

# The smart medical oncology partnership

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The current environment for medical group practice growth is challenged by a potentially overwhelming set of choices. Unfortunately, the most frequently overlooked, but most essential, variable for the successful management of that practice environment is the personality of the individual doctor. Once a physician has decided that his or her personality is more comfortable in a group instead of a solo environment, then three essential design elements must be accepted in order to achieve a smart medical partnership. Those elements are (1) choosing your partner carefully; (2) creating a non-competitive environment within the group; and (3) obtaining, empowering, and valuing professional management. With those elements firmly in place, an office initially designed to treat patients with chemotherapy will evolve into one designed to deliver total care to patients with cancer. The capacity to experience an emotional, as well as financial, benefit will be enabled by creating a smart medical oncology partnership.

**T**here are as many varied environments in which physicians are able to practice their skills as our imaginations can develop. However, most of those settings can be broken down into a few large subsets. Doctors must work in either large, medium, or small organizations. For the purposes of this discussion, let us define large entities as academic centers, integrated delivery systems like the Veterans Administration, or multispecialty medical groups. A medium-sized group would be a single-specialty group of 5–30 physicians. And a small organization would be the most common configuration—one to four doctors doing the best they can. The reasons we wind up in any one of those three practice designs are numerous. However, although a doctor can usually describe a myriad of circumstantial reasons why he or she is in a certain type of practice, the real reasons are frequently invisible.

The current environment for growth in professional medical group practices is challenged by a potentially overwhelming set of choices. Unfortunately, the most frequently overlooked, but most essential, variable for the successful management of any given practice environment is the personality of the individual doctor.

## Medical schools select soloists

Selected into medical schools on the basis of their performance on a wealth of knowledge tests (MCATs), undergraduate GPA scores heavily weighted toward the sciences, and an interview process designed to filter in independent decision makers, medical students tend to fit into a commonly experienced set of personality traits that has success-

fully promoted responsible leadership with respect to our patients.<sup>1,2</sup> However, those traits are frequently not the most conducive for group dynamics that are operationally and financially successful. Those very same self-assured and in-control qualities that encourage patients to feel secure with their doctors often cause doctors to feel insecure with each other.

This selection process was functional in the world defined by solo practitioners that dominated the American medical practice design for the first half of the 20<sup>th</sup> century. However, after World War II, the gradual emergence of group practices became evident. But, commonly, the personality traits of the individuals within those groups were not necessarily selected for true group success. Most often, those early groups were defined by autocratic senior physicians, who maintained control via employment contracts that rarely allowed for meritorious partnerships, or complex expense-sharing arrangements that essentially capitalized on an “eat what you kill” relationship among the associates in the group. The common group design encouraged the associates to compete with each other.

## Are you more comfortable as a soloist or a partner?

One cannot overemphasize the importance of giving oneself permission to recognize that one's first few choices for practice environments may have been in-

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correct. Do not underestimate the effect that our zero-error tolerance training has on our willingness to say, "I made a mistake." There are so many opportunities to achieve fulfillment as a physician in America today that it is almost totally unnecessary for anyone to feel stuck in an unpleasant practice situation. But, the key here is to allow your personality to have a voice in determining that practice design. If you are a soloist, admit it and be a soloist. If you are more comfortable in a group, admit it, be a partner, and act like one.

This discussion is geared to those physicians who practice in small or medium-sized groups. Future articles will be geared to soloists and other practice configurations.

### The smart partnership

In the 1980s and 1990s, as the generation of 1960s-era baby-boomers moved into positions of influence in healthcare, a different tone, style, and appearance of practices started to become evident in sophisticated communities throughout the US. Without any coordination at all, a new set of elements spontaneously arose that addressed the professional, emotional, and financial goals desired for practice success in their minds.

Those elements can be broken down into three essential building blocks:

#### 1. Choose your partner carefully

Once you've decided that a potential new partner has the clinical and moral qualities to match your own, then confirm that he or she is someone you can be friends with. Then, actively make him or her your friend. Be sure that you can trust this person when you will be at your most vulnerable. You should be absolutely secure that you would send any member of your family to him or her for medical care. It doesn't matter how big a practice this person has or may develop. If this first set of conditions is not met, the next building block will never be attained.

### Case study

## Choosing your partner

THIS SIX-PHYSICIAN PRACTICE with two office locations in the Midwest was considering purchasing its own CT scanner. All of the partners were worried about being able to afford this investment, some much more than others. At one of the monthly partner's dinners, a presentation was made regarding bringing another established group of three physicians into the main group. Clearly, the motivation for this was the financial concern over the contemplated purchase.

The personalities of the two groups were profoundly different. The larger one was an equal partnership; the smaller one had a single owner with two employed physicians. The larger one had a stellar reputation in the community for taking the high road, treating patients within accepted guidelines, and trying to treat all patients the same regardless of their ability to pay or insurance coverage. The smaller group suffered from the reputation of its authoritarian physician owner, who, unfortunately, was consistently observed by his colleagues as overtreating his wealthier patients, undertreating the poorer ones, making unilateral business decisions, and undermining his younger associates.

From a purely financial view-

point, this deal made sense. The smaller group made much more bottom-line income per physician than the larger one, primarily due to its tendency to "game the system" effectively, something the larger group refused to consider doing.

The partners all looked at the financial opportunities of the relationship. Then they looked at each other. Every partner treated each other as protectively as he would his own family. They all knew that joining up with this aggressive smaller group would permanently alter the quality of their relationships and voted down the association with the smaller group.

By valuing their interpersonal relationships over the financial security that would have enabled the purchase of the CT scanner to take place with absolutely no anxiety, they stuck to the first tenant of a smart medical partnership—choose your partner carefully. As events unfolded, this group has brought in two young physicians out of fellowship, is molding its behavior into the group's norm, and is now looking to replace its original machine with a faster one that will work alongside the group's new CT/PET machine.

—Laurence J. Heifetz, MD, FACP

#### 2. Create an environment of non-competition within the group

I cannot overemphasize the power that a senior partner has. The new associate has only one goal: to be a partner. So, never call your new associate anything else but "partner." Establish a goal of never competing with your partner for patients. Place all of the partners at risk with each other for the good of the partnership, just as if you

were all children in one family.

Make every effort to keep it equal. Insist that everyone has close to the same-sized offices and that your names are listed alphabetically everywhere. Give the big corner office to three secretaries instead of the senior partner. Try to split the income as evenly as possible. If equality is encouraged, then effective governance has a chance to be created. A team

atmosphere will not only enable the group's leaders to make decisions but, more importantly, encourage everyone to stick to those decisions.

Don't require shameful buy-ins with unsupportable concepts like "good will"; rather, feed the new member of the group as many new patients as possible in order to nurture his or her growth in the community. Create fair "sweat equity" tracks that allow for a gradual increase in compensation to equality over a reasonable period but allow for full voting rights early.

### 3. *Get professional management*

Develop the maturity, humility, and wisdom to accept that you are probably the worst person on the planet to manage your practice. Bring in seasoned professional business management, listen to them, and let them do their job.

All too often, the senior physician

in the practice insists on micromanaging the office as an extension of micromanaging his or her patients. Let it go—and actively empower those managers to do what they know how to do, so that you can be free to do what you know how to do. The key here is to value this person by linking his or her compensation to the overall productivity of the practice. But, this strategy will only work if the business managers are able to do their job without being undermined by overly controlling physician partners.

Once those three elements are in place, sit back and watch the organic growth of the practice take place dramatically. A governance structure can now be created with an executive committee or leadership team that can make decisions with the executive director or administrator without the traditional roadblocks of 100% partner consensus. Such a group will be able to expand its services far be-

yond the possibilities of any comparable number of individuals competing with each other. The individual members of those groups will think that they are lucky to be together. They are not lucky; they are smart. We should define their group as a "smart medical partnership."

### **Smart medical oncology partnerships**

The personality of an organization takes on the dominant personality of the leadership team. The patients, as well as the referring medical community, sense this and feel secure with this. The practice will flourish or perish based far more on this quality than technological prowess. By paying close attention to those human details, profoundly productive operational, management, and growth decisions will be facilitated.

The business terms for two of those directions are consolidation and diver-

## *Editor's note*

**A**N IMPORTANT QUESTION FOR ANY PRACTICE is how you structure the work and split the income. But most doctors understand little about management, and poor management can lead to needless hours of hassles and infighting.

Although I appreciate Larry Heifetz's article, most physicians face very different practice environments. Dr. Heifetz came from a Beverly Hills practice which took no HMO patients, had high-end clients, a well-diversified income stream, and was paid at rates above Medicare. With its significant income flow, they were able to distribute money equally to all partners. Certainly, the fact that the members got along as best friends as well as colleagues helped foster a uniform work ethic and standards, which made equal income sharing work for them.

While Dr. Heifetz makes great arguments for professional management, the changing practice environment and increasing complexity of cancer care will likely lead more solo or small practices to join together in different ways to improve the quality and comprehensiveness of community cancer care. Doctors with very different philosophies and backgrounds *can* work together. Such physicians are probably not close friends, but rather col-

leagues who come together with a commitment to improving cancer care in their communities.

The income arrangements described in this article had serious consequences for the group practice I am involved in when younger members refused to work 8–10 times more than senior members for the same salary. Our group restructured 12 years ago toward a reality-based productivity system, which better respects the diversity of our doctors. This method has minimized conflict among doctors over work schedules and time off while encouraging each member to maximize productivity and take responsibility for the service of our group toward patients and our colleagues.

I believe there are likely to be several successful models that readers could share for consideration. Presenting a broader array of options, their pros and cons, would help different groups find the best way to balance productivity with collegiality and financial rewards in their particular practice environment. Dr. Heifetz has presented a well thought out methodology for his type of practice which serves as an excellent foundation for our review.

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*Care to comment? We'd like to hear from you about your partnership experiences. What worked for you—and what didn't? Write to us at [editor@CommunityOncology.net](mailto:editor@CommunityOncology.net)*

sification. But, before we can dream of growing, we must reaffirm our mission to ourselves. Our patients consider us to be their leaders in helping them through everything that relates to their malignancies. Do not allow yourself to be defined as “chemotherapists.” We are empowered by the vast majority of physicians and patients as the true captains of the oncology ship. So, don’t walk away from it, but stand up and take the helm. That means accepting the responsibility for everything that happens to your patients. Once that is done, you have enabled your capacity to expand your diagnostic and therapeutic services.

In the world of medical oncology, such groups have been able to enjoy unexpected opportunities for economic stability, growth, and community influence due to the simultaneous occurrence of two events. We have experienced extreme economic pressures to increase the outpatient management of cancer patients. This took place simultaneously with the development of profoundly creative technological achievements that created safer and consequently better care for our patients in the outpatient setting.

Once the treatment of cancer patients moved into those upgraded doctors’ offices, the physicians’ capacity to upgrade their diagnostic and therapeutic tools dramatically expanded. Diagnostic laboratories grew from blood cell-counting machines to chemical analyzers capable of running small hospitals to tumor marker analyzers. Laboratory information systems (LISs) became economically feasible, enabling the linkages of those machines not only with integrated report generators but also with billing systems and electronic medical record systems (EMRs).<sup>3</sup>

Diagnostic imaging opportunities are very possible in a smart partnership. The only way a group of physicians will be able to take the financial risks necessary to expand their services from a machine that takes chest

### Case study

## Cooperation trumps competition

THIS GROUP OF NINE ONCOLOGISTS on the East Coast has six locations, all strategically associated within a short distance of a hospital. The two founding partners in the group both had similar experiences in their earlier careers. They came to town from excellent training programs and were hired by well-established physicians who had long-standing relationships in the community. The standards at that time included having these young physicians buy into their seniors’ good will, develop their own referral patterns, and be paid according to what they collected. They both observed that when they got a patient from their seniors, it was always the one with marginal insurance. They felt that they were in direct competition with their own associates.

After 4 years in practice, they both decided to leave their seniors, take their own patients with them, and form a new partnership. This time, however, when it became time for them to bring in a younger associate, they did the unheard of—they pushed as many of their referral sources straight to their new associate. They knew they risked losing a referral source, but they also realized that the only way to ensure that that

never happened was to make the practice environment better than any alternative for their new associate. They refused to consider non-compete clauses in their partnership agreement. They called the new associate a “partner” from the very first day and officially made her a partner after 1 year. She was free to take all of her patients away at any time, but she never forgot that her seniors took the high road.

Within 5 years, the group has grown by merging with selected former competitors and acquiring younger physicians out of training. The financial rewards are split almost equally, with minor adjustments for profound overproductivity. In a standard productivity model association, the associates are always watching their own backs. In a non-competitive model partnership, the partners are secure that their partners are protecting each other’s backs. Now the group is free to compete much more effectively in its sophisticated community.

This group has just successfully opened up its own radiation oncology facility, something that none of them had even remotely considered when the group was formed.

—*Laurence J. Heifetz, MD, FACP*

x-ray and kidney-ureter-bladder films to a CT and/or PET scanner is if they value their group as an economic force that is greater than the sum of each of the doctors in it. Choices of online reading by an imaging group versus bringing in an in-house radiologist become simple business decisions that will vary with numerous local factors. But, now your partnership can provide studies that are scheduled faster, read faster, and viewed by the

doctors throughout the facility as well as their homes via the office PACS (picture archiving and communication system). Better service for our patients will always mean a healthier practice for us.

From the beginning of our training in medical oncology, we have experienced a natural and intimately intertwined relationship with radiation oncologists. This creates a tremendous opportunity for the smart part-

*Case study*

## Professional management

WHEN THE PARTNERS in this eight-physician group with three offices on the West Coast realized that they needed professional management, they had a very difficult time deciding how to do it properly. They had an accountant who managed their billings and accounts payable, a nurse who bought their supplies, and a confused administrative staff. Their employees seemed to run the office, and the physicians just tried to do the best job they could without any real understanding of business realities. They would pretend to make decisions in a partner's meeting, only to individually ignore them the next day. Although they prided themselves on consensus building, they found that they were really over their heads regarding office management.

Eventually, they agreed to bring in someone to run their practice from their own accountant's company who had spent years on their account. This MBA had earned their trust and knew what they needed. Within a short time, things began to improve dramatically.

The physicians still pretended to relinquish control to their administrator, as they never hesitated to have their doors open to the staff

and unwittingly undermined a difficult decision made by the administrator. Those healing personalities that their patients valued were consistently manipulated by their own crew.

Eventually, the group needed to make some complex decisions regarding its future. They identified their administrator as an integral partner in their success. However, they needed to ensure that he felt appropriately valued as such. Consequently, they changed his salary structure to a percentage of a full partner's annual draw. As the partnership increased in productivity, so did the administrator's income. At the same time, the partners realized that they needed to truly relinquish control to him. By establishing an executive committee, with rotating 3-year time limits, proper and timely business decisions could finally be made.

Now the group has just successfully negotiated the purchase of its own building in an extremely expensive area. The trust that was created by their respectful relationship with their professional management enabled that serious investment in their mutual future.

—*Laurence J. Heifetz, MD, FACP*

nership. The result of expanding the services of a medical oncology group into radiation oncology immediately converts the group into a cancer center. But it will only work if it is done with a "win-win" philosophy maintained from the initial design discussions all the way through to the day-to-day operations.

Consolidation and diversification will then enable improved access to clinical trials. The best way to man-

age the costs of participating in clinical research is in a smart partnership. When necessary, nonprofit cancer research foundations can be created with their own independent management structure.

### **A real team doing teamwork every day**

The key to the success of a smart medical oncology partnership is that it will only work in an environment of

trust, caring, and respect among the partners. But, to truly achieve stability and meaning in your community, that same respect must be broadened to include the entire organization and, most importantly, your executive management.

By valuing everyone in the practice as an essential element for our capacity to provide our patients with a superior experience, we stand the chance to establish an emotionally satisfying experience for ourselves as well as our patients. To disregard the benefits of that experience is to ignore the opportunity to develop a sound professional organization with those elements of diversification necessary for practice stability in our continual environment of economic change.

The individual original partners rarely anticipated these successful endeavors when they began their practices. By paying attention to this special organizational design, we can all experience the emotionally and financially secure benefits of a smart medical oncology partnership.

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