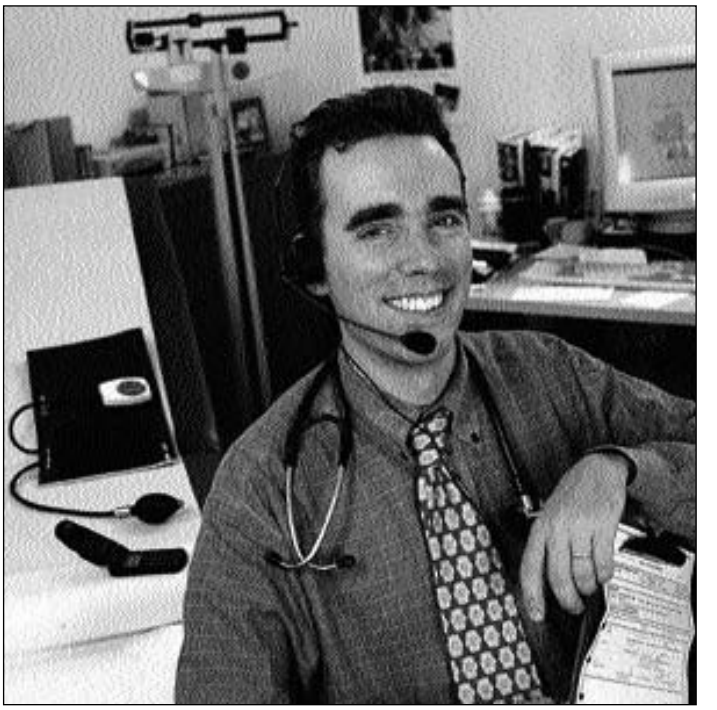
Going Solo: Making the Leap

Why one family physician left the security of salaried practice to pursue ideal patient care completely on his own.

Gordon Moore, MD



PHOTOGRAPH BY MIKE GREENLAR

Twelve months ago, I did what some physicians might describe as the unthinkable: I left the security of a salaried position and entered the wild world of solo practice. I walked away from an established office that had given me generous paychecks with benefits for seven years. It had staff members to take care of everything from payroll to billing to greeting patients, making it generally easy for me to come in and just be a family doctor.

Now, I do all of that work myself. My practice is literally solo (I have no staff), so I get to sweat the small stuff: submit claims, answer the phone, check in patients, turn over the room, give shots and review EOBs. (If you're wondering what an EOB is, you're just as far out of the loop as I was before I made the jump.)

Why did I do it? Why did I leave the security of employed practice, simultaneously taking on all of the office activities I knew nothing about and had thankfully avoided for the past seven years? Put simply, the current reality of practice had become untenable and the trajectory looked no better. What finally tipped the scales was getting a taste for how good practice could be – and figuring out that the transition was a lot simpler than I had imagined.

The sad reality

Not long after I finished residency, I began to realize that medical practice wasn't the bundle of unfettered joy for which I had yearned. Yes, the pay was much better and the call more sane, but I began to be embarrassed by the monotonous frequency with which I started patient encounters with, "Sorry I've kept you waiting." I was chagrined when my open-ended question, "What can I do for you today?" was met with, "I was sick last week but thought I might as well come in today since it's so hard to get an appointment."

The issues that arose during my employed phase were hardly unique to my organization. Across the country, health care systems were creating new practices and purchasing old ones, and private practices were banding together in local networks to

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CME

KEY POINTS

- Frustrated by current practice and convinced of a better way, the author left his salaried position and opened a solo practice with no staff.
- Because his overhead costs are extremely low, the author is able to see fewer patients per day and create more meaningful interactions.
- By offering unfettered access, the author finds that his patients trust him more and actually call him less.

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Leaving the security of salaried practice, the author opened a truly solo practice, which operates with no support staff.

Like many practices across the country, the author's previous group was pressured to see more patients and generate more income in order to support a growing bureaucracy.

A pure pursuit of revenue eventually cuts into the time physicians need to build patient relationships based on trust.

Tweaking the current system's mess would not achieve the results the author desired. Medical practice had to be completely redesigned.

become larger systems. To manage these practices, the health care systems created administrative arms, which wasted no time in developing numerous policies and procedures. They purchased billing systems to maximize their returns on physician work and began to hire or rent billing experts, JCAHO experts and CLIA experts. Expensive T1 lines were installed to pipe information between the practices and the central billing office, and couriers were hired and supplied with vans to move materials and meeting minutes (of course, meetings were established to discuss all of the new policies and procedures).

On top of all of this added expense and bureaucracy, the money wasn't as good as it used to be. The insurers were working to restrain premium increases and did all they could to pay us less. In turn, we were called upon to increase revenue via increased throughput (i.e., "see more patients"). Then, we were asked to increase scheduled time with patients. Then, our compensation plan changed from a salary guarantee to a percent of revenue (i.e., "you eat what you kill"). And then we got back to another round of "see more patients." It seemed that all of the conversations in our office were about money. The only measure of success was "revenue." A good doctor, it seemed, was one with high visit volume.

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Of course, this pure pursuit of revenue eventually cuts into the time we need to build trusting relationships with our patients. In turn, we lose the joy in our work and can begin to feel that we are no longer making meaningful contributions to our patients' lives but are merely going through the motions to receive our paycheck.

The fear of ending up this way was probably the most important factor motivating me to make a change. While the finances and the absurdity of current practice operations were maddening, I could put up with the stench if I felt I was able to deliver excellent, personal care. But I came to understand that this is not possible in the way we have configured our current offices. Our system is so broken that we must completely redesign it if we are to achieve the results we desire. (For more information, see the Institute of Medicine reports in the reading list on page 32.)

In the summer of 1998, I heard Don Berwick, MD, MPH, president and CEO of the Institute for Healthcare Improvement, describe the practice of the future and an IHI initiative called the Idealized Design of Clinical Office Practice (IDCOP). (For more information, see the reading list on page 32.) Berwick made the obvious but necessary point that health care is all about the interaction with the patient and that fundamental redesign would be the means to this end.

Accepting a part-time administrative position under Robert Panzer, MD, chief quality officer at Strong Health, I had the opportunity to participate in the IDCOP project and learn new ways of delivering care, such as offering same-day appointments regardless of urgency, using continuous flow processing so that I could see all patients on time and using 21st century technology to achieve breakthroughs in all aspects of practice.

This is where I was in October of 2000: intolerable current reality that only promised to get worse with time versus a compelling vision for the practice of the future. Paul Plsek, a guru of change management (www. directedcreativity.com), teaches that the willingness to make a change is based on the balance between the pain of the current situation and the pain of making the change. Finally, I had reached the tipping point. I was ready to do anything to move toward that vision.

Opening an office – the wrong way

One final stumbling block remained in my way on the road to solo practice. I feared the unknown – that is, the difficulty and expense of opening an office myself. Was it really as hard as I imagined it to be?

For no discernible reason, I had the impression that I would need a loan of $125,000 to open a new practice. With my current practice mode in mind, I built a mountain of expectations and expenses. I would need someone to manage the clerical work: incoming phone calls, mail, faxes, supplies, co-pays, referrals, etc. I would need clinical support staff to room patients, take vitals, give shots, assist during procedures, etc.

My space requirements would need to accommodate the three exam rooms I used when at peak efficiency, a front office, a nursing area, a waiting room, bathrooms, a break room, a storeroom, etc. Then, of course, I would need all of the equipment.

Next, I began to look at office spaces to get a feel for the square-footage costs ($16 to $25). With the room needs I had stipulated above, I thought I could combine some of the spaces and perhaps get away with 1,100 square feet, which would require renovation of an existing space. In the end, I was looking at spending $60,000 before I spent a dime on office furniture.

I then began researching salary and benefit costs for nurses and secretaries. I called billing software vendors to begin reviewing their products and was pleased to find that one highly respected local billing outfit had developed a linked electronic record. But for just the billing component and a few computers, I was looking at $40,000 up front, then a percent of revenue to pay for ongoing services.

Then, I priced an answering service, cell phones, pagers, telephone systems and business and malpractice insurance. I looked into accounting firms and practice marketing strategies (newspaper advertisements, mailings, etc.).

By this time I had arrived at the inescapable conclusion: I would have to be independently wealthy to open a new office. How did anyone ever go into private practice? No wonder the private docs sold their practices in droves when the hospitals and health care systems came knocking.

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What happens when you challenge assumptions

Just as I was about to put my hopes for a new practice into the hands of Lotto, I decided to question all of my assumptions. What was I trying to achieve? I did not want to recreate a mini version of my current practice. I wanted something better, a practice where I had time to interact meaningfully with patients, explore shared decision making, listen to patient stories and address all of the issues that arise during visits. I wanted an office where prescription refill requests, messages and forms were all so easy to fulfill that last-minute requests could be met with the honest answer, "Sure, no problem, I can do that right now." I wanted a practice with superior data collection capabilities to prove superb outcomes in patient care. I wanted a better balance between work and home and didn't want to spend so much time doing paperwork. In short, I wanted the ideal practice, for both my patients and myself.

To create this, I had to focus on what was essential. Health care is at its core a very local, personal process. When we function at our peak, we are available to patients when they need us. We treat each patient interaction as if it is the only one. We translate our understanding of the latest medical knowledge to the individual. If this is what health care is really all about – not "number of exam rooms," "productivity" and "staffing ratios" – we can strip away all of the assumptions built into current practice.

Suddenly, opening my practice became so much simpler. I had only three objectives:

1. Eliminate barriers between the patient and the doctor. I would make my phone numbers and e-mail address widely accessible, and I would create a practice Web site to answer simple questions about my practice. For appointments, I would use open-access scheduling and would always be able to offer appointments "today" regardless of urgency (for more information, see the reading list on page 32). As the IDCOP project has shown, when we reduce barriers to access, our patients gain trust in our ability to provide timely care and they demand fewer visits. This creates room in our schedules for more robust visits and allows us to manage a larger population of patients, if we choose to do so.

To handle after-hours call, I would follow the advice I had heard time and time again from those in solo practice: Taking your own call is less onerous than sharing call with others. Your own patients will be more respectful

LOOK FOR PART TWO

This article is first in a two-part series. Next month, Dr. Moore will expand on his strategies for successful practice, will answer commonly asked questions (e.g., "How do you provide uninterrupted patient care *and* answer your own phone?") and will report on his success to date.

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Through a national quality improvement initiative, the author learned new ways of delivering care, such as offering same-day appointments regardless of urgency.

In his first attempt at opening an office, the author built a mountain of expectations and expenses because he was unconsciously replicating the status quo.

By challenging every assumption about medical practice, he was able to open his ideal practice without a large financial investment.

In opening his practice, the author had to focus on what was essential in health care, not on "number of exam rooms," "productivity" and "staffing ratios."

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Unfettered access to care was an essential in the author's new practice because it helps physicians gain their patients' trust, resulting in greater respect for the physician's time.

To afford longer, more meaningful interactions with patients, the author kept his overhead costs low by hiring no staff.

His patients spend nearly 100 percent of their visit time with him, the person they are there to see.

On Feb. 26, 2001, the author opened his new practice, which is thriving one year later.

of your time, and talking only to "your own" is much easier than trying to create an effective care plan with an unknown patient.

2. Make time for meaningful interaction. Meaningful interaction is the foundation of excellent health care, but in many practices, physicians can't afford to spend the time it takes to create these interactions. How could I? I entertained a radical thought: If I were the only staff member in my office, I could dramatically reduce my overhead costs, meaning I could dramatically reduce the number of patients I had to see per day in order to be profitable. This would give me the time I required to create meaningful interactions with my patients.

> **I was able to build a Norman Rockwell practice with a 21st century information technology backbone.**

To do this, I would rent an exam room (it would double as my office) from an existing practice. I would answer the phone, make appointments, greet patients and provide all of the care. I would be fully in the loop of all that happens between my office and my patients. They would be asked only once, "What can we (I) do for you today?" They would get to spend nearly 100 percent of their visit time with me, their doctor (as opposed to 20 to 40 percent in most offices). And above all, I would have time to ask open-ended questions, allow patients to speak uninterrupted and listen to patient stories; time to create the kind of rewarding interaction that is so totally lacking in the mills we have established in the name of increased productivity.

3. Invest in technology that puts scientific and patient information at the physician's fingertips. Without this information, a practice cannot attain what IHI calls "reliability," meaning the ability to deliver all and only the care known to be effective. The Institute of Medicine has thoroughly and convincingly described in its recent reports the gap between what we currently do and what science recommends. But bridging that gap is impossible on our own. It is foolish to expect a person to be infallible and make all of the correct recommendations for all of the people all of the time. Therefore, we must look to inhuman help: computerized systems that remind us of the latest clinical recommendations and that help us keep track of all the elements involved in an individual patient's care. With the help of Keith MacDonald and Jane Metzger from First Consulting Group in Boston, I found an incredibly affordable integrated scheduling, billing, messaging, electronic medical record, patient flow system (see www.alteer.com).

The doors open

By challenging every assumption, I was able to build a Norman Rockwell practice with a 21st century information technology backbone with an investment of just $15,000. My new practice opened on Feb. 26, 2001, and is thriving one year later. My patients are well cared for and highly satisfied, my income is booming (when my practice reaches full volume/panel size, my income will actually be better than what I made in my previous practice), and my wife and kids enjoy seeing more of me. I would never go back. FM

Editor's note: Read part two of Dr. Moore's series in the March issue of FPM.

Send comments to fpmedit@aafp.org.

RECOMMENDED READING

For more information about several of the key concepts referenced in this article, see the following:

The case for system-wide redesign

Crossing the Quality Chasm. Institute of Medicine. Washington, DC: National Academy Press; 2001.

To Err Is Human: Building a Safer Health System. Institute of Medicine. Washington, DC: National Academy Press; 2000.

The Idealized Design of Clinical Office Practice initiative

"Starting a Revolution in Office-Based Care." White B. *FPM.* October 2001:29-35.

"As Good as It *Could* Get: Remaking the Medical Practice." Kilo CM, Endsley S. *FPM.* May 2000:48-52.

Same-day appointments

"Same-Day Appointments: Exploding the Access Paradigm." Murray MM, Tantau C. *FPM.* September 2000:45-50.

Note: All *FPM* articles can be accessed online at www.aafp.org/fpm.