can appoint someone to act on your behalf for management of your finances and property, as well as personal care. Although there is little likelihood that illness or injury will render a young physician temporarily or permanently mentally incompetent, it is wise to prepare for every contingency.

You should assign powers of attorney for property and personal care to your trustees when you prepare your will. Always verify that the trustees you choose are comfortable with this responsibility. To complement your power of attorney for personal care, you should also prepare a living will to express your healthcare directives in the event that you are terminally ill and not mentally competent to speak for yourself.

Ethicists at the University of Toronto have produced an excellent guide, titled *The University of Toronto Joint Centre for Bioethics Living Will.* This guide is available online; go to www.utoronto.ca/jcb and click on the living will link.

Key Message

Every adult needs to have an up-to-date will, power of attorney and healthcare directive.

What About Your Parents?

Have your parents updated their wills, powers of attorney and healthcare directive? If not, encourage them to do so. It will be in everyone's best interest.

Do-It-Yourself Will Kits

We recommend that you seek a lawyer's advice to properly prepare and customize your will and power of attorney. The peace of mind is well worth the money.

OTHER PERSONAL LEGAL ISSUES

Cohabitation And/Or Marriage Contracts

Should Rick and Ann consider a marriage contract? What if there is a significant discrepancy in their individual net worth or debt load? What if one partner has a large inheritance, or will come into a lot of money after they are married? Will there be potential problems if they subsequently separate?

Once thought to be appropriate only for the rich and famous, cohabitation/marriage contracts are a good idea for most couples to consider today. Statistics show that at least one in three marriages ends in divorce, and the negotiations for equitable separation can be extremely costly for both parties, financially and emotionally. Legal advice, mediation counselling and duplication of households are among the many expenses that will be incurred.

It may not be romantic to discuss the "what if we separate?" scenario with one's significant other, but both parties are best served if they at least make an informed decision about a cohabitation/marriage contract.

Real Estate Transactions

Rick and Ann, and possibly Beth, will probably consider purchasing a home within the year. This is a big financial and lifestyle decision. They will be dealing with a real estate agent who will broker their offer. They should also involve a lawyer, however, as soon as they are interested in making an offer, and not rely solely on the real estate agent to represent their interests. A real estate lawyer should review any offer to purchase, then complete the transaction to ensure that the title is free and clear of any liens, easements or restrictions in use. A lawyer will also advise the best way to hold title to the real estate—in your name only, or with another as tenant-in-common or joint tenant.

Apartment Leases

An apartment lease is also a complicated legal contract that typically favours the landlord, not the tenant. There is rarely little room for negotiation for a domestic lease, but read the contract and seek legal advice if you have any questions or concerns.

Professional Contracts

The intent of this module is to provide an overview of the many situations in which a physician should obtain legal advice. The various contracts listed below are addressed in more detail in other modules, including: *Module 9. Principles Of Negotiation; Module 10. Evaluating Practice Opportunities: Family Medicine; Module 13. Evaluating Practice Opportunities: Specialists;* and *Module 1. Getting Started As A Professional.*

Beth, Rick and Ann will deal with several different contracts during their professional careers. One way to look at professional contracts is to consider the four spheres in which physicians are active, because contractual issues will arise in each area:

- People you work with and for
- Physical plants in which you work
- Equipment and service providers
- Patients you serve

Contractual Relationships With The People You Work With And For May Include:

- Locum contracts
- Professional service contracts
- Group practice contracts (i.e., association or partnership contracts)
- Employment (salary) contracts
- University teaching contracts
- Institutional service contracts
- Contractual agreements for research grants
- Contractual agreements with provincial governments for fee-for-service remuneration
- Alternative payment plans with the government, institution or university
  - Family health networks (FHNs) or family practice groups (FPGs)
  - Alternative funding plans for academic teachers to complement or replace fee-for-service remuneration
- Professional incorporation (see *Module 4. Personal And Professional Accounting And Taxation*)

Contractual Relationships With The People Who Work For You Include:

- Staff employment contracts
- Services provided by contractors

Contractual Relationships For The Physical Plant May Include:

- Commercial lease for the office or clinic
- Purchase agreement for a medical building or condominium arrangement
- Access and utilization of hospital, institution, office and/or clinic space
- Admitting privileges and access to operating room time

Contractual Relationships With Service And Equipment Providers May Include:

- Leasing and service agreements for computer systems, communication systems and major equipment (e.g., for radiology or ophthalmology practices)

Contractual Relationships With Your Patients May Include:

- Patient contracts, which are now recommended, so patients acknowledge and accept the terms of the office policies, services and procedures

Individual practice profiles, location and specialty will determine which of the above contractual relationships apply.

Rick will require legal advice when he is negotiating an association agreement with the established surgeons to address his obligations for overhead costs and services. His lawyer should review the existing lease to ensure that his name is included. Rick should verify that there is an option to renew the lease. He should also interview the existing staff and negotiate for additional or replacement staff, if required. If he plans to hire his own staff, he will be negotiating an employment contract with prospective employees. If Rick decides to terminate the employment of one or more staff members, his lawyer should verify that Rick satisfies all of the requirements of his province's *Employment Standards Act*. Rick also will be negotiating for hospital privileges and operating room time. If he is responsible for providing his own equipment, his lawyer and accountant should review the purchasing or leasing contracts. Finally, Rick should have his lawyer review any existing leases of the association's group, as he will be assuming some responsibility when he becomes an associate of the practice.

You Do The Negotiation, Not Your Lawyer

It would be too expensive to pay a lawyer to negotiate all of your contracts. In some instances, the lawyer's role is merely to advise you and review the contract to ensure that all of the "what ifs" have been addressed. In other circumstances, your lawyer may actually draft the contract, based on your instructions, and negotiate with the other party and his/her lawyer.

Contractual Complexity Of Salaried And Academic Practice

A common misconception of physicians—family doctors and specialists alike—who plan to work in a university setting is that they will have less onerous contractual obligations and responsibilities than their colleagues who work in fee-for-service settings. In fact, a physician who plans to work in an academic environment is well served by enlisting the services of a lawyer who specializes in contract and employment law. The academic may be negotiating simultaneously with the university, the hospital and the chief of the department. There will be complex remuneration formulas, based on individual "shadow fee-for-service" billings for clinical services, as well as the stipend for teaching, research and administrative work. All of this may need to be budgeted within the global funding given to the university in an alternative payment plan (see *Module 8. Physician Remuneration Options).*

All contracts should be signed at the same time to avoid any loose ends.
See *Module 9. Principles Of Negotiation; Module 10. Evaluating Practice Opportunities: Family Medicine; Module 11. Locums: Negotiating A Mutually Beneficial Locum Contract;* and *Module 13. Evaluating Practice Opportunities: Specialists*, which address and elaborate on the evaluation of short- and long-term practice opportunities.

Key Messages

Proactive legal advice that addresses the "what ifs" in advance will save you money and protect your interests. Always have your lawyer review a contract before you sign it.

RESOURCES

Examples of personal and professional contracts can be found on cma.ca/pmcresources.

Medico-Legal Issues

Canadian physicians have access to medical malpractice insurance via the Canadian Medical Protection Association (CMPA). Legal advice and representation is provided for issues that arise from the treatment of Canadian patients. The CMPA does not cover issues arising from the treatment of patients who are not Canadian, however. The mechanism to address this scenario is explained in *Module 3. Personal And Professional Insurance.*

Action Plan

- **Establish yourself with a lawyer.**
- **Obtain or update your will, powers of attorney and healthcare directive.**
- **Have your lawyer review any contracts you may have signed without legal advice.**
- **Ask your teachers about contracts they have signed. What mistakes have they made? What did they fail to anticipate? What would they add, delete or change if they could?**
- **Review all of your legal affairs annually.**
- **Consult cmpa-acpm.ca for all medico-legal issues.**

Module 6:
Medical Records Management

Association Médicale Canadienne
Canadian Medical Association

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plans to best fit their personal and professional aspirations. You are advised to consult with professional advisors to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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Key Learning Points

- *Why physicians must maintain good medical records*
- *How long must doctors keep their records?*
- *What are the regulatory standards for medical records?*
- *31 self-assessment questions that demonstrate the medical records standards of regulatory colleges*
- *Privacy legislation and medical record-keeping*
- *Practical advice for using paper records*
- *EMR: The electronic medical record and the future of medical record-keeping*

INTRODUCTION

The medical record is the most important practice tool used by physicians, regardless of specialty, because it supports and enhances the care that our patients receive. It is also a legal document that details the care you provide to your patients, and acts as a record of your billing practices. In the event of a random or specifically indicated review of a physician's medical or billing practice, the medical record will come under scrutiny. The medical review committees of the regulatory Colleges of Physicians and Surgeons and the health ministries base their decisions primarily on the medical record without interpretation by the physician.

As a resident, you deal with patient records every day. What percentage of your written or electronic medical records would meet regulatory standards as legible, comprehensive and stand-alone documents? When we informally poll residents attending Practice Management seminars, they typically indicate that only about 50% of the charts they work with would, to the best of their knowledge, pass a medical review committee audit. This is not acceptable from a learning perspective, a care perspective, and especially not from a medical liability perspective. All physicians have a vested interest in ensuring that their medical records meet provincial licensing standards. Unfortunately, many medical training programs still do not offer formal instruction on the best-practice standards needed to maintain the structure, content and legal requirements of medical records.

In developing this module, the author has drawn from personal knowledge and experience as an expert witness for the prosecution for the College of Physicians and Surgeons of Ontario (CPSO), from his own experience of having his office and medical records reviewed by the CPSO Peer Assessment Program in a random review, and now as a Peer Assessor for the CPSO.

Note that this module will address, in detail, the principles, policies and practice of excellent medical record-keeping that applies to either paper or electronic record management systems. *Module 7: Electronic Medical Records* will address EMR issues in much greater detail.

The author acknowledges that the key resource for the development of this module is the excellent and comprehensive CPSO administrative policy statement #4–12 *Medical Records,* last revised and approved June 2012 and published by the CPSO. This latest policy update addresses in detail the many issues that are unique to electronic medical records (also see Resources, below).

WHY PHYSICIANS MUST MAINTAIN GOOD MEDICAL RECORDS

There are five reasons to keep comprehensive medical records for every patient.

First and foremost, a comprehensive medical record enhances and supports the patient-centred care the patient receives.

More specifically, we must maintain good medical records:

- to provide an accurate and complete account of the history, examination, investigations, treatment plan and ongoing progress of the patient;
- to assist colleagues when they are consulted or are assuming care for your patients;

- to facilitate the preparation of chart summary, insurance and medico-legal reports; and
- to defend and protect the best interests of the physician and patient in the event of a review by the provincial licensing body or Ministry of Health billing review agency, and especially in the event of a malpractice action.

As an account of the patient's medical history. Considering the number of patients you will deal with over an extended period of time, it is essential that you take the time to ensure that your medical records are comprehensive, accurate, legible and complete. This applies to all physicians, whether you provide ongoing care for the patient or are brought in only for periodic assessments and consultations. Relying on your memory is a formula for disaster.

As a reference for colleagues. A comprehensive record with a clear, well-organized history and workup assists colleagues who cover for your occasional absences, or who see your patients in consultation. They will save valuable time and healthcare resources if they can avoid redundant investigations and medication trials. If you have clearly documented the next medical management steps in the chart, you can also reduce the chance that another physician will drastically change the treatment plan. Not only will you save your colleagues time, your comprehensive record will make their interaction with your patient more clinically effective and financially rewarding.

As a reference for official reports. A comprehensive, well-organized medical record will also help you to prepare reports efficiently and effectively. This will save you time (and thus generate income), especially when the preparation of a medical report is non-insured. For example, a request from an insurance company for an attending physician report can easily be prepared and dictated in five minutes if your chart has an up-to-date cumulative patient profile and medication flow sheet. In most provinces, the payment for this non-insured service was about $110 in 2010. A family physician would be hard-pressed to generate $110 for any other 15-minute service. For consultants, a copy of the comprehensive consultation report with some additional comments is often sufficient, saving the need to create a completely new report.

As evidence in a medical record audit. When physicians accept their independent licence to practise from a provincial College of Physicians and Surgeons and their billing number from the provincial Ministry of Health, they agree to comply with and be accountable to all of the rules, regulations and standards of both regulatory bodies. The college or ministry can request copies of your records from any clinical encounter, at any time, for a random review. If the college review reveals that either your record-keeping or the care documented in these records is substandard, then a more formal review will be initiated and disciplinary action can be mandated. If a Ministry of Health review of your record does not justify the fees you submitted for that clinical encounter, then a more formal review may follow and you can be required to reimburse the ministry for all alleged overbilling. This can be catastrophic, and all costs for defending and appealing a Ministry of Health decision will be your responsibility.

Disciplinary reviews. You can best defend yourself and your actions in a malpractice suit or formal review of billing practices if you have medical records that stand alone without your interpretation. Comprehensive documentation and legible record-keeping are essential.

Key Message

Physicians are required to keep accurate, comprehensive medical records that will stand alone without their interpretation. In addition to meeting medico-legal requirements, good medical records will assist you and your colleagues in offering comprehensive, effective and efficient care for your patients.

HOW LONG MUST PHYSICIANS KEEP MEDICAL RECORDS?

For certainty, reference your own province's regulations, but, in many jurisdictions, the following rules apply:

- 10 years after the last entry, or
- 10 years after the patient would have reached 18 years of age, or
- until the physician ceases to practise (subject to, in the Ontario example, subsection 2 of the *Regulated Health Profession Act*, which states that a family physician who ceases practice must transfer the records to a colleague with the same address and phone number, or
- notify each patient that records will be destroyed in two years unless the patient requests transfer of their records to another doctor).

Note that legal claims against physicians can be made up to 15 years after the alleged incident occurred, so the CMPA advises doctors to keep their records for 15 years after the last encounter.

Many family doctors who cease practice either are not aware of these requirements, or fail to follow the rules. As one can imagine, it would be very costly to contact every patient by phone or mail if the retiring doctor cannot find a physician to assume the practice. Ignorance is not a defence, however. There are now several companies that offer medical record storage and retrieval for physicians who close their practices or retire. Ensure that you verify that such a company meets your college requirements, especially if the company is located out of province. Some provincial medical associations administer a medical record storage and retrieval service for retiring family physicians, making records available to patients who request their medical information.

Because the rules for specialists are not specifically clarified, all consultants are advised to meet the requirements for GPs when applicable and clarify the best-practice standards with their specialty-specific advisors from the provincial regulatory colleges.

WHAT ARE THE REGULATORY STANDARDS FOR MEDICAL RECORDS?

The rules, regulations and standards for medical records are similar across the country. In this learning module, we will use the College of Physicians and Surgeons of Ontario guidelines to exemplify the rules and regulations. Readers are encouraged to visit the website of their own regulatory college to learn about variations that may exist in their home province.

What Must Be Included In A Medical Record?

There are clear guidelines for medical record-keeping in general and family practice across Canada. Specialty-specific guidelines are now being addressed, so consultants should contact the provincial college for advice on the standards that reviewers would expect to find in an audit of records and consult reports.

The basics are the same for all physicians, however. Although the guidelines apply to both traditional paper and electronic medical records, this discussion will focus on traditional hard-copy charting systems. Specific resources for EMR are included in the Resources section below, and in our dedicated *Module 7* on EMR.

In Ontario, for example, should the College of Physicians and Surgeons audit your medical records, the peer reviewer will use several assessment tools as the basis for evaluation. These are outlined in detail on *cpso.on.ca/members/peerassessment*. Similar protocols are used throughout the country. The quality of your medical records, as well as the quality of the medical care chronicled in the records, will be assessed and rated.

Each of the criteria will be rated on a scale, such as: present all of the time, most of the time, some of the time, infrequently. The assessor will then summarize the key components of the review of your medical records in one of four levels:

- Appropriate
- Appropriate with suggestions
- Concerns
- not applicable

After the results are summarized and reviewed with you, the assessor will make recommendations. Mandatory remedial work and medical record-keeping upgrade courses may be required if your records do not meet the criteria most of the time. If your quality of care is questioned, then a formal review will be initiated. The same process is followed when the college investigates a complaint lodged by a patient.

Self-Evaluation

Auditing your own medical records is an excellent self-directed learning experience, as well as a tool to help you prepare for a peer assessment. The College of Physicians and Surgeons of Ontario has prepared an excellent self-assessment tool that includes 31 questions. These self-assessment questions are useful to physicians in any province.

Self-evaluation: Assess Your Own Medical Records: CPSO policy statement # 4–12 Medical Records; Appendix C:

When applying the following questions—do your records meet each criteria all of the time, most of the time, or need improvement?

1. Is each individual patient file readily retrievable?
2. Is the record readable to any and all reviewers?
3. Is the patient's name on all components of the chart?
4. Are the patient's name, age, sex and address clearly shown on the chart?
5. Is the date of each visit recorded?
6. Are the family history, past history and functional inquiry (including significant negative observations) clearly recorded and maintained?
7. Are allergies clearly documented?
8. Are immunization records clearly visible?
9. Is a cumulative patient profile (CPP) summary sheet present and maintained?
10. Is the chief complaint clearly stated?
11. Are the durations of symptoms noted?

12. Is there an adequate description of symptoms present?
13. Are positive physical findings recorded?
14. Are the significant negative physical findings recorded?
15. Is there clear documentation of the requested lab and X-ray investigations?
16. Are consult requests noted, and is there documentation that the consult has been arranged?
17. Is the diagnostic impression or differential documented?
18. Are the treatment plan and follow-up instructions clearly noted?
19. Are medication doses and duration of use noted? Are medication amounts and number of repeats noted?
20. Are dated progress notes clearly evident?
21. Are pathology reports retained?
22. Are hospital discharge summaries retained?
23. Are operative notes maintained?
24. Is there documented evidence that periodic health assessments are being performed?
25. Is there evidence that health maintenance issues are periodically discussed; e.g., smoking, alcohol and drug use, obesity?
26. Is there clear evidence that the physician does a review of ongoing medication use; e.g., for chronic medical problems?
27. Is there a system in place to clearly show that all lab tests come to the attention of the physician (i.e., does the physician initial all lab reports)?
28. Is there evidence that an appropriate follow-up appointment has occurred after the receipt of an abnormal lab report?
29. Do all physicians clearly indicate their entries in the chart by signing or initialling their names?
30. Are pediatric growth charts evident?
31. Are provincial antenatal forms used?

DISCUSSION AND SUGGESTIONS

Disclaimer: The author offers the following comments and suggestions for consideration. All attempts to meet best practice standards have been made. Readers need to refer, however, to their specific college policy and guideline statements, and contact their college 'physician advisory service' whenever in doubt.

Before specifically discussing the CPSO's "Self Evaluation Tool", it is important to address a significant hurdle that all physicians must overcome, and that is the timeliness of clinical documentation, It is essential to document all clinical

information as soon after the encounter as possible to ensure accuracy and completeness. Regardless of the method—dictating, typing or writing—develop good habits and procedures to promptly complete your notes.

The following comments apply to traditional paper charts. For electronic medical records (EMR), the principles are the same. More specific information is available in the *CPSO Policy statement # 5–05 Medical Records*, and *PMC Module 7,* which is dedicated to EMR.

1. Is each individual patient file readily retrievable?
Your medical records must be accessible and organized for ready retrieval. In addition to protecting the privacy of the records, you are required to have office policies that ensure patient confidentiality, and which are clearly available to all patients. These regulations are set out by federal and provincial *Health Information Protection Acts*. The federal *Personal Information Protection and Electronic Documents Act (PIPEDA)* has been widely publicized since coming into effect on January 1, 2000, but, because health care is regulated provincially, your practice must meet the standards of your province's customized health information protection legislation. Most provinces are currently using the *Personal Health Information Protection Act (PHIPA)* 2004 for their standards.

Chart retrieval should be possible in one of three ways: by looking up the patient's name, chart number or health insurance number. Lateral filing with colour-coding for each chart is the most efficient storage format. Files should be stored in cabinets that can be closed, or at least are located in secure areas where there is no public or patient traffic. Reception staff and file clerks should be able to access them in a timely and ergonomically efficient manner.

You can use either alphabetical or numerical coding. Small group practices that offer ongoing care typically find the one-step alpha system to be the most effective. Staff locate charts by looking on the label flap for the first three letters of the last name, which are tabbed with stickers. Obviously, some alphabetical filing is still required for patients with the same name, and yes, filing errors do occur. This system is also more expensive (stickers and initial chart preparation), but the staff time it saves is worth it.

The numerical system that employs pre-numbered charts is simpler and cheaper to set up. Charts generally have five coloured digits, starting at 00001, and are purchased in units of consecutive numbers up to 50000 or more. Filing errors are minimized with this two-step system, but chart retrieval and filing requires much more staff time. The only place that the patient's name and chart number appear together is in a computer database, so someone has to use the computer to cross-reference the name and chart number so that the file can be pulled. Lab and consult reports also have to be cross-referenced, unless the labs and diagnostic departments agree to include your patient's chart number when they send you the results. If a file clerk handles 120 charts per physician daily, and it takes 10 seconds more to cross-reference the chart number, then 20 more minutes of filing time is required. Pulling charts for other purposes, such as dealing with pharmacy requests, will also take time.

The numerical filing system is generally recommended for consultants who do not see the same patients on a regular or ongoing basis. In larger family practice or specialist clinics, with clerical staff dedicated to medical record management, the numerical system will also make more sense.

Year labels, which indicate the last time the patient was seen, are essential. This makes it easy to purge the patient charts that are not current, and cues you when to dispose of a chart. A quick glance at an orderly filing area can indicate how current and dynamic the practice is. Family doctors may want to use the primary filing area for charts of patients seen within the past three years, moving the more dated charts to a secondary filing area until they meet the criteria for shredding. This will ensure that the primary filing area is efficient.

2. Is the record readable to any and all reviewers?
There is no defence for having illegible records. Yet, how often have you received a copy of an emergency encounter, or reviewed an admission or consult record, and not been able to understand all that was written? How often have you had to go to the order sheet to figure out what was done? Do not copy substandard record-keeping habits!

Dictate, dictate, dictate: All physicians should consider dictating, or at least typing, their medical records. Dictation is cost effective—in fact, a family physician who currently writes legible, comprehensive records on 30 patients a day could reduce the amount of time spent on record-keeping by at least one hour by dictating instead. That hour could be used to see four or five more patients—the income from which would greatly exceed the cost of a medical dictatypist, or have more time for lunch, or go home earlier.

Voice-to-print technology has also come a long way, and many specialists use it for consults and office records. Although typing the medical record yourself is better than handwriting it, generally, this is not good use of a physician's time. For every minute that you type, are you saving the same amount of money that you would generate if you saw another patient? Studies have shown that dictation is still more cost effective than even voice-to-print. For most physicians, a combination of writing/typing and dictation would be most practical.

3. Is the patient's name on all components of the chart?
This labelling is often forgotten when the physician or staff member adds a new progress sheet to the paper chart. Unfortunately, paper charts can fall on the floor and get mixed up.

4. Are the patient's name, age, gender, MOH number, contact numbers and address clearly shown on the chart?
Medical billing systems will have patient registration and label-maker functions that can make this task more efficient and effective. It is essential that, at every visit, staff ensure that this information is up to date.

5. Is the date of each visit recorded?
This is essential so that billing records can be cross-referenced with clinical records. Date stamps are cost effective, easy to use and available at any business supply store.

6. Are the family history, past history and functional inquiry (including significant negative observations) clearly recorded and maintained?
The past history and family history should be included in the up-to-date cumulative patient profile (CPP) that is typically taped on the inside front cover of the chart folder.

The functional inquiry is a standard part of the daily progress notes, and should be comprehensive enough to address red flags and significant positives/negatives. You may use short forms, as well as your own standardized use of common

abbreviations, such as HEENT NAD, URI and UTI. These are acceptable as long as you can provide a glossary of customized short forms to the reviewer.

7. Are allergies clearly documented?
These should be noted in the CPP. If the patient has allergies to medications, it is a good idea to also document these in the cumulative medication profile (CMP) and on the front of the chart, with orange caution labels to cue the medical office staff.

8. Are immunization records clearly visible?
It is easy to customize ink stamps to document immunizations. This is especially important if you care for children and are responsible for the delivery of primary immunization. Stamp and date the routine immunizations on the front or back of the chart for quick reference when parents ask you to complete school forms. Document immunizations in the progress notes or pediatric growth and assessment records, noting the date given, the lot number, expiry date of the immunization, the injection site, and whether the immunization was given intramuscularly (IM) or subcutaneously (SC).

9. Is a cumulative patient profile (CPP) summary sheet present and maintained?
Maintenance of an up-to-date CPP summary sheet is critical and can save you lots of time when reviewing the ongoing care of a patient. Your CPP can make the preparation of reports very time efficient and income effective. There are several formats available, such as those provided by the College of Family Physicians of Canada, which you may customize. The CPSO, for example, also provides a list of what should be included.

Having an up-to-date CPP will also facilitate the transition to an electronic medical records program, if and when you choose to do so.

10. Is the chief complaint clearly stated?

11. Are the durations of symptoms noted?

12. Is there an adequate description of symptoms present?

13. Are positive physical findings recorded?

14. Are the significant negative physical findings recorded?

15. Is there clear documentation of the requested lab and X-ray investigations?

16. Are consult requests noted, and is there documentation that the consult has been arranged?

17. Is the diagnostic impression or differential documented?

18. Are the treatment plan and follow-up instructions clearly noted?

Questions 10–18, as well as Question 20 and the functional inquiry portion of Question 6, address all of the essential components that you must include in the progress notes to document each patient encounter.

Regulatory colleges encourage the use of the "SOAP" format (Subjective/Symptoms, Objective/Observations, Assessment and Plan) in the medical record, as long as it is legible and addresses all of the essential questions. Short forms can be used, and reference to the CPP can reduce redundant documentation (e.g., CPP reviewed and UTD [up to date]).

You can either use ink stamps that summarize physical examinations or the complete examination form. One advantage of the physical exam stamp is that it enables you to chronologically document the annual or periodic health exam in the

progress notes without having to file, reference and organize a separate, complete examination sheet every time. If you use a stamp, include the areas that were examined, and whether the findings were normal or abnormal. It is good practice to complement the use of a stamp with specific comments on significant positive and negative findings. See Appendix 1 at the end of this module for an example of a physical examination stamp.

16. Are consult requests noted, and is there documentation that the consult has been arranged?

Consult letters should be copied and filed in the chart, along with a notation that the consult has been made and the patient notified. It is increasingly difficult to do this when consultants ask to review your request and then contact the patient directly, but the family physician is still responsible for closing the loop. If the consultant follows this practice, clearly indicate in your request that the consultant's office must advise your office when the patient will be seen. The components of a good consult letter are discussed later in this module (see *Hospital Charting And Operative Reports*).

19. Are medication doses and durations of use noted? Are medication amounts and number of repeats noted?

Medications must be noted in the progress notes, and we recommend that you establish a dedicated flow sheet to track all medications prescribed. Ideally, the medication flow sheet or cumulative medication profile (CMP) will be filed just after your last progress note. Note the medications vertically in the left-hand column, indicating dosage and frequency of use. On the right are several vertical columns, where you document renewals, amounts and number of repeats. The medication flow sheet allows for easy periodic review of the patient's medications, as well as for cross-reference when the patient or pharmacy calls to request renewals. This record is very helpful for accountable billing when you renew prescriptions by telephone.

20. Are dated progress notes clearly evident?

See discussion of Question 6.

21. Are pathology reports retained?

22. Are hospital discharge summaries retained?

23. Are operative notes maintained?

Physicians are obliged to review, initial and keep any medical record that involves their patient, even if it was not requested. When you request past medical files, we recommend that you do not request a copy of the entire chart. Specify the information you really want and need.

24. Is there documented evidence that periodic health assessments are being performed?

It is impossible to offer all patients an annual check-up, and doing so is not evidence-based for most patients. It is important, however, for the comprehensive family physician to encourage and document periodic health exams. Make the documentation effective and efficient by using forms or ink stamps, an updated CPP and CMP.

The CPSO Policy Statement #4–12 offers more detailed advice as to what documentation is expected for a periodic health exam. Ministries of health may use this reference when auditing for appropriate billing.

25. Is there evidence that health maintenance issues are periodically discussed; e.g., smoking, alcohol and drug use, obesity?

It is both effective and efficient to provide patients with standardized information sheets for specific health maintenance issues; plus, it saves you from having to rewrite the same information in each chart. Instead, a medical record entry might read *"Osteoporosis info sheet reviewed and given to patient".* Information sheets for lipid counselling and low-cholesterol diets, diabetic diets, smoking cessation, contraception counselling, vasectomy, diarrhea treatment, fever management, hormone replacement therapy, etc., are very valuable to patients and can be an extension of your medical record. You should document or photocopy any customization of advice for the chart.

26. Is there clear evidence that the physician does a review of ongoing medication use; e.g., for chronic medical problems?

Maintaining an up-to-date medication flow sheet makes this monitoring easy, effective and efficient. Document your review of the CMP in your progress notes; e.g., *"Cumulative Medication Profile (CMP) reviewed and updated".*

27. Is there a system in place to clearly show that all lab tests come to the attention of the physician?

As a physician, you are obliged to review and initial all information that you receive that applies to patients. This includes the reports of all tests and consults you have ordered, as well as any medical information that you receive but which you did not personally order. Accordingly, no medical information should be filed in the patient's chart until you have reviewed and initialled it. College reviewers will pay particular attention to this detail.

Are you responsible if you order a test and do not receive the results?

Yes. Physicians who order a test or make a consultation are responsible for closing the loop, so it is important to have a system in place to verify that you have received, reviewed and acted appropriately upon all tests ordered. The importance of this medico-legal responsibility was highlighted by the Canadian Medical Protective Association in its June 2004 CMPA Information Letter (Vol. 19, No. 2, IL0420E). The article is titled *Follow-up from lab reports and tests: A key to patient safety.*

How can I establish policies and procedures to audit and capture overdue tests and consult reports?

The traditional paper medical record system does not provide an easy solution, so you will require a strict protocol to monitor the receipt of tests and reports.

Charts awaiting results can be set aside in a dedicated "results pending" area of your medical records. It can sometimes take several days or weeks, however, to receive the results, and you may need the chart in the interim, so we recommend that you flag charts to indicate that tests are pending. Use colour-coded tabs or inserts that stick out beyond the edge of the chart so that, when they are re-filed, it is easy to see which charts have reports outstanding. Use dedicated colours to indicate the first to fourth week of the month. When a chart flag indicates that it is two or three weeks since the test was ordered, staff can try to track down overdue results. When the report is received, the flag is removed.

Staff can maintain a daily log of all tests ordered, cross-referenced with the appointment schedule, but this is very time-consuming to do manually. It will be easier if you are completely computerized and linked electronically with all of your labs, diagnostic centres, hospitals and consultants. Closing the loop on results

pending/overdue is one of the many advantages of electronic medical record systems. If all users and providers are linked, it is easy to implement programs that track overdue results.

28. Is there evidence that an appropriate follow-up appointment has occurred after the receipt of an abnormal lab report?

Physicians are responsible for contacting and advising their patients of all abnormal tests. To do so, it is essential to establish strict office policies. First and foremost, no report is to be filed unless the physician has initialled it and signed off for filing. In the case of abnormal test results, the physician is obligated to write clear instructions for staff on the report. When the follow-up is completed, staff initial and date that the order was carried out.

Case example: Abnormal test result. Abnormal PAP test received. Physician writes: "*Contact patient to review within 1 week*" and places the chart in the staff in-box. Staff contact the patient, then date and document "*Patient notified*" on the report. Ideally, the date of the appointment is also noted. If the patient does not attend the appointment, further measures must be taken to contact the patient (e.g., registered letter). All efforts to contact the patient must be documented.

29. Do all physicians clearly indicate their entries in the chart by signing or initialling their names?

Whether your office uses a paper system or an electronic medical records program, each physician must sign or initial his/her entries. This is essential when more than one doctor is documenting patient care in the medical record. EMR systems provide a mechanism to record signatures electronically.

30. Are pediatric growth charts evident?

This is a must for family doctors and pediatricians, but pre-formatted flow sheets, developed by Dr. James Rourke and Dr. Leslie Rourke, make the task easy. *The Rourke Baby Record: Evidence Based Infant/Child Health Maintenance Guide* is appended to the CPSO Medical Records document (see the Resources section).

31. Are provincial antenatal forms used?

Up-to-date, standardized provincial antenatal forms cue the attending physician to assess all prenatal risks and to offer the best care.

Additional Questions To Ask Yourself

In addition to the questions asked by regulatory colleges, there are additional questions that you should ask and answer when you do a self-audit of your medical record-keeping.

Are all phone-call prescription renewals noted in the chart?

It is important for physicians to document all evaluations and treatments provided indirectly or by telephone. Records should be maintained in both the daily reception phone log and the chart's medication flow sheet.

Do office staff make a note in the medical record of any telephone advice that you have directed them to offer?

An example of this would be documentation that the patient has been contacted by telephone with instructions for their continued use of coumadin. Use of patient-specific INR flow sheets, kept in a dedicated INR treatment binder, makes this easy. This is an extension of the patient's personal medical record, and enables you to discard all of the individual INR lab reports once the results are transcribed to the flow sheet. This record, as well as your appointment scheduler and your staff's daily phone log, must be retained for the same duration as the primary medical record.

Key Message

Develop good record-keeping habits at the outset of your medical career. Responsible, careful physicians can effectively and efficiently maintain excellent medical records, especially with dictation or voice-to-print, to the benefit of themselves and, most important, their patients.

Do you record telephone consults with home care workers, specialists, etc.?
Document and retain a record of all care you offer by telephone and fax. When you are on call, you should also retain your on-call log book, or save the record of encounters and instructions that you have documented electronically, such as on a personal digital assistant (PDA).

Are relevant emails and other electronic communications recorded?
Importing or recording of all types of patient encounters and related communications that pertain to patient care must be documented.

Are diagnostic and billing codes noted at each visit?
Because your medical record must stand alone to justify all of the billings you submit to the Ministry of Health, documenting your diagnostic and billing codes is an excellent exercise. This will help you to avoid overbilling for limited services.

HOSPITAL CHARTING AND OPERATIVE REPORTS

Medical record requirements are the same, regardless of where the service is offered, or how many physicians and caregivers are documenting care. Physicians can best protect their own interests, as well as those of their colleagues and patients, by keeping excellent medical records.

Referral Letters

It is extremely important and beneficial for family physicians to provide their consultant colleagues with clear and concise referral letters. When making a consultation request:

- Ensure that the referral letter is legible (ideally, typed).
- Ensure that the consultant receives the letter prior to the patient's assessment.
- State the purpose of the referral clearly, and lay out specific questions to be answered.
- Summarize the patient's history and evaluation to date.
- Include your diagnostic impression, so that your consultant can offer constructive comments.
- Include copies of all appropriate investigations; and

- Clarify whether you are requesting a one-time consultation, shared care or transfer of care.

Consultation Reports

The consultation letter or report should be typed and, like all medical records, stand alone as a record of evaluation, investigation and treatment. Referring physicians appreciate it when consultants assist in the care of the patient by responding with:

- a consultation report within two weeks of the initial assessment;
- a telephone call report when urgent issues must be addressed;
- a follow-up report when all investigations are completed;
- a clear, comprehensive but concise summary of the consultant's assessment and diagnostic impression;
- clear direction regarding the recommendations for investigation, treatment and follow-up plans;
- copies of all investigation reports;
- answers to specific questions posed in the referral letter; and
- recommendations for further evaluation by other consultants when indicated.

As a consultant, you can greatly assist your referring physicians when you provide timely reports. This enables the referring doctor to reinforce your recommendations and address questions that patients may not have fully understood when they saw you.

HEALTH INFORMATION PROTECTION GUIDELINES

The rules and regulations about privacy protection in physicians' offices and clinics were significantly upgraded with the enactment of the federal *Personal Information and Electronic Information Documents Act (PIPEDA)* on April 13, 2000. Healthcare regulations that all physicians are obliged to follow fall under provincial jurisdiction, so provinces and territories have customized their own *Health Information Protection Acts*. For example, Ontario uses *PHIPA Personal Health Information Protection Act 2004*, last updated July 2010.

The Canadian Medical Association has prepared some excellent resources to help physicians meet these new guidelines, including the CMA's *Privacy in Practice: A Handbook for Canadian Physicians* and the online Privacy Wizard to help physicians customize their own office privacy policies.

As physicians, our responsibility to safeguard personal information extends to our use of mobile devices, such as Blackberries, iPhones, removable drives and laptops. The CMPA's excellent resource "*Electronic Records Handbook*" addresses the importance of encryption and electronic safeguards. See the Resources section below for details on these products.

HIGHLIGHTS FROM PRIVACY IN PRACTICE

Physician Accountability

- The physician has ultimate responsibility for his or her patient records.
- Office employees should be aware of and adhere to privacy policies.
- Records must document a patient visit accurately.
- Clear rules must exist for the retention and disposal of records.

Patient Rights

- Patients own the information in their record but the physician owns the actual record.
- Patients have the right to timely access to their record.
- In extremely limited circumstances, patients may be denied the right of access to their record if this poses a serious risk to themselves or others.
- Patients can get a copy of their record at a reasonable cost.
- Patients can request changes in their own record, and this request should be documented by an annotation in the record.
- A standardized process exists for dealing with patient complaints.

Consent

- Only information needed for the care and treatment of the patient should be collected.
- Patients need to know how their physician will use their health information.
- Consent is implied by the collection, use and disclosure of information needed for care and treatment.
- No consent is needed to disclose patient information when the disclosure is mandated by legislation.
- Consent is required to share information with third parties for reasons other than care and treatment.
- Patient consent can be withdrawn at any time.
- The consequences of denying or withdrawing consent should be made clear to the patient.

Key Message

Privacy legislation obliges all physicians to clearly inform their patients that they have procedures in place to ensure patient confidentiality and appropriate record management in the medical office. Contact the Canadian Medical Association and your provincial Ministry of Health for educational materials and resources to help your practice meet the new guidelines.

Office Safeguards

- Access to patient records is granted on a need-to-know basis.
- Office layout should maximize protection of patient information. The location and access of the records, as well as sound-proofing exam rooms, administration and reception areas, are essentials.
- Physical safeguards should be put in place.
- Electronic safeguards should be put in place.
- Employees should sign confidentiality agreements.
- Office policies need to ensure confidentiality when physicians and staff share medical records.
- Procedures must be in place to meet college and CMPA policies for appropriate destruction of portions of the medical record.

Business Implications

- Contracts signed with third parties should explicitly address the protection of privacy.
- When physicians close or transfer a practice, they must comply with provincial regulations for the storage or transfer of patient records.

PRACTICAL TIPS FOR PAPER-BASED MEDICAL RECORDS

Avoid family charts. Few physicians still use family charts, but be aware that, if you assume a practice that uses them, they should be replaced with individual charts as soon as possible.

File the latest progress notes at the front and the latest diagnostic reports and consults at the back of the chart. Most physicians will have the latest progress notes at the front of the chart, with the medication summary list as page two. The last consult of lab results is filed at the back of the chart.

After acting on all investigations you receive, consider having your file clerk place the result at the front of the chart. When you next see the patient, this cues you to verify that the patient is aware of the results and/or has received the appropriate instructions. Then you, the doctor, can place the test result at the back of the chart. This is a double-check system to verify that you have closed the loop.

Use helpful stamps. It is easy to have ink stamps customized for routine, frequent use in your office. Using stamps for such documentation as immunization records, flu shot administration and lot numbers, physical exams, common addresses, signatures and informed consent is efficient and cost effective.

Use flow sheets. Complement the cumulative patient profile, which is most commonly taped to the inside front cover of the chart, with useful flow sheets, such as those for diabetic care, INR treatment and advice, lipid care, prenatal and pediatric care. These will enable you to document care more efficiently and effectively.

Avoid chart divider organization clips. Staff members need to release the clip before they can file lab results and consultations in different sections of the chart. While they are phenomenal for chart organization, these clips are very costly and extremely tedious for the staff to handle in a dynamic practice. In a busy family doctor's office, it is common for staff to handle 120 charts daily. Imagine the time required to break each chart down to clip in reports!

As you consider these file organizing systems, talk with your staff and familiarize yourself with material and staffing costs before implementation.

Patient information sheets are time savers. Standardized patient information sheets can save you a lot of time and documentation, plus ensure that the patient has detailed instructions to refer to at home. Design these so that you can customize instructions for individual patients. Commonly used patient information sheets include:

- Contraception options and instructions
- Osteoporosis prevention
- Diabetic information and diets
- Low cholesterol diet guidelines
- Asthma treatment education
- Sinusitis treatment education
- Back-sparing exercise education
- Tips for avoiding repetitive strain injuries; e.G., Carpal tunnel, tennis elbow
- Fever care and medication dosing instruction for pediatric patients
- Wound care education
- Postoperative care instructions
- Gastroenteritis care advice

These are just a few examples of patient information guidelines that you can customize. Because the bulk of the information is repetitive and common to all patients, you can reduce the amount of documentation required in each chart. Noting that you have reviewed and given the patient a standard information sheet, perhaps with specific instructions, will meet the assessor's requirements and save you time.

Key Message

Develop medical record-keeping practices that are efficient, consistent and effective for you and your staff.

The physician owns the medical record. Patients have access to the information in the chart and, at their expense, can request a copy of their chart. Always keep the original in your possession.

Share your tips with colleagues. Help others make their daily medical record-keeping more effective and efficient by sharing your best-practice tips.

ELECTRONIC MEDICAL RECORDS (EMR)

Electronic medical records are, definitely, the present and future of medical record systems. The efficiency and effectiveness that an EMR system can add to the daily practice of medicine is amazing, enhancing both the quality and comprehensiveness of care. The number of physicians who are converting to EMR systems is increasing every day.

Regulatory colleges use exactly the same guidelines for EMRs as for paper records. In addition, there are specific requirements that all entries and additions to the record are dated and electronically signed.

Where To Learn More About EMR Systems

While it is beyond the scope of this module to examine the issues related to the partial or complete transition to a chartless office, there are resources available to help. Provincial medical associations as well as provincial colleges offer professional guidance and resources.

While you are still in training as a medical student or resident, you should test-drive as many EMR systems as you can, because, inevitably, you will be working with an EMR in the near future. If you are joining a practice with a system in place, get objective, expert advice and assess it as part of your overall practice evaluation.

Key Message

As physicians, we are obligated to keep comprehensive, accountable medical records. Our records must stand alone, without our interpretation, to clearly indicate the medical care we have provided our patients, as well as to justify the bills we have submitted. Medical records are no longer "for our eyes only".

ACTION PLAN

- **Develop good record-keeping habits at the outset of your medical career.**
- **Periodically review the best-practice principles, and ensure that you maintain these in your daily medical record-keeping.**
- **Keep abreast of the privacy legislation in your province.**
- **Look for efficient, practical and effective ways to save time in your practice.**
- **Learn as much as you can about electronic medical record systems.**

RESOURCES

- *Medical Records* is published by the College of Physicians and Surgeons of Ontario at cpso.on.ca/policies/policies/default.aspx?ID=1686 – policy 4 – 12, updated and approved June 2012. In addition to a very comprehensive review of all policies and obligations for medical records management for paper and EMR records, this publication provides excellent examples of several flow sheets and evidence-based care guides:
  - Cumulative patient profile (CPP)
  - Periodic health exam
  - Generic diabetes flow sheet
  - Patient-requested transfer of medical records
  - Physician request for medical information
  - Antenatal records
  - Appendix C offers 31 self-evaluation questions to help you assess your own medical records.
- The Canadian Medical Association's *Privacy in Practice: A Handbook for Canadian Physicians* is available online at cma.ca or in hard copy from:

  CMA Member Service Centre
  1867 Alta Vista Drive, Ottawa ON K1G 3Y6
  Tel: 1 888 855-2555 or 613 731-8610 ext. 2307
  Fax: 613 236-8864
  Email: cmamsc@cma.ca
- The Canadian Medical Association's *CMA Privacy Wizard* is a comprehensive, easy-to-use online tool kit (see cma.ca/privacywizard.htm) that enables physicians to customize their own office privacy policies, based on the latest guidelines. It is available free to CMA members and is eligible for MAINPRO-M2 credits. For more information, contact the CMA Member Service Centre, toll free, at 1 888 855-2555, or email cmamsc@cma.ca.
- Transitioning to EMR: CMPA Perspective, June 2010, Vol. 2 #2.

APPENDIX 1: PHYSICAL EXAMINATION STAMP

The objective is to design an easy-to-use stamp that becomes part of your ongoing progress notes. The text of the stamp denotes anatomical areas and systems examined during a complete patient assessment.

All areas examined should be checked off or circled. Significant positives or negatives on examination would be elaborated in the accompanying progress notes.

On a practical note, create your own stamp (e.g., 12 cm wide, 7 cm high) with legible lettering (e.g., 10-point font or larger). Present it to your local business supply store to have a rubber stamp or self-inking model made. You can modify the following example to suit your personal preferences.

BP	Wt		Ht	
HEENT	Fundi	Nodes	Thyroid	
Chest	Breasts		Murmurs	
Pulses	Bruits		Abdomen	
Liver	Spleen	Mass	Hernia	Testis
Pap	Vagina	Uterus	Ovaries	
Rectal	Prostate	Anoscopy	Skin	
Musculoskeletal			Neuro	

Module 7:
Electronic Medical Records

Association médicale canadienne
Canadian Medical Association

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

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Key Learning Points

A well-structured design, better quality records and its effectiveness as a management apparatus makes EMR the perfect addition to a physician's toolbox. Electronic records promote an effective, efficient practice—one that is streamlined, powerful and connected.

There is no doubt that there is a now a new standard for medical record keeping in our profession. In many Canadian jurisdictions, we have seen a profound shift of physicians' recorded notes—away from paper-based charts, toward computerized processes. Recently, electronic medical records (EMR) systems have become far more robust than they ever were before. They are intelligent, they are intuitive, and they are perhaps the best tool physicians have ever seen for improving the effectiveness, efficiency and quality of their medical practices.

A recent tipping point has been reached in many Canadian provinces: The majority of primary care physicians are now using an EMR system for their charting. In Ontario, at the start of 2012, 70% of family physicians had a functional EMR process, largely due to an aggressive funding model that provides the financial incentives required to make an investment in this technology, and to take it on in a meaningful way.

In this decade, of course, it is possible to do much more for less money, as the price of computer technology has continued to fall steadily. As well, our skill with the use of computers has risen sharply as they become the prime method of communicating for many of us. Witness our comfort with email, online banking and even video calls in the past five to 10 years. As this transformation has occurred, for many physicians, working with paper seems to be a tradition that is rooted in the past.

Also, witness how the ever-expanding volume of information that the average physician is expected to manage in a given day has grown exponentially. There has been a huge increase in the quantity of notes kept by physicians, as they are expected to be the custodians of their patients' story or movement throughout the entire healthcare system. The medical 'home base' now needs to hold laboratory information, hospital notes, physician consult letters, legal reports, applications for parking permits and a host of other documents for the patient—over the entire course of his or her lifetime. Meanwhile, paper charts have quickly become so voluminous that they can barely be navigated, and the potential for lost information or decisions made on erroneous or incomplete information is growing ever larger with their use.

Computer-based record keeping had the potential to fix all of this. In many cases, information coming to the family physician starts electronically, with a document or report generated outside by a lab, hospital or consultant. It is then printed to paper and moved around the medical system by fax or mail. Offices have had to maintain a work flow for sorting, filing and maintaining all of this paper. Why, one wonders, if the information starts electronically, can it not be kept electronic and moved instantaneously between the writer and the recipient? EMR systems, with properly created regional networks of interconnectivity, can make this a reality. In the very near future, it will be possible to have information virtually follow each patient, to be used by anyone who has the authority to see it—which will improve the care of the patient by avoiding duplication, speeding up decision-making, and ensuring safety when care is being provided by multiple providers within a broad healthcare system.

Recent medical school graduates and residents do not need to be convinced of the benefits of electronic medical records. They have lived hand in hand with it in the majority of the practices where they have done their training. For them, it is impossible to think of working in a paper-based system. It is more difficult, though, to convince still hesitant physicians who are in the middle or near the end of their careers that changing to electronic record keeping from paper is worth the effort and short-term upheaval to their daily work flow. To accomplish this, we must assure them of the real benefits of electronic medical records, and create processes that will help their transition to be as smooth and easy as possible.

The medical environment in this decade has clearly changed.

As previously stated, in today's medical practice, the need exists to manage and filter vast volumes of medical information from many varied sources. Medical care is more complex than it has ever been before. Besides handling the healing of acute problems, physicians are also expected to expertly track and handle a whole range of chronic medical diseases and disorders. These are becoming even more complicated as our population lives to more advance ages. As well, some of the focus of medicine is moving—from the treatment of disease into disease prevention. In order to prevent illness, one must think ahead, into the future, and proactively deal with risk factors that may frequently slip under the radar in a very thick paper chart. Add to this the fact that patients have never been more informed about their medical conditions and health, and you can see the stress points. Patients place greater expectations and demands on their physicians and, justifiably, have no tolerance for data that belongs to them but is stored by their physician being lost, misfiled or unavailable.

WHAT ARE THE BENEFITS OF EMR?

The benefits of a well-deployed EMR system come down to three simple, primary principles: quality, efficiency and effectiveness.

EMR systems produce better quality records. First, they are legible. They are structured and easily searched and maneuvered through, so that data is found quickly. They enable faster, and more informed, decision-making on the part of the physician. They can be accessed and shared by multiple providers, even in different locations. They enable processes that decrease error, from drug interaction checks to disease/drug incompatibilities.

The quality of the EMR record derives from its effectiveness in computing, tracking and managing data, and in the manipulation of multiple variables attached to a patient. For instance, results tracking and analysis are instantaneous, with automatic lab downloads, the ability to graph and flow results over time, and the ability to find outliers in a population of patients. EMR systems enable continuous quality improvement cycles, by enabling a roster of patients to be searched for variables in their health that they would benefit from having changed. Classic PDSA (Plan-Do-Study-Act) cycles can be run for any patient panel to find patients who, if targeted, would benefit the most from any given intervention. Those at risk, or who have the most to gain, can then be recalled and proactively cared for. Reminders can be set up to recommend interventions on specific patients for high-risk issues or illnesses. These can easily be based on current guidelines or evidence-based protocols. As practices become more evolved in their use of EMR programs, it is quite likely that they will begin to look at population-based health parameters, and think about designing ways that they can improve the health of an entire group of people at one time.

The EMR is also a very efficient way of managing more than the data that builds with a patient's life. It is an efficient business management tool. Every possible work flow of a physician's practice can be sped up, or nearly automated, with an EMR system. Registration can happen with the swipe of a health card. Referrals are generated within the EMR program and sent directly by fax or email, without the assistance of a secretary. Referral requests and waiting lists can be tracked to improve cycles and wait times. Office visits can be sped up through the use of templates and quick entry methods to collect the story of the visit. Multiple office workers can interact with the patient and his or her chart, at the same time enabling a nurse, secretary and physician to have free access to the information they need to do their work now. Accounting, billing and reconciliation of claims are all best done with a computer, and become nearly automatic.

All of these items add up to a practice that, with EMR, is streamlined, powerful and connected—providing superb patient care in a business model that is as productive as possible.

THE CHALLENGES OF EMR ADOPTION

All of this is not to say that the improvements we have mentioned do not come without a significant amount of effort and planning, especially in the early days of EMR implementation. Physicians often fear the change more than they need to, though, as most troubles can be mitigated with proper planning and a lot of patience—especially if they keep in mind that the end result is worth the time and energy they are required to put in.

The challenges that must be planned for are many. When going live with an EMR program, there is both a perceived, and a real, loss of productivity. Charting initially takes longer, as the physician learns how to navigate the EMR system and enter data by typing, dictating or the creation of templates. EMR is not really productive until a cumulative patient profile has been entered, and the inputting of all the data on a well-organized paper cumulative patient profile (CPP) is pure labour.

On the positive side, going through the existing paper charts enables a physician to be in complete touch with his or her list of patients, perhaps for the first time ever. Errors are caught. Incomplete profiles are completed. Items post-due are identified. Some doctors find that it is worth the time and expense to hire a third party to enter their CPPs for them. In this case, the work gets done, but the benefits of doing it oneself, as mentioned before, are lost.

Some physicians have reduced their patient volume early on in the implementation process. Most simply worked later to get the work done. The need to do so does not last very long, however, as an 80/20 rule applies. Typically, 80% of one's time is occupied by the most demanding 20% of a practice's patients, so, as these are entered into the CPP, the work flow speeds up significantly.

People become used to the layout of their systems even more quickly. Navigation within the software speeds up exponentially in a few weeks for users who have had training in all aspects of its use.

Change fatigue is an issue. Doctors have had to contend with changes to their payment models, regionalization, new fees and codes, incentives for doing more proactive work, complex governance and business arrangements, and more, over the past 10 years. Adding the implementation of an EMR program to this workload may simply be more than some can handle. Proper change management support and training, however, can go a long way toward reassuring a physician that they can make the transition as smooth as possible.

Fear of the unknown is also a factor. People who are not accustomed to using a computer on a daily basis, think they lack the skill set, or are intimidated by technology may find the thought of adopting an EMR system daunting. The only 'treatments' for this are exposure, and trial and error. It takes only a short period of time to gain a huge degree of comfort with computer systems in general, as they become more and more 'intuitive'.

The time required to plan, investigate and navigate the choices of EMR products should not be understated. If one is to perform due diligence in planning for this degree of change and this large of a purchase, then a significant amount of time must be put into the planning and research of the options that are available. This work will often fall to one IT lead physician, who will need to add this task to the multitude of others he or she is already responsible for in the course of a workday. Such time is often not remunerated, and he or she must be a tireless visionary to continue with the mission, even when the workload seems unending.

There are real costs associated with purchasing an EMR system for an office as well. These include hardware, networking and software costs—and they are not a simple one-time outlay. Hardware must be changed every three to five years. As well, EMR vendors generate income from ongoing licensing fees, which must be planned for within a sustainable business case and budget. Luckily, most jurisdictions have some provincial funding available to offset a portion, or even all, of the up-front costs.

On the other hand, meanwhile, practices can create new revenues with their EMR capabilities, based on their ability to tap into every bonus and incentive available for maximized preventative or chronic care initiatives—which would not be possible when searching through paper records. This 'new money' must be considered when creating a workable financial balance sheet.

The computer creates a new paradigm in the typical office visit—having changed the old patient/physician/paper chart triangle into one that replaces the chart with a potentially distracting machine. The computer should be looked at as an interactive tool when sitting with a patient, though. Its screen can be turned to show a patient the record itself, including pictures, graphs, lab results and educational tools. As long as the ergonomics of the office or exam room are addressed to make patient, physician and record location equally important, the computer does not take away from the encounter, but rather adds to it. Physicians need to embrace this technology and use it interactively with the patient, rather than as a sideline tool.

Planning for ergonomics in the office set-up, including display and keyboard position, patient and desk location, chair heights, etc. makes all of this possible. The entire medical office requires examination in this regard. Workspaces for nurses, administrators, secretaries, students, residents and allied health professionals must all be taken into account.

Key Message

Plan the implementation of your EMR meticulously for the many challenges ahead. Learn to exploit every feature of the EMR to gain maximum efficiencies.

PLANNING FOR THE TRANSITION

There are seven elements to consider when planning the transition to EMR.

1. **Define A Leader.** Find your tireless visionary, the person who can map the course and encourage the team when the going gets tough.
2. **Map Out A Path Of Achievable Targets.** Create timelines and goals, and assign different staff members to each one.
3. **Involve every staff member.** Each person in the practice needs to be engaged, as the project can move only as fast as the slowest member. Keeping everyone engaged and informed, and feeling a part of the process, will ensure their buy-in.
4. **Use Every Opportunity To Redefine Skill Sets.** Rewrite job descriptions for the electronic environment, and generate excitement over potential new positions.
5. **Train Aggressively And Fully, With A Hands-On Approach.** Spend extra time in training, and consider the price of all of this as an investment rather than a cost.
6. **Prepare Paper Charts Early For Their Transition To Electronic Format.** Clean up old records. Purge patient records for those who are no longer in the practice. Make the CPP as clear as it can be.
7. **Be Creative And Have Fun.** This can be done through friendly competition, lunch-hour learning sessions, office newsletters, etc.

THE FIRST SIX MONTHS POST-IMPLEMENTATION: GETTING GOING

The first six months are the most common time for experiencing frustration, stress and worry. It passes quickly, however. During this time, it is important to meet regularly as a group to diffuse the stress. Every member of the team should be encouraged to vent his or her concerns, and the group should work on creative problem-solving and the generation of new ideas. During this period of transition, it is important to alert patients that they may experience changes, and ask for their patience. Most are very willing to bend and understand the stress, and are excited to see the modernization of their medical home happening. They are happy to be part of a state-of-the art facility.

As discussed already, entering CPPs is a task that simply must be endured, but there are multiple approaches that can be taken to move this task along efficiently. Some physicians enter the CPPs of every patient every day after going live. This will often mean working two to three extra hours each day in a “short-term pain for long-term gain” scenario. Within two to three months, the most difficult and complex patient charts will be entered. Other doctors enter a set number of charts each day. This lessens the daily load, but spreads the overall job out over a longer period. Still others do their physicals or new consultations first, and then as many charts as they feel that they can handle each day. Whichever path is chosen, usually within six months, all members of a group have nearly the same number of profiles entered—and then the entire system moves into the next ‘gear’.

Early on, it is important to plan for consistent data quality and entry. At the very least, users should agree upon a defined set of words to be used to label a core group of diseases and conditions. This allows for searches to be made much more simply, as variations in search terms do not need to be made to account for different spellings or iterations of the same illness (for example "diabetes" versus "DM", "diabetic", "T2DM", etc.). At its best, coding of diagnoses and clinical notes, using an accepted international coding nomenclature, should be implemented. In Canada, SNOWMED-CT is the system that is being most consistently recommended. With detailed coding of a record, variations in text become irrelevant.

Individuals can experiment with different methods of entering data into their system. Most will type, as this is often the most efficient for abbreviations and medical terms. Some will dictate into voice dictation software or to a recorder, to be entered by a skilled typist after the fact. This is less immediate, but can be effective for those who lack typing experience. As well, clinics can develop, import or share templated notes and structured forms, which pre-populate the record and allow for variations to be made from drop-down menus, or inserted and deleted bullets. Such notes work well for routine visits, including complete physicals, prenatal exams, diabetic visits, etc.

Toward the end of the first six months, it is also important to revisit the work flows that were developed pre-implementation, to see if they are still the best they can be, or perhaps need to be improved. Oftentimes, it is only after working a process through to completion that it is found to be 'right' or 'wrong' for a particular practice.

THE SECOND SIX MONTHS: GETTING GOOD

The second half of the implementation year is when users tend to begin to smile again. They see lab data entered automatically, and are able to use it interactively. Letters and notes begin to tell a story about a patient. Renewals of prescriptions previously entered are now instant and accurate. Speed of data entry has increased remarkably. Scanning and the inclusion of external notes is occurring rapidly.

The EMR format may not yet be second nature—but physicians begin to wonder how they ever got by, using paper, in the past. This is the time when thought turns to ending paper use altogether. Typically, for the first months, the old paper chart "archive" will need to be pulled for every patient visit, as there is no information in place yet with the EMR. Likely, though, within the year, physicians will find that they look at those paper charts less and less for their acute and episodic care. At that point, charts will need to be pulled only for physicals and chronic disease management visits.

This development will provide staff with more time to attend to other tasks (i.e., new work flows). The production of paper will decrease as well—especially as systems mature with the use of fax servers in place of fax printers, auto-faxing of letters, and greater comfort as the use of email and instant internal messaging builds. Reports will now begin to be generated for preventative and complex care. Work flows will again be revisited. The use of EMR becomes much more mature.

YEAR TWO AND BEYOND: MEANINGFUL USE AND OPTIMIZATION

EMR "maturity models" and "meaningful use" are now the buzzwords of provinces that are deeply penetrated with medical information systems. Canada Health Infoway, PITO (British Columbia), POSP (Alberta) and OntarioMD are all working on defining and measuring the degree of optimal use of the EMR systems that they have so heavily funded. Doing so encourages clinics and physicians to look at their EMR systems as much more than just a computer on a desktop, writing notes in a story.

"Meaningful use" is the most exciting concept among the possibilities offered by electronic systems. This phase is where connectivity and integration become key and desired, as physicians learn the power of the data they have collected to think about their patients in a new way, and then create change on a larger scale.

In advanced use, all work flows in the office setting have become electronic, and there is little or no use or generation of paper. Every business process has been examined for efficiency and effectiveness. Clinics run as well-oiled machines. Every member of the team has become comfortable with navigating and using the software. Patients have become empowered by being able to share and view information with their provider at each visit.

The next stage of the process, then, involves connecting all of the various systems in a province together. There are multiple federal and provincial initiatives in the pipeline to make this happen. We see an Electronic Health Record for all Canadians on the federal agenda for 2015. Large provincial laboratory repositories have been created and will be used. The same type of system for diagnostic imaging is, or will be, in place in most provinces. Hospital integration is happening, with nearly real-time population of EMRs with hospital reports in at least three provinces.

There will be public health integration, which will streamline the tracking of infectious disease outbreaks and their reporting. Home care and community services will be integrated. Many provinces are working on e-referral systems for the electronic flow of referral requests and consultation notes between offices. e-Prescribing pilot projects are being completed, and soon prescriptions will be sent directly to pharmacies without printing, ensuring greater patient safety.

Patients will become more engaged in their health care with the ability to view, and even add to, their medical record via secure messaging and patient portals. Data coding and extraction, as proposed by the Canadian Institute for Health Information (CIHI), will be ubiquitous, and true population-based health research and analysis, with reporting to physicians of their performance as compared with peers, or on any individual patient, will be in place. Health outcomes can then be viewed more globally, as well as locally.

Many provinces are introducing pay-for-performance strategies, wherein physicians will have some of their income revolve around achieving targets in measures of disease and its change. This approach has been very successful in the United Kingdom, and can likely work well here, in our publically funded healthcare system.

There are also many chronic disease strategies incorporated into "meaningful use", aimed at digging deep into the data of an EMR program, finding patients with conditions who are not being monitored or screened adequately and then targeting them with action in the hopes of changing their health outcomes soon thereafter. Using searches and the subsequent generation of reports, this measurement is easily accomplished in an EMR-enabled world.

Clinics can also use the data within their EMR systems to join larger research networks, for academic teaching, or for reporting to provincial databases, such as the Ontario Diabetes Registry. Regular practice audits for disease monitoring, quality improvement initiatives and business planning will be promoted, and even automated. PDSA quality cycles will be the norm rather than the exception. All of this is available to advanced users with enough data in their systems to make its mining worthwhile—typically, after just three to five years of use.

Patients will become true partners in their health care with EMR systems, once optimized. They are, or will be, using patient portals for education and interacting with their record. They will be accessing individualized healthcare information that is particularly useful to their condition. They will be involved in self-reporting of data (blood pressure and blood sugar levels, for example) and with various mobile technologies, through which they will receive instant advice about how to change their current status. Even now, some patients are booking their appointments online!

The future, when viewed through the eyes of "meaningful use", looks exciting!

EMR CONFIGURATION OPTIONS

There are basically three ways that an EMR system can be configured or set up.

1) **Local Solution.** This is most practical system for a group that is practising in one location. The server resides on-site. The clinic is responsible for its networking and support. Computers are networked to the server as "thin clients", running a shell program with data moving to and from the server in real time, with no confidential information remaining on the desktop after the program is closed or signed out.

   The advantages of a Local Solution system involve the speed of the (usually wired) network, control over data, and lack of reliance on an internet connection to view records. Disadvantages include the upfront purchase and licensing costs, the responsibility of backups and server maintenance, and the privacy and security of data over the long term.

2) **Application Service Provider (ASP).** This is a subscription-based service, in which data is housed in a distant data facility, managed by the EMR vendor, and often owned by a provincial e-health authority. This type of system is most practical for spread-out clinics or physicians who are practising in multiple locations. Desktops in offices provide a window on the server via web browser functionality. They are entirely dependent on internet connectivity to function.

   The advantages of this system are their ease of set-up and use; the averaging of costs over time; no responsibility for maintaining a server, backups or data; and portability. Disadvantages include speed issues with internet congestion, reliance upon an outside internet service provider (ISP), and a lack of flexibility in changing the product to meet individual needs.

3) **Federated client.** This is a scenario in which separate servers are housed in individual clinics, but locations that share patients have access to the server of every other location on a patient-by-patient basis when the need arises. A copy of the patient's record is moved to the server at the location where the patient is being seen; it is used and added to, and then updated on the home server. The record at the temporary location remains static after that time.

   The advantages and disadvantages are the same as with the Local Solution, but have the added complexity of a mandatory internet connection to the other servers in the network, and the need for software capability to communicate with all the systems involved. The federated client is largely replacing the old "hub and spoke" solutions that involved constant access from one system to another—because they require much less complicated bandwidth specifications and are therefore more reliable, and cheaper.

HARDWARE REQUIREMENTS AND CONSIDERATIONS

When developing an EMR system, consideration must be paid to the details of hardware and data input devices. Basics to take into account include desk size and location, monitor access, keyboard height, chair comfort and the placement of peripheral devices, such as printers and scanners. Spending long hours every day in front of a computer demands careful attention to ergonomics to avoid discomfort and repetitive strain injury.

Many different machines can accomplish data input. Desktop computers are relatively cheap and reliable, and they have the advantage of large screen sizes and the ability to perform other tasks, such as word processing, spreadsheet manipulation, etc.

Laptop computers can be used in some areas. They are fairly portable, but suffer from short battery lives, unless docked; and, when docked, they essentially become desktops (which would have been cheaper to purchase than a laptop plus docking hardware). Laptops have the disadvantage of smaller screens and keyboards, shorter life expectancies, and can be easily stolen or dropped.

Tablet devices are sometimes used, but they suffer from the same disadvantages as laptops—but to an even larger degree. They do enable handwriting capability, but few physicians use this. As well, tablets are more expensive than laptops, for less power and lifespan. Despite being smaller, they are still relatively heavy when carried on an arm all day, and this increases the risk of arm strain. They must be regularly docked or hot-swapped for batteries to be used for a full clinical day. Small tablets (Galaxy, Playbook or iPad, etc.) are not yet universally supported by EMR software vendors, but, when they are, they will be most useful in mobile situations—hospital rounds or house calls, for example. On the other hand, data entry with these devices is relatively difficult.

Printers will be required throughout the office, and should likely be housed in each location that a provider works. Printers are cheap and compact, and are a real asset when printing documents or forms, prescriptions, handouts and educational materials, and for producing labels (specific label printers are used for this). Most offices also have at least one large network printer for volume tasks, such as printing newsletters, bulk mail-outs to patients, etc.

Scanning is a requirement for all EMR systems, until such time when all documents arrive at an office electronically. Scanning paper to an image file (.pdf, .tiff, .jpg) is always the first step in document management. A high-quality scanner should be purchased for this task. The image file can then either be attached to the EMR note as a read-only image or, better yet, run through optical character recognition software to convert the image to text, which can then be incorporated directly into the progress note, making it searchable. Once image files are created from paper, the paper can be shredded (as long as the digital image is kept permanently).

SUMMARY

EMR systems are quickly becoming the gold standard for physician record keeping in this decade, and have evolved substantially over the past five to 10 years.

A well-implemented system can vastly improve the quality, efficiency and effectiveness of a medical practice. With careful planning and forethought, the introduction of EMR into an office setting can be both challenging and fun—but the real power of this resource becomes clear after two to three years of its use, when optimization, meaningful use and data sharing become much easier.

With connected systems across the country, effective health planning and policy can be undertaken, robust disease detection and prevention programs can be put into place, and patients can be proactively involved in their care—improving the medical system and the health of Canadians overall. The possibilities are endless, and the future is now in the e-health space. We are at a real tipping point in the adoption rate of EMRs nationally. It is an exciting time to be a doctor!

ACTION PLAN

- **Take time to investigate your EMR options.**
- **Choose the EMR that best suits your practice's needs.**
- **Follow the seven planning to transition tips.**
- **Make "meaningful use" of your EMR.**

RESOURCES

There are many excellent resources available to help you learn more about implementing and effectively using an EMR system. Some of these are listed below.

OntarioMD
Ontario's EMR funding and change management agency (www.ontariomd.ca). Change management tools and a portal are available online.

EMR Advisor
Lists all products available in Ontario, along with their market share; user ratings and comments are embedded.

PITO
British Columbia's EMR funding agency, with services similar to Ontario (www.pito.bc.ca)

POSP
Alberta's EMR funding agency (www.posp.ab.ca)

CanadianEMR
A comparative site of all Canadian EMR products and vendors, maintained by Dr. Alan Brookstone, a pioneer in EMR implementation in this country. EMR users comment on and rate their systems on this site (www.canadianemr.com).

Canada Health Infoway
This is the agency created by the federal government and an agreement among the Ministers of Health of each province to provide Canadian standards for EMR, promote benefits realization, fund EMR uptake in some jurisdictions, and promote innovation in the eHealth space (www.infoway-inforoute.ca).

Canadian Medical Association
Information on practice management, including EMR implementation (www.cma.ca)

Canadian Medical Protective Association
Advice on record-keeping guidelines and care in the e-health space, in an attempt to improve quality and limit medico-legal issues (www.cmpa.org)

Module 8:
Physician Remuneration Options

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plans to best fit their personal and professional aspirations. You are advised to consult with professional advisors to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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Key Learning Points

- *Remuneration models*
- *Alternative payment plans*
- *"Shadow billing"*
- *Differentiating between the salaried employee and the self-employed professional*
- *The scope of remunerative services physicians provide*
- *Fee-for-service (FFS) billing: The anatomy of an FFS bill and the billing process*
- *Billing the Workers' Compensation Board*
- *Third-party billing and uninsured services*
- *The golden rules of billing*
- *Billing examples: Self-learning workshop*

Author's Note:

For specific case examples of billing, the author, who practises in Ontario, has used Ontario-specific codes and fees. Resources for provincial-specific payment models and fee schedules are provided at the end of this module, along with a generic billing examples workshop.

INTRODUCTION

As medical residents, you are remunerated as salaried employees of your hospital or medical faculty. The biweekly income you receive is your net take-home pay after deductions for income tax, Employment Insurance, Canada Pension Plan, group benefits and any other dues that you are obliged to pay. Once in practice, your sources of income will be varied and, potentially, quite complicated, depending on where and how you practice medicine.

Traditionally, most physicians have been paid primarily on a fee-for-service (FFS) basis, unless they worked in an institution and received a salary. Now, there are many new and more complex ways to reimburse physicians for their services. Today, we hear more about alternative payment plans, individually negotiated salaries and other, blended remuneration models. Understanding how you may be remunerated for the many services you provide is important as you evaluate short- and long-term practice options. There are many similarities, as well as significant provincially specific differences, in payment models.

Fee-for-service billing is the foundation from which all alternative payment models evolve. An in-depth and up-to-date knowledge of your provincial specialty-specific fee-for-service billing schedule of benefits is essential, regardless of the payment model you choose. This module will therefore include a more detailed discussion of the principles, definitions and mechanics of FFS billing, after an overview of remuneration options is discussed.

REMUNERATION MODELS

Physicians are paid for their professional services in a variety of ways:

- Traditional fee-for-service (FFS)
- Enhanced fee-for-service
- Alternative payment plans (APP)
- Salary

Fee-For-Service

In the traditional fee-for-service system, the physician is a self-employed professional who bills for each service provided. The parties responsible for payment for insured services include the provincial ministries of health, the Workers' Compensation Board and federal government departments, such as Veterans Affairs, National Defence, Indian and Northern Affairs and the Solicitor General.

Each province will establish a schedule of benefits that outlines the fees paid for the many services and procedures that family doctors and specialists provide. The physician's provincial medical association negotiates with the provinicial ministry of health to set appropriate fees. When the Canada Health Act was enacted in 1969, the provincial ministries of health agreed to pay physicians approximately 90% of the fees established by the physicians' medical associations. The provincial medical associations' fees have increased in line with cost-of-living increases. Unfortunately, there has been a significant erosion of this agreement since the mid-1980s, and most provincial ministries of health have established fee schedules that are approximately 60% of what the medical associations have deemed as fair tariffs for services rendered. Each province has its own schedule of benefits, which can vary significantly. The principles of fee-for-service billing are the same across the country, but the logistics and coding are provincially specific.

Payment for uninsured fee-for-services is the responsibility of the patient or a third-party payer, such as an insurance company. In these circumstances, physicians are encouraged to use their provincial medical association fee schedules.

Enhanced Fee-For-Service

Most provinces and territories have decided to offer family physicians and some specialties enhancements and bonuses to the existing fee-for-service fee schedule, rather than embark on the more complex and varied alternative payment models that Ontario has adopted. Such enhancements include bonuses for complex and chronic disease management. Several provinces offer guaranteed block funding to complement the FFS payments in more rural areas, or for physicians who are providing care to special-needs populations. Enhancements can also include dedicated funding to assist physician groups to work in a collaborative multidisciplinary model along with nurse practitioners, social workers, etc. Enhanced models are often customized to the demographic and service needs of the particular region. Other enhancements, such as seen in Quebec, include a percentage increase in all FFS billings when the physician works in qualifying rural or remote areas. To learn more, contact your provincial medical association and ministry of health.

Many of the enhancements to FFS models are also incorporated in alternative payment plans (APPs), which will be discussed below.

Alternative Payment Models

Some ministries of health are now promoting other ways of remunerating physicians, via various alternative payment plan (APP) formats. Sometimes referred to as "alternative funding plans", "alternative relation plans" and "new payment models", APPs offer an alternative to the traditional fee-for-service remuneration.

At our Practice Management seminars, we often ask how many residents understand the latest alternative payment models proposed by their provincial health ministry. Rarely does anyone say "yes". Like many practising physicians, residents find the complexity and the variety of terms very confusing. (An overview of APPs will be discussed in more detail below.) Because APPs are constantly evolving, readers are encouraged to visit the websites of their provincial medical association and specialty-specific organization to learn about APP developments in their province.

Alternative Payment Plans (APPs)

One type of APP addresses remuneration for clinical work only, and therefore targets community-based physicians. These APPs have emerged in recent years, as some provincial governments have initiated primary care reform to address a variety of issues.

Among other issues, governments were concerned about the trend for general and family doctors to offer more episodic care and less comprehensive and after-hours care for a designated group of patients. Situations have also emerged wherein some physicians felt compelled to see as many patients or provide as many services as possible in order to sustain what they believe is an appropriate income. At the same time, physicians' lifestyle expectations have changed. Today's medical professionals are likely to claim more time for themselves, leisure activities, continuing education and community work.

Governments and medical organizations also have had to address the declining number of family physicians that are available to serve rural, remote, and now, even many urban centres. In addition, successive governments have expressed the need for cost control, predictable demand for healthcare funding and best-quality care for money spent on primary healthcare delivery. Accordingly, these APPs are targeted primarily at family physicians, although they have also been offered to some specialists.

The Complexity Of APPs

The contractual aspects of APPs are much more complex than traditional FFS or salary contracts. Current research indicates that most APPs consist of a blend of some (or all) of:

- Fees for clinical services
- Population or capitation funding
- Time-based payments, whether hourly, daily or other
- Rewards for participation in specific clinical initiatives
- Bonuses for achieving specific targets in preventative or quality care
- Remuneration for administrative duties and costs
- Financial contributions for medical information technology

In the case of APPs for academic physicians, there may also be some (or all) of:

- Compensation for teaching
- Research funding
- Stipends for administrative duties
- Partial compensation or subsidies for staff, other healthcare workers, facilities and/or equipment

Because remuneration can be paid either directly to an individual or to a group of physicians participating in the APP, how the income is shared becomes another factor in the formula. Accordingly, the contractual aspects of such new payment models can be quite complex.

Physicians participating in APPs that target community-based primary care physicians can choose from several payment formats, but they all require the physician to formally enrol patients in his/her practice and register this enrolment with the provincial government. The terms for the payment formats may differ from province to province, but, essentially, include the following:

- Fee-for-service payments
- Capitation payments
- Sessional fees
- Block funding
- Blended formats

APPs that target primary care physicians will include some or all of the following components.

Patient-enrolled models (PEMs). Any APP in which a physician or a group of physicians agrees to formally enrol patients in the practice and register this enrolment with the ministry of health (MoH) is known as a PEM. The health ministry will require the patient's signature on the enrolment form before paying any PEM bonuses.

Rostering. This is the process of enrolling patients in a physician's practice and registering that enrolment with the MoH for tracking purposes. Many APPs will pay the physician either a set fee per patient ($5 in Ontario for the first year), or a lump-sum payment for the administrative work of rostering their patients.

Fee-for-service billing. In an APP that incorporates the FFS format with a percentage bonus top-up for each service, a physician is paid only if the patient is seen and a medical service is provided. Income relates directly to the number of patients seen and the services provided for each patient. Payment, as defined in the provincial FFS schedule of benefits, is made directly to the physician who provides specific services. For enrolled patients, the fee paid is topped up; for example, by 10% during regular office hours and, potentially, an additional 30% for evenings and weekends. Additional bonuses of approximately 15% are added for the common services offered to seniors.

Another model used for an APP with an FFS blended payment format incorporates traditional FFS billing for a portion of the physician's income, which is then topped up with a guaranteed amount of money annually. This model is often employed in the more rural and remote areas.

Capitation payments. An APP that incorporates capitation provides the physician with a guaranteed fixed payment for the comprehensive annual care of a rostered patient, regardless of the number of times the patient visits the doctor or the number of services provided. The capitation payment is in lieu of FFS payment for a designated number of outpatient primary care services. The designated services are often referred to as a "basket" of services. The payment varies demographically by age and gender. The annual capitation payment for a 25-year-old male may be approximately $50, while the annual capitation payment for a 90-year-old female may be $300. If the service provided is not in the "basket" of services, then full FFS payment will be received. For example, many office procedures and biopsies are often outside of the defined "basket".

The physician bills FFS for the patients who choose not to roster, and the physician can choose to not roster patients who historically require a high volume of services. There are often limits on how much FFS income a physician participating in a capitation model can receive. The total of capitation fees, fee-for-service billings and bonuses for all patients, minus expenses, is your net income.

Shadow fee-for-service billing. The physician who is participating in an APP with capitation payments must also submit FFS invoices for all services provided to rostered patients. Although the physician will not receive full FFS payment for these services, physicians who participate in a capitation PEM may receive a percentage bonus (e.g., 15% per service) for all shadow FFS billings they submit. This is an incentive to keep accurate records of all services provided. The MoH requires this information for evaluating patient access and utilization under the various APP models.

Preventative care bonus. Most enhanced fee-for-service models and APPs offer annual bonuses when the physicians can document that they have met or exceeded certain percentage targets for preventative health care. For example, physicians who can document that they have given or can ensure that a flu shot was received by a predetermined percentage of the target population may receive a lump-sum bonus payment.

Other preventative care bonuses proposed in some provinces include biennial Pap tests for women aged 35–70; biennial mammograms for women aged 50–70;

colorectal screening every 30 months for patients aged 50–74; and primary childhood immunization, as per the latest guidelines, for children up to two years old.

Comprehensive care management fee. This is a payment for the ongoing administrative work, medical record review and upkeep that comprehensive family doctors do in addition to seeing their patients. A monthly capitation rate is paid per rostered patient. Rates vary, based on age and gender, and average approximately $2 per month per patient.

Chronic disease management bonuses. Several provinces will pay GPs an annual bonus for managing chronic diseases, such as diabetes and congestive heart failure. Clinical practice guidelines and documentation criteria must be adhered to. In certain provinces, specialists may also qualify for such bonuses.

New patient incentives. This refers to a fixed bonus to physicians who accept "orphaned" patients (i.e., those who do not have a family doctor) as new patients into their practices. There are generally a limited number of new patient enrolment bonus payments per year. For example, in Ontario, there may be a $110–$180 bonus, based on age, for the first 60 new patients accepted per year into an existing practice. As an additional incentive, new-entrant physicians may be offered these bonuses for a greater number of new patients in their first year of practice.

Administrative fees. These per-patient fees are paid annually to the physician or the group practice to help defray some of the administrative costs of meeting all of the accountability criteria required by APPs that have a capitation payment format. Not all APP formats offer administrative fees.

Sessional fees. These fees, typically based on an hourly rate, are paid for the delivery of specific services. For example, many emergency departments now offer physicians a guaranteed sessional fee for working as the doctor on duty, regardless of the number of patients seen. These physicians are obliged to 'shadow bill' so that the actual services rendered can be monitored. Failure to capture and submit all shadow bills will result in a reassessment and possible reduction of the guaranteed sessional fee in some jurisdictions.

Block funding. Some physicians receive a guaranteed payment to provide medical services for patients in a specific location or region for a defined interval of time. Block funding is often offered to physicians who work in rural and remote areas, where they would not receive adequate remuneration if they had to rely solely on FFS billings. Shadow FFS billing may or may not be required. In an APP that incorporates block funding, these physicians often also qualify for additional FFS billing and other bonuses. The block funding guarantees a monthly minimum gross income, from which physicians can pay themselves as well as their overhead expenses.

Alternative Payment Plans For Academic Physicians

APPs for physicians who work in academic centres not only address remuneration for clinical work, but also provide remuneration for academic teaching, administration, research and the provision of all facilities, staffing and resources. Community physicians who participate in an APP will negotiate and deal directly as a group with the MoH. Each of the several hundred academic physicians of a medical faculty, however, will be obliged to evaluate and understand their own individual contractual obligations and benefits when they participate in the APP contract that is negotiated between the medical faculty, the participating teaching

hospitals, their specialty-specific division and department heads, the medical research facilities and the MoH.

Case Example: An AFP (Alternate Funding Plan) For Emergency Services In Academic Centres

An emergency department has six full-time emergency physicians, presently remunerated by a combination of fee-for-service, salary and other earnings. They also perform clinical, teaching and administrative functions at an academic institution. The local healthcare authority offers the group an AFP, whereby the 'global funding' is valued at $1.5 million to provide all agreed-upon emergency room services for a fiscal year. The amount negotiated would be based on previous audits of the FFS billings and numbers of services offered annually, averaged, for example, over the past five years. Additional funding is added to cover administrative and academic work by the group. Once agreed upon, there is, essentially, a fixed limit to the 'funding pie'.

If the participants accept the AFP offer, the physicians will provide the agreed-upon services to the public, and then must agree among themselves how to share the funds. Although it may be simple to divide the income equally (e.g., $250,000 each), some of the physicians may feel they deserve higher income because of their seniority, they work more hours, or because they perform other valuable duties. Therefore, each member must negotiate a sub-contract within the overall AFP contract.

Workload increases that require the recruitment of additional emergency physicians will complicate the negotiations further. Prospective group members should not assume that they will automatically have an equal share of the remuneration offer because there is a fixed size to the existing funding pie of $1.5 million. Income for additional docs would need to come from the shares of the existing docs until the group can negotiate for an increase in the global funding. Such a request would need to be backed by shadow billing records, proving that the number of services delivered has increased. Additional documentation proving that non-clinical work has also increased would also be required in order to negotiate for an increase in the global funding.

These APP contracts are extremely complex. Each physician who participates in negotiating for individual salary and benefits, clinical, teaching, research and administrative responsibilities and obligations is actually negotiating for how his or her individual contract will fit into the very large contract that comprises the global funding of the entire institution. Each medical faculty will negotiate the specifics of their own APP—so experience with one APP does not assure in-depth knowledge of another.

Each individual contract will require the approval and signature not only of the chair of the specialty-specific department, but also of hospital officials and medical faculty administrative heads.

Ensuring that all of the "what ifs" are addressed is very important. *Module 9: Principles Of Negotiation* addresses the specifics of this in more detail.

Physicians are advised to seek independent, expert advice from their professional advisors. Accountants and lawyers who are experienced in contract law should review all aspects of the contracts offered.

Accountability

APPs strive to make the physician, the patient and the payer (Ministry of Health) more accountable so that healthcare dollars can be spent more effectively and efficiently. Meeting the accountability standards requires an excellent office management infrastructure, clear administrative policies and, above all, documentation of all clinical and non-clinical service-related activities. Even the best paper-based medical record systems will not provide physicians and staff with an efficient way to capture and document all of the direct and indirect services that qualify for bonuses offered by an APP. The potential loss in income can be significant. A comprehensive electronic medical records (EMR) system that is accessible to all participants, physicians and staff is the best solution for meeting all of the obligations required by the APP contract and, more important, for assisting the physician in capturing and receiving all of the potential benefits.

Salary

The physician who works on salary receives regular payment from an employer, which is specified in an employment contract, in consideration for services provided. Remuneration is often based on 'time-based payments'. Time-based payments provide a fixed dollar amount per specific time period. Time-based payments are made for active clinical work, but there may also be time-based fees for standby availability, administration, professional development, research and teaching. The specific time period can vary as well—annual salaries, sessional payments, shift stipends and hourly rates are all time-based payments. The contract will also often stipulate minimum expectations and maximum limits for payment. Therefore, working overtime or provided 'extra' time or services may not necessarily be remunerated.

In reality, only a small percentage of community-based GPs or specialists will work within a salaried format. Examples include physicians who work in community health centres, as clinical associates in cancer clinics, or as hospitalists. Most academic institutions will offer a variety of salaried positions.

As discussed later in this module, it is essential to dissect every APP and salaried contract in great detail to verify what obligations and benefits are included and excluded.

Key Message

There are a growing number of new payment models available to physicians. Comprehensive knowledge of traditional fee-for-service billing is essential when evaluating APPs. Conduct a detailed analysis with the expert advice of your professional advisors to help you choose the format that best suits your practice environment.

THE DIFFERENCE BETWEEN BEING SALARIED AND SELF-EMPLOYED

At the root of the question of compensation is whether a physician is engaged in a contract of service or a contract for services, and what are the subsequent tax consequences. Under the former, a contract of service physician is considered an employee, while the contract for services arrangement suggests that a physician is an independent contractor.

The consequences of whether a physician is an employee or is self-employed are considerable—particularly with respect to obligations for both federal and provincial income taxes. The many benefits of incorporation are available only to self-employed physicians.

For example, a pathologist who works solely for a single hospital that provides for all of his overhead and whose remuneration is fixed, regardless of the volume of work done, is generally considered an employee for tax purposes. A family physician who has sole control over his or her practice, is responsible for all costs related to that practice, and whose remuneration will vary with the number of patients seen or procedures performed will generally be considered as self-employed by the tax department.

When the situation is not so straightforward (e.g., a family physician who, in addition to generating FFS income in her office practice, receives predetermined payments for working one day per week at a downtown community clinic, working one shift per week at the local hospital emergency room, and teaching), Canada Revenue Agency considers several factors in the context of the entire working relationship to determine whether a physician is an employee or an independent contractor. These factors are: control; ownership of tools; chance of profit or risk of loss; and integration of work into the business of the owner/employer. The CRA offers more detailed discussion in its document titled "Employee or Self-employed" (see the Resources section). It is essential to seek the advice of an accountant in complex situations. (Also consult *Module 4. Personal And Professional Accounting And Taxation.*)

Salaried Employee

As a resident, you receive a salary that was negotiated by your provincial residents' association and is paid by the Ministry of Health. Income tax and employee contributions for Canada Pension Plan (CPP), employment insurance (EI) and other benefits are deducted at source by the medical institution that employs you. A biweekly cheque represents your take-home income, which is guaranteed by contract. You receive standard employee benefits, such as medical/dental coverage, disability coverage, potentially CMPA coverage, paid vacation and sick leave. Your contract stipulates your basic work hours, service obligations and expectations, as well as on-call duties and practice restrictions.

Regardless of the number of patients you see, the services you provide or the intensity of after-hours on-call work you perform, your income is fixed and non-negotiable. As discussed in detail in *Module 4. Personal And Professional Accounting And Taxation*, your professional deductions for tax purposes during residency are very limited. As well, you have minimal control over your work environment, the patients you serve, who you work with, the clinic's policies, holidays and your call schedule.

If you consider a long-term practice position for which you are offered a salary, you will, potentially, be subject to benefits and limitations that are similar to those you receive as a resident—unless you specifically negotiate for more favourable benefits, income and obligations. With the advent of alternative payment plans for academic centres, many new physicians will be obliged to do just that. There can be many variations in what is included or excluded in your contract. Your contract should address everything you give, everything you get and all of the "what ifs". If it isn't in writing, it doesn't exist! Therefore, it is essential that you seek professional advice before signing any contract.

Also remember that the term salary, when used to describe physician remuneration, may be a misnomer. Sometimes it is used to describe a guaranteed gross amount of payment for services rendered to a self-employed physician who is contracting services to an institution. In such cases, there are no benefits, and the physician is responsible for all professional expenses and income tax payments. Because the taxation implications can be profound, expert advice is essential.

Other PMC modules offer detailed advice about what to look for and negotiate when evaluating long-term practice options. Please consult *Module 10. Evaluating Practice Opportunities: Family Medicine*; *Module 13. Evaluating Practice Opportunities: Specialists*; and *Module 9. Principles Of Negotiation*.

The Self-Employed Physician Is Considered An Independent Contractor.

Medicine is the profession of all physicians. From an income tax perspective, however, there are limited allowable professional deductions for physicians who do not have either partial or complete self-employed status within the profession. Most physicians who qualify for professional deductions as independent contractors are self-employed, and will bill either entirely on a fee-for-service basis or participate in a blended program of FFS and alternative payment.

If you become solely self-employed, you will be responsible for generating all of your income, paying your personal as well as professional expenses, and calculating and paying your income taxes. You will have no guaranteed benefits unless you pay for them yourself, nor will you be paid when you take holidays or sick days—in fact, you may need to cover your share of operating expenses, even when you are away, unless you have a professional services agreement wherein you pay a fixed percentage of your gross income to the clinic in return for providing staff, office and equipment. This percentage would be deductible, akin to overhead costs.

As an independent contractor, you can still do some part-time work as a salaried employee, with some potential benefits. Your accountant will advise you about taxation and professional deductions. As with all scenarios, it is essential to clarify your professional status for taxation purposes with your accountant and your lawyer before you sign any contract. This is especially important for APPs in academic settings because, in many cases, the tax department will classify you as an employee, not an independent contractor.

THE SCOPE OF REMUNERATIVE SERVICES THAT PHYSICIANS PROVIDE

Physicians, like other professionals, are members of the professional services industry, where payment is offered for services rendered. It is essential that you understand the variety of services that you will be paid for and how they are measured, regardless of which remuneration model you choose. Essentially, physician services fall into two categories: clinical and non-clinical.

Clinical Services

Regular clinical evaluation, provision of procedures and management of patients. There are several categories of clinical services that physicians provide for their patients, and a specialty-specific fee may be paid for each of these services. However, not all of the time spent evaluating and managing our patients is captured for payment by specific fee codes. Alternatively, an hourly honorarium or salary may be offered, as is common in many emergency departments and institutional settings.

After-hours clinical care and medical supervision of patients. In the traditional FFS model, the physician on call would earn no income unless a medical service was provided. A salaried physician would be remunerated for after-hours work as part of the negotiated salary. In an alternative funding model, a guaranteed hourly payment could be negotiated either with the hospital directly, or with the Ministry of Health or regional health authority. Sometimes, FFS billing is possible in addition to the guaranteed hourly payment if a guaranteed "on-call stipend" is offered.

Because of the increasing shortage of physicians, many institutions offer guaranteed financial incentives for after-hours and weekend care, in addition to the FFS income generated while on call.

Non-Clinical Services

Administration and teaching. There are various ways for physicians to negotiate remuneration for administrative and teaching responsibilities. Examples include a mutually agreed upon hourly or daily honorarium, or a fixed annual payment for administrative and/or teaching responsibilities. Don't assume, however, that you will be paid for administration and teaching. Many physicians have taught and continue to teach part-time and provide hospital committee work on a voluntary basis.

Research. Alternative funding is required to cover the loss of clinical income when a physician conducts research. The institution may pay a salary or guaranteed honorarium for the physician's dedicated research time, or the physician may be responsible for acquiring grants to fund research.

Professional consulting. Physicians are often called upon to offer expert opinions. Payment for these services is typically based on an hourly fee, as negotiated with the requesting party (e.g., insurance company, pharmaceutical company, lawyer or regulatory college). Provincial medical associations offer billing guidelines for these and other uninsured services; members can access this information via their provincial association's website.

Medical record maintenance and management. While strict guidelines apply for the maintenance of physicians' medical records, for the most part, physicians are not remunerated directly for this requirement. (See *Module 6. Medical Records Management* and *Module 7. Electronic Medical Records*.)

FEE-FOR-SERVICE BILLING: PRINCIPLES AND MECHANICS

During our practice management seminars, we often hear questions such as:

"Why should I learn about fee-for-service billing if I plan to work in an academic centre where I will be paid a salary as part of their alternative payment plan, or if I am a family doctor in an APP?"

Our response is that an understanding of FFS billing is essential for all physicians, regardless of their payment model. There are several reasons.

- 95% of family physicians' and the majority of specialists' remuneration will still directly or indirectly depend upon the provincial specialty-specific FFS billing schedule of benefits.
- Alternative payment plans most often require shadow FFS billing for all services provided, so that the Ministry of Health can continue to track whether there is a change, improvement or drop in services offered under the new payment formula. This applies in Ontario, for example, where some family doctors work in capitated models, such as family health networks (FHNs), family health organizations (FHOs) and family health teams (FHTs). Shadow billing is also required of many specialists who work under APPs.
- Shadow billing requires the physician to submit an invoice for all services provided, as if still paid by FFS—even though there will be no remuneration for the individual service. To encourage compliance, bonuses for effective shadow billing are often being offered these days.
- Alternative payment plans require most academic institutions to capture and submit shadow FFS billing for all of the services provided by the faculty and residents.
- Institutions that have hired a hospitalist or government-sponsored clinical associate on salary will collect data regarding the equivalent services provided under an FFS model.

Failure to capture all shadow billings will result in an under-representation of services provided by both the individual physician and the overall group. This may have a significant negative impact when the group next negotiates for an increase in global funding. If all of the individual clinical work is not tracked, it will also adversely affect each physician's ability to negotiate his or her next contract renewal.

All physicians have a vested interest in ensuring that every service provided is documented. This can be difficult for individuals in a large institution, unless effective, efficient procedures and policies are in place. Unless one is financially dependent upon and responsible for tracking and submitting personal shadow billings, it is likely that a significant number of services will not be documented. When this happens, both the individual physician and the group may be compromised.

Case Example: Diligence Pays Off
Thanks to diligent double-checking of all clinical records, a manager who was responsible for an academic institution and her team were able to capture more than $1 million in shadow FFS billings that the physicians failed to submit in a one-year period. Imagine how four to five years' worth of missed shadow FFS billings would negatively influence the renegotiation of the APP contract renewal for that institution.

Obtaining A Billing Number

The process of applying for your MoH billing number is essentially the same in each province. Before you can apply, you need an independent practitioner licence or certificate that is granted by the provincial licensing body (e.g., the College of Physicians and Surgeons of your province) after presentation of certain required documentation, which may include:

- Photo
- Certificate of graduation from an accredited medical school
- Proof of successful completion of the RCPSC or CCFP exams
- Proof from the Medical Council of Canada of successful completion of the LMCC Parts 1 & 2
- Proof of Canadian citizenship or permanent residency status
- Evidence of standing in the College (i.e., no unethical activity or misconduct)
- Curriculum vitae
- Payment of an application fee, as well as first-year membership dues

Once you receive your independent licence to practise, you can apply for your billing number. Contact your local provincial MoH to request the application package while you are applying for your licence to practise. You also could consider applying for a billing number prior to graduation, noting that certain documentation (such as RCPSC results) is pending and will be forwarded upon receipt.

It is important to know that there is often a six- to 10-week delay before you receive payment for your first billings; therefore, seek advice from your financial advisor so that you can proactively plan for bridge financing during this period.

Once you receive your billing number, you need a way to submit your bills. In most jurisdictions, computerized billing and electronic data transfer is mandatory, so you will need to have a billing software program. This will be in place for new entrants who are joining existing practice groups. Verify that the group uses software from a reputable company that has been in business and serving many

of the local doctors for a long time, and has provided excellent on-site support and staff training.

If you are starting a practice on your own, ask the doctors in your area which software suppliers they use, and test their systems. Provincial medical associations often provide lists of available suppliers. (See *Module 7. Electronic Medical Records*.)

While most doctors delegate the responsibility for submitting their billing to a staff member, you can also use the services of a billing agent. Be aware, however, that, ultimately, you are still responsible for the accuracy and timeliness of your billings. It is essential that your office has a daily back-up procedure for all submissions made to the MoH.

Contact the provincial health insurance program to receive instructions and a manual of information about how to work with them. Your medical billing software company should assist you, however, with registering with the provincial health insurance program and ensuring that your computer submissions are readable. A test is generally submitted in advance of your start day in practice.

Once your application for a billing number and software submission are accepted, you will sign a letter of understanding with the provincial insurer, stating that you understand and accept the rules you must follow when billing. (Note: Physicians doing locums have three options for billing, which are discussed in detail in *Module 11. Locums: Negotiating A Mutually Beneficial Locum Contract*.)

The provincial health insurance program should provide all of the information required for you to carry on your daily interaction with the Ministry of Health. Read the material in detail; if ever you are in doubt, contact the office nearest you and ask to speak to an advisor.

Your physician information package will include:

- An overview of physician responsibilities
- Specialty-specific definitions, requirements and criteria for billing for services
- A schedule of benefits (general and specialty-specific)
- A claim submission and remittance manual
- A diagnostic and procedural code manual
- Remittance advice explanatory codes
- Remittance advice inquiry procedures
- An application for direct bank deposits
- Various forms
- Contact numbers

Read Everything.

It is extremely important to read everything about the schedule of fees. Ignorance of the rules is not a defence if your billing practices come under the scrutiny of your provincial health ministry. Do not rely on the example and explanations for billing you have received from peers and mentors; best practices are not always passed down by word of mouth.

Avoid Lost Income.

Learn your specialty-specific fee schedule, stay up to date, and always read every MoH bulletin that you receive, because fees can change. Don't delegate this task to staff unless you are confident that they will promptly advise you about any and all changes.

Research conducted by the Canadian Medical Association in the mid-1990s indicated that physicians, on average, failed to bill for at least 5% of the insured services they provided.

Example: A GP fails to bill for one $30 patient visit daily over the course of a year. If this doctor works 220 days (six weeks of holidays), then he or she will be $6,600 "out of pocket".

CMA research has also discovered that physicians and their staff fail to identify, correct and resubmit approximately 3% of the bills that were initially submitted but not paid by the ministry. If a physician has a potential gross income of $300,000 of insured services, the combined loss would be $24,000 per year. That means you will have provided $24,000 of insured services for which you were not paid. In many cases, the amount can be much greater. This lost income exceeds the maximum RRSP contribution one can make yearly—and the potential losses over 20 to 30 years is staggering.

All physicians have a vested interest in ensuring that their billing policies are effective and efficient. This is just as important for shadow billing, if you are participating in an APP.

Determining Specialty-Specific Fees

All MoH insured services outlined in the schedule of benefits are negotiated by the provincial medical association on behalf of their physician members. Each specialty has a specific section within the association that lobbies on the specialists' behalf for fees, removal of outdated services and addition of new services that the specialists believe should be insured by the MoH. Each specialty-specific section also determines its corresponding fee schedule for uninsured clinical services.

The Components Of A Bill

All of the following components of a bill must be correctly submitted by you or your billing staff before the MoH can review and remit payment. Therefore, every time patients register to be seen—whether at the office, outpatient clinic, ER, hospital or other location—it is important for them to present their health cards so that your staff can verify that the cards are valid. Each patient's demographic and personal contact information should also be verified and updated. In some provinces, the health cards have electronic strips that can be swiped for easy confirmation of some data, but up-to-date patient contact information is not included.

The following information may be required on your billing, depending on the service rendered:

- Patient identification (health card number with correct version code if indicated, name, date of birth and the expiry date of the health card)
- Doctor identification, including name and billing number
- Date of service(s) to the patient (multiple visits for hospital care can be submitted with one bill)
- Diagnostic (numerical) code, designating the diagnosis
- Alpha-numeric service codes, designating the professional service rendered. The number of services, if repeated, must be designated.
- Alpha-numeric procedural code, designating the procedures rendered
- Place of service, whether office, hospital, emergency, home, outpatient clinic, nursing home or other location (location identifying codes are provided by the provincial MoH)

- Premiums, extra payments, modifiers or bonus codes, if any
- Identification of the party responsible for payment (e.g., health plan insurer, Workers' Compensation Board, reciprocal provincial plan, third-party, patient or other payer)

The most common reason for rejected claims is the failure to submit the required information accurately.

Who Does The Billing?

Generally, it is your staff's responsibility to verify that the patient has up-to-date coverage and a valid health card, and to enter the demographic and personal information when you submit a bill for your services. However, you must indicate what services you performed. It is also extremely important to capture billings for services that your MoH allows you to delegate to your staff. In essence, you do the billing and your staff members submit the claims.

The Anatomy Of FFS Billing

Every clinical encounter can be broken down into essential billing components, and all appropriate components must be completed when a claim is submitted for payment. This module will reference Ontario billing codes for example purposes, but be aware that each province has its own distinct codes.

Diagnostic code. This code indicates the reason for the medical assessment or procedure. Most provinces utilize a modified three-digit version of the International Classification of Diseases (ICD) to designate how to numerically code the diagnosis. The list of numerical diagnostic codes is provided to each physician once his/her independent billing number is assigned. Note that the codes are not always specific.

Service code. These codes indicate the type and detail of service you provided during the patient encounter. This service fee covers your history-taking, examination, assessment, investigation plan and counselling of the patient, as well as the documentation of the encounter. Service codes are specialty-specific and are typically alpha-numeric combinations.

Examples for specialists would include the service code for a consultation, repeat consultation, specific reassessment or regular office follow-up visit. The coding may be different, depending on where the service was provided (e.g., the office, outpatient clinic, inpatient or emergency room). All physicians must learn the province-specific coding format.

Common service codes for family doctors include regular office visits, complete assessments, counselling, interviews, prenatal visits, well baby exams, house-call visits and limited consults. The place of service may require a specific code.

2010 Ontario fee schedule rates have been used for the examples that follow.

Example 1: An Ontario family doctor assesses a patient in her office for bronchitis. The diagnostic code for bronchitis is 466, and the service code is an intermediate examination A007A. The fee would be $32.35.

Example 2: An Ontario plastic surgeon is consulted to see a patient with a complicated fractured finger. The diagnostic code is 816, the consultation service code is A085A and the fee would be $77.55.

Procedure code: Professional, technical and tray fees. Procedures are billed in addition to the professional service fee. Minor and major procedures covered by

the MoH can be billed when performed by the physician or, when allowed, an assignee. Procedures may include a specific professional component, technical component or tray fee. The technical component and tray fee can be billed by the physician if he or she provides the equipment and staff to do the procedure; however, if the procedure is done in a hospital where all technical support and equipment is provided, then the physician can bill only for the professional component. Staff who perform procedures on your behalf must take care to include these technical and tray procedural fees in your daily billing submissions; otherwise, a lot of income can be lost. Which procedures are covered varies from province to province. Procedure codes are generally alpha-numeric.

Procedural fees are the bread and butter for such specialists as obstetricians, surgeons and ophthalmologists, and are especially important for anesthesiologists, radiologists and pathologists, whose billing is mostly procedure-based. Forgetting to bill for minor procedures, however, such as urinalysis, injections, phone supervision of anticoagulation and chemical treatment of skin lesions is very common among family physicians—and results in the significant loss of thousands of dollars of income each year.

Example 3: An Ontario family doctor who assesses a patient with rectal bleeding does a rigid sigmoidoscopy and makes a provisional diagnosis of ulcerative colitis.

Description	Code Number	Fee
Diagnostic code	556	
Service code for an intermediate examination	A007A	$32.35
Procedure code for sigmoidoscopy	Z535A	$36.80
Tray fee code for providing the instruments in the office	E746A	$5.85
Total fee		**$75.00**

Example 4: A respirologist has an office consultation with an asthmatic patient and does a flow-volume loop (volume-versus-flow study) and then repeats the test after a bronchodilator.

Description	Code Number	Professional Component Fee	Technical Component Fee	Total Fee
Diagnostic code for asthma	493			
Service code for the consultation	A475			$143.40
Procedure code for the initial flow-volume loop test	J304	$10.25	$19.05	$29.30
Procedure code for post-bronchodilator test	J327	$6.05	$2.88	$8.93
Total fee				**$181.63**

Example 5: A general surgeon sees a patient in consultation for an inguinal hernia, and performs elective surgery 12 weeks later.

Description	Code Number	Fee
Diagnostic code for inguinal hernia	550	
Surgical consultation code	A035	$89.30
Surgical procedure code (The procedural fee typically includes postoperative care.)	S323A	$331.80
Total fee		**$421.10**

Example 6: A radiologist reviews and reports on an MRI of a patient's knee. Only the professional component of the procedure is billable (unless the radiologist provides the MRI and staff—which is not allowed, for example, in Ontario). The professional procedure code is X471 and the fee is $66.10.

Special premium or modifier code. Additional fees are paid when the physician provides the service at a location other than the regular office or clinic and needs to travel to provide the service, and/or when the service is provided after regular work hours or on weekends or holidays. The terms "premium" or "modifier" may be used to describe this additional fee. In some provinces, these special visit premiums are now billed as two components: a travel premium (which is usually a set fee) and a special visit premium, which is coded and paid based on where and when the special visit is offered, as well as if one or more patients was/were seen during that visit. These codes are now very complicated. Provincial medical associations will offer additional resources to assist physicians to learn and capture these codes.

Example 7: A family doctor who is on call for his group is called on a Saturday afternoon by an emergency room nurse to come in to evaluate a colleague's patient. An ECG and chest X-ray is ordered, and is negative. The patient is ultimately diagnosed with non-cardiac chest pain.

Description	Code Number	Fee
Diagnostic code for chest pain NYD	785	
Service code for complete assessment	A003A	$68.75
Special visit premium for going to the ER on a weekend afternoon	K998 K963	$54.55 $36.40
Travel premium to ER		
Total fee		**$159.70**

In Example 7, the physician could not bill for the professional component of reading the ECG and the X-ray because all ECGs and X-rays are reviewed by specialists the next day. If this was not the hospital policy, then the physician could bill for the professional components but not the technical components, because the hospital provides the staff and the equipment.

Bonuses. As a result of primary care reform, bonuses are becoming increasingly important as a component of alternative payment plans for physicians who participate in patient-enrolled programs, as well as in provinces with enhanced

fee-for-service models, such as Alberta and British Columbia. Financial incentives are not the same in all provinces, so verify the situation in your jurisdiction.

These bonuses can apply in different formats. When a patient is officially rostered in your practice, a percentage bonus may be paid in addition to regular service fees for every encounter with a rostered patient. To join your roster, an individual will sign a patient enrolment form, indicating that he or she has enrolled with you as the family doctor. You sign and submit the form to the MoH. Once the enrolment is confirmed, the MoH will automatically pay an additional bonus fee for all services that qualify for bonuses.

Example 8: Q200 is the Ontario code for enrolling a patient in your practice when you are part of a family health group (FHG). The fee is $5.00. The bonus for seeing a rostered patient when you are participating in an Ontario FHG is 10% for routine daytime office visits. Therefore, for an intermediate exam, you would bill A007A for a fee of $32.35, and the MoH would automatically pay you a bonus of $3.23. The total fee would be $35.58.

You might also qualify for a bonus for meeting preventative care targets. Such bonuses may be offered retroactively when, for example, a physician who is participating in an alternative payment plan can confirm that he/she has given flu shots to 80% of patients in the target population over the past year.

Contact your provincial medical association to obtain the latest information about primary care reform and incentives that may be part of the offered alternative payment plans. A comprehensive electronic medical records system that will capture all of the required data will serve you well, and help to ensure that you receive all of the bonuses for which you qualify.

To learn more about FFS billing, please review the detailed self-directed learning tools provided in Appendix 1 for family physicians and Appendix 2 for specialists.

Key Message

For every clinical encounter and medical procedure undertaken by you or your staff members, verify that you have included the diagnostic code and all appropriate service codes, procedural codes and tray fees, premiums and bonuses.

The Billing Process

Now let's discuss some helpful explanations of billing mechanics.

Billing documentation. This is the process by which the physician and staff capture and document all possible billable services for submission to the MoH. Ways to capture this information include:

- Use a billing day sheet that has a list of patients seen and a column for all billing codes. This is prepared daily by staff for the physician or assigned staff member to complete. It is essential at the end of each day to cross-reference this with the appointment schedule and names of any additional patients given last-minute appointments.
- Combine billing with medical record documentation. With electronic medical record systems, the physician and staff can document bills at the same time that medical records of the patient visit are being completed. Reconciling these billings with your billing day sheet can really help to capture all billable services, especially those delegated to staff. Use a program for your personal digital assistant (PDA), designed to capture all services delivered when you are on call or providing services out of the office.

Forgetting to bill for one patient visit each regular office day will result in a loss of upwards of $6,000 per year or more.

Medical records and billing. Your medical records must stand alone, without your interpretation, to justify the bills you submit to the health plan insurer. At any time, the MoH can request copies of the clinical records that correspond to the bills you submit. Be honest and accountable. For more information, see *Module 6. Medical Records Management.*

Billing submission. Most physicians should submit billings daily, or at least three times per week. Some specialists, such as surgeons, tend to submit billings weekly. Once you and your staff have accounted for all of the appropriate billing codes for every patient, submit the bills to the MoH.

In most provinces and territories, this is done by electronic data transfer (EDT). Electronic submission enables the MoH to review all submissions and to quickly verify which, if any, are not accepted. The next time your staff go online, they can check which bills from the last submission are not accepted, pull the charts, correct the errors that the MoH will identify with explanatory codes, and then resubmit the corrected bills—so that you can be paid within the same billing period. This reconciliation, or comparison, is important to ensure that you receive remuneration for all services you provide.

Remittance. This is the process wherein the MoH or other responsible payer remits payment to you. MoH payments are generally made by automatic deposit into your designated bank account. You will receive, electronically, a remittance advice document, which you must reconcile.

Remittance review and reconciliation. Your computerized billing program will automatically reconcile or compare your billing submissions with the corresponding remittance records from the MoH. Pay careful attention to what isn't paid and why. Failure to correct unpaid remittances may result in lost income for work you have performed and procedures for which you are legally responsible.

Billing period. Depending on the province, the MoH pays physicians either once or twice monthly. In general, the billings you submit for services rendered up until approximately the 25th day of each month will be paid for as of the 15th day of the next month. Bills submitted right at the end of a month will not be paid for at least six weeks, which means that your accounts receivable (monies owed to you) can sometimes take six to eight weeks to be settled.

Submission time limits. In most provinces, physicians need to submit the bill for a service rendered within three months of performing the service. Some provinces allow six months. Those who fail to do so will not be paid and cannot bill the patient directly. This commonly happens when a physician fails to record and hand over to the billing staff the record of services performed outside of the office (e.g., when on call.) Many physicians have scribbled patient information from the hospital visit on a card, then have forgotten to empty their purses or wallets until it was too late to submit the bill. Your timely use of handheld technology should make this a scenario of the past.

Reciprocal billing. What if the patient is from another province? In such cases, it is essential to have the patient present a valid provincial health card, and to verify the party responsible for payment. All provinces and territories except Quebec have a reciprocal agreement, so you can use your billing program to submit the bill to your provincial MoH, using the patient's provincial health card number. You will be paid according to the fees of your province, not those of the patient's home province.

If you work outside of Quebec and see a Quebec resident, you have the following options:

- You can bill these patients directly, using your provincial MoH fee scale. Give the patient a receipt and record of services provided, and he/she can submit for reimbursement from the Quebec Ministry of Health. You can provide these patients with a specific form that you can order from the Quebec MoH. The "Application for Reimbursement – Health care services insured outside Quebec" is available in English and French. The patient can complete this form without the time and assistance of your office staff. This is the billing option most physicians utilize.
- You can bill these patients directly, using your provincial medical association fee scale. As above, provide an appropriate receipt and reimbursement form.
- You can bill these patients directly, using Quebec fee codes and fees. Once again, provide an appropriate receipt and reimbursement form.
- You can register with the Quebec MoH and obtain a billing number so that you can submit accounts directly to the Quebec MoH, which will remit payment to you. This option is most often exercised by physicians who work near the provincial border and see a significant number of patients from Quebec. Note that physicians pay an annual fee to the Quebec MoH to provide this convenience for patients.

If you work in Quebec and see Canadians who are not residents of Quebec, you have two options. In either case, use the Quebec government Form 2688, Out-of-Province Claim for Physician Services/Réclamation hors province pour services médicaux (available at http://www.ramq.gouv.qc.ca/fr/professionnels/form_pro/pdf/2688-f.pdf).

- You can bill the Ministry of Health in the province where the patient is resident. Some provinces will pay according to the Quebec fee schedule, others according to their own fee schedule.
- You can bill the patient directly.

BILLING FOR NON-CANADIAN PATIENTS

Sometimes visitors to Canada need medical attention and come to Canadian physicians for assistance. Generally, you would use your provincial medical association fee schedule as a guide for billing foreign patients, such as American tourists. The Canadian Medical Protective Association (CMPA), however, may not provide legal assistance to physicians who offer medical services to non-Canadians.

To ensure that you will not be incurring significant medico-legal liability without knowing it, contact the CMPA to verify what criteria are needed to maintain your coverage, or whether you should obtain other liability coverage. Some information is available on the CMPA website (www.cmpa.org), including such policies as CMPA assistance in legal matters initiated by non-residents of Canada and CMPA assistance in internet and cross-border prescribing to non-patients.

BILLING THE WORKERS' COMPENSATION BOARD

You must register with your provincial Workers' Compensation Board (WCB) before you can submit bills. Once you contact the WCB to establish a billing account number, you will be sent the physicians' guide, which explains how to bill for clinical services and how to complete the required forms.

There are two components to a WCB bill: the bill for the professional services, and the bill for completion of the specific WCB forms. In some provinces, physicians bill the WCB for the professional service and/or procedure in the same way that bills are sent to the MoH. The only difference is that it is important to change the "responsible party" window of the MoH billing template to "WCB". (Note: You will be paid by the MoH with your next remittance and the MoH will be reimbursed by the WCB.) Some provinces oblige you to bill WCB directly for both the service and the form completion.

When billing for form completion, physicians typically send the paperwork directly to the WCB. The physicians' first report form and the progress report forms requested by WCB have billing codes and a section where the physician enters his/her WCB billing account number, as well as the patient's provincial health number. Because the WCB pays physicians directly for completing the required forms, you will need to establish an accounting format for tracking the submission and payment of WCB forms and other uninsured services.

Family doctors are usually the ones involved with the first reports and progress reports, but consultants may also bill WCB for their services.

Example 9: You evaluate a patient who works several hours per day at a computer terminal and presents with a right lateral epicondylitis that, by reasonable history, is secondary to repetitive strain injury. You recommend physiotherapy (covered by WCB) and an ergonomic evaluation of the patient's workstation.

You complete the physician's first report (Form 8 in Ontario) and fax it to the WCB. The diagnostic code is 727 (tendonitis), and the service fee is an intermediate exam A007A ($32.35), billable to WCB via the MoH. The fee for Form 8 is $65.00, which will be sent to you directly by the WCB. The total is $97.35. The patient must be advised to complete her own form, and have her employer complete a form for WCB so that she can receive a claim number. You will be paid for your office visit and Form 8, regardless of whether the patient is ultimately accepted for a claim number.

All provincial WCBs are members of the Association of Workers' Compensation Boards of Canada and can be located through the national website (www.awcbc.org).

ALWAYS DETERMINE THE PARTY RESPONSIBLE FOR PAYMENT

With every patient's medical consultation, it is important to verify who is the party responsible for payment.

Billing the MoH for a work-related condition contravenes the agreement physicians sign when obtaining the MoH billing number. It also negatively affects MoH global funding limits, because WCB services will be included inappropriately in the statistics of total physician billings. Failure to submit the physician's first report and progress reports to the WCB compromises patients' access to insured physiotherapy treatment, and many other resources.

Physicians are obliged to proactively inquire whether the patient is covered by WCB. If in doubt, send in a physician's first report and bill WCB for the service (and remember that WCB will also pay you for completing the required forms). If the patient is not covered by the WCB, you will be able to submit the bill for medical services (but not form completion) to the MoH.

If it is a WCB case but the patient does not allow you to notify the WCB, document the situation and bill the patient directly for the service—the provincial health insurer will not cover work-related conditions that should be billed to the WCB as the party responsible for payment.

THIRD-PARTY BILLING AND UNINSURED SERVICES

Many of the services that physicians provide are not insured by either the MoH or the WCB. The party responsible for paying for the service may be an insurance company, the employer or a lawyer—but very often it will be the patient.

Uninsured services have always existed, and are clearly defined in the preamble of the MoH schedule of benefits. Recommended fees are updated annually by most provincial medical associations. When you compare your medical association fee schedule with the provincial MoH fee schedule, note the often significant difference in fees recommended by your association compared with those paid by the MoH.

Common uninsured services include insurance reports; medico-legal reports; missed appointments; phone call prescription renewals; sick notes and medical certificates; cosmetic procedures; medical examinations for work, travel or insurability; and chart transfer and summary.

Many of today's physicians still hesitate to bill their patients for uninsured services. Prior to 1969, physicians billed patients directly at provincial medical association rates and, on average, collected only about 70% of all billings. When universal health care was introduced in 1969, medical professionals welcomed the MoH as a guaranteed payer for insured services. Physicians subsequently lost touch with both the concept and the practical aspects of billing patients for services rendered. The guaranteed FFS payment by the MoH, which at the time was negotiated to pay 90% of the provincial medical associations' fee schedule, allowed physicians to distance themselves from this very important business responsibility—and they then became less diligent in capturing and billing for uninsured services. For many years, patients also assumed that all medical services, not just "medically necessary" services, were insured.

This has resulted in a generation of physicians who are reluctant to bill patients for uninsured services, even though reduced income is the most common complaint of physicians across the country. The reduction in individual physicians' incomes has been largely due to the provincial health ministries' decision to increasingly distance their fee schedules from the provincial medical associations' recommended fee schedules for insured services.

A significant percentage of residents have had little or no exposure to third-party and uninsured service billing during residency.

Surveys have determined some of the perceived reasons why physicians don't bill for uninsured services:

- It will create public relations problems.
- It will create administrative problems.
- It is not financially worth it.
- I have never done it.
- I don't want to be the first in my group to do it.
- I don't know how.
- My patients won't like me.

Key Message

Before you offer medical services, always determine who is responsible for payment. Then be sure to bill the appropriate payer for all services rendered.

As a new-entrant physician, you will need to develop your own policy regarding billing for uninsured services. Alternatively, if you think you will be joining an existing group practice, part of your evaluation will include determining the group's policy. It may be necessary for you to educate other physicians regarding the appropriateness and benefits of billing for uninsured services. If you do not attach a value to your time, neither will your patients and society. By establishing that your time and expertise for services outside of Medicare have value, your patients will not assume that your available time is endless.

What will really happen when you bill for uninsured services?

- Your patients will recognize that several services they have requested of you are not insured by the provincial MoH.
- You will accept that your time spent providing these services is valuable time.
- You will get paid for things that were provided free of charge in the past.
- Your revenues will increase.

Be Proactive From Day One.

Include your policy regarding uninsured services billing in your new patient information package (see *Module 12. Starting Your Practice On The Right Foot*).

Always inform patients of their responsibility for payment prior to providing the uninsured service. Doing otherwise is deemed professionally improper by the regulatory colleges and is a very common reason for patient complaints.

Example 10: You evaluate a patient in your office for an exacerbation of asthma and the patient requests a medical certificate for sick leave for the three days he will miss work. He receives paid sick leave benefits. Your diagnostic code is 493 fo asthma, your service code is A007A ($32.35) and you charge the patient $15 for a completed and signed medical certificate of illness that notes the date he is to return to work.

Remember: Any time you sign a form, you are in fact offering a medical opinion for which you are medically and legally liable. Never devalue the significance of your professional signature. This is a key reason why a charge should be levied for your effort.

Appendix 1 provides more examples of uninsured services billing for you to work through.

Always Use Discretion.

You should always use your discretion when billing patients, particularly if you suspect that a bill will cause financial hardship. By tactfully inquiring about a patient's ability to pay, you can consider either reducing the bill or delivering the invoice and marking it as "No Charge". In such circumstances, we recommend that physicians inform their patients of the decision to reduce charges or not charge at all. Patients will appreciate this immensely, and will not feel demeaned or patronized.

Always back your staff up when they carry out your office policies. If a patient disputes any policy that your staff members carry out, act immediately and personally to diffuse the issue.

THE GOLDEN RULES OF BILLING

You should always follow the Golden Rules of Billing.

- Be honest.
- Be accountable.
- Be knowledgeable.
- Be meticulous.
- Be effective.
- Be efficient.
- Always close the loop to be sure you're paid for all billable services rendered.

Although many of the billing tasks will be delegated to staff, establish a protocol so that you personally review the status of all aged accounts receivable (outstanding unpaid accounts listed chronologically) on a monthly basis.

Billing Checklist

- Stay up to date with the fee schedule.
- Complete all components of the bill.
- Always verify what party is responsible for payment.
- Capture all billings, no matter how small.
- Bill the WCB whenever appropriate.
- When billing the MoH, confirm that the billing is for an insured service that is not work related.
- If the patient is responsible for payment, inform him/her before you provide any medical service.
- Be proactive, but use discretion when billing uninsured services.

Key Message

Every physician needs to understand fee-for-service billing. Stay current with the fee schedule, and bill for uninsured and third-party services as appropriate.

ACTION PLAN

- **Understand the different remuneration models for physicians.**
- **Clarify your independent contractor status before signing any contract.**
- **Become very competent and knowledgeable about your specialty-specific FFS billing.**
- **Get expert advice to assist in evaluating any APP.**

RESOURCES

Valuable Websites

Provincial Medical Association websites can be accessed via cma.ca.

Resources available on cma.ca:

- *Alternative Payment Models to Fee-for-Service*
  An analysis of how physicians are remunerated for clinical and non-clinical activities was prepared by the Physician Consulting Group Inc. on behalf of MD Financial Management. This self-learning module is designed to assist CMA members who are considering new payment models as an alternative to conventional fee-for-service or salary.

- *A Physician's Guide to Implementing an Electronic Medical Record (EMR) in Medical Practice*
  As increasing numbers of CMA members consider a migration to electronic records, MD Financial Management offers this self-learning module to help doctors prepare for the changeover. The module outlines a process by which to assess readiness, identify vendors, evaluate products, then choose and implement an EMR program. See the MD Financial Management website at cma.ca.

Resources Available From Canada Revenue Agency

- *Employee or Self-employed*
  Visit the CRA website at http://www.cra-arc.gc.ca/E/pub/tg/rc4110/

Resources Available From The Canadian Medical Protective Association (www.cmpa.org)

- The CMPA offers assistance in legal matters initiated by non-residents of Canada.
- The CMPA also offers assistance in internet and cross-border prescribing to non-patients.

Module 9:
Principles Of Negotiation

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plans to best fit their personal and professional aspirations. You are advised to consult with professional advisors to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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Key Learning Points

- *Negotiation is a life skill*
- *Essential negotiation points of any position: Income, service obligations, financial obligations and potential benefits*
- *How research and personal assessment will help you to find and optimize the right practice opportunity*
- *The three steps of negotiation: preparation, bargaining and settlement*
- *The dynamics of successful negotiation: amicable rapport, trust and fairness*
- *Who is authorized to approve the terms you have negotiated?*
- *The importance of having your lawyer review any and all potential agreements*

INTRODUCTION AND OVERVIEW

Although physicians are often timid about entering into any type of negotiation, each of us has observed, practised and exercised negotiation skills, particularly during medical school and residency. Whether you have negotiated with your program director for a desired elective or rotation, reasoned with fellow residents over call schedules, or compromised with your significant other about who should take out the garbage, you are not a stranger to negotiation skills and methods.

The need for negotiation is everywhere. Although most residents in their final years of training are particularly concerned about how well they can bargain for potential practice opportunities, the following discussion is applicable to all types of negotiation, both inside and outside medicine. Negotiation is a life skill and everyone improves with experience. Understanding some of the theory behind negotiation will help you gain confidence and skills for future bargaining encounters.

The Times They Are A-Changin'

Singer-songwriter Bob Dylan's third studio album, "The Times They Are a-Changin", released in 1964, predicted the tumultuous political and social environment of the 1960s. These same words may be suggestive, however, of the changing environment of medicine that physicians in Canada are facing today.

In recent years, physicians finishing residency and fellowship programs have seen a considerable change in the number and quality of practice opportunities in Canada. Previous concerns of a shortage of physicians in Canada prompted an increase in medical school enrolment, to 2,800 in 2011/12 from 1,577 in 1997/98 (*CMAJ*, October 18, 2011). Today, the consequent increase in the number of physicians completing training, combined with expanding scopes of practice in some specialties and issues surrounding resource planning, as well as certain other factors, have resulted in a growing risk of unemployment and under-employment for residents in an expanding numbers of specialties, including cardiac surgery, nephrology, neurosurgery, plastic surgery, public health and preventative medicine (community medicine), otolaryngology, radiation oncology and orthopedic surgery (*CMAJ*, October 4, 2011).

Complicating the growing supply of physicians in Canada are the fiscal implications of decreased funding for health care, as federal, provincial and territorial governments move to counter growing fiscal deficits. After talks between Ontario's doctors and the minority Liberal government stalled, on May 7, 2012, Ontario Health Minister Deb Matthews unilaterally imposed reductions to the provincial physician fee code. The website *canadianhealthcarenetwork.ca* reported that Matthews said the "... very highest-paid specialists where we've seen the windfall gains" will be targeted. Indeed, three days later, in the same publication, former provincial Minister of Health and Long-Term Care George Smitherman was quoted as saying "... the government [has] decided to make [Ontario physicians] the poster child for austerity". A number of provinces are closely following the actions in Ontario as they evaluate alternatives to control healthcare spending in their own jurisdictions.

Physicians graduating today will surely confront the consequences of the increasing supply of physicians, as well as the implications of the actions of governments to balance their budgets to counter unfavourable fiscal realities. When progressing through the steps of any negotiation, the prudent resident or fellow should consider these factors as they apply to members of their respective specialty, as well as to their own respective situation.

CRITICAL NEGOTIATION POINTS

When approaching the end of training, residents and fellows confront at least two major challenges: successful completion of their respective RCPSC or CCFP qualifying examinations, and identifying the optimal practice opportunity. Before investigating practice alternatives, however, astute physicians should set aside preparation time to evaluate themselves, their lifestyle desires, career goals and objectives, as well as such aspects of their specialty as expected workload and remuneration. Questions commonly asked include:

- What potential income or billing level should I expect?
- What will my clinical and academic responsibilities be in the position?
- What will my financial obligations be to the practice, group or department?
- What benefits are available?
- What other requirements, duties or responsibilities will the position demand?

These questions are important, and finding answers should not be left until the interview stage. Take the time to research and prepare. You then will make a more objective and informed evaluation of prospective practice opportunities—and your reward will be personal and professional satisfaction with the practice opportunity you choose.

The essential negotiation points for any practice opportunity include income, service obligations, financial obligations and benefits, such as paid holidays, time for continuing medical education (CME) insurance, pension plans and moving expenses.

Income And Remuneration

Income is a touchy subject for many people. However, physicians who attend an interview or enter into contract negotiations without knowing what level of income or gross billings they can expect from the opportunity risk shortchanging themselves, both financially and personally.

Potential gross billings and net income for your specialty are not necessarily secrets, and you may find this information from many sources. Colleagues who recently started practice are excellent sources of information regarding current income trends, and may have other tips based on their own experience in looking for positions. In addition, your program director, the head of your department and other staff physicians may be willing to share their insights regarding the financial prospects for your specialty. Staff physicians will not only be aware of the current remuneration rates, but may also know of useful contacts or potential opportunities in both academic and community medicine.

Provincial medical associations often provide their members with data about the average annual billings for each specialty. Some provincial medical associations have done detailed studies of remuneration of physicians in their jurisdictions. As these figures typically represent gross billings, you must factor in overhead costs when evaluating the before-tax net income of your field of medicine. In addition, many professional specialty associations provide data, by province, on the average income for their academic and community physician members.

When evaluating any opportunity, inquire about all of the potential income sources that may be available to you. In addition to gross billings and/or salary, many positions provide opportunities to earn additional business income, including remuneration for uninsured services. Although academic positions often provide stipends, such remuneration may be minimal, particularly for junior staff physicians.

This research will place you in a better position to determine whether potential offers are equal to, below or above existing market rates. When obstetricians in a particular area have gross billings of $300,000 a year, for example, opportunities that promise $150,000 per year should be looked upon with suspicion. Doing your homework provides an informed and objective perspective with which to evaluate offers and conduct subsequent negotiations.

Service Obligations

All residents can recall a junior staff person who seemed to be doing more work and earning less income than more senior colleagues. Although many professionals may be willing to pay their dues to "climb the ladder", astute residents will do their homework and determine what their responsibilities will be before accepting any offer. Those who plan ahead will avoid unpleasant surprises later.

There are numerous questions to ask about what one's role will be in various situations. If the position is in a group, association or department, what will the new physician's responsibilities be? What workload will be expected? What will the on-call responsibilities be? For university appointments, will there be expectations in terms of publications in peer-related journals?

If you are considering an academic position, what are the clinical and teaching responsibilities? Is research a requirement? Who is responsible for preparing and submitting the research funding applications? Is administration of the practice the responsibility of the physician, is it shared among other physicians, or is it provided by another group? Is there a specified term for the agreement or will it continue indefinitely? If the physician decides to leave at some time in the future, what will be the required notice of termination, and what penalties, if any, will be incurred?

Service obligations will vary, depending on the individual, the specialty and the opportunity. Ask questions! Research is the best way to gain an understanding of your potential position should you decide to accept a particular opportunity.

Financial Obligations

In a sole proprietorship, financial obligations almost always rest entirely with the physician. Most newly graduated physicians, however, will become members of an association, partnership, group or department, and will share the costs of administration and operation of the practice with the other members of that organization. The financial terms and obligations are generally set out in an agreement or contract, such as an association or partnership agreement. Anyone who considers joining a group practice should review the agreement with a lawyer to determine if the allocation of costs and obligations is fair and equitable, and that their understanding of the opportunity is correctly reflected in the document.

If you are considering a group practice, ask about potential liabilities within the group. If the group owns the office building, is the mortgage liability shared? In addition, it is important to determine how the group makes decisions (e.g., simple majority, two-thirds vote or some other method) and whether such a method is acceptable to you. If you fail to assess the appropriateness of the decision-making process, you may find that you have unknowingly assumed a share of the liability for the purchase of an expensive piece of equipment—perhaps a purchase to which you had objected!

Never assume that someone else is paying all the bills, and don't, through ignorance, put yourself in the position of assuming all the responsibility for the cost of operating a particular practice. Ask questions, do your research and become knowledgeable about the financial obligations of any practice. It is in your best interest to fully understand your potential commitment.

Benefits

Many physicians who practise in a fee-for-service environment assume that no additional benefits are available for their position and that they must assume all costs related to the practice. Because of the shortage of family practitioners and other specialists, however, the situation may have changed in these respective jurisdictions. Some specialists working fee-for-service have negotiated a guaranteed minimum billing amount for each year of practice, reducing their risk in the event that their access to operating rooms or other resources is restricted. Some hospitals have offered salaries on top of fee-for-service billings in an effort to recruit and retain physicians. Many hospitals and communities also offer financial incentives, such as moving costs, signing bonuses or relocation allowances, to attract family practitioners and certain specialists.

Educate yourself about the market for your specialty, because knowledge is power. If benefits are available to others in your specialty, a prospective practice opportunity may wish to match the offer in order to recruit you. Benefits may include:

Insurance. Life, medical and dental insurance may be provided by the department, hospital, health region or province of your potential practice. Even if you are responsible for your Canadian Medical Protective Association (CMPA) dues, many provinces reimburse physicians for a portion of the CMPA dues, depending on location and specialty. Some employers may cover that portion of CMPA dues that has not been reimbursed by the province or territory.

Holidays and time allowed for continuing medical education (CME). While physicians who work in fee-for-service arrangements must arrange their own vacation time, the hospital may assist in finding locum coverage. It is essential that physicians who work in a group or departmental practice are guaranteed a certain amount of vacation (typically, at least four weeks per year) and time for CME (the market rate for CME time and funding is 10 working days and at least $4,000–$5,000 per year). Please be aware that certain provincial medical associations, such as the Ontario Medical Association, have programs that may provide financial relief for CME costs incurred by members.

Professional association dues. Although membership dues for the Canadian Medical Association, specialty societies and provincial medical organizations may be tax deductible as either a professional due or business expense, some hospitals or health boards may offer to pay such necessary costs of practice.

Pension plans. Most physicians are not members of registered pension plans (RPPs) and must rely on contributions to registered retirement savings plans (RRSPs) to ensure that they have adequate resources for retirement. A pension plan provided by an employer is generally a very welcome benefit, and the details should be reviewed by your accountant and/or lawyer. Most RPPs are generous, and the individual physician's contributions are often matched or exceeded by the hospital or health region.

Car allowance and parking. Parking may be provided by the group, department, hospital or other institution. In addition, when the physician must utilize his or her car for hospital purposes (e.g., administrative meetings), a tax-free allowance may be provided.

Moving expenses. This perk was almost unheard of just 10 years ago, but today, hospitals attempting to recruit family doctors and specialists are increasingly willing to cover moving costs to entice physicians to relocate. This benefit can amount to a considerable amount of money—particularly helpful for a new graduate who is struggling to build cash flow in the early days of practice.

Start-up loans. Specialists and family physicians are often surprised by the initial investment required to set up their offices. Ophthalmologists, for instance, must invest between $150,000 and $250,000 in specialized equipment before they begin to see patients. Hospitals and other organizations sometimes offer low- or no-interest loans to help a physician set up for practice. However enticing the preferential interest rates, the potential tax implications should be reviewed with your accountant.

Other Requirements

There will be many additional pertinent questions that are crucial for an appropriate evaluation of any practice opportunity. What operating room time is available? Is a procedure room available and appropriately staffed? Is office space available? If the position provides support staff, will you be able to select and hire the people who will be working with you? If you will be performing research, who will provide the research staff and equipment? Will parental leave be available?

You should give considerable thought to any and all positions you are evaluating, and investigate the "what ifs" of every opportunity. Don't make assumptions—ask questions instead.

More information is available in *Module 10. Evaluating Practice Opportunities: Family Medicine; Module 11. Locums: Negotiating A Mutually Beneficial Locum Contract;* and *Module 13. Evaluating Practice Opportunities: Specialists*.

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.

A RATIONAL APPROACH TO NEGOTIATION

In medicine, an educated and organized approach leads to optimal patient care. Similarly, an educated and organized approach to negotiation leads to optimal agreements, and subsequently, to personal and professional satisfaction.

Negotiating skills can assist you in both good times and bad. If you want a particular opportunity but feel your position is weak, negotiating skill can help you to avoid a power confrontation that may result in failure. If you feel that your position is very strong, negotiation skill can help you to expand an existing agreement and maximize your remuneration—both financial and non-monetary.

Objectives: Integrative Versus Distributive

The objective of negotiation is to attain the best possible deal that will improve your existing position.

Traditional business school teaching states that the goal of a negotiator is twofold:

1. to increase the size of the pie (*integrative negotiation*); and
2. to maximize one's share of the pie (*distributive negotiation*).

Although the value of *distributive negotiation* is self-evident, we often forget the value of *integrative negotiation*. Suppose, for example, that, because of your interests and training, you bring a unique skill to a medical group that may help the group to see and care for patients more efficiently and effectively. The total remuneration pie for the group—both monetary and non-monetary—will be increased, and all members—including yourself—may benefit from a larger pie. In addition, the value of your contribution may reap additional rewards, such as a more amicable, professional and successful professional relationship with your partners and colleagues.

Under-Confidence And Overconfidence

As a consequence of long years of study, extended hours of work, exam pressures and often playing a subservient role, many residents undervalue their abilities and assets. A lack of confidence is a real disadvantage in negotiation, however; you may make unnecessary concessions without adequate return and may settle for a suboptimal agreement that, ultimately, will be costly—both personally and professionally.

There are many positive factors senior residents and fellows should keep in mind when considering job opportunities and offers. The demand for medical services is growing, and your role in the delivery of health care is important and, quite often, pivotal. Today's residents have more specialized skills than any generation of physicians before them, and residents already make a significant contribution to the health care of patients. Furthermore, physicians who have recently completed either FRCPC or CCFP qualifying examinations are considerably more up to date with the medical knowledge and skills for their respective specialty. This more accurate perspective of your abilities and skills and the demand for your services will serve you well in any bargaining situation.

Be wary of overconfidence on the other hand. Overconfident negotiators often think they know in advance how a negotiation *should* end. They consequently ignore useful information and refuse to consider alternatives or creative solutions. Although overconfidence may be infrequently exhibited by graduating residents and fellows, you may encounter it with your negotiating counterparts from a recruiting department, hospital or community. For example, a resident may be contacted by a hospital that provides little or no information about itself or its potential opportunity, yet expects the resident to quickly and unquestionably accept any offer. Such unfortunate situations may be the consequence of poor management or ignorance of the market, but may also result from the recruiter's overconfidence. Do not allow yourself to feel that you need to accept an offer that doesn't recognize your value!

NEGOTIATION STRATEGY

An educated and organized approach to negotiation will help you to achieve optimal agreements that provide both professional and personal satisfaction. There are three important stages to any negotiation: preparation, bargaining and settlement.

1. Preparation

Ensure that you have done your homework before evaluating—or even contacting—potential practice opportunities. Review your goals, desires and objectives, both personal and professional. Research the market for your specialty, including identifying potential opportunities, determining the gross billings or average rates of remuneration in your field, and investigating the monetary and non-monetary benefits that might be available. You should also learn about your negotiating partners and the specifics of the opportunities you are considering—such as the likely number of applicants for the position, the specific professional needs of the group or institution, and the positive and negative attributes of the respective practice.

Set Your Boundaries.

Before initiating negotiations, you should set certain boundaries and frames of reference that will enable you to evaluate an opportunity. Appropriate research should give you enough knowledge to objectively position your own skills, training and abilities in relation to the "market rate" and the specifics of the opportunity.

Best Alternative To A Negotiated Agreement (BATNA)
Your objective in any negotiation is to obtain the best possible deal that will actually improve your position. Knowing and assessing your alternatives protects you from making unwanted commitments. Your best alternative is your BATNA. Your BATNA is the Plan B that helps you to say no to existing negotiations if the possibility of reaching a satisfactory agreement becomes doubtful.

For example, a senior resident may be bargaining for Position 1. After assessing and evaluating other opportunities, the resident realizes there is at least one other opportunity available with similar benefits but slightly lower remuneration. If, during negotiations for Position 1, the other negotiator begins to demand unreasonable concessions, having knowledge of an alternative—or BATNA—will empower the resident to back out of the faltering negotiations.

Some physicians negotiate for their dream job without a BATNA, only to discover that their counterpart demands significant concessions as the deal comes to a close. Stressed because they appear to have no alternative, they feel pressured to concede and make the deal. These physicians often accept all concessions and sign a suboptimal deal because they feel they have no option. In fact, they've failed to establish a BATNA.

Reservation Price
A *reservation price* is closely linked to your BATNA and represents the value below which you would accept an impasse rather than concede to the terms of an existing offer. With appropriate research and knowledge of the benefits and obligations of a particular position, you can easily have a reservation price in mind that ensures that you will not settle for less.

A reservation price may be monetary, such as a given level of remuneration, or non-monetary, such as a set number of operating room or procedure room days.

Expert negotiators confirm that it is always useful to establish one set of conditions that describes one's reservation price, then evaluate all offers against this set of conditions. Never make a deal below your reservation price without careful consideration.

As a resident earning a fixed income, you may think it would be irrational to choose impasse over *any* agreement that provides more compensation than you currently receive as a resident or fellow. If you are willing to walk away from marginal opportunities, however, you will keep yourself free to find and consider other options that may offer a better agreement.

Target Price
A *target price* or *target set of conditions* describes your wish list or dream agreement. Setting a target price helps to shift the direction of negotiations away from obtaining just enough with an eye trained instead toward obtaining what you truly want.

During negotiations, you should focus on the target price rather than your BATNA or reservation price. This ensures that the potential benefits of any agreement can be maximized. Expert negotiators will remind you that "you cannot get something if you do not ask for it". Furthermore, you will not even think to request certain benefits if you are unaware of the components of your ideal agreement or target price. Planning and establishing your target price is essential.

Some bargaining partners may test your resolve by keeping their offers of remuneration and resources closer to your reservation price or BATNA rather than your target price. If your research demonstrates that you are in a strong negotiating position (e.g., few or no other candidates), it may serve you well to create doubt in your counterpart's mind about the point at which you would prefer impasse. A sense of doubt, raised in a diplomatic and professional manner, may shift negotiations back in your favour and the offer may more closely approach your target price.

Information Is Essential.
As you can see, being prepared is essential to attain successful negotiation. Having accurate information before, during and after negotiations is equally essential. Without good information, the bargaining parties may not stay open to mutually beneficial opportunities, may incorrectly assess the pros and cons of available opportunities, or may allow discussions to falter without good reason. Just as doing a surgical consult without seeing the patient or reviewing X-rays and the hospital charts will probably lead to suboptimal patient care, failing to obtain accurate information or relying on inaccurate data can doom a successful negotiation.

Continue doing your research as negotiations progress. Document your findings instead of relying on your memory (see below). Be flexible and open minded, and explore ideas or suggestions that may lead to preferred solutions for both you and your negotiating counterpart.

Importance Of Documentation
Documentation is important. Although verbal promises may be made during negotiations, the respective parties may not recall (deliberately or inadvertently) such commitments once the contract is completed. Documenting what is agreed upon during the talks will protect both parties. Remember the advice from *Module 5. Legal Issues For Physicians:* "If it isn't written in the contract, it did not happen."

Major terms and conditions should be documented within a binding contract. Before you sign any agreement, have your lawyer review the draft contract to ensure that your interpretation of your benefits and obligations is consistent with what is documented. Verbal agreement on less critical issues should be documented as well for possible future reference.

Many residents find that email correspondence is fast, efficient and effective, particularly in negotiations. Emails provide a chronological record of discussions between specific parties. You may wish to follow the example of one resident who, at the successful conclusion of negotiations, printed all pertinent emails and saved the hard copy in a confidential file.

Email can also be used to document and confirm verbal promises. Send an email to your negotiating counterpart, describing your interpretation of the conversation, and ask for confirmation of their intention. You can print and retain the reply for future reference, if necessary.

Although emails will generally not override a signed contract, documentation of such communication may be a useful reminder of past promises, should verbal commitments not be fulfilled after the contract is signed. The best advice is to make sure that what has been negotiated is reflected in the final agreement.

Key Message

Preparation is the most important step of any negotiation.

2. Bargaining

Bargaining is dynamic and may take many different forms, depending on the parties and the particular circumstances. Bargaining is not restricted to the actual interaction between the parties, but also involves terminology, timing and tone of discussion, among many other factors. During negotiations, be aware of these dynamics in order to avoid pitfalls and to capitalize on opportunities.

Building Rapport

Negotiators are people; so, during negotiations, it is prudent to be diplomatic, professional and courteous. Friendly interest in the position, organization and person you are negotiating with is a good way to establish the trust and rapport that will encourage cooperative, integrative problem-solving and mutually beneficial negotiations.

Fairness And Trust

People tend to be very sensitive, often irrationally so, about the issue of fairness. Many negotiators will walk away from an economically rational agreement if they believe they have been unfairly treated.

> ***Case Example: An Unfair Offer***
> *A senior resident was offered a position for which the remuneration and conditions were well below both the existing market and the individual's reservation price. He had such strong feelings about being treated unfairly that he became consumed by mistrust. The resident refused to respond to any further offers by the institution.*

Trust is necessary to create and maintain a perception of fairness between negotiating parties. It, in turn, is based on integrity, fairness and consideration of the other party's position. Trust will offset any suspicion of ulterior motives, traps or deceptions between parties.

Wise negotiators listen to their counterparts and respond to their perceptions and concerns of fairness. While some posturing to show yourself in the best light during negotiation is expected, you must not misrepresent your abilities or training, or mislead your counterpart in any way. When lies and misrepresentations are uncovered, trust evaporates and negotiations often collapse.

Remember that, if negotiations are successful, you may be working with your counterpart for a significant period of time. Even if they are unsuccessful, you may be dealing with the other party in a professional capacity, perhaps at meetings or projects of common interest. Establishing trust, respecting fairness and maintaining a professional demeanor can help your professional and personal career in the long run.

Control Emotions And Reactions

Although overconfidence, anger, pride and over-competitiveness hinder negotiations, emotional reactions can have a constructive effect. A positive demeanor and willingness to explore opportunities and solutions will often impress your negotiating counterpart. Furthermore, a positive attitude, combined with an amicable and trusting relationship, can lead to mutually beneficial exchanges of information and, ultimately, optimal agreements.

On the other hand, uncontrolled emotion can be detrimental. Verbal or non-verbal expression of shock or surprise—the "flinch" or "wince"—raise doubt about whether you can come to agreement, and your negotiating counterpart may alter the bargaining position to counter your reaction.

Case Example: Thanks, I'll Think About It.
A senior resident received an offer that provided for income well below her BATNA and reservation price. Instead of wincing at the offer and creating an uncomfortable encounter, the resident thanked her counterpart for the offer and said she would have to spend some time evaluating the proposal. After several weeks of no communication, the resident received a call from the potential suitor, who was now very willing to increase the offer.

Anchors And Escalation Of Commitment
We often classify information for ease of comparison. An anchor is a base figure from which negotiators add or subtract when judging offers. Anchors guide our judgment of subsequent offers. Be aware, however, that anchors can be unrealistic, irrelevant or outdated.

Case Example: This Anchor Won't Hold.
A senior resident was recruited to a community hospital where a solo practitioner of his specialty offered to split clinical duties evenly with the new graduate, but offered remuneration that represented approximately 60% of the market rate. After further research, the resident discovered that his suitor billed at least 200% of the average rate for the specialty in the previous year. Seeing an offer to divide work evenly but accept significantly less than half of the remuneration left the resident with a sense of mistrust toward his counterpart. Although an anchor for subsequent negotiations had been set, the anchor was unrealistic, and only served to antagonize the resident. Negotiations subsequently fell apart.

Escalation of commitment is another dynamic of negotiations that we frequently see in our profession. The typical medical student has worked for and enjoys considerable success. The requirements and challenges of residency only further entrench our desire for more success and accomplishment. Some physicians view negotiation for a specific opportunity as another goal or accomplishment that must be achieved at all costs. The fear of failure and feelings of not being wanted drive many to sign suboptimal agreements without giving adequate consideration to personal satisfaction, professional aspirations and financial expectations.

Beware the emotional yearnings that escalation of commitment can provoke. Be patient. Be objective. Always try to "see the forest in spite of the trees". Focus on satisfying the personal and professional goals that you established during the preparation stage of negotiations.

Making The First Offer
The first figures presented in a negotiation often become the baseline against which all subsequent negotiations are measured. Whether you should make the first offer depends partly on how experienced both you and your negotiating counterpart are; inexperienced negotiators are more likely to make mistakes.

If you decide to make the first offer, information will be your strongest asset. With appropriate research, you should be able to estimate the BATNA of your negotiating counterpart. Although your offer should be ambitious, it should be close enough to your counterpart's BATNA to ensure that he/she will be convinced that negotiation should reach a mutually agreeable conclusion.

Making the first offer, however, is fraught with potential pitfalls. If your demands exceed the potential offer of your counterpart, it may reflect unfavourably on you. Alternatively, if your initial demands are below what your counterpart was willing to offer, you may receive what you have asked for—and no more.

Many senior residents believe they should avoid making the first offer—partly because of their inexperience, and partly because of the possibility that the counterpart will err and misread their expectations. If you are offered terms and conditions that are better than you anticipated, you will be in a very favourable negotiating position. Alternatively, if the offered terms and conditions are very close to your reservation price, you will realize that significant negotiation may be necessary to approach your target price and BATNA, and reach agreement.

One of the most confounding interview questions a senior resident or fellow will face in an interview is: *"How much do you think you're worth?"* or *"How much do you feel you should earn?"*. Answering with specific numbers may place you in an unfavourable light. Too high a number may make you appear greedy, while a low number may doom you to that remuneration level in any subsequent negotiation. One way to answer this question without inadvertently making the first offer is to say, *"I feel I am at least as qualified, if not better qualified, than most of my peers across the country, and I feel I should be rewarded accordingly".*

Impasse

Negotiation often continues until neither party feels they can achieve a deal better than their BATNA, and there appears to be no bargaining room. Experienced negotiators know that creative and integrative problem-solving will be needed to realize more value for each party. If such efforts are unsuccessful, negotiations should cease. Stopping negotiation, however, is different than walking away and abandoning the opportunity.

When negotiations are stopped, an impasse has occurred. Although an impasse may be unavoidable in many circumstances, there are several strategies that can help to restart talks.

Focus on interests rather than positions. Positions tend to become matters of pride for negotiators. Try to re-examine the potential opportunity in terms of your and your counterpart's interests rather than positions. Often, you will find integrative solutions that can satisfy the interests of both parties and allow the negotiations to continue.

Make a small concession. Sometimes negotiations need to be set free from entrenched positions. If you make a small concession and ask your negotiating partner to do the same, you may get the "ball rolling" so that negotiations can continue. Sometimes your counterpart will not match your concession, and it will not be prudent for you to retract your offer—however, the reward from making a small concession is often worth the risk.

Take a break. Sometimes all parties need a time-out from negotiations. This time may be spent consulting with peers or colleagues, refocusing on interests instead of positions, or letting emotions cool. The respite can help both parties to investigate and discover an integrative solution that can be brought back to the table.

Bring in a third party. Sometimes it is helpful to bring in a third party, perhaps a trusted colleague, staff physician or a significant other. A fresh perspective sometimes gets negotiations back on track.

Key Message

While there are many dynamics in bargaining, you should strive to negotiate fair-minded agreements to the mutual satisfaction of both parties. Always be professional and courteous, and never misrepresent your position.

Negotiate For The Long Term.
Whether negotiations are successful or not, you may be working with—or at least interacting with—your counterpart on a professional level, now or later in your career. It is wise to treat your counterpart with respect and courtesy, exhibiting behaviour that is worthy of trust. In other words, don't "burn your bridges".

If you negotiate too strong a position for yourself, the other party may feel the agreement is lopsided. A concession that makes the other party feel cheated may result in you winning the battle but losing the war. Be gracious when receiving concessions, and be sure that your counterpart understands that you value such concessions very highly. Always ensure that the other party is satisfied as well. You do not want to create any bitterness or negative attitudes that will last long after negotiations have concluded. Always treat your counterpart with courtesy, fairness and respect.

3. Settlement

While negotiations sometimes inch toward conclusion, in other situations, a creative solution quickly emerges to expedite a settlement. Always negotiate to the end.

Because wording can be ambiguous, both parties should have a shared understanding of the meaning of every provision in an agreement before anything is signed. A clear, well-understood agreement paves the way for a profitable, amicable and long-term relationship.

Once both parties are sure that an agreement is in sight, tension should ease and posturing and strategizing should end. The agreement may need some minor adjustment or tweaking that can benefit both parties; nevertheless, approach any post-settlement adjustments with caution.

Whose Signature Counts?
All negotiations come down to whose signature counts. A physician who intends to join an academic department or institution will need to negotiate with several groups before securing a position that offers security and satisfaction. Even then, several contracts may apply. Have your lawyer review and approve all applicable contracts concurrently before committing to an offer. It is wise to sign all contracts at the same time to ensure that there are no loose ends.

In community settings, it is prudent to ensure that the person you are negotiating with has authority to grant the terms and conditions of your contract. If, for example, you are negotiating for a surgical position with the department head but a separate committee grants operating room time, make sure that the appropriate authority has consented to your terms before signing any agreement.

Depending on the particular position and hospital, any of the following may have the authority to contract with you: the chief executive officer, vice president of medical affairs, vice president of human resources, chief of staff, or head of a department/division. Always determine who has the authority to approve the terms and conditions of your agreement.

Key Message

Always negotiate to the end. Then, before you sign any agreement, have your lawyer review the draft contract to make sure that all of the terms and conditions you have negotiated are properly documented.

Importance Of Legal Advice

We have noted in other modules that physicians are experts in medicine while lawyers are trained in legal affairs, including contract law. Yet, while few of us would purchase a home without having a lawyer review all documents, many physicians accept practice opportunities without ever reviewing the contract or even having a lawyer see the document.

Negotiating a contract for a practice opportunity has significant potential value in both monetary and non-monetary terms. Because the financial value of a contract often greatly exceeds the value of a home, it makes sense to have a lawyer ensure that all negotiated terms and conditions are properly documented in the contract. This will minimize potential problems and ensure that you are fully aware of your clinical, financial and other obligations. The earlier you involve your lawyer, the better. A legal advisor who is knowledgeable in the field can best advise you on negotiation points.

ACTION PLAN

- **Dedicate time to prepare for any negotiation.**
- **Research what the market offers in terms of remuneration, work environment, service obligations and benefits.**
- **Identify your personal and professional goals, desires and objectives.**
- **Set your target price, reservation price and BATNA in relation to your negotiation points.**
- **Negotiate for an agreement that will satisfy both parties.**
- **Negotiate for the long term by staying professional, courteous and fair-minded.**
- **Ensure that the appropriate authority has approved your terms and conditions.**
- **Have your lawyer review any agreement to make sure that all terms and conditions that you have negotiated are properly documented.**

RESOURCES

- **Online Resources Online At cma.ca**
  - Practice Management Education Contract Checklist
  - Statistics on physician workforce and remuneration, including results from the CMA's Physician Resource Questionnaire and national data
  - Practice Management Education modules:
    Module 10. Evaluating Practice Opportunities: Family Medicine
    Module 11. Locums: Negotiating A Fair And Mutually Beneficial Locum Contract
    Module 13. Evaluating Practice Opportunities: Specialists
- **MD Management**
  - Your local MD Management office can help you to find lawyers, financial consultants and other professional advisors. To find the MD Management office nearest you, call 1 800 267-2332.
- **Provincial Medical Associations**
  - Many provincial medical associations offer contract negotiation services, including reviews of contracts and advice for members or potential members who are relocating to that respective province or territory. Contact information for all provincial medical associations is available on cma.ca.
- **Provincial House Organizations**
  - Some provincial house organizations offer residents advice and assistance when identifying, evaluating and negotiating for a position. Contact information for all provincial house organizations is available on cma.ca.

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Module 10:

Evaluating Practice Opportunities: Family Medicine

Association médicale canadienne
Canadian Medical Association

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plan to best fit their personal and professional aspirations. You are advised to consult with a professional advisor to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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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 Messages

- *Be thorough.*
- *Do it yourself.*
- *Delegate tasks, not decisions.*
- *Delegate tasks to those who have a vested interest in your success.*
- *Don't assume that others are acting in your best interest.*
- *Most important: Get professional advice.*

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	

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.*

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.

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 underserviced 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.

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

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 long-term practice opportunity.

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.

Key Message

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

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.

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-serviced 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.

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.
- 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.

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.

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.

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_2, 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 polices?
- 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?

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.*

Key Message

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

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/pmcresources**
- ***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?

Module 11:

Negotiating A Mutually Beneficial Locum Contract

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

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Key Learning Points

- *Advantages of a locum experience*
- *Evaluation checklist for locum opportunities*
- *Fee-sharing arrangements and billing responsibilities*
- *Plan ahead to ensure a smooth transition into the locum*
- *The importance of a fair and mutually beneficial contract*

Introduction

Family physicians who have recently completed residency often find there are many advantages to working as a locum before making a long-term practice commitment. Whether you provide short-term coverage for a vacation or long-term relief for a maternity leave or sabbatical, a locum is an excellent opportunity to gain experience in medical practice.

Some reasons to consider working as a locum:

- You can earn a good income, without committing to the long-term obligations of a medical practice—such as the capital investment required to start a practice.
- You will have opportunities to travel and experience different medical communities and practice styles.
- You will be able to see first-hand what works well and, more important, what to avoid. This experience will help you to make wise choices when it comes time to make decisions about setting up and managing your own practice.
- You will be able to evaluate group practices and different communities before deciding whether to join an existing practice or start your own, and where to live.
- You may find a future associate or partner.

Where To Look For Locum Opportunities

Locum opportunities are easily accessed on the websites of all provincial ministries of health, provincial medical associations and resident associations. Many provinces have dedicated recruitment agencies, such as Health Force Ontario and the Alberta Medical Association's Locum Services. You should also use and build your own networks. Depending on where you want to work, you can generate leads as well via staff physicians, department heads, program directors, hospital administrators and community liaison representatives.

Links to all provincial and territorial resources are available at cma.ca.

The Written Contract: Red Tape Or Wise Precaution?

When committing to a locum, a physician essentially agrees to assume the responsibilities and practice style of the host doctor. Historically, such arrangements were informal, verbal or arranged by a handshake between the parties.

Today, however, both medical practice and the business of medicine are much more complicated—and physicians develop their own ways of doing things. There are many different approaches to such matters as scheduling appointments, billing for uninsured services, providing extended hours, accepting walk-in patients and keeping medical records.

Because every physician strives to develop a style of practising medicine that best suits his/her personality, it is no surprise that a host physician and a locum might have quite different approaches to the provision of medical care and the management of a medical practice. This could lead to misunderstandings, which could potentially make a locum experience unpleasant for both parties.

The best way to ensure a positive experience is to have a formal, written contract that takes into account the terms of the locum and the potential contingencies (the "what if" scenarios). This module explains what you should include in a locum agreement.

Key Message

Locums are excellent case examples of different practice styles and formats. Copy best practices and note things to avoid. A locum contract is essential.

Evaluating Locum Opportunities

Today's market definitely favours the locum as more physicians are looking for someone to temporarily cover their practices. Before you begin the search for a locum, develop a list of questions to ask about the medical practices you are evaluating. Keep in mind that the way you ask the questions should communicate your sincere interest in the practice and your desire for a locum arrangement that is realistic, fair and mutually beneficial.

Scope Of Practice

You will want to know as much as possible about the host physician's practice—the pace, hours and call commitments; the volume and variety of patients you will see; the receptiveness and experience of the staff; and the availability and obligations to the host physician's associates. While the host physician will be your primary source of information, ask permission to talk to the office staff as well—the people who book the appointments, manage the business, prepare and file medical records, and receive the patients. Also ask to speak with physicians who have worked locums for this host in the past. These different perspectives will paint a realistic picture of the practice opportunity.

Some physicians post pertinent office policies and procedures at the office, and record them in a patient information pamphlet, which is distributed to new patients. Knowing that the patient population is informed about the host physician's practice policies (e.g., missed appointments or phone-in prescriptions) is advantageous to a locum. Be sure to ask whether the office staff or the host physician enforces office policies.

Scope Of Practice Checklist

- What are the patient demographics (e.g., pediatrics, women's health, geriatrics, adolescents)?
- Does the practice have a specialty interest or special needs population?
- Does the doctor follow current practice guidelines and evidence-based medicine?
- Does the doctor follow current guidelines for prescribing antibiotic, narcotic and anxiolytic medications?
- Does the host doctor have patients on long-term narcotics for non-malignant pain, and, if so, have these patients signed a contract?
- Does the host doctor charge patients for non-insured services? If so, for what services? What are the fees? What is the process for billing and collection?
- What are the office policies for phone-call prescription renewals and missed appointments?
- How does the doctor handle sick notes?
- Does the physician practise obstetrics, shared obstetrics (prenatal care to 28 weeks) or perform minor surgeries? Will you be expected to perform the same procedures? Are you competent and comfortable in delivering these services? If not, will the physician make arrangements for other colleagues to cover these tasks during the term of the locum?
- A list of procedures should be clarified in the contract.
- What are the regular office hours?
- What on-call obligations will you be expected to assume? Are there additional obligations related to a group after-hours clinic, hospital, nursing home or emergency department?
- Do you have the option of not filling any of these obligations?
- Will the physician's trusted colleagues be readily available to assist you in an emergency?

- Are the practice policies (e.g., missed appointments, phone consultations) clearly posted in the office? Does the doctor provide each patient with a patient information handout that explains the practice policies? Do staff members enforce the policies?
- Is the office clean and comfortable, with up-to-date equipment?

The Appointment Schedule

When evaluating a locum opportunity, ask what patient volume the practice typically handles in a day or week. A locum physician will likely see aprroximately 25% fewer patients than the host—unless the locum is for an extended period of time or the practice is in an underserviced area where physician services are in short supply. There will be a minimum number of patient visits required to generate enough revenue to cover overhead expenses and make it financially worthwhile for both the locum and host physician.

Ask how many time slots are dedicated to same-day call-in appointments. Generally, the more slots allocated, the more dynamic the practice. A higher percentage of same-day call-in visits will correlate with a higher volume of patient visits while you are covering the practice.

Ask to examine the appointment schedule. We recommend that you look at the bookings on three dates: the current day, the same day two weeks ago, and the same day two weeks in the future—and evaluate the scheduling practices.

Appointment Checklist

- What is the average number of patients seen per day?
- Do the reception staff triage appointments?
- Is the reason for the patient visit recorded on the appointment schedule?
- Does the doctor use 10-minute or 15-minute time slots for the average patient visits?
- Are two or three time slots reserved for check-ups and counselling?
- How many dedicated slots are allocated and protected for same-day call-ins?
- Are most visits for the next two weeks already booked? If so, how would the doctor fit same-day call-ins into 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 doctor have clear guidelines for booking double appointments?

If applicable, ask the host doctor to show you the appointment bookings from previous locums. If the volume was low, you should determine how the host will encourage more patients to see you in his/her absence. An alternative would be to ask for a guaranteed daily minimum income.

If the volume was high, consider carefully whether you are comfortable with the physician's scheduling practices.

The Medical Charts

The medical chart is the key communication vehicle between the host physician and the locum. If the records are legible, well organized and comprehensive, you will easily be able to verify medical history, conduct appropriate follow-ups, maintain the practice and emulate the physician's prescribing patterns. Because patients will expect you to practise and prescribe as their family doctor would, the chart will be the most important tool you have.

Randomly pull five to 10 charts to evaluate record-keeping, and learn how you will be expected to maintain the charts. Remember that the host doctor will expect to find legible and comprehensive notes when he or she returns. Do the same if the charts are electronic.

Medical Chart Checklist: Traditional Or EMR

- Are the medical records comprehensive, legible and well organized?
- Does the physician dictate or write progress notes? Do progress notes follow the SOAP (Symptoms, Observations, Assessment and Plan) format? Are progress notes complete and clear?
- Are the medical records generally well organized?
- Does the physician keep up-to-date Cumulative Patient Profiles (CPPs), and such records as cumulative medication sheets, diabetic, INR and lipid flow sheets?
- Are allergy 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 physician's prescribing habits for controlled drugs, anxiolytics and antibiotics?
- Do the records raise any concerns regarding medical competence?
- Do the medical charts have year labels to indicate the number of patients whose charts are active? A practice with 5,000 charts can be a lot quieter than a practice with 2,000 active charts where most patients have been seen within the last two years.

You can conduct the same type of file review on an electronic medical records (EMR) system. Prior experience with an EMR program will be advantageous to you if the host physician has a computerized system. All systems are different, however, and training on the office system *before* you start the locum will reap rewards in efficient patient management and accurate record-keeping. Ensure that enough time is set aside for you to learn how to use the system.

Key Message

Patients will expect you to practise and prescribe like the host physician. Employing a Locum Evaluation Checklist will ensure that you are comfortable with the quality of the host doctor's clinical practice, medical records and staffing support.

Information From Billing Records

During your evaluation, ask to review the physician's billing information and, ideally, the billing summary from the last locum. The remittance sheets from the Ministry of Health, as well as the records for non-insured and third-party billings, offer a wealth of information, including:

- Daily patient volume, total billings per day and total remittance per month
- The variety of clinical problems seen in the practice, as determined by diagnostic codes
- The scope of professional services and procedures provided, as determined by service and procedural codes
- Patient demographics

To analyze the remittance sheets, you must be well educated about the service, diagnostic and procedural codes, as well as the available premiums.

Fee-Sharing Arrangements And Billing Responsibilities

Fee-Sharing Agreements

One of the many points of negotiation between the host doctor and locum will be a fee-sharing agreement, in which the gross fees generated and received during the locum are shared. The locum's objective is to gain a ready income stream without having to invest time, capital and ongoing commitment to generate income. The host doctor's objective is to find a competent replacement and, if possible, to cover most of the overhead costs during the locum period.

(Use of the term "fee-sharing agreement" instead of "income split" to describe the sharing of gross fees generated often lets the parties avoid GST/HST implications. If the locum is obliged to pay the host doctor GST/HST, then it will be beneficial to try to negotiate that the host doctor's share includes GST/HST. Your accountant should review and clarify the GST/HST implications of any fee-sharing agreement.)

National statistics collected by the Canadian Medical Association demonstrate that the overhead costs of running a family medicine practice typically represent 35%–40% of the physician's gross professional income from all sources; rarely do family doctors have overhead costs of less than 30%.

The average physician's gross income is generated from several sources, including office work, hospital income, after-hours clinical income and third-party billings. Because overhead is still incurred on those half-days when the physician is out of the office, even non-office billings help pay for overhead expenses.

Because the volume of patients seen by the locum physician is often 75%–80% of that seen by the host doctor, the share of fees that the host doctor receives from the locum will rarely cover the proportionate overhead costs incurred during the locum. Most host doctors understand, however, that the deficiency is a small price to pay for a much-deserved holiday and the reassurance that their patients are well cared for in their absence.

Twenty years ago, the standard "split" was 60/40. As with all service industries, however, supply and demand dictate cost. Locums are increasingly hard to find, and practising physicians must now compete with the 'splits' offered by walk-in clinics if they want to have coverage. Host physicians are now prepared to accept a fee-sharing agreement that is much more favourable to the locum, as well as to consider a variable fee-sharing split for services rendered outside the office. Many locum agreements now have fee-sharing arrangements that range from 70/30 to 80/20 for office coverage, and sometimes even more attractive for after-hours and hospital coverage. If the locum has the opportunity to do additional shifts in an emergency department—which do not compromise the obligation to cover for the host doctor—then the locum should receive 100% of the fee. The host would also have no claim to special incentives, such as bonuses for locums in under-serviced areas.

Regardless of the split, the gross income generated during the locum is what determines the net gain for both parties. The host should encourage patients to see the locum, not only to ensure their health care, but also to contribute the maximum amount to overhead costs. The result is a win-win scenario. The locum gets a ready income stream, works with different professionals in different practice settings, and "test runs" a potential long-term practice opportunity. The host doctor gets a holiday, no crushing workload looms over his/her return to work, and a portion of overhead costs are covered.

Unfortunately, in the past few years, there have been cases where locum physicians have been less than considerate with their fee-sharing demands. Neither party should attempt to take advantage of the other. You have a vested interest in each other's success, and you both should feel that the arrangement serves you well. Remember, "what goes around comes around"—in five years, you may be looking for locum replacement too.

What If Dr. Host Participates In A "Capitated" Alternative Payment Model?

A physician participating in a capitated model will receive a monthly payment per rostered patient, based on the patient's age and gender, regardless of whether the patient is seen or not. This automatic payment is for provision of a "basket" of common GP services that are offered for outpatient, non-emergency services. The range can be approximately $50 per year for a 20-year-old male and $375 per year for an 80-year-old female. They will often also receive a monthly "comprehensive care management" (CCM) fee for each rostered patient, which can average approximately $2.20 per month. The host's doctor will bill "fee for service" for patients who are not rostered.

This could make the fee-sharing arrangement very complicated. Therefore, most capitated host physicians will offer the locum a predetermined daily gross income that takes into account all of these variables.

- The host doctor guarantees a daily payment of approximately $800–$900 per day for office-based coverage. This guaranteed income will be in lieu of a fee split for any and all insured or non-insured services in the office, unless otherwise negotiated.
- Additional monies for out-of-office work, such as house calls, will typically be agreed upon (for example, $60 per house call).
- Most capitated models exclude in-patient care or obstetrics within the basket of services. Therefore, when applicable, a fee-sharing split for these additional out-of-office services may be negotiated.

Capitation is explained in detail in *Module 8. "Physician Remuneration Options.*

Guaranteed Minimum Income

Guaranteed minimum daily incomes are often included in government-sponsored locums, especially in certain circumstances (e.g., rural practices) where patient volumes are low. Present rates for guaranteed minimum daily income are approximately $800, with additional travel cost support when applicable. A percentage split of fee-for-service billings above this is also often included. If the locum and host doctor have evaluated the practice opportunity thoroughly, and the host ensures that the locum is busy, then there should be no need to negotiate such an arrangement. However, if in doubt, negotiate a guaranteed daily minimum income.

Example: Dr. Locum has a 70/30 split and is guaranteed a minimum daily income of $800. Fee-for-service, non-insured, WCB billings for a Wednesday total $1,200. Dr Locum keeps $840 and Dr. Host gets $360. If the total billings were $1,000, then the 70/30 split would be $700/300—but, because the guaranteed daily minimum is $800, Dr. Host would receive $200 rather than $300.

Who Should Do The Billing?

Most provinces require billings to be submitted using the billing number of the physician who provides the service. As such, fees generated and paid by the Ministry of Health will be deposited directly into the locum physician's account,

not the host physician's. Exceptions occur in British Columbia, where the locum signs an assignment form so that the payment goes to the host doctor's payment number. Many clinics operate in the following manner: All doctors practising within a clinic assign their billing number to the common clinic payment number. This way, all billings are tracked by the party that provided the service; the payments are then pooled into the common account and all expenses (including the physician's portion) are paid out of the common account.

Generally, there are three options for the submission of billings.

- **Billings are done via the host doctor's billing service/software.** This may not be the best plan. In our opinion, a locum should not use the host doctor's office to do the billing, unless the following conditions are met:
  - The host doctor's office submits the billings under your billing number, so that the medical services plan remittance and benefits go directly to you. The billing software provider may levy an additional licensing charge to the host physician to put your name on the office billing system, unless the billing software is provided by the health ministry, such as in New Brunswick.
  - You verify that the host doctor's staff members are competent and diligent in billing submission, reconciliation and, most important, resolving unpaid accounts in a timely fashion.
  - You will be readily available after the locum is completed to clarify outstanding accounts and resubmitted bills. It often takes up to three months after a clinical service is provided for submitted claims to be settled.

  National surveys indicate that, on average, physicians fail to bill for at least 5% of the services they provide, and then fail to resubmit and capture at least 3% of their unpaid claims to the health ministry. These statistics result in a loss of more than 8% of gross income.

  It is, therefore, essential that these three conditions are met and that the host physician's office completes the billing cycle to ensure that all of the insured services you have provided are paid for.

  If you, as the locum, agree to have the host physician's office submitting the billings during the locum, take personal responsibility for auditing the billing sheets and reconciling them with the monthly remittance report from the provincial government. This due diligence will help you to avoid any misunderstanding if there are errors in the diagnostic or billing codes, or if claims are unpaid.

- **The locum physician does his or her own billing.** In our experience, this is exceptional—and rarely time, or cost, effective.

- **The locum physician uses the services of a billing agent.** Most agreements are best served when the locum uses a dedicated billing agent who charges a commission—typically around 2%–3%—based on total billings collected. This agent has a vested interest in collecting all billings submitted under your number, and will know the latest changes to the fee schedule. The cost of the service is both minimal and tax deductible. Every medical association should have a list of billing agents used by their members.

During the locum, the office staff will prepare a daily billing sheet, which you complete and forward—usually by fax, or online, to your billing agent. In addition to performing all administrative tasks, the agent will do all of the required legwork,

including communicating with the host doctor's office about such matters as resubmissions. You will then receive the medical services plan payments in a designated bank account by auto-deposit.

Third-Party Billing

The service fees paid by third parties (e.g., Workers' Compensation Board [WCB] or private insurance companies) will typically be remitted to the host physician. In the case of WCB payments, it is preferable to have all reports and accounts submitted under the host's account number, so that future WCB requests for progress reports will be sent to the host—not the locum, who has since moved on. The host doctor will then forward the negotiated share of fees to the locum. Both parties must receive copies of all billing records during the term of the locum, and mutually agree to remit the proportionate share to the other within one week of receipt. This arrangement should be documented in the contract.

Billing For Non-Insured Services

Clarify the office policy regarding medical services not covered by the Ministry of Health. Some physicians are still uncomfortable with billing their patients for non-insured services, while others routinely bill their patients for such services. Note that billing for non-insured services can increase gross revenues by 5%–10%. A locum must always exercise discretion, however, regarding such billings. Avoid unnecessary friction with patients, as well as possibly upsetting staff, should you require them to enforce decisions that run contrary to their usual practice.

If the host doctor charges some patients an annual "block fee" for uninsured services, then the locum should negotiate how the host doctor will pay the locum for providing non-insured services to these patients. The easiest approach would be as follows: The host pays the locum the regular rate for the service; e.g., $15 for a phone prescription renewal.

Defining Gross Billings

'Gross billings' refers to the total fees submitted and received for services rendered, regardless of the responsible payer (e.g., Ministry of Health, WCB, Workplace Safety and Insurance Board, insurance company, or the patient). The locum contract should also include a clause that will allow for sharing any retroactive increases in the fee schedule that occur after the locum has ended. This is particularly important in provinces where primary care reform and alternative payment agreements are in transition, because the fees paid often do not match the billings submitted.

Fair Payment Schedule

Regardless of which party receives payment, the locum and the host should agree to remit the proportionate share to each other within one week of receipt of the payment. Note that billing periods vary from province to province. Remittance payments are made once a month in Ontario, and every two weeks or twice monthly in most other provinces. Accordingly, it can be as much as six weeks before accounts receivable are paid.

This can be a problem for graduating residents who start locums in July or August, as delays in Ministry of Health remittances could leave a locum with no income until mid-September. It is both inappropriate and unfair, however, to demand advance payment from a host doctor before remittances have been received by either party. Some host doctors may generously offer an interest-free advance loan to help with cash flow. Such an arrangement would be included in the locum contract.

Finances And Billing Checklist

- How will you be paid for the locum if you are covering for a doctor who participates in a capitation format?
- Will you and the host doctor have a fee-sharing agreement? If so, clarify the percentage of fees you will receive for office services, hospital work and on-call services.
- Will the host doctor consider a guaranteed minimum daily income for you?
- Is the host doctor obliged to charge GST/HST? If so, has the host doctor verified his/her GST/HST number?
- Can you negotiate that the host doctor's share of the fees includes GST/HST?
- Who is responsible for submitting and reconciling the billings for your services? If the host doctor's office is doing your billing, are you confident in the staff's competence in handling these tasks?
- Is it in your best interest to enlist the services of a dedicated billing agent?
- Will your billing number be used, or the host physician's?
- How will unpaid accounts be collected?
- How will you share Ministry of Health fees? How will you receive the service fees paid by third parties and the Workers' Compensation Board?
- Does the host doctor charge patients for non-insured services? If so, for what services?
- Has the host provided a fee list for non-insured services billed directly to patients?
- Have you agreed on a schedule to remit shared fees to each other?
- Have you both agreed to non-performance clauses?
- Have you arranged financing to tide you over until you start to receive an income from the locum?
- Will you have an opportunity to do additional work outside the locum contract?

Key Message

Fee-sharing, billing and payment arrangements should be clearly spelled out in a locum contract. Address all obligations and "what if's" in the contract. Negotiate a fair and mutually beneficial agreement.

Plan Ahead To Ensure A Smooth Transition

Professional Responsibilities

Most host physicians expect a locum to cover their regular schedule, unless the parties have agreed to alter the schedule for the locum period. The office, hospital, outpatient and call responsibilities, plus any customizations, should be clarified in the agreement. If the host physician has medical responsibilities (e.g., obstetrics) that you are not expected to take over, ensure that arrangements have been made with other physicians to cover those activities, and that these arrangements are documented.

Some locums are interested in taking on extra clinical work (e.g., extra emergency shifts) that is not part of the host physician's responsibility. Such "moonlighting" should not be restricted—as long as you meet all of the requirements of covering the practice and do not compromise the host doctor's share of the gross income. Any additional work you assume would be considered to be outside of the locum contract.

Office Staff

It is essential that the host provide you with experienced staff, people who are familiar with the office policies, communication systems, referral network, preferred specialists and patients. This is especially important if the host's spouse is a key employee in the medical office, and is also going to be away on family holiday. You do not want to arrive for your locum to find that, not only are the patients and mechanics of the practice unfamiliar, but temporary personnel are also now managing the office!

If you are covering for a physician who is part of large group practice with shared staffing, verify which staff members will be assigned to you during the locum. All commitments for office staff should be documented in the agreement.

Contact Information

Ask the host physician to provide important referral and key contact information, including:

- A list of healthcare facilities (e.g., labs and diagnostic services)
- A list of local pharmacists
- Preferred consultants
- Call group members, along with their contact information and hand-over policies

Special Needs Patients

While the medical charts will represent your primary communication tool, ask the host doctor if there are patients who may pose particular problems, or who may require special attention during the locum. For example, does the host have patients who are being treated with narcotics for chronic non-malignant pain? Have patients signed a prescription renewal policy contract? Ask for a hand-over list, and request that the host clearly document recommendations for the management of these patients. You should prepare a similar hand-over list to assist the host physician upon his/her return.

Hospital Privileges

The host has a vested interest in helping you to obtain hospital privileges, but the agreement should document specifically how this will be arranged. Typically, the locum provides the host physician with a copy of his/her curriculum vitae, references and registration cards from the CMPA, CCFP and the provincial College of Physicians and Surgeons. The host then applies for temporary privileges on the locum's behalf. It is important to make these arrangements early, so that the privileges are granted before the locum starts.

Hospital Environment

If applicable, ask the host to arrange an orientation tour of the local hospital and introduce you to the key staff members and physicians in advance. This will make the experience of starting work in an unfamiliar setting less stressful and confusing.

Outpatient and hospital on-call obligations should be discussed and clarified, then documented in the locum contract. You should also discuss practical matters. If you are expected to cover in the emergency department, do you take a regular shift, take calls from home, or both? Is a call room available at the hospital? Will parking at the hospital be a financial or practical constraint? Is it possible to borrow the host physician's hospital and office parking passes?

Community Orientation

Confirm that the host will notify the community of his/her planned departure, and inform the appropriate officials that you will be covering the medical practice. You should also inquire about recreational facilities, sports clubs, cultural activities and other attractions. In smaller centres, community leaders may take the opportunity to make you feel comfortable in all respects—it is, after all, an excellent opportunity for them to recruit a new physician.

Although it is not a requirement of a locum arrangement, the host may offer to help you search for appropriate short-term accommodation. The host may even offer you his/her own home; if so, you will need to agree on common tenancy issues, such as cohabitants, children, visitors, pets and liability.

Non-Performance

This clause in the locum contract addresses the *unlikely* circumstance that either the host physician or locum fails to honour their obligation.

Case examples (these actually happened):

1. Dr. Locum called Dr. Host the Sunday before he was to start to ask if there were any last-minute issues. Dr. Host sadly informed Dr. Locum that his daughter had a sudden illness, requiring hospitalization, and thus he cancelled his holiday and decided to be at the office. Dr. Locum was left in the cold, without any guaranteed work for the next two weeks. Was Dr. Host malicious? No—but he did not honour his obligation to provide Dr. Locum with the opportunity to make income. In this case, there was no written locum contract and no non-performance clause.

2. Dr. J. Host was called two weeks before Dr. Locum was to begin a four-month maternity coverage—Dr. Locum informing Dr. Host that she had received a better offer, and would not be honouring her verbal agreement to do the maternity coverage. There was no written contract, and Dr. J. Host did not find another locum—she returned to work two weeks after delivery!

A non-performance clause would have given the affected parties above some compensation for lost income/coverage. The clause will generally clarify any monetary penalty that the responsible party will remit to the affected party. The amount would be similar to a daily guaranteed minimum for the locum, plus a daily guaranteed overhead cost coverage for the host; for example, 30% of the daily guaranteed minimum.

Getting Ready For The Locum

- Have you confirmed all of your office, hospital, outpatient, on-call and any other responsibilities?
- Have your hospital privileges been secured?
- Will you be provided with experienced office staff?
- Do you have contact information for call group members, consultants, labs, diagnostic services, pharmacies and other important referrals?
- Have you received a hand-over list, identifying special needs patients?
- Have you verified that the host doctor will assume medical legal responsibility after your term has ended for all pending investigations that you initiated?
- Have you met the key staff members and physicians at the hospital?
- Have you arranged for parking or transportation?
- Will the host doctor arrange for your orientation within the community?
- Do you have a place to stay?

Key Message

Develop a comprehensive checklist of details for either you or the host doctor to attend to before you begin the locum. This planning will go a long way to ensure a smooth transition.

THE IMPORTANCE OF A FAIR AND MUTUALLY BENEFICIAL CONTRACT

The best way to ensure a positive experience is to have a formal, written contract that takes into account the terms of the locum and the "what if" scenarios. This serves two objectives: It provides a checklist of important matters that you and the host physician need to address, and it ensures that both parties have a shared understanding of the terms and expectations.

Important Components Of A Locum Contract

- Length of locum
- Patient schedule and any customization
- Additional responsibilities (e.g., on-call arrangements)
- What office staff are provided
- Application for hospital privileges
- Fee-sharing arrangements
- Billing arrangements for insured services
- Billing policy for non-insured services
- Reciprocal fee payment schedule
- Host doctor's responsibilities prior to hand-over
- Locum's responsibilities at end of agreement
- Non-performance

Other clauses to consider in a locum contract include specialty back-up, non-competition, non-solicitation, "moonlighting" and GST/HST.

It is quite easy to develop a generic locum contract that can be customized for different scenarios and circumstances. Generic locum contracts are available on the web, but we strongly recommend that your lawyer review your generic contract to ensure that your interests, and the host doctor's interests, are protected.

Because locums used to be arranged informally, not all physicians will perceive that a written agreement is needed, and some may resist signing a contract. If this is the case, explain that the intent of a written contract is to protect both parties while clarifying the expectations for the locum. The agreement should be mutually beneficial and fair. If the host physician is still unwilling to sign a written agreement, you should look elsewhere. Locum opportunities abound.

Key Message

A written contract protects you and the host physician by ensuring that both parties have a shared understanding of the terms and conditions for the locum. Ensure that you address all the "what if's" in the contract.

ACTION PLAN

- **Develop a checklist to help you evaluate locum opportunities. Be thorough.**
- **Draft a generic locum contract before you negotiate, and review it with your lawyer.**
- **Customize the contract as required for each new locum.**
- **Always strive to negotiate a mutually beneficial contract.**
- **Plan ahead to ensure a smooth transition into the locum.**

APPENDIX 1: LOCUM EVALUATION CHECKLIST SUMMARY

Scope And Style Of Practice

- What are the patient demographics (e.g., pediatrics, women's health, geriatrics, adolescents)?
- Does the practice have a specialty interest or special needs population?
- Does the physician do deliveries, or shared care obstetrics (prenatal care to 28 weeks), or perform minor surgeries? If you are expected to perform the same procedures, are you competent and comfortable in delivering these services? If not, has the host made arrangements for other colleagues to cover these tasks during the term of the locum?
- A list of procedures should be clarified in the contract.
- What are the regular office hours? Can you modify the office schedule if necessary?
- What on-call obligations are you expected to assume? Are there additional obligations related to the group's after-hours clinic, hospital, nursing home, house calls or emergency department?
- Do you have the option of not filling any of these obligations?
- Will the physician's trusted colleagues be readily available to assist you in an emergency?
- Does the host doctor follow current practice guidelines and evidence-based medicine?
- Does the doctor follow current guidelines for prescribing antibiotic, narcotic and anxiolytic medications?
- Does the host doctor have patients on long-term narcotics for non-malignant pain, and, if so, have these patients signed a contract?
- What are the office policies for phone-call prescription renewals and missed appointments?
- How does the doctor handle requests for sick notes?
- Are practice policies (e.g., missed appointments, phone consultations) clearly posted in the office? Has the doctor provided each patient with a patient information handout that explains the practice's policies? Do staff members enforce the policies?
- Is the office clean and comfortable, with up-to-date equipment?

Appointments

- What is the average number of patients seen per day?
- Do the reception staff triage appointments?
- Is the reason for the patient visit recorded on the appointment schedule?
- Does the host doctor use 10-minute or 15-minute time slots for average patient visits?
- Are two or three time slots reserved for check-ups and counselling?
- 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?
- How does the doctor fit same-day call-ins into the schedule?
- How many dedicated slots are allocated and protected for same-day call-ins?
- Does the doctor have clear guidelines for booking double appointments?
- Are there a reasonable number of time slots over the next two weeks for new bookings?
- Can you modify the appointment schedule if necessary?

Medical Charts

- Are the medical records comprehensive, legible and well organized?
- Does the physician dictate or write progress notes? Do the progress notes follow the SOAP (Symptoms, Observations, Assessment and Plan) format?
- Does the physician keep up-to-date cumulative patient profiles (CPPs), and such records as cumulative medication sheets, diabetic, INR and lipid flow sheets?
- Are allergy and immunization records clearly marked?
- Do the records indicate compliance with evidence-based medicine and practice guidelines for preventative care and screening?
- Do the records indicate the physician's prescribing habits for controlled drugs, anxiolytics and antibiotics?
- Do the records raise any concerns regarding medical competence?
- Do the medical charts have year labels that will help you to determine the number of patients who have been seen within the past two years?
- If EMR, are all of the above requirements met and, if required, will you be orientated to the EMR system in advance?

Finances And Billing

- How will you be paid for the locum if the host doctor participates in a capitation model?
- Will you and the host doctor have a fee-sharing agreement? If so, what percentage of fees will you receive for office, hospital and on-call services?
- Will the host doctor consider a guaranteed minimum daily income for you, if appropriate?
- Will you be charged GST/HST? If so, has the host doctor verified his/her GST/HST number?
- Can you negotiate that the host doctor's share of the fees will be GST/HST-inclusive?
- Who is responsible for submitting and reconciling the billings for your services? If the host doctor's office is doing your billing, are you confident in the staff's competence for these tasks?
- Is it in your best interest to enlist the services of a dedicated billing agent?
- Will your billing number, or the host physician's, be used?
- How will unpaid accounts be collected?
- How will you share Ministry of Health fees? How will you receive the service fees paid by third parties and the Workers' Compensation Board?
- Does the host doctor charge patients for non-insured services? If so, for what services?
- Has the host doctor provided a fee list for non-insured services billed directly to patients?
- Have you agreed on a schedule for when both parties will remit shared fees to each other?
- Have both parties agreed to non-performance clauses?
- Have you arranged financing to tide you over until you start to receive an income from the locum?
- Will you have an opportunity to do work outside the locum contract?

Getting Ready For The Locum

- Have you confirmed all of your office, hospital, outpatient, call and other responsibilities?
- Have your hospital privileges been secured?
- Will you be provided with experienced office staff?
- Do you have contact information for call group members, consultants, labs, diagnostic services, pharmacies and other important referrals?
- Have you received a hand-over list, identifying special needs patients?
- Have you verified that the host doctor will assume medical legal responsibility after your term has ended for all pending investigations that you initiated?
- Have you met the key staff members and physicians at the hospital?
- Have you arranged for parking or transportation?
- Will the host doctor arrange for your orientation to the community?
- Do you have a place to stay?

The Locum Contract

- Have both parties agreed to and signed a locum contract that addresses all relevant issues?

Module 12:

Starting Your Practice On The Right Foot

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plan to best fit their personal and professional aspirations. You are advised to consult with a professional advisor to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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CMA National Practice Management Curriculum

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Key Learning Points

- *Balance public and government expectations with what you can competently and realistically provide your patients.*
- *Establish realistic expectations for yourself, your staff and your patients.*
- *Establish appropriate policies and procedures for your medical practice.*
- *Develop patient information pamphlets.*
- *Establish protocols and procedures to accommodate and schedule new patients.*
- *Develop a first-visit protocol for new patients.*

Author's Comment:

Throughout this module, the author has provided examples of scripted statements, questions and answers. Advice has been sought and received from the physician advisory team of the College of Physicians and Surgeons of Ontario. These examples have been carefully scripted to ensure that you and your staff will, at all times, communicate with all parties (patients, family members, colleagues and staff) with consideration, understanding and mutual respect. The importance of this cannot be overstressed!

INTRODUCTION

Most family medicine residents are exposed to office-based clinical practice in academic or institutional teaching settings that may not mirror the environment in which the majority of family doctors practise. Many of these teaching units are managed by the university or hospital and have mixed funding arrangements. Consequently, the staff physicians and residents who work there may have limited influence over operational decisions, such as staffing, practice demographics, triage and appointment protocols, or clinic design.

It is important that teaching units book fewer patients per hour for first-year family medicine residents so that they have more time to develop their clinical and communication skills, and staff physicians have ample opportunity to supervise. However, feedback from the thousands of senior family medicine residents who have attended practice management seminars since 1992 suggests that there continues to be limited opportunity, especially in the final months before graduation, for a senior resident to have input into the triage and scheduling of his or her own patients. Residents trained in university teaching centres and community-based practices have shared the same concerns.

Consequently, when new-entrant family physicians are responsible for developing policies and procedures for their own practices, they are alarmed and concerned that they are not prepared—personally or professionally—to meet the challenges.

In particular, residents report that they are overwhelmed to discover that, under most payment models, they will need the equivalent of 30–35 regular patient visits per full clinical day to cover their overhead costs and meet reasonable income aspirations. They comment that they have no experience or knowledge of how appointments are triaged and scheduled. The majority express feelings of frustration and alarm because they believe that, if or when they open their own practice, they will be obliged to address all of a patient's concerns and issues at every visit, as they often did during residency. They don't know when it is appropriate, or how, to say, "I am sorry, but we will have to arrange for a follow-up visit to address these additional concerns" when a patient brings up the third or fourth complex medical issue during a regularly scheduled office appointment.

Informal polling reveals that, during their training residencies—working especially in academic centres—they rarely experience office schedules that include a realistic number of same-day urgent visits or follow-up appointments to address pre-determined issues. They are not accustomed to seeing a schedule that balances short visits and long, complex appointments. It is not surprising that, when asked about their short- and intermediate-term practice plans after graduation, the vast majority say they will do locums, and many favour working in walk-in clinics. They believe that, in these practice formats, they will not have to deal only with patients who have complex medical issues, and that they will be able to see enough patients each day to generate sufficient income to address their significant debt issues.

The number of trained family physicians who decide to establish a long-term practice continues to fall short of public need and demand. Those that do, and are accepting new patients, feel pressured to care for an increasing number of patients, as well as more clinically complex patients. To reduce the perceived risk of overload, many have incorporated a variety of methods to screen patients, some of which can justifiably be interpreted as discriminatory. Consequently, the number of complaints—by people not accepted by doctors to provincial Human Rights Commissions—have increased dramatically, and most regulatory colleges have adopted a policy that doctors must accept new patients on a "first-come, first-served" basis.

It may be difficult to envision lifelong vocational and professional satisfaction if you believe that you will have little control of your working environment or practice profile. It may be especially discouraging if you feel that you will be unable to improve on poor or inefficient practices, like those that you may have worked in during residency. But remember—you were also exposed to many "best practices", and several family doctors do continue to balance their personal and professional lives with both vocational and financial satisfaction.

When you prepare to start your own practice, incorporate the best practices that you have witnessed during your residency and locums. Ensure that the group you join, or the practice you assume or start, strives to provide excellent medical care by integrating effective practice management protocols.

Your mission statement and policies should inform prospective patients of all the services your new practice can and cannot offer. Patients understand that you can't be all things to all people, and they will appreciate your efforts to inform them. Consequently, they will have realistic expectations right from the start.

This module will help you to learn how to establish and meet realistic expectations for yourself, your staff and your patients. Appropriate policies and procedures, accompanied by simple measures, such as patient information pamphlets, a practice website, effective phone management and appointment scheduling, and an introductory first-visit protocol for new patients, will help you to start your medical practice on the right foot.

It may not be practical or appropriate for every family doctor to implement all of the action points discussed in this document. Practice location, patient demographics, medical group dynamics, physician remuneration models and the availability of allied healthcare professionals are just some of the considerations that will determine the most appropriate action plan for you. Once you establish a fair, ethical and reasonable approach to offer ongoing comprehensive medical care, good communication will help your prospective patients to accept, and be comfortable with, the services you can provide. This will establish the foundation for a mutually rewarding long-term relationship.

It is recommended that you develop the following as part of your new practice action plan:

- Appointment scheduling policies and procedures
- Comprehensive office policies and procedures
- An office procedures manual
- A detailed patient information pamphlet
- A practice website
- Clear and concise telephone procedures for your receptionist
- A standardized plan for first visits by patients

SCHEDULING APPOINTMENTS: OVERVIEW

This section will be of interest to physicians who plan to establish their own comprehensive family medicine practice. Scheduling practices for after-hour or walk-in clinics are not addressed here.

Key Message

Copy the best practices you have experienced as a resident and during locums. Establish workable policies and procedures for your practice well before you start seeing patients.

Most patients have little understanding of the intricacies of how a family medicine practice operates. They have minimal knowledge of the challenge of balancing the office appointment schedule with a physician's many other daily commitments and responsibilities. Few patients realize that physicians spend a significant amount of time, in addition to direct patient encounter, meeting patients' comprehensive care needs. They do not know that their physician's remuneration is not based on time spent or the number of issues addressed at each visit. Accordingly, you should consider how to educate your patients in terms of the fact that the time you can offer for a "regular" office appointment may limit the number of medical issues that can be addressed during a single visit. This is especially true on the occasions when you need to attend to more than the usual number of unanticipated emergencies or same-day medical appointments.

The only way to avoid falling 30–60 minutes behind schedule every day is to initiate procedures and guidelines—and follow them. This will show your patients that you value their time, as well as your own. Unexpected delays will happen—but long waits should be the exception, not the rule. Patients with prescheduled appointments shouldn't routinely wait 30 minutes or more to see you.

If, every day, you are managing the equivalent of 30–35 regular patient visits in a comprehensive, effective and efficient manner, you will need to educate all of your patients about having realistic expectations of what you can accomplish during a routine office visit. Patients should also be educated regarding how to request more time for those circumstances that warrant an extended consultation, such as a complex medical issue, a counselling session, a periodic health examination or a medical procedure. Note that the time allotted for a counselling session, periodic health exam or procedure would likely equal that of at least two 'regular' patient visits. It is essential to train your receptionist to assist and guide patients, so that, together, they can determine appropriate time requirements when booking appointments.

There are several reasons to consider allotting 10–15-minute time units for a routine patient visit to address a specific issue, a routine follow-up visit, a potentially complex medical concern or a combination of minor concerns. The few occasions when a physician can thoroughly address a patient's concerns in five minutes are more than offset by the appointments that could take more than 10–15 minutes. This is especially true in practices that have a high proportion of geriatric patients and same-day call-ins.

Another factor that contributes to the ever-increasing complexity of daily practice is that some patients choose the convenience of going to the closest walk-in clinic for what they consider to be "minor problems" that they don't want to bother their own doctor with. Instead, they save their major concerns for their trusted family physician. Furthermore, specialists are now obliging GPs to "work up" their patients to a much greater degree before they will agree to see that patient.

A further reason to establish guidelines is that, after a thorough assessment, there should always be time to ensure that the patient clearly understands the diagnosis and action plan. This will improve compliance and reduce the number of follow-up visits. If you routinely try to address several medical concerns in a single visit when you are significantly behind schedule and pressured for time, the patient may feel satisfied, but is unlikely to retain much of the information you provide.

Patients who are educated that 10–15 minutes is scheduled for a regular appointment may be more inclined to prepare to offer a comprehensive, succinct history of their concerns. This facilitates a more effective and efficient assessment and treatment plan. When the time is well managed by both parties, many physicians find that they also have time to determine whether the patient has prescription renewals pending, or whether preventive care procedures, such as Pap tests, mammograms and immunizations, are overdue.

There will always be exceptions. Some patients have complex care issues that routinely take more time. If this is identified in the patients' registration profile, your reception staff will automatically set aside more time for their appointments.

How do you decide whether to allow 10, 12 or 15 minutes for "regular" office visits? There are several things to consider as you make this decision.

First, how much time will you require to do a thorough, effective and efficient evaluation of the common medical issues you see each day? In your first six to 12 months of practice, you should consider scheduling more time for regular visits, or, preferably, block off one slot per hour for catch-up time. Once you get to know your patients and have polished your assessment skills, it will become easier to assess your patients in the time allotted for a regular visit. Even if you feel financially pressured to see a certain number of patients each day, you must first and foremost provide excellent care.

A second factor is the provincial physician remuneration model under which you are working, and whether you are obliged to generate gross billings to provide a reasonable income. (A brief summary follows; you are also encouraged to review *Module 8. Physician Remuneration Options.*)

If you are a full-time salaried physician with no responsibility to pay for the practice overhead costs and your remuneration is not contingent upon the number of patients you see, then you may have the luxury of allotting 15 minutes or more for regular office visits, depending on your contractual service agreement. This scenario would apply, for example, to a physician who works in a community health centre or a primary health care team, where allied healthcare workers, such as nurse practitioners, physician assistants, physiotherapists, pharmacists and social workers, may be part of the collaborative care management team.

If you participate in an alternative capitated payment system, you will receive a monthly and yearly payment for each of your enrolled (or rostered) patients, regardless of the number of times you assess an individual within the year. Ontario is the primary province evaluating these models. These funding models also allow physicians the latitude to delegate more care to a nurse practitioner, or to offer indirect advice and care via telephone or, potentially, by email. The physician is not required to personally see the patient. This scenario may give you more latitude to offer longer patient appointments, during which you can address several medical issues—because your income is not fully dependent on the number of patients you see per day or the complexity of the services or procedures that you provide for each patient. However, 'shadow' fee-for-service billing will be required, so the Ministry of Health can be assured that patients are still being served as well as (and, ideally, better than) the traditional fee-for-service model. Thus appointment scheduling and time management are still important.

In Canada, the majority of family physicians work in a traditional or enhanced FFS (fee-for-service) model, where physicians are obliged to generate most, if not all, of their gross income from the services they personally provide for their patients. If

Key Message

Payment models and practice demographic and complexity will have considerable impact on how much latitude you have when developing appointment scheduling practices for your office.

this is how you are remunerated, your appointment scheduling objective must balance your responsibility to provide excellent patient care with how many regular patient visits or equivalents you must manage each day to cover your practice expenses and generate a reasonable income. In this payment model, physicians have limited ability to delegate payable services to other staff—so you personally must provide most of the medical services for which you bill. In most provinces, fees paid for a regular office visit would require a family physician to manage the equivalent of 30–35 regular patient equivalent visits per full day to balance these two objectives.

PATIENT INFORMATION PAMPHLET

Every physician should have an up-to-date information pamphlet that is available and, ideally, given to all patients. Patients appreciate having a comprehensive, concise resource document that they can refer to at home or on the internet. Because it will reflect your medical practice, your pamphlet should be prepared in a professional manner. We recommend that you also document that the patient has received this information in the event that disagreements regarding office policies occur later.

All of this information should be available on your practice website, which offers an accessible portal for new and current patients to easily find your group's most current policies, services, procedures and patient information. The CMA offers several helpful resources, including *Physician Guidelines for Online Communication with Patients*. This document, which is posted on the CMA Policy database at www.cma.ca, outlines the best practices and norms of communicating by email and through the internet. Another very useful resource is mydoctor.ca, a CMA service to help even techno-challenged physicians create websites for their medical practices. The mydoctor.ca site also offers new portals to assist physicians and patients in monitoring chronic medical conditions, such as diabetes and hypertension.

The following is a list of the type of information to consider including in your patient information pamphlet and website. You are encouraged to customize your own material so that it clearly outlines the depth and breadth of the medical services, as well as the office polices that you and your group practice colleagues have adopted. Always respect professional standards, obligations and ethics.

> **Disclaimer:**
>
> All of the following suggestions are presented only for your consideration. This guide is not all inclusive. Your practice profile, patient demographic, payment model, contractual obligations and personal preferences will determine the extent to which you will incorporate the following considerations for your practice.

Contact Information

- Office address, phone number, after-hours access number and address, website URL
- Parking and public transit access
- Office hours
- Hours when phones are answered
- Can patients leave messages regarding cancelling appointments on your system?

You And Your Associates

- A brief biography, introducing each group member
- The scope of family medicine you practise and the services you provide; e.g., shared-care obstetrics; newborn, pediatric and adolescent care; women's health; men's health; geriatric and palliative care; inpatient or supportive hospital care; minor procedures
- Any family medicine services that you do not provide
- Services that may be provided by an associate; e.g., shared-care obstetrics
- Special interests and training of all physician associates
- Physician availability and accessibility (example: *"Urgent visits requested by telephone will be evaluated and offered a same-day appointment whenever possible. No walk-ins, please."*)
- Holiday cross-coverage (example: *"When your physician is away, the associate physicians will reserve additional same-day visits to accommodate your urgent needs."*)
- Physician gender-neutral policy, if applicable, to avoid overburdening individual colleagues when you are not available (example: *"Patients must be comfortable with receiving all of their urgent comprehensive care by the trusted associate [male or female] when their regular physician is away."*)
- A policy that discourages transfer of patients within the group
- The language proficiencies available within your medical office
- Resources, if available, to accommodate special needs patients; e.g., multilingual staff, access to assistance for the hearing impaired

Appointment Scheduling Policies

- All requests are triaged by the receptionist and documented for chief complaint(s)
- Specific information about the patient's concern(s), as required for appropriate scheduling
- Patient confidentiality assured
- Reminder to arrive on time (example: *"Come early, because parking can sometimes be a problem."*)
- A policy for patients who are late for appointments (example: *"We reserve the right to fit in or rebook patients who are late for appointments."*)
- New patient first appointments: Explain the objective of this visit and indicate how much time is allotted; e.g., 10–15 minutes.
- Regular visits: Describe the time allotted for a regular visit; e.g., 10–15 minutes allotted to address patient's main concerns. State clearly that secondary issues will be addressed if time permits; otherwise, a follow-up appointment will be offered within (e.g.) one week.

- Complex medical issues and special considerations (example: *"If you are travelling a long distance and/or believe that your concerns will require more time with the doctor, it is important for you to inform our receptionist so that an extended appointment can be booked as soon as possible."*)
- Follow-up visits; e.g., 10 minutes allotted
- Same-day urgent visits; e.g., 10 minutes allotted (examples: *1. "We routinely reserve several appointment slots to accommodate concerns that should be seen urgently." 2. "When you are sick, we will see you quickly—help us help you by calling early for a same-day appointment."*)
- Walk-in visits: Will you see walk-ins during regular office hours? In general, this is discouraged, especially if you book same-day urgent visits. Because walk-in patients should need to wait until patients with appointments are seen, they will save time and be better served if they call ahead for a specific time for a same-day visit. Clarify your policy in your patient pamphlet.
- Periodic health exams; e.g., 20–30 minutes allotted (example: *"Periodic health examinations must be booked in advance, as this visit will be dedicated to do a comprehensive health audit and education session. Patients should not save problems or urgent issues for this appointment. Make an appointment to be seen much sooner for specific or urgent concerns."*)
  Note: Not all provinces pay physicians for periodic health exams.
- Counselling, interviews and stress management issues; e.g., 20–45 minutes allotted (example: *"Patients should inform reception when they are calling about counselling, interviews or stress management issues so that more time can be scheduled."*)
- Procedures; e.g., 10–30 minutes allotted

Appointment Schedule Templates

How often have you heard that an individual with a sore throat or cystitis could not be seen by their own GP for at least seven to 10 days? This is absolutely unacceptable.

Objective:

A balanced daily work schedule, while at the same time ensuring that patients are seen when they need to be seen. To attain this objective, it is essential to establish a weekly appointment schedule template that suits your practice style, patient demographic and complexity. The challenge is to prevent a backlog of available appointments—especially when you are offering a broad spectrum of primary care services, such as:

- Same-day urgent visits
  - More on Mondays than Fridays
  - Recommended at end of morning and afternoon
- Follow-up visits
  - Offered earlier in a.m. and p.m.
- Periodic health examinations
  - Most GPs offer three to four per day
  - Offered first thing in a.m. or p.m.
  - 20–30 minutes allotted

- Complex medical care management, such as diabetes and congestive heart failure
  - 20–30 minutes allotted
- Antenatal and well baby
  - usually mid-a.m. and early afternoon
- Office procedures
  - Allow adequate time
  - Often done end of a.m. and p.m.
- Preventative health management
- Counselling and primary mental health care
  - 20–45 minutes allotted, dependent upon payment model

The first week in practice will most likely be dedicated to new patient visits, unless you are assuming a practice. Your weekly template should start as of week two, because you will have several new patients who will need follow-up visits and periodic health exams. The time allotment for the different types of appointments is discussed below. The key is to decide when and how many periodic health exams you feel you can do daily, how many same-day appointments you should reserve, and when during the day. When do you prefer to do your counselling, well baby and antenatal care? Review this weekly with your staff and make appropriate adjustments. Within three months, you should have your scheduling fine-tuned so that you are meeting acute and ongoing demands without being constantly late.

Once you establish this schedule, it is essential for you to follow your own policies. If your receptionist is following your protocols and screening the reason for visits, and you are constantly getting 30–60 minutes behind, then you are the problem—not the schedule. Either you have set unrealistic expectations of what you can provide in the set time, or you are not following the policies that you have established for your patients.

"Advanced (Open, Easy) Access Appointment Scheduling"

Most, if not all, of the above objectives can be met by the utilization of the "Advanced Access Appointment Scheduling Approach". This approach is discussed in detail in an excellent web-based format, accessed via:

- http://toolkit.cfpc

This tool was developed to assist doctors who are already in practice and who have lost control of their schedule because they did not establish clear protocols or did not follow them.

The objectives of Advanced Access Appointment Scheduling are:

- Patients are seen when they need to be seen. This objective is met when the "third next available appointment" = same day or next day.
- No backlog: "Can't be seen for 2 weeks" does not occur.
- Patients see their physician.
- No waiting/no wasting of time.

- The supply of patient service supply and demand is balanced on a daily, weekly and seasonal basis.
- Patient, physician and staff satisfaction improves.

Requirements for success:

- Ten-minute appointment time blocks are used.
- Different types of appointments receive different block time allotments.
- Regular: 10 minutes
  - Routine, follow-up, same-day urgent, minor procedure, well baby, prenatal
- Extended: 20–30 minutes
  - Periodic health exam, counselling, primary mental health care, complicated medical issues, procedures
- First approximately 1.5 hours in the morning are allotted for elective and follow-up bookings. May consider the first hour of the afternoon session if working a full day.
- The rest of the appointment slots are offered to patients who call that day—urgent or not.
- To succeed, all parties must buy into the system; therefore, establishing office procedures and policies, and proactively educating all new patients, are essential.
- All physicians and staff must comply with their established policies—and learn to say "No".
  - "I am sorry, but we will need to address that issue at another appointment," when the patient raises a third, or fourth, issue not mentioned when the appointment was booked.
- Patients must accept the importance of reception applying triage to the reason(s) for a visit.
- Success requires ongoing review and audit, utilizing patient and clinical satisfaction surveys.
- Special consideration for special needs patients is essential.
- Patient roster size and clinical needs demographics must be monitored, to avoid taking on too many new patients.
  - You can always work more.
  - It is tough to work less.

The Advanced Access system will work very well—if all the above requirements are met.

Unfortunately, some physicians have misinterpreted the objectives and protocols of this system, and have instead adopted a 'same-day' appointment schedule where there is no advanced elective bookings and patients will be seen only the day they call, if there is room. This leads to a phone lottery approach—which is not acceptable.

Missed Appointments Policy

- 24 hours' cancellation notice is required, or patient could be charged for a missed visit
- Reminders for regular appointments (examples: 1. "*Office staff are not able to call or send reminders for regular appointments.*" or 2. *"Office staff will call at least 48 hours ahead to confirm your appointment.*")
- Policy with respect to charging patients for missing a periodic health exam or counselling session. Consider a policy of offering one reminder call within the week before a periodic health exam.
- Policy with respect to charging patients for missing more than one regular visit
- Current uninsured service fees for missed appointments—posted in the office, in the patient information pamphlet and on the website
- Fees for all uninsured services subject to change

Requests For Phone Call Advice

Your policy regarding medical advice offered via the phone will be significantly influenced by the payment model you participate in. In most fee-for-service payment models, physicians are not remunerated for assessing patients by telephone. Exceptions occur in some provinces, where phone monitoring and management of chronic diseases, such as diabetes, can be billed to the Ministry of Health. If it is not specifically covered under the payment model, phone advice is deemed to be an uninsured service.

In a capitated payment model, the physician does not always have to see the patient to be remunerated. There is latitude, therefore, to address certain medical issues by phone if you decide that a face-to-face visit is not required.

Regardless of the payment model, there will always be situations when it is appropriate for a physician to talk to home care nurses and housebound patients. This is more common when the medical team does not include a well-trained family practice nurse. Adopt effective, efficient protocols, so that you can minimize the amount of time your office patients will need to wait while you are on the phone. Suggestions include having your staff obtain relevant history, and having the chart ready and the patient on the phone when you take the call. Remember that you are medically liable for any and all telephone advice offered by you or your staff—and it is mandatory to document telephone consultations in the patient's chart.

Examples of text to include in your patient information pamphlets: *"Because a patient interview and examination are essential for us to provide quality care, we have adopted the following office policies:*

- *"Receptionists are not qualified to offer medical advice."*
- *"Nursing staff (if available) will offer phone advice when indicated."*
- *"Only basic advice will be offered by telephone."*
- *"The physician does not routinely offer medical assessments or diagnoses on the phone, but will be available to assist staff when necessary."*
- *"Same-day or appropriate appointments will always be offered, depending on the nature and urgency of the problem."*

- *"All test results are reviewed by the doctor. Patients will be called for a follow-up visit if laboratory or diagnostic tests are abnormal."* (Imagine how much additional staff time would be required to notify patients of all their normal results! It is critical, however, to ensure that all diagnostic investigations are received and reviewed.)

- *"Telephone advice that is not directly related to an insured service, or that is requested after significant time has passed since the last appointment, may be considered uninsured and billed directly to the patient."*

Prescribing Policies

Will you routinely renew prescriptions by telephone?

It takes at least five to 10 minutes of staff and physician time to pull or access the chart, assess whether a medication renewal without a visit is appropriate, document each request in the chart, call the patient back, and call or fax the pharmacy. This interrupts your staff from serving the patients in the office, and ties up your phone lines, making it more difficult for patients to call in. Take a minute, whenever possible, at the end of a routine visit to review and renew a prescription that is unrelated to the visit. This will be appreciated by your patients. Doing so will also significantly reduce both the number of phone renewal requests and the number of office visits required just for prescription renewals. An up-to-date cumulative medication profile is essential.

Consider the following for your patient pamphlet and office information signage:

- A policy of offering renewals during any visit, regardless of the presenting issue (example: *"Help us to help you—if you have no repeats for a medication, let us know during your office visit and we will renew it. If a detailed medication review is appropriate, then a dedicated follow-up visit will be scheduled."*)

- A policy about 'best practice' evidence-based guidelines (example: "*This office follows evidence-based guidelines for all prescriptions, including antibiotics, narcotics and medications for stress-related conditions.*")

- A prescription renewal policy (example: *"An uninsured service fee will be charged for phone prescription renewal if the patient fails to book an appointment for appropriate follow-up before the last repeat runs out. A charge also may be levied if the patient calls, or if the pharmacy calls on the patient's behalf."*)

Investigations

- Appropriate and current evidence-based guidelines direct all medical investigations.

Referrals To Specialists

- Appropriate referrals, made to specialty colleagues when indicated (example: *"Before any referral is arranged, patients must see the family doctor for pre-consultation information-gathering and investigations to facilitate a faster and more effective consultation."*)

After-Hours And Holiday And Weekend Coverage

- Address and phone number for after-hours coverage clinic, clarifying the hours, walk-in and/or appointment policy

- Clarify if and why it is your policy to discourage your patients from going to alternative after-hours providers, such as walk-in clinics (example: *"We receive a medical report within 24 hours when you visit the colleagues we designate for after-hours care, but we do not receive such information from alternative providers.").* Note: Some patient-enrolled payment models and enhanced fee-for-service models actually offer a financial incentive/bonus if your patient sees you or a group practice member for their after-hours care.

Uninsured Services

Always exercise discretion when billing for uninsured services. Patients often assume that all of your services are paid for by the government. Physicians are mandated by the regulatory colleges to inform patients of their obligation to pay before providing any uninsured service. Your patients will appreciate being educated about the situation in your province.

For the significant number of patients who may not be able to afford charges for uninsured services, you should consider either no charge or a nominal fee. You can also consider giving the patient an invoice that identifies the service but states "No Charge". Before developing your policy on uninsured services, review *Module 8. Physician Remuneration Options*, as well as your provincial medical association and college guidelines. Most provincial medical associations offer, and annually update, a suggested fee schedule for uninsured services.

You should also consider the following as you develop your policy on uninsured services.

- Clearly state that many services are not covered by the provincial insurance plan, and that patients may be charged appropriate fees for these services (example: *"Fees for medical services that are not covered by the provincial insurance plan are the responsibility of you, the patient. The fees assigned are as per the recommendations of the provincial medical association. We realize and will always take into consideration that some patients may not be able to pay for these services. Please don't hesitate to inform us if these charges pose a financial hardship to you."*).
- Patients must be informed and agree to the fee before an uninsured service is provided.
- Physicians may request, but they may not demand, payment in advance for professional services.
- Physicians may require deposits for prosthetic devices or any applicable facility fees.
- Uninsured services should be listed and clearly visible in the waiting room and exam rooms, as well as in your patient information pamphlet and on your website.

Information Signage In The Office

Patient information posted in waiting rooms and examination rooms complements your patient information pamphlet and website. This is a particularly valuable way to provide comprehensive information regarding uninsured services and fees that are subject to change. It is much easier to update this information in the office than to repeatedly edit and reissue your pamphlet to all patients.

By themselves, however, office signs can be misleading, and may not adequately convey the intent of your office policies. If you have followed the comprehensive guidelines suggested in this module, your patients will already understand what you

Key Message

Establish comprehensive office policies and procedures, and educate patients by means of a patient information pamphlet, distributed to every new patient and posted on your website. Establish an "Advanced Access Appointment Scheduling System"—and adhere to it.

can offer during a routine office visit, as well as how to make appointments to address complex issues. Your pamphlet and your verbal explanation during the first visit will convey your message much better than a sign can.

For example, signs stating *"One visit – one problem"* or *"The doctor can only address one issue at each appointment"* are absolutely inappropriate. When there has been no other direct communication about the policy, patients have often interpreted these signs to mean "one symptom per visit" and that the doctor will inappropriately oblige them to make several appointments to address their concerns. These patients believe that doctors are abusing and restricting their access to health care.

Regulatory colleges are addressing an increasing number of patient complaints regarding such use of office signs. Communicate effectively—don't rely on signage to educate your patients.

TELEPHONE PROCEDURES FOR PRACTICE START-UP

As a new family physician, you can expect to be flooded with calls from prospective patients, even before you formally announce that you are open for business. It is, therefore, important to develop clear and concise guidelines for your receptionist to follow when responding to new patient inquiries. You will need to have this policy in place when your receptionist starts to accept calls a few weeks before your practice opens its doors for business.

Your reception staff should be given a standardized approach to follow when fielding the inquiries of prospective new patients. The objective should be to educate prospective patients regardiing your practice profile and the services you can provide. Offering a standardized approach will also give the prospective patient an opportunity to decline before a first visit is offered.

At no time should any of these questions be scripted to avoid accepting patients who have difficult medical or emotional problems. Any form of "cream skimming" (accepting only healthy, uncomplicated patients) is both wrong and unethical. As discussed later, inquiring of one's medical history must be deferred until after the patient has acknowledged acceptance of your practice and office policies and has been accepted as a patient.

New Brunswick Provincial Human Rights Commissions are handling a dramatic increase in numbers of complaints from people who have not been accepted into a physician's practice. Our provincial regulatory colleges are now looking to mandate that physicians accept new patients on a "first-come, first-served basis", and disciplining physicians suspected of "cream skimming".

"First-come, first-served" does not oblige physicians to accept everybody who calls. A physician can decline to accept a patient if the prospective patient does not accept the physician's practice policies or service limitations. In essence, the patient does not accept the physician. In any case, this should be rare.

Phone Message Tree: Maximize The Benefits Of Technology

A programmable phone message tree for your group practice is worth the investment, especially when a new doctor joins an existing group. This system can be programmed to automatically direct incoming calls to the appropriate staff, such as the receptionist or nurse, and to advise patients of frequently requested information (e.g., the schedule for flu shots.) Remember that simply adding more phone lines does not solve patient access problems—because one staff member can answer only one phone at a time.

Considerations For Message Tree Programming	Examples For Recording
1. Develop a brief and clear telephone access tree.	*Welcome to the ABC Medical Practice. To help us direct your call, please choose from the following options.*
2. Give first-message priority to current patients, unless a new associate has just joined and requests for new patients are frequent. If so, the second message (#3, below) should be first.	*Current patients, please press 1.* Callers who press 1 will be transferred to a line that the receptionist answers during office telephone hours. If the line is busy, automatic messages can play until the line is free. If the call is received outside of telephone answering hours, the message should indicate office hours, how to reach the receptionist, the after-hours medical coverage number and similar frequently requested information.
3. Make the second message for patients who inquire about joining the practice.	*If you are looking for a new family physician, please press 2.* The message after pressing 2 should indicate which doctors are accepting new patients and which are not.
4. Clearly indicate when new patient requests will be answered to avoid being swamped by inquiries throughout the day.	*"Our staff have dedicated 2:30 to 3:30 p.m. on Tuesdays and Thursdays to accommodate inquiries from new patients. When you call back during this dedicated time, please press 1 to reach reception. Please go to our website at www.mydoctor.ca to view a description of our medical practice."*

Dedicating a specific time to field inquiries from new patients is advisable, because it takes a significant amount of time to inform each caller about the practice. In spite of hearing this instruction in a voicemail, some people will ignore the direction and call at other times. It is appropriate to direct your staff to politely ask these patients to call back at the appropriate time. (Example: *"We appreciate your desire to find a doctor; however, we have to restrict our morning and early-afternoon telephone calls so our established patients can reach us. When you call back on [day and time], we will have more time to answer your questions and tell you about this practice. Thank you. Please call back at that time."*)

Ensure that your receptionist is sensitive to the anxiety and pressure that individuals feel when they are searching for a family physician. For the exceptional occasion when a caller persistently refuses to phone at the designated time, you should decide whether your staff has your approval to advise them that individuals who choose not to comply with office policy cannot be accommodated. Your receptionist can provide the provincial college's find-a-physician telephone number and politely end the call. Should this happen, other staff members should be advised of the decision. The need to do this should be rare.

It is important for your staff to know that you will totally support their actions and decisions when they implement the office telephone policy.

Author's Comment:

The author has provided examples of scripted questions and answers for reception to use when fielding calls from prospective patients. Advice has been sought and received from the physician advisory team of the College of Physicians and Surgeons of Ontario. These examples and case scenarios have been carefully scripted to ensure that your receptionist will, at all times, handle all inquiries with consideration, understanding and respect. Remember, your receptionists are speaking for you!

Receptionist Telephone Interview Protocol For New Patients

A standardized phone interview should be scripted for your receptionist. This allows your receptionist to efficiently educate callers about your policies and the enrolment criteria for new patients.

Examples Of Interview Questions	The Purpose Of The Question
"Our office is only able to offer medical services in English [or other language spoken by the physician and staff]. Are you, or the family member you are calling for, able to communicate in English [or other language]?" **If the answer is no:** *"We regret that we can only accept patients who can communicate in English [or other language]. Please contact a community health centre that offers multilingual medical services."* **Alternative:** *"Any prospective patient who cannot communicate in English [or other language] will need to bring a trusted friend or family member who is. Please remember that the doctor will eventually do a physical examination and ask questions that may be very personal. The patient must always be accompanied by someone with whom he/she can communicate very openly. We will also make a longer appointment for you to see the doctor."*	Most doctors prefer to offer medical services to patients who can communicate in the physician's first language, unless the physician and staff are multilingual. Few family physicians in community practice have the resources to offer translation services or to employ multilingual staff members. Staff would also be obliged to find a family member who speaks the language of the office whenever they had to contact the patient. Your obligation for confidentiality could be compromised. Some physicians may be prepared to accept new patients who do not speak the office languages. If you do, remember that it takes considerably more time for your staff to respond to patient inquiries and for you to fully evaluate a patient with whom you cannot communicate directly. Also be aware that the patient may not freely discuss certain health issues in the company of the family member or friend who is providing translation. If you are in an area that is rural or under-serviced, or does not have community resources to assist special needs patients, investigate whether the provincial health department offers alternative or supplementary funding to help you provide the additional time and resources required to serve special needs patients. Capitated and blended alternative payment plans may allow the physician more latitude to spend extra time with individual patients (see *Module 6. Physician Remuneration*).
"Do you currently have a family doctor?" If the answer is yes and your priority is to meet the needs of patients without a family doctor: *"Unfortunately, at the present time, we can only consider patients who do not have a physician."*	In most Canadian centres, urban and remote, there is a shortage of family physicians who commit to offering ongoing comprehensive care. There are also countless people who do not have a family doctor. It is a common consideration to give first priority to those who do not have a family physician.
When Dr. X is away, do you agree to see any of Dr. X's associates (male or female) for all of your urgent and comprehensive care until your doctor returns?	This policy will ensure that all physicians within the group can cover for each other without gender bias by patients. Otherwise, some group members may be overburdened with coverage.

If you are accepting patient transfers, consider the following question: *"May we ask why you want to leave your current physician?"*	If you are accepting patient transfers from other medical practices, consider asking why the patient wants to leave the care of another physician. If their expectations cannot be met by your practice style and policies, your staff should advise them of this.
If you are not accepting transfers from your previous clinic: *"Are you presently a patient of Clinic X?"* **If the answer is yes:** *"Dr. J is not able to accept patient transfers from Clinic X."* **Or, if accepting these transfers:** *"Please be advised that, in this office, Dr. J. does not have access to the many resources and healthcare professionals that are available to you at Clinic X."*	As a professional courtesy, or by choice, physicians who move from one practice to another may not accept the transfer of patients from the original clinic, including patients who were assigned to other physicians. In some cases, the medical resources and funding may have been more extensive at the previous clinic (e.g., a community health centre) and patients will expect the same access and time that they were offered there. If this is your approach, explain your policy to callers who ask about transferring. If you will accept them, then it is important, and courteous, to direct your staff to inform them, in advance, of the differences in your new policies and practice resources. Also clarify these points during the first visit.
"Dr. J's practice focuses on... X, Y, Z. Do your healthcare needs fit this profile?"	Some family physicians have special skills, unique training, cultural background or professional interests that they have decided to focus on in their practice. For example, focusing on a group with a demonstrated need—such as new Canadians, who, because of language barriers, have limited access to care. Make sure the telephone interview script communicates this clearly and in a respectful manner. Regardless of your practice focus, do not engage in "cream skimming".
"For all prospective new patients, we offer an initial 10 (or 15) -minute first visits, where Dr. X will review the services we can provide and our office policies, and can answer any questions about his/her approach to family practice. This visit offers Dr. X the opportunity to decide whether he/she can meet your expectations, and you and the doctor can assess whether you are comfortable with each other. Assuming you find everything acceptable, the doctor will then start to address your medical issues during the time remaining. A follow-up visit will also be offered within one week to further address your current medical concerns, and a complete health review will be scheduled." *"Please visit our website* [e.g., www.mydoctor.ca], *where you can find a wealth of information for your review."*	Callers who agree to this office policy can book an appointment for the new patient's first meet-and-greet visit. Callers who do not wish to accept this policy should be thanked for their inquiry. Once the first appointment has been scheduled, your staff should be instructed to refer patients to your website, if established. This allows patients the opportunity to review your office policies in advance, and cancel their first visit if they find those policies unacceptable. The more prepared they are before the first visit, the less time it will take for you to review policies. More time will be available to start to address their current concerns.

Key Message

Develop an interview protocol for your receptionist to follow when responding to prospective patients. Be sure your staff members are confident that you will support their efforts. It is good protocol to interview people, and offer them the opportunity to interview you.

What About Urgent Requests?

You can expect your new patient first-visit appointment schedule to fill up quite quickly, and patients may easily wait many weeks before their initial visit. In addition to the calls from patients who want to book initial visits, you will hear from individuals with pressing requests, such as urgent medical problems or expired prescriptions.

Because you are accepting responsibility for your patients' health, it is important not to deviate from your policy of having individuals come for a first visit before accepting them into your practice. Callers who require more immediate attention should be advised to go to the nearest walk-in clinic or emergency department. Your staff should advise callers that you can assume responsibility only for patients who have been enrolled in your practice.

THE NEW PATIENT FIRST VISIT

Registration Procedures For The First Visit

A new patient's first visit has often been referred to as a "meet and greet" visit because the intent is to welcome the patient into the practice. Unfortunately, as discussed earlier, some new physicians have abused the label and their 'meet and greet' has actually been a 'meet and screen' visit—which is absolutely unacceptable. Callers who are offered the next available first appointment should be advised to arrive at least 15 minutes early for registration. Staff should advise callers about parking locations and limitations. A map on your website will be very useful.

Once patients are registered and their health card and demographic information are verified, they should be given a new patient package, which includes your detailed patient information pamphlet and a summary of uninsured services. Patients should be encouraged to read the material before meeting you. If your staff members suspect that an individual has difficulty reading, they can discreetly offer assistance. They should also convey their observations to you before you see the individual.

Consider advising your staff to not colour-label the chart folder (if used) with the patient's name and access numbers until after the visit. This will allow staff to verify that all demographic information is correct. Once the patient is accepted and enrolled in the practice, the chart can be properly coded and integrated within your paper or electronic medical records. As per regulatory college guidelines, you must archive the office encounter notes—even in the rare cases when an individual does not accept you or your policies, and therefore is not accepted into your practice.

Do not ask prospective patients to complete medical questionnaires before they meet you. If you chose to not accept that patient, he or she could allege that you turned them down due to their medical problems, a practice that is unethical and unprofessional. If you want to use a questionnaire, provide patients with the form after you have accepted them into your practice. They can complete the form in the waiting room after the first visit and leave the profile with your staff.

Before adopting this practice, be advised that it is often more time efficient to take the medical history yourself. This will eliminate the need to transcribe the patient's questionnaire information to your cumulative patient profile. If patients complete their own profiles, there is also great potential for illegibility or inaccuracy. Ideally, an electronic medical records system would offer new patients the opportunity to sit at a private computer area, where they could complete a medical questionnaire that your staff can easily format and import later.

Standardized Approach

Standardize your approach for every first visit. The first thing to determine is how much time you should reserve for the first visit (e.g., 10–15 minutes). It is crucial to stay on time. Imagine the negative impression new patients will have if, on their first visit, you are 30–60 minutes behind schedule.

We suggest you consider the following approach.

- Introduce yourself, and briefly review your practice objectives and your approach to family medicine.
- Ask what the individual is looking for in a family doctor.
- Verify that each person has read and understood the material offered in the waiting room. If you or your staff suspect that a patient may have literacy challenges, discreetly probe further.
- Answer any questions the patient raises about the office policies and patient information pamphlet. It is quite encouraging when patients ask for clarification, but it should be a red flag if they contest your policies. Agreeing to adhere to all of your office policies should be a criterion for any individual who wishes to be accepted into your medical practice. If you decide to make exceptions for a particular patient, advise your staff members and have it noted on the patient's profile; this will avoid misunderstandings when your staff carry out standard policies in future.
- Discuss your policy about the time allotted for a regular visit. Explain that you need the time to address their main concerns thoroughly, especially if this may require a detailed assessment. Several minor issues may be addressed, when time allows. Advise patients that a regular visit cannot accommodate a long list of issues, and that, when they have several concerns, they should request a longer visit when they call in. Assure them how important it is to tell the receptionist the problem(s) that need medical attention when they call for the appointment, and reassure patients that you will see them again soon to address additional concerns. Do not follow a rigid policy of one complaint per visit.
- If you are accepting patients who are transferring from another medical practice, ask why the individual is leaving the previous family doctor. It may be because the patient did not accept a clinical approach, prescribing practice or office policy. If you have or endorse a similar approach, advise the patient that you have the same policies and that you will respond in the same way.
- Educate patients about your approach to prescribing narcotics, antibiotics and tranquilizers (example: *"I believe it is very important to protect my patients from inappropriate medications, and I only prescribe medications as indicated by the latest guidelines. I am very judicious when offering antibiotics and strong pain medications or tranquilizers."*) This does not preclude you from accepting patients who are appropriately on these medications, but it enables and encourages such patients to identify themselves, so you can communicate your approach. In cases such as when patients take narcotics for chronic non-malignant pain syndromes, have them sign a contract that outlines your shared understanding about the renewal of these prescriptions.
- Assuming both parties are agreeable to entering into a physician-patient relationship, ask the patient to sign an acceptance form, acknowledging that

he or she understands and agrees to the office policies outlined in the patient information package. This can be kept as part of the cumulative patient profile. Should the patient not comply with your office policies in the future, having the signature will support any decision you make about continuing to offer medical care.

- Having provided prospective patients the opportunity to review your office policies and practice philosophy in advance of the first visit, there should be time left to address current medical concerns or gather medical history. If indicated, the patient should be offered a follow-up visit within one week to further address their current concerns. A periodic health exam (complete assessment) should also be scheduled to complete your information-gathering. Be sure that your schedule has sufficient flexibility to accommodate these follow-up appointments and is not overbooked with first visits.

- We do not recommend that you book a periodic health exam as the first medical visit. Without knowledge of the patient's past history and current concerns, you do not know what you are getting into, and other patients' appointments may be unreasonably delayed.

Billing For The New Patient's First Visit

Check with your provincial insurance plan and the provincial medical association's Section of General/Family Practice about the appropriate way to bill for this first visit. There should be time to start to address specific medical issues during this visit, so the specific diagnostic code and a "regular" office service code will likely be appropriate.

If you do not accept the patient, or if the patient chooses not to accept you and no medical issues are addressed, the visit is considered to be uninsured. Billing a patient who does not join the practice is inconsiderate, unless the prospective patient clearly indicated in the first telephone call that he or she wanted to interview you before deciding to become your patient.

Physicians are advised against billing the more remunerative counselling or time-based service codes for new patient interviews. Billing for a service without meeting all of the criteria is inappropriate.

Can A Physician Refuse To Accept A Patient For Medical Care? Can A Physician Discharge A Patient From The Practice?

The answer is a qualified "Yes". Each provincial regulatory college has guidelines for managing these situations.

For example, the College of Physicians and Surgeons of Alberta Guidelines (revised August 2005) suggest that, in making the decision to accept or not accept a new patient, the physician should:

- identify the person's needs and expectations;

- disclose the physician's knowledge, skills, limitations of practice and the mode of after-hours care;

- determine whether terms of the relationship will be mutually acceptable; and

- be mindful of human rights issues.

Sometimes, physicians and patients part because the physician is unable to continue for such reasons as illness, retirement or lack of appropriate knowledge or skills. More often, the reason is a breakdown of the doctor-patient relationship, which might happen for one or more of the following reasons:

- Appointments missed repeatedly, without adequate reason or notification
- Refusal to comply with treatment advice (Note: Physicians must, however, "respect the right of a competent patient to accept or reject any medical care recommended"; CMA Code of Ethics #24.)
- Rudeness or threats by the patient toward the physician, staff or family

It is important to review your provincial regulatory college guidelines with respect to these situations.

How To Say "No"

These situations should be exceptionally rare. It is important for you to feel reasonably comfortable that you can meet your patient's expectations, while at the same time knowing that you can say "No" when it is appropriate to do so. If you are concerned that a prospective patient will not respect your office polices and you still accept them, you may be setting yourself up for a potential confrontation that is not in their, or your, best interest.

On the rare occasion that you decide not to accept a patient, politely say something like: *"Thank you for coming in. However, I do not feel that I can meet your expectations. I am sorry, but I will not be able to accept you as a new patient."*

Should the individual still express a desire to be your patient, you should restate your position, but not enter into a debate. For example, *"I appreciate that, but it is important for me to feel confident in my ability to offer you comprehensive care."*

Frame your statements in a manner that avoids any derision of the individual. Say goodbye, wish them well and leave the room. Be sure to notify your staff immediately, so they can put this person's name on the non-acceptance list.

If your practice is limited to a specific population or clinical profile (e.g., women's health, men's health, geriatric care, sports medicine, general practice psychotherapy), state this clearly in your patient information pamphlet and include it as part of the receptionist's phone interview. This will prevent the need and the discomfort of having to say "No" during a first visit.

Advise your staff of your decision before the individual returns to the waiting room. Instruct them that, if the patient attempts to negotiate, they should respond that your decision is final. Staff can provide the provincial telephone number where the individual can inquire about other physicians who are accepting patients.

Are You Obliged To Accept All Patients Into Your Office Practice When You Are Working In An Under-Serviced Or Rural Area?

Accepting the responsibility of offering ongoing, comprehensive care to patients in your own office-based practice is significantly different than offering episodic care for patients when you are covering emergencies in a hospital or urgent care clinic, or when working in a walk-in clinic.

If your practice locale or contractual agreement does not offer any latitude regarding the acceptance of new patients, it is even more important to prepare a

detailed patient information pamphlet and establish reasonable office policies. You may be obliged to accept all patients, but you are not obliged to meet unrealistic expectations or to offer care that you believe is inappropriate. When all parties—patients, staff and physicians—understand this, it will make it easier to "agree to disagree".

The need for more comprehensive family practitioners in rural, remote and urban centres is significant. However, physicians who fail to set appropriate limits on what they can and cannot do will be much more likely to burn out. Stress is profound in our profession, and it is the primary reason for disability and physicians leaving clinical practice. Always use discretion and compassion when deciding if you can take on more responsibility. A comprehensive approach to starting your practice on the right foot will help establish the foundation of a rewarding, long-term relationship for you and your patients.

The recommendations and suggestions in this document are presented only for your consideration. Remember that it may not be practical, or appropriate, for you to implement everything. Customize your action plan to reflect your wishes and your particular circumstances. If you educate prospective patients to have realistic expectations of the care you can provide, they will respect your efforts and honesty.

Key Message

Proactively establish concise practice objectives and policies, so that your patients will have realistic expectations of what you can and cannot do.

Action plan

- **Establish clear office policies and procedures long before you see your first patient.**
- **Customize your own patient information pamphlet.**
- **Create a website for your new practice.**
- **Develop a telephone interview profile for your receptionist.**
- **Standardize your interview for new patients.**
- **Adhere to your own policies and support your staff, as they do the same.**
- **Set realistic limits for what you can and cannot do.**
- **Use discretion. Don't be rigid. Be considerate. And always be ethical.**

RESOURCES

- Your provincial College of Physicians and Surgeons
- Your provincial medical association's guidelines on uninsured services

The Following Resources Are Available At cma.ca:

- The Canadian Medical Association Code of Ethics
- mydoctor.ca is a service developed by the Canadian Medical Association that enables you to easily create a website for your medical practice.
- *CMA's Physician Guidelines for Online Communication with Patients:* These guidelines outline the norms, best practices, privacy issues and other things to consider when establishing a protocol for communicating with patients via email or the internet. The document is posted in the CMA Policy database.

Additional References:

- Casting call: The perils of auditioning patients; Canadian Family Physician, Volume 54, June 2008, pages 831–832.
- Accepting New Patients: The College of Physicians and Surgeons of Ontario
  - Policy #1-09, approved by council November 2008 and published April 2009.

Module 13:

Evaluating Practice Opportunities: Specialists

Association médicale canadienne
Canadian Medical Association

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

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Key Learning Points

- *How to identify and evaluate short-term and long-term practice opportunities*
- *Lifestyle and personal issues: a top priority*
- *Trends in medicine and their potential impact on you*
- *Costs and benefits of various medical practice models*
- *Remuneration options*
- *Useful resources*

INTRODUCTION

Whether you are a senior resident or a fellow envisioning your ideal career path or a practising specialist looking for a change, there are a number of issues to consider when evaluating practice opportunities. Although personal aspirations, lifestyle and location will be important considerations, other factors—such as national and provincial medical-political issues, trends in health care, professional issues and the specifics of your field—should influence your decision. This module will explore pertinent issues that senior residents, fellows and new-entrant physicians should consider when establishing a medical practice.

THE CHANGING DYNAMICS OF THE MEDICAL ENVIRONMENT IN CANADA

In recent years, physicians finishing residency and fellowship programs have seen a considerable change in the number and quality of practice opportunities in Canada. Concerns regarding a shortage of physicians in Canada in the 1990s prompted an increase in medical school enrollment—from 1,577 in 1997–98 to 2,800 in 2011–2012 (*CMAJ*, October 18, 2011; 183 (15), p. 1801). Today, the consequent increase in the number of physicians completing training, combined with expanding scopes of practice in some specialties and issues surrounding resource planning, as well as certain other factors, have resulted in a growing risk of unemployment and under-employment for residents in an expanding number of specialties, including cardiac surgery, nephrology, neurosurgery, plastic surgery, public health and preventative medicine (community medicine), otolaryngology, radiation oncology and orthopedic surgery. (*CMAJ*, October 4, 2011; 183 (14), p. 1673).

Complicating the growing supply of physicians in Canada are the fiscal implications of decreased funding for health care as federal, provincial and territorial governments move to counter growing fiscal deficits. After talks between Ontario's doctors and the minority Liberal government stalled in 2012, Ontario Health Minister Deb Matthews unilaterally imposed reductions to the provincial physician fee code on May 7, 2012. The website canadianhealthcarenetwork.ca reported that Matthews said the "... very highest-paid specialists where we've seen the windfall gains..." will be targeted. Three days later, in the same publication, former provincial Minister of Health and Long-Term Care George Smitherman was quoted as saying, "... the government [has] decided to make [Ontario physicians] the poster child for austerity". A number of provinces are closely following the actions in Ontario as they evaluate alternatives to control healthcare spending in their own jurisdictions.

When identifying and evaluating practice opportunities, physicians graduating today will surely confront the consequences of the increasing supply of physicians, as well as the implications of the actions of governments to balance their budgets to counter unfavourable fiscal realities. As they search for the optimal practice opportunity, the prudent resident or fellow will consider these factors as they apply to members of their respective specialty, as well as to their own respective practice situation.

WHERE TO LOOK FOR PRACTICE OPPORTUNITIES

Residents approaching their final year of study are often overwhelmed by clinical, teaching and research responsibilities, as well as preparation for fast-approaching qualifying examinations. Although it may be daunting to also identify, research and evaluate potential opportunities, these tasks are important. All too often,

systematic evaluation of practice opportunities becomes an afterthought, a "luxury" to be accomplished during non-existent down time. It is, however, one of the most important decisions of one's professional career, with far-reaching implications. This module will help you to approach this critical task in an organized, efficent and effective manner. In addition, it will identify other resources that are available to assist you.

Talk to current and former senior colleagues. Excellent advice regarding the identification of potential practice opportunities is close at hand. When entering the CaRMS residency match, many residents recall receiving excellent advice from former students and interns who had recently completed the "matching" process. Similarly, a recent graduate with whom you may have worked and trusted may be an excellent resource. These specialists have experienced the process that you are just now beginning—and they may be able to provide useful information regarding market conditions, remuneration and incentives, as well as other relevant facts. The information and advice provided by these trusted colleagues will typically be unbiased, timely and accurate.

Talk to your staff physicians. Tap into the wisdom of your program director, department head or other staff physicians whose opinions you respect and value. Academic and non-academic institutions often contact program directors and/or department heads directly with regard to potential prospects amongst recent graduates. Furthermore, these are individuals who will most likely be contacted to provide references about your aptitude, ability and character. Discussing your career and personal aspirations with these staff physicians may provide an important source of practice opportunities, perhaps even within your own faculty.

Consult the Canadian Medical Association's website. This is another excellent starting point. On cma.ca, you will find links to the most effective and efficient resources for practice opportunities.

- **Classified ads online.** This includes the classifieds published every two weeks in *CMAJ*.
- **Residents' associations.** Provincial and national residents' associations compile practice opportunities and lists of locums. Some of these organizations have staff on hand who will help you to write a résumé and prepare for interviews.
- **Professional organizations and provincial governments.** Provincial medical associations also keep lists of the specialties that are in demand in their jurisdictions, along with contact names and numbers. Ministries of health are also an important source of practice opportunities. Links are available on cma.ca.

Consult specialty publications and websites. Almost all medical specialties have publications that provide lists of practice opportunities. Many of these specialty organizations have websites with similar listings, and some provide members with access to databases of remuneration data for different groups within the specialty, often by region.

Consult medical journals. The print edition of *CMAJ* includes extensive listings of positions for physicians of every specialty. The same ads are posted online at cma.ca.

Go to job fairs. In some parts of Canada, provincial and faculty-sponsored job fairs cater to both family physicians and specialists.

Consult physician recruiters. Several provinces and territories employ physician recruiters. For more information, contact the ministry of health of that respective jurisdiction.

Consult with community development officers. Some provincial health ministries employ community development officers (CDOs) to liaise between the area's medical faculty and the geographic region it serves. CDOs assist both family medicine and specialty residents, and are well connected to the communities and medical practices that are recruiting new physicians. CDOs can also assist you by contacting their counterparts in other provinces.

Key Message

Utilize all available resources to identify practice opportunities.

Pay attention to word of mouth tips. Simple, but invaluable! When attending national and regional academic meetings, be sure to introduce yourself to counterparts across and outside the country. One can often discover practice opportunities at these meetings, and taking the opportunity to meet a potential employer face to face can yield future benefits. At these meetings, it is common for specialists to ask colleagues within their field for hiring recommendations.

HOW TO EVALUATE PRACTICE OPPORTUNITIES

There are a number of factors to consider when you are evaluating potential practice opportunities.

Lifestyle, Location And Personal Aspirations

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

Key Message

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

- Will you and your family be happy living in the community for a long period of time?
- Are affordable, quality housing and schools available?
- Are there satisfactory employment and education opportunities for your significant other?
- Does the area offer the cultural, religious, shopping, recreational and sports activities that are important to you and your family?
- Will the location, and available transportation, allow for travel to (and visits from) extended family and friends?

Remember: If you are not happy at home, it is very likely you will be unhappy at work.

National And Provincial Issues

Even before beginning the search for the most appropriate practice opportunity, consider the national and provincial environments for medical professionals. What are the current trends in health care? What will the impact of these trends be in the future? Is there a shortage or surplus of specialists in your discipline? Are there restrictions on practice opportunities for someone in your specialty in a given region or province? These and other factors may affect your job search and evaluation of opportunities.

Supply Versus Demand

In the 1980s and early 1990s, several reports suggested that Canada had an oversupply of physicians. Many medical schools responded by significantly reducing class sizes. Past projections did not account, however, for the combined impact of an ever-growing population, a reduced number of new trainees and attrition within the aging physician population. The end result was an increasing shortage of physicians in almost all specialties and sub-specialties as we entered the twenty-first century.

The tide, however, has turned once again. Increased medical school enrollment from 1997–98 through 2011 has created a larger cohort that has recently completed residency and has begun to seek practice opportunities. This increased supply of specialists, combined with the ever-increasing fiscal constraints on healthcare spending faced by the provinces and territories, has resulted in a more conservative outlook for many physicians seeking positions.

The consequences are significant and, depending upon one's specialty, can be either beneficial or detrimental For those specialties with continuing demand, the job market can still be inviting, receptive and even rewarding. For those specialties in which the supply has now exceeded demand for their services, however, increased competition for fewer positions will require creativity, due diligence and flexibility in the search for the optimal opportunity. In addition, these challenges will often require preparation, negotiation skills and perseverance on the part of the successful applicant.

Senior residents should review the job market for their specialty area to determine how national and provincial trends specifically apply to them. Unfortunately, many will face more restricted opportunities than their predecessors. Do your homework and research the market value of remuneration packages and incentives being offered to your specialty (also see *Module 8. Physician Remuneration Options*). If you properly assess the supply, demand and market value of your specialty, you will be in an informed position to accurately evaluate potential practice opportunities.

Other Trends In Medicine

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 have been uncommon, some regulations do exist. In Quebec, for instance, Plans régionaux d'effectifs médicaux (PREM) have placed significant restrictions on where and how a newly graduating specialist or family physician may practise. In certain specialties in other provinces, only limited numbers of positions are available in a given year or period. In some jurisdictions, billing caps or maximums, which can be specialty-specific, may be imposed. Some of these billing restrictions may be removed if a physician who is new to a designated under-serviced area meets certain criteria, such as performing specified "in-demand services" or staying for a predetermined period of time. Some regions of the country may offer bonuses and other incentives to recruit sought-after specialists. To learn more about regional incentives and restrictions, contact the relevant provincial medical association and ministry of health.

Some residents may wish to practise in a specific location with the intention of replacing a senior colleague who is approaching retirement. Although some hospitals and jurisdictions may have a mandatory retirement age for specialists, particularly surgeons, this will not always be the case. Be wary of agreeing to complete additional training with the view of replacing a senior specialist. It is not uncommon for a resident to return from training only to find that the senior colleague refuses to retire. Without a legally binding contract, the resident may be without a position or livelihood. If you are considering such a scenario, obtain legal and professional advice to protect your career and future position.

Hospital downsizing, healthcare restructuring and centralization of medical services may have considerable impact on those who practise in institutions. Investigate whether hospital restructuring is pending or has already occurred in all of the locations 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—or disappear entirely.

Alternative payment plans (APPs) and alternative funding plans (AFPs) are increasingly more common, both inside and outside academic environments. It is important to critically appraise their implications and impact in detail. If evaluating an opportunity involving an APP or AFP, it is strongly recommended that you seek professional advice from qualified accountants, as well as lawyers who specialize in contract law.

The pressure on health funding in Canada has resulted in more services provided by doctors being delisted or uninsured by provincial healthcare plans. It is very important for all physicians to familiarize themselves with existing guidelines, recommended fee schedules and the mechanics of billing patients directly for uninsured medical services. Such billings contribute a greater proportion of the remuneration for both family physicians and specialists than ever before.

Following this trend is the advent of point-of-service payment machines for debit and credit cards within the physician's office. Furthermore, computerization has led most provinces and territories to require electronic data transfer (EDT) billing from their physicians, leaving individuals with minimal computer skills scrambling. These issues are discussed in greater detail in *Module 8. Physician Remuneration Options*.

These are among many trends that medical practitioners will encounter. All should be researched and evaluated by senior residents who are assessing different practice options and locations.

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? Will the demand be so onerous as to threaten your quality of life? Consider being the only specialist in your field in a busy community hospital with a one-on-one call schedule.

Be sure to evaluate office space, hospital facilities, on-call requirements, radiology and laboratory support, other necessary services and useful resources. Review operating and procedure room facilities, as well as resources for research and academic activities, if applicable. Will the institution meet your personal standards of practice? Is there a group practice or association that you may join? What are the personalities, qualities and professional reputations of the members of that group? Will you be able to work well with them? Are these specialists excellent clinicians and colleagues to whom you can entrust your patients? Are quality consultants, specialists and other professionals that you require available? Are these professionals well recommended?

As you are the new professional on the block, will your potential colleagues or institution try to limit you to suboptimal operating room times, or will you have equal access to the facilities? If you have a specific skill set or training (e.g., endoscopic retrograde cholangiopancreatography, or ERCP), will you obtain sufficient referrals to maintain competence? Will call responsibilities be shared equally among all your colleagues, 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?

Key Message

Consider national and professional trends in your respective specialty area, as well as the specific professional issues that may pertain to any practice opportunity.

Appropriate and accurate research of all aspects of the opportunities that you are considering will help you to effectively evaluate your suitability to the respective practices and uncover potential deficiencies. No one likes surprises after starting practice. Not only will good research help you to plan for your future, but it may also demonstrate your interest, initiative and enthusiasm to the parties with whom you are negotiating.

PRACTICE OPTIONS

Researching a potential opportunity also includes evaluating the mode or structure of that 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 funding plans, to name a few. Learn about these different models to appreciate the costs and benefits associated with each.

Solo Practice

Although the majority of specialists today are solo practitioners, their numbers and the popularity of solo practice are in decline as more cost-efficient practice structures—such as groups and associations—gain popularity. The vast majority of new specialists should consider an association or group practice to capitalize on economies of scale and save on overhead costs, sharing them with colleagues. 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 generally greater than for a group practice
▸ Dedicated staff and resources	▸ Economies of scale—by sharing costly overhead (e.g., rent, utilities, staff) with a partner or associate—are not available
▸ Freedom to set working schedules, patient volume and practice style	▸ No daytime coverage while you're away
▸ Quieter office, with fewer distractions	▸ No on-site peer support

Group Practice

A group practice is defined as two or more professionals who practise in the same office. The professionals do not need to be associates, or even of the same discipline (e.g., a family physician who specializes in sports medicine, an orthopedic surgeon and a physiotherapist, all sharing an office).

The key advantage of a group practice is sharing the costs of office space, medical equipment, supplies and staff. These economies of scale can reduce the overhead cost per member significantly. There is a limit to the economies of scale, however, as savings eventually plateau. Bigger is not always better.

Group practice is becoming more practical in Canada, because of the changing medical environment and the inherent cost efficiencies. The percentage of physicians who work in group practice varies between family practice and other specialties, urban and rural settings, and from province to province.

Association Versus Partnership

The two most common forms of group practice are associations and partnerships. If you're considering joining a group practice, endeavour to meet all associates or partners to determine your personal and professional suitability with your potential associates or partners. By identifying problems early you can avoid making a hasty and regrettable decision.

An association is an expense-sharing arrangement. It can range from sharing only the rent and waiting-room costs to sharing everything, including staff, equipment, all medical supplies and office resources. Associates do not share income, nor do they specifically share professional or legal responsibility for others in the group. The degree to which expenses are shared should be clearly specified in a legally binding association agreement. Anyone considering such an agreement should review it with legal counsel before making any commitment.

A partnership group practice shares not only expenses, but also income, personal liability and medical liability. As a partner, you will be legally liable for the actions of other members of the partnership—even though you may not be aware of, or condone, specific actions. Careful drafting of the partnership agreement is critical to help you to manage these liability issues. A formula for each partner's share of income and expenditures must be specified in a legally binding partnership agreement, which is generally much more complicated than an association contract. It is essential that you review any partnership agreement with a lawyer prior to deciding whether to join or not join such a group.

Most group practices today have a cost-sharing association arrangement rather than a partnership agreement.

Advantages Of Group Practice	Disadvantages Of Group Practice
▸ Economies of scale for expenses (e.g., office space, medical equipment, supplies and staff)	▸ Loss of autonomy
▸ Minimal or no start-up costs, if joining an existing practice	▸ Resources and staff must be shared
▸ Convenient on-site consultations with colleagues on difficult cases	▸ Daily practice routines and schedules may depend on other physicians and staff
▸ Cost effective to employ a dedicated office manager to hire staff and run the practice efficiently	▸ Complex personnel structure means greater possibility of personality conflicts
▸ More financially practical to have sophisticated medical and computer equipment	▸ Excellent and ongoing communication is essential to maintain a comfortable work environment
▸ Physicians can make best use of their time—to see patients!	▸ Greater possibility for disagreement over such things as capital purchases (e.g., what voting structure will the group use to make such decisions? majority agreement? unanimous agreement?)
	▸ More difficult to find a group practice that is a good fit, both personally and professionally

Key Contract Points

The association contract or partnership agreement is of paramount importance to anyone who considers a 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.

The detailed contract should address all existing issues and potential problems, outlining courses of action on the "what ifs". A well-drafted agreement, which has been reviewed with legal counsel, will ultimately save you time, stress and money. Some specific issues that a partnership or association 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 on future activities (e.g., a non-competition clause in which the departing member agrees not to set up a similar practice within a certain radius for a defined period of time).

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

The group's obligations. This section specifies the benefits each member is to receive (e.g., 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? Have your lawyer review the lease and association/partnership agreement concurrently. This will verify that existing group members have negotiated the best deal possible, and ensure that there are no potential timing problems. For example, if an association agreement is for a three-year renewable term and a lease agreement is for a five-year term, a new associate may face the possibility of not being renewed after three years—but retain lease obligations for two years thereafter!

Billing and expense responsibility. This defines such issues as who does the billing, who is responsible for administration, and how shared expenses will be allocated.

Authority regarding business decisions. This determines how decisions will be made (e.g., majority vote, two-thirds or unanimous).

Staffing issues. When you join a group, interview the shared staff members as if you were hiring them in the first place. Negotiate that you will have the ability to replace staff if existing personnel are unsatisfactory. Also, negotiate that you have an equal say in performance evaluations, office policies and staffing plans.

Financial arrangements. The formula for distributing revenues and expenses among the group members must be detailed in the agreement.

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

Liabilities and debt. The potential debt responsibilities of each individual member, and the group as a whole, must be delineated.

Insurance. The contract should specify how much disability, practice overhead and life insurance is required of each member of the association or partnership 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?

These are just some of the issues to address in any association or partnership agreement. The expertise of a lawyer who has experience in contract law and who has worked with physician groups in the past is essential. You and your lawyer should work closely to ensure that the agreement reflects your understanding of the association or partnership, and that all of the "what ifs" that you and your potential associates or partners may not have anticipated to date (e.g., maternity/paternity leave, leave of absence, incorporation of individual members) will be dealt with in an agreeable arrangement.

Incorporation considerations should be reviewed with your financial planner and accountant. Detailed information is available in *Module 5. Legal Issues For Physicians*.

Key Message

There are advantages and disadvantages to all modes of medical practice. Seek assistance from professionals. Your lawyer, accountant and financial advisor will be invaluable as your explore and evaluate your options.

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

Most physicians in Canada are self-employed professionals whose income is generated by fee-for-service billing, and who work in either solo or group practices. 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 fact, employees of their hospitals or organizations.

It is a misconception, though, to assume that the monetary and non-monetary benefits (e.g., pensions, sick leave, holidays, disability insurance, and medical and dental insurance) enjoyed by other salaried individuals, such as nurses or government employees, will also be available to salaried physicians. The benefits available to salaried physicians are generally specified in their individual employment contracts. If you are negotiating a salaried position, determine what benefits are included, and ensure that they are documented in the employment contract. Like any partnership or association contract, your employment agreement should be reviewed and approved by legal counsel before you agree to the terms. It may also be prudent to have your accountant review the agreement. Tax planning opportunities may exist, and there may even be tax implications if your employer pays for certain benefits on your behalf (e.g., partial or complete payment of employee disability insurance premiums by the employer will make any disability benefits that may collected taxable to the employee).

Examples Of Salaried Positions

In academic institutions, physicians commonly derive their income in the form of a salary, or through some predetermined mix of salary and fee-for-service income. Outside academic institutions, physicians on salary include pathologists, hospitalists and doctors hired by community health centres to provide care for the population served by the clinic. 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 salary and contract. In addition, many provincial governments employ salaried physicians for under-serviced areas.

With increasing numbers of doctors not maintaining hospital privileges, an increasing number of facilities now offer hospitalist positions as well as clinical associate positions to family doctors. These physicians are hired by the

hospital to work in specialty clinics and cancer clinics, as well as to serve as surgical assistants.

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 have limited available deductions under the *Income Tax Act*. A physician whose entire income is paid as a salary generally cannot deduct association dues or liability insurance premiums. Under such circumstances, physicians should negotiate to have their employer pay these expenses.

Salaried physicians should always consider negotiating for the ability to do additional fee-for-service work to earn business income. For example, the physician could negotiate for regular time—perhaps one day per week—to work as a fee-for-service provider independent of the contractual obligations to the employer. Under this scenario, expenses such as liability insurance premiums, convention costs, automobile deductions and association dues should be tax deductible if they're incurred to earn business income. Salaried physicians who pursue additional fee-for-service work are strongly advised to seek the advice of a tax accountant.

Advantages Of Salaried Positions	Disadvantages Of Salaried Positions
▸ A secure, agreed-upon income, received each pay period	▸ Limited ability to earn more, except by renegotiating contract; workload could also increase without a parallel increase in earnings
▸ Generally no requirement to manage the practice	▸ Limited control over the working environment
▸ No responsibility for overhead costs	▸ The employer often makes decisions about staff, working conditions and overall operations
▸ Benefits may include guaranteed paid vacation, CME time, sick leave, medical and dental benefits, life and disability insurance	▸ Benefits are generally limited to those defined within the employment contract
	▸ No guarantee of employment beyond the term of the contract
	▸ Tax deductibility of certain expenses, such as CMPA fees or association dues, are limited

Hospital-Based Academic Positions

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

Although academic institutions often allow opportunities for physicians to generate business income, some groups and departments have income ceilings, in which earnings in excess of agreed-upon limits revert to the department, hospital or academic institution. 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, unlike their non-academic counterparts, academic physicians often have little autonomy regarding practice management decisions.

Because contractual and professional arrangements are likely to be mixed, academic opportunities are potentially the most complicated form of practice

arrangement. Academic physicians must learn how to negotiate contracts with the institution, the university, their clinical group members, as well as with their department chair. When negotiating in an academic setting, don't make the mistake of assuming that there will be no latitude or flexibility. *Module 10. Principles Of Negotiation* addresses this issue in detail.

Academic physicians need expert personal and professional advice. Contact your lawyer, accountant and financial planner prior to signing any contract.

ALTERNATIVE PAYMENT PLANS (APPS) AND ALTERNATIVE FUNDING PLANS (AFPS)

Alternative payment plans (APPs) address alternative methods of remunerating physicians for clinical work. Alternative funding plans (AFPs) address alternative methods of paying physicians for clinical and academic work. APPs and AFPs are relatively new compensation models for medical practice, but they are growing in popularity across Canada.

APPs are being implemented by many provincial governments as a component of primary care reform initiatives. 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 significant time and resources to teaching, research, administration and other duties. None of these services or duties, however, can be billed under a fee-for-service model.

An APP or AFP is created upon mutual agreement between a group of physicians and the province or territory. The agreement is documented in a binding contract, signed by the province, the physicians, often 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 contract to provide agreed-upon levels of their clinical, teaching, research, administration and other activities (i.e., the "guaranteed deliverables"). The parties agree on a mechanism to account for these defined deliverables and compare them to 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 their income as fee-for-service specialists—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 money.

Case Example: An AFP For Emergency Services
An emergency department at an academic institution employs six full-time emergency physicians who are presently remunerated by a combination of fee-for-service, salary and other earnings. They also perform clinical, teaching and administrative functions. The local healthcare authority offers the group an AFP valued at $1.2 million to provide all agreed-upon emergency room services for a fiscal year.

By accepting the AFP offer, the emergency physicians will provide the agreed-upon services to the public and must agree among themselves how to share the remuneration. Although it may be simple to divide the income equally (i.e., $200,000 each), some of the physicians may feel they deserve higher income because of their seniority, or because they perform other valuable duties. The recruitment of additional emergency physicians may complicate the negotiations further. Prospective group members should not assume that they will have an

equal share of the remuneration offer. Therefore, each member must negotiate a contract within the overall AFP contract.

For these and other reasons, AFP-funded academic group practices can be the most complicated of all contractual obligations for physicians. You are strongly urged to seek professional legal and accounting advice before committing to any APP or AFP arrangement.

TERM POSITIONS AND LOCUM OPPORTUNITIES

Locums are a starting point for an increasing number of specialists. Portability, combined with the absence of significant overhead, enables many anesthesiologists, for example, to choose locums rather than seek permanent positions upon completing residency. For a variety of reasons, members of many other specialties also prefer short-term positions.

Physicians who undertake a locum as a way of considering a permanent practice opportunity will find that the experience provides an excellent on-site way to evaluate the practice, the resident physicians, their practice management and staffing styles, the practice layout, the hospital, community and other factors. The experience can be invaluable if a permanent position is available at a later date.

The locum doctor should develop a checklist to thoroughly assess the locum before accepting the opportunity. Be prepared to evaluate such issues as practice and patient profile, volume and workload, the charting system, staffing support, scheduling policies, office hours, call obligations and insured and uninsured billing policies. For detailed information, see Appendix 2. Locum Evaluation Checklist Summary (below) and *Module 11. Negotiating A Fair And Mutually Beneficial Locum Contract*.

Key Message

A locum is a practical way to evaluate a potential long-term practice opportunity.

The process that one uses to evaluate a locum or term position is the same as that used to evaluate long-term practice opportunities; see Appendix 1. Sample Practice Evaluation Checklist (below). Use the locum as a case-example study and evaluate the specifics of the opportunity. Note the characteristics you dislike about the practice, but be sure to use the more favourable ones in your future practice.

ACTION PLAN

- **Know what is important to you and your significant other regarding lifestyle, location and personal aspirations.**
- **Use the many resources that are available to help you to identify and explore practice options.**
- **Review national and provincial issues and trends as they apply to your specialty, and assess their impact on potential practice opportunities.**
- **Consider the advantages and disadvantages of the various practice modes that are available for your specialty.**
- **Evaluate all practice opportunities to select the most optimal agreement for your professional and personal satisfaction.**
- **Select a lawyer and accountant to be part of your professional advisory team.**
- **Ensure that any and all contracts are reviewed concurrently by your contract lawyer prior to accepting a position.**

RESOURCES AND REFERENCES

The following resources are available at cma.ca.

- Practice Management Education Modules
  - *Module 5. Legal Issues For Physicians*
  - *Module 8. Physician Remuneration Options*
  - *Module 9. Principles Of Negotiation*
  - *Module 10. Evaluating Practice Opportunities: Family Medicine*
  - *Module 11. Locums: Negotiating A Fair And Mutually Beneficial Locum Contract*
- **CMA's Career Centre for Physicians** (drcareers.ca)
  Check out employment opportunities at the CMA's career centre for physicians.
- **HealthForce Ontario** (www.healthforceontario.ca)
  This Government of Ontario website offers services and valuable links to physicians, including:
  - **The HealthForceOntario Marketing and Recruitment Agency**, which offers individualized help for health professionals and their families from outside Ontario who want to relocate to the province. Case managers are available to help individuals navigate their entry into the Ontario practice environment.
  - **HFOJobs**, an online portal that enables physicians to search for practice opportunities and for community information, as well as to build their curriculum vitae, set job alerts and apply for jobs.
- **Alberta Physician Link** (www.albertaphysicianlink.ab.ca)
  Alberta Physician Link is a "one-stop" provincial recruitment website for physicians who want to find jobs/practice opportunities in Alberta, including locum opportunities. The website also provides linkages to various resources to help navigate the processes for licensure, supports for immigration and various information sites to learn more about living in Alberta.
- Links To Provincial Health Ministries And Medical Associations

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 desirable schools, shopping, recreational, cultural and religious facilities readily available and accessible?
- Can you, your family and friends visit each other easily?
- Are desirable employment and/or academic opportunities available 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?
- Is your understanding of your promised remuneration, including benefits, specifically documented in the employment contract? Has your lawyer reviewed your contract and agreed with your impression?
- Are important parameters of your practice—such as OR time, administrative and medical personnel, overhead charges, and time and resources for such specific procedures as colonoscopy, bronchoscopy or EMG—documented in your employment contract to the satisfaction of both you and your legal counsel?
- Is your employment contract written for a set period of time? If so, does it automatically renew unless appropriate notice is given by one of the contracting parties?
- Is there a probationary period? Do all benefits commence after employment begins, or after a predetermined probationary period? Is there any penalty if you are terminated during the probationary period? Is there a cost if you choose to resign prior to the end of the probationary period?
- What constitutes "cause" for dismissal? Would you be provided with time to refute any reported cause for an employer's dismissal action?
- If you will receive pension benefits, what is the duration of time before you have legal ownership of all employer contributions to your pension plan? (A "vesting" period of two years is common; for example, if you resign prior to two years of employment, all employer contributions to your pension plan remain with your employer and cannot be taken with you to your next employer or transferred to your RRSP.)
- Will your remuneration be entirely salary, or will there be an opportunity to earn business income and avail yourself of available tax deductions and/or tax credits?
- Do you have control over the hiring and termination of any para-professionals and other personnel who will be working for or with you (e.g., secretaries for office-based practices, technologists for radiologists or laboratory physicians, specialty technicians for ophthalmologists, nurses for employed surgeons)? If not, will you have input as part of a staffing committee, or are such decisions made by others, such as the human resources department of a hospital? Will these individuals be unionized, and what are the potential implications should you wish to end an individual's employment contract?

When Assuming A Practice And/Or Joining A Group

- Is the practice limited to practitioners of the same specialty? Alternatively, are there different professionals and/or para-professionals within the same group (e.g., a group of three orthopedic surgeons with a physiotherapist, family physician and nurse practitioner)? If different professionals or para-professionals are part of the group, how is their remuneration calculated: equal share? fixed salary? blended arrangement? If the practice is an expense-sharing arrangement (such as an association), how is the sharing of costs calculated?

- Does the practice have a sub-specialty interest or a special needs population (e.g., pediatric gastroenterology, adolescent psychiatry, geriatric medicine)?
- Do the members of the group adhere to current practice guidelines and evidence-based medicine? Does the group have an excellent reputation among the medical community, or have others expressed some concerns (e.g., an emergency department that has not been able to recruit an emergency physician)?
- What are the regular office hours? Is there flexibility for your schedule? Will support staff be available if your office hours extend beyond the regular business hours? If so, will you personally bear any additional cost?
- If duties are divided among members of a group (e.g., MRI, CT scans, ultrasound, X-rays, PET scans among a group of radiologists; or the duties of microbiology, biochemistry, genetics, immunofluorescence, cytology, autopsies and histology among a group of pathologists), how are they allocated? Are the more financially lucrative activities available equally to all members?
- If duties are best assigned by allocation of hours, such as for emergency physicians or intensivists, how are the shifts assigned, and by whom? Is there a minimum or maximum number of shifts in a given period (e.g., a minimum of eight shifts per month for an emergency room physician)? Can you request your shifts during a period, subject to an approval mechanism, or are they assigned to you?
- What are the on-call obligations? Do all physicians in the group share call equally? Is call coverage limited to your hospital, or does it include a group of hospitals within a municipality? Is there provision for on-call obligations to decrease or end after you reach a certain age or level of experience (e.g., a group of internists and related sub-specialists that provides no call after members reach 50 years of age)? If so, how will this provision affect your on-call obligations in the next five to 10 years as more group members reach exemption status?
- What are the arrangements for after-hours, weekend and holiday coverage? Who sets the on-call schedule, and what provisions are in place to request time off for vacation or CME? Will the remaining group members cover your medical and/or surgical responsibilities while you are away?
- Are there teaching opportunities or obligations? Have you satisfied all of the requirements of the institution? What will the duties of your academic role be (e.g., teaching medical students, educating residents, preparing didactic lectures, conducting research and publishing peer-related articles)? If research is involved, is a certain percentage of your work time protected from increasing clinical and other duties?
- Does the practice have a policy for the allocation of referrals and consults among group members? Are consults that are addressed to a specific specialist delivered to that individual, or to anyone in the group? If the latter, how are the consults assigned: on a rotational basis, to whomever is in the office, to the specialist on call, or some other way?
- Are patients charged for uninsured services? If so, for what services? Are these services and their respective rates in accordance with provincial guidelines for uninsured services? How are such fees collected? Does the office have cash and revenue controls to appropriately reconcile uninsured billings and the amounts received in cash or credit card receipts?
- What are the office policies for phone-call prescription renewals and missed appointments?
- Have you interviewed the administrative and office personnel? Are you satisfied with their medical and interpersonal skills? Are there potential problems (e.g., terminating an employee's contract, or hiring a qualified nurse to assist with procedures) that would be best dealt with before your start date?

- Are there supplies of narcotics on site (e.g., cocaine for nasal epistaxis in an otolaryngology practice)? If so, what policies and safeguards are in place for storage, administration and inventory control?
- Is the practice in an area where hospital restructuring has happened or is pending? If so, what is the potential implication for your practice?
- If you are joining a group, does the allocation of overhead fairly reflect your use of the office, equipment and personnel? Is such allocation detailed within the association or partnership agreement? Has your legal counsel reviewed this document and agreed with your impression?
- Are there other agreements, such as leases or equipment contracts, that must be assumed when you join an existing group? Do these agreements match the duration of the association or partnership agreement? Have all relevant agreements been reviewed by legal counsel concurrently?

Appointment Scheduling

- What is the average number of patients you can expect to see per day? What is the mix of procedures, follow-up visits, new consults, etc.?
- How much time is allocated for a procedure, new consult or follow-up visit?
- Can you customize your appointment schedule? Can you adjust the time allocated for a particular procedure, consult or office visit if this is more applicable to your practice?
- Is time built into the schedule for emergency consults or same-day call-ins? How are these patients accommodated in the schedule?
- How do office staff handle situations when you are unexpectedly unavailable and unable to see scheduled patients (e.g., an obstetrician attending at multiple deliveries, or a surgeon in emergency trauma or surgery)? Will the office staff anticipate such situations and reschedule all appointments if necessary? Can they be relied upon to make the appropriate decisions if you cannot be reached?
- Is the turnover time for the examination rooms acceptable? Do administrative and medical staff ensure that each examination room is appropriately supplied, organized and cleaned?
- If you are to perform procedures in your office (e.g., gastroscopy, indirect laryngoscopy or colposcopic examinations), who is responsible for cleaning the equipment? Are all established guidelines met?
- Is the reason for the patient visit recorded on the appointment schedule? Are you provided with your appointment schedule in advance?
- Does the secretarial staff ensure that all necessary supporting documents (e.g., pathology and radiology reports) are available before an appointment, and will they reschedule appointments when necessary, such as if pertinent pathology or radiology reports are incomplete or unavailable? Are all supporting documents and charts available to you before you see the patient?
- Does the practice have an extensive list of contact phone numbers, including those of group members, other consultants, operating and procedure rooms at the hospital, family physicians, labs, diagnostic services and pharmacies?
- Is there close correlation between appointment scheduling and billing? Are administrative personnel adequately trained to record all billable procedures and fees once you have completed such activities and passed along relevant documentation?

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? If dictated, are reports typed on-site or by an outside service? Are the turnaround time and quality of reports acceptable?

- Has the professional group evaluated or considered voice-to-print software?
- Does the practice have, or intend to have, an electronic medical record and chartless office?
- If the group utilizes electronic medical records, what system is in place? Is technical support reasonably priced and available in a timely manner? Does the IT service provider have a good track record?
- Are all reports, letters and referral requests in paper form? Are some diagnostic parameters, such as radiology and laboratory tests, available via computer? Are they available in real time?
- Are the existing notes appropriate, and do they contain all necessary and relevant information (e.g., drug allergies, previous surgeries and medical problems)? If you must care for the patients of another group member, will you be comfortable working with these records, or do you feel such records may be incomplete?
- Do records comply with standards set by the College of Physicians and Surgeons of your province or territory? Do the records raise any concerns regarding medical competence?
- Will the group members welcome standardization of medical records?
- After completion of a consult, what is the turnaround time for your completed consultation letter to be received by a referring physician?

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?
- If the office or building is owned, what is the market value? If a mortgage exists, what are the terms of the mortgage? As a new member, will you be required to be a part owner of the building and assume a representative share of the liability? At what cost?
- Will important diagnostic and hospital resources continue to be close by? (An obstetrician who is considering a five-year lease for an office across the street from the community hospital may wish to reconsider if the hospital is planning to move all delivery services to a distant part of the community in the near future.)
- If renovations of your office are necessary, who will bear the cost of such improvements? Will the group share the cost as an enticement for you to join, or will you be responsible for renovations? Can renovations be completed before your arrival?
- What is the duration of any office lease? Does the duration of the lease conflict with the proposed term of your contract? Have all pertinent leases been reviewed by legal counsel?
- Which office functions are computerized? Which are still done manually?
- If the office is computerized, what service agreements are in place? If a computer problem arises, what is the maximum down time you could anticipate? Do existing service providers have good reputations? Is technical support timely, comprehensive, effective and reasonably priced?
- What communications equipment does the office use?
- If the office uses email, does it have its own internal server? Are procedures in place to address the potential medico-legal implications of receiving emails from patients?
- Is the office accessible, modern, comfortable, clean and pleasant for patients, staff and physicians? Is your allocated office space satisfactory?
- Are the exam rooms and common areas well designed for function and comfort?

- Is the office and medical equipment up to date? If equipment cost is considerable (e.g., for otolaryngology, ophthalmology, radiology practices) what existing lease, lease-to-buy or financing agreements are in place? Have such agreements been reviewed by legal counsel and/or an accountant to identify potential financial and tax opportunities and pitfalls?
- 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 of the office, equipment and personnel resources? If the latter, is your proposed allocation fair, based upon your planned usage of the office, equipment and overhead?
- 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 health, dental or other benefits available through the practice?
- How are the physicians remunerated: fee-for-service? alternative payment plan? salary? blended format?
- Have you reviewed and approved the office accounting system? Does each group member assume his or her respective billing responsibilities, or is this handled by an employee who is dedicated to this task? If the latter, have you reviewed this individual's qualifications and experience to ensure that all billing will be thorough, complete and reconciled on a regular basis? Will you be entitled to review your billing records at any time?
- Who will handle the receipts, disbursements and all banking responsibilities? If a dedicated employee does such activities, have you reviewed the individual's experience and qualifications to ensure that your financial interests, and those of the group, will be best served? Is this individual trustworthy and reliable?
- Are there clear policies for the billing and collection of fees for uninsured and third-party services?
- Is there a 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 uninsured 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?
- Who will prepare financial statements? Will this be the responsibility of each member of the group, or is there an employee dedicated to this task? How regularly are financial statements prepared and reviewed?

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 potential losses or obligations for the term of the group practice agreement?
- Are there provisions within the agreement for the resignation or death of a group member to ensure an orderly continuance of the practice?
- Does the agreement provide for maternity or paternity leave? If so, what are the financial arrangements and obligations for anyone taking parental leave?
- Has your lawyer reviewed and approved the office and any equipment leases?
- 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?

APPENDIX 2: LOCUM EVALUATION CHECKLIST SUMMARY

Scope And Style Of Practice

- What are the patient demographics of the practice? How do such demographics compare with your specialty and sub-specialty or area of interest (e.g., the locum is general pediatrics, but you have a specialty in pediatric gastroenterology)?
- Does the practice have a sub-specialty interest or a special needs population (e.g., pediatric gastroenterology, adolescent psychiatry, geriatric medicine, cardiovascular anesthesiology)? How does this compare with your interests and training?
- If the locum is in a surgical or procedural specialty, what will the allocated OR time be, or access to procedure rooms during your locum time? Will this availability be guaranteed, or is handled it on a first-come, first-served basis?
- Does the physician you are replacing perform specialized procedures (e.g., reporting of PET scans for a radiologist, or ERCP procedures for a gastroenterologist or surgeon)? If you are expected to perform the same procedures, are you competent and comfortable in delivering these services? If not, has the host made arrangements for other colleagues to cover these tasks during the term of the locum?
- What are the regular office hours? Can you modify the office schedule if necessary? Will support staff be available if your working hours exceed the regular office hours?
- What on-call obligations are you expected to assume? Are there additional obligations related to the hospital, group practice or emergency department? Do you have the option of not fulfilling any of these obligations?
- Will the physician's trusted colleagues be readily available to assist you in an emergency or for a second opinion on a difficult case?
- Does the host doctor follow current practice guidelines and evidence-based medicine?
- What are the office policies for phone-call prescription renewals and missed appointments?
- Are practice policies (e.g., missed appointments, phone consultations) clearly posted in the office? Has the doctor provided each patient with a patient information handout that explains the practice policies? Do staff members enforce the policies consistently?
- Is the office clean and comfortable, and does it contain up-to-date equipment?
- Have arrangements been made for hospital privileges? Will such privileges be available before your start date? If you are practising in another province or territory, have the necessary criteria of the provincial College of Physicians and Surgeons and medical association been satisfied? If you will be billing the Ministry of Health directly, do you have an active billing number? If you are practising outside of Canada, have the appropriate malpractice, medical and other necessary insurance needs been obtained?

Appointments

- What is the average number of patients seen per day? What is the mix of new consults, follow-up visits and procedures? If a variety of skills are required (e.g., ultrasound, PET scan, CT scan and X-ray for a radiologist), what is the mix in the locum arrangement? Is the mix appropriate to your skills, expertise and style? Will financially rewarding procedures be available equally to the locum physician and the other specialists of the group or institution?
- Do the reception staff triage appointments and consults?
- Is the reason for the consult or patient visit recorded on the appointment schedule?

- Does the host doctor allocate a particular amount of time for a new consult, follow-up visit or procedure? Are these time allocations appropriate for the way you practise?
- In a surgical or procedure-based practice, how are procedures scheduled: through the host physician's secretary for in-practice procedures, or by an Operative Room Co-ordinator for surgical cases? How flexible are these individuals in establishing schedules? Have they been advised of the locum arrangement?
- How does the host doctor fit emergency consults and similar procedures into the schedule?
- Are there a reasonable number of time slots over the next two weeks for new bookings?
- Can you modify the appointment schedule if necessary?

Medical Charts

- Are the medical records comprehensive, legible and well organized?
- Does the physician dictate or write notes into the locum doctor's charts? Are all consultant letters and reports dictated? Are the dictations typed by a transcription pool from the hospital or the locum physician's office staff? What is the turnaround time for dictations? Is a dictate-to-write system in place?
- Does the physician keep up-to-date records for each patient? Is pertinent information (e.g., radiology and pathology reports, operative notes, referral and consultation letters) updated to the chart in a timely manner?
- Do the records raise any concerns regarding medical competence? If you are seeing another physician's patient in a follow-up, would the charts allow you to assess the patient problems effectively and efficiently?
- Are the patient files organized effectively so that office personnel can retrieve any patient's chart quickly and easily?

Finances And Billing

- How will you be paid for the locum?
- Will you and the host doctor have a fee-sharing agreement? If so, what percentage of fees will you receive for office services, hospital services and on-call services?
- Will the host doctor consider a guaranteed minimum daily income for you, if appropriate?
- Consider whether HST/GST will apply to your arrangement with the host doctor, and ensure that your agreement is reviewed by your tax and/or legal advisors to reduce or eliminate this possibility.
- Who is responsible for submitting and reconciling the billings for your services? If the host doctor's office is doing your billing, are you confident in the staff's competence in handling these tasks?
- Instead of relying on the host doctor's billing staff, is it in your best interest to enlist the services of a dedicated billing agent?
- Will your billing number, or the host physician's, be used?
- How will unpaid accounts be collected?
- How will you share Ministry of Health fees? How will you receive the service fees paid by third parties and the Workers' Compensation Board, such as an orthopedic surgeon reviewing WCB cases?
- Does the host doctor charge patients for uninsured services? If so, for what services?
- Has the host doctor provided a fee list for uninsured services billed directly to patients?
- Have you agreed on a schedule for when both parties will remit shared fees to each other? Have both parties agreed to non-performance clauses?

- Have you arranged financing to tide you over until you start to receive an income from the locum?
- Will you have an opportunity to moonlight outside the locum contract?
- Have your lawyer and accountant reviewed the locum agreement to ensure that your liability is appropriate and that potential income can be maximized?

Getting Ready For The Locum

- Have you confirmed all of your office, hospital, outpatient, call and other responsibilities?
- Have your hospital privileges been secured?
- Will you be provided with experienced office staff?
- Do you have contact information for call group members, other consultants, labs, diagnostic services, pharmacies and other important referrals?
- Have you received a hand-over list, identifying any special needs patients?
- Have you verified that the host doctor will assume medico-legal responsibility for all pending investigations you've initiated after your term has ended?
- Have you met the key staff and physicians at the hospital?
- Have you arranged for parking or transportation?
- Will the host doctor arrange for your orientation to the community?
- Do you have a place to stay?

Potential Tax Implications

- Has a tax accountant or lawyer reviewed the locum contract to avoid potential GST/HST liability and minimize income taxes payable?

The Locum Contract

- Have both parties agreed to and signed a locum contract that addresses all of the above relevant issues?

APPENDIX 3: GETTING STARTED

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

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

Starting Your Own Practice

Today, many specialists 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. Although it would be most advantageous to introduce yourself to all other specialists and family physicians in the area, such activity generally takes months or even years. It may be very prudent to draft a letter of introduction to all family physicians and specialists who will form the bulk of your referral base. Such a letter can include your training, additional qualifications and fellowships, as well as any special interests. In addition, the document could detail your office hours, on-call and office policies and other pertinent issues. Specialists who have followed this advice say that the letter not only serves as an introduction until they have had the opportunity to meet other physicians, but also establishes and streamlines their referral base. For example, a new specialist with a fellowship in adolescent psychiatry may see significant referrals from family doctors who, upon reading the introduction letter, found an appropriate consultant for many of their patients.

If you are starting a solo practice, 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. Its appendix will also help those who are joining or forming a group practice to conduct an inventory of what is being provided and what is missing.

If you are starting your own practice as a new member of a group, make sure that your new colleagues have the same approach to office policies, practice style, prescribing methods and uninsured service billing. 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 personality conflicts among physicians, staff and patients. You are advised to expand on the criteria for evaluating prospective locums (see *Module 11. Locums: Negotiating A Fair And Mutually Beneficial Locum Contract*).

Whenever you are evaluating the pros and cons of joining a group, make sure that your future colleagues have a vested interest in your success and are prepared to accommodate you. Also make sure that your expectations and requests are realistic.

Have your accountant review the existing group's accounting books, year-end summaries, and capital and equipment liabilities. At the same time, your lawyer should review any leases and the existing group contract in detail, so you can customize it for your requirements.

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 a practice of a physician who is retiring or leaving may be a very sound option.

Assuming An Existing Practice

Advantages	Known Disadvantages	Potential Disadvantages To Watch Out For
▸ Instant full practice, with steady income stream	▸ If the opportunity is well researched, there will be few disadvantages	▸ Inheriting someone else's problems and mistakes
▸ Office and staff in place	▸ May be expected to pay significantly for the "goodwill" of the practice (see Buying a Practice, below)	▸ 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, to the extent that staff and patients must be re-educated
▸ Medical records and cumulative patient profiles are already prepared		▸ Potentially more work and stress in the first few years compared with starting your own practice
▸ New patients can be accepted selectively		▸ Potential attrition of patients
▸ Less need for meet-and-greet visit with all patients		▸ Potential financial liability if your predecessor does not terminate employee(s) before you arrive—interview staff first and treat the meeting as a job interview
▸ Existing patient roster puts you in a good position to consider AFP or another remuneration format		

Before you assume a practice, you should expand on your Locum Evaluation Checklist (see Appendix 2).

- Do a detailed evaluation of the practice profile and demographics.
- Do a detailed evaluation of any remaining group members.
- Does the outgoing doctor practise medicine the way you do?
- Is he/she practising evidence-based medicine?
- Has the physician educated his/her patients to have realistic expectations?
- Will the outgoing doctor actively introduce and endorse you to his/her patients?
- Interview each staff member to verify that you want to work with them, and that they are willing to stay.
- Does the office and all the equipment meet your expectations?

- Are the communication systems up to date?
- What computer technology does the office use? How easily could you move to an electronic medical records system? Would new equipment be required?

If at all possible, do a locum in the practice to give you a real appreciation of whether or not you can see yourself taking it over. If so, your first two years in practice should be less stressful than if you were to start from scratch.

Buying A Practice

It may appear that assuming and buying a practice are the same, but financially they are quite different.

Assuming the practice primarily requires 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 generally not significant and can be easily financed. Ensure, however, that the equipment is up to date and meets your requirements and expectations.

Purchasing a practice also involves paying "goodwill" to the outgoing physician—for the patient roster and the opportunity to have an established and assured income stream. It is often difficult, however, for physicians to sell a practice, because a consultant generally becomes flooded with referrals almost anywhere he/she locates.

Who purchases a practice these days? One example might be a senior ophthalmology resident who wishes to return to his/her hometown, where another ophthalmologist who plans to retire in a year or two has an efficient, attractive office with up-to-date equipment and an established referral base. Acceptable capital equipment, an opportunity for an immediate consultant practice and on-site support from a senior ophthalmologist for a defined period of time may well be attractive at a fair and reasonable price. If a practice that meets all of these criteria is available, it may be worthwhile to pay some goodwill to get started on the right foot. The monetary value of this goodwill is best evaluated by your professional advisory team, especially your accountant.

Do not necessarily assume that you, as the purchaser, will be obligated to continue the employment of employees of the previous physician. In light of existing provincial employment legislation, however, the purchaser should consult with qualified legal counsel in order to fully understand the implications of retaining or re-employing staff members who worked for the outgoing physician.

Key Message

Consider the pros and cons of setting up your own practice, as well as assuming or buying another physician's practice.

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 and mode of practice. 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 that you respect.
- 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 medico-political issues of today. They may affect decisions you make about your future medical practice.
- Talk to as many physicians as you can to learn what they have done right and—more important—what they did wrong.
- Ask questions until you get all the answers you need.
- Explore the resources that are available to help you make decisions about your future.

Module 14:

Setting Up Your Medical Or Clinical Office

Association Médicale Canadienne
Canadian Medical Association

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

MD Financial Management and the author encourage readers to critically appraise this material and other resources in order to customize their personal action plan to best fit their personal and professional aspirations. You are advised to consult with a professional advisor to ensure that all of your specific needs are met. The information contained in this document is intended to be used for discussion and educational purposes only. While every effort has been made to provide accurate and current information, MD Financial Management does not make any representations, warranties or conditions (either expressed or implied) with respect to the accuracy or reliability of the information provided.

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Key Learning Points

- *Needs assessment for optimal design of your medical or clinical office*
- *Public access areas and the waiting room*
- *Reception, administrative and clerical areas*
- *Examination and procedure rooms*
- *Private areas for physicians and staff*
- *Choosing office equipment, supplies and providers*
- *Planning for communica–tions technology*
- *Computers in the medical office*

INTRODUCTION

Physicians-in-training often comment that they would prefer to delegate office or clinic design, set-up and operation to others because they see it as boring and tedious. Setting up your office is an important step, however, in setting up your practice. Throughout your professional career you will probably spend more time in your office than in your home. An efficient and comfortable working environment caters to more effective and efficient service delivery to patients, less stress for you and your staff, more professional satisfaction, and more income.

Physicians' office requirements vary greatly according to their specialty. A community-based family physician, pediatrician or internist will have much more complex office requirements than an anesthetist who works in an academic hospital. Regardless of your specialty, however, whether you work alone or in a group, or whether you are self-employed or an employee, you have a vested interest in ensuring that your "home away from home" is personally and professionally comfortable, and managed effectively and efficiently. Even if you join an established practice or work as a salaried employee in an institutional setting where an office is provided for you, negotiate for an office that meets all of your personal and professional requirements.

This module will help readers develop their own checklists of questions to ask and issues to address when setting up a medical office.

YOUR OFFICE: THE PHYSICAL ENVIRONMENT IN WHICH YOU WORK

Most new-entrant physicians will join group practices in office clinic settings, rather than design and build a medical office from scratch. The evaluation process for your professional medical office addresses the same issues that you would when considering your personal home: comfort, function, personality, accessibility and street appeal.

To learn how to evaluate whether the physical environment in which you will be working meets your personal and professional requirements, study the examples you are exposed to now. Evaluate every office and clinic you work in during the rest of your residency. Establish your "ideal office" file, keeping notes and diagrams (with measurements) of the layouts of the examination and procedure rooms, medical records areas, and the personal office space dedicated for physicians. Note the spaces that you find the most comfortable, efficient and effective to work in. Assess the ergonomic comfort and safety factors for physicians, staff members and patients. Ask staff what they like, and what they would improve. Most important, keep notes of what you want to avoid. Will these layouts accommodate future equipment needs and computerized electronic medical records?

When evaluating an office setting, it may be helpful to divide the clinic into the following components:

- Public access areas, including parking, wheelchair access, elevators, halls, washrooms, diagnostic and allied health services on-site
- Pharmacy and confectionary services
- Patient areas, such as the waiting room and public washroom
- Office reception, administration, clerical and common areas
- Examination and procedural areas
- Private areas for physicians and staff

Use the following questions as a basis to help you evaluate each area of a medical office or clinic.

Public Access Area Checklist

- Is your office building or clinic easily accessible by car and public transport?
- Is adequate parking available on-site or nearby for patients, staff and physicians?
- Can physically challenged patients be dropped off at the front door?
- Are the building, elevators, public halls, washrooms and offices wheelchair accessible?
- Can a stretcher be accommodated in the elevators, the offices and all public areas in the event of an emergency?
- Is the office building clean and well maintained?
- What allied health services are on-site? Having a pharmacy, blood services laboratory and ECG clinic, as well as radiology, ultrasound and physiotherapy services nearby, offers one-stop shopping for patients and may result in quicker diagnostic test results.
- Is there a coffee shop on-site? Being able to leave the office for a break is a great benefit for you and your staff.

The Waiting Room

How often during your training did you come into a clinic or office through the waiting room? Most physicians have private entrances to their offices, and often have no idea whether the waiting room is well maintained. Because patients spend a lot of time waiting to be seen, any effort to make the wait more comfortable will benefit everyone.

Waiting Room Checklist

- How many patients and their companions must be accommodated at any one time?
- Does the entrance door open without risk of injury to people who are using coat and shoe racks?
- Are there adequate and accessible racks for coats and shoes?
- Are hand sanitizers and masks (when appropriate) conveniently provided for everyone to use upon arrival?
- Are there sufficient, comfortable chairs, appropriately spaced, so that no one's personal space is compromised and no one needs to stand?
- Is there dedicated space for patients who require wheelchairs or walkers?
- Is there an unobstructed path to the reception area window?
- Is the room painted and decorated in calming colors? (This is especially important if the physicians are routinely behind schedule.)
- Is there a sound system for music or white noise to ensure that conversations from the clinical side of the office are not overheard in the waiting room?
- Should a television be provided, with channel and volume controlled by your staff?
- Is the reception window positioned away from the seating area so that confidentiality can be maintained as new patients register?
- Can the staff close reception windows to maintain privacy for their conversations, telephone calls and work?
- Are current magazines available?
- Is there need for a dedicated children's play area?
- Is a washroom available for patients?

The Reception, Administrative And Clerical Areas

An analysis of the numerous tasks required from a patient's first call to the medical office to the completion of the assessment, investigation and treatment reveals that the vast majority of the work is done by the multi-tasking office staff. If the office runs well, physicians can dedicate their time to the clinical encounters and delegate most, if not all, other tasks. Efficient, effective and ergonomically well-designed reception, administrative and clerical areas in your office will be of significant benefit to your staff, and reap big dividends.

During residency, however, most physicians have minimal exposure to office operations outside of the examination rooms. To learn how to design and manage a medical office, don't just ask the physician—ask staff members. Imagine the insight you would gain if, for a day, you were the receptionist in the clinic in which you are training. You would have a much better understanding of how focused staff must be to answer the phones, welcome and register patients, prepare examination rooms, do procedures, update and prepare clinical records, do the filing, and complete the call-backs, diagnostic bookings, consults and other tasks the physicians continually assign.

Privacy is a concern, and meeting the latest requirements for maintaining patient confidentiality is mandatory. Reception staff should be able to make telephone calls, have conversations with the physicians or other employees, and generally carry on their work without being overheard or constantly scrutinized by people in the waiting room. A wicket-style window, made of partially frosted glass, creates an effective barrier.

Take the time to talk to staff you work with during residency. Ask them what they like and what they would change if they had the chance to redesign or upgrade their work areas. Then, when you are evaluating your own potential office, take advantage of the expertise of the MD Financial Management consultants (see the Resources section, at the end of this document).

Reception Area Checklist

- Is the reception area inviting for patients?
- Is there adequate room for staff members to receive and discharge patients?
- Can privacy be respected when patients register, ask questions or pay for uninsured services?
- Is there sufficient privacy for the reception staff?
- Is there adequate room for employees to get up and move around without disturbing each other?
- Are the desks and working areas ergonomically designed to maximize function and minimize repetitive strain injury (RSI)?
- Have you provided your staff with adjustable, ergonomic chairs?
- Are phone, computer and communication systems designed to maximize use and minimize RSIs?
- Are fax machines and photocopiers located for timely, efficient and effective use?
- Does the area have excellent lighting?
- Is there a sound system for music or white noise to ensure that conversations from the clinical side of the office are not overheard in the waiting room?

Administrative And Clerical Areas

- Are there designated areas away from the reception area where staff can do administrative work?
- If the office is open concept, can privacy issues be respected?
- Do the file storage set-up and retrieval protocols meet privacy standards?
- If traditional paper files are used, are medical records within easy reach, to save time when pulling and filing? Can staff members access files in a timely and ergonomically safe manner? (See *Module 6. Medical Records*.)
- Will the reception, administrative and clerical areas accommodate an electronic medical records (EMR) system without a major renovation?
- Is adequate accessible storage available for office supplies, to avoid clutter?
- If in transition to EMR, is there adequate storage to archive the paper charts?

Common Areas

- Are inner office hallways wide enough to accommodate wheelchairs?

EXAMINATION AND PROCEDURE ROOMS

During residency, you probably experienced working in a dreary, too-small examination room, with inadequate lighting and outdated equipment, which created an environment that was uncomfortable for both you and the patient. The reality is that, over the next several years you will probably spend more time in your examination rooms than in your home kitchen or family room—so invest in your practice environment and make it functional and comfortable.

In days past, a physician first would interview a patient in a consultation room before moving to an examination room. This time-consuming and costly approach is rarely used today, and the examination room is actually an interview, examination and procedure room. Because the room will be used for many purposes, it should be sufficiently spacious to accommodate chairs, examination tables, a workstation for chart completion and computer, sinks, equipment, supplies and people. A room that feels crowded is uncomfortable for both physician and patient.

For family physicians, pediatricians and internists, an examination room that is 8 feet wide and 11 feet deep can accommodate most requirements without being too big. Surgical specialists will likely find that they require larger procedural rooms to accommodate equipment. National and provincial specialty associations often have resources available to assist in the design and outfitting of examination and procedure rooms.

During the rest of your training it would be wise to make detailed notes about the procedural rooms you like the most. You should consider the following when you finally set out criteria for the ideal examination or procedure room.

Examination And Procedure Room Recommendations

- The room dimensions should comfortably accommodate the patient and at least one companion, as well as any staff, technicians and physicians who would likely be in the room at the same time. Also take into account the space required for an examination table, sink, desk, equipment, supplies and anything else you need or want when consulting with patients.
- All rooms in the clinic should function as multi-purpose rooms, so that neither you nor a patient needs to wait for a particular room to be available.
- Have enough chairs in each room for the patient and a companion, as well as the physician. Patients are more comfortable being interviewed while sitting in a chair rather than when they are perched on the examination table in a sheet or skimpy gown.
- Ensure that the patient can disrobe in privacy. Offer patients adequate and warm gowns and a place to hang their clothes.
- Ensure that window coverings guarantee privacy. Reflective film on windows prevents anyone outside from seeing into rooms on sunny days, but not if it is dark. It is essential to install effective blinds or curtains.
- The door to the exam room should be placed and hinged so that patient privacy is respected when the door is opened. Patients do not appreciate being in full view of others in the waiting room or hallway when the physician enters the room.
- Ensure that the room is well ventilated, with climate control.
- The exam room must be soundproof. Walls are easy to insulate, but sound transmission via non-insulated ceilings is often missed by contractors and physicians alike.
- If possible, make good use of any natural light. Physicians, like patients, can suffer from seasonal affective disorder, and a periodic look outside provides a healthy distraction. Dedicate inside rooms for radiological or ophthalmological procedures that require darkness, so that you can take maximum advantage of natural light for other rooms. Provide excellent overhead lighting that does not create much shadow. Procedural lights should be flexible (and portable, if required) and placed for maximum illumination.
- Ensure that power and service supplies meet your technical requirements, present and future.
- Position the examination and procedure tables and chairs so that both patient and physician can access them comfortably. Most physicians are taught to examine the patient from their right side, and therefore place the examination table with the left side parallel to the wall. If you do procedures that require access from both sides, consider adapting the examination tables with caster rollers that can be locked in position. Don't risk back injury by pushing examination tables around.
- All equipment should be within easy reach of the physician and staff, without having to reach over or around the patient or in any way disrespect their personal space.
- Ensure that waste and sharps disposal containers are close by and safely out of easy reach of children.
- The sink should be conveniently positioned in the examination room for ready access by the physician.
- For personal safety, do not place the physician work area in the corner farthest from the door.
- The physician's chair should be positioned so that he/she can easily pivot from the examination area to the sink, medical waste disposal, chart completion area, computer screen, phone/intercom and any requisitions or patient handouts.
- Ensure that the room can accommodate computer upgrades for electronic medical records in the future.
- By minimizing the number of steps and movements to complete all of your tasks, you will save time and reduce repetitive strain injury.

Private Areas

The dedicated personal office has, traditionally, been larger than most examination rooms and is often redundant in utilization, because most physicians do not see patients in their office and use the room solely to do charting and reports. If personal dedicated space is important to you, then the extra cost for the space is worth it. If not, you can save either some rental costs or dedicate more space to the examination and common use areas.

Private Areas For Physicians And Staff Checklist

- Is there a dedicated staff lounge or kitchen area, away from patient contact areas, so that all staff members can take lunch and breaks there?
- Are there counter and sink areas that are dedicated for cleaning and sterilizing equipment? These should not be the same counters and sinks that staff members use for food preparation.
- Is there a private washroom for staff?
- Are there secure coat and storage areas for all staff members?
- Does each physician require a personal office, or are the physicians willing to share a dedicated area where they will have their own, personal workstation?

OFFICE EQUIPMENT, SUPPLIES AND PROVIDERS

Even though specialists will have custom requirements for equipment and supplies, all medical offices require furnishings, procedural equipment and supplies to operate. This is a brief overview of the general requirements related to setting up an office.

Furnishings

Comfort caters to effectiveness, and quality pays dividends over time. The furnishings throughout the office, which should be able to withstand constant use, should be comfortable and exceed the ergonomic requirements of all users. The best chairs and workstations should not be reserved for the physicians; your staff will probably spend far more time at their workstations than you will. Office supply companies often offer corporate rates when an office is being furnished. If you require customized cabinetry and workstations, be sure to get input from the staff members who will be using those work areas before final decisions are made about the design.

Medical Equipment

It is beyond the scope of this module to offer a detailed inventory of specialty-specific medical equipment and office and medical supplies. You are encouraged to ask the managers of the clinics where you are presently working to share their lists of equipment and ongoing supplies, as well as the suppliers. Provincial and national specialty associations often have resources that are designed to help new physicians outfit their offices.

Family physicians should refer to *Appendix 1: Setting Up Your Office: Office Contents, Equipment And Supplies*. The costs of setting up a solo practice, as well as the first year's operational costs, are presented as a case example. Readers who understand the implications of a solo set-up will be able to factor in the savings that will be realized when they join a group practice.

Key Message

Setting up your office requires a lot of planning and attention to detail. A comfortable clinic that is well designed, well equipped and well furnished caters not only to better patient care but also to professional satisfaction.

COMMUNICATIONS TECHNOLOGY IN THE MEDICAL OFFICE

The world of personal and professional communications is constantly evolving. The sophistication of your clinic's communication systems will depend on need, availability and cost. This section addresses some of the basics.

Telephone Systems

Telephone systems are the lifeline of your medical practice. Before evaluating phone systems, you should understand the logistics of setting up the system as if you were designing a new office. In addition to talking to users—for example, the receptionists with whom you presently work—you should consult communications experts.

Develop a needs list before calling any suppliers. Begin by planning your system architecture: the number of lines, and the number and location of extensions. Estimate the number of lines that you will need to handle incoming calls from patients, as well as dedicated lines for outgoing calls, private office phone, dedicated internet line and the fax-modem that will be used to send bills to the Ministry of Health by electronic data transfer. Then make sure the system has the capacity for additional lines if your practice grows.

Telephones In Examination Rooms

There are two schools of thought about having telephones in the examination rooms. Some physicians feel that they should not be interrupted while with a patient, and that office confidentiality could be breached should staff or patients use these phones.

The other perspective is that it can be effective and efficient to have access to a phone in all work areas. For instance, reception and administrative staff can help patients to rooms without being far from the phone—which will allow them to take calls that otherwise might go unanswered or would go to voicemail. Sometimes physicians need to interrupt a patient consultation to take a telephone call, but it is easy to standardize protocols so that staff know when it is appropriate to interrupt and how to maintain confidentiality. Taking the call when it comes in saves the common time-consuming frustration of calling back, only to get a voicemail message. Having a hands-free intercom system would enable the physician to respond to outside callers or to staff without having to leave the patient. It is also important, and easy, to incorporate functions that prevent patients from making long-distance calls or listening to other conversations.

Phones Must Be Used Wisely

The telephone's primary role in the medical office is to give the best possible patient service. Calls should be answered quickly and politely, and your staff should be trained in how to keep calls as brief as possible. Phones also interrupt the flow of other office work, however. Ensure that your staff members have some time during regular office hours that does not require time to answer phones. For example, turning phones over to voicemail, an answering machine or answering service from 11:30 a.m. to 1:30 p.m., and then 30 minutes before the end of the work day, will enable your staff to have some uninterrupted time to attend to other tasks.

The most common arrangement for after-hours calls is to offer voicemail or an answering machine. It is important to change the message daily to inform callers when the office is open next, and how to obtain after-hours urgent medical attention. Although most systems can accept messages, it is more efficient (and medico-legally appropriate) to provide whatever information is necessary, and request that the caller phone back the next day; it is time-consuming for staff to retrieve voicemail messages, and in most cases, a return telephone call would be necessary anyway. Therefore, it is advised that the only messages that patients are allowed to leave are to cancel an appointment. Clarify that all other requests must be made via phone during regular office hours. Some physicians choose to employ an answering service, but be aware that most charge by the number of calls received—something you have no control over.

Special Telephone Features

Think about how you expect your office to work as you evaluate the potential effectiveness of special features, such as line groupings and a rollover option, speed dial, hands-free intercom and headsets, automatic phone triage via voicemail system, call forward and conference calling, and having a single phone number for office and cellular phone. There are many other features to choose from, but these are some of the most common in medical offices.

Line groupings enable multiple phone lines to be served by a single phone number—so five family doctors, for example, can have five incoming lines that use the same common clinic number. Given the convenience that this offers patients and other callers, it is well worth the small monthly charge.

Rollover options permit an incoming call to roll over to another distinct line that is not in use, reducing busy signals.

Speed-dial is a time-saver for frequently called numbers, such as colleagues, hospitals, labs and pharmacies.

Intercom and **call transfer** to exam rooms can be very time efficient, as long as confidentiality protocols are strictly observed.

Hands-free headsets generally increase efficiency for staff who must multi-task, particularly in offices where the person answering the phone also needs both hands to run a computer station and help to usher patients to exam areas. Headsets also reduce repetitive neck strain injury.

We have all experienced **automated phone triage systems** when we have called utility companies and other business offices. In medical practice, voicemail triage of all incoming calls is very effective and efficient—even for solo practices. Callers can be triaged to different options for making appointments, cancelling appointments, booking procedures, getting general practice information or after-hours/emergency contact information, and so on. One excellent triage function allows patients to call outside of office hours or when the system is busy to cancel their appointments; if you use this option, however, you should also clarify whether it is the patient's responsibility to call back during regular office hours to rebook.

For medico-legal reasons, you are advised to clearly state that your office will not respond to any patient inquiries or messages left on the system. Imagine a message for urgent advice on a Friday afternoon that your staff does not pick up until Monday. Procedural specialists who offer diagnostic services, such as radiology and ultrasound, are well served by a voicemail triage function that allows callers to leave test requests and contact information for staff.

Call forwarding is useful for after-hours service and times when the physician is on call.

Conference calling is generally not that useful in medical practice, but can be helpful for multidisciplinary teams and telephone conferences with family members who are out of town.

For physicians who are often out of the office but need to remain in close touch, an integrated service that allows *one number* for both office and cellular phone can be very useful.

Because all calls that come into the office must be answered, you may find that *call display* and *caller identification* are not useful features.

Good technical support and advantageous pricing are also important considerations.

Fax Machines, Photocopiers And Scanners

Used for such routine tasks as requesting consultations, booking diagnostic procedures, transmitting or receiving test results, and communicating with pharmacies, fax technology has been a cost-effective and time-efficient addition to medical office communications.

Your office should use faxes instead of telephone calls whenever possible. Not only will you have a written record of the communication, both you and the recipient can deal with the fax when it is convenient. Because the fax machine will be used frequently, it should have a dedicated line. Speed dial is an essential function, and automatic redial, delayed transmission programming and auto-sizing are useful features.

Similarly, the photocopier has become an essential piece of office equipment. A common use is for copying and transferring medical records. Good-quality photocopies can reduce external printing costs, although commercial printing is typically cheaper for forms, pamphlets and patient information sheets that are used daily.

The fax machine and photocopier should be located in the reception area for maximum convenience. Although equipment that combines fax, photocopying and scanning technology is becoming less expensive and more common, most medical offices create too much volume for a multifunction machine to be practical. Unless yours is a low-volume office (e.g., a psychiatry practice), a multifunction machine may not be a good choice in the long term.

Scanners are essential for offices that utilize electronic medical records. Many diagnostic and laboratory centres, pharmacies, hospitals and physicians' offices do not have the capability to send all of their communications electronically, and these reports will need to be converted into electronic form for an EMR system.

Computers In The Medical Office

Computers play an integral part in almost all medical practices today. Like most businesses, any medical office benefits from word processing and accounting software. In all provinces, computerized programs significantly ease the burden of submitting billings and reconciling payments. In provinces that issue health cards with a magnetic strip, maintaining a demographic database is as simple as swiping a patient's health card at every visit.

More offices are also using appointment scheduling software. Although the quality varies, good scheduling programs are very effective and offer several advantages. One is that appointments can be linked to the billing software to verify that every visit is billed. In addition, future appointments can be easily searched to verify whether and when the next visit is scheduled. Because information required for the appointment can be drawn from the patient database, it is easy and quick for staff to enter new appointments.

Now that computers are entrenched in medical office technology, they are being used for new and different purposes, as the following table indicates.

USES FOR COMPUTERS IN THE MEDICAL OFFICE	
Excellent for:	**Increasingly used for:**
▶ Word processing	▶ Communication
▶ Accounting	▶ Research
▶ Billing	▶ Voice recognition
▶ Demographic databases	▶ Encounter notes
▶ Appointment scheduling	▶ Tracking and audit of service delivery and targets
▶ Medical records	▶ Electronic medical records
▶ Clinical record keeping	

Few physicians are without access to email for personal home use, and more physician offices are linked to the internet. Because of medico-legal guidelines, security and remuneration concerns, caution is still recommended when considering direct patient-to-physician communication by email.

Being able to link to the hospital, office and home via the internet, however, allows for long-distance delivery of health services. For example, radiologists on call can review ultrasounds, CT and MRI scans on their home laptops, transmitted from hospital. The potential benefits of this electronic communication, or "e-health", are still being explored. Access to the internet also makes it more practical for physicians to do research or to pursue continuing medical education from home or office, at their leisure.

The use of voice recognition software is increasing rapidly, especially among specialists. The doctors who benefit from this technology have invested time to familiarize themselves with the software, although most still have their staff review and edit the dictation. You may find it worthwhile to search out established physicians who are using this technology in their practices to learn more about its use in practice.

Systems that provide electronic linkage, tracking and audit capability between physicians and all allied healthcare professionals who participate in the delivery of patient care are essential for doctors who are remunerated by alternative payment plans (APPs). Shadow billing is generally mandated, and many of the comprehensive care bonuses proposed in primary care reform initiatives require accurate tracking of the services provided, not only by physicians but also by their staff, including telephone contact. Tracking non-clinical work, such as teaching, administration and research time, is also important. Physicians who participate in APPs need the ability to capture and submit shadow bills for all clinical services they provide or delegate in order to substantiate their workload and support contract negotiations.

Electronic Medical Records

The future of the medical office, of course, lies in the chartless office and electronic medical records (EMR). Major improvements have been made to EMR systems, and today better than 30% of Canadian physicians use some version of EMR. Implementation is becoming more affordable and, in some provinces, financial assistance is available to physicians who are willing to convert their paper charts to a computerized system.

Unfortunately, the degree of provincial government support and resources for EMR systems and electronic health service delivery varies widely across the country. A further complication is the lack of standardization and common formatting that currently exists between provinces. For example, a system that meets all of the Ontario requirements may require significant customization for Alberta. Accordingly, few EMR providers offer comprehensive national service; many suppliers are still small, regional companies, vying for your investment (see the Resources section, below). It has also been difficult to convince physicians who are already in practice to invest in EMR systems. They are understandably hesitant to make the significant investment of time and money for an EMR system that may not meet their future needs.

Key Message

Physicians rely on their office communications equipment, computers and other technology. There are many resources available to help you determine your current and future needs.

The willingness of new-entrant physicians to adopt EMR technology is driving change, however. It will be very important for you to ensure that any group you join is keen to consider implementation of an EMR system as soon as possible. As you prepare to enter practice, you should make the effort to learn what systems are available and how they are being utilized. It will be beneficial for you to test as many EMR systems as possible during residency.

More information about buying and implementing an electronic medical record system is offered in *Module 7: Electronic Medical Records*.

GROUP PRACTICE AND ECONOMIES OF SCALE

Group practice yields economies of scale for the participating physicians. These are achieved in several ways, including:

- Lower staff to physician ratio
- Lower overhead cost per physician
- The ability to negotiate better prices for supplies
- Sharing of fixed-cost resources, such as office automation technology, medical equipment and communication tools
- Better quality equipment
- The ability to consider APPs

In most medical offices, staffing costs account for the largest portion of overhead expenses. Typically, a solo physician needs the equivalent of at least one full-time staff member just to have someone answer telephone inquiries during regular business hours and provide administrative or chaperone assistance. The efficiencies of group practice can enable doctors to staff their practices with a variety of staffing skills and wage levels. There are cost savings as well; when one doctor is out of the office, the staffing costs are shared by others.

Group practice also reduces the cost per physician of both supplies and capital equipment. By consuming larger quantities of supplies, the group can generally obtain better pricing. Expenses are also reduced by sharing fixed-cost resources, such as office automation technology, medical equipment and communications.

Sharing capital equipment not only reduces the cost per physician, but also offers the potential to obtain better quality tools to work with.

Because of these and other efficiencies, it is not surprising that most of the alternative payment plans offered by provincial governments require a group practice model. Being in a group will make it easier for you to consider these options.

ACTION PLAN

- **Evaluate the offices and clinics where you presently work as case examples.**
- **Ask physicians and staff what they like and what they would change or improve.**
- **Make notes and drawings of set-ups you like.**
- **Access the many resources that cma.ca offers.**

RESOURCES

The following resources are available online at cma.ca.

- ***Infection Control in the Office***
  - This document, published by the College of Physicians and Surgeons of Ontario, is available from the Publications section of www.cpso.on.ca.

Module 15:
Staffing And Human Resources

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

MD Financial Management acknowledges the significant contributions of the author of this resource document, as well as the efforts of the MD Financial Management team.

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Key Learning Points

- *Assessing your staff requirements*
- *The hiring process*
- *Interviewing and making a staffing decision*
- *Being a conscientious employer*
- *Your responsibilities as an employer*
- *Terminating an employment contract*

INTRODUCTION

The success or failure of a medical practice more often depends on the quality and performance of the office/clinic staff than on the quality and performance of the physicians. Your staff members are the most expensive—but most important—resource in managing your practice.

According to findings from the Canadian Medical Association's Physician Resource Questionnaire, staff account for approximately 45% of the average physician's overhead costs. This will vary, obviously, among medical specialties, with the physician:staff ratio ranging from as little as 1:0.25 to as high as 1:3 or more. A solo psychiatrist may have only a part-time typist, while procedural specialists, such as radiologists and ophthalmologists, will require both administrative and technical staff.

Even so, some residents believe that human resource issues will be of little interest to them. We have heard statements like the following countless times since we started to offer Practice Management seminars to residents across the country in 1997.

> *"I plan to be a physician working on salary and will not be responsible for hiring or managing my staff. Therefore, staffing issues are not a concern of mine."*

> *"I am joining a group practice, where my staff will be provided for me."*

> *"I have no experience or interest in human resource issues and plan to delegate this to others."*

These are common opinions, but they do not reflect the realities of the medical workplace. During the seminars, we ask residents the following:

> *"Who has gone through medical school or residency without ever having a conflict with a nurse, ward clerk or administrative person?"*

Invariably, every participant can readily remember someone they didn't enjoy working with, or whose performance didn't measure up. We then ask them to try the following exercise:

Envisage the person(s) you least enjoyed working with during your training. Now imagine how much you would enjoy working with the same person(s) for the next 10 years.

Does this happen? Absolutely. Many Canadian physicians have called MD Financial Management, asking for help in firing employees whose performance has been unsatisfactory for years, but whom the doctors have failed to let go.

Regardless of practice profile, all physicians have a vested interest in human resources issues. This includes having significant influence on the decisions about who is hired to work with us, their job description, how they are evaluated, and whether they should continue in a particular position or be let go.

Key Message

All physicians, regardless of their practice environment, have a vested interest in having excellent staff support, and should understand essential human resources issues.

EVALUATING YOUR STAFFING REQUIREMENTS

As physicians, we have a vested interest—personal, professional and financial—in surrounding ourselves with skilled staff members who will maximize our time seeing patients and minimize our time doing inappropriate tasks and administration. In an efficient clinic, staff members handle the vast majority of related tasks, enabling the physicians to concentrate on clinical encounters. Not only should the ideal employees be cost effective for the practice, they should have great interpersonal skills, communicate well and create a pleasant environment for everyone.

In analyzing your staffing requirements, it is important to consider several variables:

- Your specialty-specific requirements (e.g., consultations, procedures and follow-up visits)
- Patient volume
- Clinic office hours (for seeing patients)
- Phone reception hours
- Phone volume
- Level of medical technology and diagnostics required in the practice
- Requirements for trained technicians (e.g., radiology, audiology)
- Opportunity to delegate clinical procedures
- Computer and related technology support
- Practice location
- Practice style (i.e., some physicians require more/less staff support than others)
- Need for chaperone for examinations
- Solo or group practice
- The practice's requirement for nursing and/or nursing triage
- Level of staff interaction with patients
- Level of delegation of administrative and other non-clinical tasks
- Examination room preparation
- Patient flow requirements (e.g., reception to exam room to diagnostics, etc.)
- Administrative support (including the need for a group administrator or manager)
- Spoken or written language requirements
- Cultural profile of patient base
- Layout of clinic space (e.g., a central switchboard receptionist or a triage nurse may be needed in a large office with an atrium)

Frequently, a medical office cannot afford the 'ideal' staffing arrangement because of the manner in which physician and medical services are funded. While employees must be able to multi-task, they should be hired primarily to perform the duties that they are trained and qualified to do. If you don't require nursing expertise, then you should not hire a nurse to do the tasks that a good medical receptionist could do at a lower pay scale. If you do require a nurse, however, consider whether the right person could function as a nurse-receptionist. It may also be practical for technicians to triage patients.

Because the lifeline to most medical practices is the telephone, you need employees who demonstrate efficient and effective phone skills to manage the stress and volume of incoming calls, plus register patients as they arrive. In family practice and general pediatrics offices that offer continuity of care, the phone volume may at times be overwhelming. In a general surgeon's office, on the other hand, telephones may be answered at certain times only, and the surgeon may be in the office only three or four half-days per week.

If you don't use an automated telephone triage system, you may require an extra receptionist. Then consider who brings the patient to the exam room: the physician, the receptionist, another staff member, or perhaps a nurse?

You will also need to consider the work flow in the office. Do you use paper or electronic medical records? Do you have an integrated electronic lab results system? What will your clerical needs be? How many charts are handled daily? Do you write, type or dictate your notes and reports? How many referrals do you make each day? How much lab work do you order, receive and review daily?

The most common staffing requirements include:

- Receptionist
- File clerk
- Procedural technician
- Nurse
- Secretary and/or dictation typist
- Bookkeeper
- Billing clerk
- Bill collector
- Banking coordinator
- Librarian
- Patient advisor
- Office manager (to handle inventory and service providers)
- Office cleaner and maintenance

There are many issues to consider. Can the equivalent of one full-time employee handle all of these functions if you are in solo practice? Should you consider creating an administrative position to be job-shared? Can you share staff members with group colleagues to minimize costs, especially when you are not in the office? Is your clinic best served by several part-time employees, who are on-site only when their services are required? Can staff generate practice income by doing certain procedures?

While you are still in training, you can learn a lot about what happens behind the scenes in an office or clinic. Talk to the receptionists, clinic managers, technicians and nurses. How were they hired? What are their job descriptions and responsibilities? How are they evaluated? Who do they report to? How much are they paid, and by whom? If possible, obtain copies of job descriptions, office policies and procedural manuals for the staff positions you think you will need in the future.

HOW TO FIND GOOD, QUALIFIED EMPLOYEES

Word of mouth is still a valuable resource for staffing medical offices, because people in the medical service community know each other and are constantly networking through their professional interactions. Receptionists, secretaries, nurses and other physicians frequently know excellent, qualified individuals who are looking for positions. Hospitals and clinics are also good places to look for medical staff.

Advertising electronically in the professional employment classifieds of a local newspaper will also attract qualified applicants. You may find it useful to contact business schools (e.g., for a medical receptionist) or technical schools (e.g., for radiology technicians). Other staffing resources include placement agencies and federal employment centres operated by Human Resources and Skills Development Canada.

Key Message

There are many variables to consider when determining your staffing needs. Learn how other medical practices operate, and do the appropriate research to clarify your staffing requirements.

THE HIRING PROCESS

Regardless of where you find your applicants, it is essential to have and to follow a detailed, rigorous hiring process. Your objective is to hire the right employees for the long term, so you need to invest time and effort in finding them. This includes preparing or updating job descriptions, selecting and interviewing candidates, checking references, setting out work objectives and evaluating performance against measurable criteria.

Employment Standards legislation is a provincial responsibility, and most provincial governments maintain excellent websites that describe their regulations in detail, often with interpretative examples. You can also contact your provincial Department of Labour to learn more about human rights legislation, minimum employment terms and your responsibilities as an employer.

Before you advertise, you should prepare or update the following:

- Detailed job descriptions
- A statement of office policies and working conditions
- Telephone interview questions to screen applicants
- Face-to-face interview questions for selected candidates
- Questions for future performance evaluations
- Salary levels or ranges

Be sure to research the market to understand the range of hourly rates you should expect to pay for the position you are advertising. Only when you have clearly established the hiring terms and a protocol to choose the right applicant should you advertise the position.

Advertising

A working knowledge and comfort level with computers is essential for all staff members who work in a medical environment. Therefore, it is recommended that you use electronic media to advertise. The ability of the applicants to respond electronically helps to ensure that they have some basic computer skills. What electronic media does not offer, on the other hand, is the chance to evaluate the legibility of a prospective staff member's handwriting, but this test can be incorporated later on.

Your advertisement should describe the available position, including whether it is full- or part-time, what specific skills are required, and experience, if required. Request that applicants provide a covering letter along with their résumé, as well as two or three references, at least one of whom was a previous employer or supervisor. You may also indicate that only selected candidates will be contacted. Stating salary within the advertisement is optional; some employers ask applicants to state their salary expectations instead.

Some medical practices serve specific patient populations. Women requesting abortions, specific ethnic groups or patients with AIDS often require sensitive attention, and the practice potentially will conflict with some people's personal opinions or religious beliefs. Outline the patient population when you describe the practice to ensure that you attract appropriate applicants. If you are in a larger urban centre, you should also include a general geographic reference for the location of your practice.

We recommend that you do not give your office phone number, address, fax number or personal email address within the advertisement. The number of applicants can overwhelm your phones, fax lines and email, or applicants may deliver their application in person to try to gain an advantage and request an interview. Your options include using a fax number that is less critical than the one you use in the office, setting up a separate website or email address to receive applications, or arranging for a post office box.

Consider posting the advertisement in hospital and clinic staff rooms, sharing it with colleagues and sending it to other contacts before advertising in the online newspaper. If the local newspaper turns out to be your best option, however, then determine which are the traditional job advertising days (often Wednesdays and Saturdays), when job seekers expect to find a robust section of classified ads. File your advertisement with the newspaper and verify the pre-publication proof that is prepared for you. Ads should be posted on the newspaper's website.

Reviewing Applications

Review all applications and rate them *definite yes*, *possible* or *no*. Then you (and, if applicable, your associates) should select about 10 applicants for a pre-interview telephone call. This enables you to evaluate candidates' rapport on the phone—which is extremely important for any staff member who will be handling the phones. Establish a protocol for these questions, such as:

- Briefly review their résumé.
- Ask them why they are interested in this position.
- Encourage them to ask questions to clarify their understanding about the position.
- Rate their answers.
- Rate their comfort, confidence and rapport on the phone.
- Ask about their salary expectations.
- Ask when they would be available for an interview.
- If they are presently employed, ask why they are interested in leaving their present job and whether their employer is aware that they are looking for other employment.
- Ask when they would be available to start work, if offered the position.

As a matter of courtesy, advise all of the applicants interviewed by telephone that you will get back to them, whether or not they will be offered an interview. Once you have selected between three and five applicants to interview in person, send these candidates a detailed job description and a statement of your office policies to help them prepare for their interview. You should also encourage them to visit your practice website, if you have one. Consider keeping the résumés of applicants to whom you have not offered an interview, in the event that another position becomes available in the future.

Interviewing And Making A Staffing Decision

Dedicating time to interview well is an excellent investment. Failing to hire the right person will cost you and your associates much more time, money and stress than the clinical income lost by setting aside two or three hours for interviews.

Because you want to be fresh for this task, try not to schedule interviews at the end of a busy clinical day, and never interview between patients. It's best to dedicate a full morning or afternoon, and schedule several interviews. Don't overdo it, either—too many interviews scheduled consecutively can prove very tiring and may affect your judgment regarding who might be the best candidate. To ensure that emergencies don't force you and your colleagues to cancel at the last minute, do not interview when you are on call.

You should interview candidates alone if the person to be hired will be dedicated to you. If the employee will be assisting colleagues, however, at least two (but, ideally, all) of the physicians involved should interview together and agree on the most suitable candidate.

Provincial human rights legislation protects individuals against discrimination, so be aware of the kinds of questions you may and may not ask. It is unacceptable to ask about family responsibilities, age, marital status, health, religion, national or ethnic origin, nor can an employer request a photograph of a candidate prior to the interview. Only after you hire a candidate can relevant inquiries be made for payroll requirements.

While most residents have interview experience as job seekers, not everyone has experienced the employer's perspective. Here are some suggestions to help you manage an effective interview.

Interview Checklist:

- Set an agenda by preparing an interview template. This will ensure that you ask all applicants the same questions, and will cue you to be thorough.
- Establish rapport by creating a relaxed but professional interview environment.
- Note and rate first impressions of the candidate's bearing, confidence, attire, etc.
- Start with a brief overview of the position, and sell the job without embellishment. Be candid about the work required in a typical day, your expectations of staff members, the working environment and the importance of good staff relations and team spirit.
- Briefly describe the staff and doctors, and explain how the applicant would be expected to work and interact with the office or clinic team.
- Now ask questions and let the candidate do the talking. Start by reviewing points from the applicant's letter; e.g., experience, education, most recent positions.
- Referring to a list of all office/medical equipment and systems that your clinic uses, learn about the candidate's skill and familiarity with communication devices, computer systems and medical software. Also assess their experience with all of the office and medical administration procedures they will need to perform. While you may not know how to program the message tree on the phone system, change the toner on your photocopier or free a paper jam on the fax machine, your staff members must attend to technical troubleshooting tasks daily.
- If transcription skills are required, ask candidates to type a short dictation you have prepared.
- Ask applicants to write out a short paragraph in longhand. Your writing may be terrible, but your staff members should have legible handwriting. Computers have not yet eliminated the need for handwritten notes and instructions in most medical offices.
- Ask specific questions to evaluate the prospect's ability to problem-solve and work under pressure. For example, *"Can you describe a time when you had to work independently to reschedule a lot of patients because the doctor was sick? How did you handle the unhappy patients?"*
- If a candidate hesitates over an answer, always wait at least 30 seconds before commenting or talking. It is better for a candidate to say *"I don't know"* or *"Could you clarify that for me?"* than not respond. You will learn much more if you wait for candidates to speak than if you try to help them answer.
- Consider asking the candidates to describe their strengths, as well as areas where they feel they could improve. Ask how they would improve their skills (e.g., night courses) and when they plan to do so.

- Ask if and how they improved procedures or policies at previous places of employment. This encourages applicants to sell themselves.
- Frame questions to assess how they would handle stressful situations. For example, *"How would you handle a confrontational patient in a packed waiting room who is annoyed about waiting more than an hour to see the doctor?"* or *"What would you say to a patient who is upset about receiving a bill for missing an appointment?"* These types of questions also offer you the opportunity to educate the candidate regarding how you want these type of situations handled, and how you will back them up when they follow your procedures.
- For a nursing candidate, consider a scenario, such as *"How would you handle parents who refuse to hold their 18-month-child safely for their immunization?"* The desired answer here is that all shots are to be given in a controlled and safe manner; therefore, if the parents don't comply, then you would instruct the nurse to request safe restraint of the child for their shot from another staff member or, ideally the physician, with documented parental approval.
- Invite questions about the job description and office policies, to ensure that candidates have reviewed, understand and agree to both. Remember that the applicant is interviewing you too.
- An important question: *"Will it be difficult for you if we sometimes have to work late?"* This question is framed so that the applicant can inform you if their schedule at day's end does not allow for flexibility to be late. Remember, you cannot directly ask if they are married or have young children who need to be picked up at a certain time from daycare. However, there will be times when you will be behind and in need of staff support and chaperone duties. If an excellent candidate is not able to stay late, there can often be some means of accommodating them—especially when additional staff members are available who may be interested in staggered office hours.
- Ask the candidate if you may contact previous employers who have not been used as references. If the answer is *"No"*, ask *"Why not?"*.
- Rate your comfort level with the applicant.

Observe Interview Problems

Remember that first impressions are important. Red flags include poor eye contact, uncomfortable posture, poor or excessive grooming, no enthusiasm or coming on too strong. Be cautious of the candidate who starts the interview by immediately asking about salary, hours, benefits, holidays and sick leave.

Review And Clarify Office Policies

All short-list candidates must be fully aware of and agree to your office policy statement, which should include:

- Patient confidentiality and the employee's obligation to understand and adhere to your strict code of health information protection
- Regular work hours
- Fixed salary and overtime pay policies
- Sick leave policy and prompt reporting of illness
- Personal conduct
- Personal appearance and office dress code
- Employee-patient relationships
- No-smoking policy
- Personal calls at work
- Vacation policies
- Periodic salary review
- Performance evaluations
- Probationary period
- Training

Always Check References

Before calling references, prepare a phone questionnaire to ensure that you ask the same questions for each candidate and reference called. Examples include:

- What was the applicant's work attitude?
- Did the individual show initiative? Ask for an example.
- How was his/her attendance record?
- Was this a competent employee?
- How did the individual interact with the other staff and physicians? Ask for examples of good and poor behaviour.
- Why did the applicant leave the previous employer?
- Would you hire this person again?

Because many applicants will not have notified present employers that they are planning to leave, they will not offer them as a reference. It is still important, however, to obtain an evaluation from someone the candidate reported to or worked for. You should require applicants to provide a reference from at least one previous employer or supervisor.

Rate each applicant, based on the information provided by the referees. Encourage reference sources to tell you as much as possible, but be non-committal about your own impression of the candidate. Chances are, the applicant will hear an account of the reference call.

It should be noted that employment law has evolved to the point that previous employers are often hesitant to offer any evaluation of previous employees. You may be able to simply get confirmation that the person did work there, and for how long.

Making A Decision

Once all candidates have been interviewed, review the ratings of each candidate with your colleagues and establish a final ranking.

Offer Of Employment, Employee Contract And Letter Of Employment Offer

Verbal agreement and a handshake are not enough when engaging a staff person. A written contract that clearly states the terms and conditions of employment, signed by you and the employee before the first day of work, protects both parties.

Prepare an offer of employment, in which you specify all of the terms of employment: the start date, hours of work, salary, overtime policy, holiday policy, sick leave provisions etc. Clarify the probationary period and your office policy for performance reviews. You should also specify the terms under which employment would end, also known as the termination clause. Include copies of the job description and office policies for signature. Before you present it to the new employee, review the entire package with your lawyer to verify that you have observed all legal obligations.

Telephone the successful candidate, advise him/her of the general terms, and invite a verbal acceptance of your offer. Then advise that you will courier or drop off two copies of the written offer of employment, already signed by you, for signature. One copy is for the new employee, one copy is for you. The offer of employment should be open for a specific number of days, by which time you expect the candidate to return one signed copy to you. This becomes part of your employee contract.

Key Message

Invest time and effort to be sure that you hire good employees. Your objective should be to hire the right person for the long term.

Once the successful candidate has signed and returned his/her written acceptance of the offer, call the other candidates to thank them for their consideration and time. Ask good candidates if you can keep their files for future reference—you may have met some wonderful people who you would consider if another position opens up, or who you would recommend to a colleague. While you should consider the interviews to be confidential, keep all notes and evaluations in the event that an unsuccessful candidate contests your hiring decision.

EMPLOYER RESPONSIBILITIES AND STAFF MANAGEMENT

Be A Conscientious And Appreciative Employer

As a good employer, you should encourage ongoing two-way communication with your staff. Because they know more about the details of the daily operation of your practice than you do, encourage employees to improve procedures and provide constructive feedback and suggestions.

Also acknowledge on a regular basis the hard work that employees do. Medical office and clinic staff members are often underpaid relative to their peers, because physicians are hard-pressed to compete with the salary/benefit packages offered by hospitals and institutions. Don't underestimate how much your staff value vocational satisfaction and a pleasant work environment, but reinforce those rewards by expressing your genuine appreciation for their efforts.

A good employer will facilitate employee motivation by addressing five key variables:

- **Skill variety.** Ensure that the position allows and encourages employees to use mutiple skills and talents.
- **Task identity.** Specify the degree to which a job requires completion of clearly identifiable pieces of work.
- **Task significance.** Ensure that the employee is aware of the impact and importance that their work and performance have on the work and lives of others—patients, fellow staff members and physicians alike.
- **Autonomy.** The job should provide freedom, independence and discretionary decision-making for each individual.
- **Feedback.** Ensure that your employees are motivated by ongoing feedback regarding their job performance.

Every Day, Thank Your Employees For A Job Well Done

Studies show that, in most service industries, staff are rarely thanked by their supervisors and employers. On the other hand, physicians are frequently thanked by appreciative patients, and this approval contributes significantly to our vocational satisfaction. Do the same for your staff. If they enjoy working with and for you, they will make your life much less stressful—and the office or clinic will run more effectively and efficiently.

Probationary Period For New Employees

A typical probation period for a new employee is three months, although it can be longer if you wish. New employees should be offered performance evaluations, formal and informal, on a frequent basis—perhaps weekly at first, then monthly. During a three-month probationary period, there should be at least three constructive performance evaluations that offer positive feedback for improvement. Each performance evaluation should address the issues of concern that pertain from from the last one. You can also invite the new employee to self-evaluate what has improved and what still needs work, prior to your meeting.

Performance evaluations should be documented and dated. Any concerns raised by the staff member should be documented and addressed as soon as possible.

If repeated performance evaluations reveal that an individual is not meeting expectations, you have two options:

- Extend the traditional three-month probationary period for one, two or three more months; or,
- Let the employee go.

Staff dismissal is discussed in detail at the end of this module.

Regular Performance Evaluations For Long-Term Staff

Performance evaluations don't stop at the end of the probation period, and are critically important for staff members who have been with you for awhile. Every employee should have a job appraisal at least once per year. You and your staff should address the performance evaluation in a positive light, not as a meeting to be dreaded. It is a time to step aside from the daily routine, talk about work, give and get constructive feedback, and look at how to make the future even better.

Each performance evaluation should emphasize preferred workplace behaviours and attitudes, and address any issues of concern from the last one. It can be quite instructive to ask your long-time employees to do a self-evaluation of their achievements, strengths and potential areas for improvement, prior to your meeting. Annual performance evaluations should also document any concerns raised by the staff member.

The performance review also presents an opportunity to set work objectives for the coming evaluation period. Perhaps you need the filing system overhauled, or you require staff members to have additional training. If you document this in a job plan, achievement of the objectives becomes part of the evaluation cycle. You should also offer individuals who are weak in certain areas the resources or opportunity to upgrade their skills. Remember that you have a vested interest in helping staff members to improve their skills and performance.

The performance review should have a section where employees can write comments if they wish. It is also advisable to have the employee sign the evaluation. Staff members may find this intimidating, particularly if the performance evaluation is critical, but if you maintain this practice from the outset, your employees should trust that this is a reasonable reflection of your annual "chat", constructive feedback and good intention to nurture a positive working relationship.

Key Message

Performance evaluations are essential for both new employees on probation and long-time staff members.

Performance reviews are typically a factor in the annual wage review, although many physicians hold them at distinctly different times (e.g., performance reviews in December and wage reviews in February). Because any discussion about money has emotional overtones, separation of the performance and wage reviews permits a more objective discussion between employer and employee. Good appraisals should not lead to unrealistically high wage expectations; nor should negative appraisals lead to bitterness or recrimination.

While remuneration is tied to performance, ideally, wages are reassessed at reasonable intervals, so that employers also can consider changes in employee responsibilities and changing circumstances (e.g., fluctuations in the Consumer Price Index, general wage levels of medical personnel, or the financial success of the organization).

Managing Payroll

Medical residents are very accustomed to receiving a bi-weekly cheque from the hospital. The cheque stub indicates your net take-home pay, tax deducted at source, employment insurance premiums and Canada Pension Plan contributions. Deductions for a benefit plan will also be noted.

As an employer, you will be responsible for paying your staff and managing payroll documentation, but it is probably not worth your time to manage payroll directly. For a reasonable fee, you can delegate the task to one of many payroll and bookkeeping services, including accounting firms and professional bookkeeping services. You should know and understand what you are delegating, however, because you are ultimately responsible—financially and legally—even when you are part of a large group.

The best way to get started is to contact the Canada Revenue Agency (1 800 959-5525) for a payroll kit, and to register to obtain a business number. If you are joining an existing medical group, speak to whomever is responsible for payroll about how it is managed and whether a group practice employer number pertains. As you will be contributing to employee salaries, seek your accountant's advice.

Employer Responsibilities

Employers are required to do the following:

- Agree to a payment schedule with staff (traditionally, every two weeks or bi-monthly).
- Collect employee deductions and remit these, along with your required employer contributions on behalf of staff, to the Canada Revenue Agency on the 15th of each month following the month of withholding:
  - Canada Pension Plan (CPP)
  - Employment Insurance (EI)
  - Provincial and federal income tax
- Pay employer contributions and remit these to the Canada Revenue Agency on the 15th of each month:
  - Dollar-for-dollar matching of each employee's CPP deduction
  - 1.4 times each employee's EI deduction
- Collect any employee benefit contributions (dental, health) and corresponding employer contributions, as well as group RRSP withholdings, and submit to the group insurer as required.

Individual provinces may require other statutory employer contributions. Be sure to confirm what is required in your jurisdiction. Your accountant is often an excellent resource.

At the end of the year, the employer must also provide:

- T4 Supplementary for each employee, summarizing the employee's gross pay and all employee deductions during the year
- T4 Summary of each employee's gross salaries, deductions and employer contributions

You can prepare these yourself, delegate the task to an office or clinic administrator, or outsource the work to your payroll provider.

In general, employer contributions cost approximately an additional 8% of gross salary. You must budget funds for this additional expense.

Case Example: What It Really Costs

You hire a receptionist and offer to pay a salary of $30,000 per year (approximately $15.35 per hour). When employer contributions are calculated, you will actually be paying about $32,100 per year for that staff member.

By The Hour, Or Salary?

Should you pay your staff by the hour, or by salary? Salary (based on an average hourly wage) is generally advised. Once agreed upon, the bi-weekly pay and payroll calculations will be the same for the entire year. If you pay your staff by the actual hours they work each week, you will need to do payroll calculations every pay period. This is not only tedious, but is also more expensive in terms of bookkeeping. Furthermore, employees appreciate a guaranteed bi-weekly salary.

The signed offer of employment contract should state how employees will be compensated for overtime that you have requested; options include paying for overtime or offering equal amounts of time off. If staff members are routinely obliged to work more than the agreed numbers of hours per week, then it is advisable to adjust their bi-weekly pay to reflect the additional hours worked.

Employee Benefits

Common full-time employee benefits include:

- Medical, dental and prescription drug plans
- Short-term sick leave
- Long-term disability leave
- RRSP contribution or pension plans

You are not obliged to offer benefits to your employees. There are benefit packages that physicians can purchase, but most are expensive. You and your accountant should review the pros and cons of buying coverage for yourself, as well as offering benefits to employees. Before you choose a plan, check to see what programs are available through your provincial medical association, as they may be more cost effective than those available privately.

Benefits, including sick leave and vacation, are not generally extended to employees during the probationary period. When drafting an employment contract for a new employee, state when he/she will be eligible for benefits (e.g., *Commencing three months from your start date you will be eligible to participate in the benefit package available to current, full-time employees.*) and clarify your policy about absenteeism during the probationary period (e.g., *Any absenteeism that occurs in the first three months of employment is without pay.*).

Vacations And Statutory Holidays

Physicians are obliged, in most provinces and territories, to offer employees two weeks of paid vacation per year, or 4% of gross salary in lieu of time off, and in some provinces, this percentage increases after five years' employment. Employees must also be given statutory holidays off work with pay.

After a staff person has worked with you for some time, it is appropriate to give them more vacation days, in compliance with provincial regulations for paid holidays based on years of service. It is recommended, however, that physician clinics set a policy regarding the maximum vacation time that an employee may earn over their years of employment.

Maternity Leave

It is important for physicians to acquaint themselves with provincial regulations regarding maternity and parental leave, because the combination can extend up to a year and the law requires you to keep the position available for the returning employee. In most cases, the physician employer hires temporary staff until the employee returns from maternity leave. The employee on maternity leave will receive Employment Insurance benefits from the federal government. Physician employers are not obliged to pay additional maternity benefits, unless this is part of an additional benefit package that has been offered to all employees.

Absence Due To Illness Or Sick Leave

We recommend that you, as an employer, offer paid sick leave to your full-time employees, even though you are not obliged to do so. You should clarify your policy right from the start, however, to avoid any criticism or challenge. A formal policy is equitable to all employees and gives the physician something to fall back on, particularly in the case of excessive absence.

It is common to grant full-time employees sick leave credits with pay on the basis of, for example, one half-day per month, cumulative to a maximum of 10 days. Employees would be paid from the first day of illness in accordance with the following terms:

- Sick leave with pay is granted only due to illness, and employees may be requested to provide a certificate from their family physician.
- No sick leave benefits will be provided to an employee during the period she is entitled to maternity leave.
- All sick leave credits will be cancelled upon termination of employment.
- Sick leave credits are not subject to any payout provision.

Having employees who job-share gives you some assurance that experienced part-time workers are available to cover for employees who are ill.

Workplace Injury And Workers' Compensation

Depending on the size of your clinic/practice and the services offered, you may be required to provide workplace injury coverage from your provincial Workers' Compensation Board. It is not expensive, is a valuable benefit for staff, and reduces the physician's personal liability if employees are injured at work. In the common case of repetitive strain injury, for example, your staff would be eligible for physiotherapy that will help them to continue work. Absent staff may easily cost you more than the WCB premiums, which are based on an employee's salary and paid once per year. Contact your provincial Workers' Compensation Board for details.

Letting Staff Go

Your primary objective is to hire staff for the long term. Frequent changes in staff cost time and money, in addition to being very stressful for you and other staff members. Things don't always work out, however, and it is more important to have an efficient, pleasant medical practice than to put up with an untenable situation. If you need to dismiss an individual, analyze what went wrong, so you can avoid repeating the situation.

Contact your lawyer in advance of giving any employee notice, to verify that you have met all of the criteria for terminating the contract.

Key Message

If you need to terminate an employment contract, have your lawyer review your documentation and the severance arrangement you have planned, to ensure that you are protected and that you are being reasonable with your severance award.

SUMMARY

Great staff members are essential if you want to provide your patients with effective and efficient care. Taking time to establish and implement good hiring procedures will pay dividends. The more duties you can delegate to trusted staff, the more you can focus on patient care—a win-win scenario. Never forget that your staff work very hard: not only do they triage patients for you, they also handle the vast majority of patient concerns and complaints. Let them know how much you appreciate their hard work and commitment. Thank them every day.

ACTION PLAN

- **When hiring staff, dedicate time to do it right.**
- **Develop a standardized interview protocol.**
- **Draw up a comprehensive contract for every employee.**
- **Conduct regular performance evaluations.**
- **Consult your lawyer before terminating any employment contract.**
- **Never hesitate to thank staff for a job well done.**
- **Be a good employer.**

RESOURCES

- **Employment standards legislation in your province**
  - Most provincial labour departments post comprehensive online information about employment standards.
- **Workers' Compensation Board in your province**
  - Contact your provincial WCB regarding workplace injury coverage for your practice.

APPENDIX 1: GENERIC FAMILY PRACTICE STAFFING PLAN AND JOB DESCRIPTIONS

Practice Staffing Objective:

Hire staff who work well together, are capable and happy to cover for each other, and who are committed to the effective and efficient operation of our practice.

We, as physicians, appreciate that our staff members work very hard. We will continually strive to treat all of our staff with respect, appreciation and consideration. To this end, regular staff meetings and performance evaluations will be booked. Constructive feedback from staff will be welcomed.

Staffing Requirements:

Reception/administration/office management/nursing/dictation/filing

Primary Receptionist

The receptionist manages the reception area. Due to the volume of calls and patients seen in the office, the receptionist must ensure that s/he, or the administrative staff, are always available to receive patients and receive incoming calls. When the receptionist requires assistance of the nurse or physician, s/he is to page them. If they do not answer, then the administrative staff is to assist to relay the message. The receptionist is to ask the admin staff or nurse to cover for her when away from the reception area.

Primary Duties

- Opens office
  - Reviews phone messages
  - Daily open and closing of active phone lines
  - Starts up and shuts down computer systems
  - Unlocks waiting room and verifies that it is presentable in a.m., and locks waiting room door at end of patient-hour days
  - Opens and triages all new mail

- Handles and triages all incoming calls to appropriate personnel (physician or staff)
  - Appointments
  - Pharmacy requests—pulls chart and clarifies with specific physician
  - Patient callbacks—responds or triages to nurse or admin
  - Diagnostic callbacks—offers appointment for education or triage to nurse
  - Consultant office callbacks—triage to admin or nurse
  - Calls triaged to nurse or doctor
  - Responsible for making sure that all logged phone calls are addressed and tasks are completed by end of day

- Handles and triages all daily faxes

- Receives all incoming patients to reception
  - Verifies and updates MOH (Ministry of Health) and patient information
  - Verifies that charts are prepared and placed in appointment in-basket of appropriate doctor

- Handles all outgoing patient tasks
  - Makes follow-up appointments
  - Addresses any outgoing patient inquiries
  - Handles all non-insured billings/receipts and discharges all patients at reception desk

- Billing

- Prepares and updates daysheets
- Submits completed daysheets to MOH
- Reconciles all non-insured billings
- Keeps cash books updated
- Cues the senior administrative assistants monthly regarding outstanding debts
- Responsible for ensuring that the cash drawer is locked and secure
- Responsible for documenting and transferring cash to each physician at the end of each work week that exceeds the $30 float per physician for change

- IT and communications system responsibilities
  - Oversees operation of the fax machine and photocopier
  - Oversees operation of the debit machine
  - Oversees operation of the phone system
  - Responsible for keeping the procedure manual re: operation of all of these systems, updated and filed in a common/dedicated area, available to all staff

Senior Administrative Position

Note:

- Two staff members will work full-time in this role.
- Each will have full knowledge of all of the reception and administrative tasks required to support all of the administrative team.
- Each of the two senior administrative staff members will be assigned primary responsibility for a subset of higher-level administrative tasks.
- Both of these staff members will spend 50% of their time supporting the reception at the front desk and 50% of their time at the senior admin desk.

Primary Responsibilities:

This staffing position is intended to complement and bridge reception and nursing areas and functions in the office. Additional management duties will, ideally, be assigned based on skill set and experience. The skill set required for this position includes full capabilities as the receptionist, as well as management skills. Initiative, problem-solving and leadership skills are essential.

Key duties are summarized as follows:

- Addresses staffing in-basket
  - Consultation and diagnostic bookings
  - Patient callbacks that do not require nursing
  - Delegate to nursing callbacks when medical knowledge is indicated
  - Doctor-requested chart pulls

- Manages all in-office patient flow after patients have been registered by the receptionist
  - Monitor individual baskets of files of patients waiting to be seen
  - Assist doctors whenever possible to bring next patient in
  - Prepare room for next patient whenever possible
  - Prepare patient for visit whenever possible
  - Cue and assist doctors and nurses for patient prep
    - Adult check-ups, weight and height
    - Prenatal visits, weight, and place Doppler in room
    - Well-baby visits—advise parents to undress baby to dry diaper (See procedures for patient preparation.)

- Liases between reception and nursing area

- Office management duties
  - This administrative position will eventually include office accounting, bill payment, billing reconciliation, office inventory management; potentially, banking duties and other administrative duties that would fall under the duties of an office manager
  - Scheduling and prep of agendas for regular staff meetings

- Reception back-up
  - The admin/manager is to be capable of doing all of the tasks of the receptionist
  - Back-up reception when phone lines are busy or receptionist is indisposed
  - Assist reception to receive patients when reception area is busy
  - Be able to perform all reception tasks and duties
    - Holiday and illness coverage
    - Weekly switch day, where receptionist and admin assumes the other's role
      - Objective: to provide variety, avoid burnout, guarantee cross-coverage

- IT responsibilities
  - Responsible for trouble-shooting any problems with the computer system, and communicate with software support resources; keep a log of all calls/contact names and the reasons for contact, as well as advice given

- Responsible for keeping the procedure manual re: the operation of all of these systems, updated and filed in a common/dedicated area, available to all staff

Clerical/Reception/Administrative Assistant

Primary Responsibilities:

This staffing position is intended to complement the two other administrative positions. This staff person will take primary responsibility for all medical record management and assist the receptionist with management of all incoming phone calls, as well as patient reception. In fact, this staff person will be our medical record manager and co-receptionist.

Duties will include:

- Medical record procedures
  - Responsible for pulling and preparing all charts for appointments, based on reason for visit
  - Prepares appropriate forms/lab requisitions for the visit (biopsy, Pap requisitions and labels, etc.)
  - Charts to be pulled three days in advance of appointment
  - Pulls and prepares same-day visit charts
  - Doctor-requested charts pulled for review

- Filing
  - Opening all daily lab, consults, etc., as received
  - Proactive chart pull for abnormal results, as per physician guidelines
  - Place all incoming lab reports, etc., in doctors' in-baskets
  - File all initialled lab reports, etc., that do not require secondary action

This staff person is expected to become proficient in all of the duties listed under the primary receptionist section above. This staff person is also expected to assist the administrative management staff person in any way possible. Therefore, familiarity with the skills and proficiencies listed in the appropriate section above is expected.

Nursing Position

Two job-sharing nurses will work out of the nursing station in the office. The traditional skills of a comprehensive family practice nurse/receptionist are essential. The nurses are to be able to back up the receptionist and admin staff for their essential duties, including making appointments, debit machine use, fax and phone use, etc.

The nurse will be primarily located in the nurses' area and responsible for overseeing this area, as well as the outfitting and upkeep and re-stocking of the examination rooms.

The primary duties of this position are as follows:

- Nursing procedures:
  - All immunizations: adult and child/infant
  - All allergy shots and IM shots
  - TB testing
  - Glucometer use and patient education
  - Urinalysis for UTI, prenatal and pregnancy tests
  - Suture removal
  - Ear syringing
  - Dressing and packing (abscess) changes
  - Potential N2 Rx of warts
  - Well-baby prep for weight, height, HC exams
  - PFT testing, using a spirometer
  - Prenatal visit: BP, measurements of weight, FHR, SF height (training will be done)
  - Assist the physician whenever requested, or chaperone exams when requested

- Patient flow
  - Assist the physicians and admin staff in preparing patients for examinations when clinical prep is required
  - Review the appointment books of each doctor in advance to assist in effective patient flow during the workday

- Nursing phone responsibilities
  - Phone triage upon request of patient whose chief complaint is vague, or to assess urgency of visit
  - Phone management of patient requests for nursing advice (note this is not encouraged as a rule; patients are to be offered a visit first)
  - Patient callbacks regarding abnormal tests, as directed by physician

- Nursing area management
  - Responsible for monitoring vaccines and injectables, as per MOH and local health department guidelines
  - Review and read, along with physicians, all health deptartment bulletins, to advise docs and staff of any guideline updates
  - Staff and patient protection re: instruments and needles
  - Temperature monitoring and documentation of refrigerator and contents
  - Responsible for upkeep of N2
  - Instrument cleaning and autoclave
    - Ensure that speculums and surgical instruments are placed in exam room soak buckets daily
    - Daily change and cleaning of instrument soak buckets

  - Monitoring and upkeep of wet trays in procedure rooms, autoclave and all wet soak instruments, monthly, even if not used
  - Clean and dirty laundry management
  - Inventory of all medical supplies (provided by labs, MOH or purchased by office)

- Examination rooms
  - Restocking, inventory for all exam and procedure rooms
  - Assist physicians in keeping exam rooms safe and clean
  - Reception/Admin duties
    - Nursing staff must learn how to manage all of the communication systems, so that they can cross-cover reception staff when needed
    - A working knowledge of all office IT and communication systems is essential

Medical Transcriptionist

A part-time medical transcriptionist position is required.

Primary duties include:

- Typing daily progress notes, with a maximum turnaround time of two working days
- File completed charts that do not require additional physician attention, such as:
  - Consults to be signed
  - Medical reports to be signed and reviewed
- Transcription is to be done on-site
- Additional filing duties may be assigned

APPENDIX 2: GENERIC NURSING STAFF INTERVIEW TEMPLATE

SAMPLE INTERVIEW QUESTIONS FOR JOB-SHARING NURSING POSITIONS

Ensure that the candidate has received a job description and a list of office policies prior to interview.

General Introduction To Interview

Introductions

- We have reviewed your CV. Is there anything you would like to add to it?
- Clarify any questions from CV.
- May we call your references? (Get phone numbers.)
- Do you have any questions from the job description or office policies we have provided?
- Could you tell us about yourself and your professional experience to date?
- Have you worked in a family practice office before?
- If not, what exposure to family medicine and pediatrics did you have during your training?
- Why do you want to work in a physician's office?

Evaluation Of Experience And Office-Based Skills

Nursing Procedures

- Chem strips
- IM, SC and SD injections and immunization protocols
- Are your experienced and comfortable with giving injections to babies and children?
- Allergy injections and protocols
- TB testing
- Infection/sterile procedures/protocols for instruments/speculums, etc.
- Using an autoclave
- Ear syringing
- Liquid N2 treatment for warts
- Changing packing for small abscess care
- Spirometry

Nursing Phone Management

- Do you have experience in triaging phone calls from patients, to decide if they should be seen as a same-day patient?
- Do you have experience with dealing with pediatric problems: fever, rashes, feeding problems?
- Do you have experience in making callbacks to patients, to give them abnormal lab reports and to offer them a follow-up visit?

Office It And Communications Systems

- Computer billing and software, and patient registration
- If so, what systems?
- Word processing and typing speed
- Use of fax machine, photocopier
- Phone system with intercom
- Debit machine

Experience With Confrontational Patients

1. You take a call from a patient who is very upset that they have received a bill for missing their pre-booked checkup. They become verbally abusive on the phone. How would you handle this?

2. A patient arrives 10 minutes before their appointment and now has been waiting for 40 minutes in the waiting room. The doctor sees three other patients who arrived after they did, but have been shown in for their appointments. The patient gets angry and demands to be seen now. The patient becomes agitated and noisy in the waiting room and verbally abusive to you and the receptionist. What would you do?

3. A parent will not hold their screaming child appropriately for you to give a shot. Another parent persists in trying to negotiate with their crying 2-year-old so you can give the shot. We are behind, the child is screaming. What should you do?

Initiative And Leadership

- Can you tell us about the tasks that you disliked most in your previous job?
- What did you like most about your present or previous job?
- Did you improve any procedures in your last job?

General Questions

- What was your last employer like?
- What was the pace of the day and patient load in your previous workplace?
- May we ask why you are looking for a new job?
- Can you work under pressure? (Our day is unpredictable.)
- Can you remember names and faces?
- Can you multi-task? Please explain.
- Will it be difficult for you if we need to run late/overtime?
- May we ask, where do you see yourself professionally in three years?