POLICY BRIEF

Fewer Family Physicians Are in Solo Practices

Lars E. Peterson, MD, PhD, Elizabeth Baxley, MD, Carlos Roberto Jaén, MD, PhD, and Robert L. Phillips, MD, MSPH

Over the past 20 years there has been a statistically significant trend toward fewer family physicians identifying as being in solo practice. Further study to determine the reasons for this decline and its impact on access to care will be critical because rural areas are more dependent on solo practitioners. (J Am Board Fam Med 2015;28:11–12.)

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A current common perception in medicine is that physician practices are rapidly integrating with larger health care systems and that solo practices are vanishing. Little has been published on the subject; however, 2 recent studies suggest that about 18% all physicians and primary care physicians are in solo (physician) practices.[1,2] Our objective was to examine changes in family physicians reporting being in solo practice from 1993 to 2013.

We used practice organization data provided by family physicians as part of their application for the American Board of Family Medicine's recertification examinations in 1993, 1998, 2003, 2008, and 2013. We used descriptive statistics to calculate the percentage of family physicians reporting solo practice in each year and tested for trend using Cochran-Armitage tests. Ethical approval for this study was granted by the American Academy of Family Physicians Institutional Review Board.

Numbers of family physicians in each cohort ranged from 6,252 in 1998 to 10,063 in 2013 (Figure 1). The percentage reporting solo practice was 13.9% in 1993, stayed nearly constant around 16% from 1998 to 2008, then decreased significantly to 11.0% in 2013 ($P < .01$).

There may be several explanations for the trend of declining solo practice. For example, physicians in solo practices may lack resources to undergo necessary practice transformation, and merging with larger practices or networks may provide such resources.[3] Other research suggests that solo physicians experience more environmental and individual barriers to the adoption of innovation.[4,5] Regional extension centers were established in part for this very reason: to provide resources and facilitation to small and solo practices to speed the adoption of electronic health records. The Primary Care Extension Program was authorized by the Affordable Care Act for similar reasons but with broader transformation support. Despite the Primary Care Extension Program not being funded, the Agency for Healthcare Research and Quality has funded related demonstrations in several states. In addition, Vermont and North Carolina have created for small practices shared resources that they could not afford independently, such as mental health providers, social workers, and chronic care mangers.

Is the observed trend important? Similar trends in other countries raise concerns about threats to continuity and its value.[6] It may also threaten access to care in rural and remote areas, where solo practices are

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From the American Board of Family Medicine, Lexington, Kentucky (LEP, RLP); the Department of Family Medicine, East Carolina University, Greenville, NC (EB); the Departments of Family & Community Medicine and Epidemiology & Biostatistics, University of Texas Health Science Center at San Antonio, San Antonio (CRJ); and the Research to Advance Community Health (ReACH) Center, San Antonio, TX (CRJ).
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Corresponding author: Lars E. Peterson, MD, PhD, American Board of Family Medicine, 1648 McGrathiana Parkway, Suite 550, Lexington, KY 40511-1247 (E-mail: lpeterson@theabfm.org).

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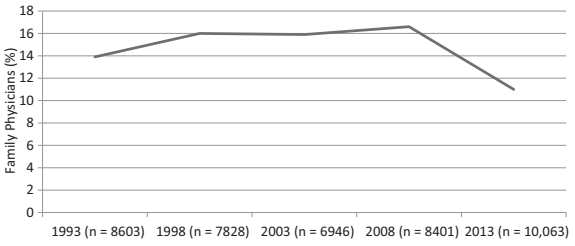
Figure 1. Percentage of family physicians recertifying with the American Board of Family Medicine who reported working in a solo practice in 1992 to 2013.



more common.[7] With recent evidence indicating that small practices (1 or 2 physicians) have fewer preventable hospital admissions[8] and a systematic review finding little evidence that small practices have worse quality,[9] studying this trend will be important to determine its underpinning reasons and its impact on access to and quality of care. If solo family physicians are an endangered species, we need to understand what it means and why it is happening because once they are gone, they will be difficult to revive.

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