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The Bigger Picture: Death of Solo Practice A Myth

By Pamela Moore | November 1, 2008

William Balcom, an orthopedic surgeon, left a six-physician group to join Fallon Clinic, with its 250-odd docs in the Boston area.

“The advantages are the stability of the book of business, the ability to hire professionals to guide the business, and the ability to use your skill sets to improve patient care,” he says, happy with how he can specialize at Fallon.

Balcom is part of a trend. There has been drip-like decline, slow but steady, in the number of small practices.

According to the Center for Studying Health System Change Community Tracking Study, 41 percent of physicians were in solo or two-physician practices in 1996-1997. By 2004-2006, that number had dropped to 33 percent.

Where did they go? Many rolled into bigger or hospital-owned groups. The percentage of eight- to 50-physician groups grew by 39 percent over the same period. Practices bigger than 50 physicians jumped by 45 percent.

The shift is real, but hardly rings the death knell for small practices. More than three-quarters of patient visits are still to physician offices of five doctors or fewer, and fully 90 percent are to offices with no more than 10 physicians.

Still, theories about the shift to bigger practices abound: Younger physicians looking to share more call, work fewer hours, and avoid the intricacies of practice management; larger groups getting more leverage in managed-care contracting; hospitals reprising efforts to capture referrals by buying practices and creating mega-hospital practices.

Yes, yes, and yes. There certainly are some business and personal advantages to bigger groups. Balcom, for example, loves how the team approach at Fallon improves coordination of care and allows physicians to focus on quality. And he points out that having more than one set of eyes on business matters is “probably healthy.”

Agreed. Yet my impression is that well-managed small and even solo practices can do just fine, and the success and pleasure of any model depends mainly on the attitude and temperament of the physician(s) in charge.

Pam Wible, for one, wouldn't go back to group practice now that she works solo in Eugene, Ore. "I was treated like a bad puppy with a mean dog trainer following me around," she recalls. "I couldn't do good enough." Pressured to see more and more patients a day, Wible felt she "had to stay in my little cubicle and not think about the other parts of the system. It was frustrating."

Now, "I'm in the loop and understand what's going on. I feel empowered."

She focuses on patient care not through the team approach Balcom prefers, but by setting up a business model that lets her spend substantial time with each patient, in keeping with her role as a primary-care physician.

"The choice of solo practice over a group or academic setting is one I've never regretted," commented another solo physician, anonymously, on a Medscape blog called "Solo Practice: Making It on Your Own." "When I wanted to move to an open-access model, I just did it. There was no board of directors to convince; no managing physician to persuade; no partners to get to buy into a new paradigm," he crows.

What matters is making your practice work for you, not obsessing about trends.

Pamela Moore *is editorial director for* Physicians Practice. *She can be reached at pmoore@physicianspractice.com.*

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