INTRODUCTION

The purposes of this article are

- to define and understand the market forces which have lead to professional loss of income, dissatisfaction, and disillusionment;
- to redefine "private practice of urology;"
- to outline and discuss potential models for urologists to regain clinical, professional & financial autonomy; and
- to understand the causes leading to "wither private practice".

The definition of "wither" is …to make or become shriveled, to lose or cause to lose freshness and vitality." Clearly, this crisis of withering of our practice of urology is upon us.

The Health Policy Survey in 1998 by the Western Section AUA, reported that 29.5% of their urologists were dissatisfied with their profession. 46.7% were specifically not financially satisfied, as 50% of the Western Section, AUA, reported an income decrease from the previous year and 54% of the urologists noted income decrease when compared to their income three years ago. 39% reported a decrease of income of 10-50% when compared to three years ago.

Today’s main concerns of American urologists are (1) loss of income, (2) loss of professional satisfaction and autonomy and (3) inadvertent fraud and abuse from coding and billing of their private practice (table I). The loss of income is well illustrated by the Western Sections AUA Survey (1998). The loss of professional satisfaction and autonomy is quite real in market places where there is more than 20% penetration by managed care, such as California. Physician incomes have decreased by 30% or more in California and the cost of professional work has dramatically increased through the constant need for prior treatment authorization, justification and accountability, including frequent prospective and retrospective denial of payment of services already rendered. The costs of time and labor to provide adequate standard of care for our patients have dramatically increased. Managed care has become more officious and onerous by recruiting physician specialists with MBAs to deny more complex and expensive services.
They have established “technology” committees to assess new and old therapies and reclassified them as “investigational” and thereby denying payments. The net outcomes are decreased revenue, inefficient practice environment, unhappy patients and frustrated physicians.

Physicians feel that they are assailed by outside forces of managed care and now government with the mandate for coding and billing predicated upon "template practice of medicine" where professional work is rated by a point system prior to conversion into a payment schedule. This new system of accountability and practice is a cultural affront to the private practice of medicine.

It is anticipated the by year 2007, health care spending will double and increase to more the $2.1 trillion or a whopping 16.6% of our nation’s gross domestic product. Spending per person will rise from $3759 in 1996 to $7100 in 2007. These increases will be mostly by increase in the costs of new technologies and new drugs. 85% of working Americans with health coverage are now already enrolled in some form of managed care plans and Medicare spending will be constrained by the 1997 Balanced Budget Act, easy savings by switching from traditional indemnity coverage have already been realized. Urologist incomes will continue to decrease unless they belong to practice models, which will allow them to take advantage of ownership of new technologies (ancillary revenues) and alliances with drug companies (clinical research and drug distribution).

In-order for the private practice of urology to survive the forces of managed care, the current proficiency in science, technology and healthcare will not be enough, as the practice of urology in our local communities has become very complex. Urologists must partner with each other and with professional management and finance to gain access to ancillary revenues in the new environment of healthcare.

DEMOGRAPHICS OF UROLOGY INTEGRATION

AUA Gallop Poll of 1995 showed the 68% of urologist are in single practices (36%) and three or less (32%), 18% in groups of 4-5 physician, 11% in groups of 6-10 practitioners and 3% in groups of more than 11 practitioners. However, in 1998, we have spoken to more than 4000 urologists in America and have noted many forms of loose integration of practices into medium and large IPAs and MSOs. Some groups are now as large as 100 members. Other aggressive physician groups have organized into single specialty networks. The advantages of these loose networks are strong physician leadership with "benevolent dictators" linked with a contracting team for local contract negotiations. Some groups are able to provide infancy data on differentiating outcomes and cost for contractual advantages. More importantly they have been inclusive of most urologists in their community to stabilize reimbursements.
However, the services rendered by urologists (consultation, diagnoses and surgery) will continue to decrease as service commodities, as global capitation rates inevitably fall in their local communities. Success is predicated upon access to professional financing and management who will provide ownership of ancillary revenue projects (technology), and management of data and information (medical information system). Unfortunately, professional management and financing is expensive and difficult to develop. Most physician owned IPAs and MSOs are poorly capitalized and managed, and as a result in California, more than 50% of large integrated IPAs and MSOs are now bankrupt.

PRIVATE PRACTICE REDEFINED

Professional dissatisfaction and malaise by urologists is due to the perception and reality that we are being assailed by outside forces much stronger than us and our inability to control our economic destiny. Unfortunately, we may be the most caring and professionally skilled urologists, unless we are able to sustain our values, dreams and lifestyles, frustration, disillusionment and depression is to be expected. Although our professional associations are doing their best to impact the macroeconomics on the regional and national basis, our values, dreams and expectations are determined in our local communities. Despite increased productivity by physician practices, incomes have continued to decrease. Moreover, managed care has created conflict of trust between physician and their patients. This is especially true in a capitated environment. Trust is a fragile but firm belief or confidence in the honesty, integrity, reliability and justice of another person or thing. This is the critical foundation of an effective patient-physician relationship.

To be satisfied with the private practice of urology we need to reexamine the definition of "private practice". We all understand the "practice of medicine" as medicine is not a perfect science and as such we learn from each other and from our patients. We attend continuing medical education courses because the knowledge, science and technology change. We share our successes and failures with our colleges to increase the total collective clinical experience. The controversy is what is "private". "Private" is the total sum of our knowledge and experiences which we share in trust with our patients, one patient at a time. This definition of "private practice" meets the ethics and values of our practice within our community. The joy and satisfaction of "private practice" does not even consider the issues of financial remuneration. However, it is still predicated upon financial satisfaction and stability.

UROLOGY PRACTICE MANAGEMENT COMPANIES (PPMCs)

As an industry practice management companies on Wall Street has fallen into hard times and disfavor when Phycor and MedPartners failed to merge in February of 1998 and FPA
declared bankruptcy, leaving physicians in California with millions of dollars of unpaid professional services.

The goals of practice management are well and good, by providing professional management, marketing, scales of economies, contracting, improved quality of care, risk diversification, disease management and capital development for ancillary revenue. But how and why did they fail? In order for physician practice management companies (PPMCs) to succeed, they must have physician leadership, commitment, and participation, in partnership with professional management and financing. Professional management cannot solve the conflicts within the 28 specialties of medicine competing for the same discounted capitated payment, as we have often seen in large "integrated" IPAs and MSOs in California and elsewhere. Benefits need to be in alignment with all parties (partners). Such is usually not the case within large, multi-specialty IPAs or MSOs in California, especially if it is a "gatekeeper" model. Single specialty urology PPMCs have the advantage of similar culture, vision and mission.

The first generation PPMCs were focused upon consolidation of practices rather than "same store growth" (physician practice growth). Clearly the values of professional management is to improve the efficiency of each practice one at a time by applying business principles of accountability, budgets, staff management and the use of the latest practice management informatics and electronic medical records. Professional management can assess local strengths and weaknesses of professional practices and develop local plans of operations to sustain and gain market share through direct marketing and local contracting. Contracts can be negotiated locally and regional benchmarks can be developed, thus lending credibility during the negotiation process.

The successes in PPMCs have been demonstration in many single specialty management companies such as American Oncology Resource, Inc and Pediatrix, Inc. They have been able to create "same store growth" by improving coding/billing and thus fraud proofing each practices one at a time. They have successfully developed and implemented clinical guidelines for efficient and proper monitoring of care and quality of drug management of diseases. Both companies have sustained continued 20% or more growth each year in the past seven years. Critical to their successes is their understanding and mutual respect of the partnership with physician leadership and professional management. Pediatrix Inc is now the highest valued PPMC traded on Wall Street.

There are numerous varieties of second generation models of PPMCs today and each need to be reviewed, assessed by their success or failure in their local markets. The emerging single specialty urology PPMCs are at their infancy and only time will tell if they will be successful. Clearly there is a continued strong interest of American physicians to join PPMCs.
CODING, BILLING, FRAUD AND ANCILLARIES

The greatest fear and concern of American physician today is committing inadvertent fraud and abuse by the need to implement HCFA 1999 standards for coding and billing. This infancy accounting systems is both complex and contradictory to the practice environment of most thoughtful practices which are focused on patient’s needs, fear, satisfaction and physician communications and bonding of trust during their professional encounter. Now physicians need to be focused upon both time and volume of documented activities prior to coding their billings. The easy answer is a software program, which encodes these activities while physicians continue to work in their caring environment. However, a simple and reliable software is not yet available in urology and instead we have sponsored a new educational industry teaching physicians the new methods of coding, and billing to allay their fear of fraud. This is truly another clear example of creating inefficiency, cost and complexities within our practice of medicine. Our practice cost will undoubtedly increase significantly as a result of this governmental regulation and the negative impact upon patient care and trust will be immeasurable.

Ancillary revenue opportunities in urology are numerous but they will all require professional management and financial analysis prior to development and implementation. The principles are to own the technologies and capture the facility and technical revenues in partnership with other medical specialists and cooperative integrated delivery systems (hospitals). We need to provide leadership and guidance to our business partners so that these services are ethical and have sustainable quality for patient care. Each model requires a unique analysis in the local environment for cultural acceptance and implementation. Urology as a profession has just begun to explore its mandate for requisite services within its professional horizon. Clearly, the next revolution in urology advancements will be non-surgical or lesser invasive management of urology diseases. This mandate has the commitment and sponsorship of patients, technology and drug industries. Urinary incontinence is such an example. Non-surgical incontinence in our senior population is a major social concern effecting quality of life and cost, yet few urologists have committed their interest to addressing this societal concern. Incontinence has been estimated to be greater than $20 billion dollar industry.

The pharmaceutical costs in urology will be the greatest concern in this decade. The payment by health plans for Viagra for impotence will singularly increase the cost of monthly healthcare premiums by $1/month. Future genetically engineered drugs will significantly change how we will practice urology. Partnership with drug industries for clinical research and appropriate drug utilization is absolutely necessary as another significant source of urology services and ancillary revenue.

CONCLUSION
It is no longer tenable to continue to diagnose, to provide consultation and to perform surgeries to sustain the private practice of urology. This form of "private practice" of urology is doomed to withering. We need to create and develop a sustaining practice model(s), which capture the entire healthcare dollars for urology care within our community.

It is still unclear which model(s) will survive. It is clear that urologists must understand and change their vision of "private practice" so that their practices will not "wither". This vision must include patients within their communities and professional management and financing. Those necessary changes are personal and local. Those changes are predicated upon knowledge, patience, acceptance, trust, letting go, non-judging and beginner's mind. The "private practice" of urology will become stronger and more gratifying if we are committed to the next steps along this path of change.

REFERENCES: