Socioeconomic tips of the month

Adding new associates to practices

At the recent Clinical Congress in Chicago, Fellows, Initiates, Candidates, and others had an opportunity to get one-on-one practice management tips through a consulting service sponsored by the Health Policy and Advocacy Department. The requests for information had a dominant theme—transition in practices. Tom Loughrey, CEO of Economedix and a practice management consultant for the College, has the following suggestions for surgeons considering adding a new associate to their practices.

Q. How do we find a new associate?

A. First of all, the time to start is right now. Surgeons finishing training programs in mid-summer are looking at opportunities now and want to have a good idea where they will be by the spring. Since time is short, the fastest way to reach qualified surgeons is directly through the training programs.

Obtain a list of the residency programs and their directors and chief residents. The programs geographically closest should receive your attention first. The most complete list of residency programs is available from the Accreditation Council for Graduate Medical Education (ACGME). They can be reached at *www.acgme.org* or by phone at 312/464-4920. They have complete listings of program directors and coordinators, along with their addresses and phone numbers.

A letter or an e-mail should be sent to the residency programs of interest briefly summarizing the opportunity, including the location, the surgical specialty, the size of the practice, and whether the position leads to a partner/shareholder position. Ask that the information be shared with qualified residents and provide a contact name and phone number or e-mail address.

Another good option is to use the College's Career Opportunities Position and Resume Data Bank established by the College's Candidate and Associate Society. It can be reached through the ACS Web site at *www.facs.org/jobs/toc.htm* and allows you to review resumes and directly contact candidates.

Q. What do new associates want?

A. Of course, wants vary from one individual to another, but, generally speaking, surgeons coming out of a training program need security and opportunity. The security need is best met with an agreement that provides a base salary and benefits. The opportunity need is best met by having an agreement that offers an equity position in the practice at some future point in time.

There are trade-offs between security and opportunity. For example, a young physician with a stronger need for opportunity might opt for a lower salary guarantee if it is possible to attain a better income based on productivity or to become a partner sooner and under better terms. Conversely, someone with a higher security need may be satisfied with a better salary but less opportunity to participate in a productivity bonus arrangement.

Salary guarantees at some level are expected for just about any new associate. Expected pay levels will vary by surgical subspecialty, and other elements of the offer may include signing bonuses, moving expenses, bonus opportunities, and so forth. Generally, the most productive salary arrangement is based on a guarantee against production. The idea is that the new associate will have an increasing level of productivity over the first year and resulting practice income will exceed the cost of both the associate and related overhead. For example, a new associate may be guaranteed a salary of $120,000 per year but actual compensation is based on 30 percent of productivity (measured by dollars collected). The breakeven point is $400,000 in collections. Under this arrangement, the new associate would receive $120,000 in the first year even if he or she brought in less than $400,000 for the practice. If production exceeds $400,000, the new associate would receive 30 percent of the excess.

Q. Are there other common income-sharing formulas?

A. One of the most common income-sharing formulas is to have an income base and a bonus payable for any productivity above a predefined goal. A new associate may have a base salary of $100,000 with a bonus available for any production over $250,000. The level of bonus will reflect the practice's overhead. A practice with 50 percent overhead may consider a bonus up to 50 percent of the excess production. In reality, though, the bonus percent will be something less than 100 percent of the profits. If this amount were being given there would never be a financial incentive to become a partner or shareholder in the practice. Typically, bonuses will be somewhere between 10 percent and 40 percent of the productivity over the goal. The actual amount will depend on the salary base and benefits.

Q. What benefits usually are expected?

A. At minimum, the new associate will expect the same health coverage the other physicians receive. In addition he or she will expect two to three weeks vacation with time to prepare for board certification, if appropriate. An allowance for moving expenses may be given and in some cases will be structured as a loan, which will be forgiven after one year. This protects the practice (to the extent the loan is ever collectible) in the event the associate leaves before one year. Under certain circumstances, practices have provided signing bonuses. This is not the norm, though, and usually is offered only in unusual situations, such as geographic location, loss of other income, or special skills that the practice has a strategic need to fill.

Q. What about "noncompete covenants?"

A. It is reasonable both for the practice to protect a marketplace that has taken a lot of hard work to develop and for an associate to have some reasonable ability to remain in practice if a separation is beyond his or her control. One way to ensure such parity is to have a "noncompete covenant." Under this arrangement, the associate agrees not to go to a competing practice within a reasonable geographic area if he or she voluntarily withdraws from the practice. In the event the practice terminates the associate for reasons beyond his or her control, the noncompete covenant does not apply. Thus, both parties must arrive at an agreement that will work, and stick to it.

There is, however, much discussion over whether noncompete covenants are ever enforceable. The only way to really find out is to try and enforce them. In any event these covenants can be expensive to enforce even if one party prevails over the other. The key is whether the covenant is reasonable. This is a judgment call, but most arbitrators do not like enforcing provisions that limit competition and commerce.

Q. When should an associate become a partner or shareholder?

A. First, it is entirely possible that a new associate never will become a partner. Partnership is reserved for those individuals who want to take responsibility for the development of the practice and its business operations. This work is usually nonclinical and carries no extra remuneration. For some associates, never attaining partnership will be perfectly fine. They expect good working conditions, a good income, challenging clinical work, and a progressive environment. They may not want anything to do with running a practice.

More often, though, a new associate will want an equity position in the future. They also expect it to match the position of the other partners. Typically, partnership occurs within two to four years from the time the associate joins the practice. The time may vary based on the guarantee the employee receives and the cost of buying into the assets.

The buy-in will usually be based on purchasing an equal share of the collectible accounts receivable plus an equal share of tangible assets of the practice less any outstanding debt. In addition, it may be reasonable to expect a payment for the intangible assets, or "goodwill" of a practice. The amounts for all of these items can be difficult to determine. It is appropriate to lay out from the beginning of the association when the associate will become eligible for partnership and what they will be expected to buy into. If the exact value cannot be determined at that time (which it usually cannot), then the methodology for determining it should be agreed upon.

Q. Do we need to have a contract?

A. The quick answer is, "yes." The purpose is to make certain there are no surprises later. Without a contract, the only record is the memory of the parties involved, and even among honest, well-intentioned people memories and intentions can differ. A good contract lays out facts and intentions that are mutually agreed upon and that can be reviewed later by both parties as well as independent arbitrators in the event of a disagreement.

There is only one time to negotiate a contract and that is up front. Contracts are normally prepared by the practice as an offer. It is very reasonable to expect the offer to be negotiated, and neither party should be put off by the other wanting to add or eliminate conditions. If there are disagreements, this is the best time to get them out in the open. Honest negotiation working toward a win-win outcome is a mark of professional maturity. A potential associate who has many questions, concerns, requests, or even demands may appear to be someone who is not a team player. In the end, if the haggling produces a good agreement, that will be all that matters.

Q. What issues face a solo surgeon who is bringing in a new associate?

A. There are several. One deals with family members, such as a spouse, working in the practice. At some point, if the associate will become a partner, it is reasonable to expect that family members will step aside. This can be very difficult and may even have a negative impact on the practice if the person cannot be adequately replaced. This is usually short-lived, though, and the increased harmony that is produced may be worth the short-term disruption.

Second, the practice will need to be keeping a clean set of books. Closely held businesses often have a mix of business and personal expenses intertwined. In the solo practice this may not be harmful, but for a group, even a group of two, it will be unacceptable. It will be expected that business expenses be clearly identified and separated from personal expenses. The partners may even have employment agreements or expense-sharing agreements between them that define exactly how various expenses will be treated.

Third, work habits can become an issue. One physician may be very self-reliant and compulsive about time. Another may be very dependent on staff and much less concerned about time and punctuality. These personality differences need to be determined from the outset, and, if they are profound, agreements need to be in place that minimize the impact on each person. In the event this cannot be done, it may be better that this alliance never occurs. A good employment agreement, honest and candid conversation, and a strong, well-trained staff will help minimize these differences.

In addition, an immediate change may be purely economic. Most new associates' practices will develop from business that is handed to them by the current partners. This is business that established partners give up to get someone started. Ideally, the solo surgeon has been overburdened and has been looking for some relief. In other situations this may not be the case, and the established surgeon may be taking a difficult pay cut. If the pay reduction is unanticipated, it could lead to unpleasant clashes and feelings between the surgeons. Such problems can be minimized, avoided, or at least anticipated by carefully evaluating the demand for services from patients and referring practices before a search for an associate is even initiated.

Sometimes the additional business simply is

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is not renewable thereafter.

General policies concerning the granting of the George H. A. Clowes., Jr., MD, FACS, Memorial Research Career Development Award are:

- The award is restricted to a surgeon who has completed specialty training in a residency or an accredited fellowship in general surgery or a surgical specialty within the preceding five years and has received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the United States or by the Committee for Accreditation of Canadian Medical Schools in Canada. Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.
- The award may be used for salary support or other purposes at the discretion of the recipient and the institution. Indirect costs are not paid to the recipient or to the recipient's institution.
- The American College of Surgeons Scholarships Committee will look favorably upon applicants who have received investigator-initiated, peer-reviewed research awards (for example, National Institutes of Health [NIH] R01 grants). The committee will not consider applicants who have received research career development type awards from either the NIH, the American Heart Association, or other funding agencies. Also, the recipient may not receive another career development award during the five-year period of support. It is the responsibility of the recipient to notify the Scholarships Division of the College if another source of scholarship/fellowship funding is received.
- Approval of the application is required from the administration (dean or fiscal officer) and the head of the applicant's department or administrative unit. This approval would involve a commitment to continuation of the academic position and facilities for research during the entire period of the award. Furthermore, it must be assured that at least 50 percent of the applicant's time will be spent in the research proposed in the application.
- The applicant must submit a detailed research plan and propose a budget for the five-year period of the award. The applicant also is required to submit a cover letter of approximately 400 words that describes career objectives, how these career objectives will be achieved, and how the research protocol furthers the applicant's career development. The Scholarships Committee of the College requires an annual progress report from the recipient on which annual renewal is based.
- While holding the award, the recipient is expected to attend the Clinical Congress of the American College of Surgeons in 2003, 2005, and 2007 to present reports to the Scholarships Committee.
- Upon completion of the five-year funding period, the recipient will be required to submit a summary of research progress and to provide information regarding current academic rank, sources of research support, and future plans.

The closing date for receipt of completed applications is August 1, 2001. Application forms may be obtained upon request from the Scholarships Division, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College's Web site, *www.facs.org.*

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not there. This can be fine if the intention of bringing in a new associate was to replace a retiring or departing partner. Again, short-term economic consequences can be predicted and the departing physician can be economically prepared to have the pay cut. This will work best when the time period to be covered by both surgeons is minimal, probably no more than one year.

Retirement will be discussed in the next issue. Please feel free to contact Mr. Loughrey with your practice management questions at tloughrey@economedix.com or 714/633-2251. Ω

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail HealthPolicyAdvocacy@facs.org.