

Better Off Alone? Why Physicians Don't Merge

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The era of the small medical practice is over. How many times have we heard that? It was widely proclaimed back in the 90s, in the wake of the Clinton administration's healthcare reform proposal. But 15 years have passed, and there are still plenty of physicians working in solo and small group practices. Despite all the predictions that small practices could not survive in an environment of "big healthcare," they persist. A report published recently by the U.S. Centers for Disease Control and Prevention¹ estimated that as of 2003–2004 more than 35% of office-based physicians were in solo practice, and roughly 66% practiced in groups of five or fewer. This article examines why, in spite of the challenges of being in solo and small group practices, many physicians still prefer the status quo and resist forming or joining larger groups.

Key words: Merge; solo practice; group practice; hospital practice.

THE CURRENT STATE OF AFFAIRS

It's not news that solo or small group practices have become more stressful as the healthcare system has become more complex. Treating an adequate volume of patients to make ends meet while managing staff, keeping up with the latest regulations, and finding time for the family is enough to make a physician wonder if the autonomy of being an entrepreneur is worth the hassle.

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What I see in my work with practices around the country (and this is confirmed in my conversations with colleagues in other firms) is that small practices struggle to maintain current income levels, never mind trying to increase revenue year to year. Small primary care practices sometimes limp along with income levels 30% to 50% below national averages.

When I ask physicians in these practices about joining a larger group or merging with another practice, even in dire situations where there would be a clear and immediate financial benefit to doing so, they show a surprising reluctance. They tell me they value their autonomy and don't want to be part of a larger organization. Later, many of these same doctors pursue a hospital employment relationship in which they lose that highly valued autonomy, and instead of working *with* their peers, end up working *for* a hospital administrator.

LESSONS FROM THE PAST

The 1990s saw major upheaval in the business of physician practice management, and it's rare to find a practice that didn't have some brush with it. Driven by fear of capitation, healthcare reform, or some unseen bogeyman, physicians sold out to hospitals, affiliated with practice management companies, or jumped into ill-advised mergers.

Hospitals lost hundreds of millions of dollars due to their inability to successfully manage doctors' practices. Physician practice management companies (PPMCs) failed so spectacularly as to almost become the definition of "mismanagement." Lawyers, consultants, and accountants with little or no experience in physician practice mergers created groups that were doomed to failure.

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The publicity around all of this was extensive and memorable. Groups that had been around for decades—legacy groups with stellar reputations—sold out to PPMCs only to disappear within a few years. One that comes to mind is the Nalle Clinic in Charlotte, North Carolina, which partnered with PhyCor in the early 1990s and closed its doors in 2000, after 79 years in operation. Another is the 120-doctor Burns Clinic in Petoskey, Michigan. It opened in 1931, partnered with PhyCor in 1994, and shut down in 1999. Perhaps these groups were flawed to begin with, perhaps not.

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To be fair, some physician organizations that were formed during the 1990s did survive and thrive to this day. But the very public failure of so many of these initiatives left a bad taste in the mouths of physicians and a reluctance to be “fooled again.” Much of the “group up or die” mentality was driven by fear. The horror stories of doing and undoing deals remain firmly planted in the memories of more than a few doctors. Anyone who lived through that period of time is understandably wary of the idea of becoming part of a larger organization. But that was then, and this is now.

THE ADVANTAGES OF A LARGER GROUP—REAL OR IMAGINED?

There are two phrases that roll easily off the tongues of physicians considering a merger: “negotiating clout” and “economies of scale.” There is something uniquely satisfying about the prospect of being in a position to call the shots, dictate the terms of a managed care contract, and “get back” at those “evil” HMOs. And everyone understands economies of scale. We’ve all heard “two can live as cheaply as one.” If only it were that easy, that simple.

Economies of scale in operating expenses are difficult to attain unless locations are consolidated and staffing levels reduced, both of which are easier said than done.

While a larger group can gain negotiating clout, success in doing so is far from certain. Simple practicalities and complex legalities must be considered. Merging with the primary intent to negotiate better prices may be considered anti-competitive, and an FTC investigation

What to Do If a Merger Isn't for You

Get creative. Physicians who want to stay in solo or small practices are doing all sorts of things to make it work. Concierge or boutique practices, micro-practices (working out of one small room with little or no staff), and working from a fully equipped medical van and making house calls are some of the solutions that have arisen in the past decade.

Get lean. Reducing overhead can go only so far (most physicians still need an office and malpractice insurance), but if you want to have a no-frills practice in order to maintain your independence, you can make some adjustments.

Get a simple life. For some physicians, living on less is the way to go. Running a small, lean practice, working part-time, and taking home \$75,000 or \$100,000 a year may be preferable to giving up autonomy in exchange for higher figures. Get clear about what you most value, and design your life around that. Money isn't everything.

Get involved. If you don't like how healthcare is going, get involved in shaping it for the future. Check for opportunities within your specialty organization, set up a meeting with your congressperson, write letters, educate your patients, or do whatever you think might make a difference in your area.

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There are some significant potential benefits that can be gained in a larger organization. An important one is the ability to recruit new physicians. Aside from the financial aspect (i.e., you need a cushion of cash to bring on an associate who won't be paying his or her own way for at least a year), there is the issue of having a practice that a potential recruit will find attractive. Offering a ready base of patients, a reasonable call schedule, good-quality management, and solid finances will help you recruit your first-choice candidates.

Physicians fresh out of training are often saddled with huge debt. Your ability to present a picture of long-term security and financial viability will work in your favor at recruitment time. Starting salaries are a real dilemma for small practices. Driven up by shortages in many specialties, we are now seeing starting salaries in excess of not only what a practice can afford, but also beyond what the senior partners are earning. If a practice can't generate income levels for its owners greater than the starting salary for a newly trained physician, the long-term viability of the practice is at risk.

Increasing the bottom line with ancillary services is more feasible in a large group. A small practice simply doesn't have the volume to support a radiology service or surgical suite. Larger groups tend to have an easier time obtaining financing to add these new services (as well as for building projects, practice expansion, and investments in new technology such as electronic medical records). Once a practice is at the 10- to 15-physician level, it can often persuade banks to forgo requiring physicians to make personal guarantees on business loans. You're more likely to think strategically and be able to plan 5 or 10 years into the future if you know you have ready access to capital.

And, finally, there is management. It is challenging for managers of small practices to develop and maintain the wide range of skills necessary to direct today's multifaceted physician practice. Larger groups have the resources to employ higher level administrators who can not only manage the practice, but who are also skilled in strategic planning and complex managed care negotiations, and who are equipped to make tough decisions when called upon to do so.

THERE ARE TRADEOFFS

When I work with physicians on a merger, the main issue is always the same: no one wants anything to change. Everyone wants the benefits of a larger organization while preserving their autonomy. In reality, a reasonable level of autonomy can be retained as long as individual office sites are not consolidated.

But there are tradeoffs. For example, personnel policies and benefits must be consistent, as must financial reporting. You won't negotiate the best prices on supplies if everyone insists on buying from their pet vendors. And if the new group offers health insurance benefits to employees and your group hasn't historically done so, you are going to have to start—and your costs will go up as a result.

When a merger is in its infancy, it needs positive energy and creative ideas to get off the ground. It does not need someone pointing out every imaginable hazard, downside, obstacle, and reason it won't work.

Every physician can't be involved in every decision. A governance structure that delegates the majority of the responsibility for management to a strong elected board is vitally important in my experience. I've worked with groups of 25 physicians who wanted to call a shareholders meeting every time a minor decision was about to be made. This reminds me of many hospital boards and just doesn't work. The ability to turn over decision-making to a trusted board is a right of passage during the critical first year of any new group.

AND STILL, MERGERS DON'T GET OFF THE GROUND . . .

I've found that physicians stay put, even in extremely challenging situations, for the following reasons:

- ***The need for autonomy.*** Physicians are trained to be independent. Being told what to do—whether by a colleague on the board or a nonphysician administrator—is unacceptable for many doctors. If you feel this way, you are probably better off continuing to go it alone (or nearly alone) and doing the best with what you have. (See sidebar “What to Do If a Merger Isn't for You.”)
- ***Start-up cost.*** Getting together to chat with colleagues about possibilities doesn't cost anything, but to get beyond early talking stages each physician has to ante up a sum of money to get started. The first investment should be for an experienced merger consultant. I've found that physicians who balk at making a modest investment to see if there is anything worth pursuing aren't really serious.
- ***No guarantee.*** Business, especially a start-up business, has risks, and many physicians are overly risk-averse. Some of this certainly comes from the failures of the 1990s, discussed above. The harsh reality is that groups may invest time and money, sit through numerous meetings, have a great business plan, and still fail in executing it. There are no guarantees except the guarantee that if you don't at least make a reasonable effort toward change, things will continue along the current path.
- ***Inertia.*** Sometimes doctors make noises about “getting together” or “joining up” but nothing happens. There is no momentum, no leader, no consensus builder, and no plan of action. In the 1990s, fear was the motivator. Today the motivator is more likely to be frustration, and physicians may be too worn down to take the steps necessary to get out of the rut they're in.

AND IF THEY DO GET OFF THE GROUND . . . WHY THEY STILL FAIL

I'll never forget a harried call I got from a doctor about 10 years ago. He said the physicians in his community had formed a “physician organization” and wanted to know if I could manage it. My company doesn't manage physician practices, but out of curiosity I asked him about their business plan. They didn't have one, he said, but they had some real nice legal documents.

In my experience (and I've been involved in more than a few of these deals), the number one reason mergers don't come to fruition once the process is underway is that physicians start by hiring lawyers. Don't get me wrong, I like lawyers—most of the time. They're valuable and absolutely necessary, but not in the early stages of a merger.

Lawyers live in the world of risk rather than in the world of possibility. When a merger is in its infancy, it

Table 1. Factors to Consider

| Method | Advantages | Disadvantages | Initial Steps |
|-------------------------|---|--|---|
| Join an existing group | <p>There is much less business risk; the group is already established and presumably successful.</p> <p>Management and infrastructure are already in place and operating.</p> <p>The start-up “pain” and mistakes have already been made and are in the past.</p> | <p>There is probably little room for negotiation—the group likely has a model for acquisition and compensation.</p> <p>You may not be given a full voice in governance.</p> | <p>Make sure your house is in order—strive to put the best face on your practice.</p> <p>Make sure all your physicians are in agreement and any internal issues are dealt with prior to beginning discussions.</p> |
| Form a new group | <p>You won’t be burdened or saddled by the decisions of others.</p> <p>You will be able to be part of creating something from scratch.</p> | <p>Start-up costs can be significant.</p> <p>There is business risk in execution of the business plan.</p> | <p>Find an experienced advisor to work through an initial feasibility study before investing major funds.</p> |
| Affiliate with hospital | <p>Hospitals learned from their early failed efforts at practice ownership and management and say they are better at it now.</p> | <p>Don’t expect a huge price for your practice; hospitals can pay only fair market value.</p> <p>The big buy-outs offered in the 1990s are gone, as are long-term salary guarantees. And expect productivity standards and targets.</p> <p>You’ll be successful if your hospital partner has either a successful track record or firm commitment to investing in adequate physician practice management infrastructure. Choose wisely.</p> | <p>Get your practice in order. Nobody wants to buy a practice that needs a management turnaround.</p> <p>Talk to peers and colleagues who have sold their practices, focusing on their post-acquisition experience.</p> |

needs positive energy and creative ideas to get off the ground. It does not need someone pointing out every imaginable hazard, downside, obstacle, and reason it won’t work. Lawyers drag physicians into technical legal details, like choosing the type of entity long before those decisions need to be made. Talking about whether you should be an LLC, S-corp, or C-corp is just a distraction until you’ve decided whether you want go into business with the folks sitting across the table. Competent and experienced healthcare lawyers are key to a successful merger, but don’t put them on the agenda until you have a pro forma financial projection, know what your business plan is, have weighed the risks and rewards, and have made a commitment to move forward.

Another obstacle is what I call the “unwinder.” These are individuals who willingly participate in the merger process while overtly or covertly attempting to undermine progress. Under the guise of “protecting my doctors,” unwinders are sometimes practice managers or physicians’ spouses who, for reasons of their own, don’t want to see the deal go through.

Unwinders can also be physicians who, for example, don’t want to lose power and control or who want to continue to use friends and relatives as the group accountant, attorney, or pension administrator. Attorneys (here I go again) and accountants can also be unwinders if they feel they stand to lose a client.

Unwinders show up in almost every merger—they are extremely common, come in many forms, and have a variety of motivations. All are counterproductive and have stymied many a potential merger.

When I begin working on a potential merger, I lay down the gauntlet early for potential unwinders. Just putting the issue on the table can prevent problems. If more than two groups are involved, I also insist on a provision that allows me the latitude to recommend that any group’s participation be terminated, subject to the vote of the other participating groups. As the objective expert, part of my role is assessing the “fit” of a group or physician to the merger. I find that making this request puts potential unwinders on notice and can neutralize their undermining activities.

The third saboteur of an already-underway merger is irreconcilable differences among physicians. This is a little different than the unwinder situation. Instead of a hidden agenda, there is a disconnect in terms of the business’ vision, personal or professional values, work ethic, views about money, cultural norms, or the definition of medical ethics. Irreconcilable differences don’t mean that anyone is right or wrong. It simply means there isn’t a good fit. Just as it’s better to cancel a wedding even if the invitations have been mailed rather than set two people up for future misery, calling off a merger due to irreconcilable differences is, in most cases, the best decision for all involved.

Three definitions of “merger”

The business definition: The combining of two or more entities into one, through a purchase acquisition or a pooling of interests.

The legal definition: Writing a long and very expensive prenuptial agreement that kills a forest of trees and no one will ever read until they go to divorce court.

The physician definition: Joining with some other docs to share some management functions as long as nothing changes in my office and no one tells me what to do or how to practice.

WAYS TO GET THERE

There are multiple ways to pursue becoming part of a larger organization. You can join an existing group, identify one or more practices similar to your own and bring the players together to form a new larger group, or you can affiliate with your local hospital by entering into a management agreement or by selling your practice outright. Each of these methods has risks and benefits. Table 1 highlights the pros and cons as well as the first few steps you should take if you're considering moving forward.

DON'T BE A LEMMING

When faced with the choice to merge or maintain the status quo, each physician has to do what is right for himself or herself. Sure, being in a small practice is challenging and probably not as financially rewarding as working in a larger group, but the decision must be made based on each physician's own personal and professional values and goals.

Don't be a lemming. Don't jump off the cliff just because all the other kids are jumping off the cliff. Know yourself, and do what is right for you. If you want to merge, you can make it happen. Just don't overcomplicate the process. If you decide to stay in a solo or small practice, then make that work for you. Think ahead to the day you retire and try to imagine what it would take for you to say to yourself: “I'm glad I chose medicine. Being a doctor turned out to be satisfying and meaningful, and I had a darn good time.” ■

REFERENCE

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