

From my perspective

Because this issue of the *Bulletin* is dedicated to the concerns of the members of the American College of Surgeons' Resident and Associate Society, I thought this column should focus on the environment in which these young surgeons are likely to find themselves practicing.

As we all know, the government, physician and hospital associations, consumers, business consortia, and so on are spending a great deal of time and resources planning the creation of a new health care system. Most of these discussions, however, fail to recognize the internal changes occurring in medical and surgical practice that may significantly affect the way patients, regardless of insurance coverage, receive care.

Wither independent practice?

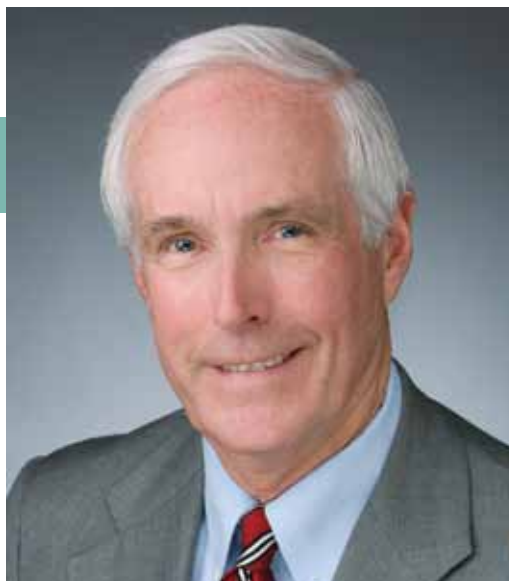
Perhaps the most noteworthy movement occurring within the profession is the migration from independent solo or small-group practices to hospital-based or health system-based practices. According to a report in the February 12 *New England Journal of Medicine*, the percentage of U.S. physicians who own their practice has been declining at a rate of approximately 2 percent for each of the last 25 years, and the percentage of independent surgeons dropped from 75.5 percent in 1996-1997 to 68.4 percent in 2004-2005.*

The reasons for the decline in independent practice are complex but can be traced largely to payment, regulatory, and lifestyle concerns.

Like other physicians, surgeons increasingly are growing tired of fighting with the government and insurers over declining reimbursement rates at a time when practice expenses, including liability insurance premiums, are on the rise. This financial stranglehold has led a growing number of physicians to give up independent practice and either to accept salaried positions in larger health care organizations or to retire early. It also may discourage young physicians and surgeons from entering private practice, especially when they are concerned about paying off the massive debt that they incurred during medical school and residency training.

Surgeons and other physicians also have grown weary of demands that their practices comply

*Isaacs SL, Jellinek PS, Ray WL. The independent physician—Going, going.... *N Eng J Med*. 2009; 360(7):655-657.



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with government-imposed regulations, some emanating from agencies that typically have little influence over health care. A recent example is the Federal Trade Commission's (FTC's) “Red Flags Rule,” which was scheduled to take effect May 1, but was delayed at press time. Issued in November 2007, this regulation requires entities that regularly extend, renew, or continue credit to establish a written program for preventing identity theft. The FTC has taken the unofficial position that hospitals, physicians, and other health care providers fall under the definition of “creditors” if they issue invoices, receive payments in installments, or otherwise defer payment for services. Each “knowing violation” of the regulation will result in a penalty of up to \$2,500.

Another driving force for the movement to contracting with hospitals and health care systems is the demographic change in medical school graduating classes and the lifestyle concerns of the new generation of surgeons. According to the American Association of Medical Colleges,

women accounted for 49.1 percent of medical school graduates in 2007.[†] Many women, and an increasing number of men, want to spend more time with their families and less time worrying about administrative details.

In addition, evolving public and professional demands for more comprehensive and validated care and electronic recordkeeping may be contributing to the decline of independent practices.

Attractive benefits

Most surgeons who enter large group and institution-based practices are seeking to break free from the hassles of independent practice. As part of these large health systems, they need not worry about reimbursement issues because generally they are salaried employees. Furthermore, the hospitals or health plans often take responsibility for liability coverage and for regulatory compliance. Hospital physicians also work a prescribed number of hours, so they have a good idea of when they will be off-duty and able to fulfill personal obligations. And, institutional practices afford surgeons more opportunities to provide coordinated care to patients with chronic conditions, to compare outcomes and adopt best practices, and to install and implement health information technology.

I have spoken with several surgeons who have left private practice to work for health plans and hospitals, and most of them seem very satisfied with their decision. For example, a surgeon in Fresno, CA, recently joined the Kaiser-Permanente health system. On a scale of one to 10, this surgeon rates his satisfaction with being a salaried physician as a 10. Before the move, this individual was experiencing all of the frustrations described previously. He says he is relieved that he can now focus on patient care rather than on the business of running a practice.

More and more residents also have expressed interest in contracting with large groups. For example, I recently met two residents at Scott and White Hospital and Clinic in Temple, TX, who are in the process of negotiating a salaried position at other institutions in Temple, TX.

Nonetheless, the movement has its critics. They worry that the intelligent, ambitious,

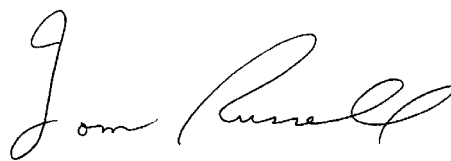
[†]Available at: <http://www.aamc.org/data/facts/charts/1982to2007.pdf>. Accessed April 27, 2009.

independent people once drawn to private practice will enter other professions that will allow them to have more autonomy. Others say that salaried employees have fewer incentives to be productive and to work hard. Furthermore, most large-group and institution-centered practices are found in metropolitan areas, so this trend may make access to care even more difficult for rural populations.

Effect on the profession

As a professional association, the American College of Surgeons must address these concerns and play a role in ensuring that surgical patients receive the best possible care—regardless of whether it is from an independent or a hospital-based practitioner. Obviously, we intend to maintain our rigorous requirements for attaining Fellowship in this organization. But we also need to think about the very different needs our members may have as they enter into institutionalized practices and what we can do to help those surgeons who want to remain in independent practice fulfill that aspiration.

Suggestions that I have received on this subject include establishing group purchasing alliances for medical liability insurance and for health information technology. The College intends to explore these and other possibilities. I am certain that many of you in the trenches have other ideas about steps the College needs to take in order to better serve your evolving needs. If you have recommendations about how the College can better serve the membership during this time of transition, I would like to hear from you.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.