Alone at the End

The solo practitioner was once an icon of American medicine. Now, economic pressures have made these doctors increasingly rare. By Margot Sanger-Katz

Ambulatory medicine: Home visits went first; now independent doctors.

Dr. Robert Eidus might seem like the perfect person to run his own medical practice: The New Jersey family physician has an M.B.A. and taught courses to other doctors in the business of medicine. Unlike many of his peers who went stag with only medical training, he knew his way around contracts and balance sheets. Indeed, in 2009 his office was making a healthy profit. That's when he decided to get out of the solo-practice game. "You see my head above water, but you don't see how hard I'm treading water below," he told puzzled students when he shared his plans.

Eidus was responding to pressures in the medical economy that are driving an increasing number of doctors out of the traditional mom-and-pop small practice and into larger, more-corporate arrangements. Eidus, 64, joined local colleagues to form a 20-doctor practice. Others are going much bigger—joining giant physicians' groups or selling their practices to hospitals. No one has perfect data, but the trend is clear: The consultancy Accenture estimates that the share of independent physicians has declined from 57 percent of the profession in 2000 to just 39 percent last year. Merritt Hawkins, the country's largest physician-recruiting firm, saw the number of searches for solo and two-person practices decline from 38 percent of its business to less than 10 percent over the same period. Marcus Welby is vanishing.

The traditional doctor's practice relied on the idea of the physician as an entrepreneur, but the business of medicine has grown more complicated and time-consuming. Doctors need to negotiate with insurance companies, master complex billing systems, and manage payroll and benefits for administrative staff. New federal regulations also require them to report a growing volume of data to qualify for bonus payments. The electronic health records needed to measure that information require big investments and ongoing maintenance.

When Charles Cutler, 64, finished his internal-medicine residency in 1979, he and a partner picked out office space in King of Prussia, Pa., and waited for the patients to come. "At night, I'd sit at the kitchen table and write out the invoices, whether it was to BlueCross or to Medicare," he says. "I used to use a pen." Last year, he sold his practice to a local hospital. Cutler wanted to use electronic records to deliver better care to his patients, but the price tag was daunting. "It's like buying a car, but a lot more expensive," he says.

Younger physicians are entering medicine less enamored of the old free-enterprise approach. Several surveys show they prefer modern systems, predictable hours, and fixed incomes over long days and total autonomy. (These physicians are about 20 percent less productive than independent doctors.) "The concept of owning your own practice as a source of identity is not the same as it was for the baby boomers," says Dr. Kaveh Safavi, a managing director at Accenture.

The U.S. payment system rewards the big over the small in medicine. Doctors in small practices typically have no leverage to negotiate with insurance companies on their fees, while their organized peers have enough market share to demand higher rates.

A report from the Center for Studying Health System Change found that doctors in large groups could command substantially higher prices than those who work alone. Medicare also pays more for many services if they are delivered in a hospital; that fact can make it profitable for health systems—particularly in certain specialties such as cardiology and oncology—to add physicians. Big practices, meanwhile, can use economies of scale to lower their overhead on payroll, benefits, real estate, and supplies.

In addition, the new payment models that are emerging in the wake of health care reform reward large, organized groups. Programs that pay doctors according to their overall management of a patient's health make the most sense in big systems, where all the doctors caring for a patient work together and share data and financial incentives.

Unfortunately, it's still unclear whether large practices are actually achieving those objectives. While those with long histories—such as Kaiser Permanente—credit their efficiency and good outcomes to physicians working in teams, the transition is not always easy for newly consolidating practices. Information-sharing can improve quality, but handoffs between doctors can also result in errors. "I don't think we have definitive proof that it automatically starts to deliver higher quality or, frankly, lower costs," says Erik Johnson, a senior vice president at Avalere Health, a consultancy. "The uniqueness of those cases is what makes them so noteworthy."

Many docs who are holding onto independence have changed their business model. The Accenture survey found that about one-third of independent doctors were experimenting with practices where patients paid them extra fees for their services—in some cases a modest subscription fee, in others a large sum for deluxe "concierge" care. Certain specialties, such as plastic surgery and dermatology, can also supplement their core income with sidelines in cosmetic work.

Some analysts think the growing wave of consolidation will end soon. Jeff Goldsmith, an industry consultant and an associate professor at the University of Virginia, points out that many hospitals are actually losing money on their doctors.

He sees strong representation by small practices, even in highly consolidated markets. "The reports of the demise of the solo and partnership practice are greatly exaggerated," Goldsmith says. But the trend hasn't slowed down yet. Eidus's group is looking to expand—the goal is a practice of 60 to 100 physicians. "Almost everyone realizes that they have to realign," the doctor says. ■

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