

The Climb to Partnership

You've paid your dues, worked hard for a few years, and impressed the partners. They offer you a piece of the practice. Now what?

By Wendy J. Meyeroff

AFTER LEAVING THE NAVY IN THE EARLY 1970S, GREGORY SOBCHAK, MD, returned to Pennsylvania and joined forces with a senior doctor he'd enjoyed working with during his residency. "The hospital patients liked him, he had a good attitude and he was well-respected," says Sobczak, so the opportunity not only to work with this doctor, but to eventually buy into the practice seemed a fantastic opportunity. "I worked with him on salary for a year and then started buying in."

Unfortunately, it was after he started the buy-in that his partner showed his true colors. "He went on vacation and I covered his patients for two weeks. He had at least 30 or 40 patients on thyroid medications that didn't need them. When I went to look for their histories I found he had 5x7 cards that said something like 'June 5: Same,' 'August 10: Same,' and nothing else." His colleague was practicing atrocious medicine and doing so just so he could charge hundreds of patients for unnecessary services, including additional office visits. "That's when I started talking to other doctors and they said, 'Yeah, well we could have told you.'"

The good news is that at the time Sobczak didn't lose too much money in learning his lesson. Still the experience was extremely disillusioning.

Although there's no way to guarantee the decisions you make regarding practice buy-ins, there are ways to increase the chances of coming to an arrangement that is satisfactory to everyone involved.

Paying your dues

Being an employee is a fairly standard way of getting to know a practice before buying in. This gives you a chance to get a sense of such things as: What are these people like to work with, what's their patient-care philosophy, how do they feel about change, and what kind of business do they seem to be doing (but remember this question can be tricky).

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What is the price of the buy in?

Over how long a period may this amount be paid?

How much of the buy-in cost (if any) is the practice financing?

CLIMB TO PARTNERSHIP

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ond buy-in experience, a group of six family practitioners and two internists in Michigan. A few years in, a surgeon joined the group. “The chief partner told us, ‘You’re going to refer all your patients to him.’ I was the only one who spoke up saying, ‘No, my patients have the right to decide.’” Once again he left a partnership, this time staying independent for seven years.

Two to three years isn’t an unusual waiting period before buy-in, but there are locations and specialties in which the window is narrowing. [Jeffrey Sansweet](#) is a

Gregory Sobczak, MD was already buying into his first practice when he discovered his partner was practicing poor medicine. “He went on vacation and I covered his patients for two weeks. He had at least 30 or 40 patients on thyroid medications that didn’t need them. When I went to look for their histories I found he had 5x7 cards that said something like ‘June 5: Same,’ ‘August 10: Same,’ and nothing else.”



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health-care attorney and a partner in [Kalogredis, Sansweet, Dearden, and Burke](#) in Wayne, Pennsylvania. He acknowledges that between terrible reimbursements and skyrocketing malpractice premiums, it’s hard to attract doctors to the Philadelphia area, so it’s not unusual for senior partners there to sweeten the pot with a shorter buy-in period.

However, the shorter waiting period may not always be in your best interest. George Conomikes, the president of [Conomikes Associates](#), a medical practice management consulting firm based in Los Angeles, says that 25 to 30 percent of salaried employees walk away from a group within two to three years. “Their practice styles aren’t compatible with other physicians in the practice. He says that whereas he used to recommend that a physician secure a partnership offer after two or three years, they now recommend that doctors ask themselves, ‘Do I really want this partnership?’

[Stuart Kaplan](#), a partner in the health care group at the law firm of [Eckert, Seamans, Cherin, and Mellott](#), based in Pittsburgh, recommends seeking out an annual review with the head partner (like corporate executives go through). “Ask questions like, ‘Am I fulfilling your expectations?’ and ‘Am I likely to be considered for partner?’ Don’t panic if you receive some less-than-encouraging feedback. You should expect a little wiggle room and constructive criticism,” he says and suggests you see it as a positive. If they say your record-keeping leaves something to be desired, you can dismiss them as a nitpicking bunch or learn to get better at it.

If you’re being lured from out-of-town with a buy-in offer, there are some other ways to do your homework. The Medical Group Management Association (www.mgma.com) has an excellent annually-released listing of salaries for various specialties. Kaplan also suggests talking to the doctor that heads the department in your specialty at the local medical school or hospital. Presumably that person knows the going rates for salaries and maybe even has some other business advice.

Some non-financial questions that department head might also be able to answer are: “What’s this person (or group) like?” and “What’s their reputation?” (both as doctors and as people). Kaplan says that, “practices

that abuse young people are well known” so such questions may shed light on a questionable situation before you commit to being a partner. However, as Sobczak’s experience proves, what colleagues know and what they’ll tell you aren’t always the same.

Dangerous assumptions

Be careful of assuming that if you pay your dues you’ll automatically make partner at the appointed time. Although that used to be an unwritten rule, what you will probably see in contracts and hear in conversation, according to Kaplan, is “after three years you’ll be considered for partner.”

He says, “For the senior partners, that’s how it has to be. They have to get to know you. It lets them evaluate your work ethic, see how well you work with the other doctors and the staff in general, and whether you’re likely to pay your way by bringing in patients and helping to carry expenses.” Such phrasing does leave the doctor at some risk, however.

Michael Fleming, MD, a family physician in Shreveport, Louisiana, and also the president of the [American Academy of Family Physicians](#), minimizes problems by having employees attend the monthly meetings at which practice decisions are made and giving them a vote. He says, “I think if someone came in they couldn’t tell the partners from the employees in these meetings.” So far his group has taken in nine partners and not one has left.

There are risks to being a partner, however, especially if the practice has a “status quo” mentality. J. R. Thomas

Your Buy-in Checklist

Here are just a few questions to think about before you buy into a practice:

1. Who are this practice’s patients? Where do they come from? (e.g., referrals from the current doctor’s friend who has no interest in you) Where are they employed?
2. What are the practice’s fixed costs (e.g., rent, utilities, equipment) and length of terms on those?
3. What kind of malpractice do you have and who owns it?
4. What other liabilities (such as taxes) are there?
5. Who owns the accounts receivable—the practice or individual doctor(s)?
6. How efficient are collections? Ask to see the billing for any 10 patients who’ve been seen in the last 90 days so you can check the status of the accounts.
7. What is this office’s attitude toward the amount of time spent with patients?
8. How are major purchasing decisions made?
9. What is my liability regarding the buy-out of the senior partners?

is the president and CEO of Dallas-based [Medsynergies](#), which started as a practice management company in 1996 and has expanded into providing practices with financial data systems. He points out, “If it’s a small town and 60 percent of the practice’s income comes from the local GM plant, what happens if the plant closes?” Too often doctors—both the current part-

ners and those seeking new opportunities—fail to take such possibilities into account.

Another situation to consider when weighing partnership agreements is the eventual retirement of other partners. According to Kaplan, “It used to be a senior partner would leave gracefully with whatever his accounts receivable said he was owed. But then a mindset developed with the seniors saying, ‘I want you youngsters to buy me out in style.’ A bad contract now reads that the senior partner will get five times the practice’s earning at the time of buy-out.”

If the practice is earning sufficient profits that may be fine, but how can you be sure it’ll be sufficient if the senior partner isn’t planning to retire for another 10 years? You can’t without a crystal ball, so Kaplan recommends a buy-out clause that says the buy-out is based on the practice’s profitability at the time the retiring physician “pulls the trigger.”

Also bear in mind that more and more doctors are retiring earlier than ever. “In Pennsylvania, the cost of malpractice has skyrocketed, especially for ob/gyns,” says Kaplan, “so lots of physicians are retiring as young as they can,” with 55 versus 65 not being unusual.

That’s good for physicians buying in for two reasons: it can create more opportunities (as the remaining partners seek someone else to share the debts as well as profits) and younger “seniors” may be more flexible about buy-in terms. Kaplan says, “Doctors in their 40s and 50s are more likely to still have vivid memories about being saddled with debt from medical

school, so they're a lot more reasonable."

Medicine may be an art, but it's also a business. Thomas says, "It's not only acceptable for physicians to learn to merge medicine and business, it's imperative that they do so in an age where they're under siege for reimbursement."

Doctors seem to be agreeing with him and asking for help. One source that's offering more of it is state medical associations. Some associations, such as Texas, have divisions designed specifically to handle various practice management issues, including practice valuations. Others periodically provide seminars designed to address various business questions for physicians.

The [Kentuck Medical Association](#), for example, offered a one-day practice management seminar in November 2003 with a focus on evaluating various practice opportunities, including partnerships, group practice, and employment contracts with buy-ins.

Show me the money

There is no one method for buying into a practice, according to Fleming, who says, "There are as many different ways to buy in as there are practices." Kaplan agrees, and he says that the three main questions you need to ask initially are: What is the price for the buy in? Over how long a period may this amount be paid (i.e., do you have to fork over your \$50,000 right away or over a certain time period)? Finally, how much of the buy-in cost (if any) is the practice financing?

An example of the latter: The practice is financing 100 percent of the buy-in and is willing to apply your partnership share until it's paid off. It's more likely to happen if you're

someplace where they're desperate to attract doctors or (as noted earlier) if the "senior" partners are still fairly young and remember their crushing debt burdens.

There are also numerous methods for splitting the pie once you become partner. The three most common are a totally equal split among partners, basing income on productivity (that is, how much income you generate), or a combination of the two.

Asking for help

Even seemingly clear-cut divisions aren't always as simple as you might expect. Consider the following story, which often happens in the productivity module: A Type A doctor is very productive and generates tons of income. Under the formula in place when he joined, that would be his to keep. But then the others look around and say, "We'd like some of this, too" (without doing the extra work themselves) and change the arrangement to an equal division. Kaplan's solution: "An agreement that says, 'for the term of his employment and thereafter, until otherwise mutually agreed in writing, compensation will be allocated based on the following formula _____.'"

It's generally harder to divide monies (and responsibilities) "fairly" in a multi-specialty group. The family practitioner doesn't make as much as the plastic surgeon; orthopedists have different expenditures than cardiologists.

Sobczak notes that his third group practice, a family-practice group in Michigan from which he is now retired, was productivity-oriented, but "doctors could practice any type of family medicine they wanted." So the

hot-shot FP who also did surgeries could easily bring in a \$30,000 quarterly bonus, "and I'd get \$5,000, spending an hour instead of only 15 minutes with patients who needed me." Sobczak's approach wasn't as profitable for him and his group, but his colleagues let him practice medicine the way he wanted.

Even in a single-specialty practice differences can arise, including the costs of each doctor's malpractice premiums. Sobczak has a subspecialty in obstetrics. Today, the odds are the malpractice rates would be much harder on his fellow FPs than they were in the '70s. A group today might refuse to carry that cost altogether, make him sacrifice something else in exchange for their generosity, or (in the ultimate scenario) not ever accept him as partner.

This is where a good accountant or attorney is critical in clarifying what you'll be entitled to at the end of the day. Fleming says, "I've always believed that a physician needs a team [including] a good lawyer and accountant."

[Stuart Kertzner, CPA](#), a partner who specializes in health care at the accounting firm of [Gettry, Marcus, Stern, and Lehrer](#) in Woodbury, New York, goes further. He says, "Lots of young doctors taking over their fathers' practice also inherit the accountant and attorney. Make sure they are health-care specialists." Some accountants, he says, may provide great basic IRS and business advice, but they have no real expertise in practice buy-ins.

Also don't forget to ask about buying out. There may come a time (as Sobczak's story shows) when you may want to get out of your deal. With the

onslaught of managed care, many physicians started forming groups to help with the paperwork and to get power. Experts say that it really didn't work for most physicians and so more and more doctors are breaking the group so they can go back to being in control of their own destinies.

Among the places to find help specific to practice buy-ins: other young doctors who've recently been through a buy-in, state medical associations, and specialty associations like the American Health Lawyers Association (www.healthlawyers.org) the National CPA Healthcare Advisors Association (www.hcaa.com) and the Medical Group Management Association (www.mgma.com).

Other financial questions

There are other money issues that may affect how existing partners feel about accepting a new doctor into the arrangement, some relating to medicine and some not.

Medical equipment can be a source of conflict. The latest high-tech gadget is nice but does a family practice group need it for one doctor or can he do his procedures at the hospital? The answer's often the latter, so who decides? Does the group all have equal votes and do they have a history of abiding by the majority? Or have they agreed to let their accountant investigate, determine if it's a good investment, and abide by the decision?

Thomas notes that it's not unusual for conflicts to arise over computer technology. Sobczak says that at his second group, the head partner "wanted to buy a computer at the time when one took up a whole room," and he had the decision-making power. Nowadays with

everything computerized, the issue is now about upgrades and ancillary technologies. Thomas says senior partners often believe five-year-old equipment is just fine, while the younger generation may not only be seeking upgrades but

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great new doodads like PDAs for every partner.

Conomikes has a slightly different perspective. He doesn't think the issue arises as often as one might think: "If the practice is really in the [technological] dark ages, the younger physician will have walked early saying, 'They're outmoded and I don't want to be affiliated with them.'"

Real estate investments can be another sticking point. Conomikes says that the senior partners may not want to bring in another investor. Sansweet counters that not every physician wants to be that kind of an entrepreneur.

Way out of pocket

There are a host of intangibles that may or may not add value to a practice—or interest you even if they do. Consider the "productivity" division. What happens when some doctors define it as more than just the number of procedures each doctor performs? Kaplan notes that "public speaking, working on boards, training younger people" and other abstract "assets"—usually brought in by

the senior partners—are considered beneficial to a practice by many and yet may be totally dismissed in a productivity-only compensation model.

Fleming doesn't bother putting a price tag on such contributions. "If I'm the buyer, I want dollars and cents. When we valued our business this year, my being president of the AAFP didn't factor in at all."

Some physicians seek out a group whose income is greatly generated by the name recognition of the lead doctor. But what happens if the doctor retires or dies? It's critical to ask what steps have been taken towards this eventuality.

Marketing is an important part of maintaining profitability, but Thomas admits the promotional mindset is still very much in the minority among physicians. He says, "I don't think doctors spend enough on marketing business development yet." The exception was a group of plastic surgeons with which Kaplan was familiar. The offices were decorated lavishly, patients were offered cappuccino in the waiting room, and an entire "atmosphere" was carefully created.

It might be easy for physicians to see the importance of such "investments" for plastic surgeons seeking to project an upscale image and court high-income clientele. Does that mean it's worthless for others? What about other forms of promotion? Are you and the practice you're seeking to join compatible on issues like a regularly maintained Web site, a quarterly newsletter, or other marketing tools?

Undoubtedly the most critical issue is: Are these people you can work with? Kertzner remembers the group that spent around \$70,000 on legal fees, only to conclude, "We agree on all the governance issues, but clinically we don't

practice medicine the same way.”

Don't forget to consider how well you interact with the entire staff, not just your fellow physicians. When Sobczak came to his second practice, “I was the only one who practiced Lamaze or advocated breast-feeding and had to fight the nurses.” But fight didn't mean raging battles; the staff understood that this was his philosophy when he joined and everyone was willing to work with him.

Sobczak says that in any sort of group arrangement, “you give up the ability to decide everything yourself, so you have to be compatible. You can't have wars going on all the time.” Ultimately, he believes, it's “harder than a marriage.”

Thomas finishes by telling of the evening he'd taken his two youngsters out for dessert and two interns come in studying for their boards. After he struck up a conversation, they confessed to being worried about the financial pressures that awaited them: managed care, technology expenses, malpractice, and so much more. So he said, “Maybe I can make you feel a little bit better. You have to make the right decisions, the right partners. It's competitive. It's not without risk, nor should it be.”

But, he concluded, “There's not a better business existing today than the practice of medicine. You can help people. You can get PAID for helping people. You can be rewarded handsomely for that and the capital outlay is relatively inexpensive; returned in two or three years instead of eight to 10 for most people.”

So find good business help, join forces wisely, and enjoy practicing medicine. ■

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