

## Is it Time to Add a New Doctor to Your Practice? What Kind Should You Hire

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Before we confuse ourselves with the details this month, it's helpful to remember that for all the complexities and frustrations that come with running an eye clinic, we have only two core dimensions of your practices to manage: your volume of patients and your capacity to serve them.

The first, patient volume, is largely controlled with internal and external marketing. The second, capacity, is solved with a checkbook—to buy new facilities, new technology or new staff. And the toughest staff to hire and manage are the doctors in the practice. Is it time to add another physician or optometrist in your practice? Do current or projected patient volumes warrant the addition of more provider capacity? Let's see.

There are a number of drivers that substantiate the addition of one or more new providers to your practice. The most common of these is sheer patient volume, although this can be deceptive. Energetic surgeons I work with think nothing of seeing 700 patients a month. Others end the month gasping with just half of these patients. What's the right number, the figure that says, "Now is the time!?" In the interest of being practical and directive here, I'll assert that if the average general ophthalmologist in your practice is approaching 550 or more patient visits per month (including post-operative visits), or your subspecialists are routinely transiting 450 or more visits, *and your practice is growing*, it may be time to add doctor capacity.

As you evaluate this, please be sure to examine both growth rates and the seasonality of your practice. It can be tempting to add a provider in your busiest months, only to create a lot of down time for everyone in the quiet months. In those extreme snow-belt and sun-belt practices which are most subject to migrating retirees, do what you can to fill in the seasonal lulls with well-timed vacations or a move toward serving a younger, year-round patient base. Also, is your practice flat or growing? A solo surgeon with a 20% annual growth rate seeing 500 patients a month now may be a little past due starting to recruit another doctor.

Patient demands for subspecialty care drive a significant percentage of new hiring decisions. Most general ophthalmologists start out providing comprehensive services, including services that might ordinarily be referred out, out of personal interest and a lack of other patients to serve. But with any degree of success and growth, the same surgeon years later may be able to substantiate the addition of a glaucoma, retinal or plastics subspecialist. The best—if labor intensive—way to evaluate this is to tally internal and external service and referral patterns for several months. Doctors working semi-autonomously in a group practice are often surprised to find that the aggregate of their referrals could not only support a new subspecialist, but that the boost in cash flow supports fixed overhead, giving every established provider a substantial pay raise

Another large influence on the addition of a provider is the need to rebalance the practice's professional team between primary, secondary and tertiary caregivers. In most settings, it can be

both financially wasteful and professionally frustrating for a cataract surgeon to be providing optometric-level care, or for a sub-specialist to be providing routine medical eye care. And many high-volume Lasik surgeons would rather bring in a keen cataract surgeon than continue to dabble in an area they no longer love.

It's rarely possible to optimize individual output, but to the extent possible, techs, optometrists, general ophthalmologists and subspecialists should all be working to their highest professional potential. If you're not doing this in your practice now, adding a provider at the right level may allow every professional in the practice to skirt burnout, work to their highest and best purpose, as well as provide better patient care.

Of course, not every new doctor hiring decision is driven by economics, or even patient demands. Some practice owners put lifestyle and "workstyle" issues first. Here are a few examples:

- The surgeon whose emerging physical disability obliges the addition of someone to take over his cataract cases.
- The doctor who is willing and able to take a pay cut for extra vacation time off.
- The small urban retinal practice with call coverage that's become too large a burden for just two doctors.
- The solo doctor in his last few years of practice, who doesn't really have a large enough practice for two doctors, but who wants to pass his practice on, and semi-retire.

It's important to examine your practice's actual production needs, and not assume that the only option is to hire a peer. There are numerous alternatives to adding a full-time, partner-track fellow surgeon to your practice. What can you do if you don't have quite enough business to substantiate the addition of another full-time surgical provider? Here's a typical scenario...a surgeon who is seeing an abundance of clinical patients and feels he's at 120% of his personal capacity seeing patients, but who is only at 50% of his desired surgical loads.

Like this common scenario, your own patient mix may suggest the addition of one or more optometrists, who are often easier to recruit than physicians, and whose labor costs are somewhat lower. Or you may prefer to bring aboard a medical ophthalmologist as an extender, allowing you to increase the percentage of your time spent in surgery. Finding a part-time surgeon is getting easier in my experience. About half of all graduating ophthalmologists are now female, and many of these new doctors are preferring to work part-time for a few years while they start a family. It also seems in the last decade that new graduates of either gender are more interested in balancing life and work, which is quite feasible in today's numerous two-doctor families. In addition, I have discovered that many retirement-aged surgeons who thought they could be financially free are now moonlighting to bridge diminishing returns on their savings.

Remember that another alternative to adding providers always exists: you can simply reduce the volume of patients. This is a common tactic in managed-care-intensive markets, where a younger provider may establish a practice accepting all payer contracts, and then—years later—selectively drop low-paying contracts. Doctors in growing practices who decide they want to stay solo can also start limiting their practice to selected dimensions of medical and surgical eye care, referring all other patients on to compatible colleagues in the community.

Ultimately, every doctor addition to your practice will result in at least a transient dip in profits available to pay existing providers. This profit drop is readily affordable in a 10-partner practice...not so in a solo practice, where the hiring physician's take-home income may be cut in half for a year or more. There are several ways to blunt this pay cut if yours is a smaller practice.

You can save up capital reserves before you hire. You can tap the practice's line of credit to sustain your family income, paying back the shortfall over time. But most importantly, you should make sure that your practice volume is sufficiently robust and growing so that the new doctor is busy from the outset.

Let's imagine that the gross facts suggest that you should indeed bring another doctor into your practice. Before actually recruiting and hiring, some additional, refined due diligence is indicated. It's critical that you examine carefully the projected financial impact of your decision. Even if there is going to be a long-term profit from adding a doctor, there is certain to be a near and intermediate term loss. Your administrator or accountant should draw up a table of forecasted cash flows, taking into consideration the cost to recruit and relocate, and to cover wages and benefits, along with supplemental promotion, staff, equipment and supplies. Even if Dr. New is a shining star, several months may pass between her arrival (and cost to your practice), her credentialing as a provider in local plans, and her actual generation of first collections. Still more time will pass before new doctor earnings pay back monthly costs and the accrued backlog of expenditures. In some settings, it can take as much as a year or longer to break even on your investment.

No practice expansion costs more or is harder to manage than adding the next doctor. Wise choices will lead to better care for patients, a larger and more harmonious team, and greater profits.

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