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Partial Retirement – What Happens When Cardiologists Want to Slow Down?

Introduction

If your cardiology practice is like most your colleagues practices, you are already feeling understaffed and you are experiencing significant financial pressure to make the most use out of *all* your available resources, including the most costly ones: the physicians. What do you do now, when one of your financially well-off doctors has reached a point where he or she chosen not to handle the demanding pace and lifestyle typically required, and instead desires a less-intense schedule?

Your practice will need to decide first, if you can afford to lose the doctor – Is retirement the only option? Assuming, like most practices that you cannot, you must not decide how to compensate this physician for a more limited workload and how to handle his or her partnership status.

Many – but not all - of the practicing physicians feeling overwhelmed or “burned out” started to practice medicine before Stark II regulations and possibly back when fee-for-service was the only type of insurance reimbursement. During this time, malpractice insurance premiums were still manageable, and a small cardiology practice was still both feasible and common. Now the complexities of cardiology and its ultra-subspecialty, capital-intensive requirements, and sheer size – management make some physicians feel disenfranchised from the practices "they started." And, after years of saving prudently, they can afford to retire early, if they want to do so.

Every practice needs both new (young) members. Agreed. They also, however, need senior physicians, for their years of clinical expertise, to mentor young associates, and to maintain patient and referring doctor satisfaction. Some senior physicians, however, simply are not willing when they can afford not to, to take the late night "first call." Your practice choice may be only: have one of your physicians retire and go down a doctor, therefore shortening the first call rotations by at least one – or, work out a feasible alternative to full retirement what we refer to as partial retirement."

How should your practice deal with this choice?

Some groups have chosen successfully to deal with this issue on an informal level, as the situation present itself. This may have worked well when you were in a smaller group, and less afraid of litigation. Others trying this approach more recently have had less than favorable results, as issues of politics and the particulars of who wants to phase down took the foreground.

It is in the best interests of your practice to decide if this option is even right for your practice and then assuming it is, to prepare for a partial-retirement request ahead of time with a formal policy.

The customized guidelines should reflect your practice’s present and future situation and the adopted policy should incorporate your practice’s corporate and inter-doctor agreements. It must also be regularly updated. So, how do you even begin to think about this, without a free for all?

To approach this decision logically, you need a **process**. Start squarely at step one and move forward from there.

Step One: Should we Allow Physicians to Partially Retire / Phase Down; At All?

In this environment, where it is hard enough to recruit a new physician, the benefit of having one already in place in the Practice is clear. However, partial retirement usually implies a decrease (or elimination) of call responsibilities. Leaving aside the financial complications, some groups, particularly those who divide income (and intended workload), equally stop here. No one wants to feel that one of

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their partners – especially the one making the request, is not pulling their load. If your group **cannot** move beyond this phase, stop here. You may not be up to the following steps. Lots of your colleagues stop here, too.

Physicians must reach a consensus on this first issue before committing the practice to allowing partial retirement. It is important to understand that what works best for one practice might not work **at all** for a practice that *appears* to be identical. (Personalities change, facts are the same.) Market situations differ among practices; so do many other variables, such as how much they really need doctors to make each practice and that make each medical group unique over time. Make sure your partial-retirement policy, if you decide to create and implement one, applies to the entire group and will be flexible enough for doctors in the future.

Step Two: What Does Partial Retirement Mean to Us?

To most cardiology practices, partial retirement means reducing one's work level. Most often, that is "code" for eliminating some or all of that person's call responsibilities. Always start with the worst case. Assume it means **dropping** all call, and the requestor is an interventionalist, so that instead of taking his share of the first call, he drops out entirely. Obviously, this change shortens the first call pool in which the requestor participated. It usually also shortens the second call pool, though, because - he's no dummy - he knows that if he backs up a non-invasive cardiologist, that's virtually as bad as first call – and he goes to see the hospital. So, no call means "no call," and that shortens the second call pool, as well.

If you are like most middle to large groups (mega groups are beyond this problem), you probably have any number of call pools (at least two) for any number of hospitals that are either geographically not capable of having a share call pool or for whom the work demands are too great to share call. So, you may end up with a first call pool of 5 at one hospital grouping and a 6 at the other, by virtue of this request. (More on *this* issue later.)

Well, first, you are not likely to be burdened with the credentialing hassles just to make the call pools even. Credentials bring too many other commitments. Second, even if all of the facilities are in one health system so credentialing as not the issue, you are still not likely to change the call pools due to the differences in how facilities hand staff, routines and the subtle differences away those facilities run - still a good reason not to change the spinning tops of call, and warrant your physician to learning even more routines.

So, if you allow a physician to partially retire by dropping call (and maybe some hours, but that is the easy part), do you do anything about the possible intra-group inequities of the frequency of call?

Step Three: How Does Someone Become Eligible for Partial Retirement?

Assuming that the partners have theoretically decided to allow partial retirement, the next real issue is who is eligible? Can anyone apply? Can more than one person request this reduced status? What if more than one person makes this request? Should a member who is at least 50 to 55 years old be entitled to partial retirement status? Must there be a minimum number of years of service with the practice to qualify? Many groups use an eligibility requirement, starting that the requestor must, except in special circumstances (death of a spouse, etc.), have worked for the practice for some predetermined number of years - say 15 years. These details of eligibility must all be decided.

Also consider if there are any other "special circumstances" such as a member cutting down his or her activity level due to a health problem before being qualified in age and in years of service. You may want to consider allowing partial retirement for a health reason or "life change" if a lesser eligibility standard has been met, such as 10 years.

Almost everyone uses the first to file issue.

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Step Four: What Else Does Partial Retirement Mean?

For most physicians seeking partial retirement, it is a bridge. It might be a bridge through a challenging time in one's life, or it might be a bridge to retirement. For most groups considering it, it is both favor and accommodation. It is a favor, as it allows the group some time period to find a new physician to fill the gap left, and it is an accommodation to the physician, as the gracefully phasing doctor retains the referral patterns.

But all of these benefits are temporary. At some point, the group must move on and replace the physician to fix the call inequity, to make room for someone looking for the same option, or to simply to allow everyone to recognize and define the temporal nature of the situation.

Since the requesting physician has (usually) voluntarily sought this reduction, most groups will require that within one year (of not immediately) the physician will back his interest in the company. After all, he is now on a different agenda and his priorities may not be the same as the group's priorities.

Then, within another time frame (usually two to three years) he must either resume his full time status (tougher for an interventionalist) or fully retire. At that time, he would also be bought out of his related practice entities (cath lab, real estate, etc.) So partial retirement is more than a bit of breathing room. Seeking it has consequences.

Step Five: How Do We Pay a Partially Retired Physician?

It is difficult to decide in advance on an in advance pay level that will exactly reflect a member's reduced activities. After all, from year to year, partner pay probably fluctuates. Your practice may determine that payment directly corresponds to productivity, whether it is some gross charges, net charges, or actual collections. Be aware that such a productivity payment both fails on the one hand to recognize senior members' greater or lesser usefulness once they are no longer fully active, and on the other to recognize that an office based cardiologist servicing new patients for any needed diagnostics may be able to influence the productivity of his friends. On the one hand, these physicians may still offer valuable leadership and "rainmaking" skills that go above a straightforward dollar production. On the other, how will they be deployed in the office and will that affect the compensation of the others?

There is also the possibility that the fully active office physician involved in new patient work and available to supervise treadmills and read echoes may generate more income than you think is fair given that he is not getting up in the middle of the night.

Most practices handle this when by placing the requestor on a "salaried" or "salaried-plus" position, which may be literally salaried or a predetermined hourly rate depending on the work expectations. When setting that compensation rate, recognize the two steps you are taking valuing this physician's production capabilities and his intangible contribution to the group; and valuing call.

It is this latter issue that causes such consternation, so you best recognize up front that many practices "value" call at 25%-50% of total pay, depending on group size.

Step Six: Laying Out the Process

If your practice decides to go ahead and commit to developing a plan in writing, make sure that a component of the plan is a specific application process. That is, an eligible requestor must submit a request, reason for request, and executed duration from the Board. This allows your practice to be informed of a member's intentions of scaling back his or her activities well enough ahead of time so the partners can decide how to accommodate the request. It is generally a good idea to require a physician seeking partial retirement to apply in writing from 6 to 12 months before the effective date. Unless your practice has an automatic compensation formula, the request should also indicate a proposed salary reduction. The Board should always retain the right to accept or reject the request within a specified time

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period, although not all physicians agree. If for some reason the Board cannot accommodate that request, it should inform the requestor of the reason (Physicians out on disability, too short already, etc.), at which point the requestor can decide if he would rather make under his retirement options.

The duration of the request for partial retirement should only be for one year at a time. Each year, unless stated to the contrary there should be a renewal. It is difficult to predict if the work pattern or the pay level will work out fairly, and it is best for both sides to evaluate the situation as the year progresses. Once the year is up, the physician should reapply unless he originally requested and was granted multiple years dispensation for the next year of partial retirement. In this manner, the practice can evaluate and monitor the requestor based on its own needs. Some practices limit partial retirement status to a term of two to three years, and then full retirement must immediately follow. The reasoning behind this is that practices are best served by fully active physicians. As a partially retired doctor is increasingly removed from involvement in the practice, his or her usefulness generally declines.

A crucial part of a partial-retirement policy is the issue of partnership. A physician that goes into partial retirement should cease to be a partner. Recall that at the end of the first year, this individual must sell back his interest in the corporation or partnership. At the end the partial retirement period he must sell back any other related properties. If a physician isn't fully involved in all aspects of the practice, he or she cannot be permitted to participate in decisions that affect it, nor can he or she take part in the risks and rewards that come from full involvement. This sell-back requirement may be more symbolic than real, but it is still an important feature of a partial-retirement plan.

Step Seven: What about Deferred Compensation?

Consider also the right to termination pay. Usually a material change in status, such as not being a shareholder triggers the payment of deferred compensation or pay-off plan. This obligation was probably intended only for full retirement or another complete withdrawal.

Should the group be saddled with that payment now if it was counting on the "profit" from the replacement associate to cover that payment? Most senior physicians chose not to receive their payout until they have completely withdrawn, as these funds will provide a cushion when their regular compensation is no longer there. Your Board should discuss and decide if it wants to defer that payment until final separation and if any adjustment to that deferred compensation methodology is warranted. If so, this would then freeze the retirement payout until full retirement.

In Summary

Partial retirement issues handled on the fly are tough – they lead to disputes and difficult problems, even for group practices that are generally compatible. However, if your practice does not have some method or policy on how to handle a partial retirement request, the situation can become worse.

Your partners have worked diligently to build and maintain a successful medical practice, and each partner has adapted to each member's special needs, to the extent they do not disrupt the practice. Concessions have been and will continue to be made to help fellow physicians maintain a high level of satisfaction and to ensure that a stronger team of medical professionals will result. Update your partial-retirement policy regularly, and apply it fairly.

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