

# *Taking on or Becoming a Partner?*

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The reluctance of surgeons to aggregate in practice groups is well known. If adding a partner is a problem for most surgeons, it is perhaps an even larger problem for plastic surgeons. Most plastic surgeons, particularly those with interest in aesthetic surgery, seem to prefer solo practice. Indeed, one client we spoke with stated that he didn't know of any successful plastic surgery partnerships other than those in which the purpose for forming the partnership was to facilitate the transfer of practice ownership within a short number of years from the senior doctor to the new doctor. Nevertheless, there are good reasons, along with some bad ones, for plastic surgeons to entertain the idea of adding a partner. In approaching such a consideration, there are a number of steps one must take:

Assess the market. Before contemplating a partner, take stock of the competitive climate in your market. Include dermatologic surgeons, ENT facial plastic surgeons and other so-called “*cosmetic*” surgeons. Can the market really support another reconstructive or aesthetic plastic surgeon? On the positive side, will the addition of a partner possibly open up some satellite opportunities that a solo cannot consider?

Assess yourself. This is an especially important analysis and one that is, more often than not, glossed over. The chief reasons why a solo plastic surgeon might consider adding partners are to:

- Reduce overhead burden;
- Effect an “exit” strategy;
- Facilitate taking more time off;
- Mitigate call pressures.

Probably, the sharing, rather than the reduction of overhead burden, is the most valid reason for bringing in a partner. In a properly managed practice, the overhead of two busy plastic surgeons will be a good deal less than their combined overhead of each practicing solo. To structure and facilitate an exit strategy, whereby the new physician takes over the senior doctor's practice after a relatively few years, is another valid reason for bringing in a partner. If the addition is a mechanism for providing time off, however, we have seen some occasional undesirable bi-products. If the senior doctor is considering cutting back to two-thirds or one-half of his or her full practice, then this is not a discussion about the addition of a partner, but rather, to some degree, the substitution of an acquired physician for the senior physician. This can lead to a number of unhappy consequences, particularly in income distribution, since the now part-time senior surgeon will be increasingly unwilling to pay an appropriate share of the fixed overhead. The fourth reason cited, to reduce call, is rarely a valid basis for adding a partner. Only when the practice is engaged primarily in reconstructive work is call a potential problem. And then, it is better managed via a call schedule with colleagues rather than by employing an associate.

Assess the candidate. In comparing potential partners, you should consider and ascertain the following:

- Be sure the candidate comes from a first rate training program. You should vet the candidate by contacts with the director of that training program. Additionally, conversations with doctors a year ahead of the candidate and floor nurses are often revealing.

- Scrub-in with the candidate to observe style and skill in the operating room. How does he or she treat the OR staff? This is an important piece of information that frequently is not obtained by surgeons considering a new partner. In this connection, it might be a good idea to obtain before-and-after photos reflecting the previous work of the candidate. A fellow or resident who presented cases at national or regional meetings has a measurable product to assess.
- Assess value, culture and professional goals and compatibility. These are always important in any relationship, whether it's a professional medical practice, a marriage, or any other. Seek a candidate who represents a complimentary and/or expansive practice opportunity depending on market factors.
- If the proposed partner is to facilitate the exit of the senior partner, you are far more likely to be successful by delaying full partnership until you are one to four years away from retirement. Few partner candidates will be willing to accept a five to ten year wait for your exit.
- Spouse compatibility. This is an obvious and pervasive concern in any medical group practice. We all know of partnerships that have literally come apart primarily because of incompatibility of the spouses.

Avoid significant problem areas. As you might expect, there are several potential problem areas when one considers bringing a partner into a situation in which the senior doctor has always been solo:

**Staff resistance** - Probably the most likely saboteur to the effectiveness of any partnership arrangement will be your staff. This is particularly so if they have always worked for you as a solo doctor and have come to adopt a proprietary feeling toward you and “*their patients and practice.*” Among issues that are liable to raise the hackles of one or more staff members are:

- Resentment that there will be no more Fridays off;
- If the new recruit is going to be involved in reconstructive cases, the staff must learn, or re-learn, the coding and managed care rules.
- There will likely be resentment that the waiting room will be “*messed up*” by reconstructive patients causing a deterioration in the ambiance that aesthetic patients prefer in the reception room. Staff members can be very upset about something as cosmetic as a change in waiting room ambiance;
- Probably the most potentially divisive act of behavior that the staff can demonstrate is to adopt a “*caste system*” under which they view Dr. Senior as enjoying a superior status to that of the junior doctor. This can be reflected in all sorts of ways, including fair allocation of new patients, phone and scheduling protocols, availability of staff when a problem arises, etc.

The new physician will be less efficient. Initially, the new surgeon will probably lack the speed and efficiency of Dr. Senior until he or she has more experience. Yet, they charge the same case rate as Dr. Senior, which can put a stress on the allocation of overhead issue, since the young surgeons incurs excess overhead. There are numerous ramifications this can take, and until the younger doctor approaches Dr. Senior's efficiency, it can be a constant irritant.

Your “*plant*” (office, staff, equipment, etc.) may not be able to comfortably accommodate a second physician, leading to the necessity that the practice must add infrastructure or resources, which are, of course, expensive;

If the junior doctor will be involved in reconstructive work, it will be necessary that the practice join or rejoin managed care organizations, which, of course, are not necessary in a purely aesthetic practice. If this is the case, it will be similarly necessary to train or retrain staff in the

protocols involved in managed care. This is especially relevant to the several elements involved in the reimbursement process for Medicare, as well as managed care plans. This can be a timely and irritating learning experience.

Similarly, in a reconstructive situation, it will be necessary that Dr. Young handle emergency room call, something Dr. Senior has avoided with a purely aesthetic practice.

If the recruit is to be salaried, Dr. Senior will bear the financial risk of the recruit not generating enough collections to cover his or her compensation, fringes, and overhead. If, on the other hand, the recruit is brought in as an immediate partner, Dr. Senior will probably forego any opportunity or power to “clone” the recruit in Dr. Senior's style. This could be important if the context is a transfer ultimately of the practice from Dr. Senior to Dr. Junior, in which case style continuity can be very important to patients and referral sources.

An alternate consideration is merging with another solo plastic surgeon in your market. There are a number of clear benefits from taking this route if all other things are equal:

- The other surgeon already has a book of business and referral sources - therefore, there will be no “*ramping up*” of his practice.
- He or she already knows the territory and the people in it. As a functioning plastic surgeon, there is no learning curve implicit in this arrangement.
- If he or she has good relationships with the hospital personnel, the nurses in the OR, ER doctors and administration – this beats an unknown.
- The addition of a successful partner from the outset could facilitate quicker acquisition of new assets, such as construction of an ASC, updated computer software, or more sophisticated management and staff.

Most of all, realize that no successful group just “*happens*” -intentionality, dialogue and holding egos in check are essential to success.