

## **“What is a Partnership, Really? What Kind Do You Have?”**

By John B. Pinto

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In an average year, I spend hundreds of hours constructing, deconstructing and patching up doctor-to-doctor partnerships. At the surface, there are scores of hot-button issues that make partnerships so difficult to make and keep happy. But at deeper levels, there is perhaps just one core attribute, the degree of partner equality.

Not that *unequality* is bad. Extremely strong business partnerships (and for that matter, other kinds of partnerships like marriage) exist where both sides agree who is going to lead and who is going to follow. But the most extraordinary environments for surgeons to work in are often those where equality prevails.

What is a partner, really? Here's a dictionary definition that's suitable for most competitive ophthalmic environments: "A partner is one of two or more people who play together in a game against an opposing side." A drier, more legalistic definition is, "A partner is someone involved in a close, cooperating relationship with others, regulated by mutual rights and responsibilities, to further a common enterprise."

All English lessons and legal jargon aside, ophthalmic partnerships fall into two very broad and profoundly different categories.

Unequal Partnerships: *Surprise!* This is the most common form of partnership, in eye care and elsewhere. Even if partners are legally and economically equal, they are rarely equal in actuality. An examination of the typical ophthalmology practice reveals a rank order of leaders and followers. The hierarchy is most commonly along lines of either tenure (who came first?), economic production (who collects the most?) or natural leadership (who by raw personality is granted the most authority?) In these kinds of partnerships, decisions and resource allocations are lopsided. The senior doctors get the choice mid-week, morning hours in the practice's surgery center; the junior doctors get Friday afternoons. The seniors get their pick of the best technicians; the juniors by default run the tech training program. The seniors are excused from call sharing, the juniors are excused from a sound night's sleep. Not a bad arrangement...if you're a senior. So long as everyone gets to rise through the ranks and agrees to this approach ahead of time, unequal partnerships can work just fine.

Equal Partnerships: In these rare partnerships, doctors most often (but not always) have equal shares in the practice and all of its subsidiaries such as optical shops, buildings and surgery facilities. Both younger and older doctor partners have an essentially equal voice in management; more decisions are made by consensus rather than formal vote. Perhaps the most important contribution to harmony, is that everyone in an equal partnership setting gets an equal share of resources. Marketing dollars are split equally among the various subspecialists. Everyone gets to rotate through the most productive satellite offices. Every doctor gets a turn at being the

managing partner. Perhaps most importantly, all partners rise or fall with the total success of the total organization.

Here's a recent example from a client setting. A large midwest practice was exploring the admission of a new partner, a well-respected local surgeon who would be merging his smaller solo practice into the larger organization. For the first several hours of our merger conference, the five partners of the larger practice were adamant that the soloist, if he joined, would have to be 100% at risk. His compensation methodology was going to be different from everyone else for the first year or two, in a way that I saw was going to potentially result in the new partner's income rising while the old doctor's income fell—or vice-versa. I suggested that for the first several years the partners might index their split of available profits to their current incomes. If the profits rose 10% after the merger, every doctor would get a 10% pay raise. All boats would float together. It's interesting to note that as soon as the doctors in the larger group understood the inherent fairness of their incomes rising and falling together based on the success of the entire team, they went on during the rest of our conference to equalize everything else: access to the best techs, sharing of the evening and weekend hours, and responsibility for covering distant satellite offices. I have a high level of confidence that this merger is going to go very well, indeed.

### **What Kind is Yours?**

When two or more doctors draw themselves together, the kind of partnership they choose—equal or unequal—has huge implications for everyone around them. In an equal partnership, the practice administrator is less likely to take sides. In equal partnerships, even junior staff realize that it will be hard to play one doctor off the other. I suspect that even patients get a sense that all doctors are interchangeable, and are more willing to see whichever doctor is most available. I think the reverse is also true. If there's clearly a dominant, "head" doctor, patients gravitate to that one provider, especially for their surgical care. This can amplify rivalries that naturally occur in unequal partnerships.

It's more likely for truly-mutual, equal partnerships to form naturally when two young, equally novice doctors start a practice together. Equality is far less common when a young surgeon joins an established doctor 10 years or more ahead in his or her career. In these situations, the young surgeon, even after a successful associateship, will likely remain in the senior doctor's shadow until the older doctor retires, although there can be hope for greater equality with the passage of time. It's been my observation that with age and success, senior ophthalmologists become somewhat less controlling, and more acquiescent to true partner equality. Of course, this usually happens just about the time when the younger generation is wanting to take over and control the practice, themselves, which is why most unequal partnerships stay that way. Perhaps this article will stimulate an internal discussion within your group practice on how authority and control is shared.

A discussion of partnership models wouldn't be complete without reviewing how young surgeons make it through the ranks from employed associated to partner. I've always been critical of the all-or-nothing approach most commonly taken in private practice medical employment, where junior doctors are often moved after two or three years, in one leap, from 'associate' to 'full partner.' This works against basic human nature and the experience of most large institutions (military, educational, religious, trade union, business, political, etc.) These institutions move their members from novice to expert in small, incrementally stages. Perhaps the most intelligent approach to granting partnership in an ophthalmic practice is to grant similar, incremental

shares—“merit badges,” if you will—so that junior doctors feel a sense of steady progression in their early years.

Whether partners are equal or unequal, the biggest factor for success and harmony is mutual agreement about the development path of the practice. Partnerships are hardest to maintain when there are no large goals held in common—and yet, few group ophthalmology practices have anything like a written business plan. The angriest doctors I counsel are those with partners who don't share their goals, or far worse, hold them back from accomplishing their dreams. In extreme cases, these toxic pairings can lead to the polar opposite of my favorite saying about partners and partnership: “A partner is someone with whom you can accomplish things that you can't accomplish alone.”

Finally, some doctors don't really play well in groups, and should probably not be part of a partnership, just as some people should probably not be married. It may take you several years of struggle (or several practice divorces) to learn this about yourself. Fortunately for such doctors, the environment today is allowing eye surgeons who would like to remain solo to do so, with open access to managed care patients, more and more under-served rural pockets of the country needing doctors, and practice costs that have at least temporarily stabilized.

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