Module 12: Starting Your Practice On The Right Foot

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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.**

**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 feeling 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—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.

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!
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.

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 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 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 regarding 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.

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**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.*
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.

<table>
<thead>
<tr>
<th>Considerations For Message Tree Programming</th>
<th>Examples For Recording</th>
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<tbody>
<tr>
<td>1. Develop a brief and clear telephone access tree.</td>
<td>Welcome to the ABC Medical Practice. To help us direct your call, please choose from the following options.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>3. Make the second message for patients who inquire about joining the practice.</td>
<td>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.</td>
</tr>
<tr>
<td>4. Clearly indicate when new patient requests will be answered to avoid being swamped by inquiries throughout the day.</td>
<td>“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 <a href="http://www.mydoctor.ca">www.mydoctor.ca</a> to view a description of our medical practice.”</td>
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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.

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.

### Examples Of Interview Questions

<table>
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<tr>
<th>Questions</th>
<th>Purpose Of The Question</th>
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<tr>
<td>“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]?”</td>
<td>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.</td>
</tr>
<tr>
<td>If the answer is no:</td>
<td></td>
</tr>
<tr>
<td>“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.”</td>
<td></td>
</tr>
<tr>
<td>Alternative:</td>
<td></td>
</tr>
<tr>
<td>“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.”</td>
<td></td>
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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.”

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?

If you are accepting patient transfers, consider the following question:
“May we ask why you want to leave your current physician?”

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.”

“Dr. J’s practice focuses on… X, Y, Z. Do your healthcare needs fit this profile?”

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.

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 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.

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.

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”.
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.

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.

“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.

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“The New Patient First Visit TMP”

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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.

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**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
- *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.