AI-04715 Event Tree Analysis Thriving MD Year 1

#eta

Perform an Event Tree Analysis of a new Internal Medicine MD in Hernando, FL lasting/surviving/thriving 1 year as a co-practicing physician in a small 35-year medical clinic.

Event Tree Analysis (ETA)

New Internal Medicine MD — Surviving, Lasting, and Thriving for One Year in a Small, Established Medical Clinic

Scenario: A newly recruited Internal Medicine physician joins a small, approximately **35-year-old medical clinic in Hernando, Florida**, as a co-practicing physician alongside the existing physician or physician-owner.

Analysis objective: Identify the sequential conditions that determine whether the new physician:

1. **Fails early** — cannot safely or sustainably integrate.
2. **Survives** — remains employed and clinically functional for 12 months.
3. **Lasts and succeeds** — develops reliable clinical, operational, and financial integration.
4. **Thrives** — becomes a trusted, productive, and durable member of the practice.

> **Important distinction:** An event tree is a *forward-looking consequence analysis*. It begins with the physician joining the practice and follows the success or failure of critical conditions. It is not a prediction of whether a particular physician will succeed.

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1. System Definition

Element	Assumption
Initiating event	New Internal Medicine MD accepts and begins practicing
Location	Hernando County, Florida
Practice type	Small, established outpatient medical clinic
Clinic maturity	Approximately 35 years of operating history
Practice structure	Co-practicing physician arrangement, not necessarily an employment-only role
Clinical scope	Internal Medicine / adult primary care, subject to credentialing and privileges
Time horizon	First 12 months

Primary stakeholders	New MD, existing physician-owner, staff, patients, billing team, referral network, hospitals, payors
Desired end state	Safe, trusted, financially viable, sustainable co-practice

A 35-year-old clinic has an important characteristic: **it is not a blank slate**. It likely possesses established patient relationships, workflows, habits, informal authority structures, reputation, and financial expectations. Those assets can accelerate integration—but can also create resistance to change.

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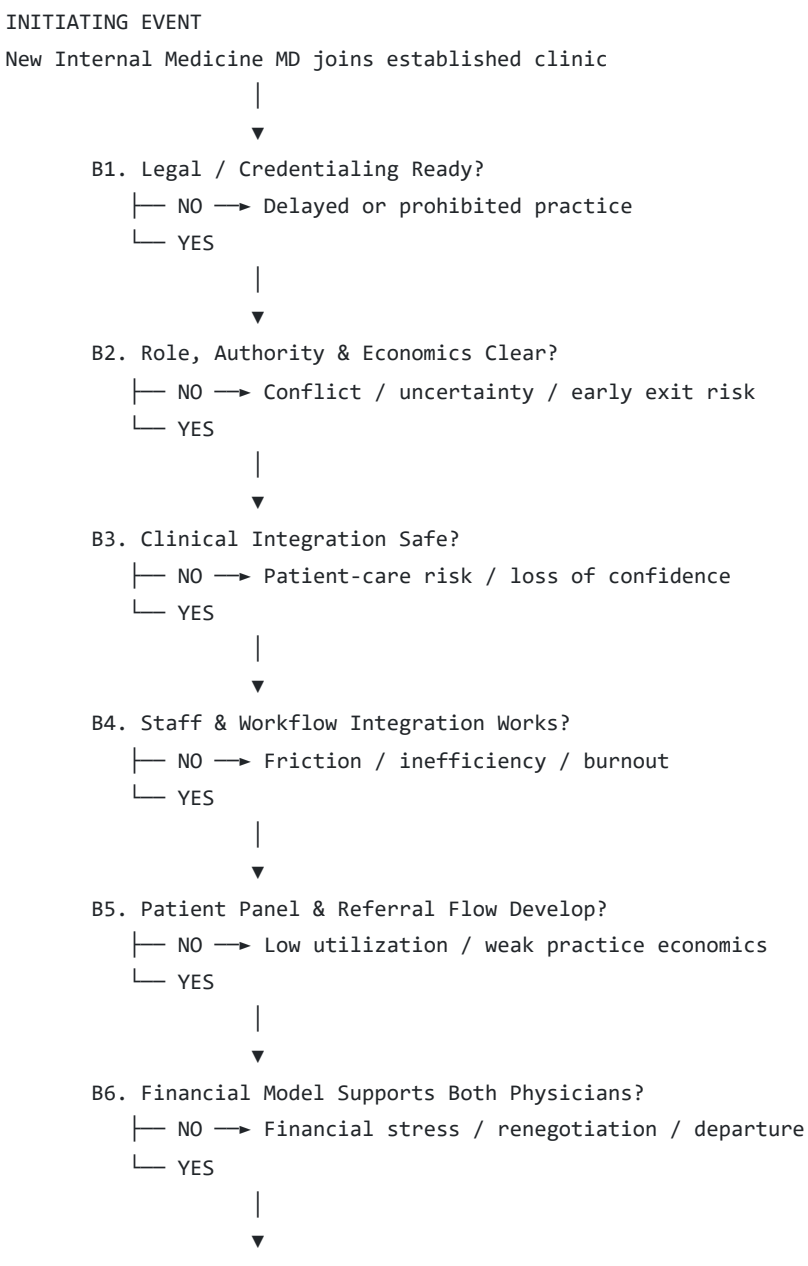
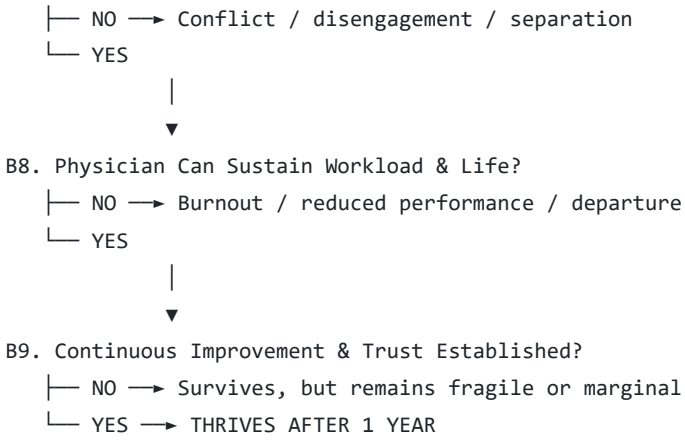
2. Top-Level Event Tree

Initiating Event

E_0 — New Internal Medicine MD begins co-practice at the established clinic

The physician's one-year outcome depends on whether the following critical conditions succeed.





Interpretation: The physician does not need every process to be perfect. However, failures in certain foundational conditions—especially licensure, patient safety, role clarity, economics, and professional trust—can overwhelm success elsewhere.

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3. Detailed Event Tree

B1 — Legal, Licensing, Credentialing, and Practice Readiness

Question: Can the physician legally and operationally perform the intended duties on the intended start date?

Florida requires a valid Florida medical license to practice medicine in the state. The Florida Board of Medicine also identifies financial-responsibility requirements and applicable statutes and rules that physicians must understand before practicing. (Florida Board of Medicine)

Success conditions

- Active Florida medical license verified.
- DEA registration, if controlled-substance prescribing is part of the role.
- Malpractice coverage confirmed.
- Appropriate payer credentialing and enrollment initiated or completed.
- Hospital privileges confirmed if hospital work is expected.
- Clinical scope and permitted duties defined.
- EHR access, prescribing access, lab and imaging access established.
- HIPAA, privacy, and security procedures understood.
- Employment, shareholder, independent-contractor, or partnership arrangement documented.

Event-tree branch

Branch	Outcome
B1 = Success	Physician is authorized and operationally ready to practice. Continue to B2.
B1 = Partial	Physician can begin limited duties but loses productivity while credentialing or access issues are resolved.
B1 = Failure	Start delayed, clinical duties restricted, or arrangement becomes legally/operationally untenable.

Primary risk: Assuming that signing a contract means the physician is ready for every clinical duty. In practice, onboarding should be defined duty by duty—clinic visits, prescribing, procedures, hospital work, telehealth, call, and supervisory responsibilities may each require separate readiness checks. (**The Doctors Insurance Agency**)

B2 — Role, Authority, Compensation, and Ownership Clarity

Question: Do both physicians understand exactly how the practice will operate with two doctors?

This is one of the most important branches in a small, long-established practice.

Critical decisions

Area	Questions that must be answered
Relationship	Employee, independent contractor, shareholder, partner, or future owner?
Clinical autonomy	Which clinical decisions are independent? What requires consultation?
Schedule	Days, hours, holidays, call, hospital rounds, urgent coverage?
Patient assignment	How are new and existing patients allocated?
Revenue	Salary, collections percentage, productivity formula, or profit share?
Expenses	Who pays malpractice, licensing, CME, staff, supplies, EHR, billing, rent?
Overhead	How is shared overhead calculated and allocated?
Ancillary services	Who owns and benefits from labs, imaging, procedures, or other services?
Decision rights	Who controls staffing, vendors, schedule, pricing, technology, and policies?
Disputes	How are disagreements resolved?
Exit	What happens if either physician leaves, becomes disabled, retires, or wants to sell?
Buy-in / buyout	Is there a defined valuation and timeline?

Florida practice-formation guidance emphasizes governance documents, employment terms, compensation, restrictive covenants, billing, credentialing, call coverage, compliance, and malpractice coverage as important considerations. (**Self-Insurance Programs**)

Event-tree branch

Branch	Outcome
B2 = Success	Both physicians know the rules of the relationship and can make decisions without guessing.
B2 = Partial	The practice functions, but hidden expectations create recurring tension.

B2 = Failure	Compensation, authority, patient ownership, or workload disputes become a major threat to retention.

High-risk failure pattern

> "We will figure it out as we go."

In a small practice, ambiguity that might be absorbed by a large organization can become **personal, financial, and existential** when only two physicians share responsibility.

B3 — Clinical Integration and Patient-Safety Readiness

Question: Can the new physician deliver safe, consistent, high-quality care within the clinic's actual capabilities?

The new MD may be clinically excellent but unfamiliar with:

- The clinic's patient population.
- Local referral patterns.
- Existing treatment philosophies.
- EHR templates and documentation habits.
- Staff competencies.
- Lab and imaging turnaround times.
- Hospital systems.
- Local specialists.
- The existing physician's expectations regarding risk and follow-up.

Success conditions

- Clinical orientation and chart-review period.
- Clear protocols for urgent and abnormal results.
- Medication reconciliation process.
- Referral and consultation workflow.
- Hospital admission and emergency escalation procedures.
- Clear coverage when either physician is absent.
- Defined handling of complex, unstable, or high-risk patients.
- Consistent documentation and coding expectations.
- Peer review or case discussion without humiliation or territorial behavior.

Florida healthcare risk-management guidance identifies patient-care, medical-staff, financial, regulatory, and operational exposures as areas requiring structured risk management. It also emphasizes identifying incidents, implementing corrective procedures, and monitoring outcomes. (**Florida Healthcare Risk Management**)

Event-tree branch

Branch	Outcome
B3 = Success	Patients receive safe care and the physician gains clinical confidence within the practice.
B3 = Partial	Minor errors, rework, inconsistent workflows, or near misses occur but are corrected.
B3 = Failure	Patient harm, serious complaint, malpractice exposure, loss of trust, or regulatory consequences may occur.

Critical insight: Clinical integration is not simply "the new doctor knows medicine." It is **the doctor + staff + EHR + referral system + escalation process functioning as one care-delivery system**.

B4 — Staff, EHR, and Workflow Integration

Question: Can the physician work efficiently with the existing team?

In a small clinic, staff often hold substantial operational knowledge. They may know:

- Which patients are difficult to reach.
- Which specialists respond quickly.
- How referrals actually get processed.
- Which insurance plans create problems.
- How labs and records are retrieved.
- Which workflows are formal versus informal.
- How the clinic historically handles exceptions.

Success conditions

- Staff introductions and role map.
- Defined physician-to-staff communication channels.
- EHR training and template alignment.
- Clear inbox ownership.
- Prescription refill responsibilities.
- Lab and imaging result routing.
- Prior authorization process.
- Referral tracking.
- Patient messaging expectations.
- Medical assistant and nurse assignment.
- Front-desk scheduling rules.
- Standardized handoff process.
- Mechanism for staff to raise concerns safely.

Event-tree branch

Branch	Outcome
B4 = Success	Staff support the physician; throughput and patient experience improve.
B4 = Partial	The physician spends excessive time compensating for workflow problems.
B4 = Failure	Staff resistance, miscommunication, bottlenecks, and turnover threaten the arrangement.

Common hidden failure mode

The clinic hires a physician but does not increase operational capacity.

The result may be:

> More patients → more messages → more refills → more labs → more referrals → more administrative work → physician frustration.

Adding a physician without examining the supporting workflow can create **more demand than the existing system can absorb**.

B5 — Patient Panel, Community Reputation, and Referral Development

Question: Does the new physician develop a sustainable patient panel without damaging the established clinic's existing relationships?

A new Internal Medicine physician may receive patients through:

- Existing clinic patients needing a new physician.
- New-patient appointments.
- Medicare and commercial insurance networks.
- Hospital discharge follow-up.
- Specialist referrals.
- Local community reputation.
- Physician-to-physician referrals.
- Word of mouth.
- Chronic disease management demand.
- Seasonal population changes.
- Local employer or community relationships.

Success conditions

- New physician listed correctly in scheduling and directory systems.
- Payor participation visible.
- Appointment availability communicated.
- Existing patients introduced appropriately.
- Referral sources informed.
- New-patient access is realistic.
- No promise of volume that the clinic cannot deliver.
- Physician's clinical strengths are accurately represented.
- Patient retention and continuity are monitored.

Event-tree branch

Branch	Outcome
B5 = Success	Patient panel grows, physician becomes known, and utilization becomes predictable.
B5 = Partial	Physician remains underutilized but can continue if economics and expectations are favorable.
B5 = Failure	Low volume creates financial pressure, professional discouragement, or renegotiation.

Important: A 35-year-old clinic may have a valuable patient base, but **historical reputation does not automatically transfer to the new physician**. Trust must be transferred through patient experience, continuity, communication, and clinical results.

B6 — Financial Viability and Revenue-Cycle Performance

Question: Does the addition of the physician produce a financially sustainable arrangement?

This branch should be analyzed at both levels:

1. **Clinic-level viability**
2. **New-physician personal compensation and sustainability**

Financial drivers

```
Patient Volume
      ×
Completed Visits
      ×
Payer / Service Mix
      ×
Collected Revenue per Visit
      =
Gross Collections
      │
      ├── Physician Compensation
      ├── Staff Expansion
      ├── Billing Costs
      ├── Malpractice
      ├── EHR / IT
      ├── Supplies
      ├── Rent / Utilities
      ├── Credentialing / Licensing
      ├── Benefits / Taxes
      └── Other Shared Overhead
      │
      ▼
Net Contribution / Practice Margin
```

Questions to quantify

- How many visits per day are expected?
- How many workdays per month?
- What is the expected payer mix?
- What is the average collected revenue per encounter?
- How long is the ramp-up period?
- What is the break-even visit volume?
- What is the compensation guarantee, if any?
- What happens if volume is below forecast?
- How are no-shows handled?
- Who bears unpaid claims and denials?
- How are collections attributed?
- Are shared expenses allocated transparently?
- What is the expected time to positive contribution?
- Is the physician expected to generate revenue immediately while also building the practice?

Event-tree branch

Branch	Outcome
B6 = Success	Compensation and clinic economics are sustainable; both parties see a rational long-term benefit.
B6 = Partial	The physician is clinically successful but financial returns are below expectations.
B6 = Failure	Financial losses, compensation disputes, cash-flow stress, or early departure become likely.

Example financial logic—not a forecast

Assume, purely for modeling:

- 16 completed visits/day
- 18 clinical days/month
- 288 visits/month
- $110 average collected revenue per visit

Then:

288 × $110 = $31,680 monthly collections

That is **not physician income**. From this amount, the practice must account for compensation, benefits, billing, staff, malpractice, technology, supplies, occupancy, taxes, and other expenses. The actual economics depend heavily on payer mix, coding, collections, service mix, and overhead.

B7 — Physician-to-Physician Relationship and Governance

Question: Can the established physician and new physician work together without persistent conflict?

This is the **co-practice-specific branch**.

A two-physician practice is structurally different from a large medical group. There may be no department chair, HR director, medical director, or executive team to absorb disagreements.

Relationship dimensions

Dimension	Healthy condition
Respect	Both physicians recognize each other's competence and professional standing.
Autonomy	Neither physician micromanages the other unnecessarily.
Communication	Difficult topics are discussed early.
Workload	Call, coverage, administrative duties, and patient complexity are reasonably balanced.
Money	Compensation and shared costs are transparent.
Patients	No destructive competition for “ownership” of patients.
Change	New ideas are evaluated without dismissing the clinic's history.
Feedback	Corrections are specific, professional, and actionable.

Conflict resolution	Disagreements have a defined process.
Trust	Each physician believes the other will act in good faith.

Event-tree branch

Branch	Outcome
B7 = Success	The physicians become complementary rather than competitive.
B7 = Partial	The clinic operates, but unresolved tensions remain.
B7 = Failure	The arrangement becomes emotionally exhausting or financially adversarial.

Typical conflict triggers

- "I am carrying more work."
- "You are seeing the easier patients."
- "You changed the workflow without asking."
- "You are not contributing enough to overhead."
- "You are not available when needed."
- "My patients are being redirected."
- "You are not documenting/coding/referring the way we do things."
- "The original agreement is not what I understood."
- "The clinic is becoming too corporate."
- "The clinic is not modernizing fast enough."

The central question: Can the clinic preserve its identity while allowing the new physician to practice as a professional—not merely as an extension of the founding physician?

B8 — Workload, Personal Sustainability, and Burnout Resistance

Question: Can the new physician maintain the workload and emotional demands of the practice for a full year?

A physician may survive clinically but fail personally because of:

- Excessive patient volume.
- Unpaid administrative work.
- Poor schedule control.
- Excessive call burden.
- Difficult patient population.
- Lack of time for documentation.
- Inadequate staff support.
- Financial uncertainty.
- Conflict with the existing physician.
- Isolation in a small practice.
- Lack of professional development.
- Inability to take time off.
- Relocation or family dissatisfaction.

Success conditions

- Predictable schedule.
- Protected documentation time.
- Reasonable patient complexity.
- Defined after-hours expectations.
- Cross-coverage.
- Vacation and illness coverage.
- Administrative burden monitored.
- Ability to say “no” to unsafe or unsustainable workload.
- Access to peer consultation.
- Personal and family adjustment to the community.
- Financial expectations aligned with reality.

Event-tree branch

Branch	Outcome
B8 = Success	Physician maintains energy, reliability, and professional engagement.
B8 = Partial	Physician remains but begins reducing effort, availability, or enthusiasm.
B8 = Failure	Burnout, disengagement, absenteeism, or departure risk increases substantially.

Key principle: A practice arrangement that is financially attractive but personally unsustainable is not a successful one-year system.

B9 — Trust, Continuous Improvement, and Long-Term Fit

Question: By the end of 12 months, has the physician become a trusted and durable member of the clinic?

This is the final branch. It distinguishes **merely surviving** from **thriving**.

Success indicators

- Patients request or recommend the physician.
- Staff trust the physician's judgment and communication.
- The physician trusts the staff and existing physician.
- Clinical workflows are stable.
- Referral relationships are functioning.
- Billing and collections are predictable.
- Patient complaints are managed constructively.
- Both physicians can discuss finances without hostility.
- The physician has a clear future role.
- The clinic has improved capacity without losing its identity.
- The physician is interested in remaining beyond year one.
- The existing physician sees the new MD as a long-term asset.

Event-tree branch

Branch	Outcome

B9 = Success	**Thriving:** trusted, integrated, productive, sustainable, and positioned for year two.
B9 = Failure	**Survives but remains fragile:** still practicing, but dependent on unresolved compromises.

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4. Complete One-Year Outcome Tree

The following is a qualitative event tree, not a statistically calculated probability model.

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E₀: NEW INTERNAL MEDICINE MD JOINS CLINIC
│
├─ B1: Legal / Credentialing Ready?
│  ├─ No → Start delayed / restricted / possible failed launch
│  └─ Yes
│
├─ B2: Role & Economics Clear?
│  ├─ No → Ambiguity → conflict / dissatisfaction / exit risk
│  └─ Yes
│
├─ B3: Clinical Integration Safe?
│  ├─ No → Patient-care risk → complaints / liability / loss of trust
│  └─ Yes
│
├─ B4: Staff & Workflow Integration?
│  ├─ No → Operational friction → low efficiency / burnout
│  └─ Yes
│
├─ B5: Patient Panel Develops?
│  ├─ No → Underutilization → financial pressure / discouragement
│  └─ Yes
│
├─ B6: Financial Model Works?
│  ├─ No → Losses / renegotiation / departure
│  └─ Yes
│
├─ B7: Physician Relationship Healthy?
│  ├─ No → Persistent conflict → disengagement / separation
│  └─ Yes
│
├─ B8: Workload Sustainable?
│  ├─ No → Burnout / reduced performance / departure
│  └─ Yes
│
└─ B9: Trust & Continuous Improvement?
   ├─ No → SURVIVES BUT FRAGILE
   └─ Yes → THRIVES AFTER 1 YEAR
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5. Outcome Classification

Outcome A — Failure Before One Year

Definition: The physician leaves, is terminated, cannot practice as intended, or the arrangement becomes functionally unworkable.

Typical pathways

- Credentialing or licensing failure.
- Major contract disagreement.
- Serious patient-safety event.
- Unresolved physician conflict.
- Financial model fails.
- Chronic staff dysfunction.
- Unsustainable workload.
- Lack of patient volume.
- Loss of confidence in the practice's leadership.

System result: The clinic loses recruitment investment, continuity, reputation, and potentially patient confidence.

Outcome B — Survives One Year, But Barely

Definition: The physician remains after 12 months but is not fully integrated or satisfied.

Characteristics

- Adequate but disappointing patient volume.
- Persistent workflow problems.
- Compensation is acceptable but not compelling.
- Staff relationship is functional but tense.
- Existing physician/new physician relationship is cautious.
- Physician feels like an outsider.
- Some unresolved contract or governance questions.
- Workload is tolerable but not sustainable indefinitely.

System result: The arrangement continues, but year two is vulnerable.

Outcome C — Lasts and Succeeds

Definition: The physician is clinically reliable, financially viable, and functioning effectively within the practice.

Characteristics

- Stable patient panel.
- Reliable staff support.
- Safe clinical processes.
- Predictable compensation.
- Clear duties and coverage.
- Reasonable physician relationship.
- Patients accept and trust the new physician.
- Practice capacity increases.
- Problems are corrected rather than hidden.

System result: The new MD becomes a productive member of the clinic.

Outcome D — Thrives

Definition: The physician is not merely retained; the physician and clinic become stronger because of the relationship.

Characteristics

- Patients actively seek the physician.
- Existing physician experiences meaningful workload relief.
- New physician contributes ideas without disrespecting the clinic's history.
- Staff become more capable and organized.
- Revenue and collections become predictable.
- Clinical quality and access improve.
- Both physicians trust each other.
- The new physician sees a credible long-term future.
- The clinic becomes more resilient to retirement, illness, or market changes.

System result: The practice evolves from a single-physician legacy operation into a durable, collaborative medical practice.

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6. Critical Success Factors Ranked by Importance

Rank	Success factor	Why it matters
1	**Role, compensation, and authority clarity**	Prevents disputes that can destroy a two-physician practice.
2	**Clinical safety and reliable handoffs**	Protects patients, physicians, and the clinic's reputation.
3	**Trust between physicians**	There are few organizational layers to absorb conflict.
4	**Adequate staff and workflow capacity**	A physician cannot succeed if the support system fails.
5	**Financial viability**	Clinical success cannot compensate indefinitely for an unsustainable economic model.
6	**Patient-panel development**	Creates the physician's long-term clinical and financial foundation.
7	**Workload sustainability**	Prevents burnout and early departure.
8	**Credentialing and operational readiness**	Prevents a failed or delayed launch.
9	**Continuous improvement**	Converts survival into long-term thriving.

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7. Leading Indicators: What to Monitor During Year One

An event tree becomes more useful when its branches are converted into observable indicators.

First 30 Days — Launch Stability

Indicator	Green signal	Warning signal
License / credentialing	All required access active	Repeated unresolved delays
Contract	Signed and understood	Verbal assumptions remain
EHR	Physician can document and order independently	Repeated access or workflow barriers
Staff	Clear roles and communication	Staff unsure who handles what
Clinical coverage	Escalation and handoff defined	“Just ask someone if needed”
Schedule	Realistic patient load	Immediate overbooking
Patient introduction	Existing patients informed appropriately	Confusion over physician roles

Days 31–90 — Integration

Indicator	Green signal	Warning signal
Patient volume	Gradual, sustainable growth	Empty schedule or unsafe overload
Documentation	Completed within expected time	Persistent after-hours backlog
Referrals	Trackable and timely	Lost or delayed referrals
Results	Clear ownership and follow-up	Unassigned inbox/results
Staff relationship	Problems discussed constructively	Passive resistance or blame
Physician relationship	Regular communication	Avoidance of difficult topics
Billing	Claims submitted and tracked	Unexplained denials or delays

Months 4–6 — Stabilization

Indicator	Green signal	Warning signal
Patient retention	Patients return and request follow-up	High dissatisfaction or leakage
Collections	Trending toward forecast	Persistent gap from assumptions
Workload	Predictable and manageable	Chronic overwork
Clinical quality	Near misses reviewed and corrected	Problems hidden or repeated
Governance	Decisions documented	Repeated “who decides?” disputes
Time off	Coverage works	Physician cannot take leave

Months 7–12 — Durability

Indicator	Green signal	Warning signal
Trust	Open discussion of money and quality	Defensive or adversarial conversations
Productivity	Stable panel and collections	No clear path to sustainability
Patient experience	Positive feedback and continuity	Complaints increasing
Physician satisfaction	Wants to remain	Quiet disengagement

Practice resilience	Coverage and succession improving	Entire practice still dependent on one person
Future planning	Year-two plan exists	No discussion of next steps

8. Failure Modes and Mitigations

Failure mode	**Event-tree branch**	**Early warning**	**Mitigation**
Physician starts before full operational readiness	B1	Missing access, unclear privileges	Duty-by-duty readiness checklist
Contract ambiguity	B2	Verbal disagreements about pay or schedule	Written agreement reviewed by healthcare counsel
Existing physician micromanages new MD	B7	Repeated second-guessing	Define clinical autonomy and consultation rules
New MD changes everything immediately	B4/B7	Staff confusion, defensive reactions	30–90-day observation and staged improvement
Staff overload	B4	Delayed messages, refills, referrals	Capacity assessment and staffing plan
Patient volume below expectations	B5/B6	Empty schedule after ramp-up	Marketing/referral/access plan and financial runway
Revenue assumptions unrealistic	B6	Collections below forecast	Monthly financial dashboard and scenario modeling
Malpractice or coverage gap	B1/B3	Unclear policy responsibility	Verify individual and entity coverage
Poor result follow-up	B3/B4	Unassigned abnormal results	Explicit result ownership and escalation
Physician burnout	B8	Chronic after-hours work	Schedule redesign, delegation, coverage
Patient ownership conflict	B2/B7	Competition over established patients	Written patient assignment and continuity rules
No exit mechanism	B2/B7	Fear of discussing departure	Buyout, termination, disability, and succession terms

Florida practice guidance specifically identifies malpractice coverage, governance, staffing, billing, compliance, credentialing, call coverage, and operational policies as important considerations when structuring a medical practice. (**Self-Insurance Programs_**)

9. The 12-Month Success Gate

At the end of one year, ask the following **10 yes/no questions**:

#	One-year gate question	Required for thriving?
1	Is the physician fully licensed, credentialed, and operationally authorized for the intended duties?	Yes
2	Are compensation, expenses, authority, and exit terms understood by both parties?	Yes
3	Are patients receiving safe, timely, and coordinated care?	Yes
4	Can the staff support the physician without chronic overload?	Yes
5	Has the physician developed a sustainable patient panel?	Yes
6	Is the financial arrangement viable for both the physician and clinic?	Yes
7	Can the physicians disagree professionally without damaging trust?	Yes
8	Is the workload sustainable without chronic burnout?	Yes
9	Do patients and staff view the physician as a trusted member of the clinic?	Yes
10	Is there a credible reason for both parties to continue into year two?	Yes

Interpretation

- **9–10 Yes:** Strong probability of a durable, thriving arrangement.
- **7–8 Yes:** Functioning arrangement, but important vulnerabilities remain.
- **5–6 Yes:** Surviving, but unstable or dependent on unresolved compromises.
- **Below 5:** High risk of failure, conflict, or departure.

This is a **management scoring tool**, not a validated clinical or actuarial probability model.

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10. Final Assessment

The Central Event-Tree Logic

> **A new Internal Medicine MD thrives in a 35-year-old small clinic when the practice successfully integrates a new professional—not merely a new revenue producer.**

The most dangerous assumption is:

> "The physician is competent, therefore the partnership will work."

Clinical competence is necessary, but the one-year outcome depends on the interaction of:

Clinical competence + legal readiness + role clarity + staff capacity + patient access + financial viability + physician trust + sustainable workload.

The most likely high-impact failure chain

```
Unclear agreement
      ↓
Different expectations
      ↓
Workload / compensation conflict
      ↓
Physician dissatisfaction
      ↓
Reduced collaboration
      ↓
Staff and patient friction
      ↓
Financial underperformance
      ↓
Early departure
```

The most likely thriving chain

```
Clear agreement
      ↓
Safe, structured onboarding
      ↓
Staff-supported clinical integration
      ↓
Reliable patient access and referrals
      ↓
Predictable collections
      ↓
Mutual trust and shared governance
      ↓
Sustainable workload
      ↓
Continuous improvement
      ↓
Trusted, productive co-practicing physician
      ↓
THRIVING AFTER 1 YEAR
```

Bottom Line

The first year should be managed as an integration project with clinical, operational, financial, and relationship milestones—not as a simple hiring event.

For this specific type of practice, the **highest-leverage controls** are:

1. **A precise written agreement before the first patient.**

2. **Duty-by-duty clinical and operational onboarding.**
3. **A transparent financial model with realistic ramp-up assumptions.**
4. **Explicit physician autonomy and decision rights.**
5. **A reliable staff, referral, results, and coverage system.**
6. **Monthly review of clinical quality, workload, collections, and relationship health.**
7. **A deliberate 12-month plan for trust, patient-panel growth, and long-term fit.**