Internist Jeffrey M. Kagan opened a solo practice in Newington, CT, in 1991. He added a PA in 1994, but soon decided that he needed an MD with a vested interest in the practice. “There was a bigger issue than simply sharing expenses, and that was call coverage,” he says. “I take care of several nursing home patients, and physicians who don’t do nursing homes don’t want to cross cover for those who do, as they generate many phone calls that can’t be billed for.”

Kagan began looking for an associate, but didn’t want to spend the thousands of dollars a headhunter would charge. “In the fall of 1996, a third-year resident approached me at the hospital and asked if I knew how he could get a job in this area when he graduated,” Kagan continues. “We arranged for him to spend a month rotating at my office in the spring of 1997, and soon after that I offered him a job.”

Adding another doctor can ease your workload, attract new patients, and increase income. Here’s how to go about it.

By Gail Garfinkel Weiss
SENIOR EDITOR
Like Kagan, soloists typically start thinking about teaming up with another physician when the demands on their clinical—and perhaps personal—time can no longer be managed comfortably. Joining forces can make for a more fulfilling work life and allow for more hours away from the office. It can also make your patients’ and employees’ lives easier.

“If you’re a few years from retirement, adding a physician will allow for continuity and a smooth transition,” says Judy Capko, a practice management consultant in Thousand Oaks, CA. Another benefit, she adds, is that group practices are more attractive to managed care payers than solo practices because they can offer more diverse services and coverage with one contract. This allows larger practices to negotiate better deals.

And two physicians can usually practice more cheaply than one. “Although you may need additional staff, exam rooms, and back-office space, you can share reception, front-office, and medical records space, plus hallways, bathrooms, and everyday expenses,” says Kenneth Hertz, a consultant with the Medical Group Management Association who’s based in Alexandria, LA. You also can divide the costs and duties of promoting your practice.

Like marriages, however, not all medical unions are gratifying or enduring. But you can maximize your chances of success if you select your potential partner carefully and re-engineer your practice accordingly, says Hertz, who adds a caveat: “You have to be prepared for and comfortable with the notion of compromise.”

The transition from a solo practice to a partnership can be accomplished by merging two practices or by inviting another doctor to join yours. Here are the pluses and minuses of each, and how to make the new entity work.

### Merging with another practice

When two solo practices come together, far more decision-making and reorganization is required than when a freshly minted or hospital-based physician signs on with a soloist.

“Before you move forward, each practice has to understand the other thoroughly,” says Hertz. “Draw up a checklist of all the things you and your advisers need to evaluate, including the accounts receivable, fee schedules, payer mix, referral patterns, hospital relationships, and staff salaries. If Dr. Smith pays his LPN $11 an hour and Dr. Jones pays his $17 an hour, what will the Smith & Jones practice pay their LPNs? No one wants to come into a partnership making less money than they did the day before.”

Other items that should be on the list:

- Which office will be kept open? Or will both remain open, but under the partnership’s name? Or will the new partners set up shop elsewhere? “There are obvious financial benefits to closing one office,” says Robert G. Baldassari, a CPA in Fairfax, VA. “But you’ll probably lose patients if you relocate several miles away, especially if you’re a primary care physician or a pediatrician.”
- Which accounting, billing, and electronic health records systems will the partnership use? You need to determine which types of hardware and software are more adaptable to a larger practice, says Baldassari. “System A might only allow for one user at a time, while system B can accommodate multiple users.”
- Will you and the other physician draw a salary from the practice, or will compensation be based on production? Management consultants generally recommend income based on production, with perhaps a small base salary attached.
- Will accounts receivable be maintained separately or put into the partnership? Baldassari recommends that the A/R be maintained separately. “It’s only fair that the physician who earned the money gets the money,” he says. “The merged practice can charge the

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**Power Points**

- Whether you bring someone in or merge two practices, planning is key.
- When you merge practices, it’s better to dissolve the practices and create a new entity, so that existing liability situations aren’t carried over to the new practice.
- A/R should be maintained separately. The merged practice can charge the physicians a fee—about 5 percent of collections—to compensate the practice for the accounting work.
- When bringing on an associate, bring in someone who’s different from you; that’ll broaden your appeal to patients.
- Structure partnership agreements with clauses that spell out how you’ll dissolve the partnership if it comes to that.
physicians a fee—about 5 percent of collections—to compensate the practice for the accounting work in billing, rebilling, recording payments, and so forth.

▶ How will medical records be maintained and protected?
▶ How and when will staffers be told about the merger? If the new venture needs only one receptionist, will it be Dr. Smith’s or Dr. Jones? Can “excess” staffers be redeployed, or will some have to be let go?
▶ How are you going to deal with managed care? If you want to see each other’s patients, you’ll have to arrange to be on the same health plan panels. That means discussions about which plans to retain and which to jettison.

“Moreover, you’ve got to understand your prospective partner’s views about practice governance, leadership, and development,” says Hertz. “And ask about plans for the future. There’s no sense in teaming up with someone who has a very different vision of what the practice should look like in five or 10 years.”

Once you agree that you’re compatible, put the legal and financial pieces together and commit them to writing. “These include addressing how revenue and expenses will be shared and establishing a methodology for dealing with a withdrawing partner or, if necessary, the dissolution of the partnership,” says Mark Coel, a healthcare attorney in Boca Raton, FL.

“Choose advisers with expertise in medical practices. I’ve seen many instances where parties haven’t received the correct advice or have inadequately addressed key issues, which potentially leaves the resolution of a dispute in the hands of a judge or jury as part of a costly legal battle.”

An accountant can help you decide on a business structure for your joint practice. (See “S corp, C corp, LLC, LLP—which is best?” March 5, 2004; available at www.memag.com.) Then ask your lawyer to do the necessary paperwork to either dissolve the practices and create a new entity, or to merge them. “You probably should create a new entity so that existing liability situations aren’t carried over to the combined unit,” says Steven I. Kern, a healthcare attorney in Bridgewater, NJ.

“The new entity can then purchase computers, furniture, medical equipment, and other assets from the predecessor practices.”

**Adding another doctor to your practice**

Melvin H. Kirschner, an FP in Van Nuys, CA, took on a partner who had been unhappy with his group practice. “We had taken call for each other, and I knew that he was an excellent physician,” says Kirschner. “I already had a billing clerk, receptionist, office manager, and medical assistant. Most of the durable equipment and the extra exam rooms were there. We hired a second assistant, bought some extra surgical instruments and new stationery and business cards, had the computer reprogrammed, added my new partner’s name to the answering service, and we were in business.”

More frequently, a solo physician hires a younger doctor as a salaried associate, with the understanding that if all goes well he or she will be able to buy into the practice within a predetermined period of time—usually two or three years. “The associate might pay a flat fee or a portion of the practice’s book value,” says the MGMA’s Ken Hertz. “Or the buy-in might accrue over a multiyear period, during which a percentage of the associate’s yearly compensation goes toward practice ownership. A consultant, CPA, or attorney can advise you, but no matter what your agreement, it’s critical that both parties see it as a win/win.”

Once the new doctor signs on, take steps to make him or her an official member of your practice. “Start by adding him to the building’s directory and your door signage, along with all the printed matter for the office,” says consultant Judy Capko.

Patients will need to know about the change, too. Send each one a letter about the new doctor, and tell staffers how the phone should be answered and what they should say if patients have questions about your associate. The letter should outline the new physician’s background and experience, and indicate that you’re expanding your practice to serve patients better. Specify
any additional services the associate will offer.

Early on, have the associate shadow you for a day or two so she can see how you handle patients, document visits, order tests, complete charge tickets, and deal with staff. Schedule lightly, Capko advises, so you can have a discussion between each patient, and review office operations at the beginning and end of each day.

Assigning patients to the new physician can be a challenge, especially if he’s fresh out of medical school and has no track record. Jeffrey Kagan directed all of the practice’s new patients to his associate, who became a partner after three years with the practice. “And some of my patients who saw him urgently on my day off decided to switch to him,” Kagan says.

“Whatever you do, don’t assign all the least desirable patients to Dr. New and give him or her the responsibilities and tasks you dislike the most,” Capko notes. “That’s a recipe for disaster. Be fair and share the burdens.”

How to make a two-doctor practice work

“The biggest mistake you can make is not seeing to it that the new doctor feels at home in your practice,” says Capko. “To help do that, you need to sell your employees on the wisdom of adding another physician and encourage them to make the transition a priority.”

Additional tips for making a go of it:

Give associates time to establish themselves. Pediatrician Scott Katz has no regrets about waiting three years to become a partner in a Plano, TX, practice, because a shorter partnership track would have put him under pressure to produce revenue faster. “If you don’t build up a large enough patient base before you become a partner, you won’t be able to pay yourself and cover your share of salaries, rent, supplies, and other expenses without taking out a loan,” he says.

Decide how you’ll handle money matters. Disagreements over money have tossed many a business relationship on the rocks, so it’s important to work out an arrangement that you’re comfortable with. Once a month, Melvin Kirshner and his partner assess each physician’s total collections, determine their outlay for all expenses, and pay a proportionate share of the total. Kagan and his partner split expenses evenly, and income is partly determined by each physician’s productivity average for the prior two years. “This way, if you’re absent for several weeks, the income drop isn’t as steep,” says Kagan.

Don’t hire a clone. “I think that the gut reflex is to look for someone who’s similar to you,” says Kagan, “but you’ll have a more diverse practice—and the new doctor will have an easier time attracting patients—if he or she is quite different from you.” Kagan, who’s 50 and Jewish, shares a thriving practice with a Turkish Muslim 10 years his junior.

Prepare for the possibility of irreconcilable differences. Allergist Lewis Kanter of Camarillo, CA, was optimistic when he hired a part-time associate in 2000; 18 months later, the doctor bolted to open a rival practice down the street. “He took patient files and gave me only four days’ notice, despite a 120-day notification clause in our contract,” says Kanter. “The contract also contained a non-compete covenant that turned out to be unenforceable.”

That’s typical, says attorney Steve Kern. Not only are restrictive covenants difficult to enforce, they can be deal breakers in trying to attract associates. “Alternatively,” Kern notes, “a written agreement that prohibits an employee from soliciting staff and from contacting patients, and which stipulates that patient records belong to the employer, may be almost as effective as a covenant not to compete, and easier to get the employee to agree to.”

Scott Katz’s pact with his practice’s senior doctor allowed either party to exit gracefully. “If he didn’t think the relationship was to his advantage, he could terminate it,” says Katz. “If I wanted to end the deal before making partner, I could buy out my contract for a set amount—which decreased by $4th every month for the three-year period—and open an office across the street.”

Keep communication lines open. From the get-go, convey your expectations clearly to your new associate, and let her know whether she’s meeting those expectations. After his negative experience, Kanter hired a young woman allergist. “We meet every couple of weeks so that issues get addressed promptly and we can establish that we’re on the same page,” he says. Kanter also keeps his associate posted about the practice’s financial performance and her progress toward partnership. Consultant Ken Hertz approves. As he puts it, “When you take on an associate, you can’t overplan and you can’t overcommunicate.”

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—Consultant Ken Hertz