Going Solo

Private practice otolaryngologists share the benefits and challenges of their business model

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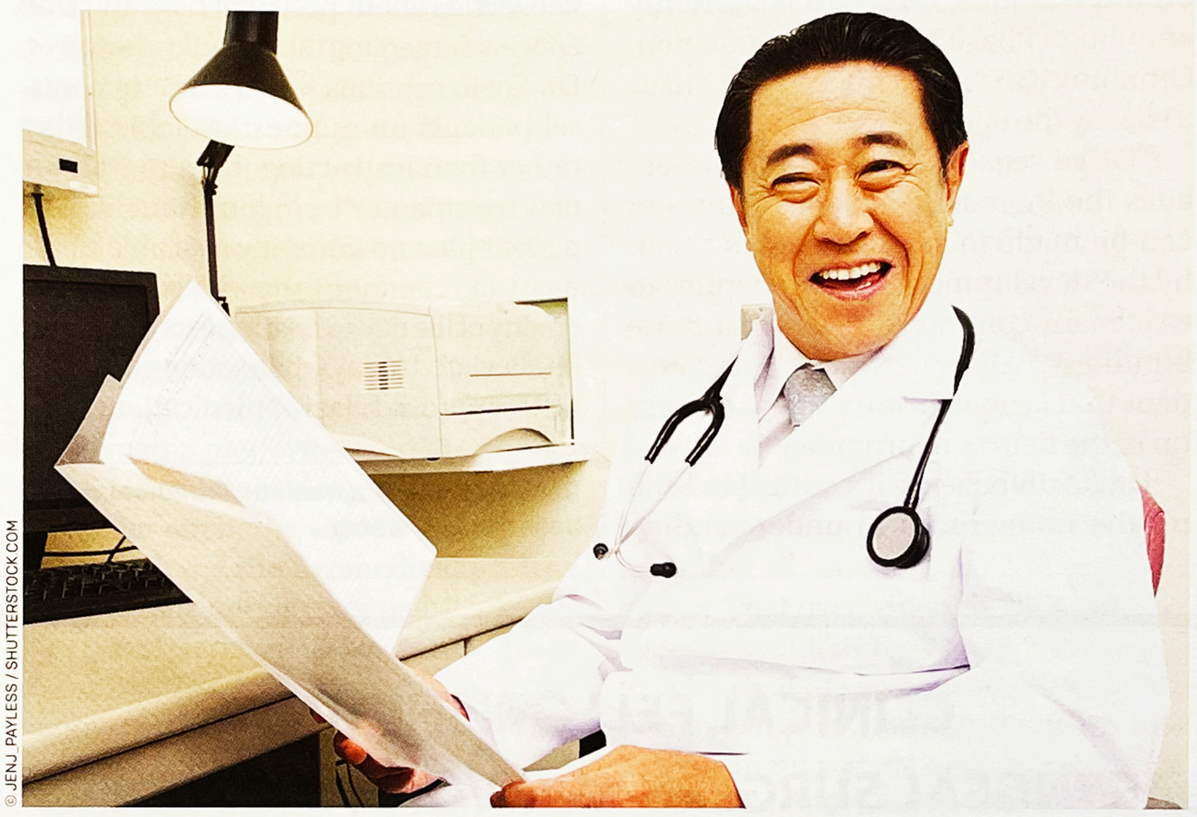
>
> ***—Adam Rubin, MD***

By **Thomas R. Collins**

Private practice otolaryngologists say they are under intense pressure with stagnant reimbursement, increasing administrative burdens, and challenges recruiting the next generation of physicians—all factors that have led to practice consolidation and sales to hospital systems or private equity.



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The loss of autonomy that has resulted from these changes can affect the quality of patient care, they say. And while many say that these shifts can have their upsides, others note that the dwindling of smaller, independent practices will continue to limit access to otolaryngology care in rural communities and can have ripple effects through the entire field.

Douglas D. Backous, MD, a neurotologist at Puget Sound ENT in Edmonds, Wash., was a fellow at The Johns Hopkins University School of Medicine, where he served on the faculty. After that, he worked at a multispecialty group, and then was employed at a hospital before moving to private practice in 2017.

"I have a pretty global view of all the different practice styles, and I can tell you that it all boils down to the fact that people don't understand the opportunity that private practice presents to physicians to really have a very fulfilling practice career," he said.

The dawn of work-hour restrictions for residents has made community rotations for residents less common. The University of Washington in Seattle, for example, no longer has a community rotation, said Dr. Backous. "So, residents coming out of training have no exposure to private practice—they don't know what it's like," he said.

He once thought that ear and skull base surgery was impossible outside the setting of a large institution; his view has dramatically changed, however. "What I found is that it's actually easier to do outside the structure of an organization," he said. "I think there's a misunderstanding that people in private practice aren't doing high-end complicated surgery and getting good outcomes. The problem with big institutions is that, oftentimes, you've got people telling you how to practice who don't even know what you do. That's very frustrating."

Benefits of Private Practice

To William R. Blythe, MD, an otolaryngologist at East Alabama Ear, Nose & Throat, a three-physician practice in Opelika, Ala., nothing beats being a general otolaryngologist able to meet all the otolaryngology needs of the community. "There's no other medical specialty that offers the breadth of technical challenges and medical expertise as does otolaryngology," he said. "A good general otolaryngologist can see large numbers of patients with a broad range of disease and pathology and treat the vast majority with skill and expertise." The physicians at his practice work hard and take lots of on-call duties, "but there is nothing that compares to being your own boss, answering to no one but our patients and one another, and sharing in the risks and benefits of a robust, busy practice," he added.

Christopher Chang, MD, a solo practitioner at Fauquier ENT Consultants in Warrenton, Va., said he cherishes his autonomy. "In a small group, it's very easy to make decisions," he said. "If I decide, 'You know what? I want another piece of equipment,' I just buy it. I don't need to have a committee meeting and go through a bureaucracy. In a larger group, you can't just get whatever you want when you want it."

"Preserving small independent groups also helps communities by keeping specialty care available in the local marketplace," added Eugene G. Brown, MD, RPh, an otolaryngologist at ENT & Allergy Partners, a 30-physician group in Charleston, South Carolina.

Challenges of Private Practice

The pressures on small, independent otolaryngology practices are mounting. When Dr. Blythe first began practicing, general otolaryngologists did "the bulk of the heavy lifting," evaluating and treating all patients and providing care to all but a few who were referred to tertiary centers, he said. Now, however, there is a trend toward subspecialization, with individual and group practices combining to form larger groups to take advantage of volume discounts for market leverage, better call schedules, and economies of scale.

To have a true subspecialty practice, Dr. Blythe said, a physician has little choice but to join a large regional group or an academic practice to have enough referrals. "As more ENT residents are pursuing subspecialization through fellowships, we can see that recruitment challenges will continue to increase in rural areas and in private practice overall," he said.

Adam Rubin, MD, vice president and director of the voice center at Lakeshore ENT in the Detroit area, said that the practice—now with 18 physicians, up from seven when he joined—has grown to provide subspecialty expertise to multiple hospital systems, to gain market share, and to support the infrastructure necessary to be able to handle the increasingly complex world of regulations and insurance issues.

"Staying on top of those things requires staff and can add significantly to the cost of practice," he said. "Private practitioners can survive, but size matters. You need to be able to spread cost over multiple physicians to afford good infrastructure and as negotiating power with the hospitals," he said. "One survival method is to grow. I think it's going to continue to be very

difficult for one- or two-person private practices to stay independent and survive in this environment."

Dr. Blythe agreed that larger private practices have advantages in scale that smaller practices don't have. "There's probably a sweet spot of financial efficiency between a solo practitioner and a mega group with bloated administration," he said.

To ease his administrative burden, Dr. Chang, the solo practitioner in Virginia, joined a multispecialty administrative group in 2014. But he did so in a way that preserved his autonomy.

In the case of one group he spoke with, he would have essentially become an employee, so he said no. Another insisted that he use their electronic medical record system, but he liked his own system, which he has tailored to his needs, so he declined that offer as well. The third group was just right: His practice still functions independently, but he had to negotiate for two years to craft the agreement, he said.

The most significant development in recent years, said Dr. Blythe, is "the constant drive and need of all payers and systems to control their own patient and referral base." Organizations such as hospitals and accountable care organizations are buying or contracting with primary care physicians and offering incentives to have their patients referred to that local healthcare system. Hospitals and healthcare systems are offering to purchase private practices, and if they refuse, they're employing primary care physicians who then compete against these practices and choke off referrals to the outside groups, he added. "This is a scenario that has been repeated over and over on scales both large and small, throughout communities of all sizes," he said.

With the idea that bigger is better and offers more protection, independent "super groups" have emerged. These groups, in turn, have generated interest from private equity firms, who see them as a financial opportunity to buy a group, then sell at a profit later. The main draw for physicians in these arrangements is a payout at the time of the second purchase, but the ultimate success of these arrangements in otolaryngology remains to be seen, Dr. Blythe said.

Paul Neis, MD, who runs Mountain Home ENT & Allergy in Mountain Home, Ark., has, like other physicians, been feeling the effects of diminished reimbursement. For instance, if it's determined during an office visit that a procedure needs to be done, there's no longer reimbursement for both the office visit and the procedure—it's one or the other, he said. (When a physician at a hospital has a patient visit, however, the hospital bills for the patient visit and a facility fee.)

Of course, he could just schedule the procedure on another day, but many patients live far away from his practice. "We live in a place where some of our patients drive two hours to see us," he explained. "I just can't in good conscience say, 'I'm going to make you come back next week so I get paid more,'" he said.

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—William R. Blythe, MD

RECRUITMENT IN PRIVATE PRACTICE

NEARLY FIVE YEARS AGO, CHRISTOPHER CHANG, MD, SET out to find a physician to bring into his solo otolaryngology practice in a rural part of Virginia. He's still flying solo.

Although he's hired a recruiter, placed ads in publications, and contacted chairpersons and attending physicians of area residency programs, so far, he hasn't found the right person. Because he can't keep up with the volume of patients by himself, he's stopped accepting new patients who live outside his office's county and the surrounding counties, and no longer accepts certain insurance.

"It's hard for me to recruit someone as opposed to some of the larger groups that seem to have a much easier time recruiting," he said. "I think the fact that I'm a solo private practice kind of scares them."

Finding a physician to join the practice would allow him to lift the geographic and insurance restrictions, and hopefully double his patient volume. Until then, he'll need to continue to ask area otolaryngologists to cover when he's away from the clinic.

Meanwhile, at Lakeshore Ear, Nose & Throat Center in the Detroit metropolitan area, recruitment couldn't be easier.

"We receive applications from numerous excellent candidates," said Adam Rubin, MD, a vice president with the group. "We're an attractive practice, as we offer the opportunity to provide subspecialty care, do research, and train residents in a private practice setting. A well-organized large private practice can afford many of the same opportunities as an academic center."

The practice recently hired four new doctors as other physicians with the group neared retirement, for a total of 18 physicians—16 otolaryngologists, one medical allergist, and one maxillofacial surgeon with a fellowship in head and neck surgery.

A small, two-person practice is about to come into the fold as well, Dr. Rubin said. "We're going to have 20 physicians soon," he said. "Practices are actually asking us now to help manage them because they see what we have to offer in terms of stability and infrastructure."

Paul Neis, MD, at Mountain Home ENT & Allergy, a three-physician practice in northern Arkansas, has been trying to find another physician for about three years. He and his fellow physicians are getting older and have plans to cut back on their patient volume.

A few years ago, he found a candidate who would have been a great match. In addition to the right career interests, the physician was a pilot, just like Dr. Neis and his son. He was in contact with the candidate for six months, taking him out to a steakhouse dinner in Chicago during an AAO-HNS meeting.

"That was probably, at that point in my life, the most expensive dinner I've paid for," Dr. Neis said. But the candidate didn't end up joining the practice—his wife wanted to be closer to her parents' home. "It was understandable, but yes, very disappointing," he said.

With plans to reduce his workload, he and the other physician in the practice will become hospital employees, receiving a salary plus bonuses for extra work, and his son will buy out their share of the practice. The hospital will make payments to help cover overhead at the office. Otherwise, the practice would have been hard to sustain, Dr. Neis said. This way, otolaryngology services will continue to be provided in the area.

Dr. Neis said he wishes young physicians had more awareness of private practice. He once suggested to the state's only residency program that residents spend some time at his practice during their training. He was told they were too busy at the academic medical center and couldn't spare the time.

"Nobody is exposing them to private practice general ENT," he said. "And that's the biggest disservice that I think is being done."

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Planning for the Future of Private Practice

In a recent poll of members of the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS), private practitioners reported feeling that their groups have little voice or influence in negotiating with payers and that reimbursement is flat. They reported that they're overburdened with administrative hurdles that complicate the delivery of care, and that they can't afford to build the infrastructure needed to navigate these challenges.

Private practice physicians, "consumed in their business of private practice," often don't relate to academy initiatives and feel unseen, unheard, and unrepresented, the poll found. As two-thirds of residents want to pursue fellowship, while 60% of practicing otolaryngologists are in private practice, "the pipeline is not satisfying the market need," according to the group's summary of the poll findings. "Practices are dying because they simply can't attract young doctors."

These concerns have prompted the academy to create a Private Practice Study Group, intended to identify challenges to private otolaryngology care, their root causes, and their potential solutions, with the goal of establishing a new section within the academy dedicated to these issues.

"It just kind of gnawed at me over time, seeing doctors become employed, and seeing the way that other stakeholders seemingly told doctors what their ground rules would be. I got involved in policy and the engagement in how the playing field would be constructed," said Dr. Brown, who spearheaded the AAO-HNS group.

The study group's forum on ENTConnect, a private online network for AAO-HNS members, started with 35 physicians and has quickly grown to over 400. The forum is dedicated to all otolaryngologic private practitioners, but so far has generated the most interest from smaller independent groups, Dr. Brown said.

"The people who are most active in the organization are independent practitioners who want to preserve independent groups," he said. "One value of being independent is that our costs are lower because we aren't attached to higher hospital-based site-of-service fee schedules."

The three main goals of the group are to develop and recruit leaders, to create more organized private physician involvement in advocacy for policies and regulations that are more mindful of private practice challenges, and to practice management and business viability support.

"We anticipate that the information shared on the ENTConnect platform will be invaluable to all practicing otolaryngologists regardless of practice setting," the group's leaders wrote in a guiding document.

Although the group is geared to private practice, it isn't an adversarial endeavor, Dr. Brown said. "Our efforts really are focused on making the specialty stronger overall, he said. "The business of medicine is complicated and anything that we can do to advocate for better pay and fewer administrative hurdles will help all otolaryngologists regardless of their practice setting. If we can improve access and the delivery of otolaryngologic care, then we can impact our patients and improve their quality of life. We believe that a healthy balance between private practice, academic practice, generalists, and subspecialists is vital to our long-term specialty success."

The very existence of the group has been a step forward, Dr. Brown said. Doctors seem relieved to have a group with whom to share their experience and try to find solutions to problems. "It's been electric," he said. "We've seen people come out of the woodwork wanting to be involved." ▲

Thomas R. Collins is a freelance medical writer based in Florida.