



Can This Partnership Be Saved?

By Karen Zupko

“Can This Marriage Be Saved?” was a McCall’s Magazine column I used to read with great fascination as a teenager. Each month, a psychologist would address questions from real readers whose marriages were on the rocks. The problems were frequently related to miscommunication, money, incompatibility, or the children. In most cases, the marriage was a risk of falling apart because the couple had not taken the time to set expectations, clarify what each of them really wanted, or have an open and honest conversation.

Physician partnerships are much more like marriages than business transactions. Over the years I’ve watched dozens of successful surgeons think their “problems” will be solved if only they would hire a young associate to help them with the overhead or call coverage. They court and “marry” a good set of hands with a fine demeanor only to realize that they brought the associate on too hastily, with no thought given to what’s required to integrate an associate. The result is a bitter dissolution of the arrangement—typically in two years or less. And, just like the McCall’s column, the most common problems we see in physician partnerships that need to be saved are miscommunication, money, incompatibility, or the “children” (the senior physicians’ staff).

Here are some of the common reasons for this. All are avoidable with proper expectation setting, communication, planning, and an honest self-assessment. Any resemblance to your colleagues is purely coincidental. The stories are composites based on a 30-year history of working with plastic surgeons.

1. Integration of a new partner was more difficult than expected.

Dr. Senior was a bachelor in practice his entire career. All he ever knew was “my patients,” “my staff,” “my office,” and “my overhead.” He enjoyed a professional lifestyle in which he was able to make all decisions unilaterally, and run the practice without interference.

Enter Dr. Junior, a newly minted fellow. Dr. Junior has had to be collaborative and work as part of a team his entire career. He’s eager to grow his practice, but as if he were stealing a toy out of Dr. Senior’s toy box, Dr. Junior and his long-term and loyal practice manager have summarily told him that, no, he can’t access the patient list for an



open house. Marketing expenses for things like changing the door signage will be taken out of his salary directly. And oh, by the way, the patient care coordinator will only be available 25% of the time to discuss fees with his patients.

Just as psychology research shows that a child over the age of seven will find it shocking to have a new baby sibling, the physician who has practiced solo for seven years or more typically finds the integration of a new associate much harder than they thought. The transition from solo to a second doctor is like only child syndrome. Similar to the only child, these doctors find it difficult to share because they have never had to. Or at least they haven’t had to for a very long time. They aren’t practiced at being collegial on a day-to-day basis. Collaboration confounds them because they’ve always been the one to make unilateral and sometimes whimsical decisions about staffing, supplies, the schedule, block time, and the marketing budget.

It’s not only the physician who has difficulty with the integration. Staff often put the new partner through a hazing process that impedes success. For instance, Dr. Junior arrives and no one on the staff wants to support his practice or give him patients because the staff has a strong sense of loyalty to the senior

surgeon. Or, staff are told nothing about how and which types of patients to schedule, what the fee should be, or how to explain Dr. Junior’s credentials to callers and existing patients. Staff protect “their doctor” and make the new surgeon jump through hoops to get patients on the schedule. Logically, of course, this makes no sense. But if staff has been given little to no information and feels threatened that the new doctor might somehow change their work environment or succeed at the expense of “their doctor,” they will obstruct progress and ignore the new physician’s requests.

Don’t underestimate the amount of upheaval a new associate creates. The arrival of a new professional partner brings many changes to a practice. Typically, most of the transition energy is spent on logistics and operational concerns. But fear of change and underlying loyalty issues are what cause staff to “act out” and make life difficult for both physicians.

As the “first-born child,” Dr. Senior must prepare and involve the entire team for the arrival of the “new baby.” Don’t wait until the partnership agreement is signed and Dr. Junior’s start date is on the schedule. Prepare

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for the seismic shift by telling staff about the change early. Communicate regularly about the changes so that staff issues are addressed and they understand their role in making the new associate successful.

2. All you really wanted was call coverage.

Dr. Senior loves his patients, enjoys the autonomy of being in solo practice, and has a thriving practice. He's worked hard his entire career and rarely takes vacation. Now that their kids are out of the house, Dr. Senior's wife has been telling him that she wants the two of them to have more time together, and spend some of his hard-earned money to take a few nice vacations each year. So, Dr. Senior brings on a partner to help him cover nights and weekends, and increase his opportunity for vacation time. Problem is, when Dr. Senior is in the office (which, let's face it, is 90–95% of the time), he no longer has the autonomy he enjoyed and he's begun to dread the meetings, staffing issues, and drawn out decision-making that come along with expanding the practice.

Before you take the partnership plunge to solve the call coverage problem, take an honest inventory of whether you can tolerate all the other things that come along with adding another physician to your world. If all you want is more time off, hire a nurse practitioner or First Assist instead. These clinical professionals can work independently (check your state's scope of practice) and extend your productivity. As a staff person, they will help build loyal relationships with patients—without “taking them” from you. Your autonomy stays intact and you can continue to enjoy the solo practitioner way of life—with an improved quality of life.

3. The Millennial work ethic.

Dr. Senior brought on a whip smart new associate who was fellowship-trained in a highly regarded program. Dr. Junior was skilled in several new procedures, and the hope was that he would enhance the practice by expanding the services and procedures offered. Dr. Senior expected Dr. Junior to immediately get to back slapping and glad-handing with referrals and practice building. But instead, Dr. Junior kept strict work hours and wasn't so keen on

community networking and referral building, after hours events, or putting in the time to build a sufficient number of new patient consultations by blogging or doing much on social media.

How can a person survive eight years of postgraduate work and the rigor of surgical training without having a work ethic, you ask? I don't have the answer, but I hear this complaint regularly from clients and contemporaries. Call it generational differences or an unwillingness to put career ahead of personal goals but the times they are a changin', and the number of “work horse” young surgeons has diminished since the Golden Age of medicine. Many young physicians place more value on work-life balance. They fail to correlate their high earning potential with effort made and hours worked, and are ok with doing good work then going home instead of going the extra mile to build the practice they said they wanted. “They expect it to be given to them,” said a client recently.

You should expect some level of practice building and patient development from your new associate, but you'd better discuss and clarify the expectation during the interview process so neither of you make assumptions. That said, if you are the type of surgeon who expects a high level of business building skill from Dr. Young, you might never find an associate who will satisfy you. The “back in my day, I did x, y, z...” story gets old fast. If that's the case, acknowledge the benefits an associate does bring—such as call coverage, collegiality, and perhaps a new surgical technique—and dial down your comparisons and expectations. If that is too difficult for you, stay solo.

4. Poor cultural fit.

From the moment he read it, Dr. Senior was in love with Dr. Junior's CV. The new associate completed his fellowship in a prestigious program and trained with one of Dr. Senior's old colleagues. He had performed an impressive number complex breast revision surgeries. And, he was published and was a first author. All this and an avid tennis player, too.

At first, Dr. Senior felt as if he hit had the jackpot by hiring the young surgeon. But tensions

The Professional Battle of the Sexes

(a.k.a., She Became Too Popular with Your Female Patients)

A client who specializes in breast surgery recently brought on a female associate. He had not prepared for the percentage of breast consultation patients who began to choose the new associate over him. He hadn't fully considered the fact that a certain amount of self-selection from this patient group was to be expected, and stemmed from something he could never compete with: Dr. Junior is a woman, too. So, despite this client's 20-year, positive reputation as a breast surgeon, a certain amount of the new associate's breast practice began to grow seemingly without effort.

If you are a male surgeon who is considering the addition of a female associate, recognize that the situation will likely be similar in your practice. Consider it an opportunity to grow the overall revenue from breast procedures.

arose quickly after Dr. Junior came on board. Dr. Junior consistently showed up for clinic sloppily dressed. He dropped a lot of “f bombs”—sometimes even in front of patients. His cases went long in the ASC and he was wasteful with supplies. And Dr. Senior began questioning some of Dr. Junior's clinical decisions.

Like any good merger or marriage, cultural fit is a most essential success factor and it's probably the biggest reason for break-ups. Yet, it continues to be mutually overlooked during the hiring process. In order for a partnership to be successful, the new associate must be a

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good fit with both the behavioral and clinical culture of the practice.

Behavioral fit includes things such professional and personal presentation, interactions with patients and staff, and issues around money. It's just like a married couple. How (or whether) we pick up after ourselves around the house, how we save and spend, how we behave in social and professional situations—all of these can become core sources of tension, unhappiness, and arguments.

The issues may seem small at first, but they can quickly grow and even erode your relationship with a new associate if they don't align with your practice and philosophy. If your practice branding preference is to conduct consultations in a suit and Dr. Junior wants to wear scrubs, that may not fly. Or you discover that your new partner has been staying at the Ritz when attending meetings, and running that through the practice. Or Dr. Junior shows up late on a regular basis, and that's starting to make your teeth itch. When Dr. Prudence hires Dr. Profligate, it creates tension. How you each regard the overhead, staff salaries, supplies, and marketing dollars really matters.

And how will you feel if staff or patients tell you that Dr. Junior is posting personal Facebook pictures of him or herself at rowdy parties? Or "friending" patients? (Always a no-no, in my opinion, as well as most attorneys'.) I recently helped a surgeon dodge the "inappropriate personal conduct" bullet before he made an offer. Dr. Senior knew the young surgeon's father and was predisposed to hiring him based on this relationship. I was asked by Dr. Senior to weigh in on the young surgeon candidate, so we had dinner together when he was in town for his boards. In just a few hours, the young surgeon drank too much. Way too much—two nights in a row.

The point here is that you must outline your expectations about professional decorum before you make an offer. Don't just assume that with ten or twelve years of training the associate will behave like a professional. Put in writing and share your "Rules of the Road" for behavior and conduct in the office and OR. Do this during the interview process. In addition, when your one doctor practice goes to two, institute inventory controls, accurate

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time reporting, and detailed financial tracking systems so that the books accommodate doctor-direct expense posting. That way, the numbers are clear and unmistakable.

Clinical fit includes the associate's surgical and patient care philosophy, technical skills, and clinical decision-making abilities. It's hard to know this at a granular level after only two site visits with a candidate—even if he or she scrubs in with you. And during those reference checks, chiefs don't always tell the truth.

I had an OR manager tell me recently that a newly hired physician consistently misrepresents breast cases—often booking an augmentation but actually performing an augmentation and a mastopexy and consistently running over his OR time. In another practice I work with, the young associate under-bills for the number of neurotoxin units injected.

Is there a perfect way to interview for culture fit? No, but awareness is important. For behavioral fit, a good question to ask candidates is, "Tell me about your family home and your experience with money." And to understand clinical fit, create three, what-if scenarios that require nuanced judgment. "What if you had this complication—how would you handle it?" Or, "If you found yourself with this issue during the case, how would you handle it?" You want to determine at what point the candidate would contact you for help, and if he or she doesn't suggest that as an option at all, that's a potential problem.

Be up front with candidates that you would like to conduct some informal, clinical peer review during the first year. You might say, "One of the advantages of bringing on an associate is the collegiality we gain in our

patient care. For the first six months, I'd like to have monthly pow-wow where we review five cases..." As reported by a young surgical associate who said one of the advantages was that she and one of her partners would sit by the pool almost every Saturday for the first six months and review cases together. This, she told us, was a great way for her to learn and get feedback without feeling spied upon.

5. The new associate's spouse doesn't like your location.

Dr. Junior accepted the offer despite protest from his wife. She preferred to live in a major city, near her family, and refused to move to the mid-sized town where Dr. Senior's practice was located. She agreed to allow her husband to accept the job as long as the two of them could buy a house in a neighboring, larger town. This resulted in Dr. Junior driving 120 miles round trip to the office. He wasn't readily available after hours when a patient issue arose, didn't relish evening events, and began showing signs of exhaustion.

It's essential to ask candidates about their spouse's geographic preferences during the interview process. Did she grow up in the same area and is looking for an opportunity to return and raise her family in a place that feels like home? Does the candidate or his wife have family nearby? Ask the spouse the same question during a face-to-face visit, and observe not only the verbal answer but the non-verbal too. If you sense any discomfort or squirming, that's not a good sign for long-term success.

I recently talked to a group of surgical residents, mostly men, asking them where they wanted to practice. More than a few said to me, "Wherever my wife tells me we are going." That's an honest answer. If the spouse isn't happy, the associate won't be with you long.

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