Private Practice for the Colon and Rectal Surgeon

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ABSTRACT

Autonomy and independence as a surgeon represent the pinnacle of our training model, and private practice offers the trainee in colon and rectal surgery an opportunity to realize such goals as both a clinical surgeon and a business owner. Personalized care of patients and the immense gratification from providing such expert surgical care continue to be the ultimate reward for us as surgeons. However, private practice ultimately involves responsibilities of functioning as a small business owner. The health care environment in which we find ourselves provides great challenges to the viability and financial success of the private practitioner. Rising overhead expenses, malpractice, reduced reimbursement, and others factors confront the private practitioner as business owner. A career in private practice mandates acquisition of business acumen to preserve the privilege to practice our profession in this very challenging and changing economic environment. The opportunities for such a career vary considerably according to the scope of practice, hospital sophistication, geographic locale, and size of practice.

KEYWORDS: Private practice, business, revenue, reimbursement

Objectives: Upon completion of this article, the reader should be: (1) familiar with the clinical advantages and disadvantages of private-practice colon and rectal surgery; (2) able to describe the business aspects of private practice; and (3) able to review methods by which practices can improve financial viability.

PRIVATE PRACTICE

What is private practice? Scouring the tables of contents and glossaries of major textbooks of surgery and colorectal surgery reveals not a single reference to private practice, yet this is likely to be the career option for most colorectal surgeons. Textbooks and residency training programs teach us how to evaluate and surgically treat patients injured or suffering from disease. How one provides such service as an independent business entity in the marketplace of the "health care system" is generally not taught in our hallowed books or as part of our medical school curriculum or residency training program. This dichotomy—humanitarian service and business enterprise—has long been recognized and demands balancing the professional ethical codes governing our relationship with patients and the increasingly difficult business environment of health care that confronts the practice of medicine. This tension proves sobering for the realist and offensive to the idealist—both of which reside in each person. There simply is no avoiding this and other challenges (Table 1). The sooner one accepts this fact, the faster one is able to acquire the necessary knowledge and skills to be a responsible and fiscally astute business owner. The motivation: preserve our continued mission to provide expert colorectal surgical care for our patients as independent, autonomous business entities.

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Table 1 Challenges Facing Private Practice

- Malpractice premiums
- Uninsured population
- Decreasing reimbursement
- Diminished respect for profession
- Increasing overhead expenses
- Predicted shortage of physicians
- Hospital closings
- Pay for performance and heightened expectations

Scope of Private Clinical Practice

Private practice career opportunities vary widely in terms of the scope and size of one's clinical practice. A fellowship-trained colon and rectal surgeon's practice ranges from exclusive colon and rectal surgery to a general surgery practice with an interest in colorectal surgery. Multiple factors influence this: geographic location, sophistication of the medical staff and hospital, presence of surgical house staff or skilled operating room assistants, practice type (solo or group), and personal preferences.

The geographic location of the practice and the size of the community deserve particular attention. This spectrum ranges from rural to metropolitan communities. Technology and subspecialty representation on the medical staffs of hospitals vary accordingly and influence the scope of practice. For instance, opportunities to care for patients with inflammatory bowel disease are limited unless gastroenterology specialty practices exist. The availability of a linear accelerator for radiation therapy limits treatment options for the patient with rectal cancer. In general, larger communities offer increased sophistication in terms of medical subspecialty support and medical technologies. Such settings, in general, favored subspecialization and offered more opportunities for surgeons to limit their practice to colorectal surgery. That being said, shortages of general surgeons are becoming evident even in larger communities and the need for emergency room coverage by general surgery is beginning to influence medical staffs' by-laws and the requirements for new surgeons participating in such coverage.

Teaching hospitals with surgical house staff create a unique setting for private practice surgeons. Although these hospital types are generally found in large cities, there are exceptions. Involvement in graduate medical education provides additional opportunities for personal and professional gratification, and the benefits of service coverage enhance care of patients and reduced work for the private practice surgeon. This may enable the solo practitioner in such a setting to provide a greater range of services than the solo counterpart in a small rural hospital.

The size of practice—solo versus group—can influence the scope of services offered. For one, group practice offers the benefit of the cumulative fund of knowledge of the group—the "two heads are better than one" phenomenon. Internal consultation enhances one's ability to care for patients with more complex clinical problems. In addition, within a group practice a partner can offer expert surgical assistance for technically challenging operations such as restorative proctocolectomy or coloanal anastomosis after low anterior resection. In addition, learning curves for new procedures potentially can be reduced in a group practice where surgeons are exposed to increased volumes of such procedures by virtue of the opportunity to assist on a partner's case.

Group practice offers the advantage of improved opportunities for professional growth. New knowledge and skills acquired by attending conferences and courses can be disseminated among the group. This addresses one of the most important professional challenges we face as surgeons: continuing education and developing new surgical skills. This increases our longevity and relevance as individual practitioners and reinforces the concept of collective experience of a group and ultimate benefits for patients. Such professional growth expands our ability to offer patients new and improved treatment options.

The scope of our practice ultimately results from our career goals and personal and family preferences. For some, obtaining fellowship training resulted from a desire to be a subspecialist with focused clinical interest. For this individual, practice opportunities will dictate the place of practice. Others choose continued practice in general surgery with a special interest in colorectal surgery. Fellowship training may have enhanced one's ability to obtain a job in a particular location with a competitive practice environment. The additional training therefore improved one's attractiveness to the general surgical practices looking to add a partner.

MODELS FOR PRIVATE PRACTICE

Models for private practice include solo practice and group practice. Each model offers distinct advantages and disadvantages for the surgeon contemplating a career in private practice (Table 2). Although different in many respects, each is characterized by the fundamental essence of surgeon ownership. This distinguishes private practice from other models such as university-based practice, clinic practice, and military medical practice. Issues related to how a surgeon or group of surgeons does this are the focus of the following discussion.

Solo Practice

This represents the smallest unit, so to speak, of the model of private practice. As such, an initial discussion of solo practice provides a basis and framework for

Table 2 Comparison: Solo versus Group Practice

	Solo Practice	Group Practice
Advantages	Continuity of care of patient	Patient coverage
	Autonomy	Internal consultation, operative backup/ assistance
	Limited overhead	Broader scope of practice
	Efficiencies due to simplicity	Shared overhead
	Simple decision-making process for change	Improved patient access
Disadvantages	Coverage issues	Cross coverage ''hand-off''
	Limited patient access	Loss of personalized care
	Limits scope of practice	Governance issues
	Revenue stream fluctuation	Potential for practice expense largesse
	Less negotiating power	

the many considerations of the career option of private practice and helps when considering issues of group practice. Although many of us will never start a solo practice, an understanding of such an endeavor gives one insight and appropriate perspective when considering private practice as a career.

CONTINUITY OF CARE OF THE PATIENT

Residency training involves progressive, increased clinical responsibility and autonomy until one reaches chief surgical residency with the expectation that a chief surgical resident ideally be capable of functioning as an independent practitioner. Thus, perhaps from a clinical standpoint, the solo practitioner model in some respects represents the culmination of this training model: solo practitioner as an independent surgeon, self-sufficient in knowledge and surgical ability. There is an inherent desire to achieve this status of independence given the nature of our training, and for some being solo is the pinnacle.

We hold the patient-physician relationship among the highest of values characterizing our profession. Our steadfast commitment to patients sets physicians apart from other professions. Clinically, patients benefit from the continuity of care by one surgeon. From presentation of the disease to the healing of the wound, a solo practitioner in the strictest sense provides the most consistent service to an individual patient. No one can know better the history or the clinical presentation of the disease process, and no other person can appreciate changes in the serial examination of the patient. Continuity of care remains an essential aspect of surgical care, and the solo practitioner model ensures this. As a result, there can be no greater satisfaction or personal reward than the successful recovery of a patient. On the other hand, the burden of being solo becomes apparent when one confronts the inevitability of morbidity and mortality. Intellectually, we can rationalize such outcomes, but this requires ego strength, secure in knowing that we have done the very best possible for a patient in spite of an undesirable outcome.

ACCESS TO SERVICE

Although patients benefit from such individualized care, access to one surgeon remains limited. One surgeon can see and care for only one patient at a time and can be in only one place at a time. Access to a solo practitioner is limited and vulnerable to the unexpected, unplanned event. For instance, when in the operating room, a solo surgeon cannot attend to a patient in the emergency room with lower gastrointestinal bleeding and hemodynamic instability. At times, emergencies occur on a clinic or office day requiring cancellation of appointments and rescheduling. For a busy surgeon with a waiting period for appointments, this wreaks havoc for the office staff. True colorectal surgical emergencies number fewer when compared with the field of general surgery, and thus the scope of clinical practice may influence one's vulnerability to this issue.

A busy surgeon may find his or her waiting time for the next available appointment starting to increase. Finding space in the schedule for patients with problems that should be seen quickly such as cancer can become problematic as a surgeon's practice grows. Although this generally provides a surgeon with a sense of accomplishment and job security, access issues in the worse-case scenario can lead to unreasonable delay and changes in referral patterns regardless of the talent and bedside manner of such a surgeon. A solo surgeon's access issues limit practice growth and, inevitably, force a surgeon to consider recruiting an additional surgeon to improve access.

NO SURGEON IS AN ISLAND: NECESSITY FOR COLLABORATION

Autonomy defines solo practice, yet collaboration represents a necessity. There must be some mechanism for coverage of one's practice. Practice coverage allows continuing medical education, vacation, and a personal or family life. Difficulty in obtaining such call and practice coverage differs depending on the medical community in which one lives and availability of surgeon colleagues.

Call and service coverage ideally involves coverage by surgeons with similar skill sets and work ethic. Solo practitioners may have difficulty in this regard, especially if surgeons available for coverage are not specially trained in colon and rectal surgery. There may be specific instances where level of service may not be comparable to that of the attending surgeon. This may also be true of a group practice if the group is general surgical and the colorectal-trained surgeon in the group needs service coverage. Another colorectal surgeon would provide the ideal call coverage for patients. However, the makeup of the medical staff and community may limit coverage and could determine an individual surgeon's scope of practice.

Assistance at the operating room table may limit the solo practitioner in terms of the scope of practice. Inadequate operative assistance may make more complex operations unfeasible. On occasion, sick, complicated patients make consultation with another surgeon advisable to clarify a diagnosis and treatment plan. Developing collegial relationships improves care of patients and reduces stress for the solo practitioner. Recognition of the potential physical, psychological, and emotional burdens of solo practice is critical when considering this career model. Burnout is real phenomenon for any surgeon, and a solo practitioner is at greatest risk for obvious clinical reasons.

SOLE BUSINESS OWNER

Clinical autonomy is coupled with the challenges of being sole owner of the business. From a business model standpoint, the simplicity of the hierarchical structure makes this an efficient model for decision making and implementing change. A solo practitioner is the owner, and relationship with employees is vertical in nature. The advantage is the absence of potential conflicts with individuals of similar status (e.g., partners). This allows quick responses to problems that arise. For example, if access problems related to office hours are identified, the solo surgeon can simply add an additional office day to the weekly schedule without considering other surgeons' schedules and conflicts in space and staffing resources.

Remember, for the sole owner, all aspects of the business must be addressed, no matter how large or small. This can involve seemingly mundane tasks such as choosing the type of letterhead and stationery. Signing all checks may seem like a tedious process, but this provides an opportunity to view all expenses firsthand. The advantage is the intimate knowledge of all processes and aspects of costs to the practice and an opportunity to avoid unnecessary, wasteful expense or inefficiencies.

SOLO PRACTICE AND THE REVENUE STREAM

The most important feature of solo practice is related to revenue stream. Revenue depends entirely upon one surgeon's clinical, billable activity. When a solo surgeon attends a conference or goes on vacation, billing stops and collection of revenue decreases. Responsible budgeting for time away must occur to account for the dips in the revenue stream. This is clearly one of the main disadvantages of solo practice. The potential temptation will be to spend less time away, costing the surgeon unfavorable sacrifices of personal and family activities and potentially leading to burnout.

Overhead remains the sole responsibility of the solo practitioner and represents both a burden and limiting factor and an opportunity. The former occurs when considering technology for practice, whether it pertains to care of patients or office administration or management. Information system needs often require computers and software systems for purposes of scheduling and practice management. In addition, for billing to be efficient, electronic transfer of information reduces the age of accounts receivable and improves revenue stream. In regard to office procedures, the buying power of one remains limited for high-priced items such as endorectal ultrasound units or colonoscopes. Although such practices as in-office colonoscopy are financially attractive, the initial outlay of cost shouldered by one surgeon must be taken into account.

Solo practice, if kept simple and efficient, can be cost effective in this regard. Technology needs can be solved by directing such purchases and ownership to hospitals where the solo surgeon works. Limiting practice expense clearly maximizes potential income.

GROUP PRACTICE

In contrast to solo practice, a group practice involves two or more surgeons who share in the business and clinical practice of surgery or medicine. Partnerships develop from common interests and the opportunity to achieve goals and objectives more readily than if pursued as an individual. In a group, a surgeon agrees to participate as part of a team caring for patients and to share in the business responsibility. Surgeons by their very nature are strong willed, egotistical, and rigid individuals. Group practice requires collaboration, teamwork, consensus building, and understanding that, as a group, surgeons have greater potential for clinical achievement and practice viability.

Essentially, partners have to commit to the concept that personal happiness and fulfillment occur only when the group succeeds in its mission. The mission of the group outweigh the needs of the individual. Sounds like a marriage and a family? Absolutely. Just as with a successful, committed relationship, active communication, honesty and integrity, mutual respect, willingness to reconcile—all of these attributes and values must exist for a group to attain effective administration and governance and as a consequence its clinical objectives of caring for patients.

Groups can vary from single-specialty groups of general or colorectal surgery to multiple-specialty surgical groups in which a variety of general surgery and fellowship-trained surgeons work together. The size of a group practice may vary from a partnership of two to groups of 10 or more. As the size of the group increases, the practice management and governance become more complex and sophisticated, and the further members depart from the autonomy of the solo practice model.

Clinical Benefits of Group Practice

Although independent activity represents the goal of surgery residency training, residents in surgery learn at an early stage the necessity of interdependence and the benefits of functioning as a team. Group practice formalizes this innate need for collaboration. Issues such as consultation for difficult cases, the need for expert surgical assistance on complex operations, and the need for dependable call coverage—all of the clinical challenges facing the solo practitioner are addressed by the formalization of partnership and group practice. Individual surgeons have the opportunity to expand the scope of their clinical practice, performing more complex operations and addressing more challenging pathologic processes. The collective fund of knowledge and surgical judgment potentially expands as well. Collaboration thus presents distinct advantages for the care of the patient. The team surpasses autonomy as the highest ideal or value, and successful care of patients requires commitment of all partners to this end.

Cross Coverage and Continuity of Care

Cross coverage presents one of the most important advantages of group practice. Important challenges must be considered. Each surgeon within a partnership commits to the idea that each patient cared for by the practice is, in fact, the surgeon's own patient. Such a sense of ownership usually occurs during the interview process with an initial patient with the attending surgeon, and cross covering patients places the patients under the care of a surgeon who was not involved in that initial encounter. Each physician must be committed to the idea that each patient of the practice will receive the same level of interest and care as if each were the physician's own patient as a solo practitioner. The buy into such a concept is more likely to occur within a group as opposed to cross coverage by a nonpartner surgeon.

Within a group, the care and outcome of each patient have practice and financial implications and provide a distinct incentive for more consistent coverage.

In addition, cross coverage within a group involves partners chosen by the group. This selection process should minimize quality issues even if members of the group have different skill sets or training backgrounds.

Hand-offs must be thorough between the surgeon and the covering surgeon. Patients and their families must be apprised of the "changing of the guard." Communication issues represent the greatest challenge for the covering surgeon and require additional effort on the part of the covering surgeon, who must start from scratch the process of developing rapport and trust with the patient and family. This necessary process of safe hand-offs reduces clinical error, and consistent communication with family reduces the potential sense of abandonment because of the attending surgeon being relieved.

An important issue relates to the need for reoperation for postoperative morbidity. The author's preference is for the attending surgeon of record to perform such urgent reoperations whenever possible. In other words, the patient's surgeon has a "right of first refusal" with the understanding that immediate availability depends on the attending surgeon and the physiologic status of the patient. This policy acknowledges the primacy of continuity of care and reinforces the patient-physician relationship. Such commitments are appreciated by the patient and the family and reduce opportunities for misunderstanding and feelings of abandonment, which reduces litigious issues. If the quality of care and the commitment to the patient remain consistent, cross coverage within a group practice can minimize the risk of the nature of cross coverage. The keys to a successful group practice are listed in Table 3.

Group Practice and Expense Reduction

In the current health care environment, a group practice has a distinct advantage over solo practice in regard to practice expense. Overhead expenses continue to increase, while the payment for services by Medicare and third-party payors continues to decrease. The economics of such a system mandate reduction of practice expense whenever and wherever possible. As the number of surgeons increases in a partnership, there is a potential for reduction of business expenses (office space, personnel salaries, administrative fees, new instrumentation, information systems) per surgeon.

Table 3 Keys to Group Practice

- Patient care—ensure proper hand-offs/sign-outs
- Equitable salary distribution
- Call and work schedules must be consistent
- Vacation and time
- Mutual respect
- Consistent communication
- Governance—inclusive of all members

Remuneration

Salary issues represent one of the most important issues for group practice. The perception that the distribution of income is inequitable cannot exist in a successful group practice. Remuneration remains complex and problematic for many reasons, the most important of which remains the method of reimbursement by payors. The system at times defies common sense and does not necessarily reflect actual clinical work or effort. This makes comparisons of clinical activity difficult to objectify. For example, an abdominoperineal resection in a patient with multiple comorbid medical conditions requires increased perioperative decision making and increased bedside patient care, yet compared with screening colonoscopy this activity remains undervalued. In terms of practice building and increased value of the group within the medical community, providing service and expert care has important value in terms of practice growth perhaps not measurable by relative value units (RVUs) or collectible revenue. Remuneration within a group must promote industrious activity and financial incentive. The system must also maintain incentive for group collaboration on care of patients and preservation of quality of life for the individual surgeons and their families.

The options for remuneration vary from equal split to pure productivity. The advantage of equal split is that it reduces internal competition and creates a financial incentive for collaboration. Equal split places the financial welfare of the group over that of the individual surgeon: what is good for the group benefits the individual. Equal split does not, however, recognize differences in financial needs of individuals, nor does it account for differences in work ethic or practice patterns. Although surgeons by their nature are hard working, there are still variances and the stage of one's career and financial needs affect motivation and incentive. In other cases, some surgeons are simply more efficient and faster and therefore more productive. Equal split works if services are similar and work ethic or patterns remain relatively consistent among partners.

Productivity-based models encourage individual responsibility for practice-building activities. Superior service provided to patients and referring physicians results in increased referrals. In this model, an individual's income is directly related to the individual's billable activities and encourages increased clinical activity. Unfortunately, at their extreme, productivity-based salary schemes may negatively affect care of patients as they inherently favor individual as opposed to group activity and potentially discourage clinical collaboration, one of the main reasons for groups. Assisting a partner, for instance, would be less productive than performing an operation where one acts as primary surgeon. Productivity also encourages internal competition and carries implications ranging from the simple mechanics of assigning office appointments of patients to issues affecting cross coverage.

Models of pure productivity and equal split each have drawbacks. Financial issues can undermine a group, and it is critical that a balance be struck between providing incentives for work and promoting collaboration. A base salary with bonus incentives based on productivity probably represents the most reasonable model for remuneration. The salary scheme adopted will reflect the value system of that group. Resolution of this challenging issue requires wisdom and equanimity on the part of the partners.

Administration and Governance

How does a group function in terms of decisions for practice management and administration? The day-to-day running of the business of the practice generally falls to an office manager or administrator, whose skills and responsibilities vary according to the size and complexity of the group practice. Administrators organize the office staff, oversee day-to-day operations, manage human resource issues, oversee bookkeeping and the accounting of the billing and collections of the practice, oversee compliance with Stark regulations, and bring to the partnership issues related to practice expenses. Administrators must anticipate needs for practice development. Suffice it to say that the health and well-being of a practice rest with such an individual, and perhaps there can be no greater business decision facing a group than choosing a new partner.

Governance, on the other hand, refers to the hierarchical structure of the practice and the formal operations and processes that enable the group to make decisions and implement change. Governance structure and processes are outlined in an operating agreement or the by-laws of the group. Such a document exists in every group practice, yet rarely is it brought to the table for purposes of direct reference. A candidate considering joining a group should understand how the practice is governed as this process of governance determines the management and direction for a group. Generally, one would expect that the larger the group size, the more formal and complex the hierarchal structure. Size also has important implications for the method of decision making. For instance, small groups may have all partners serve on a "board of governors" and thus all partners participate in setting the agenda for meetings. Small groups have the advantage of requiring less effort to coordinate schedules to arrange for meetings in which partners can participate. Decisions for small groups ideally are made by obtaining consensus—uniform agreement—as small groups are much more vulnerable to dysfunction if one partner fails to buy into a process change or major capital purchase decision for the practice. In such small groups, decision making by majority

rule often leads to a sense of alienation for the minority party, which may develop into resentment and disharmony. Small groups allow a greater sense of participation and inclusion in governance and a better sense of group commitment.

Larger groups (more than 8 to 10 surgeons) are challenged by their size and ability to engender a sense of inclusion and value of participation. Large groups have logistical issues as simple as gathering the partnership for meetings. More formal hierarchal structures are required with designated officers of the group who set the agenda and can make basic, inexpensive decisions without approval from the partnership. Major decisions of the partnership are usually by majority rule as opposed to consensus. Consensus of large groups is difficult, and decisions requiring this could render the organization inert. With majority rule, it is important that partners participate in the decision process. The minority must feel part of the process even though they may not necessarily agree with the outcome. One way to accomplish this is to allow each partner to serve a term at the level of the board.

Small groups are challenged by intimacy and intensity, and large groups have the potential for malaise and lack of participation. Each group needs consistent structure, informal meetings for day-to-day issues, and more formal board meetings to address larger issues such as salary structure or major clinical decisions such as expanding to a new hospital or recruiting a new partner. The author firmly supports group outings for leisure and entertainment to strengthen the bonds between partners. Group retreat activities on a yearly basis remind partners of the mission of the group, allow long-term planning, and, again, reinvigorate the relationships upon which the group depends.

Learning about the governance structure is critical when considering a job opportunity. Review the bylaws or operating agreement. How often do meetings take place and who runs the meetings and sets the agenda? Who attends such meetings, and do nonpartners participate? Who votes at such meetings, and are decisions made by consensus or majority rule? Is a sergeant at arms necessary and present?

GETTING A JOB IN PRIVATE PRACTICE

I hope that the preceding discussion has introduced the candidate considering a career in colorectal surgery to the idea that options for private practice remain broad and of varying appeal depending on one's personal and professional goals. The decision process for choosing a particular career path after obtaining fellowship training should involve thoughtful introspection about one's personal desires and professional goals, open discussion with significant others about spousal and family needs, and consideration of the various experiences and advice of respected mentors. Ultimately, personal and family happiness is the name of the game, and pursuing a satisfying and challenging career will be one of the major determinants of whether one realizes such contentment. Decisions about job opportunities thus boil down to weighing personal values—where one lives, financial goals and needs, and family lifestyle issues—balanced by professional issues such as desires regarding scope of practice (colorectal versus general surgical), involvement in education and teaching, and sophistication of practice.

Opportunities

Solo practice opportunities are created through the initiative of individuals. In this case, the individuals have decided that there is a particular place where they want to live, and if no opportunity exists for partnership or if they prefer solo practice, they will create their own opportunities. Start-up money for solo practice represents one of the greatest challenges. Personal savings, family loans, and bank loans were traditional means to finance the solo practitioner. Hospitals also offer opportunities for getting the solo practitioner started. Initial costs for practice can be addressed through salary guarantees offered by the hospital. This start-up "loan" can then be repaid over time either by service provided in that hospital for a predetermined period of time (typically 2 years) or by actual repayment of the debt.

Partnerships and group practice opportunities are discovered through various means and media. Historically, the best jobs were always felt to be those found by "word of mouth" communication. Direct communication of a group with the program director of one's fellowship or contact between the individual and a group of surgeons with whom one worked as a resident remain common means by which one learns of good opportunities. This can be a passive process, where the group seeks out the trainee from a particular program, or it can be an active process, where one initiates contact by "networking" friends and colleagues.

The advantage of such opportunities lies in the fact that there is preexisting knowledge of the parties either first hand or reliable second-hand information. In addition, the chairperson or other attending surgeon through whom this contact is made serves an important purpose of witness to both parties, thereby improving the process by which one learns of the values and character of the partner or partners of the group. Similarly, the group can learn about candidates and their abilities and skills. This leads to accountability and perhaps improved likelihood of successful partnership.

Other methods include advertisement of positions in journals or on websites such as those offered by professional societies and organizations. For instance, the American Society of Colon and Rectal Surgeons website posts such job opportunities and also provides

postings by candidate surgeons seeking a position. This posting board enables candidates to focus their energies to known existing opportunities. Public advertising ensures wide dissemination of the opportunity and often results in multiple responses and a larger pool of prospective candidates.

This leads to another method again initiated by the candidate—direct mail introductions and inquiries—where letters are mailed to practices with enclosed information about the candidate and the candidate's professional goals. These may be "shots in the dark" as such direct inquiries may be to groups without a personnel need, but sometimes the right candidate with commitment to practicing in a geographic area may offer the group new skills and training that the group cannot afford to pass on.

Secondary networking can then occur after a positive response to either a response to an advertisement or posting on a website or after direct mail introduction. Again, a mentor willing to serve as an informal representative on the part of the candidate will improve the information process upon which these decisions will be made.

Lastly, physician recruiting services are available to assist a candidate search for opportunities. These recruiters are generally retained by a hospital or practice with which the candidate will be interviewing. Therefore, unlike the mentor serving as informal representative advocating on behalf of the candidate, the recruiter may be viewed as the "selling agent," to borrow an analogy from real estate. Nonetheless, the recruiter offers the candidate resources and information about geographic areas, hospitals, and practice opportunities about which the candidate may not have knowledge and thus broadens the scope of opportunities for a candidate.

Starting a Practice

Why does one start a practice? Obviously, the surgeon who prefers the solo model does so. The other possibility is the individual who wants to start a group and, being the initial partner, can influence the design and culture of the group practice. Whatever the case, most of us never choose to start a private practice. However, reflecting on the process and financial commitment to do so provides important insight and perspective as one interviews for a practice opportunity with a surgeon or a group and the appreciation of the privilege when one is offered a position in such a practice.

Setting up a practice involves several steps (Table 4). First, one needs professional guidance, both legal and from a businessperson such as an accountant who specializes in medical practice accounting. One must purchase a business license and a tax identification number from the state. Credentialing processes provide hospital staff privileges but, more important, allow participation with Medicare and third-party payors. Office space must be leased or ideally sublet initially and then be outfitted for practice in regard to staff, office practice supplies, telephones, computers, furniture, examining tables, instruments, and supplies.

Table 4 Steps for Setting Up a Practice

1. Professional assistance—accounting, legal
2. Obtain business license
3. Credentialing—hospital, Medicare provider number, third-party payors
4. Office practice: space, equipment, instruments
5. Office personnel
6. Billing service, bookkeeper

Obtaining financing remains the most daunting prospect for the solo practitioner. The financial commitment and risk of subsequent partners, if there are any, will never be as great as those of the founder. Personal savings, family loans, bank loans, and hospital support in the form of a salary guarantee all represent possible means for such start-up financing.

Undoubtedly, starting a practice is exciting, tedious, stressful, and ultimately gratifying as one creates an entity through which patients receive expert colorectal surgery care. The value added to medical communities and hospital staffs remains immeasurable if our specialty skills are brought to a community that had none.

Growing a Practice

The keys to a successful clinical practice are familiar to all us: availability, affability, and ability. These were the descriptors of the successful third-year clinical clerk, and they remain relevant for the colorectal surgeon in private practice. The reality for a specialist is that our practice depends upon referrals of patients. Advertising in the phone book or in a medical staff listing of physicians may produce walk-in referrals.

However, far and away, the main source of patients is physician referrals. This includes other general surgeons and gastroenterologists, who will identify your subspecialty training and expertise more readily than other physicians. This obviously presents a potential "turf" issue given overlap of our services. Thus, paramount for our success depends upon developing collegial relationships with these specialists. Internists and family physicians, by virtue of their numbers and role as primary care physicians, represent the greatest source of referrals of patients. Unfortunately, this group may be least likely to understand the nature of our training and scope of our expertise. In spite of the numbers of training programs and increased presence of colorectal surgeons in academic medicine, in many communities colorectal surgery continues to be relatively novel and education of the medical community

concerning the interest and skills offered by a fellowship-trained colorectal surgeon is often necessary. In addition, in hospitals with "hospitalist" physicians providing inpatient medicine services, many primary care physicians often do not practice in hospitals and choose to limit themselves to office practices. Occasions to introduce oneself to such physicians require actual visits to such physicians' offices to initiate a referral relationship. Some hospitals have addressed this phenomenon by creating a physician liaison service where the express purpose of the liaison is to introduce new physicians and especially specialists to the medical community.

The busy private practice surgeon makes himself or herself available to potential referring physicians, always enthusiastic and open to hear about a potential patient whether it involves a pilonidal abscess or a low rectal cancer. Simply being pleasant, respectful, communicative, and dependable toward other physicians, nurses, and, most important, the patients we care for—these continue to be the keys to developing a successful practice in a model that relies on patient referrals.

Challenges for Private Practice

Colorectal surgery as a subspecialty field has gained deserved recognition for efforts to understand, prevent, and effectively treat colon and rectal cancer. Sphincter-preserving operations for rectal cancer exemplify the many advances our specialty offers to patients, and the public and medical communities now recognize the preeminence of colorectal surgery for the treatment of diseases related to the anus, rectum, and colon. As a result of these advances, private practitioners are as busy as ever. Combined with the aging population and the increasing need for our services, the demand for new trainees remains strong and career opportunities appear numerous in many communities throughout the country.

However, as with other career models, economic forces continue to shape and change the nature of private practice. The current reimbursement scheme of third-party payors follows Medicare, with most contracts for fee schedules based upon a percentage Medicare reimbursement. Medicare unfortunately has not provided any increases in reimbursement for nearly 15 years, and in fact cuts in reimbursement are again the subject of upcoming federal legislation. Practice expenses unfortunately, like any other commodity, continue to rise with inflation, and as we all know malpractice premiums and health insurance premiums rise at rates defying reason or predictive models. This scenario clearly has a potential end where surgeons conclude that a minimum salary does in fact exist at which they will choose career change or retirement as opposed to accepting anything lower. What that floor is the author dares not suggest for fear that he will have to eat his words. Perhaps needless to say, surgeons are working harder for less every year and resentment and cynicism have affected us. How has private practice managed to survive, and will true private practice survive into the future? These are difficult and painful considerations, and the predicament of the family farm comes to mind as a possible analogy.

How can surgeons address the economic challenges? First, we must take responsibility for income that is lost by inadequate coding practices and lost revenue related to ineffective billing and collection practices. This essentially involves getting paid appropriately for the work that we are doing. Improved accuracy in coding clearly results in improvement in revenue. Most physicians, especially in regard to evaluation and management (E/M) services, fail to code at the level appropriate to the level of service provided and as a result systematically suffer from reduced billing and reduced revenues. Generally, this results from misunderstanding of the E/M system and failure to provide the necessary documentation reflecting the level of services. Billing practices must be evaluated to reduce rejected or lost claims and again improve collections. Electronic submission of claims reduces turnaround on payment and further reduces the age of accounts receivable. Such electronic claims rely on electronic billing capabilities and again favor larger practices with increased buying power. As a business, we cannot afford to allow losses to occur because of inaccuracies in coding or ineffective billing and collections. Stopping the bleeding is the initial step in preserving practice revenue.

Second, we have to analyze all practice processes and staffing to ensure that practice expense reduction is maximized. Office expenses such as space assessment and utilization, human performance of tasks, cross training of personnel, and thoughtful use of professional services (accounting, legal) must be reviewed on a consistent basis to eliminate waste. Benefit plans must be inspected and tailored to reduce overhead while providing continued benefits to staff that attempt to maintain employee satisfaction and retention.

Third, we must renegotiate existing fee schedules with third-party payors. This remains one of the more daunting tasks, given the inexperience of physicians in such activity. An experienced and prepared administrator earns his or her keep by keeping third-party payors at the table and negotiating, and the most effective negotiation occurs when surgeons are present and willing to stand up to the third-party payors. Larger groups generally have more leverage because of their practice volume, but as important is the ability to demonstrate clinical excellence and improved outcomes enabling a practice to demonstrate justification for improved fee schedules.

Increasing income by simply increasing clinical activity—seeing more patients and doing more surgery—ultimately reaches limits of surgeon time and lifestyle concerns. Alternative avenues for generating

Table 5 Alternative Revenue Sources

- Office endoscopy
- Office surgical procedures
- Industry—e.g., research, teaching, consulting
- Joint ventures with hospitals—e.g., ambulatory surgery centers
- Hospital contracting—e.g., medical directorships, management agreements

revenue must therefore be considered (Table 5). Examples of this include office-based procedures such as colonoscopy and minor anorectal surgical procedures, which provide differential professional fees compared with procedures performed in the hospital. Also, depending on state regulations and accreditation issues, office surgical procedures provide an additional means of revenue as practices are often able to bill a facility or technical tray fee, which result in increased revenue. This, of course, requires an initial investment to have office space, instrumentation, additional staffing, and administrative costs to obtain and maintain quality and certification standards for the facility. Practices that have invested in such procedures have seen demonstrable stabilization and in some cases improvement in practice revenue and surgeon income. How long such opportunities will continue remains a question for the future.

Surgeons also have the opportunity to partner with industry and hospitals to provide their expertise as consultants for technology development, teach advanced or new skills, perform clinical research, serve as medical directors, or provide management services for hospital-based programs. Hospitals have engaged physicians in joint ownership projects involving ambulatory surgery and endoscopy centers, thereby providing surgeons opportunities to supplement incomes based on revenue sharing. These opportunities again are not traditional means of generating revenue yet are to be considered given the circumstances of increased financial pressures.

SUMMARY

The career option of private practice offers a range of opportunities from both clinical and business standpoints. The need for colon and rectal–trained surgeons continues to grow, and the value of a colorectal surgeon within the medical community and hospital staff has never been more appreciated. Choices regarding scope of practice and model for practice are ultimately personal ones that balance professional and personal goals. Choosing well requires self-knowledge and preparation for the process of evaluating job opportunities, hence the timeliness of this issue dedicated to career development.

The preceding provides a sobering yet realistic view of the financial constraints and pressures affecting private practice. Interestingly, both solo practice and group practice models can preserve their viability even in competitive markets. Practices have to be willing to acknowledged the various forces at work and be willing to examine all aspects of practice: coding inaccuracies, billing and collection failures, practice expense reduction, and new ways to generate practice revenue. Solo practice allows straightforward decision making and simpler, less expensive office practices. Successful groups with effective governance and leadership can take advantage of their size in terms of more sophisticated office practice capable of generating more income based on office endoscopy and minor surgery. Practices that are thriving have been willing to change. Although offensive to the idealist, the sooner we confront these real concerns, the better will be our chances to preserve our practices and the privilege of serving our patients as independent practitioners.

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SUGGESTED READINGS

American Society of Colon and Rectal Surgeons website: http://www.fascrs.org

Choat DE, guest ed. Office Management. Clin Colon Rectal Surg 2005;18:247–283

Pavlock EJ. Financial Management for Medical Groups: A Primer for New Managers and a Refresher for the Experienced. 2nd ed. Englewood, CO: Medical Group Management Association; 2000

Tinsley R, Havens JD. Performing an Operational and Strategic Assessment for a Medical Practice. New York, NY: John Wiley & Sons; 1999