Multispecialty Clinic Practice

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ABSTRACT

A multispecialty clinic practice is a common practice arrangement for colorectal surgeons. A practice of this type has a variety of features, both positive and negative. This article explores the location, practice patterns, lifestyles, compensation, and academic opportunities associated with a multispecialty clinic practice. This information can assist younger surgeons in choosing a practice opportunity and guide experienced surgeons' career progression.

KEYWORDS: Colon and rectal surgery practice, clinic, practice patterns, compensation

Objectives: Upon completion of this article, the reader should be familiar with the characteristics of a multispecialty clinic practice.

A multispecialty clinic practice (MSP) is a common practice pattern for colorectal surgeons. This type of practice has both positive and negative features, depending on the surgeon's perspective and needs. In general, there are six or seven large clinic practices (e.g., Cleveland, Henry Ford, Lahey, Mayo, and Ochsner) and several medium or smaller clinics. These have many similarities but also some specific differences. This article describes the characteristics of an MSP and explores some of the variations including location, practice patterns, lifestyles, compensation, and academic opportunities. Descriptions of these characteristics have some overlap, and several of the topics discussed have an emphasis on the authors' home institution, the Ochsner Clinic Foundation, New Orleans, LA (DEB, DAM), and previous places of employment, (Henry Ford Health System, Detroit—DAM) or training (Cleveland Clinic—DEB).

LOCATION

The majority of MSPs were initially located on the periphery of major urban centers. Historically, these clinics were urban institutions developed from a variety

of ideas: a multispecialty surgical group could provide a higher quality of patient care (Ochsner), the average person and worker deserved the best possible medical and surgical care (Henry Ford), desire for a practice close to favorite hunting spots (Mayo), and even discord with the local medical school (Cleveland Clinic).^{1,2} With changing populations, these institutions have often maintained their core location while developing health care systems that broadened their outreach to match population shifts and bring tertiary care closer to the patients. As such, MSPs usually serve a large local population of patients and have a wide geographic referral base. Since the 1930s, the formative years of MSPs, these institutions have developed and flourished in all regions of the country, giving practicing physicians the opportunity to locate in regions of their choice. Furthermore, as these institutions have developed into tertiary care centers, they have created affiliations with institutions of higher learning (from medical schools to universities).

PRACTICE PATTERNS

Although we are emphasizing MSPs, all colorectal clinics, both large and small, are some form of group

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practice. Most of the large ones are MSPs, and some of the smaller ones are single-specialty groups. In MSPs, the colon and rectal surgeons are usually grouped into a department or section. As in academic institutions, a separate department of colon and rectal surgery carries more influence. A section within a general surgery department may have less influence in determining both the structure and function of the group. The number of colorectal surgeons in an MSP varies depending on the work available. Nonetheless, for the department or section to continue to grow and perpetuate itself, there needs to be a spectrum of age and experience. This requires an influx of younger surgeons who contribute new ideas from their training while benefiting from the experience of their senior partners. As the senior partners' practice matures, they may decrease their call and change the dynamics of their practice. For example, they can increase their anorectal surgery and endoscopy practice while decreasing the amount of major abdominal surgery. Often this practice shift can be accomplished with minimal alterations in their production numbers.

Regardless of the practice demographics, physicians in an MSP are either partners (actually own a part of the practice) or employees of the parent institution. In most of the larger groups the employee pattern is more common. As a partner (owner), you theoretically have more decision-making authority and have a direct financial stake in the profit or loss. As an employee, you have less authority but have some employee rights (e.g., due process, labor law) and a lower liability for institutional issues.

In the established MSP, there is a significant base of patients in addition to a well-developed referral pattern. In most situations, a new surgeon should expect to be busy from the start. Because an MSP serves the role of a tertiary care referral center and sees a large number of complicated and interesting cases, over time a surgeon can develop a challenging specialty practice based on individual interests. However, as the MSP grows and expands to new locations, a physician may need to develop a satellite practice in an area where the MSP's footprint is not welcome. One advantage of being in an MSP is having the backup of a large institution with all its resources. This should give the practitioner not only salary support but also referrals of patients from the MSP primary care physicians in that region.

Most MSPs have office space immediately adjacent or in close proximity to a hospital which is owned or closely affiliated with the MSP. Initially, most MSPs used one or two hospitals, minimizing time spent traveling between hospitals. However, as MSPs develop health care networks, surgeons are often required to practice at these outlying institutions, thus limiting the relations with department or division at the main facility. Most MSPs utilize a closed staff model (i.e., all or almost

all of the physician staff at the hospital are MSP physicians). Because all providers are members of the MSP, the staff often shares a commitment to the institution's vision, resulting in a quality of patient care that is usually consistent and uniformly high. As most MSPs use a closed physician staff model, the MSP administration can control access to its facilities as well as having a direct impact on resource utilization. Obtaining new equipment or supplies must usually go through some committee process. This degree of control can be a problem for the practitioner if he or she decides to leave the group. Many MSPs utilize noncompetes clauses, which can place limitations on future practice locations. Although these clauses are difficult to enforce, they can be very expensive to fight through the legal system.

The daily work schedule varies among MSPs and somewhat among colorectal surgeons in each institution. A surgeon's time is divided between the operating room, clinic, and endoscopy facility. As physicians mature, there is often opportunity to engage in administrative activities. At the Ochsner Clinic, each colon and rectal surgeon's weekly schedule includes two days of colonoscopy, a day and a half of clinic, and a day and a half in the operating room. Additional operating room cases and physiologic testing are often done on afternoons after colonoscopy. The time devoted to colonoscopy at Ochsner is more than at other clinics. There is additional time available for research and educational activities. In the Henry Ford System, clinical responsibilities were very similar; the main difference from Ochsner was the use of a satellite office. Staff utilized a satellite facility not only for clinic visits but also for endoscopy and ambulatory surgical procedures. Inpatient surgery was done at the main hospital, but follow-up and initial patient visits could be performed closer to the patients' homes. In Detroit it was not difficult to convince patients to travel 20 to 30 minutes to the main hospital for inpatient surgery.

The number of physician positions at most MSPs is relatively stable, but there has been recent expansion and some turnover of staff. Physicians interested in a clinic practice should contact the chair or section head at each institution and inquire about available positions. Postings on the American Society of Colon and Rectal Surgeons (ASCRS) website can also serve as a good, although often outdated, resource.³ Qualities often sought in applicants for staff positions at the larger clinics include quality of training, experience, and ability to operate, care for patients, teach, and conduct research. Newer staff are often recruited to bolster or expand certain capabilities at the institution (e.g., laparoscopic surgery, endoscopy, physiologic testing, research). Diversity of background and training is important. The applicant's personality also must mesh with other staff members and the culture of the institution.

LIFESTYLE

As MSPs are group practices, the call schedule is distributed. Larger clinics have less frequent call, but each physician must cover more patients when on call. If a training program is present, the residents and fellows spare the staff many duties such as emergency room evaluations, fever workups, history and physicals, and discharge summaries. Surgeons often work hard while at work but have sufficient time to spend with family and pursue outside activities. There are respected colleagues with whom to discuss difficult cases and resources to cover patients when the physician is spending time with family, on vacation, participating in educational activities, or becoming involved in organized medicine such as the ASCRS and the American Board of Colon and Rectal Surgery. Most institutions have delineated vacation and sick leave policies.

COMPENSATION

One potential drawback of an MSP is that physician compensation is ultimately based on income generated (revenue) minus overhead expenses. By definition, an MSP has a mixture of both specialists and generalists, each producing revenue and utilizing resources at different levels. Although this may lead to an optimal environment in which to practice medicine, it can often be an inefficient model of health care delivery. As MSPs grow, they lose the benefit of economy of scale, have a more difficult time controlling resource utilization, and often have a higher percentage of managed care patients than the solo practitioner.^{4,5} Furthermore, it is imperative that the MSP administration develop a compensation plan that the physicians perceive as fair, equitable, and understandable that at the same time protects the financial viability of the institution.

Individual compensation includes several components such as salary, retirement, malpractice, health and dental insurance, and other monetary and nonmonetary support. Salaries are usually guaranteed for the first year or two in practice. After this period, there is some form of increasing salary over several years ("ramping up time" or "buy in") until one reaches a "parity" level. During this period, the surgeon's productivity should also increase. At the parity point, each physician's salary is established by an institutional method. At some institutions, a salary level is determined by specialty and some method of seniority or experience. Such factors as historical salaries, market forces, and production are also taken into account. In addition, external benchmarks such as the surveys published by the Association of American Medical Colleges (AAMC), the American Medical Group Association (AMGA), McGladrey and Pullen, or the Hay Management Group can serve as a comparison.⁶

More institutions are currently implementing some form of performance-based compensation system.

Current measurements of production include gross charges, net charges, or relative value units (RVU). Gross production (what you bill as professional fees) is easy to measure but has limited relationship to actual money collected. Most institutions set their gross charges at some multiple of Medicare reimbursement (i.e., 200 to 300% of Medicare allowable). Updating or changing charges (which all practices should do periodically) will affect the total credit assigned to providers despite their putting forth the same amount of effort. Net charges correspond to actual cash received. However, in MSPs these charges are extremely difficult to determine accurately. Net collections are dependent on payor mix and efficiency of billing and collections. Thus, problems in the billing department or poor contracting could result in the physicians receiving less credit for similar work. At larger institutions, the billing function is often standardized and centralized. Although this limits the time a surgeon must devote to this function, the limited physician involvement can lead to uncertainty concerning the adequacy and accuracy of this critical activity. Few institutions are willing to share their net collections data, so it is difficult to compare net production between institutions.

Because of the difficulties in using billing or collection data to determine physician production, many MSPs are turning to RVU-based compensation systems. RVUs are based on the Resources Based Relative Value Scale (RBRVS). This scale attempts to value the resource used to provide a specific physician service (Current Procedural Terminology [CPT] code) relative to other services. All CPT codes receive a value relative to other CPT codes based on the work necessary to perform the service. Total work is broken down into three time periods: preservice, intraservice, and postservice work. Work is more than the time used to perform the service; it includes the complexity of the service, mental effort, knowledge, judgment and diagnostic acumen, technical skill, physical skill, psychological stress, and potential iatrogenic risk. Total RVUs are composed of work RVUs (RVUw), practice expenses RVUs, and malpractice RVUs.^{7,8} For compensation purposes, most institutions use RVUw. The RVUw produced by a provider can be used as a measure to compare the work of different providers or different specialties. This also allows the institution to have a benchmark against other institutions of similar size. There are limitations to work RVUs. Newer procedures can take 2 to 3 years to receive a CPT code and thus an RVU value. In addition, the work involved in codes can change over time. These value discrepancies and changes in physician work are adjusted, by federal statute, every 5 years.

Institutions can assign compensation value to work RVUs in several ways. As institutions receive a specific payment for each RVU (standardized Medicare reimbursement or contracted value), providers can be

assigned an institutional value for each RVU they produce. With this method, work is valued in a consistent manner and all providers receive the same compensation for each RVU they produce. This maintains the spirit behind RVUw that work equals work: one RVU of a surgeon's work is equal to one RVU of an internist's work is equal to one RVU of a psychiatrist's work. However, market forces and payor mix issues (e.g., some providers get mostly Medicare reimbursement whereas others may get more fee-for-service patients or lucrative contracts) make a salary based on this type of formula noncompetitive for some specialties. To compensate their providers competitively, the institution must make some modification to the calculated amount to bring the salary in line with market values. To avoid making this kind of modification (which may be politically uncomfortable for some institutions), most institutions use a specialty-specific RVUw compensation value. This value is calculated by dividing compensation received by a specific specialty by the RVUw performed. In this type of system, an internal medicine provider may receive \$60 per RVUw and a colorectal surgeon may get only \$46 per RVUw. Typically, proceduralists generate larger numbers of RVUw than nonproceduralists. Unfortunately, although the RVUw data generated allow the institution some external comparisons and limit the problems associated with charges, these specialty-specific RVUw payments are in many ways just a surrogate for the charges/collections model.

Several management firms or associations have collected compensation and production data from groups or institutions and make it available to members of the organization (e.g., AMGA) or offer it for sale.⁹ Administrators of most large institutions use one or more of these surveys to set or compare their compensation plan with national benchmarks. Data from one survey are presented in Table 1. Unfortunately, each of these compensation or financial surveys has limitations. The data compiled are only as good as the data received. The data are submitted by the institutions and their accuracy varies. The groups sampled (large versus small, academic versus clinical) and the sample size affect the usefulness of the data. Colon and rectal surgery is a small specialty, and the number of respondents in typical

surveys has ranged from 20 to 60. With this small sample size, activity or changes by a few institutions (such as hiring several younger surgeons or reporting incorrect data on a few individuals) can significantly alter the data. In contrast, specialties such as general surgery with hundreds of respondents have better statistical sampling. Most organizations have some type of administrative committee that sets the salaries (using some or all of the criteria described previously) on an annual or semiannual basis. Negotiation by the chairman, section head, or physician with the committee is often a significant factor in determining final value of compensation.

At almost all clinics, malpractice coverage and health and dental coverage are included in the compensation package. Retirement options vary from defined compensation plans to opportunities for 401K, 403B, or 457 plans. Institutions that do not have a defined plan usually provide some form of match to the employee's participation in other retirement plans.

As discussed previously, most of the larger institutions provide support and encouragement for participation in activities outside the clinical practice. These include the society (ASCRS), board, American Medical Association, American College of Surgeons, regional and state societies, and socioeconomic entities. Support may include time away from work, stipends for dues, or production credit.

ACADEMIC OPPORTUNITIES

Most MSPs have associated training programs. These may be general surgery or colon and rectal surgery residencies or both. Trainees are a mixed blessing. They perform many of the less desirable components of patient care such as histories and physicals, discharge summaries, daily rounds, and orders for diagnostic studies. The price for shifting some of these patient care activities is having to relinquish the performance of procedures or evaluations to others. In this form of practice, the physician often needs to supervise and instruct rather than doing it him- or herself. This takes a different skill set and personality, which must be understood and embraced if a physician is to be happy and successful. For individuals who like to teach, an MSP is extremely rewarding. It can

Table 1 Compensation Data for Colon and Rectal Surgeons

Category	No. of Groups	No. of Responses	20th Percentile	Median	Mean	80th Percentile	Standard Deviation
Compensation	18	67	274,811	327,927	357,410	404,000	138,510
Gross Production	16	54	1,069,16	1,466,136	1,698,608	2,228,410	815,822
Work RVUs	13	41	5,491	7,782	8,045	10,474	2,776
Ratios: compensation to gross production	16	54	16.6%	24.7%	23.8%	29.9%	
Compensation to work RVU	13	41	\$33.08	\$46.60	\$58.03	\$47.53	

From American Medical Group Association Compensation & Financial Survey. 2005 report based on 2004 data. Available for purchase at www.AMGA.com.
RVU, relative value unit.

be especially gratifying to see former trainees achieve professional and personal success.

At most clinic practices, there is abundant opportunity for scholarly activities. Large bases of patients and institutional support provide the means for research and publication. Most MSPs have affiliations with medical and graduate schools that allow basic science collaborations. Senior staff often serve as mentors, providing guidance and assistance with academic pursuits and participation in professional organizations. The prestige of clinic affiliation often leads to invitations to participate in meetings and symposiums as well as to submit manuscripts. Many institutions encourage these activities through compensation methods described previously and by providing protected time.

SUMMARY

A multispecialty clinic practice can be very rewarding. It has characteristics of both an academic and a private practice. The exact balance varies among institutions. If the features match the desires of the individual surgeon, an MSP will be a good career choice. It is hoped that the material included in this article will aid the reader in career choice and provide guidance in career progression.

DISCLOSURE

The authors are employees of the Ochsner Clinic Foundation, a large multispecialty clinic.

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