**Physician leadership**

**Don’t fumble when you pass the baton**

*Identify and groom future practice leaders*

When the current managing partner retires, dies, must leave because of unforeseen circumstances, or just wants to take life a little easier, you’ll need someone to step into that role.

Planned or unplanned, the day will come when your group’s top-level management responsibilities must be passed on to someone who is probably seeing patients in your practice this very minute. It could be years until this happens, or it could be next week.

Performing in a leadership position is a serious and time-consuming duty. Not every young physician wants to take on such a role, and only a few have the skills and temperament for the job.

That’s why it’s wise to start identifying and grooming candidates now.

**Involving young partners**

Ohio consultant Jack Valancy¹ advocates inviting associates to take part in practice meetings as a way to assess their level of competence and interest in taking on leadership roles.

“They may not yet have a vote, and of course they can’t be involved in every discussion, but young physicians should have a voice,” says Valancy. “It’s helpful for them to see how the group runs, how decisions are made, what the process is.”

Mike Fleischman², a health care consultant from Atlanta agrees. “Start working with a physician early if you think he or she has the potential to be a group leader,” he says.

“Let the associate sit in on meetings with the practice accountant or when managed-care negotiations are taking place. After the meeting, talk with the associates to answer any questions and assess whether they understood what went on. Also, get them involved in the preplanning of these meetings.”

As younger physicians become involved and learn more, they’ll naturally begin to speak up and make their opinions known. This is when senior partners should watch and listen. Are you witnessing the birth of a leader or just the discovery of someone with a bit of an ego?

**Challenge young physicians**

Valancy also recommends “testing” physicians to see how they handle responsibility.

“Give them small projects and see how they do. Find out whether they have the ability to gather information, ask the right questions, and see a job through to completion. It’s not a good sign if they’re hesitant and keep checking back on every detail, or if they don’t fully do the project. On the other hand,

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¹ Contact Jack Valancy in Cleveland Heights, OH at 800/786-5225, jack@valancy.com; www.valancy.com.
² Fleischman is a principal with Gates, Moore & Company in Atlanta; 404/266-9876; mfleischman@gatesmoore.com; www.gatesmoore.com.
if you give someone a little responsibility and they run with it, you may be looking at a future leader.”

Give younger partners projects with increasing levels of complexity and responsibility to help them learn the ropes.

Assign some of the tasks you’ve been wanting to do but haven’t had the time to address.

Working on projects will also help associates evaluate for themselves whether they want to take on larger management roles.

“What you don’t want to do is end up with a situation where the young doctors are lost at sea when the senior partners retire because they haven’t been involved in anything up to that point,” says Valancy.

**Letting go**

Senior physicians sometimes struggle with relinquishing their positions of power. They’ve become comfortable calling the shots.

Although they say they’re ready to turn things over, they might withhold information or not share the decision-making authority when the time comes to make the transfer. Don’t let this happen.

If you’re a physician leader nearing retirement, let a thriving practice with quality leaders in place to make the practice successful be part of your legacy.

Succession-planning is crucial to the long-term success of any group practice.

Carefully identify future leaders and groom them for management roles. Doing so will give senior leaders the confidence and comfort to gracefully pass the baton when the time comes.

I’ve seen some groups lose the person who might have been their ideal candidate simply because they didn’t follow up right away.

Physician recruiter Frank Vigil is involved in so many groups’ hiring efforts that he knows what makes the difference between success and failure.

“I cannot overemphasize the importance of prompt follow-up with candidates.”

Even if it’s just a five-minute phone call or an e-mail, let the candidate know that he or she is being considered—or not being considered if such is the case.

If he or she is under consideration, keep the communication lines open at all times. Encourage the prospective candidate to ask questions and be sure to provide answers promptly.

“I’ve seen some groups lose the person who might have been their ideal candidate simply because they didn’t follow up right away.

“Candidates sometimes mistakenly believe that a group has no interest in them because they’re not contacted quickly, when in fact that might not have been the case at all.”

- Respond hiring

**Respond promptly to candidates—or else**

*Slow follow-up can kill a recruit’s interest*

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1 Contact Vigil at Southwestern Health Care Recruiters in Albuquerque, NM; 800/378-0207; fsvigil@swhcr.com; www.swhcr.com.
Physician compensation

Arranging second and third year salaries up front

*With less time before partnership, not many groups set pay beyond a year*

In the November GPS, we reported on readers’ new physician hiring patterns and the trend for practices to hold back on base salaries but offer incentive pay based largely on their associates’ productivity. Groups seem to be saying, “We can’t afford to guarantee you as much, but we’ll pay more if you’ll produce it.”

That makes sense for a new doctor’s first employment year in view of medical-practice finances these days, but after that break-in year, our survey shows a mixed bag for promising second- and third-year salaries. The table below shows results on a specialty-by-specialty basis to give readers specific information on practices like their own.

Many practices do not specify future pay arrangements. This contradicts our usual advice to cover all employment years in the initial hiring contract. By doing so, you avoid getting into another round of pay negotiations as you approach the end of a year’s service. We’ve seen too many boats rocked when this uncertainty arises.

Given last month’s data on first-year incentive pay, it makes sense to arrange similar, perhaps even more heavily production-based compensation with little or no increase in guaranteed salary for years two and three.

**Promising partnership**

The table also shows that many practices are promising partnership right in their new-doctor contracts. We favor setting forth the partnership deal in broad terms early on to avoid boat-rocking negotiations as your associate matures into partner material. But be sure you don’t promise that status. Make it clear that you’ll offer it only if you’ve concluded that he or she meets your criteria for becoming a partner.

Note how quickly young doctors are being invited into co-ownership. Two years appears to be the norm, but a number of specialties offer the promotion even sooner than that. Cardiology, perhaps the hardest-to-recruit specialty these days, is a touch on the long side at just over two years. ■

### Future salary promises by specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Specify 2nd year salary</th>
<th>Specify 3rd year salary</th>
<th>Promise partnership</th>
<th>Avg. years until partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td>26.7%</td>
<td>11.8%</td>
<td>60.0%</td>
<td>1.4</td>
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<tr>
<td>Internal Medicine</td>
<td>50.0%</td>
<td>0.0%</td>
<td>80.0%</td>
<td>2.0</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>30.0%</td>
<td>20.0%</td>
<td>56.7%</td>
<td>2.4</td>
</tr>
</tbody>
</table>

| P.C. Surgical:         |                         |                         |                     |                          |
| ENT                    | 42.9%                   | 0.0%                    | 14.3%               | 2.0                      |
| Ob-Gyn                 | 40.0%                   | 20.0%                   | 80.0%               | 2.3                      |
| Ophthalmology          | 75.0%                   | 25.0%                   | 100.0%              | 1.8                      |

| Spec. Int. Med.:       |                         |                         |                     |                          |
| Cardiology             | 100.0%                  | 60.0%                   | 90.0%               | 2.3                      |
| Gastroenterology       | 33.3%                   | 0.0%                    | 100.0%              | 1.3                      |
| Hematology/Oncology    | 100.0%                  | 0.0%                    | 60.0%               | 2.0                      |
| Neurology              | 50.0%                   | 50.0%                   | 50.0%               | 3.0                      |
| Pulmonology            | 100.0%                  | 75.0%                   | 100.0%              | 2.6                      |

| Surg. Specialties:     |                         |                         |                     |                          |
| General Surgery        | 50.0%                   | 50.0%                   | 50.0%               | 2.0                      |
| Orthopedics            | 64.7%                   | 0.0%                    | 70.6%               | 1.7                      |
| Urology                | 100.0%                  | 50.0%                   | 100.0%              | 1.5                      |

| Hospital-based:        |                         |                         |                     |                          |
| Anesthesiology         | 83.3%                   | 41.7%                   | 100.0%              | 1.8                      |

| Other                  |                         |                         |                     |                          |
| Dermatology            | 0.0%                    | 0.0%                    | 100.0%              | 1.0                      |
| Allergy/Immunology     | 100.0%                  | 0.0%                    | 100.0%              | 2.0                      |

*Source: Advisory Publications New Physician Salary Survey*
Allocating overhead fairly when paying your members

No formula is perfect, but you have choices

The overwhelming majority of groups compensate their partners largely (though not always wholly) in proportion to their revenue production. But there’s a second issue lurking behind the scenes: how to allocate practice costs, which does not necessarily truly relate to how the doctors produce revenue.

Of course, some formulas seem to disregard the question by dividing the group’s net income—the bottom line after expenses are already deducted. This is a simple way to compute physician pay since it requires only one calculation, but it causes overhead to be allocated without really considering what is fair in terms of use of costs. That’s why so many formulas call for two calculations. The first divides practice revenues and the second allocates practice expenses.

Geoffrey T. Anders¹, medical management consultant and lawyer, addresses these questions in his 168-page book, Playing Fair: Planning Group Practice Compensation. “If life were simple, the relationship between overhead and charges (or revenues) would be clear,” he writes. “We would be able to state without any hesitancy that there is a direct relationship between overhead dollars and revenues. It costs as much to earn the first dollar as it does to earn the millionth. Practice overhead is not volume-sensitive.”

Not that simple

“Some items of overhead are fixed and some are variable, but most are semi-fixed. You pay overhead for a system to handle up to a certain volume of patients. If you want to increase the number of patients seen [over that volume], you must expend another slug of over-head.”

This reality makes allocating expenses in paying physicians more difficult and often more contentious than we’d all like.

You could, of course, undertake true cost-accounting. This system treats each physician as a profit center.

The method might seem ideal, says Anders, “but deciding how to treat each and every item of practice expense is a can of worms all by itself.” In addition, it may not make sense for each member of a group to be absolutely independent of the entity’s combined operations, and the politics of allocating general expenses so precisely may lead to more divisiveness than agreement.

Two choices

Anders offers two basic approaches: the “productivity-proportionate overhead allocation” and the “productivity-equal overhead allocation.” The question is whether the overhead should be charged equally because it is equally available, or on productivity because that is how it is used.

Dividing overhead equally?

Consultant Geoff Anders¹ tells this story about a two-doctor group dividing income equally:

“A senior general surgeon divided facility cost equally with her new partner. Except on surgery days, Dr. Senior held office hours in the morning between 7 a.m. and 11 a.m. Dr. Junior had the office to himself during the afternoon hours between 1 p.m. and 5 p.m., giving them equal use of the facility. This might strike you as a fair arrangement: Equal use, equal cost. But how about if we tell you that the vast majority of patients preferred the morning hours so they could still get in a day’s work?”

The question is whether the overhead should be charged equally because it is equally available, or on productivity because that is how it is used.

¹Anders is president of The Health Care Group, a consulting and law firm in suburban Philadelphia. Contact him at 610/828-3888; e-mail to ganders@healthcaregroup.com. Order his book for $96 from HCG’s Web site: www.healthcaregroup.com.
of productivity.

This approach charges the most productive doctor with an expenditure whether he or she uses it or not, perhaps on the rationale that, if it’s spent or on hand, then the more one produces revenue—no matter how he or she does it—the more of it he or she should pay for.

Sometimes, notes Anders, the approach is eminently fair. He gives an example of two orthopedists, one of whom “works calmly and smoothly” while his partner is a “wild man, ordering assistants hither and yon, racing up and down the corridor and getting his patients into any available exam room.”

That latter physician consumes more of the available resources.

- **Equal allocation.** This formula has “its own delusional world view,” Anders says. It assumes that each doctor has an equal opportunity to use the facility and services, that each one actually uses an equal share of overhead and that none have any overhead costs directly related to his or her individual practice.

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**News**

**Group practice salary trends**

*Pay raises greater for small-group administrators*

Practice administrators with six or fewer full-time equivalent (FTE) physicians received an average 15% increase in compensation in 2003 over 2002, according to the Medical Group Management Association (MGMA).

Pay increased less for managers with seven to 25 FTE physicians and those with more than 25 FTEs, averaging just 4.19% and 3.48%, respectively.

But overall, compensation is higher for those leading larger groups.

A compelling study described during the recent MGMA annual meeting suggests that the optimum size for group practices is five to eight FTE physicians.

It brings up the question of whether larger groups are better off segmenting themselves into smaller subgroups.

**Performance areas**

MGMA also reported on its recent survey of its administrator members.

The survey asked members to rate, on a scale of one to five (one being not at all important, five being very important), the importance of various performance areas to their groups’ success. (See the above chart.)

“If the group’s objective is growth and increasing market share, this method may well be the very worst,” says Anders. It favors the senior and most productive doctors and can badly shortchange the younger doctors building up their practices.

This approach has its proponents who argue that practice overhead is equally available to all the users. We often see it forced on groups when the largest producers have the strongest sway in key practice decisions.

Each method has its advantages and its shortcomings. The decision may depend on the dynamics of your group, for no one answer is necessarily the right one. None is perfectly fair, he says, so you have to find the one that works best for your group.

Sometimes a combination approach will work well, charging some portion of overhead equally and another portion on productivity, compromising so there’s a bit of fairness and unfairness for everyone. Still, “you’ve got to pick something,” Anders says.

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MGMA is the top quality organization for managers and administrators of physician groups. With over 19,000 members representing some 11,000 organizations, 60% of its membership comes from groups of 10 or fewer physicians.

Its annual meeting recently included more than 5,100 registrants and hundreds of seminars, while its smaller specialty conferences during the year cover specific group topics.
Your group is humming along since you added your sixth physician a year ago. Everyone is getting along, productivity is good, staff and patients are satisfied. Then, out of the blue, your young superstar gives notice that she’s leaving.

Could you have prevented this exit?

Physicians who join a group and then leave within a year or two do so for a variety of reasons—for example, if his or her spouse doesn’t like the area or there’s a serious personality mismatch. In these cases, there may not be much you can do. But many early departures are preventable.

A young physician’s unmet expectations can actually stem from a simple communication problem.

Missed production goals may be a sign of not knowing how to code properly. A disenchanted physician in a practice might feel he or she has no ability to influence the situation. In all of these instances, mentoring can help keep a new recruit satisfied and productive.

The case for mentoring

“The benefits of mentoring a newly recruited physician are quick and tangible. Helping new associates become productive right away and learn how to code and bill properly will help them feel like they’re contributing to the practice,” says consultant Mike Fleischman.

“You can see the payoff for mentoring a new recruit in as little as three to six months. New physicians, especially those right out of residency, have no way to understand the nuances of what makes a practice successful. It’s up to the practice to help them get up to speed quickly.”

Select a mentor who is a high-functioning member of the group with an interest in helping new doctors. If your group is large enough, consider assigning two mentors to a new recruit.

Over time, the new associate will gravitate to one or the other, or perhaps use them both for different matters. He or she may go to one partner with operational concerns and to another with personal or clinical questions.

Another approach is to simply ask the young doctor whether there is someone in the group with whom he or she felt comfortable during the interview process.

Clearly define the expectations of both mentor and new associate. Review the kinds of issues the associate can discuss with his or her mentor. These might include operational issues, patient care concerns, staffing problems, or perhaps even personal questions such as where to find a new dentist or preschool. At the outset, determine the format and plan for mentoring.

“Mentoring doesn’t need to be especially formal,” says Fleischman. “But weekly or biweekly sit-down sessions will prove useful. Find out how the new physician is doing and if he or she’s comfortable and getting what’s needed to do [the] work. Let him or her know where he or she stands in terms of production. All of these things will help a new associate develop loyalty to the practice.”

Be sure to spell out the level of confidentiality a physician can expect from the mentor.

Mentoring opportunities

New physicians may find mentoring helps them with the following:

• Managing a full patient schedule
• Supervising medical assistants and other staff
• Navigating systems at the hospital
• Coding and billing
• Using the practice’s technology
• Handling a difficult patient
• Challenging clinical cases
• Balancing work with home life
• Coping with stress
• Finding resources in the community

1 Fleischman is a principal with Gates, Moore & Company in Atlanta; 404/266-9876; mfleischman@gatesmoore.com; www.gatesmoore.com.

Be sure to spell out the level of confidentiality a physician can expect from the mentor.
When concerns of new physicians are ignored, they leave,” says Fleischman. “Physicians get frustrated if they don’t understand why a practice functions as it does or why the culture is the way it is. A mentor physician can help develop loyalty in a new recruit by showing him or her the ropes.”

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**Buy-ins and pay-outs**

**The ‘shoot-out’ approach to an ownership split-up**

*In an equal-partner situation, don’t leave it to chance*

When one partner of a two-doctor practice wants to break away from the other, there’s potential for a stalemate.

The same risk can arise in an ancillary ownership situation, for example with two or four co-owners of a building, lab, or x-ray partnership.

It can even occur when the ownership numbers aren’t even, but the contracts aren’t clear about split-ups.

Suppose, for example, that one partner wants to withdraw and continue his or her practice separately from the partner.

The physician could, of course, open up a new office, buy new equipment, obtain a new phone number, and inform patients of the new location. But in addition to being very expensive, that puts him or her at risk that most patients will stay put.

On the other hand, the physician might insist that he or she has at least an equal right to the office and ask the partner to move out with the ultimatum of otherwise dissolving the partnership (or corporation)—a sort of mutual destruction approach.

**The shoot-out**

Such potential dilemmas demonstrate why groups need effective, legally binding inter-partner agreements carefully covering their owner-partner rights and obligations to each other and the practice itself.

On the other hand, the physician might insist that he or she has at least an equal right to the office and ask the partner to move out with the ultimatum of otherwise dissolving the partnership (or corporation)—a sort of mutual destruction approach.

**Forcing agreement**

This pricing dilemma brought the partners to a real determination of the practice’s value. No amount of outside expert appraisal could get to the guts of value this well.

In fact, the doctor who moved out received a generous price and the doctor who stayed is happy with his status. The shoot-out worked well for both.

There are no easy solutions to a possible equal-owner split-up, but ignoring the potential dilemma isn’t the best choice.

Agreeing upfront how to handle the contingency makes better sense than waiting for it to strike.
Group strategies

Agreeing on a consultant’s fees
Define the price so you’ll get what you pay for

The most important criteria in hiring an outside medical management consultant is his or her ability to serve the group’s needs. But the search process must include a determination of how much to pay for the services you’re seeking.

The conclusion of our series on hiring an independent advisor asks two well-respected consultants how to handle fees. Both of our sources are used to estimating their fees and reaching a satisfactory agreement so the consultation can proceed.

Discuss hourly rates

Raise the question of fees early on, at least to get a general feel for hourly or daily rates. But don’t expect a definitive quote until the project scope is well-defined.

“There are wide ranges of fees out there, and firms will be reluctant to quote any fee without a clear understanding of the work,” says Randy Bauman1 of Delta Healthcare in suburban Nashville, TN. He consults nationwide on important matters like group organization and strategic planning. Craig Heiser2 of Wolfe Consulting Group adds that early in the search, “discussion is hourly fees only.”

Bauman, Heiser, and most other consultants set their fees as a function of their hourly rates. In developing project proposals, they typically estimate the total fees based on the work plan and deliverables agreed to.

Both Bauman and Heiser agree that the best structure from the client’s standpoint is actual cost, estimated in hours at their standard rates with a cap that the consultant will not exceed.

Of course, if the nature of the work changes or if unanticipated issues call for more hours than quoted, the consultant should be able to raise that concern—before taking on the extra work—for agreement.

Hourly rates for top-flight consultants range generally from $150 to $250 or more. Some limit their charges to an eight-hour day, but others more properly bill all the hours for which they provide service.

Travel time and expenses

Both advisors report that their fees sometimes vary according to special circumstances.

Bauman charges more for weekend undertakings, but sometimes less for retainer arrangements and long-term engagements.

Heiser’s hourly fees may be $50 or $100 greater when more complex tasks such as direct negotiations and expert testimony are involved.

Travel time can also be a significant expense, especially if you’re hiring an expert from far away.

Bauman typically charges for travel one-way, essentially making travel time cost half his hourly rate. Heiser charges a higher rate when travel of more than an hour is involved and the job is out of his primary service area.

Both advisors require reimbursement for reasonable out-of-pocket costs.

Bauman requires one third to one half of the estimated fee upfront from new clients to protect his firm and ensure the practice is serious.

Heiser breaks up assignments of more than 20 hours into phases and bills on completion of each phase; if the job is more than 40 hours and doesn’t have logical phases, he requires a 20% deposit.

It makes sense to expect to pay for much of a project either in advance or as it unfolds.

You get what you pay for

Especially in times of tight finances, the fee arrangement is a natural and understandable concern. But remember the old adage, “You get what you pay for.”

“There are no barriers to entry into this [consulting] business, and anyone can hang out their shingle. Many consultants are between full-time jobs and, while there may be nothing wrong with that, a lot of clients are left in the lurch when the consultant finds the job he or she is looking for,” Bauman cautions.

“Be aware, too, of consultants who significantly low-ball fees and then try to make it up by selling additional work or changing the scope of the project,” he adds.

In the end, your most important fee protection is the experience and quality of the consultants you hire.

Identifying experience, determining the right fit for your needs, and checking references through past clients is the way to ensure that you’ll get what you pay for.

1 Contact Bauman at 800/467-3310 or 607/337-0250; e-mail to rb@deltahealthcare.com.
2 Heiser can be reached at his firm number, 602/266-8700, or directly at 602/324-0416; e-mail him at chh@wolfecon.com.