Private Practice:
The backbone of community health care

The Root residence in Slaterville Springs, New York, where Dr. William Root, founder of AΩA, and his wife, Anna, raised their four children, ran his private practice, and housed the AΩA national office. His medical practice was in one of the back rooms.

Joseph W. Stubbs, MD, MACP; introduction by Richard L. Byyny, MD, FACP

Dr. Stubbs (AΩA, Emory University, 1978) is President of Albany Internal Medicine, LLC, a private practice in Albany, Georgia.

Introduction

by Richard L. Byyny, MD, FACP

> "Medicine is always the child of its time and cannot escape being influenced and shaped by contemporary ideas and social trends."
>
> — G. Gayle Stephens, MD[1]

Alpha Omega Alpha Honor Medical Society (AΩA) was founded by a group of medical students 117 years ago. Since then, medical education and the practice of medicine have drastically changed.

In 1902, most medical schools were proprietary with variable quality curricula that included apprenticeship training by fellow physicians. Farming was the major industry, and production was increasing with the Industrial Revolution. Health care was unstructured, and doctors primarily worked as the only physician in a community, hanging out a shingle for a private practice run out of their home. Payment was fee-for-service, doctors often bartering with patients and accepting goods and services—chickens, pies, and other fair trades—in exchange for care.

William Root, MD, the physician credited with establishing AΩA, was a community physician who for several decades cared for the people of Slaterville Springs, New York, and surrounding communities.

Medical residency training in hospitals began in the late 19th century to provide more experiential education and training with increasing responsibilities for physicians. Residencies in medicine became structured and institutionalized for the principal specialties in the early 20th century, but even by mid-century only a minority of physicians participated. After World War I, the medical doctor degree was given upon graduation from medical school, but the license to practice was administered by each state board. Doctors-in-training became known as interns. By the mid-1920s the internship had become required of all United States medical graduates to get a medical license.

By 1935, there were major changes to medical education, including standardization of the pre-doctoral medical education, that awarded all physicians the same medical degree; specialization was based on extended graduate education or residency. That led to increased specialization and subspecialization; and the use of technology. Hospitals became a major focus of medicine using and developing technology, and medicine became more institutionalized, based in medical schools and city/county hospitals and evolving health systems.

The medical residency became the defining educational feature providing residents with the responsibility of patient management. Residents evaluated patients, made decisions about diagnosis and therapy, and performed procedures and treatments. They were supervised by—and accountable to—attending physicians, but they were allowed considerable clinical independence. The residency experience emphasized scholarship and inquiry as much as clinical training, and was considered the best way for learners to be transformed into mature physicians.

Between 1940 and 1970, the number of residency positions at United States hospitals increased from 5,796 to 46,258. Thus, the number of residents seeking specialty training soared.[2] However, during this time, private practice and fee for service medicine remained the predominate praxis of medicine.

Private practices in the U.S.

The American Medical Association has conducted several surveys with physicians in private practice. In the 1980s, physician practice ownership was dominant. In 1983, 76.1 percent of physicians were practice owners; however, in 2012 that number had dropped to 53.2 percent. The year 2016 marked the first year in which physician practice ownership was no longer the majority. According to data from that year's survey, only 47.1 percent of physicians were practice owners, of which 27.9 percent were under the age of 40, and 36.6 percent were females with some ownership stake.[3]

The report indicated, "most physicians—55.8 percent in 2016—continue to work in practices that are wholly owned by physicians."[3] The report also showed that 13.8 percent of physician work at practices with more than 50 physicians; however the majority, 57.8 percent, practice in offices with 10 or fewer physicians. The most common practice type is the single specialty group.

Multispecialty group practices are more likely to be wholly or partially hospital owned. The number of physicians working in practices owned by a hospital or integrated delivery system is more than 50 percent.[3] A number of factors are involved in these changes, including physician payment and compensation plans; outstanding student debt; the complex business of medicine; practice expenses; expanding use of technology, e.g., EMR; life-work integration; pursuit of higher paying specialties by physicians and corporate hospital and entities; complex regulations; and professional perceptions.

Despite these changes private practice remains common, especially in less populated and rural areas of the country.

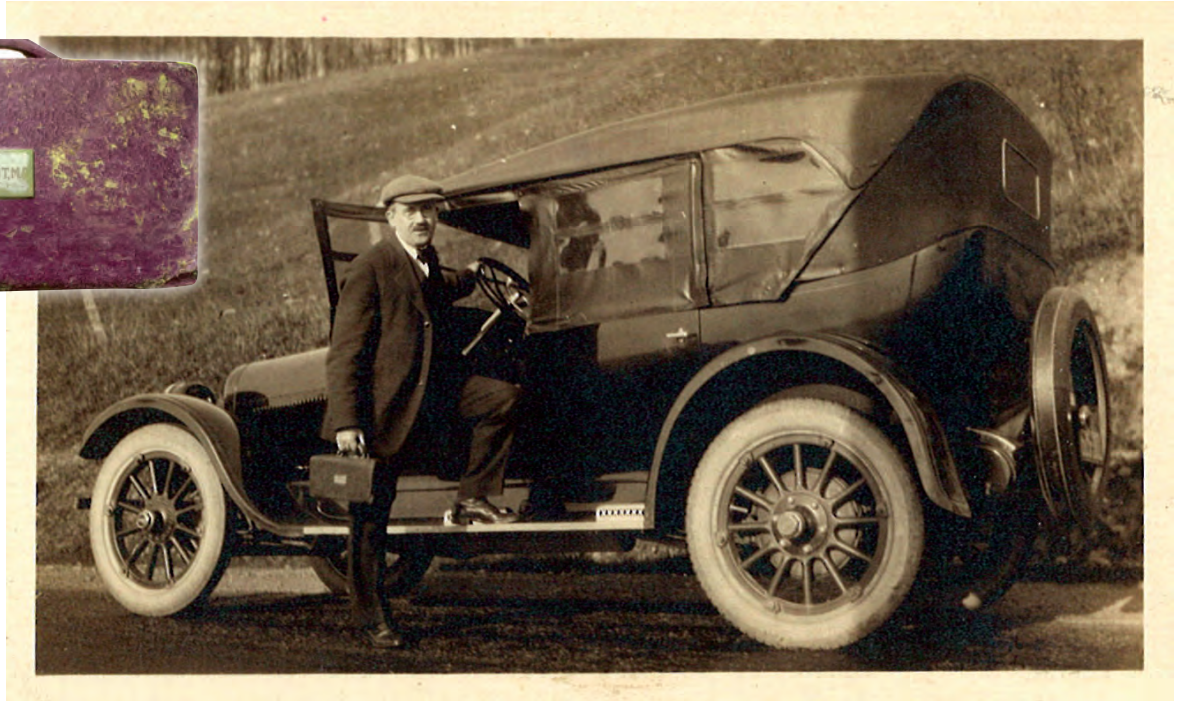
A pillar of the community

Joseph W. Stubbs, MD, MACP has been in private practice specializing in internal medicine and geriatrics for 37 years in the relatively small diverse city of Albany, Georgia on the Flint River. He is a physician owner of Albany Internal Medicine.

Joe graduated summa cum laude from William and Mary in 1975. He received his medical degree, also summa cum laude, from Emory University School of Medicine in 1979. He did his residency and was Chief Resident in internal medicine and primary care at the University of Washington affiliated hospitals in Seattle. Joe is board-certified in internal medicine and geriatric medicine and is a Master of the American College of Physicians.

As a community physician, Joe has published scholarly articles in *Lancet* and the *Annals of Internal Medicine*, and is very active as a physician and leader at Phoebe Putney Memorial Hospital in Albany. He is President of the Albany Internal Medicine Private Medical Group; a Clinical Assistant Professor of Medicine at the Medical College of Georgia at Augusta University; and Clinical Assistant Professor of Community Medicine at Mercer University School of Medicine.

Dr. Root's medical bag.



Dr. Root setting out on a house call in his Buick, circa 1923.

He is a leader in his local community, the state of Georgia, and nationally. He is an active member of the American College of Physicians (ACP) Georgia Chapter, and joined the Georgia ACP Governor's Council in 1988 where he has served on the Public and Professional Communications Committee, the Health and Public Policy Committee, and as Chapter Secretary.

Joe was elected to serve as the ACP Governor for Georgia from 1999 to 2003. In 2003, he was named a Laureate of the ACP Georgia Chapter and was recognized by ACP with an Evergreen Award for outstanding chapter activities and advocacy. He served two terms on the ACP Board of Regents, where he was Chair of the Medical Service Committee, and the Services Committee, and served on the Scientific Program Committee, the Member Insurance Subcommittee, the Publication Committee, and the Managed Care Subcommittee. He was the Chair of the ACP Foundation in 2009/10, and served as President of the American College of Physicians that same year.

He is a Master of the American College of Physicians, Fellow of the Royal College of Physicians in Edinburgh, and Fellow of the Royal College of Physicians of Ireland.

Joe was elected to the Board of Directors of the Alpha Omega Alpha Honor Medical Society in 2008, and served as President in 2016. He serves as the Chair of the Investment Committee, and sits on the Leadership Committee.

Throughout his career as a community practice physician, Joe has been an accomplished leader, teacher, mentor, and community member. He is the personification of the private practice physician who preserves and cultivates his local medical community as well as the medical profession at-large.

Private Practice: The backbone of community health care

by Joseph W. Stubbs, MD, MACP

I remember looking around the boardroom at my first national AΩA board meeting in 2008, and realized I was the only one practicing clinical medicine full-time in a private practice. All the others were accomplished faculty members and leaders of academic medical centers or major medical organizations, or incredible medical students. I wondered if this was just some opportunity for me to take refuge from the blistering challenges I face each day in the office, or did I really have something to contribute to this amazing group and organization. I asked myself, "Is AΩA really relevant to my work in private practice?"

Many of my colleagues in private practice perceive AΩA to be an organization that recognizes medical students for academic and professional excellence, and has little relevance to those of us in private practice.

At that first meeting, I looked at my briefing book and on the front cover was the insight for which I was searching, "Be worthy to serve the suffering." I then realized that AΩA is an organization that fosters academic excellence, teaching, and research, but more importantly, it is an institution that carries the torch of professionalism. This seemingly

simple almost trite motto contains within it profound and foundational implications for practicing physicians. The call for professionalism needs to be as loud and as central in private practice as it is in any other corner of the House of Medicine.

Our worthiness is not derived from title, status, financial wealth, or family background, but rather from an intense desire to serve. It involves a willingness to be vulnerable for the sake of others; to humbly replace our own needs with those of the patient; and to be physically and mentally present for our patients.

The ties that bind

Early in my career I was on-call for our medical practice when a patient of one of my partners who had been in the hospital multiple times with congestive heart failure was once again admitted and was not going to make it. The family and patient pleaded with me to have my partner come and see him. Though I knew how much my partners treasured their few moments away from work, I went ahead and called and informed him of the situation. He did not hesitate. He thanked me for calling and immediately came to the hospital. He met with the family expressing his condolences, and then used silence to give space for the family's grief. He held the spouse's hand and said, "You cared for him so lovingly and did all you could do." His words and presence were a defining moment in that family's ability to accept death and begin healing.

In return for the inconvenience of coming to the hospital when not on call, my partner experienced a sense of gratification and fulfillment through that deeply human doctor-patient relationship.

It's not always what it seems

Worthiness to serve requires trust—trust that as a community physician, and often times friend, you will be honest and forthcoming with patients. I once lost the trust of an elderly female patient who suffered from painful shoulder arthritis, despite multiple efforts to treat it. On one office visit she blurted out as soon as I walked in the room, "Why didn't you tell me about Viagra to help my shoulder pain!"

I replied in a confused tone, "Viagra?"

She said, "Yea, you know that drug being advertised where this guy tries to throw a football through a swinging tire but can't even get the ball to the tire, and then with Viagra he is able to throw that football like a rocket right through the center of the tire."

I hesitantly replied, "So, you think Viagra helped him with his arthritic shoulder?"

"Of course," she replied, "what else could it help?"

She had lost trust in my ability to care for her shoulder pain because I had not prescribed Viagra. Needless to say, the conversation to regain her trust was a delicate one, and not without some embarrassment as this woman was not only a patient but someone with whom I interacted with in the community.

Reliability and accountability

Trust also involves reliability and accountability. This can be simple, everyday things: returning phone calls on the same day the patient placed the call; or taking the time to alert other physicians who care for the patient about important changes in medications or conditions. Or, it can be big things like accepting responsibility and acknowledging when mistakes are made. It involves being transparent about prices you charge, and about your clinical outcomes.

A patient's trust comes from a belief that you as their physician are committed to stand by them throughout their illnesses, offering realistic hope, and doing all you can whether it be for cure or for comfort. It comes from your patients knowing you not only as their doctor, but also as their fellow community member who they see and interact with at church, the grocery store, and community events.

As a community physician you are many things to many people, all of which require confidentiality, reliability, accountability, trust, and friendship.

Opportunity trumps scorecards

The AΩA motto states "to serve," not to treat or to care for. As community physicians, we must always be mindful about rendering care in a manner that respects the patient's autonomy and ability to choose. I am a physician who, like all others, aspires to excel, particularly when it comes to quality scores. I like the blood pressures under 140/90, and the A1Cs less than eight.

My patient Rosemary was a chain smoker who refused to even think of quitting, had high blood pressure for which she was always forgetting to refill her medications, and was obese but loved Coca Cola. During every visit with Rosemary my quality metrics sank lower and lower.

The quality strategists might suggest dismissing such a patient due to persistent noncompliance, but such a decision would reflect not knowing the whole person. Rosemary started a soup kitchen for the homeless, cared for a husband with dementia, always wanted a hug instead of a handshake, and always wanted to see pictures of my grandchildren. Sure, I would try to nudge Rosemary into some more healthy decisions, but often at the end of a visit,

I wasn't sure who was the patient and who was the healer.

The opportunity to serve always trumps scorecards.

Committing time and resources to the patient

Patients want to be "served" with information and options to make informed decisions with their caregiver. This requires a commitment to continuous learning of both clinical skills and scientific knowledge in order to accurately diagnose and adequately inform the patient. The exponential growth in medical research and advances in medical knowledge make this very challenging. In the blink of an eye, something in the standard of care of my patients will have changed.

"To serve" also requires communication and time. Today, for every hour in the room with the patient, physicians are spending two hours doing paperwork, documentation, and electronic health record (EHR) work. Even during the time in the exam room with the patient, physicians are spending close to 40 percent doing paperwork and documenting in the EHR.

We need to turn this communication pyramid on its head because it is paramount that patients feel their stories have been heard before they are willing to become engaged in our assessments and treatment plans. They need to feel their stories are heard not just with ears, but with eyes, hands, and most importantly with the heart.

We have powerful and effective medications and treatments at our disposal, but none more effective and potent than empathy. The words of Francis Peabody are as true today as they were when in 1927 he said, "The secret of the care of the patient is in caring for the patient."[5]

In today's world of highly specialized health care, our responsibility as communicators is not just with the patient but also with the other physicians and health professionals. This has become extremely daunting at times as patients over 65 years of age are likely to see seven different physicians and fill 20 different prescriptions each year. Further, a primary care physician is likely going to annually interact with 220 other physicians in 117 different practices.[6]

The lack of coordinated care due to inadequate communication can prove disastrous. For example, a primary care physician refers a patient with abdominal pain to a surgeon for possible gallstone disease. The surgeon sees the patient, does a CT of the abdomen showing the gall stones but also sees a mass in the liver that turns out to be a hepatocellular carcinoma. The surgeon removes the gallstones and sends to patient back to the primary care physician, but the primary care physician never hears about the CT report showing a mass in the liver, resulting in a tragic delay of diagnosis.

We need to break down our silos of practice and expertise and find ways of sharing and communicating with one another. Much has been written about measures to resolve these care coordination problems such as Health Information Exchanges and referral contracts. All of these may be beneficial, but sometimes the simplest thing to do is just pick up the phone and call one another.

We are not there to serve just one sufferer or one patient, but to serve the population of "suffering", as a whole. As practicing physicians, we must take responsibility and accountability for the stewardship of the needed health care resources for all patients if we are to continue to have those resources for our own individual patients.

In 1970, total health care spending was about $75 billion, or $356 per person. In less than 40 years these costs have grown to $2.6 trillion, or $8,402 per person. As a result, the share of economic activity devoted to health care grew from 7.2 percent of the Gross Domestic Product (GDP) in 1970 to 17.9 percent of the GDP in 2010. The United States' health care costs far exceed other nations. Our $8,000 per person per year expenditure on health care is 50 percent more than the next highest industrialized nation (Switzerland), and 90 percent higher than many global competitors.[7] Yet, our quality of health metrics, such as infant mortality, mortality amenable to health care, and safety are in the cellar when compared with other industrialized nations.[8] To make matters worse, the Institute of Medicine estimates that approximately $750 billion annually, or 30 percent of medical expenditures, are spent on unnecessary care, inefficiently delivered care, excessive administrative costs, or fraud.[9]

Private practice/community physicians understand these issues all too well. They bring an expertise on what is needed, and what is important, on the front lines of patient care. They are leading the way in the implementation of care models that are more patient centric where the patient is not a care recipient but a care participant. They are developing models where reimbursement is value-based rather than volume-based. New team-based models of care, such as the patient-centered medical home, are transforming the practice of medicine where physicians are leading a team of medical professionals, all working at the top of their licenses, to provide continuous, comprehensive, coordinated, quality care.

Engaging the private practice physician in AΩA

We need to find ways of fostering more continued engagement of the private practice of medicine in AΩA. Much can be done at the Chapter level. Although our 132

Chapters reside in medical schools, they need to find ways of reaching beyond the walls of academia. With the help of the national AΩA office, Chapters need to find ways of identifying active AΩA members in private practice in their locales. AΩA physicians in the community need to be invited and encouraged to participate in the programs for electing and recognizing new AΩA members.

Each year, Chapters can elect as members three to five alumni who were not previously selected to AΩA but who have excelled in leadership, teaching, service, and professionalism. Chapters need to find ways of engaging AΩA members in the community to help in the identification and selection of such individuals. The broadening of the AΩA community beyond medical schools and academic health centers has a plethora of dividends. It fosters mentoring opportunities and encourages community physicians to serve as volunteer clinical faculty.

Participation in my local AΩA Chapter activities and ceremonies has had a powerful impact on me, reminding me, again and again, of why I became a physician, and reinforcing my commitment to "being worthy."

At the national level, the engagement of AΩA members in private practice needs to continue to be a priority. The majority of those "worthy to serve the suffering" are indeed in private practice. And, the AΩA Board of Directors needs to continue to find ways of seeking out qualified candidates in private practice to serve as Board members.

Engaging the interest of private practice AΩA members could occur through some of the national programs, such as the Fellows in Leadership program, which enhances the leadership skills of early to mid-career physicians in academic centers, medical organizations, or private practice. Since the inception of the program in 2014, there have been very few applications from people in private practice, and only one Fellow from private practice.

Additionally, to create engagement of the private practice physician, AΩA could consider the creation of a new award for private practice physicians, such as an AΩA Innovator's Award for members who in the practice of medicine help create novel solutions for health care delivery that create more patient centric, less costly, and better quality care.

Efforts to enhance the engagement of the private practice of medicine in the AΩA will be challenging but a benefit for all. With it, AΩA will be a stronger, more diverse organization and have a greater impact on the quality of health care in this country. Likewise, AΩA members in private practice need AΩA as a compass that always points them North, in the direction of professionalism, as a beacon illuminating a path of joy and fulfillment that being a physician can offer.

Ultimately, it is the suffering who we are worthy to serve who benefit the most from the unique breadth and knowledge that the private practice/community physician brings to the profession of medicine. These physicians have been a staple of the community for centuries, and with the shared knowledge of their academic health center partners, they will continue to be the local doctor with a shingle and black bag caring for families.

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The author's E-mail address is josephwstubbs@gmail.com.