commentary

Community-Based Group Practice: Is the Grass Greener on This Side of the Fence?

By Neil W Treister, MD, FACC

It comes as a surprise to my patients and to many of my colleagues in "the private sector" that I am such an ardent supporter of the Southern California Permanente Medical Group (SCPMG) and of the Kaiser Foundation Health Plan—especially since I left SCPMG in 1988 to practice cardiology in the community setting and have not returned—not yet, anyway.

During the past 15 years, I have worked in several communities, at both large and small hospitals, and in solo practice. I also founded a single-specialty group practice that has grown to five cardiologists. While maintaining a private practice, I have consulted with health care organizations, served on hospital boards and committees, worked as medical director of a medical management company, and survived a health care MBA program at a local university.

I have seen great triumphs and huge disappointments in our disjointed, community-based, entrepreneurial, fee-for-service practice of medicine. And having trained as both an internal medicine intern and as a cardiology fellow at the Kaiser Permanente (KP) Los Angeles Medical Center and worked as a staff cardiologist at the "new" KP Woodland Hills facility, I feel well qualified to share with you some perspectives of life "on the other side of the fence."

I always just assumed that physicians in SCPMG understood what it was like to practice in a community-based solo or small-group practice setting. I was therefore surprised when, during my recent conversation with a prominent SCPMG physician, he expressed genuine astonishment at some of my stories about medical practice in the non-KP setting. He encouraged me to present this perspective for SCPMG physicians. Naturally, these ideas are derived from my own personal observations and represent a limited sample. However, I believe that my experiences are not isolated and reflect some fundamental challenges faced by all clinicians who try to deliver high-quality, patient-focused care in a community setting.

"Groupness" in Group Practice: Fact or Fiction?

My practice has almost always been busy, and I have little recollection of facing the threatening prospect of trying to make ends meet. Therefore, unlike the situation faced by many other physicians, financial uncertainty has not been my greatest concern in private practice. For me, the most difficult challenge in private medical practice is the absence of "groupness." In the private sector, many physicians are engaged in solo practice and thus are truly on their own. Most medical groups are small, and those that manage to stay together do not function as true groups: instead, they seem more like individual doctors sharing overhead costs. What holds them together (not always for very long) is that group practice can ensure reliable after-hours coverage and the misguided belief that their arrangement affords them economy of scale.

I always just assumed that physicians in SCPMG understood what it was like to practice in a community-based solo or small-group practice setting.

That doctors who are members of a group practice can feel alone and behave as individuals has tremendous implications. These clinicians experience little or no teamwork on a day-to-day basis and have no common professional culture based on shared values and goals. Because they do not think and act as groups, most doctors in private practice do not consistently or productively address issues such as mentoring new physicians, developing clinical guidelines for patient care, subjecting themselves to peer review, and adopting reliable processes for ensuring overall quality. Physicians who work together in "nongroups" often compete instead of collaborate, choosing to distribute income on the basis of individual fees collected and without any thought as to group performance.

The lack of a group culture and regular teamwork in community medical practice underlies what is probably my single most startling experience in private practice: In more than 90% of cases, I am asked to render cardiology consultation not by the ordering physician but by a nurse or ward clerk who has read an order in a patient's medical chart. The caller usually is unfamiliar with the ordering physician's concerns and often does not know the patient's current health status. In some instances, the physician who wrote the order did not discuss the case with me in person even though he

Neil W Treister, MD, FACC, practices in Fallbrook, California, and is the founder of Salus Heart and Wellness as well as medical director of the Cushman Wellness Center at the Sharp Memorial Hospital campus. He can be reached by e-mail at ntreister@salusheart.com.

or she was present on the ward—perhaps even sitting beside me! This situation gives the impression that the physician is embarrassed about wanting or needing assistance in the care of his or her patient.

I do not believe that physicians refrain from consulting me in person because I am difficult to talk to or because cardiology does not require physician-to-physician communication; in fact, my medical colleagues in virtually all specialties experience the same phenomenon. Nonetheless, this lack of face-to-face communication can lead to wasted time and resentment. For example, cardiologists making rounds at two, three, or more hospitals are periodically called back to a hospital because a chart order for a consult was not recognized promptly. This type of event has far-reaching implications for the quality, efficiency, and timeliness of patient care as well as for collegiality among physicians.

In most medical groups, time and forums are rarely devoted to meaningful discussion of patient care. Indeed, most medical groups lack the resources (time, money, and staff) to address the need for better education and timelier clinical information. These medical groups do not formally address adoption of new technology or how new medications might be used consistently. Decisions about acquiring a new piece of equipment may be determined by how much revenue the equipment can generate and not by its appropriateness and contribution to quality of care. In short, most physicians in private practice lose opportunities for learning, quality improvement and personal growth. In contrast, during my two years at KP Woodland Hills, each physician was expected to participate in Tuesday-afternoon educational meetings and had access to an information infrastructure created and maintained through adequate investment.

To this day, I look wistfully at electronic medical record systems …

When physicians act alone and not as a group, decisions and outcomes are more personal. In my private practice, for example, I had to create and run a small business and make decisions that had tremendous implications for my employees as well as for me. I had to decide who received a salary increase and when. I had to choose health insurance coverage for my employees and then pay for it out of my own pocket. I was seen as too permissive by some and too strict by others. At times, I could not find an experienced manager whom I could trust to oversee the front and back office functions. When equipment or processes have broken down, I have had to put patient care responsibilities on hold and switch over to solving business problems. I have been unlucky enough to be sued for malpractice and felt very much alone navigating that complicated process with little help from the people around me. To this day, I look wistfully at electronic medical record systems, knowing that investing in such a system in the near future would not be feasible for our practice.

In my experience, hospitals and physicians seem to be in conflict much of the time, and hospital-physician relationships are unclear at best. Hospitals are seen by physicians as their rightful domain—an entitlement—and physicians do not understand the many challenges and compromises that must be made. Physicians also do not understand why they cannot dictate important decisions about capital outlay and daily operations. Hospitals see physicians as selfish and shortsighted. Only a few physicians meaningfully contribute to how hospitals address patient care decisions; instead, most physicians approach these issues by asking, "What can I get to make my practice better?" The result of this situation can be underlying distrust and lack of any meaningful collaboration; rarely does better patient care result. I have repeatedly seen hospitals and physicians together tolerate illegible writing, medication errors, and disruptive physician behavior.

The physician's time in the community setting is unprotected and can be characterized as "feast or famine." A cardiologist making rounds at one hospital who has 14 patients yet to see at two other hospitals tends to have mixed feelings about running into an internist friend who might have just admitted a patient with atypical chest pain. Or a cardiologist whose service is quiet might be afraid of what another cardiologist would say at seeing a colleague wandering through the emergency room to see if any cardiac patients are waiting there.

Benefits of Collaborative Medical Practice

From a broader perspective, I am deeply troubled by the waste and inefficiency in the private practice setting. Outpatient tests are repeated and other services duplicated because we lose records or don't share them with other offices. We spend an enormous amount of time and money trying to extract information from other doctors' offices or from our own offices at different locations. We must bill a wide assortment of payers, each of which requires slightly different information. In addition, hospitals and managed care organizations update credentialing on a regular basis, each with a unique form that must be filled out by hand. In the private sector, specialty groups underuse nurse practi-

tioners and physician assistants, who can improve both efficiency and quality of care.

Our private practice model imposes a phenomenally large cost to the country. For some of the for-profit health plans with whom we work, less than 80% of each premium dollar (ironically termed the "medical loss ratio") is spent on medical care;[1] the rest is allocated to administration, marketing and profits. As a member of the health care community, I find distressing that these unnecessary layers of costs take chunks out of the health care dollars and rarely add the value that they promise. I am well aware that KP spends nearly 95% of each health care dollar on patient care.[1]

Another point is perhaps the most important. Having trained and worked in the KP system, I find the incentives under fee-for-service medicine very disquieting. If you are paid a fee for service, you can immediately—and rightfully—start worrying about whether you are yielding to the temptation to order more tests and create more visits—services that have immediate effects on your income. And another disquieting fact is that the tests and treatments you order often have substantial costs for your patients. I have found myself debating the cost effectiveness of my recommendations from the patient's perspective—a difficult, slippery slope. In addition, without good practice guidelines or adequate information systems, physicians having to make these decisions are hard-pressed to do so adequately and consistently.

As a result of lack of consistency in medical decision making, some practitioners do far too much, and some others do far too little. I have known cardiologists in private practice who administer treadmill tests annually, echocardiography regularly, and Holter monitoring routinely without evidence supporting the medical value of these tests in many cases. In contrast, when paid on a capitation basis for the same patient, these same physicians realize that such tests aren't needed "in this particular case." I found that in the KP system, I did not worry about how much money my decisions were costing the patient or whether I was personally benefiting from the services I performed. At KP, I practiced in a purer and more ethical environment—one that is very difficult to achieve in the usual private practice setting.

At KP, I practiced in a purer and more ethical environment—one that is very difficult to achieve in the usual private practice setting.

Conclusions

The private practice world is very different from the Permanente Medical Group workplace. In my tenure at KP, I experienced a highly consistent group culture that helped me make better decisions on a regular basis. The incentives were conducive to unbiased and patient-oriented choices. I had ready access to help from experienced people who were on the same team. Neither my colleagues nor I had to contend with the distractions inherent in running a business.

I admit, my perspective might have been clouded by 15 years' separation from KP Woodland Hills and might not reflect the current environment at that (or any other) KP facility. Moreover, I was particularly fortunate to train and work with some very special friends and role models, such as Jack Braunwald, Peter Mahrer, Joe Ruderman, Al Dreskin, Lew Seager, and Jeff Weisz. Perhaps my SCPMG experience was unusual. Nonetheless, if you are a PMG physician longingly peering over the fence and marveling at the green grass at the community hospital, you should understand that what you are seeing might be artificial turf. You may underestimate what you have and how it has molded and conformed to your personal and professional values and goals. The fit in the private sector might not be as good.

I left KP Woodland Hills in 1988 and do not regret my decision; I have learned much from the rich variety of my professional experiences in the "outside" world. However, I now practice cardiology part-time, which is the compromise I make to work in a "system" that is disjointed and inefficient. And—as I say each time someone asks—I am sure that if I ever go back to full-time clinical practice, it will be with SCPMG or in a similar organization that embodies the values and professionalism that are so important to me in my practice. ❖

Reference

1. California Medical Association. 10th Annual Knox-Keene health plan expenditures summary, FY 2001-02. [Sacramento (CA): California Medical Association; 2003] Available from: www.calphys.org/assets/applets/0102_knox_keene_report.pdf (accessed October 22, 2003).