Before and Beyond the Contract

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Approaching a first job after completing residency training, a young physician usually concentrates on the financial incentives being offered by the target practice—salary, bonus, fringe benefits, and so forth. In most cases, such financial packages lie within a narrow range dictated by the regional market, and the recruited physician has few opportunities to alter them. The employment agreement is certainly an important document—see my 3-part article, "The Employment Agreement: What Every Doctor (Junior & Senior) Needs to Know," downloadable from www.karenzupko.com—but it likely includes only a few items that are of concern or can be negotiated.

Of much greater concern, in all probability, is the ability of the target practice to present you with an organization that is congenial, economically viable, and growing in all the important parameters. Assuming the recruit is attractive to several medical practices in various locations throughout the country, there are 3 key areas for performing a due-diligence examination on practices before deciding which to join.

Does "Group Think" Exist? To What Extent?

By *group think,* we speak of that rare and desirable dynamic within a group practice in which each physician feels that the interests of the group and the protocols to advance those interests are more important than his or her individual preferences as to how things should be done. More often, we see groups in which some and perhaps all of the physicians prefer to exercise their individuality about practice operations. Inquire about how group think exists or does not exist among the groups with whom you are interviewing.

Values and goals compatibility. It is important that the members of a group see the practice through the same prism with respect to values and goals. For example, tension can arise in a practice if some of its physicians are very profit-focused, at the expense of correct coding, responding to emergency department calls, and bearing their fair share of administrative work. Similarly, a practice can encounter problems if some of its members are eager to assume financial risk while developing ancillary services (and by so doing become competitive to some degree with their hospital) while others are comfortable using the hospital's ancillaries and not assuming significant investment risk. Ask potential partners and the administrator what causes tension in the group.

Governance style. How does the group get things done? How often are physician meetings held, and how common is absenteeism? Does the practice have candid and open discussion of difficult issues, such as income distribution, or do its members talk about these issues with staff, spouses, and managers but not with one another? The matter of the style and accommodation in reaching practice decisions regarding significant change is an important benchmark for a harmonious and forward-thinking practice.

Extent of family intrusion, if any. Not infrequently, particularly in small groups, one or more spouses or other family members become involved in the practice. This can be a major problem, particularly when allocation of precious resources is concerned—such as patients, money, and time off. "It's all in the family" can be a flash point for group practices. Other times, doctor–staff dating creates suspicion.

> "Does the practice have candid and open discussion of difficult issues, such as income distribution..."

Discipline. Is there a protocol for dealing with bad behavior by physicians? Not taking call, not dictating charts, not turning in charges, regularly starting office hours late, and going away and leaving a junior doctor to check on postoperative patients—all these issues require a group's attention.

Retirement-and-recruitment policy. When a doctor retires, is recruitment of a replacement automatically triggered? Optimally, both retirement and recruitment should be planned and pursued before taking call becomes a crisis.

Retirement. Are any "pullbacks" contemplated? This harks back to how physician departures are handled—is it by means of a firm, planned policy or by ad hoc decisions. A related problem area involves senior physicians who do not want to retire but want to pull back by giving up call duties and by working fewer days than before. The problem arises because they do not want to be paid any less, which obviously presents their colleagues with an intolerable situation.

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Practice Dynamics

The practice dynamics are the various attributes of the practice's day-to-day activities that bear on the issue of overall strength and efficiency. You will want to pursue the following areas and get some clear trends.

Number and subspecialties of physicians. Are there plans to add physicians after you come on board? Will you be the only physician practicing in your subspecialty? If not, how many others will be recruited? Does the practice have the volume to support two hand specialists, for example?

Satellite offices. Does the practice have or plan to open any satellite offices? If so, is it common for such satellites to be served primarily by the younger physicians? Being away from home base in the early stages of practice growth is usually not a plus.

Turnover trends. Physician and staff turnover is an important proxy for internal problems of morale, competence, and so forth. Make sure you look into this if the trend is high. If possible, talk with departed physicians and staff; if not, talk with hospital personnel and nurses who have informed opinions about the reasons for such a trend. Turnover is a symptom that suggests possible group dysfunction. Recruiting, training, and monitoring such physician and staff replacements cost time and money.

Income distribution plan. Has it been changed in the past? How often? What is the current degree of anxiety among the physicians with respect to how revenues and expenses are allocated? Income distribution is unquestionably the most inflammatory issue for all medical practice groups. The reasons are fairly obvious. A professional physician practice is a closed loop with respect to increases and decreases in compensation. That is, any change in how income and expenses are allocated that results in increasing the take-home pay of one doctor will commensurately decrease the take-home pay of one or more other doctors in the group. This situation is certain to create problems, and, in this area, more than in any other, spouses become involved. Notwithstanding that income distribution becomes directly relevant only when a member becomes a partner, it still is an important issue for a recruit to consider, especially if problems exist.

Relative productivity of full-time physicians. Ascertain these data over a 3- to 5-year period to note trends. Does one doctor (usually the spine subspecialist) outproduce the others by an increasing percentage? This situation would present incipient income distribution issues.

Group culture. Group culture is alluded to under the group think section but is worth mentioning again. Each group has a unique culture. Although it is very subjective, it should be probed, because coming out of that culture is the likelihood of success or failure of the group across all parameters. We advise the recruit to probe the group culture of a practice thoroughly. Again, the best sources of information are departed physicians and staff or hospital administrators and nurses.

Capital expenses. Are any capital expansions or additions planned in the near future? The practice might be building, say, a new imaging center or a new satellite office. Such additions will have an impact on costs through depreciation in the computation of overhead, which may affect any bonus you might earn in your early years.

How Efficiently Is the Practice Managed?

The bottom-line result of getting answers to the following questions is, of course, the bottom line itself. Over the years, we have found that no practice is managed as well as it might be and that many—too many—are managed nowhere nearly that well. Probe the following areas.

Staff quality and experience. Assess the quality of the staff generally and the practice administrator particularly. Will your joining the group necessitate any other additions to staff?

Revenue and expense over past 5 years. Ascertain whether the group has grown and, if so, to what extent. For a recruit, extent of growth is key information about a target practice. Incidentally, some senior physicians may well resent inquiries into what they view as a private area. Their resentment is misguided, and you should insist on seeing the data.

Expense ratio over past 5 years. Expense ratio, the percentage of each revenue dollar that is consumed in overhead, is a benchmark for how well the practice is managed and particularly how well expenses are kept in line. For orthopedic groups, this ratio should be under 50%.

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Market share over past 5 years. Market share provides some assessment of how the practice is doing competitively with similar practices. Note that potential competitors for spine surgical procedures include neurosurgeons.

Receivables management. Managing receivables is one of the most important ways a practice can help or hinder its bottom line. Who performs receivables management—in-house personnel or third-party agencies? You should ask to see an aged receivables report and, if possible, reports going back 5 years, so you can determine whether receivables management has gotten better or worse. The area of receivables has too many aspects to cover in this short article, but you should examine it in more detail than other areas. You will probably benefit from professional help here.

Scheduling efficiency. Ask about efficiency in scheduling patient consultations, trauma calls, and so forth. This is a seemingly simple area that, if not properly managed, can disgruntle patients and physicians.

Professional courtesy as part of practice culture. This area has been phased out to a considerable extent over recent years, and it is one we think should be phased out entirely.

Electronic and computer sophistication. Have electronic medical records been proposed or considered? Is the staff well trained and experienced in this area? Do the physicians receive necessary (and no unnecessary) reports from the administrator?

Meetings. How many, how often, how long—and are their agendas fixed? How meetings are run bears on the issue of governance (mentioned earlier) and is an important proxy to how well decision making is managed.

Administrator invited or permitted to manage. Although seemingly a simplistic point, the administrator's being able to do his or her job is extremely important. Far too many practices hire a well-paid administrator and then downgrade him or her into doing clerical work while the doctors argue about decisions, make them in an unofficial way, or do not make them at all. There is no more important asset to a practice than a very competent and empowered administrator. It is in a practice's best interest to let its administrator administrate, but you will be surprised how many groups have a problem with this.

Conclusion

Recruits do not usually go through the process described in this article. We feel strongly that they should. Too many recruits become dissatisfied and leave their initial employer, sometimes during their first year. The practice that offers an attractive first-year financial package may not be the best setting for you if there are problems in some of the areas identified here. The pain and cost of making a change almost always exceed those associated with the due diligence we recommend.

Author's Disclosure Statement

The author reports no actual or potential conflict of interest in relation to this article.