

Flying Solo

Despite the trend toward group practices with big bargaining power, some doctors prefer to practice medicine the old-fashioned way. On their own.

By Renée Gearhart Levy

When Nancy Blake, MD '99, finished her family practice residency at St. Elizabeth's Hospital in Utica, New York, in 2002, she did the same thing most of her peers did—she joined a large group practice.

Hers was a 140-physician multi-specialty group. "It was very corporate," Dr. Blake says. "There was a board that set policy and the physicians were expected to follow them."

Because compensation was productivity based, patients were seen very quickly. "I was essentially an employee doing what my boss told me to do," she says.

It wasn't long before Blake found that model of medicine didn't work for her—for her lifestyle as the mother of young children or as a physician.

"If you're seeing 40 patients a day, there is absolutely no way you can really take care of them," she says. "You can't do what needs to be done for people in five minutes."

In 2004, Blake became a pioneer by doing something that once would have been the norm in her field: She went out on her own.

Today, you might catch Blake doing her medical segment on WSTM NBC *News at Noon*. Or out on a house call. Or in her Liverpool, New York, office where she runs her solo practice, with her kids in the playroom because they had a snow day from school.

"I have total autonomy," says Blake. "I have the freedom to run my practice the way I want to. I can't imagine doing it any other way."



In the 1960s, when family medicine was a new field, most office-based doctors were solo practitioners. In 1980, more than half of family practitioners reported being in solo practice. By 1997, however, this figure declined to just 25 percent and less than five percent of graduating residents chose to enter solo practice.

The family practitioners are not alone. According to survey data from the American Medical Association, the proportion of post-resident patient-care physicians practicing primarily as employees nearly doubled between 1983 and 1994, while the number of self-employed solo-practice physicians decreased from 40.5 to 29 percent. This transformation was largely driven by widespread changes in physician compensation. As fee-for-service medicine was replaced by insurance contracts and managed care, the complexity of the system heavily influenced the way many physicians practice medicine.

Blake concedes that, financially, being in a group practice was "wonderful. I had a set salary. They paid my malpractice insurance. They paid for the nurse," she says. "And I do not have the bargaining power (with insurance companies) that a big group has."

Indeed, many of the challenges of solo practice are financial. "There is nobody to share expenses with and there are economies of scale that I can't take advantage of," says Leonard Levy, MD '60, a pediatrician in solo practice in Fayetteville, New York, for the last 23 years.

He'd been in a partnership for nearly 20 years, and when his partner left practice, opted to stay on his own. "It wasn't the norm even in 1984," he says.

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Being a solo practitioner gives Nancy Blake, MD '99, total autonomy to run her medical practice in accordance with her own medical philosophy and the demands of her family.

For pediatricians, one of the greatest expenses is vaccines. "Some companies have minimum orders, which are large for someone practicing by themselves," says Dr. Levy. "I can't order a small amount that I might need for a limited population of patients so I may have to order more than I might want at any given time."

Andy Rurka, MD '70, is a Syracuse pediatrician whose private practice caters primarily to low-income families. He began his career at the Syracuse Neighborhood Health Center. When that clinic closed, several of the doctors went into private practice, sharing office space with each other. Although each maintained his or her own practice, they shared expenses of the rent and a receptionist, as well as evening and weekend call.

But one by one, the physicians left for other situations and for years Dr. Rurka has been on his own. "I've never been in a corporation. I've always done my own thing," he says.

In addition to being a solo practitioner, Rurka is unique in that more than a third of his billing is Medicaid managed care. "Because of increased bureaucracy, you have to stay on top of the billing in a way you didn't have to before, otherwise you can get squeezed," he says.

But it's not all bad news. Because they are paying their own expenses—and because most solo docs are also their own chief financial officer—doctors practicing on their own tend to run lean practices, often keeping overhead to less than 50 percent of their gross income.



"I know everyone who comes through the door," says Leonard Levy, MD '60, a solo pediatrician for more than 20 years.

"With just one doctor, it's easy to keep things simple. You don't need sophisticated computer, records, and billing systems. You don't need a huge staff of employees," Dr. Levy says.

He practices with a full-time office manager and a part-time nurse. Blake's husband is her office manager and they employ one medical assistant. Rurka has a receptionist and two billing clerks.

One challenge can be the call schedule. Unless other arrangements are made, these doctors can be on constant call, although many have arrangements with other solo doctors to cover for each other during vacations or when otherwise needed.

Rurka cross covers with three other solo doctors. Each is on call every fourth night and every fourth weekend. And they cover for each other when one is sick or on vacation.

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Blake's coverage doesn't stretch quite as far. "I'm on call 24/7," she says. "Unfortunately, if I'm sick, the office is closed."



For those who've chosen the route less taken, the positives far outweigh the drawbacks of solo practice. Most solo docs are on their own for one simple reason—they're able to practice medicine the way *they* want to practice it.

"You make your own choices," says Rurka. "You hire, you fire. You take the insurances you want to accept. I've always liked making those decisions for myself. I've always felt more comfortable being in control."

Almost all solo doctors cite the relationships with their patients as one of their greatest pleasures.

"I know everybody who comes through the front door," says Levy. "There's a high level of personal interaction. Because I know the child, the family, and their response to adversity or sickness, I have insight into how to handle a situation."

That's especially unique in pediatrics, he says, where families today are accustomed to seeing multiple doctors as part of a group practice. "I think it's unusual anymore for a child to see the same doctor each time. I have families transfer in to my practice because that is the kind of medical experience they want," he says.

Rurka points to one family he has treated since his senior year of medical school. "They still come to me—it's now the third generation. They want that one-on-one attention and continuity of care," he says.

Although in practice a much shorter period of time, Blake already sees those benefits. "My patients know there is nobody else they're going to see except me," she says. "And because I'm by myself, there's no crowded waiting room full of people with the flu. There are four chairs and I don't run late."

That also means making decisions about treatment and referral. "In solo practice it's certainly easier and less cumbersome to make medical decisions for the benefit of the patient," says Levy.

"In the group practice I was in, a board developed guidelines about when and where patients could be referred," Blake says. "I prefer to make those decisions myself."

While the quality of patient care she offers is very important to her, the lifestyle afforded by her solo practice is of equal importance to Blake.

"I could have chosen to join a smaller group," she says, "but my husband and I opened this practice for us as a family. We're building our careers together and can tailor our time around our children as we need to. That was the driving factor."



Despite the high quality of care they provide and the high satisfaction of practitioners, the fact is, fewer and fewer doctors choose to practice on their own and changes in medicine are only more likely to make that so. For a physician just ending residency, the start-up capital required to begin a solo practice is often not financially feasible.

"The financial constraints of graduating medical school today are such that you can't go into solo practice—at least not in pediatrics—unless you

come out of medical school debt free," says Levy.

According to Rurka, the bureaucracy now involved with practicing medicine makes being solo more difficult than it was years ago. "When I first started, we had one billing clerk for five doctors. I now have two full-time people just to take care of billing and collection because there's so much more paperwork."

He believes eventually psychiatry may remain the only field where a large proportion of practitioners are on their own.

"I think doctors are afraid, financially," adds Blake. "They want the comfort of the salary, or they don't want the administrative headaches. That's reasonable if you're okay being an employee."

Though clearly on the decline, these solo doctors say this model of practice is not obsolete.

"My experience getting to know families over the years is that there's still a niche for the solo practitioner," says Levy. "I think patients prefer it." ■

"Solo practice allows you to make your own choices about how to practice medicine," says Andy Rurka, MD, '70.

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