THE MORE THINGS CHANGE...

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Column Editor

On November 1 and 2, 1926, 21 lay administrators and physician leaders of group practices met in Madison, Wisconsin, for the First Conference of Clinic Managers (which subsequently became the Medical Group Management Association). Invitations were sent to 37 clinics, including a number of clinics that remain prominent to this day (e.g., Mayo, Cleveland, Virginia Mason, Scott & White, Guthrie, and Marshfield). They addressed issues ranging from the philosophical (“What is the ‘atmosphere’ in your clinic?”) to the quotidian (“Are there many of you who use the window envelope?”).1

The transcript of the meeting reveals several issues these leaders identified as important for the success of a physician practice:

• **Teamwork** (“Building up and moulding together a thoroughly capable, well-balanced, smooth-running, energetic organization of men and women; developing and maintaining a close, constant co-operation between the strictly professional staff and non-professional staff”)

• **System** (“We all want system and we must very largely work out our own system to meet our local requirements. Systems in clinics do not merely happen.”)

• **Patient appointments and registration** (“Don’t you think that two rooms for each doctor makes quite a difference? “You can’t make an appointment for an exact time. We give the patient to understand that there may be a variance of an hour or so.”)

• **Pricing** (“I think the biggest problem directly facing this group today is to see that the cost of producing professional service is kept within the ability of the average citizen to pay. “We do not call them discounts. We call them adjustments.”)

• **Collections** (“Essentially, collection is resale. It consists in reinstating so far as possible the mental attitude of the customer at the time when he made the original purchase... How can we keep this memory green?” “People are accustomed to postpone payment as if the doctor were asking for charity instead of for money which rightfully belongs to him.”)

• **Charity care** (“We feel that it is better to dun a person for some time and to insist on their paying even a little bit, and then finally forgetting about it, than it is to allow them to go home and . . . broadcast that Doctor So-and-So did a big operation and didn’t charge a penny.”)

• **Office equipment** (“A year ago I made a trip, and I made a special study of bookkeeping machines.” “We have found one piece of equipment that possibly may be new to most of you, and that is cash registers.”)

• **Medical protective/malpractice insurance** (“We had our rates doubled and then we asked for an experience rating, and we were able to get what we had hoped we could get, and which they said was the first policy of its kind that had ever been written.”)

Some of these issues, and the responses of practice leaders to them, sound charmingly naïve to the modern ear. However, most of them ring true to the management of contemporary physician practices. This similarity suggests at least 4 hypotheses:

• **Hypothesis 1**: We have not made much progress in resolving these issues. Unlike other parts of the economy, physician services have largely remained a cottage industry. A plurality of physicians still are in 1- or 2-physician practices. This small size limits the amount of infrastructure and expertise that physician practices can devote to business problems.

• **Hypothesis 2**: Physician practices have not been — and still are not — well run. Too many practices may be relying on self-taught, inexperienced staff (including the physicians themselves) who do not appreciate the intricacies of practice management.

• **Hypothesis 3**: The issues facing physician practices in 2002 are the same as those in 1926, but the solutions are different. What worked for practices 75 years ago cannot be expected to apply to an environment with an overabundance of

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state and federal regulations, disparate and demanding managed care organizations, and empowered patients.

**Hypothesis 4:** The solutions to the issues facing physician practices are never permanent, but need to be tended to. Peter Drucker argues that every organization has a “theory of the business” that incorporates the assumptions, values, and competencies of those who run it. Eventually, every theory of the business — no matter how successful — becomes obsolete because technology, markets, or customers change. What may be occurring in healthcare is that the theory of the business behind physician practices is aging. To survive, those responsible for these practices must rethink the structure and very purpose of a physician practice.

I strongly suspect that the latter 2 hypotheses are more applicable than the first 2. After all, the traditional structure of physician practices has withstood 2 major onslaughts in the past decade: the rise and fall of physician practice management companies (PPMCs) (eg, PhyCor, MedPartners) and the frenzy of practice acquisition (and then divestiture) by hospitals and health systems. These failed attempts, despite an abundance of Wall Street funding and management “expertise,” have revealed the fundamental strength of physician practices.

Nevertheless, Hypothesis 4 suggests that physicians should not become complacent and assume traditional approaches will continue to succeed. The challenge to physicians — and those who work with them — is to devise practice structures and processes that place the primary emphasis on the delivery of care to patients, while recognizing the exigencies of the business environment. We do not yet know the exact form(s) of medical practice that will be needed for the future, but we do know the following exchange that took place at the 1926 Conference of Clinic Managers (which was replicated in spirit by the PPMCs and practice-acquiring hospitals of the 1990s) should never happen again:

“Doctor, what do you expect a business manager to know?”

“Everything. A physician shouldn’t know anything except how to operate.”

**References**