

# Five myths in General Practice a novice's viewpoint

Ronald G Kapp, MB ChB (Stell), MFamMed. (Stell)

Department of Family Medicine and Primary Care, University of Stellenbosch

Correspondence: RG Kapp, Glenwood Shopping Centre, Cnr. Townsend /Pinewood Streets, Goodwood  
Email: r.kapp@freemail.absa.co.za, Tel: (021) 591-6871, Fax: (021) 591-6893

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## Abstract

This is a reflective article describing the author's insights gained during his establishing of a new general practice. These insights are shared by discussing five myths the author has had to dispense with in his first year as a private practitioner. These myths relate to professional advertising, income generation outside the practice, adopting the role of businessman, handling of debt defaulters and the role of home visitation. (*SA Fam Pract* 2003;45(3):8-9)

## INTRODUCTION:

Having worked in state hospitals for 13 years, I made the bold move to venture into private practice – by “squatting” in a suburb where 22 other GPs practise. Exactly one year after seeing my first patient on 01-02-2001, I now have more than 1000 families on the books and would like to share some of my experiences with my colleagues.

What follows is not the product of an intense study of several meta-analyses or randomised control trials. Nor will it even remotely satisfy the rigorous research standards upheld by protégées of the evidence-based medicine doctrine. It is merely the personal reflection of a doctor entering his toddler phase of general practice. Here then follows five myths I feel I can confidently lay to rest after my first year in practice.

*Myth 1: Aggressive advertising is unbecoming of a professional like a doctor.*

On my account information sheet that new patients fill in, I have a section asking them how they knew about the practice. By far the majority have responded to my advertising: regular advertisements in several local newspapers, and giving out my business cards. And I have a big bold sign. Some

of my well-meaning colleagues ask me whether the practice is growing well, or whether I still need to advertise, the implication being that advertising is only necessary if you are really desperate for business. I wonder what the commercial sector would say to that: even established multi-billion dollar enterprises spend millions a year on advertising. The effect of the “word of mouth” referral by patients takes time to establish and can only be felt once you have a decent patient-base – and that comes from advertising.

*Myth 2: An additional source of income is essential for the initial lean months.*

It seems to be conventional GP wisdom that you need to have an additional source of income to tide you over in the first few months / years, in order to keep the overdraft down and to feed some hungry mouths at home. This income is usually derived from assisting in theatre, sessional work at factories and hospitals or even a second practice (a cash practice). Unfortunately all these options take the doctor away from the practice – in my opinion a recipe for disaster for the new GP. I found that in the beginning, when my contact details were not yet in the directory, most of my patients were “walk-ins” without appointments. Many people also just

popped in to meet the new doctor.

Telling a patient that he can only see the doctor in three hours' time (because the doctor is assisting in theatre) is acceptable to a patient who has been at a practice for 20 years, but certainly not for a new doctor: the patient simply goes elsewhere. If it happens a second time, he tells his friends that that doctor is never there. I am unshakably convinced that the rapid growth of my practice can be attributed largely to my availability at the practice in these formative months. By “availability” I mean physical presence, not cell phone availability.

I have probably lost thousands of Rands by turning down invitations to assist and do part-time work, but I have gained a large, loyal client-base in a short period of time, where I see a steady flow of paying patients daily. The confidence gained by owning a financially viable practice means far more to me than the false security of earning a salary outside the practice. I find it interesting that patients would rather sit in a full waiting room (a sign of a popular doctor in demand) than come to an empty practice.

*Myth 3: I am a doctor, not a businessman.*

When I ask colleagues advice regarding financial or administrative aspects, I am astounded by the poor business

knowledge many GPs have of their own practice. I know one successful GP who boasts that the administrative part of his practice is so separate from his clinical practice that neither he nor his receptionist knows the age analysis / bad debt status of the patient sitting in front of him. My practice is next to a large retail chain store. I wonder what the owner's response would be if I were to suggest that he not worry about the creditworthiness of the customer standing at the till.

I hear colleagues moaning all the time about the consequences of *not* being involved in their business: financial difficulties, dishonest receptionists / book-keepers, problems with the Receiver, and a frustrated doctor who has to see more and more patients to earn less and less.

***Myth 4: Handing over patients with bad debts is not advisable for a new practice.***

I was told that handing over patients to debt-collectors is an inadvisable step for a new practitioner, as those patients usually slander the doctor and the resultant negative impact it has on the practice is not worth it. I disagree. Having handed over a dozen patients and threatened at least double that number, I've made the following observations:

- Even though the patient handed over often has several family members and friends attending the practice (has possibly even referred them to

the practice), I am not aware of having yet lost any of these "adherents".

- Our debt-collectors inform me that several of these defaulters are on the bad debt list of several other practices. Why are we doctors such suckers that we don't network with each other regarding our bad debts?
- Many medical aid patients whose funds have run out expect the doctor to oversee their debts because they feel that the doctor makes enough money the rest of the year from their medical aid. I feel that such an attitude seriously undermines the trust vital to the doctor-patient relationship. Such patients therefore get treated the same as any other defaulter.
- I find the easiest way to deal with bad debt is to prevent it: a validity check on available funds is performed electronically on all new medical aid patients. My receptionist is not afraid to confront patients coming with "empty cards".

***Myth 5: Home visitation in the city is a dying practice.***

As a Family Medicine graduate, I am entitled to call myself a "Huisarts". Directly translated this is a "Home Physician". How can a doctor call himself a "home physician" when he never even ventures inside a patient's home? While the time spent on a house call isn't justified by the inadequate reimbursement and can probably be a

nuisance in a busy practice, home visitation has played an invaluable part in building up my practice. The bond that forms during a home visit (especially after-hours) greatly accelerates the building of a relationship between doctor and patient, compared with an office consultation: just what the doctor ordered for a new practice.

Home visitation also plays a big role in my marketing strategy: when visiting a patient I find myself slamming the car boot just that much harder (the rusty boot of my 1984 Toyota seldom closes first time anyway) to get the neighbourhood dogs barking. This distraction results in many inquisitive neighbours peering out to see what doctor is actually doing a house call: a source of many referrals.

Furthermore, in a suburban practice where every family has their own personal gynaecologist, paediatrician and left upper parathyroid lobe physician, I feel strongly that the GP who provides a good home visitation service won't easily be compared unfavourably to a specialist, as not even an oncologist – whose job it is to care for the terminally ill – will go to a patient's house.

Now that I'm on a role, I would love to carry on writing, but a patient (probably a bad debt) has phoned to request a house call. My wife is also complaining that I know nothing about business. She says I'll have to find extra work to cover all my advertising costs. Oh well, I did say this was just my first year in practice. □

**GlaxoSmithKline donates albendazole for elimination of lymphatic filariasis in 350 million people by end of 2005**

A study published early this year estimates that nearly 80 million people in the world's poorest countries have now been treated with medicines to prevent lymphatic filariasis (LF), also known as elephantiasis. A target of reaching 350 million people by the end of 2005 has been set with an ultimate goal of disease elimination by 2020. The figures are published in a supplement to *The Annals of Tropical Medicine & Parasitology* (Vol. 96, S15-40, Dec 2002) in which the Global Alliance to Eliminate Lymphatic Filariasis (GAELF) reports its early progress.

The strategy for disease elimination is to use annual community-wide treatments of the antiparasitic drug albendazole with either ivermectin or diethylcarbamazine (DEC) for five years. GlaxoSmithKline has committed to donating its drug albendazole for the life of the programme.

Current projections estimate this requirement to be around six billion treatments.

LF is a disabling and disfiguring tropical disease caused by thread-like worms (filariae) that live in the human lymphatic system. LF symptoms include gross swelling of limbs and genitalia, and fever attacks. It mainly affects people in tropical and sub-tropical areas of Africa, Asia and the Americas. Around 120 million people are affected by LF, with 1.2 billion at risk of infection.

In a typical endemic village in sub-Saharan Africa, 260 of every 1000 villagers are infected with LF or have chronic symptoms of the disease. Many of these suffer one or more episodes a year of painful localised inflammation and fever lasting several days, during which time they are unable to work.