Senior Physician Slowdown—Problem or Opportunity?

By Bruce Genovese, MD, MHSA

As more and more physicians approaching retirement age seek to reduce their workloads rather than leave their practice entirely, the manner in which medical groups deal with senior physician slowdown is widely variable.

As an apparent significant physician shortage looms, practices must seriously consider the benefits of retaining older physicians by adjusting workloads and call schedules. The physician shortage is the result of a variety of factors. Over the past two decades, graduate medical education programs (GME) decreased their number of enrollees based on recommendations from the Graduate Medical Education National Advisory Committee (GMENAC).

While it was subsequently determined that the GMENAC projections were not accurate, there was not a significant rebound in the graduation rate in these programs. Additionally, the present trend toward restricting the number of international medical graduates admitted to the United States affects the overall supply of physicians in this country.

Another factor is an increased departure rate of practicing physicians. Physicians saw a relatively steady growth in their retirement assets and many retired earlier than expected.

The rush to earlier retirement is aided by the changing character of medical practice, including sub-specialization, consolidation of small practices into larger groups, the trend toward consumerism and a relative decline in income in many specialties. Many physicians see their role, independence and prestige changing drastically as a result of these factors.

Nor should the impact of the present negative legal climate regarding malpractice be overlooked as an impetus for physicians to either leave practice or modify the scope of their practices.

IN THIS ARTICLE...

- Examine a plan for physician slowdown or relief of call and—learn how it can extend the professional lives of experienced physicians at a time when practices are facing a physician shortage.

'No relief in sight'

Efforts presently under way to increase the supply of physicians will be slow to overcome the present deficit. Only one new medical school (at Florida State University) opened in the last two decades. Further funding is required for additional GME positions that will be difficult to come by given the present health care funding crisis. It is unlikely that significant changes in immigration policy will occur in the present world climate.

From the demand side of the equation there appears to be no relief in sight. As the baby boomer generation continues to age, the incidence and prevalence of disease continues almost unabated.

The demographic shift in the population toward an older, more disease-prone age group portends greater demand for services from both primary care and specialist physicians. The growing demand by the elderly is particularly unmet due to the paucity of trained gerontologists.

Relatively reasonable premiums for Medicare Part B insurance, the widespread availability of “MediGap” coverage and the potential for Medicaid to cover some of these premiums enables this population to seek physician services in both outpatient and inpatient settings without major financial restraints.

Increased demand also is generated by the widespread availability and patient knowledge of advanced technology. Patient requests for access to advanced testing are generated by both news media reports and marketing efforts by organizations. These technology dependent studies require physician time for interpretation, review of results and explanation of the findings to the patients.
Another influence on demand is the malpractice liability climate. The proliferation of direct physician services as well as diagnostic and therapeutic procedures related to defensive medicine adds a tremendous demand on physician time.

Follow-up of medico-legally necessary—but often non-medically needed—testing and procedures by physicians can delay or prevent the provision of more appropriate services.

This combination of the limited number of physicians and the ever increasing demand for services results both in greater stress on the health care community and patient dissatisfaction with access to health care providers. These issues are reflected in the desire of physicians to either limit their practice responsibilities or leave medicine entirely despite a relatively young age and clinical competence.

Rather than losing these valuable resources, medical practices must find ways to keep this group active by adjusting the traditional practice model. Let's consider some tactics that can be used to maintain experienced physicians in the workforce in ways acceptable to their younger colleagues.

Ownership and entitlement

A clear culture difference is apparent among physicians of varying generations in medical groups. Senior physicians feel a sense of ownership and a sense of entitlement. Younger physicians feel that they bring major benefits to the practice. They often bring new skills to the group and are trained in more advanced techniques. A clear culture difference is apparent among physicians of varying generations in medical groups. Senior physicians feel a sense of ownership and a sense of entitlement. Younger physicians feel that they bring major benefits to the practice. They often bring new skills to the group and are trained in more advanced techniques.

Physicians in larger groups. Senior partners tend to discount their younger partner's claims of harder work.

Younger physicians, on the other hand, feel that they bring major benefits to the practice. They often bring new skills to the group and are trained in more advanced techniques. Their “fund of knowledge” is more current and they carry with them some degree of academic conceit. Many sense that they are bringing the practice up to date and that the tendency of referring physicians to try the new doctor on the block is a personal preference for them.

They sometimes feel the time spent by older physicians in hospital politics is wasted and that they are doing the real work of the group. And of course they see themselves in the position of indispensably saving the senior physicians from an unbearable workload.

These different estimates of the value of experienced physicians to the group practice have a major influence on negotiations regarding physician call relief and slowdown. At one end of the spectrum are those who take a positive approach to the issue. They feel that the senior physicians are owed something in return for years of work building the practice and taking the risks involved in growth.

In addition, there is a sense of continued value in the contribution these physicians bring by keeping the practice connected with referral sources and upholding the reputation in the community.

Most importantly, in most specialties, practices are operating in a “sellers market.” Due to the shortage of physicians available to fill the
demand for access, thoughtful groups look upon senior physicians as a resource. As a result, the practice makes fair accommodations to retain some of the senior physicians.

At the other extreme there are those who feel that any accommodation to older physicians requesting fewer hours, decreased intensity of work and/or reduction in call should be accompanied by substantial financial penalties.

physician with debilitating that impair his or her ability to make sound judgments and offer quality care.

In general, however, practices will be better off establishing an equitable slowdown plan for competent physicians. These plans must take several factors into consideration including:

- Practice needs
- Physician desires

If the referring physicians' staffs realize that there is an obvious scramble to find patient slots rather than easy availability, their physician referral patterns may change. Even patients' impressions of access issues may affect a practice's reputation in the community.

Projecting demand in the future is not a simple task. A detailed analysis of demographic trends is required to analyze demand for most specialties. Utilization rates for specialists, testing modalities and procedures must be reviewed. In addition, a projection regarding future changes in accepted practice, based on knowledge of research in the appropriate field, must be made.

As practices take on more midlevel providers, their role in responding to increasing demand for care must be factored into any estimate. Combining these factors with an evaluation of existing and potential competition can result in some judgment regarding future demand for practice services and an estimate of physician staffing requirements.

Determining whether the aspirations of senior physicians match the needs of the practice is another step in the process of designing a slowdown plan. Due to a combination of pride and anxiety partners interested in reducing work hours or call may not be forthcoming with their requests for alterations.

A proactive approach to older physicians regarding future

Planning on retiring "when the market goes up" is not the best strategy.

In this approach there is no "credit" for previous efforts in practice development or the risks of hiring new talent. Generally there is a feeling among the younger physicians that they are really "carrying" the older physicians.

Often practices espousing this attitude are not cognizant of existing patient access issues within the organization and don't understand the problems that a physician shortage and a growing demand will present in the near future.

As a result, maintaining the services of a senior physician requesting less than a full workload is looked upon as a burden rather than as a benefit.

Problem or opportunity?

Is the senior physician issue a problem to be confronted or an opportunity to be seized? The real answer varies to some extent with the particular situation and practice. Certainly practices should not continue to employ an older

- Partnership status and tenure
- Compensation plan
- Duration of contract
- Benefits
- Ownership interest in assets

All members of a practice may not see a need for accommodating the slowdown request by a senior partner. It may be in the group's best interest to objectively determine present access and future demand.

Assessing the present state of patient access to the practice requires more than a determination of time to the next available appointment (for both physician visits and, in many cases, testing and procedures).

Referring physicians' perceptions of ease of access is vitally important. While a one-month wait for a routine appointment may seem reasonable to physicians in the practice, it may be intolerable to a referring physician under pressure from patients.
Compensation and call

Another major hurdle is determining compensation for the new role being taken by the physician. For those practices functioning under a total incentive or productivity-related compensation plan, the process is simpler. The same plan might readily fit the new arrangement.

For those practices that are in an equal share or minor proportion productivity situation, the issue is more complex. Calculating a salary using some estimate of productivity as well as considering other contributions the physician may make (committee work, weekend coverage, etc.) may not be simple.

In either case, if the physician is eliminating or reducing call the difficulty in reaching an equitable agreement escalates. The burden of call weighs heavily on physicians in many specialties. Many practices value call in the range of 25 to 50 percent of physician income, deducting that much if a physician is completely relieved of call.

The definition of call can vary from group to group. In some cases call relates to right call while in others it includes daytime duty on weekends. In some specialties there are differing levels of call.

In cardiology groups, for example, a general cardiologist may be on call for hospital and patient issues while an invasive/interventional colleague may be on call just for procedures. Call may include picking up leftover work from regular business hours or the group may be set up to function primarily in the office during the day with the call doctor responsible for hospital consultations in the evening.

Some practices develop a shift system so that a physician works the “night shift” for a week, sleeping during the day and then rotates back to a daytime schedule without call responsibility. Calculating the impact on income that should result from a reduction in call as part of a slowdown package will vary from practice to practice based on its call program.

How long a slowdown plan should extend before a physician retires is another variable to be considered. While an indefinite period with at least annual or biannual renewal cycles is one method, many times it is advantageous to both the group and the physician to plan for a retirement date. This allows the practice to better develop a physician resource plan so that recruiting in a competitive market is more successful.

Setting a target retirement date forces the physician to be realistic in his or her financial and lifestyle planning. Planning on retiring “when the market goes up” is not the best strategy for either party.

One aspect related to a slowdown plan that may not be obvious is benefits provided by the group, particularly health insurance. A physician who is younger than 65 and who significantly decreases the number of hours worked may not have access to health insurance. While older physicians are eligible for Medicare, younger part-time physicians may not be eligible for the organization’s health care plans.

Similar concerns may relate to disability and life insurance benefits supplied to full-time employees by the practice. Some consideration may have to be made in the negotiated salary to help cover this deficiency. On the other hand, practice-paid malpractice insurance is generally not reduced significantly if a physician substantially reduces work hours. Just as overhead is generally not reduced when a physician decreases work hours, the full-cost malpractice premium remains and may have to be factored into the compensation agreement.

Medical practices frequently form other corporations that own medical buildings and equipment.
Generally these are completely separate entities with the ownership interest held by members of the practice. It is frequently a point of controversy as to whether this ownership interest with an associated income stream should be maintained by a slowing down or retiring partner. Younger physicians may feel that as a physician becomes less active in the practice that physician should not profit from the work of the full-time physicians as they contribute to the rent and leases on equipment.

More senior physicians, on the other hand, might be concerned that their initial risk not be overlooked and feel that they should continue to profit from their investment.

Some middle ground must be found in this situation, perhaps involving a limit on how long the slowing down or retiring physician can maintain this financial interest as well as eliminating the voting rights of part-time or retired physicians in these corporations.

Other aspects of the retirement process that relate to buyout compensation must also be taken into account upon retirement or transition out of partnership into an employment status, such as calculation of the share of the accounts receivable and determination of the value practice assets.

These should be settled well in advance of a request for slowdown. There may also be unusual, practice-specific issues that will affect a transition plan. Short of a major breakdown in relationships these issues should be able to be negotiated, sometimes with the help of a neutral third party.

The key to a successful slowdown/call reduction plan resides in an understanding of the needs of the practice and the benefits that senior physicians can provide. Thoughtful analysis of these factors combined with a desire to arrive at an equitable agreement will pave the way for a mutually beneficial outcome.

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