Medical Mergers, Hospital Takeovers and the Changing Face of Medicine: Does Solo and Small Dermatology Practice Have a Future?

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Abstract

The trend toward business consolidation, which has affected industries as diverse as car manufacture, advertising, and banks, has been accelerating among entities that provide medical care. That is, there are fewer and fewer entities that provide medical care, although the ranks of these larger medical entities have swollen. The Great Recession of 2008, and the "The Patient Protection and Affordable Care Act" (PPACA) of 2010 (commonly called the "Affordable Care Act" (ACA) or, colloquially, "ObamaCare") have hastened this consolidation. More and more residents (including dermatology residents) completing their training after 2010 have joined hospitals or large multi-specialty groups. This trend continued and quickened through 2015, and gives no signs of stopping or reversing in the foreseeable future.

Numerous and complex factors underlie this merger mania, and the residency rush to regular hospital jobs, but the following reasons typify what is most often heard among practitioners: (1) the need on the part of sellers of medical care, such as hospitals, to scale up and expand in order to negotiate with ever-larger insurance companies; (2) the shrinking number of insurance companies who can negotiate effectively with hospital and other large medical services entities and suppliers (including pharmaceutical companies)

(3) the quality metrics and requirements for coordinated care under the ACA, together with the general increase in regulations (such as electronic health records (EHRs), HIPAA, E-prescribing, the swap of ICD-9 for ICD-10, etc.), all easier for larger practices to comply with; (4) the falling fees, reimbursements, and capitated contacts that put pressure on small practices to reduce the cost of providing care; (5) the competitive advantage of large hospitals, which can command higher fees due to certain laws (e.g., the 340B discount program--designed to encourage care for the poor and uninsured--which requires pharmaceutical companies to supply their cancer meds at about half the usual cost) and through split billing and facilities fees (in particular through Medicare payments); and (6) the competitive advantage of large hospitals' ability to "cross-sell": using primary care as a funnel to increase the provision of (for example) oncological drug administration, diagnostic test analysis and radiological services. This article proposes to add a seventh reason to this list, a reason that may be surprising to some (and perhaps ontologically offensive to others): the increased percentage of women in the physician work force, including in dermatology. This article posits that this is yet another factor supporting the trend toward larger practices in dermatology in particular, and that this spotlights some of how small and solo dermatology practices will need to adapt in order to remain an attractive career path for many in our profession.

Summary

Yeats famously and fatalistically wrote "Things fall apart; the centre cannot hold." This poetic turn (which smacks of grandiloquent dysthymia) has been borne out in the American medical markets, particularly in specialties such as dermatology, where the "center" of practice for the majority of doctors has been the small or solo medical practice. That center is moving: 2015 saw 65% of graduating physicians going to work for hospitals or multi-specialty groups. According to articles written in 2012, this is much higher than it was just five years before, when only 40% of graduating physicians went to work for large organizations.[1,2] In 2006, the percentage of degrees earned by women dropped slightly – perhaps in some way due to the recession of 2000-2001. In any case, that exception proves the rule.

I believe that one factor in this migration toward larger organizations – this sea-change in young doctors' preferences -- is the increased representation of women in medicine, including (and for purposes of this article, in particular) in medical specialties such as dermatology.

The numbers are striking, and strongly trend in one general direction. Women's share of medical degrees increased from 5% in 1952 to 48% in 2011. The total number of men and women applying to and enrolling in medical school was fairly equally split as of 2013, with male enrollees accounting for approximately 53 percent and female enrollees accounting for 47 percent of that class.[3,4] Moreover, as Medicare fees fall and as regulation increases,[9] and medical mergers continue, the increase of women as a percentage of physicians is likely to accelerate. 58% of applicants who matched in a dermatology in the 2006 match were women.[12] Female dermatologists outnumber their

male counterparts among the Academy's younger members; 63 percent of respondents to the AAD's 2012 Dermatology Practice Profile Survey under 40 were women, as were 52 percent of respondents between 40 and 49 years of age.

These are not blips, but clear trends, fueled by basic advances in equal opportunity in STEM education. Given the amount of distance yet to cover in that regard, and the irrepressible nature of the human spirit to learn and to overcome barriers, the future is clear: women will play an increasingly large, and soon dominant, role in dermatology's future. The majority of dermatologists are likely to be women within a decade. Unfortunately, many will elect not to pursue solo or small group practice.[13] As small-practice physicians – members of a declining and possibly endangered species -- we should ask why this is the reality we face. Why do qualified female physicians gravitate away from small and solo practices in dermatology? How might small and solo practices adjust, or adapt, both in order to continue to be financially viable, and also (what is equally important) to continue to produce the kind of life-long professional experiences that have made solo and small practice dermatology something we value and wish to pass on to others.1[5]

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Fewer female physicians own their practices and more work part-time. In 2004, 41% of women owned at least part of their practice, compared to 59% of men.[6] A 2006 survey physicians under 50 years of age found that 2% of men physicians and 24% of women reported working part-time at some point.[7] This gap is most pronounced in the primary care specialty of pediatrics, in which 55% of physicians are female versus 29% of all physicians being female as of 2010.[8] More men are applying for jobs in business, law and consulting to a greater extent then women.[9] With more men who do not get in during their first attempt to gain admission to medical school deciding to purse careers in business, technology, and engineering.[10] There might be a trend among men who seek status in their careers not to purse a career in medicine despite a pre-graduate school history of medical research.[11]

In a study of JD-MBAs at Wharton School MBA Program in Heath Care Management at the University of Pennsylvania from 1981 to 2010, the majority of respondents were male (85.1%), and of these in the years between 2000-2010, 29.6% did not pursue residencies, pursuing business careers instead.[14] In a study of MD-PhDs, and in another study of what applicants do if they fail to gain medical admission on their initial attempt, it was found that men are more likely to pursue business or consulting after preparing for medical school admission, changing their minds not to purse a medical school education or a career in medicine.[11] While falling slightly since 2010, women are well represented in medical school, with entering classes in the last three years being roughly 53% male and 47% female.[15]

Dermatology in the United States has traditionally been a small-office specialty. Even today, with a growing number of physicians practicing as employees, more than 60 percent of dermatology practices are solo or two-physician offices according to an article published in 2012.[1,2] Nevertheless the tread of dermatology practices being owned and managed by a central entities seems likely to overtake small practices.[16] Yet with a health care system in upheaval and a clear trend toward fewer young physicians hoping to open their own practices, a number of significant players in the health care industry are making bets on what they believe will be a big part of the future of dermatology: practices that are owned and managed by a central entity.

According to Dermatology World in April 2012, only one in 20 dermatology residents (5.3 percent) plan to enter solo practice and only 13 percent of young physicians within eight years of residency are currently practicing in that setting.[1,2] Many hospital and other medical entities are buying up practices including dermatology practices.[17] In Long Island New York, a group called Prohealthcare.com has bought many health care practices including that of Daniel Siegel former president of the AAD.[18] In the New York Metropolitan Area, practices such as Advanced Dermatology run and owned by Joshua Fox MD FAAD with 13 locations[19] and Schweiger Dermatology Group[20] run by Eric Schweiger MD FAAD and owed by Schweiger and his investors operates more than 20 offices in New York State and several in New Jersey and has raised approximately $12,000,000 to effect its business plan. Advanced Dermatology Group and Schweiger Dermatology Group have been buying up the practices of older dermatologists and consolidating them. On its Murray Hill website of Schweiger Dermatology Group notes that "[r]enowned dermatologist Dr. Darrel Rigel heads up our Murray Hill dermatology

office."[21] Rigel is another former president of the AAD. I have heard from pharmaceutical reps that some dermatologists who have sold to Schweiger Dermatology Group chaff under the business plan of their new employer. According to a rep one dermatologist who sold his practice to Schweiger Dermatology Group said "I never sold products before I do not know how to do so now." According to another rep another dermatologist said "he did not like being told how to practice medicine" and "using physician assistants when previously all my patient saw me 'a dermatologist'." At dermatology conferences there are nationwide entities which will value you practice, buy your practice and retain you as an employee. They make their money by consolidating dermatopathology, cosmetics, product sales, cancer surgery (Mohs) and medical dermatology in one group capturing all revenue. I have been told that Florida, in particular, is filled with dermatology groups providing all dermatology services with multiple locations. Someone else will merge these dermatology groups with other specialty groups to build something BIG.

These big practices greatly increase the cost of health care, multispecialty groups refer patients who come in for a cold to a PCP to an ENT who orders a CT. Their doctors roam from room to room with MAs and scribes in tow, while ICD-10 transmutes a 706.1 into

L70.0 Acne vulgaris
L70.1 Acne conglobata
L70.2 Acne varioliformis
L70.3 Acne tropica
L70.4 Infantile acne
L70.5 Acné excoriée des jeunes filles
L70.8 Other acne
L70.9 Acne, unspecified

and 99202 into a possible justifiable 99205 (in case you want to do this it is illegal, immoral and illogical-- so don't). These practices' EHRs generate a worthless bloviated mega-note that assures high encounter codes from template driven "encounters" - most of which are filled in by an MA. It's all about maximizing charges. The patient becomes just a means to generate a fee and the doctor just an added cost. Impersonal care is the result. No one MD, NPA, MA enjoys practicing that way; but then, hey, a medical practice is just another white collar job but maybe not even that. With IBM's Watson, Apple's Siri, Google's Alpha-Go computer program, and the siren song, hallucinogenic Ponzi business model of Elizabeth Holmes' Theranos --the road will lead back to the future and to another place Italy circa 1995 with MD unemployment reaching 18%.[74] What fun!! You spend 10 years of your life in dreamtime and wind up as a cog in a corporate wheel, a prisoner at the heart of a Panopticon designed by Jeremy Bentham, decried by Michel Foucault in Discipline and Punish deified by Rashi Fein and Ezekiel J. Emanuel.

Mount Sinai Medical Center (MSMC)/ Icahn School of Medicine at Mount Sinai (ISMMS) has been buying up multispecialty groups and entering into alliances with others. MSMC/ ISMMS entered into a strategic alliance with Mount Kisco Medical Group a multi-specialty group with over 400 physicians and 20 dermatologist in 2015. MSMC/ ISMMS does not own Mount Kisco Medical Group rather MSMC/ ISMMS sits at the table when it comes to negotiating Mount Kisco Medical Group’s contracts and deciding where Mount Kisco Medical Group 's patients will be hospitalized if necessary. Most Mount Kisco Medical Group 's patients will be hospitalized at a MSMC hospital

and the doctors at Mount Kisco Medical Group has been given medical and academic appointments at MSMC/ ISMMS . New York University Langone Medical Center (NYULMC) bought "The Miller Practice" at 355 W 52nd St in 2012 which was formerly owned by St Vincent's Medical Center that went bankrupt and was dissolved. I get few referrals from The Miller Practice anymore, no matter how complex the case. Courtesy of NYU, The Miller Practice has a dermatologist, a recent graduate, who goes there once a week. There are so many takeovers, it would require a paper just to list the single and multispecialty practices bought out by medical centers.

In New York City in 2010, North Shore Long Island Jewish Hospital (NSLIJ) bought Lenox Hill Hospital,[22] outbidding NYULMC. Lenox Hill Hospital which had been in a financial death spiral like that of St. Vincent's Medical Center[23] escaped death through merger. To buttress its position NSLIJ started its own medical school in conjunction with Hofstra University[24] and started its own dermatology residency program and department in 2014.[25] In September of 2015, NSLIJ changed its name to Northwell Health, one supposes to erase any evidence of denomination and location; for Auld Lang Syne I will keep referring to Northwell as NSLIJ. NYULMC also lost a bidding war for the Continuum to MSMC in 2012.[26] MSMC bought out the Continuum which consisted of St Lukes-Roosevelt, Beth Israel, and the New York Eye and Ear Infirmary[27] outbidding NYULMC[28,29] At the same time Mount Sinai has improved its medical school, capturing more NIH grants and raising its ranking on U.S. News and World report's ranking so that the Icahn School of Medicine at Mount Sinai is now ranked 19 out of 153 accredited medical schools and schools of osteopathic medicine nationwide.[30] The Continuum had undergone protracted bitter negotiations with UnitedHealth Group[31,32] and Aetna[33,34] that

ended in agreements but foreshadowed the Continuum's demise. The board of directors of the Continuum saw the writing on the wall and put itself up for sale. Simply put NJLIJ, NYULMC and MSMC all know that bigger is better when it comes to getting the best deal from UnitedHealth Group and other vendors and syncing their practices to the 2015 medicine legal and regulatory framework of which the "The Patient Protection and Affordable Care Act" (PPACA), commonly called the "Affordable Care Act" (ACA) or colloquially "ObamaCare" (2010) is only one part.

In Brooklyn, the merger trend has been pronounced. An article in Crain's Business Daily Noted[35]

> In October 2013, Pamela Brier, Maimonides' president and chief executive, joined with her counterparts at Brooklyn Hospital Center and Lutheran Medical Center on an op-ed on the plight of Brooklyn hospitals.
> "As CEOs of three of Brooklyn's largest hospital networks, we've seen four hospitals shut or face imminent closure. Several others are on the brink of bankruptcy," they wrote. "With Brooklyn's disproportionately high number of Medicare and Medicaid patients, reduced federal reimbursement rates have taken a severe toll."

In February of 2015, Maimonides Medical Center, signed a memorandum of understanding to enter into exclusive negotiations to explore a partnership with NSLIJ.[36] In early 2015, Lutheran Medical Center of Brooklyn, which had average operating losses of $16.3 million from 2012 through 2013, responded to the turmoil in the medical markets by selling out to NYULMC.[37] Lutheran Medical Center of Brooklyn, will be renamed NYU Lutheran Medical Center. In Queen's Booth Memorial Hospital, formerly run by the Salvation Army, in 1992, became an affiliate of the New York Hospital-Cornell Medical Center. In 1993, the hospital was renamed The New York Hospital

Medical Center of Queens. Several years later, while retaining this name legally, for ease of use it was shortened to New York Hospital Queens.

Larger hospitals pay lower fees for supplies in ten ways according to Becker's Hospital CFO in 2012.[38] There are (1) focus on the continuum of care (2) design models to reduce readmissions (3) have a good relationship with payors, and renegotiate managed care contracts.(4) manage new service lines to increase market share (5) control labor costs with meticulous data collecting (6) reduce supply costs by working with vendors and physicians (7) improve deficiencies in the emergency room and operating room. (8) create population health management programs to gather health data analytics on chronic illnesses (9) consider outsourcing some services and (10) revamp the energy cost strategy. A smaller practice, lacking of consultants, legal advisors, an informational technology infrastructure and a favorable legal status (e.g. operating as a not-for-profit organization) cannot do adhere to Becker's tenets.[38]

When hospitals buy practices the price of health care goes up and hospital often operating as non-profits can make more money off the same patient base as for profit based non hospital based practices.[39] Hospitals can buy oncology drugs more cheaply than for-profit non-hospital based oncologists from pharmaceutical companies due to the fact that about one-third of hospitals participate in the 340B discount program--designed to encourage care for the poor and uninsured--which requires pharmaceutical companies to supply their cancer meds at about half the usual cost and charge more.[40,41,42,43] The New York Times reports, the exact same drugs are reimbursed at up to three times the amount per dose at hospitals than at private oncology practices. For instance, according to The New York Times, hospitals can get almost $10,000 per dose of Roche's breast cancer

drug Perjeta (pertuzumab), while independent oncologists collect somewhere around $4,000.[33] To co-opt the mantra of *Star Trek The Next Generation*'s Borg -- hospital absorption and consolidation are inevitable: RESISTANCE IS FUTILE!

This medical entity consolidation and expansion trend is not confined to New York, it has swept the United States. The Mayo Clinic[44] has a large presence in three U.S. metropolitan areas: Rochester (Minnesota), Jacksonville (Florida), and Phoenix (Arizona). The Clinic employs more than 32,000 people at the main campus in Rochester, Minnesota and the Arizona and Florida sites employ approximately 5,000 persons at each site. In addition, the Mayo Clinic owns and operates the Mayo Clinic Health System, which consists of more than 70 hospitals and clinics across Minnesota, Iowa, Wisconsin and Georgia with an employment of 14,000 persons. Mayo Clinic also operates several colleges of medicine, including Mayo Medical School, the Mayo Graduate School, and the Mayo School of Graduate Medical Education, Mayo School of Health Sciences.

A famous example of a consolidation play (that is taking over all your competitors and establishing a monopoly that makes monopoly profits) is the Carilion Clinic[45] a healthcare organization in southwest Virginia's Roanoke Valley. The Carilion Clinic is a healthcare organization in southwest Virginia's Roanoke Valley and 8 not-for-profit hospitals, including a state-of-the-art children's hospital has bought out it regional competitors and started its own medical school, which I will expand in detail to get the flavor of the Carilion Clinic as an institution. Carilion originated with Roanoke Memorial Hospital, founded in 1899 and located at the base of Mill Mountain in southwest Roanoke. The hospital expanded into related health care services and the acquisition of other hospitals. Most prominent was the acquisition of the competing Community

Hospital of Roanoke Valley in downtown Roanoke. The deal took several years to complete because of anti-trust concerns by the United States Department of Justice that two of the three major hospitals in the Roanoke Valley would now be under the same ownership. In the early 1990s, Roanoke Memorial adopted the name Carilion for its consolidated health care business. Carilion is the area's leading employer with more than with over 600 physicians and 11,000 employees, over a billion dollars of assets as of 2008.[46] As part of the Carilion Clinic's plan to promote education and research, Carilion and Virginia Tech have partnered to establish the Virginia Tech Carilion Research Institute and a small, research-oriented medical school in Roanoke. The Virginia Tech Carilion School of Medicine accepted its first class in 2010. In addition, Carilion currently operates the Jefferson College of Health Sciences which offers masters of science degree programs (M.S.) in nursing, physician assistant, and occupational therapy. In addition, Carilion has 13 associate and baccalaureate allied health care programs. I recall from an article in the Wall Street Journal that The Carilion Clinic provides 75-85% of care in its area.[46] The WSJ noted that after Carilion reached it current form: [46]

> Carilion charges $4,727 for a colonoscopy, four to 10 times what a local endoscopy center charges for the procedure. Carilion bills $1,606 for a neck CT scan, compared with the $675 charged by a local imaging center. . . . Carilion estimates it receives about $50 million a year in tax exemptions. It dispensed $42 million in charity care in 2007 and $30 million in 2006. . . . Alan Bayse, founder of a local benefits-consulting firm who has sold health insurance in the area for 30 years, says health-insurance rates in the Roanoke Valley used to be 20% lower than in Richmond, Virginia's capital, and the lowest in the state. Today, he says, they are the highest in the state and 25% higher than in Richmond, citing rate information from insurer Cigna Corp. Anthem, another health insurer, says its rates are 6% higher in Roanoke than in Richmond. Mr. Lionberger, whose

> construction company has about 100 employees, says his health-care costs have risen 50% over the past three years, hampering his ability to compete with contractors from other parts of the state. "It's frustrating," he says. . . . When some patients don't pay their bills, Carilion places liens on their homes. Carilion says it doesn't track how many liens it has outstanding, but the close to 4,000 it filed in 2007 "is representative of a typical year," Mr. Earnhart says. Carilion doesn't foreclose on homes and only collects when properties are sold, he says. Dr. Murphy says Carilion only sues patients and places liens on their homes if it believes they have the ability to pay. "If you're asking me if it's right in a right-and-wrong sense, it's not," he says. But Carilion can't be blamed for the country's "broken" health-care system, he says.

Even the mighty UnitedHealth Group has had to bow to The Carilion Clinic's fee demands. Private dermatologists still practice in the Roanoke Valley because in that area there is a shortage of dermatologists. Carilion has not found a way to attract enough dermatologist or to find a way to make an end run around the American Board of Dermatology and just mint as many as it needs but give Carilion time it does now have a dermatology residency program. Another payment method encourages hospitals to absorb hospital and physician's practices. This payment method that allows hospital entities to command higher fees is called split billing that allows hospitals to bill for professional service and facilities fees separately in particular through Medicare payments.[47,48] The recent budget act will ban this ability to raise fees at some point in the future.

This trend to hospital charging more money for service is common in New York City.[49]

> As insurers ratchet down payments to physicians and hospitals, these providers are pushing back with a host of new charges: Ophthalmologists are

> increasingly levying separate “refraction fees” to assess vision acuity. Orthopedic clinics impose fees to put an arm in a cast or provide a splint, in addition to the usual bill for the office visit. On maternity wards, new mothers pay for a lactation consultant. An emergency room charges an “activation fee” in addition to its facility charges. Psychologists who have agreed to an insurer’s negotiated rate for neuropsychological testing bill patients an additional $2,000 for an “administration charge.”

Another aspect of this consolidation is recruiting star doctors usually surgeons who can bring in millions from performing surgery and millions more on ancillary service. New York magazine noted in 2012.[50]

> Pressed to fill every bed, hospitals are unabashedly poaching star doctors—who bring prestige as well as patients—from competing institutions. Okay, so Mount Sinai Medical Center’s star urologist, Stephen Savage (his beat: minimally invasive surgery) recently decamped for Memorial Sloan-Kettering. Sloan-Kettering lost surgeon Warren Enker and oncologist Louis Harrison to Continuum Health Partners, which lost orthopedist Eli Bryk and breast surgeon Deborah Axelrod to Saint Vincent’s. Meanwhile, interventionalist Alejandro Berenstein departed NYU Medical Center for Beth Israel; laparoscopic surgeon Michel Gagner from Mount Sinai to New York-Presbyterian; and orthopedist Evan Flatow from Presbyterian to Sinai.
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> Physician recruitment is hardly new. The offer of a promotion, perhaps a department chairmanship, by the hospital downtown or down the street, or the promise of more lab space, more operating-room slots, and more support staff have always been potent temptations. “But there’s a lot more poaching now than there used to be,” believes Stanley Brezenoff, president and CEO of Continuum—himself a recruit from Brooklyn’s Maimonides Medical Center.
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> “The stakes are higher now at hospitals,” agrees Herbert Pardes, president and CEO of New York-Presbyterian Hospital. “There’s more competition. When you’re trying to maintain a broad program, it’s harder to match the bid if another institution is marshaling resources to steal someone away.”
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> Those resources are being marshaled to good purpose. With budgets in medicine tourniquet-tight, hospital administrators are increasingly intent on goosing patient numbers and increasing revenue. Luring a star—or rising star—from competitors can be an effective way for a hospital to bolster its bottom line. “I was at a conference and someone said, ‘All our volume strategies are about stealing patients from other hospitals,’ ” says Brezenoff. “You steal a doctor and you get his patients, too.”

Another article discussed the vogue to attract doctors who do minimally invasive surgery, which can cost more than traditional surgery.[51]

> But already the tide is turning, as a host of local high-end hospitals have wooed minimally invasive surgeons to stay competitive. NYU and Montefiore Medical Center have established new divisions of minimally invasive surgery in the past two years. Dr. Dennis Fowler, Jennifer's surgeon, came to New York from Pittsburgh fifteen months ago to head up a new minimally invasive division at New York-Presbyterian Hospital. Mount Sinai's new director of cardiac surgery, scheduled to arrive this month, is Dr. Lishan Aklog, a minimally invasive cardiac surgeon from Brigham and Women's Hospital in Boston. Memorial Sloan-Kettering Cancer Center, which has hired five minimally invasive surgeons in the past six months, is aggressively trying to hire still more in the next half-year. Recently, Fowler says, "it's really turned around -- there's a craze for everybody to get someone." Among laparoscopic surgeons, NYU has a reputation for resisting minimally invasive techniques, but it signaled a commitment to changing that when it hired Dr. Michael Edye, a wry Australian who was Barry Salky's first recruit at Mount Sinai. As Edye, preparing for a laparoscopic kidney removal on a Tuesday morning in November, waits impatiently for the anesthesiologist, one of his residents, a young Harvard graduate, offers up his theory of why minimally invasive surgery was relatively slow to catch on among doctors. "It was used early on by gynecologists," he says, tying on his mask. "I think that has something to do with it" -- prestigious surgeons, he speculates, were reluctant to take their cues from gynecology, long considered the least glamorous of the medical practices.

Another Article from New York Magazine reiterates this tread.[52]

> The highest-paid doctors in New York City are raking in millions of dollars each year, with some, even at struggling hospitals, getting six-figure bonuses, a Post review of hospital-based MDs has found.
> The city's top earner was urologist and prostate-cancer specialist Dr. David ¬ Samadi, whose 2012 compensation came to $7.6 million. He was chief of robotics and minimally invasive surgery at Mount Sinai Hospital before moving to Lenox Hill Hospital last June. Not far behind Samadi was his Mount Sinai colleague Dr. Andrew Hecht, head of spine surgery, whose compensation came to $6.9 million. Both doctors were paid by Mount Sinai's Icahn School of Medicine.

Being from New York, I think of the New York City health care market (and I mean not "market" not "being a doctor") as a "Hunger Game" for patients, solo practitioners and small practices and "Heaven's Gate" for large hospital centers. The centripetal pressure I think is irresistible and I believe that in 10 years there will be only 5 Care Providers in the New York Area: Mt Sinai, Columbia, Cornell, NJLIJ with NYU bringing up the rear.   I

can only image that this is going on else where as well. The chairmen of these hospitals are each paid in the millions of dollars, far more than the vast majority of their physicians. In 2011, Herbert Pardes CEO and president, New York Presbyterian Hospital made $2,327,655 and Harold Varmus CEO, Memorial Sloan-Kettering Cancer Center, Memorial Hospital made $1,693,710.[53,54] The canny Michael Dowling,[55] former head of New York State's department of Health and Human Services under Mario Cuomo, whose NSLIJ control more hospital beds than another hospital chain in New York State made $2,995,311 in 2013-14 out of NSLIJ total Organization's annual revenue of $411,060,221.[56] He is very politically adept at taking over hospitals and merging them, using the North Shore Model. I once heard him say at a lecture to the private voluntary attending physicians at Lenox Hill Hospital, just after he had taken Lenox Hospital over, that he had a simple plan for deploying the doctors under his aegis: "You will work for me full time" eliding the words to follow this dictum “someday soon.”

At the same time, the medical insurance market is contracting. In 2009, UnitedHealth Group bought out Healthnet in New York State.[57] On December 24, 2102, WellPoint completed acquisition of Amerigroup, one of the nation’s leading managed care companies that is focused on providing Medicaid managed care insurance.[58] In New York state two insurers that provided health insurance: HIP and GHI merged and successfully fought court challenges on antitrust grounds to the merger under the name Emblem. On June 26, 2013, the New York State Departments of Health and Financial Services approved the GHI HMO Select, Inc. merger with HIP Health Plan of New York. Letters were mailed to providers affected by this merger. The merger means that HIP (now called Emblem) is now responsible for GHI HMO’s Certificates of Coverage and

provider agreements.[59] Some referred to the merger of HIP and GHI as the union of "The Two Towers;" I would not use a fictional title to capture a business reality. In 2010-11. Aetna bought Coventry for $5.7 billion,[60] Cigna Corp. bought HealthSpring, a Medicare Advantage company, for $3.8 billion.[61] UnitedHealth Group, taking consolidation on to the international stage acquired a majority stake in Amil Participacoes, a Brazilian integrated healthcare delivery network, for $4.9 billion.[62]

What is to be done? Is selling out to a chain an option for solo or small group practices? In the ancient days of the 1970s a dermatology practice was generally considered worth its annual gross revenue; no longer. A practice today is worth its charts and equipment. Hospitals will not even pay for the intangible good-will that small practices have built over the years, as federal law prevents purchasing such “good will,” as a possibly illegal kick back under the Stark Laws.[63] Medicare fees are falling and the place of dermatology in the era of capitated contracts and the ACA is uncertain.[64]

The advantages for a solo or small practice selling or merging with a larger group include improved IT support, HR resources and legal and regulatory resources that might relieve a dermatologist from the day to day issues that come up in solo practice, such as hiring and firing employees, complying with state and federal regulations, and negotiating managed care contracts.[65,66,67] Another advantage to selling or merging with a larger group involve monetizing all aspects of dermatology care i.e. dermatopathology, Mohs and cosmetics.[68,69]

I still work in private solo practice but for how long I do not know. I had hoped to work as a dermatologist until the day I died but the rationalization of health care could be a road block or a deal killer. I spoke to an internist in his mid 80s who was a full

professor with hundreds of Pubmed indexed articles and several book listed on his resume of his intellectual accomplishments at an institution that had been taken over by another hospital. As a full professor his minimum salary was guaranteed, effectively this meant he made more than 2 new physicians who had just finished their residencies in internal medicine. He has had difficulty in mastering the EHR and he was no longer spoon fed patients by the MSMC. He told me some one from administration visited him fortnightly to inform him he was not making back his salary. When he proffered all that that he had done for his former hospital and medical school the publications, the teaching, the ten of thousands of patients who he had helped, the administrator, half his age, brushed that aside and asked "what have you done for the Mount Sinai lately" and warned of consequences if he did not make back his guaranteed salary. I advised him to him to consider raising the age discrimination laws instead as an aegis. How he actually defends himself I do not know. I hope that he does not end up as the detritus of downsizing. Most other areas of the economy have far fewer players than a century or a decade ago. Once there were hundreds of car companies now there are two dozen world wide. Once dermatology was a division of the department of medicine at all Medical Schools and now most medical school have a departments of dermatology but for how long? Once dermatology was a fellowship after a medical residency and now procedural dermatology is a fellowship after years of internship and three years of dermatology residency. Will the future medical school deans decide to create separate departments of medical dermatology, surgical dermatology and cosmetic dermatology? The institutional place of the specialty of dermatology in the age of consolidation is unclear.

I am trying to make the best of it and struggling to plan my future as a man with a family and a dermatologist. I think I have a future in helping patients and practicing dermatology but I am reminded of the poem by Shelley called “Ozymandias” (1818) which speaks those who think that things never change and the fortified edifices of our work and imagination are impregnable. It reads

I met a traveller from an antique land
Who said: "Two vast and trunkless legs of stone
Stand in the desert. Near them, on the sand,
Half sunk, a shattered visage lies, whose frown,
And wrinkled lip, and sneer of cold command,
Tell that its sculptor well those passions read
Which yet survive, stamped on these lifeless things,
The hand that mocked them and the heart that fed:
And on the pedestal these words appear:
'My name is Ozymandias, king of kings:
Look on my works, ye Mighty, and despair!'
Nothing beside remains. Round the decay
Of that colossal wreck, boundless and bare
The lone and level sands stretch far away.

I do not think a nuclear winter will cast a never ending pall over he practice of dermatology but change and Joseph Schumpeter's creative destruction are rules of life. Whenever I speak with Steve Feldman of Bowman Gray (and author of 779 article indexed in Pubmed), I live in hope again Dr Feldman is filled with remorseless optimism. He explains that dermatology survived the travails of the HMO craze of the 1980s, and remains filled with smart capable practitioners who help patients in ways that can not be replicated. For Steve, the glass of life is overflowing. For me, the glass of life beyond 2018 (now 2020, when the Cadillac healthcare tax kicks in) is not apprehensible. When I think of hope, I think of the exchange in Shakespeare's Richard III between Richard, the future king, and a women he needs to marry but does not love. Richard asks, "But shall I

live in hope?" and Anne, the wife of the last fallen king, replies "All men I hope live so." Richard and Anne die; the institution of England lives on. The reader should know that MSMC and NYULMC and NYU Medical School, the Mayo Clinical and the Mayo Medical School and Carilion Clinic and The Virginia Tech Carilion School of Medicine are all non-profit entities. The tsunami of legal and regulatory change, decreased reimbursement, capitation[70,71,72,73] and not-for-profit health care entities will crash over our small practice for-profit structures when the Affordable Care Act and the Cadillac Health Care tax take full effect on January 1, 2020. I hope that the great poet T.S. Elliot was not foreseeing the fate of the small dermatology practice when he concluded, in his poem "The Hollow Men" (1925), that "This is the way the world ends / This is the way the world ends / Not with a bang but a whimper."

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