

Solo Practice: The Way of the Future

*Is there still a place for the rugged individualist in medicine?
Here's one family physician who says, "Yes!"*

Douglas Iliff, MD

Situation Wanted: FP with many interests outside medicine desires income 50 percent higher than specialty average; 40-hour weeks; every fifth weekend on call; complete autonomy regarding all practice decisions; six weeks' vacation plus all major holidays; minimal dealings with insurers; loyal, friendly, dedicated staff; and flexibility to work any hours he wants.

Sound like a job you want? I already have it. The practice described above is mine. The features this "ad" describes really exist. This article is my attempt to preserve the best in traditional solo practice by liberating young minds from the mudslide of bad advice they get from the consultants, futurists and wannabes dedicated to "helping family physicians adapt to changing times" — and that includes a lot of the writers published in *Family Practice Management*.

The family practice gurus who see nothing but large organizations in the future of family medicine are stuck in the age of mainframe computers. Remember when it looked as though only giant corporations could afford those monsters in their basements? When it seemed that the little guy would never be able to compete in the Age of Information? We know what happened to *that* pre-

diction: The power of personal computers and telephone lines has produced an eruption of cottage industries and careers — the business equivalent of solo physicians.

David Vogel, a "health care futurist" and "one of the nation's leading experts in health care organization strategy and design," advises us ("Fatal Organizational Flaws," *FPM*, February 1997) that "magic models" for health care businesses have yet to be found, and no model "appear[s] to work equally well in all markets and in all organizational and individual circumstances." I believe there is a magic model for health care delivery, and that it will work equally well in all circumstances, if not for all individuals. It's called "solo practice." I'm not suggesting

Dr. Iliff is a family physician whose solo practice is located in Topeka, Kan. Conflicts of interest: none reported.



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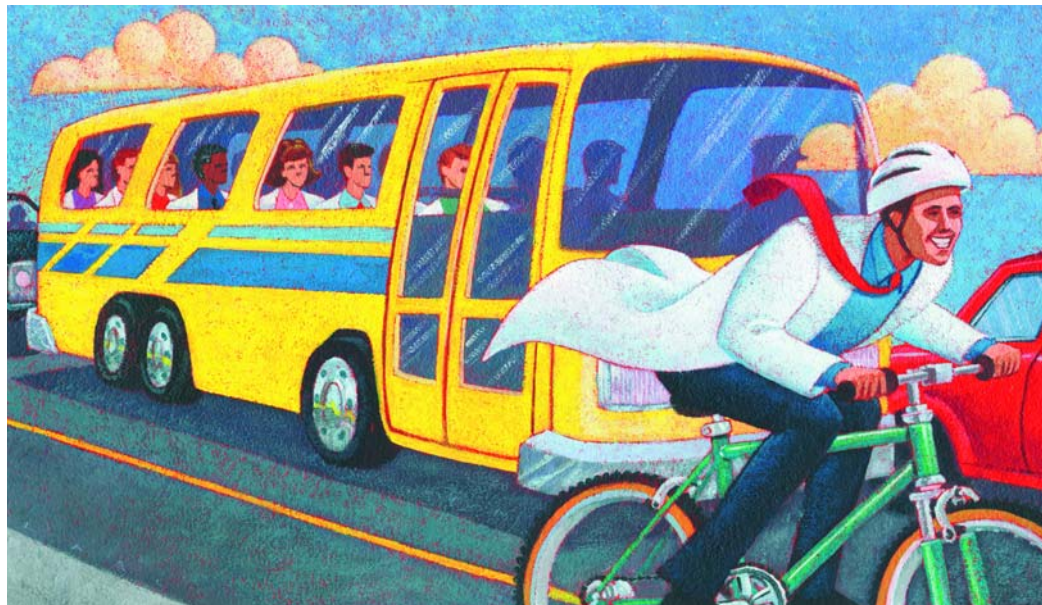


ILLUSTRATION BY LAEL HENDERSON



The family practice gurus who see nothing but large organizations in the future of family medicine are stuck in the past.



There is a "magic model" for health care delivery, and it is called solo practice.



To maximize cost-effectiveness and quality, groups should function as if they were collections of soloists.



Characteristics of excellent organizations include a bias for action, closeness to the customer, keeping things simple, being hands-on and value-driven and having consistency of purpose and an emphasis on long-term profits.

that all groups disband in order to follow this model. However, it's my belief that every group should operate *functionally* as if it were an aggregate of solo practices under one roof, just as soloists can form a group practice without walls; I think those that do will provide the highest quality of care at the lowest cost, and therefore the highest profit.

Mr. Vogel does us the favor of quoting two true visionaries, Tom Peters and Edward Deming. Between the two of them, they identify six characteristics of excellent organizations: a bias for action, staying close to the customer, keeping things simple, being hands-on and value driven, consistency of purpose, and an emphasis on long-term profits. In my opinion, the solo model equals or beats the group six ways out of six:

1. A bias for action. I hate meetings because they waste my time. Groups have a bias for argument, posturing, ego gratification, procrastination, blame shifting – anything except action. Even if committee meetings are your idea of recreation, do not confuse them with organizational effectiveness. In my solo practice, I make almost all decisions myself, in the privacy of my own mind, often while jogging or reading late at night or playing catch. Conferences with my nurse, a colleague or my accountant, when needed, are pointed and brief.

2. Staying close to the customer. All my patients make their appointments through one receptionist who has worked for me for years and gets to know them personally. Three-fourths of their questions, consultations and follow-ups are handled by the nurse hired when my practice opened in 1986. When I stand at the shelf filling out encounter forms and writing progress notes, I am 10 feet from that receptionist and six feet from that nurse, listening to their conversations with patients. When a patient tries to tell me that one of these employees is rude or incompetent, I don't have to call an office manager to investigate the situation, and I don't have to initiate a patient satisfaction survey. By the same token, if we forget someone in Room 3, or if I fail to sense how worried Mr. Jones was about his mole biopsy, we all know what went wrong, and we know it immediately. There's no place to hide in our office. Good or bad, it all hangs out.

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KEY POINTS

- Solo practices or groups that operate functionally as solo practices under one roof can provide the highest quality of care at the lowest cost.
- The simplest system is the best system because it minimizes the opportunity for human error.
- The solo practice model of decentralized decision making offers the highest probability for happiness.

That's "staying close to the customer." Group practice doctors often give lip service to the free market, while the size of their organizations buffers them from the accountability and discipline of the marketplace. Solo practice puts patients (I won't call them customers) right in your face, where they belong. In that kind of setting, as with a large family in a small house, either you learn to be a team player or you leave. Either way, the patient wins.

We are an efficient team. If you need an appointment today, you get an appointment today. My nurses have worked with me so long they know what I'm going to say without my saying it; I never talk to a patient on the phone during office hours, fully confident that my nurses will tell them the same thing I would tell them. My desk is clean. There is no "pending" box. Every problem is handled before we go home, and we go home on time.

3. Keeping things simple. Why is the simplest system the best system? Because it minimizes the opportunity for human error. Let's take the example of medical records. All of my records are handwritten during or immediately after the patient encounter. The records go from the shelf, to the receptionist, to the nurse, to me, to the receptionist, to the shelf – a round-trip of about 20 feet. Ditto for a phone call, minus me. We don't lose records, ever.

There is a large multispecialty group in my town. They are excellent physicians, some of them family physicians. Their patient records are stored in the basement of one of their buildings, or maybe in the limestone caves outside Kansas City; I'm not sure exactly. From what I understand, a moving van delivers the records before dawn for patients scheduled to be seen that day. The problem comes with phone calls or unscheduled

patients. When that happens, nurses talk to the patients about their problems, or doctors see the patients, *without their records*.

In fairness, I should admit that their typed records are much prettier than mine, and this makes health care attorneys very happy, although I don't exactly understand why. It has always seemed to me to be rather an advantage for the defense if the doctor has to personally interpret every squiggle on the page. I mean, if you can actually *read* the notes, then you *know* he made a bad decision, instead of making the other side guess. But never mind. The big groups can have their pretty charts, while I will cling to the simplicity of the solo life. I'll have pretty charts some day, when I can dictate into my pen and have the transcription roll off a laser printer into the lap of my receptionist. The technology isn't quite there, but it's getting close. I can wait.

Managing accounts receivable is another area where success depends on staying close to the customer and keeping things as simple as possible. We don't depend on a series of "strategies," but rather on keeping an employee who knows every patient as an individual. The rest is a good computer program, a good accountant and a consistent policy for dealing with problems.

4. Being hands-on and value driven.

Personal values are to some extent in the eye of the beholder. All of us have at least one colleague about whom we wonder, *why would any patient choose that individual as a physician?* The answer, of course, is that those triangular pegs have found triangular holes. And that's part of the wonder of life in a free market. So another great thing about solo practice is that the uniqueness of our personal values can be fully expressed without guilt or acrimony. Since I am in solo practice, the opinions I express are my responsibility alone. My colleagues may cringe or avoid me in the doctors' lounge, but their hard-earned reputations are unspoiled. My practice reflects my values, in ways large and small. When my patients choose me (and even in a managed care environment, the patients still *choose*), they are implicitly announcing that our values match.

5. Consistency of purpose. How does a large organization achieve consistency of purpose? It starts out with a weekend retreat to find a purpose, and maybe write a mission statement. Then it forms a committee to define goals and objectives consistent with that purpose. The committee breaks up into

informational sessions with the rank and file to bring them up to speed on the "new beginning." Then everyone promptly forgets the purpose for a few years until a new manager calls for another "new beginnings" weekend retreat.

For the solo physician, consistency of purpose is simple: Be consistent. If I stop taking new patients over age 60 to keep my practice balanced, that includes my next-door neighbor; otherwise, my employees may wonder if I'll make an exception for others, too. If I don't prescribe narcotics over the phone, *ever*, then there's no question when a patient on Friday afternoon swears to my staff that I said I would. And we don't need an office manager to interpret the vision of the boss to the nurses or to shield the boss from the receptionist's complaints. We don't have to periodically re-establish an open-door policy so employees feel comfortable talking directly to the doctor. They're in my face all day long. If I have offended or confused or exasperated someone, it doesn't take long to straighten things out.

Consistency has made it easier over the years to train my patients, too. I take all my own after-hours phone calls Monday through Thursday, and I average one or two calls a day. Because I really believe that telephone prescribing is inferior medicine, and because I am confident that every patient who calls during normal office hours will be managed appropriately before we lock the doors, my patients seldom call me at night. That would be a very difficult goal to achieve in a group that is rotating coverage every night; there will be a lot of inappropriate calls, and the doctors will be cursing the callers' stupidity or insensitivity under their breath, *but it will not be the patients' fault*. The blame lies with the system.

6. An emphasis on long-term profits.

Why would any physician with a credit rating choose to rent, rather than purchase, a medical building? My mortgage payment in 1986, when my building partnership closed on our new office, was less than rent would have been. It hasn't increased since, and \$3,500 per month will soon be added to my take-home pay with the last payment. That makes good business sense unless you want to practice in a group. Groups grow, and when they grow they need more room. Renting is a lot more convenient than buying when space needs change every year. So

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Solo practice is especially conducive to action, and it helps physicians stay close to their "customers."



Handling medical records and managing accounts receivable are examples of administrative systems that can be kept simple in solo practice.



A solo practice reflects consistent values and purposes, which come from the physician, not from group consensus.



Because they aren't likely to expand their practices, soloists can more easily purchase office space rather than renting.



Hiring physician extenders and RNs is another way solo physicians can maximize long-term profits.



By fostering a family-like atmosphere in the office, soloists can keep costs down by keeping turnover low.



The freedom of solo practice lets physicians be selective in the contracts they sign and the services they provide.



The solo practice model offers the highest probability for happiness and high profits and should be adopted as a structure even in large medical groups.

another hidden cost of group practice is that for the length of your career you are subsidizing the lifestyle of your landlord.

The gurus have recently discovered the value of physician extenders, something I learned in the Army Medical Corps many years ago. I have shared the services of an excellent physician assistant (PA) with a friend and colleague I've known since my residency days, who also operates a solo family practice, since shortly after we opened our offices. The PA makes himself invaluable by smoothing the ebbs and flows of our daily workload. He adds monetary value to my practice. We wonder how any practice can thrive without one.

Here's another example of the value of taking the long view. My nurses are all RNs (well, there's one part-time exception, but she's been a nurse forever and might as well be an RN). RNs are more expensive than office assistants, but they can make independent decisions, represent my opinions convincingly to patients and correct my mistakes before I manage to hurt somebody. Are they worth it? They are for me. They make me so productive that my overhead has been less than 50 percent of my gross income since the second year of my practice.

Furthermore, I have exceedingly low turnover. Salary should not be the only reason to remain in my employment, but it should never be the reason for leaving. I don't try to figure out legal ways to exclude employees from my pension plan; they get the same 15 percent of salary, contributed 100 percent by me, that I pay myself, plus another 5 percent to 10 percent as a bonus at Christmas. I want my employees to be the best-paid in town; some day I want them to retire comfortably. In an office of friends, our goal is to never miss a school event or athletic activity of any child in the "family," and we figure out ways to work around pregnancies, surgeries and family crises; issues like the Family and Medical Leave Act would never ripple our business as usual, even if it applied to an office as small as ours. As a result of taking this long view, I don't spend any time training new personnel.

Finally, an orientation toward long-term performance and profitability makes me very selective about contracting with insurance

companies (I don't cut my own throat on fee schedules to buy a few more patients), about clinical procedures performed (assisting at surgery is not cost-effective, at least for me), and about equipment purchases (a colposcope has yet to make the cut). But the tough choices have had to be made only once: After my practice was full, I was never tempted to sign a bad contract to help fill the practice of my next colleague. There never was going to be a next colleague.

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In fact, my mode of practice spares me from such a wide range of problems that I can afford to skip much of what fills the pages of *Family Practice Management*.

For instance, I'll never need to read about productivity bonuses, partnership buy-ins, continuous quality improvement (CQI) teams (CQI being unconscious in a well-run solo practice), or any of the multitude of problems that come with organizational bulk.

There are two caveats in all of this. First, if everyone practiced like a solo physician, with full authority, responsibility and rewards for individual performance and practice patterns, the income skew would be far greater than it is now. There would be winners and losers. Everyone in a group knows this and tacitly accepts the compromise, but it causes a lot of tension, spoken and unspoken. Second, the independent model of practice should be promoted more actively in our residency programs and semiofficial publications. I suspect that the average academician – not all, of course, or even a majority, but a substantially higher percentage than in private practice – has a natural bent toward reading and research, toward committee meetings and "group process," and toward political activities in general. All of this may be necessary, but it doesn't constitute an orientation toward the bottom line.

All in all, I'm convinced that the solo practice model of decentralized decision making offers the highest probability for happiness and high profits and that it should be adopted as a structure even in large medical groups, just as cutting-edge companies all over the world have learned to give small cells independent authority to design, build and market their products and services. **FPM**

Send comments to fpmedit@aafp.org.