

Making a Smooth Transition From Solo to Group-Practice

By John B. Pinto

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A surprisingly high percentage of ophthalmologists are still in solo practice, most quite happily. On the plus side, solo practice provides the satisfaction and serenity of absolute control. Solo surgeons don't have to consult with a colleague. They don't have to confront peers on difficult business or medical issues—they need only face down subordinates. Soloists can spend the company's profits as they see fit...the only financial negotiations are between the doctor, their administrator, and their spouse. Soloists can come and go as they please. Meetings are pared to a bare minimum. Bliss, some surgeons say.

This is not always so for doctors in group practice. And for at least *some* doctors in *some* groups, two, three or more doctors working together is not so much a trim commando squad as an armed gang, as likely to turn on each other as rumble with the local competition. Still, the economic and professional advantages of group practice are compelling, and may trump your desire for independence:

- High fixed overhead and expensive technology upgrades can be shared. Keeping in mind that a significant proportion of new technology is quickly obsolesced, the pain of buying errors can be split up.
- Patients can be better-served if several sub-specialists are present; care is better coordinated, and a patient's needs can all be addressed in a single location.
- It's much easier to afford superior management talent, along with top-flight accountants, attorneys and other advisors if their cost is borne by several doctors working together.
- With a partner, you have someone with whom you can share successes and commiserate failures.
- The quality of care may be higher in group practices for two reasons. First, because each surgeon can obviously learn from his peers, especially if periodic case reviews and chart audits are conducted. Second, because two or more surgeons working together represent a kind of internal oversight, even if there is no formal case review process.
- As a member of a group practice, you have an in-house sounding board to help you improve your good ideas, and a safety check to help you avoid following through with poor ideas. (An ideal combination is when one surgeon is oriented to cost containment, and his partner is oriented to revenue-enhancement.)
- There is greater practice security. When a solo surgeon falls ill, the practice grinds to an immediate halt. A second or third surgeon can keep the company going until the downed partner is back in action.
- There can be significant lifestyle benefits. Call coverage is shared. It's even possible to arrange periodic sabbaticals, giving each doctor a block of several weeks or even months off every few years. Two part-time surgeons can job-share.

Many soloists I consult with are unsure about the timing of adding the second doctor to the practice. It's critical to forecast the almost inevitable cash flow crunch that occurs early-on as you take on a new associate or partner, and to have both the patience and the cash reserves to take a

personal pay cut for several quarters or longer. Let's imagine a solo surgeon with \$1.2 million in revenue and a 40% profit margin. Near term, especially if there are delays in gaining licensure or panel status, the new associate will represent all outgo and no income. It's typical for a general ophthalmologist-associate's first year costs (including wages, taxes, benefits, relocation costs, insurance, staffing and other professional support) to reach \$250,000 or more. In the early months, there will be sharp drops in practice profit, and the senior doctor has no recourse except to reduce his salary or draw on loan proceeds to preserve his income. The table below shows a typical, if markedly simplified and somewhat accelerated, cash flow in the first several months.

	Base Month	Month 1	2	3	4	5	6
Number of MDs	1	2	2	2	2	2	2
Base collections	100000	100000	100000	100000	100000	100000	100000
New doctor collections	0	8000	15000	25000	30000	35000	40000
Total collections	100000	108000	115000	125000	130000	135000	140000
Base Expenses	60000	60000	60000	60000	60000	60000	60000
New doctor expenses, including salary	0	25000	22000	20000	18000	18000	18000
Total expenses	60000	85000	82000	80000	78000	78000	78000
Profit for senior doctor	40000	23000	33000	45000	52000	57000	62000

As you can see from this stylized example, if the new doctor's productivity can be accelerated (as by pre-arrival marketing, strong outreach efforts, etc.), the senior doctor has only a short-term drop in personal income, followed by a very sharp increase. Obviously, you don't want to stretch out the process. A senior doctor making \$40,000 in the base month before his new hire's arrival is going to resent his young colleague getting stuck at a "month 2" level of productivity, which would result in a significant income drop for the senior doctor.

For the same reason, you also don't want to bring a new doctor on prematurely. Here are a few rules of thumb:

1. Before you bring on a new doctor to form a two-doctor general ophthalmology practice, you should be personally seeing at least 20% more patients per month than you can comfortably fit into your schedule. This typically translates to 600 or more patient visits per month for a general ophthalmologist (inclusive of paid as well as post op visits.) Alternately, you should have reached (but not yet exceeded) your comfortable personal patients volumes, be growing total patient volumes at least 10% a year, and have a high level of confidence that this growth rate will continue.
2. This level of excess productivity (or superior growth rate) should have been in place for at least the last six months before you make a hiring commitment. From this, you can see that it's occasionally appropriate to begin the doctor search process before you think you actually might need additional help, especially if you work in a less-desirable market. It may take 12-24 months or more to find a superior candidate.
3. Make sure you have significant financial reserves in place to carry you through the first few soft quarters after your new doctor arrives. Whether these reserves are held as retained earnings of the practice, personal savings or simply a line of credit, you should have access to the equivalent of not less than six times your monthly salary and draws. Also, be prepared to curtail personal lifestyle costs temporarily if your new doctor takes a little longer than expected to build his or her practice.

After the New Doctor Arrives

Once you have transitioned from one doctor to two, your new favorite saying has to become, “I can live with that.” If you enjoy a harmonious marriage with your spouse, apply the same tactics to your business “marriage.” Even though you’re the senior doctor, take pains to ask your new partner or partner-to-be what they think about new practice initiatives or expenditures. Like an ex-bachelor, you can no longer do the ophthalmic equivalent of staying out late (not coming in on time for work), hanging out with friends (running behind in clinic), or spending money freely (buying a new laser without asking permission first.)

You should accept that bringing on a fellow doctor and becoming a small group practice will involve more than just near-term financial pain. Longer-term, there will be other discomforts. Chief among these, additional meeting and communication time is essential. Here’s the line-up:

- If you don’t already holding general staff meetings, these should be conducted at least every two months; monthly is preferable. All doctors should be in attendance.
- If the practice is up to a size suggesting departmentalization, department meetings should be held monthly; at least one doctor should attend at least every other technical department meeting.
- There should be a monthly finance and volume performance meeting with the practice manager or administrator, with all partner and partner-track doctors in attendance.
- The doctors should meet alone at least once a month. In the early months, and perhaps durably, the doctors should review a cross-section of random charts to compare care pathways, referral patterns (both intra- and inter-practice), return intervals and utilization.
- Depending on everyone’s temperament, it’s a nice touch to arrange a social meeting of the doctors every quarter or two. These meetings are most often dinners or similar outings with spouses; beyond mere enjoyment, they serve to deepen the bonds between partners. Please keep in mind that these social ties are not essential. There is no absolute requirement that doctors in a group be buddies in their private lives; indeed, too much personal involvement can cloud business judgement and create the opportunity for a personal spat (or spouse-to-spouse argument) to spill over into the business.

In the vast majority of cases, as you make the transition from solo to two-doctor practice, your new doctor will spend two to three preliminary years as a partner-track associate. During this trial period, he or she should receive their personal monthly production figures (patient visits, surgical cases, collections and average revenue yield per patient visit); ideally, these are graphed to make it easier to spot trends. In addition, I feel strongly that partner-track associates in good standing should receive some or all of the financial performance statistics for the overall practice.

Unfortunately, some senior doctors elect to keep practice financials a secret until the associate is about to become a partner. This commonly results in an associate who is untrusting, disengaged from the details of the practice, and unfit to assume the fiduciary role of a partner.

As the senior doctor, you should foster an environment of strategic intimacy. You and your new doctor should openly discuss where you want to take the practice in the future, just as young couples discuss how many children they want to raise, and what kind of home they dream of owning together. In my experience, the second greatest source of partner discord, after financial squabbles, is when doctors disagree on where the practice is heading strategically. Ideally, you and your colleague/s should collaborate on a written plan that includes:

- The geographic span of the practice (the boundaries of your service area.)
- The agreed scope of practice services and positioning strategy (eg: will you be known as a full-service provider, or a cataract boutique?)

- The provider mix (how many surgeons? Medical ophthalmologists? ODs?)
- Your current and future financial performance, out at least 5 years. This section of your strategic summary should describe if your development bias will be toward high market share (which will likely constrain profit margins) or high profit margins (which will likely constrain market share.)

For real development of your associate, make sure he has non-clinical as well as clinical duties. Every doctor, even durable associates who are not on a partner track, should have five or more hours per month that they devote to staff education, outreach in the community, outcomes research, protocol writing, etc. Every doctor should periodically sit on various management committees and task forces.

Give your new associate reasonable control over their professional environment. It can be very helpful to give each doctor in a group a dedicated lead or primary technician. While every practice needs a degree of uniformity and standards, make sure you provide your doctor with a chance to customize certain forms and protocols, especially those germane to their subspecialty expertise. Don't force your associate to adopt your surgical approach and don't impose yourself as an uninvited proctor. Presumably you have selected your new colleague wisely, and respect their existing personality, skills and professional judgement. Like love and marriage, don't hold out hope that you're going to be able to change your partner-to-be, even if they promise to change.

Disclose early on, ideally when the initial contract is signed, what the buy-in terms are going to be for partner-track associates. I most often advise clients to spell out *provisional, non-binding* terms in writing as part of the initial employment agreement. These terms should include a) when a partnership opportunity is likely to be first offered, b) what segments of the practice will be sold (eg: will ASC shares be offered, or just shares in the professional corporation), c) what percent may be offered, d) how the practice will be valued, and e) whether financing for the buy-in will be carried by the practice or by a third-party lender.

I talk to hundreds of associate doctors every year in the course of my practice consulting work. Most are happy. Those who aren't rank their chief complaints in the following approximate order:

1. "I don't really ever feel appreciated here; I feel like second fiddle"... Go overboard in expressing your appreciation for your associate, and later, for your partner.
2. "I don't have enough voice in operations; I'm never consulted"... Obviously, your partner-track associate and even your minority partner have little or no legal control over the practice. But the wise senior doctor picks associates whose counsel they respect, accept and often implement.
3. "The senior doctor gets all the cases; I'm not being fed patients, but instead have to fight for every new patient. The front desk knows who signs their paychecks, and so the senior doctor gets most of the best new patients, while I get the scraps"... Very few young associates are self-starters—they arrive on the job expecting to be fed, at least to some degree. This is solved simply with a written protocol for the entire office staff outlining how new and established patients are assigned. You can go further with consumer advertising to directly support your new doctor, and coaching help to get him pushed out and introduced in the community.
4. "Every decision my doctor-boss makes seems to be made with his personal benefit in mind. I don't trust him to make decisions that will be fair for all concerned"... This complaint is a little touchier to deal with, because it involves the core personality of the senior doctor. The best surgeons tend to have the greatest difficulties in this area. I find that insight counseling

for the senior doctor, combined with open discussion, lots of doctor-to-doctor face time, ongoing coaching for the senior doctor and checking in regularly for associate doctor perceptions gets the job done best. Even after near-term improvements are made, ongoing vigilance is essential to check the inevitable backsliding.

5. "Issues build up here without every being discussed"...The reason for this is the common observation that most surgeons despise confrontation, and harbor fears that a small confrontation will lead to an unpleasant, all-out battle. The solution includes sufficient meeting time to air out issues, and the involvement of a third party in selected doctor meetings (such as a strong administrator) to referee disagreements and gently bend the doctors toward an intelligent consensus on the most difficult issues.

There are compelling financial, quality care, lifestyle and existential motivations for a solo surgeon to take on an associate or partner. At the same time, there are compelling and often deeply personal motivations to remain in solo practice. As many larger groups have found, there can actually be severe diseconomies associated with a ophthalmic practice of over 3-5 partners. In the years ahead, as the next round of health care cost containment descends on eye care, I believe that many heretofore happy soloists will be compelled to consider group practice. In addition, the next decade will have the baby-boom generation of doctors, who are approaching their retirement years, seeking out transitional doctors to slowly take over their practices. The concepts and pearls discussed here, if applied, will help you avoid the most common pitfalls of group practice.

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