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Bucking the Trend

The Solo Practitioner

An interview with two medical oncologists who have chosen independence over affiliation

Dr. X is a board-certified medical oncologist in solo practice in a large suburb of a major metropolitan area served by three major hospitals. Dr. X is also board certified in internal medicine. He has been practicing oncology for more than twenty years and plans to retire within the next three to five years.*

Q *How has your practice evolved since you first began?*

A The challenges of operating a solo medical oncology practice have become more complex since I began practicing medicine in the early 1970s. Managed care is making an impact—I practice in an area with nearly 20 percent managed care penetration. Despite managed care's growing presence, I have been able to maintain strong referral patterns with physicians, decrease my overhead, and generate new cost centers. These factors have helped me retain my autonomy thus far.

I first began practicing oncology through a shared-expense office arrangement with three oncologists. We practiced independently and had our own staff. Since then, two general internists have replaced the medical oncologists, and we operate under a similar arrangement today. Each physician maintains his or her own staff and personal computer. We share a business manager and a separate computer for general office management.

Over the years my patient base has consisted of a mix of oncology and internal medicine patients. Fortunately I have had a very strong relationship with one of the three major hospitals in the area. I also retain privileges at the other two area hospitals.

Dedicating myself to one hospital has helped me stay competitive and maintain referrals. I am recognized for my loyalty to this hospital and rewarded in turn with referrals. I am the only medical oncologist practicing solely at this hospital. Only one other medical oncologist practices at all three hospitals. A two-person oncology group and a solo practitioner are both based in hospitals where I do not practice.

In the mid-1970s I opened a chemotherapy clinic in the hospital where I primarily practice. The hospital assumed the risk for purchasing the drugs and kept the resulting profit. At that same time I also initiated the hospital's cancer program.

When space became available in my office five years ago, I transferred the clinic from the hospital back to my office. I developed an arrangement with a pharmacy that would mix the drugs and then directly bill the insurance company. I wasn't making any profit in that area, but I didn't assume any risk for reimbursement. My profit grew solely from the administration of chemotherapy. This year I plan to purchase and mix the drugs myself. I am accepting more risk, but I am also creating more opportunity to generate revenue.

Q *How did the hospital react to your transferring the clinic?*

A Needless to say, the hospital administration was not happy. Since then the hospital has tried to recruit medical oncologists to compete with me. So far they haven't been successful. I've been practicing for many years, and I've developed strong relationships with the hospital's medical staff, surgeons, and general internists who remain very loyal to me.

Presently the hospital is merging with another hospital, and together they are creating a joint cancer center. The hospitals are pressuring their oncologists to become employees of the cancer center, intending to recapture the clinic and its profitability.

Q *What are your primary concerns about becoming a hospital employee?*

A Autonomy and flexibility are very important to me. Working directly for the hospital would mean forfeiting them both to a certain extent. At the same time, however, employment with the hospital would offer financial security.

I've weighed what the hospital is prepared to pay against my potential revenue across the next three to five years, factoring in an assessment of my competition and my ability to maintain referral patterns. Closer to retirement, I will be ready to sell my practice. If at that time I'm *not* affiliated with a hospital, selling my practice may be difficult. Ideally I should sell when my practice is at its peak. If the hospital can guarantee a decent price for my practice, then I would be willing to work as a hospital employee for perhaps three years, then eventually phase into part-time employment.

Q *What advice do you have for physicians in solo practice?*

A Under the managed care system, the primary care physician is gaining authority over patients we care for. In many cases the relationship between the primary care physician and the medical oncologist is an adversarial struggle over control of the patient. In my experience, it doesn't have to be this way.

Referrals are the solo practitioners life blood. My advice is to work with the primary care physician as much as possible, and establish a pattern of supportive consultation. When treated with deference and

* *Name withheld to protect anonymity*

respect, the primary care physician is less likely to feel threatened, and may in turn increase the amount of referrals sent to the oncologist. For example, even when the primary care physician is not involved in the active care of one of my patients, I will often request a consult, even if it is only to hold the patient's hand. Oftentimes patients have known their primary care physicians for many years and have strong established relationships. My trust in the primary care physician invites him to trust me.

Dr. Y, a board-certified medical oncologist with a background in internal medicine and clinical pharmacology, began practicing medicine in the late 1970s. Dr. Y is the only medical oncologist serving a rural region where the nearest metropolitan area is ninety miles away. Managed care penetration in the area is less than 10 percent. Recently Dr. Y was approached by a large single specialty physician group interested in purchasing his practice.*

Q *Please describe the events leading up to the physician group's offer for your practice.*

A For nearly twenty years I have served patients at a private multispecialty clinic comprised of twenty-one independent specialty physicians, including surgeons, ob/gyns, pediatricians, cardiologists, gastroenterologists, pulmonologists, and general internists. I have developed a significant referral base through the clinic. As the clinic's only medical oncologist, I am interested in recruiting an additional oncologist, but this has been difficult.

Last year I was approached by a large single specialty group of five physicians in a metropolitan region ninety miles away. This group was interested in discussing joint venture opportunities between our practices. Initially our discussions centered on developing ways we could cooperate rather than compete. As time went on and as our discussions evolved, it became apparent that the group was interested in consolidating practices. Through me the group would gain my large referral base, which it believed could be expanded even further.

This large single specialty practice had previously sold its nonprofessional assets to a major oncology management firm. I was offered partnership within the practice, but with a stipulation that I would also sign a contract with its oncology management firm. In return for my practice, the management group would offer me a cash settlement as well as stocks and bonds paid out over a period of time. I would be obligated to serve both the medical group and management firm for a minimum of five years, but it was clear that they were interested in retaining me for the rest of my professional career. The contract stipulated significant financial hardship on my part if I voluntarily broke the contract before the completion of five years.

Q *In your opinion, what were the advantages and disadvantages of the offer?*

A Affiliation with a premier, well-established, and well-respected single specialty oncology group certainly has its advantages. Being a recognized member of this group could be helpful when trying to recruit an additional oncologist.

The financial consideration was also very generous. Of course, when assessing the offer, I had to keep in mind that part of the offer included an upfront payment for revenue that I would probably earn over the next five years at the clinic. In addition, my monthly salary—a percentage of my monthly billing—would be less than what I would make in my present practice. However, while my overall earnings per year would be less than my earnings at the clinic, when the "upfront" cash settlement and deferred benefits offered and the financial security of a monthly paycheck were factored in, the group's offer might in fact have exceeded what I would otherwise earn. The management company was confident it offered a superior deal.

I was hesitant to affiliate with the single specialty group and the oncology management firm for several reasons. Loss of independence was a major concern. Professional direction of my practice could be dictated by the group's officers. Managerial policy would be dictated by the management firm. In giving up my present practice I was concerned about my personal loss of control over patient load, charges, nurses, vacation schedule, and retirement planning.

At the clinic, my colleagues and I consult over administrative policies related directly to overhead operations. However, I do not receive input from anyone about issues directly involving my professional practice. Patient care decisions are made by myself in consultation with the patient and family.

Q *What factors ultimately led to your decision to decline the group's offer?*

A My unwillingness to become an employee after so many years of independence was perhaps the most significant factor in my decision. Secondly, I've been in this community for a long time, and I've built strong relationships with my colleagues. The clinic also made concerted efforts to keep me, promising renewed commitment to improve my oncology practice, possibly with a major building project, and to increase efforts to recruit another oncologist.

Perhaps the most pragmatic factor was that in all likelihood the clinic would have recruited another oncologist to compete with me. Had this happened, there was no guarantee I would continue to gain referrals from the clinic—referrals that the single specialty group was counting on for my (and its own) success. Some of the gains I could have made by leaving the clinic I could have subsequently lost.

Q *What do you predict for the future of managed care in your area?*

A Managed care penetration will come. When, I don't know. Hopefully, the medical community will band together and present a united front in terms of a product it presents to the managed care organizations. We will not be immune from managed health care. Our hope is that as a unified health care community we are going to have a significant say in how health care is delivered.

** Name withheld to protect anonymity*