NEGOTIATING A CONTRACT

Getting Your Questions Answered

THE AMERICAN ORTHOPAEDIC ASSOCIATION®

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Fellowship Education Coalition

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Part of the Fellowship Education Transition to Practice Lecture Series, this white paper accompanies the "Negotiating a Contract" module, an educational resource to help fellowship directors answer their fellows' crucial questions about negotiating an employment contract. The Lecture Series is a production of the American Orthopaedic Association in collaboration with the Fellowship Education Coalition comprised of the following orthopaedic specialty societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA. Visit aoassn.org or one of the subspecialty society websites to access the Lecture Series. Updated January 2020.

Who?

With whom are you seeking employment? A private practice group, hospital/health system, a specialty group, academic medical center?

The "Who" is important because the issues of private practice versus hospital employment are very different. A private practice group entails an Associate Employment Agreement, a Shareholder/Owner employment agreement, and a purchase agreement to buy into the medical practice entity, a likely Ambulatory Surgery Center (ASC) entity and possibly a real estate entity. The experts needed to assist in negotiations with a private practice may be a different set of experts than negotiating a hospital relationship. The hospital negotiation is likely only for an employment agreement.

Private Practice Group

Most private medical practices already have a large number of physicians (both owners and associate/ employed) under contracts. Therefore, they will expect new physicians to operate under the same agreements the rest of the physicians have signed. In the long run, you will want to be on the same contract as everyone else.

In the private practice world, the following should be evaluated:

- Associate Employment Agreement
- Shareholder Employment Agreement – assumes you will ultimately be asked to become an owner of the practice
- Buy-Sell/Stock Purchase/Limited Liability Company (LLC) Operating Agreement – document governing the buy-in and buy-out of the practice assets
- Deferred Compensation Agreement – may be embedded in the Shareholder Employment Agreement or a separate agreement. It addresses payments for accounts receivable upon departure and any other income generating assets that have a departure payment.
- Real estate buy-in and buy-out agreements
- ASC buy-in and buy-out agreements
- PT, Imaging, etc. buy-in and buy-out agreements

> Your advisor will likely educate you more about the arrangements than the ability to change them.

Hospital/Health System/Multispecialty Group

The hospital/health system will typically have a track record of contracts executed and terms negotiated. There may be some variation in each contract likely driven by experience of the hire, local hire or out of market hire and of course, what they have paid others under similar circumstances. While the group practice will expect you to execute contracts identical to those before you, the hospital/health system may have a small amount of flexibility to be different based on the circumstances of the moment.

Full-time academic positions/contracts are a subset of this category and will likely include a unique group of other variables including funding sources, distribution of "effort," research funding, administrative or academic support, continuing medical education (CME) time and financial support, etc. Fellowship and residency mentors and others in the same practice can provide learned information for these negotiations.

Ground Level Details of the "Who"

- Who, as an agent of your potential employer, is empowered to negotiate the terms of your employment?
- How is the decision made?
- Typically, administrative office staff can fill in details about numbers such as benefits, relative value units (RVUs) calculations, existing compensation formula, employee information like support staff, overhead numbers and how it is calculated, etc.
- However, the negotiation usually occurs with the managing partner or chief physician, oftentimes in conjunction with the CEO, if applicable.
- If this is not clear, you should inquire.
- If you hire an attorney, there are legal communication protocols that attorneys must follow in terms of who they interact with on the other side. It might be helpful to find attorneys that have previously negotiated with that same group who have already undergone the necessary protocols. The most recent physician additions to the practice may be able to provide some information about this.

What?

What exactly are you negotiating or trying to obtain a detailed understanding of?

Remember many have come before you and signed the contract being put in front of you, so understanding may be more of the goal than changing the contract. This understanding will also be relevant as you compare the multiple offers you receive.

Compensation formula – for you and for current partners

As an Associate, how am I compensated and what is the methodology to earn additional compensation? If I generated a deficit, am I responsible for paying this back before I am eligible to be an owner?

As an owner, the following questions need to be answered:

- Overhead – how is it calculated, what is fixed versus variable?
- Accounting – how is your work measured?
- Charges
- Collections
- RVUs
- wRVU with multiplier?
- A blend of these?
- How is ancillary income allocated?

Benefits

What is provided and how are these paid (i.e. are these direct expenses charged against me when I become an owner? How are these handled when I am an associate employee?

- Health insurance
- Disability insurance
- CME expenses
- Licensure
- Hospital dues
- Professional dues
- Loan repayment
- Vacation

Ancillary income opportunities – including real estate, imaging, therapy, ASCs

- What is the buy-in?
- What is the buy-out?
- Are these the same for all physicians, or do some physicians have different or special deals (founders rights)?

Signing – bonus/initiation bonus/moving expenses

- Hospital sign-on bonus, and what happens if I terminate early or they terminate me early?
- Schools loans paid for?
- Moving expenses capped or uncapped and what happens when I leave (either early or at end of contract)

Malpractice coverage – including any tail obligations

- Amount
- Structure – private practice groups usually have individual policies and an umbrella policy for the practice itself
- Claims-made, occurrence and claims-paid coverage
- All geared to protecting your personal financial assets

Separation/termination

- Timing (giving "notice")
- Costs
- Obligations
- Rights
- Restrictive covenants
- Patient notification, any communication restriction with medical staff, etc.

On-call obligations

- Where
- How frequently
- Backup system
- All trauma vs specialty specific?

Call stipend

- Do I receive as an associate or only when I become an owner?
- Is this included in my salary or is it a separate revenue stream?

Teaching stipend, if appropriate

Consulting/ Royalties, if applicable

Clear **terms of employment**

Clear **path to partnership** if applicable

- Number of years
- Status in compensation formula
- Deficits generated before becoming a partner
- Board certification requirements
- Mandatory buy-in to all other practice assets (or not)

> There will be variability between job opportunities to be sure. There are no 'industry standards' for any of these items, but there are certainly outliers. For example, a physician signed a Restrictive Covenant with a distance of 100 miles and for a time of 10 years. This is so far removed from standard restrictive covenants, it was likely not even enforceable.

Items that may or may not be in the contract but should be clear and some ideally in writing.

Patient Access

- What is the call center structure? What is the operational model?
- Do primary care physicians (PCPs) have referral restrictions?
- Are any current physicians limited in the payer type they will see (and therefore you may see an unusually large number of Medicaid, self-pay and other indigent populations)?

Patient Distribution

How are new patient appointments distributed?

Work Environment

- Will you have a Physician Assistant or Nurse Practitioner? Dedicated MA? Surgical assistant?
- Do you have to pay for them?
- How many exam rooms allocated to physicians per half day clinic staffed? Full day clinic staffed?

Marketing/Promotional Plan

Does the practice have a specific plan for me upon my arrival, taking me through my first two years?

OR Block Time

Beware of the advice that you may have to negotiate with the hospitals yourself.

QA/QI program

Understand your environment – medically, politically, historically

On-call Expectations

- Is there backup? This group or another group? Relationship with other groups?
- Should I be aware of separate spine or hand call rotations? What is their impact on the call that I take?
- Is there compensation for call?

Ongoing Negotiations

- With other groups?
- With other hospitals?
- Financial implications to you or others?

Strategic Plan

Will it affect me now, in 5 years, in 10 years, etc.?

Group Governance Structure

- How are important decisions made?
- Does a smaller Executive group make the day-to-day decisions, or do all physicians participate in day-to-day decisions?
- Does the group have strong non-physician leadership (CEO, CFO, COO, CIO)?
- If in academic practice – who holds the power (e.g. your division chief vs chair, hospital CEO vs Dean vs physician organization lead)?

Understand why they want to hire you

What is the unmet need? What niche can you develop?

Understand the state in which you are going to practice

Not all states have the same rule. Certificate of need states can limit what a group can do (ASC issues, adding MRI's etc.)

How?

Negotiating your first employment agreement can seem daunting at first pass. The truth is that you have been negotiating for years now. You may have purchased a house and negotiated that price. You have likely negotiated changes in your call schedule, rotation schedule, vacation switches with colleagues, etc. Similarly, if you are married or have a significant other, you're very familiar with negotiations. In some ways, negotiating your employment contract is no different.

You have a list of things that are important to you about your job, as well as possessing a certain skill set. Your potential employer has a list of deficiencies they wish/need to fulfill. Sometimes the employer needs are obvious, sometimes they are not, and sometimes they have needs that they have not yet identified that you can fulfill. So much of "negotiation" is information gathering.

They certainly will be gathering information about you that is not necessarily confined to your clinical acumen. They will likely know if you are married, what part of the country you are from, how interested you are in their particular geographic setting, and sometimes, they are even aware of competing offers you have on the table. If they have done their homework, they will know a lot about you before they meet you.

It is incumbent upon you to do the same research on your potential employer. There are innumerable resources available and it is likely that you have a colleague or an acquaintance that has fairly detailed knowledge about either the job, the environment, and/or several physicians who are on staff there.

There are a few broad strokes one wants to consider when negotiating.

The first is something called your **BATNA (Best Alternative To No Agreement)**[1]. This is a bit of the "bird in the hand" scenario. If you have other offers on the table or other scenarios (like doing another Fellowship, or locum tenens for example), that may serve as your BATNA. In other words, your negotiated deal should be better than your BATNA, or you will just be able to walk away and take the BATNA.

The second broad stroke to remember is "**groupness**." If you are negotiating with individuals who represent the group, remember they are trying to keep the interest of the group at the front of the negotiations. One day you will be part of a group who will have physicians and qualified individuals negotiating on your behalf as a member of a group. When you are negotiating on your behalf as an individual, ask yourself as a member of the group if you would give you what you are asking for? This will come up frequently if the group presents

a covenant not to compete. As an individual, this would very well be objectionable to you. However, once you are a member of the group and start thinking about protecting the interest of the group, you will likely think a covenant not to compete is a good thing. It is important to try to put yourself in the place of the group for which you soon will be (hopefully) on the other side of the negotiation.

The third is something called **Principled Negotiation**[1]. This has 4 basic elements:

Separate people from the problem

Example: A former co-resident of yours, whom you like, may be part of the negotiating team, but you must base your decision on more than your relationship with him or her. Similarly, if you are turned off by someone with whom you are talking, but they play a fairly small part in the overall work environment, you should be cognizant of that. People are very important, to be sure, but don't be overly influenced by a single interaction, either way.

Focus on interests, not positions

Try to understand what their needs are and what their interests are. Do they want to maintain market share? Grow market share? Where? Is there a particular patient population/surgical area they have not been able to serve? How does your skill set and interest match their needs?

Invent options for mutual gains

Think about what you may be willing to do that they may not think you are willing to do. For example, they may be reluctant to ask you to take more than one call per week for fear this will dissuade you from considering their offer. You may be someone who likes taking trauma call, is comfortable with it, and would like to do more of it to build your practice, particularly if there is a stipend attached. Offering to take more call is something, therefore, that is extremely valuable to them and valuable to you, but if it is absent in the discussion, neither side may have recognized it. This is one small example, but there are innumerable other examples. Agreeing to do something they perceive is undesirable will also increase your leverage in negotiations.

Insist on objective criteria

There needs to be clarity with a number of things, including but not limited to: the compensation formula, any incentive monies, pathway to partnership in a private practice setting, metrics on job performance and productivity, etc. Most of these things can be clearly spelled out in the contract as noted previously in this document.

1. Fisher R, Ury W, Patton B. *Getting to Yes: Negotiating Agreement Without Giving In*. New York: Penguin Books; 2011.

Notably absent from this document are several important but difficult to define factors that are important in ultimately making your decision. Practice culture and environment, interpersonal professional relationships, sense of trust, and "gut instincts" are all on that list. This document is intended to augment, not replace, these intangible variables.

Where to turn for help

- MGMA
- Mentors
- Accountants
- Attorneys
- Consultants
- Proprietary websites
- Written resources
    - ***Getting to Yes*** by Roger Fisher and William Ury …. and many others

Additional Educational Resources

- AMA GME Competency Education Program. *American Medical Association*; https://edhub.ama-assn.org/gcep
- Babitsky S, Mangraviti JJ. The 10 biggest legal mistakes physicians make in negotiating contracts with their employers. *Seak.com*; 2005. https://seak.com/blog/uncategorized/10-biggest-legal-mistakes-physicians-make-negotiating-contracts-employers/
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- Hofheinz E. Contract negotiation: do thine homework. *Orthopedics This Week;* Aug 14, 2009. https://ryortho.com/2009/08/contract-negotiation-do-thine-homework/
- The Employment Contract Checklist. *American Academy of Orthopaedic Surgeons*. https://www.aaos.org/uploadedFiles/PreProduction/Membership/Member_Resources/prac_manag/The%20employment%20contract%20checklist.pdf
- Williams AC, Althausen PL, Bray T, Walker J. *The Orthopaedic Success Manual*; 2018. https://coa.org/2018/presentations/84The-Orthopaedic-Success-Manual.pdf

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The American Orthopaedic Association engages the orthopaedic community to develop leaders, strategies and resources to guide the future of musculoskeletal care. The Fellowship Education Coalition brings together the orthopaedic community to identify, curate or develop educational tools and resources to better prepare graduating fellows for practice. The Coalition is comprised of the the following orthopaedic specialty societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA.