REFLECTION

The Shoeshine Stand and the Renaissance of Primary Care

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ABSTRACT

Over the past century, family physicians have moved from small independently owned practices, many of them solo, to being employed by large hospital systems, corporate entities, or health systems. Today, almost three-quarters of all physicians are employed and the highest percentage of employed physicians are family physicians.

This essay contrasts the elements of independent practice with employed practice as part of what has been lost in the past half century, but what might be regained if physicians demanded more autonomy and control over their practices.

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In small towns and cities, one often sees medical practices in shopping malls, nestled between local small businesses and agencies. The practice usually displays the physicians' names and specialty. Some may be branches of large systems but are more likely to be independent doctors looking to accomplish the same thing that other small businesses want—to create a place that reflects their values and a belief that what they offer is needed by patients or customers. Like the clinics in New England when I started practice over 50 years ago, these offices express a personal rather than institutional vision of service. After all, there was the Mayo brothers practice before there was a Mayo Clinic.

Forty years ago, I traveled to Peru with a group of professional colleagues to see the political and economic development of the country as it emerged in the "new" Latin America. During my morning walks in the central part of the city, I noticed a long row of almost identical shoeshine stands.

The next day I decided to get a shoeshine, randomly chose one, sat in the chair and began to talk with the man whose stand it was. He told me he traveled every day from what was euphemistically called a "young town" but actually was a neighborhood of immigrants from rural parts of the country who lived in makeshift shacks powered by spider webs of jury-rigged electrical hookups with minimal water and sanitation. He carried his brushes, cloths, and polishes on an undependable overcrowded Lima jitney for an hour and a half each way to his stand. When I asked him why he persisted in the face of competition and time, his response was, in effect, because he owned his stand and he felt in control of his own life, unlike the mountain community he came from with no hope of ever having land or crops of his own. He was tired of being a serf and wanted the dignity of being responsible for his own work and the possibility of making it something.

Since that day I have looked more fondly on strip malls scattered throughout the United States—the ones made up of local owners and businesses who decide that people need a vacuum repaired, or want to buy vintage furniture, collect toy soldiers, need hairstyling or a massage, or have a craving for Chinese food. Small businesses account for most jobs in the United States each year—personal dreams, usually involving families, long hours, and unpredictable demand. But they brim with energy and confidence. Some of it is driven by desperation but all of it is driven by hope. While large industries will wax and wane, spin off, get sold, or downsize, the number of small businesses has grown by almost 50% in the past 30 years.[1]

For the greater part of the twentieth century medical practices were small businesses. Newly trained physicians looked for towns that were likely to support a new doctor. They moved their families. They borrowed to finance their offices and hire staff. They advertised their presence, showed up for civic events, befriended

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hospital staff, and introduced themselves to other physicians in the community. And then they waited to see if patients came.

By contrast, the organization of medical care in the United States in the 21st century has increasingly become corporatized. Smaller practices, hobbled with financial needs for infrastructure such as electronic health records (EHRs) and patient registries for managing chronic illness and prevention, acknowledged the need to find partnerships or support which often resulted in being bought by or absorbed into existing systems. Nationally, almost 60% of family physicians are employed and the percentage of all employed physicians is rapidly rising.[2] In some regions, employed physicians work in physician-owned multispecialty groups. In others, large hospital systems and academic medical centers own and operate the clinics. And of course, insurance companies are collaborators in all large systems. With the increased fragmentation of continuity of care, corporate entities like CVS and Walgreens and Amazon entering the urgent care world can negatively affect continuity of care even more. Those organizations measure success by market share. Larger market shares create larger practices and less physician control. Partnerships can give way to franchises.

Smaller practices have increased levels of communication among clinicians and staff, have lower levels of burnout and use more quality improvement processes.[3] Research in science innovation shows that small teams innovate and disrupt and explore and experiment less popular work while large teams develop ideas that have already been tested by small groups.[4] Trial and error in a small practice can be rectified quickly while large systems are slow to change or admit error. Smaller practices have higher levels of trust among clinicians and staff resulting in more cohesion, communication, clinician satisfaction, and retention.[5]

Over time, many newly employed physicians begin to understand what has been lost in the process of joining a large system. The design of their offices, control of their schedule, choosing the team they work with, how much time they spend with patients, deciding where their office is located, how to manage vacations and time off, are governed by policy rather than choice and by rules rather than discussion with colleagues and staff.

Being an employed physician is a mixed blessing. While financial and personnel responsibilities are ceded to the organization, so are physician autonomy and the personal accountability to patients that comes with ownership. Employed physicians accept the centralization of decision making, creating distance between the services they provide and the costs of those services to individuals and families.

Large systems could create small practices that would emulate the best elements of independent practice—local responsibility, freedom to innovate, and choice of staff—but they don't. Large systems are committed to standardization and, as a colleague put it, "commodification," as proof of quality. They would respond to a request for practice individualization with "If we do it for one practice, we would have to do it for all of them." Flexibility would lead to too much loss of control.

Increasing rules and regulations, however, are also motivating primary care physicians to look at recreating physician-owned independent practice, with all its challenges. Direct primary care clinicians are finding places to work where continuing personal care is valued and needed and where a sense of independence is valued by physicians.[6] Networks of small practices maintain local responsibility and control while creating economies of scale with improvement on measures of clinical quality.[7] In the National Health Service in the United Kingdom, practices in the most deprived areas of Scotland share experiences and innovations which resulted in a decade of reforms for the health service.[8] There are many examples of well-functioning local and regional Accountable Care Organizations in the United States whose mission is to support primary care practices and coordinate care but also recognize the need for individuality and flexibility.[9]

The Deming Cyle of PDSA (plan-do-study-act) for continuous improvement demonstrated that engaging groups of employees and managers who have a feel for what works and what doesn't has a better chance of improving quality than command and control. That process has a higher likelihood of success when members know each other well and that is more likely to exist in smaller practices. Including patients and community members as well as staff and clinicians in that process might be one way of getting primary care back to its community roots. Each community is individual as is each practice. "Freedom and flexibility to adapt education to each community" was one of the principles of the 1966 Willard Report outlining residency education in family practice.[10] The same is even more true in practices. Small, adaptable, and community-responsive practices with new tools, better communication, and networking can be a key element of a much-needed renaissance of primary care and family medicine. Primary care clinicians working in small practices with autonomy and responsibility while supporting each other's ideas and learning from them may not only improve the quality of their work but the joy they feel in doing it.[11]

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Key words: practice patterns, physicians; primary care issues: continuity of care, physician satisfaction, professional autonomy

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