2023 Family Medicine Resident
Professional Development Seminar and Career Fair
October 20 – 21, 2023

Virtually on Zoom & In-Person at Valley Medical Center
Hosted by the King County Academy of Family Physicians

CONFERENCE CHAIRS:

David Evans, MD (he/him)
Program Director
Rosenblatt Family Endowed Professor of Family Medicine
Program Director
University of Washington
Contact Info: evansd9@uw.edu

David Evans, MD is a board-certified family physician offering a broad scope of services. Evans received a B.S. in Biochemistry from the Pennsylvania State University and his M.D. from the University of Pittsburgh School of Medicine where he graduated with honors. After a year spent in Washington, DC as the National President of the American Medical Student Association he completed his residency in Family Medicine at Tacoma Family Medicine in Tacoma, Washington.
For 15 years Dr. Evans practiced at Madras Medical Group where, in addition to providing clinical care was active in his local community and with organized medicine. He is a founding board member and a Past President of the National Physicians Alliance.
In April of 2012 Dr. Evans joined the faculty of the University of Washington School of Medicine where he is a Professor in the Department of Family Medicine, the Program Director of the UW Family Medicine Residency, and the Rosenblatt Family Endowed Professor in Rural Health. Dr. Evans is the recipient of several community service and teaching awards and enjoys living in Seattle, Washington with his wife, two children and dogs.

Natalie L. Nunes MD, FAAFP (she/her)
Program Director
Clinical Associate Professor, Department of Family Medicine, University of Washington
Tacoma Family Medicine Residency Program
MultiCare Health System
Contact Info: Natalie.Nunes@multicare.org

Dr. Nunes is the Program Director at MultiCare's Tacoma Family Medicine (TFM) Residency Program where she has been on the faculty since 2009. She moved into the Program Director role in spring 2021. Dr. Nunes practices full spectrum family medicine including obstetrics and has enjoyed several years of leading the Patient Centered Medical Home team, Quality and Safety committee, and becoming an Epic Certified Physician Builder on the Medical Informatics committee. One fun fact about her is that she is the only current member of the TFM faculty who actually grew up in Tacoma and was born at the hospital where she works. Dr. Nunes also appreciates being able to serve her community by working to improve the health of Tacoma for years to come.

Tony Pedroza, MD (he/him)
Clinical Professor of Family Medicine
Residency Program Director
Valley Family Medicine Residency Program
Director of Graduate Medical Education
UW Medicine/Valley Medical Center
Contact Info: Tony_Pedroza@Valleymed.org

Dr. Tony Pedroza is the Program Director of the Valley Family Medicine Residency located at UW Medicine/Valley Medical Center. He also serves as the Director of Graduate Medical Education at Valley Medical Center. He has been involved in family medicine residency education since 1989, and is a clinical professor of family medicine in the UW Department of Family Medicine. He is a current member of the executive committee of the UW WWAMI Family Medicine Residency Network. He has served as the co-course director of the KCAFP Professional Development Seminar and Career Fair for the last 8 years, and oversees the professional development curriculum at the Valley Family Medicine Residency Program.

INVITED CONFERENCE PRESENTERS:

Tamara L. Roe, JD (she/her)
Attorney
Montgomery Purdue Blankinship & Austin PLLC
Contact Info: troe@montgomerypurdue.com or (206) 682-7090

Tamara Roe's practice focuses on representing health care practices and providers in employment issues and regulatory compliance matters. She represents both employers and employees in negotiating, drafting, and enforcing employment agreements and non-competes on a regular basis. Tammy also advises medical practices and individual physicians regarding medical staff membership and hospital privileges issues, partnership disputes, patient complaints, and charges before the United States Equal Employment Opportunity Commission, Washington State Human Rights Commission, and Washington State Department of Health. Tammy also represents employers and employees in connection with civil lawsuits involving employment contracts, discrimination, harassment, non-competes and other claims related to employment laws and health care regulations.

Svetlana Sedukhin (she/her)
Associate Vice President of Underwriting
Physicians Insurance
Contact Info: Svetlana@phyins.com

Svetlana has over 20 years of experience in the medical professional liability industry and is the Associate Vice President of Underwriting Department. At Physicians Insurance she leads a team of experts that are dedicated to delivering the best possible insurance coverage solutions for each policyholder.

Shelley Knick BSN, RN, CPHRM (she/her)
Sr. Clinical Risk Consultant at Physicians Insurance
Physicians Insurance
Contact Info: Sknick@phyins.com

Shelley is a Registered Nurse and Certified Healthcare Risk Management Professional. She has over 18 years of acute care experience and is a Senior Clinical Risk Consultant. At Physicians Insurance Shelley works with policyholders to proactively mitigate risk and to develop customized risk management solutions.

Lauren Haley, JD, CPHRM (she/her)
Director, Claims at Physicians Insurance
Physicians Insurance
Contact Info: Sknick@phyins.com

Lauren is an attorney with 20 years of experience in the medical professional liability industry including the defense of healthcare providers. At Physicians Insurance she leads a team of Senior Claims Representatives dedicated to protecting, defending, and supporting our members throughout the litigation process.

Faith Johnson (she/her)
Workforce Advisor, Rural Health Office
WA State Dept. of Health
Contact Info: Faith.Johnson@doh.wa.gov

Faith is the Workforce Advisor for WA State Department of Health in the Rural Health Office and the Washington State 3RNET Network Coordinator. As the Workforce Advisor she assists Healthcare Facilities in recruiting Healthcare Professionals for rural and underserved areas in Washington State. During her time at DOH Faith has been integral in recruitment and training services to healthcare professionals and in supporting healthcare facilities.

Carlton Wilson, MBA, MHA (he/him)
Finance Director
Providence
Contact Info: carlton.wilson@gmail.com

From 2010 – 2013 Carlton worked as a licensed Financial Advisor for middle-income families. As his wife went through residency and fellowship, he gained first-hand knowledge of the financial journey young physicians face. Though no longer a practicing advisor, Carlton continues to share the fundamentals of financial planning with local residency programs. His current role is finance director for on-demand care at Providence St Joseph Health

CONFERENCE PHYSICIAN PANEL:

Rodney Anderson, MD (he/him)
President and CEO
Family Care Network
Contact Info – rjanderson@fcn.net, 360-318-8800 ext 1211

I have been a part of Family Care Network since I graduated from residency in 2009, and I took over as President/CEO in 2019. I'm originally from Woodinville, WA, did my undergraduate studies at Stanford, and then spent a couple years working in business strategy consulting before starting medical school at the University of Washington. My wife and I have two children, a 14 yo daughter and 12 yo son, and I enjoying coaching youth sports in my free time.

Lynne Bateson, MD (she/her)
Program Director Kaiser Permanente Family Medicine Residency
Clinical Assistant Professor University of Washington
Contact Info – Lynne.T.Bateson@kp.org

Dr. Bateson is currently serving as the interim program director for the Kaiser Permanente of Washington Family Medicine Residency at Seattle. She graduated from the Keck School of Medicine at the University of Southern California, and completed residency at Group Health Cooperative in Seattle, Washington (which is now KPWA). She has been on the residency faculty since 2014, and completed a faculty development fellowship through the WWAMI Network at the University of Washington in 2016. She has also served as the Associate Program Director for Curriculum, the clinical site director for Burien, and as medical student clerkship director, and she independently developed an onboarding program at KPWA for advanced practice providers in primary care. Dr. Bateson is a Fellow of the American Academy of Family Practice, and holds an appointment as a clinical assistant professor at the University of Washington.

Megan Guffey, MD, MPH, FAAFP (she/her)
Physician
Locums
Contact Info – megan_guffey@hotmail.com

My career path to family medicine has been anything but ordinary. After studying medical anthropology and biochemistry, I took a job in healthcare marketing and public relations after college graduation. After a few years on a different side of health care, I went back to medical school and attended the Medical School for International Health - a joint venture between Ben-Gurion & Columbia Universities. Between my third and fourth years of medical school, I completed my Masters in Public Health at Johns Hopkins University's Bloomberg School of Public Health. I completed my family medicine residency at the University of Arizona and a Rural Health w/OB Fellowship at Tacoma Family Medicine. I've worked as a hospitalist, a staff physician for Planned Parenthood, and full spectrum rural family medicine

provider including moonlighting in the ED. Currently I'm working locums tenens as hospitalist, rural ED physician, and clinic physician – which affords me the flexibility I desire to chart my next career course. My interests within family medicine are obstetrics, reproductive health, care for sexual assault survivors, public and community health, international medicine, and health policy. These interests have led me to training to become a Sexual Assault Forensic Examiner (SAFE), travel to India, Togo and Ethiopia to study and deliver medical care, and work in a national role with the American Academy of Family Physicians among other things.

Matt Novack, MD (he/him)
North Olympic Healthcare Network
Contact Info – mnovack@uw.edu

Matthew Novack grew up in Kenmore, Washington. He studied biochemistry with a minor in music at the University of Washington where he played trumpet in the band. Prior to medical school, Matt worked as an assistant park ranger and chemist for a drinking water company. Dr. Novack completed medical school at the University of Washington. During medical school, he enjoyed spending time in rural communities throughout the pacific northwest and completed research in addiction medicine. Dr. Novack strives to create a safe and inclusive environment for all patients. He completed residency at Tacoma Family Medicine and then a fellowship in Rural Medicine and High-Risk Obstetrics. Dr. Novack chose family medicine because he loves building strong relationships with patients and being present for the many stages of life. He sees doctors as partners in patient health, and highly respects each patient's knowledge of their own body and unique needs. His areas of interests within family medicine include pediatrics, obstetrics, and substance use disorder. Dr. Novack enjoys gardening, bike riding, and relaxing with his family and 16-year-old dachshund.

Melissa Weakland, MD (she/her)
Owner Ballard Neighborhood Doctors
Contact Info – drweakland@ballarddocs.com

I graduated from University of Washington and matched in Rochester. I did a fellowship in reproductive medicine for my final year in Rochester which included providing abortions and vasectomies. Adolescents have been my area of focus. Prior to medicine, I worked with vulnerable teen youth in Chicago and Minneapolis. During my residency I developed, in collaboration with a midwife, a pregnant teen program. Each year for four years 16 teens enrolled and we provided their OB care and deliveries as well as life skills training and leadership/ communication skills. During residency my husband and I had our second child. Upon graduation, we moved back to Seattle and we worked for the Everett Clinic. In 2007, I joined an ND in Ballard and opened Ballard Neighborhood Doctors. Now almost 15 years later, we're running strong. I am very proud to not only run my own medical clinic but to be a successful female small business owner. Our business model is to have a very low overhead (no nurses or MAs and no marketing) to devote most of our revenue to providing patient care. We offer longer visits and spend a fair amount of time outside of patient visits educating, supporting,and advocating for our patients. We see all patients regardless of insurance status with more than 30% of my panel on Medicaid. We have a relatively large pediatric population. In addition to seeing patients and running the business of our practice, I do programming within our clinic for our patients. I'm interested in eastern medicine and have provided tai chi, qigong and acupuncture for patients. I've done group visits for mental

health issues, diabetes, and low back pain. I've provided stress reduction and meditation workshops. Most recently I've been involved in a statewide autism initiative and we are now an Autism Center of Excellence.

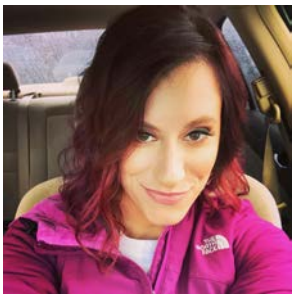
Deb Natly, MD (she/her)
Former Primary Care Medical Director
Providence Medical Group NW
Contact Info – deborah.nalty@providence.org

My career has been in one location for the last 31 years, Monroe, WA. The position has morphed dramatically from a rural hospital staffed by family physicians to an outpatient practice. For over a decade my work was full spectrum, delivering babies, admitting and managing patients to the floor and a four bed ICU, working with an inpatient substance use disorder treatment center, and seeing lots of outpatients. It gradually transformed into a suburban, no-OB, outpatient career. I also had a substantial administrative career, serving as the primary care medical director for my group for over a decade, and also as the medical director for value for Providence and Swedish in Puget Sound. I can answer queries about any or all of the above!

AMERICAN ACADEMY OF FAMILY PHYSICIANS STAFF:

Meaghan Williams (she/her)
Chapter Manager
King County Academy of Family Physicians (KCAFP)
Contact Info: kcafp@kcafp.net or (425) 780-7898

Meaghan recently started working for KCAFP after over 15 years as an elementary school teacher. She enjoys reading, dancing, and spending time with her family.



Alyssa McEachran (she/her)
Director of Pipeline and Practice Enhancement
Washington Academy of Family Physicians (WAFP)
Contact Info: alyssa@wafp.net or (425) 747-3100

Some of my favorite parts of my job are working with student and residents as well as helping people connect. Before working at the Washington Academy of Family Physicians I worked as a mental health care clinician in the Boston Area. In my free time I enjoy exploring all the beautiful corners of Washington state with my rescue dog Floyd.

EVALUATING A PHYSICIAN CONTRACT

Tamara L. Roe, Attorney
Montgomery Purdue PLLC
701 Fifth Avenue, Suite 5500
Seattle, WA 98104
Tel: (206) 682-7090
troe@montgomerypurdue.com

INTRODUCTION: I am an employment and health law attorney at the law firm of Montgomery Purdue in downtown Seattle. My firm is a full-service firm and my practice consists of representing health care groups and practitioners, particularly in the areas of employment, health law, and business. I draft and review employment agreements and also handle lawsuits and disputes such as discrimination and harassment charges with the Equal Employment Opportunity Commission and unprofessional conduct complaints with the Department of Health's Medical Quality Assurance Commission.

First, I will address some of the legal issues that arise in connection with negotiating an employment contract. And then the second major topic I will address is your legal obligations as a practicing physician under Washington law.

OUTLINE

A. YOUR EMPLOYMENT CONTRACT
1. At-Will Employment
2. Terms of Employment
3. Work Load
4. Compensation
5. Benefits
6. Practice Support
7. Termination
8. Professional Liability Insurance
9. Competition Restrictions
10. Mandatory Arbitration
11. Opportunity for Partnership

B. YOUR STATUTORY OBLIGATIONS
1. Unprofessional Conduct
2. Sexual Misconduct Rules
3. Reports to Medical Quality Assurance Commission
4. Washington Health Professional Services Program

A. YOUR EMPLOYMENT CONTRACT

1. At-Will Employment

Washington is At-Will State
Exceptions to At-Will Doctrine
- Contractual provision requiring cause or advance notice
- Discrimination Statutes: protected characteristics

2. Term of Employment

Duration
Renewal: usually automatic: referred to as an "evergreen contract"

3. Work Load

Schedule
Site of Services: can you be transferred at their discretion?
Production Requirements
Call: equal rotating basis?
Outside Employment Restrictions: are you prevented from moonlighting?

4. Compensation

Salary: change after first year?
Annual Bonus: based on productivity?
Signing Bonus
Moving Expenses

5. Benefits

Health Insurance
Disability and Life Insurance
Sick and Vacation Leave
CME: standard is five (5) days and $3,000 to $5,000
Business Expenses

6. Practice Support

Equipment
Support Staff

7. Termination

Termination with Advance Notice: standard is 90 to 180 days
Termination for Cause: ***consider narrowing the definition of cause***
Notice and Opportunity to Cure
Automatic Termination:
- Death or disability
- Practice sold or bankrupt
- Loss of license, privileges or malpractice insurance
- Felony conviction

8. Professional Liability Insurance

Occurrence Coverage:

Covers any act of malpractice that occurs during the coverage period

Claims-Made Coverage:

Most common type of policy
Covers acts of malpractice reported to insurance carrier during coverage period
Premiums low during first few years – usually increases in years 5, 6 or 7

Who is the insurance carrier?

Physicians Insurance is rated Excellent and is recommended by the WSMA
Check the rating of your carrier: should be Excellent or Superior

What are the limits? Standard is $1M per claim and $3M per year to $3M/$6M

Tail and Nose Coverage

Necessary when terminating claims-made coverage
Tail = extended reporting endorsement from old insurance carrier
Nose = prior acts coverage from new insurance carrier
Many contracts are silent as to who is responsible for tail/nose premium
Consider negotiating payment by employer, at least if they let you go

9. Competition Restrictions

Non-Disclosure of Confidential Information

Usually mirrors obligation under Washington Trade Secrets Act
Common definition is all information not generally made available to the public

Non-Compete

NEW LAW effective January 1, 2020:

It used to be that all reasonable restrictions were enforceable and that the court would reduce any overly broad provisions

Now there are penalties if the non-compete is too restrictive
There are various way in which the non-compete must comply with the law:

Income Threshold:
$100,000 for employees
$250,000 for independent contractors
Duration: 18 months following termination of employment
Geographic scope: 3 to 15 miles from any practice location
From where does the practice draws patients
Definition of competition:
practice of medicine or limited to specialty?
Exception for working at hospital or taking academic position?

RECOMMENDATIONS:

Have existing non-competes reviewed
Consider having non-solicitation provisions instead

Non-Solicitation

Patients
Employees

Remedies for Breach of Competition Restrictions

Injunctive Relief
Liquidated Damages: specific monetary penalty for breach
Attorneys' Fees

10. Mandatory Arbitration

Washington law: mandatory arbitration now enforceable if properly drafted
Exceptions: charges to EEOC or other governmental agencies
Is it one-sided?
Who is paying for arbitrator fees and costs?
Lose Constitutional Right to Trial by Judge or Jury
Favors Employers
Advantages: Less expensive
Takes less time to resolve (court cases take two years)
More predictable outcome

11. Opportunity for Partnership

When Eligible
Basis for Decision
Buy-In Amount
Consider asking for financial statements and consulting a CPA

Do you need legal counsel to review your contract? Yes

Keep in mind that contracts, including non-competes, are legally enforceable!

B. YOUR STATUTORY OBLIGATIONS

Now I will discuss some of your legal obligations under Washington law.

B.1. UNPROFESSIONAL CONDUCT

All of you are likely already familiar with the Uniform Disciplinary Act, which is the set of Washington statutes governing physician conduct.

Your packet includes as **ATTACHMENT ONE** a copy of **RCW 18.130.180**. This statute defines what is unprofessional conduct for a physician. This definition is

important because any physician who engages in unprofessional conduct can be disciplined or have their license suspended or revoked and any physician who knows that another physician has committed unprofessional conduct is required to report that physician to the Medical Quality Assurance Commission which is a branch of the Washington State Department of Health.

All types of discipline are becoming increasingly important these days because of the wide knowledge and quick and easy accessibility of the **National Practitioner Data Bank**. The Data Bank is where hospitals and other health care organization are required to report certain events such as:

1. Malpractice payments, including settlements;
2. Adverse action against your license or clinical privileges;
3. Unprofessional conduct in violation of the UDA.

ATTACHMENT TWO is a **Fact Sheet on the National Practitioner Data Bank**.

Washington law actually defines 25 separate categories of unprofessional conduct. I will highlight the major categories here:

Unprofessional Conduct Relating to Medical License:
Misrepresenting or Concealing a Material Fact to Obtain a Medical License
Practicing Without License or Beyond Scope of Licensure

Unprofessional Conduct Relating to Medical Practice:
Malpractice or Incompetence
Violation of Law Regulating Profession
Commission of Crime or Act Involving Moral Turpitude Relating to Practice
Illegally Prescribing Controlled Substances or Legend Drugs
Promotion of Unnecessary or Inefficacious Drug or Treatment for Personal Gain

Unprofessional Conduct Relating to Business:
Misrepresentation or Fraud in Conducting Business
False or Misleading Advertising
Failure to Adequate Supervise Staff If Poses Public Safety Risk

Unprofessional Conduct Relating to Behavior:
Current Misuse of Alcohol, Controlled Substances or Legend Drugs
Prescribing Controlled Substances for Oneself
Sexual Misconduct

B.2. SEXUAL MISCONDUCT RULES

The Medical Quality Assurance Commission prohibits practitioners from engaging in sexual misconduct with patients or former patients.

The rules are included with your packet of materials as **ATTACHMENT THREE**:

Washington Administrative Code 246-16-100

What behaviors constitute <u>sexual misconduct</u>?

<u>Obvious:</u>

(1) Any type of sexual contact including kissing or touching that is not medically required

(2) Asking for dates or sexual favors or offering services or medications in exchange for dates or sexual favors

<u>Not So Obvious</u>:

(1) Not allowing the patient privacy to dress and undress

(2) Discussing sexual history or preferences unless medically necessary

(3) Accepting a date at the initiation of a patient

With whom are physicians prevented from engaging in these behaviors?

Patients, former patients, and key third parties

When is a patient no longer a patient?

The fact that a patient is not actively receiving treatment or has not received treatment recently is not determinative

In order for the physician-patient relationship to be effectively terminated, you are required to terminate the patient relationship in writing and ensure referral to another health care practice

The regulations specify that you cannot engage in any of the listed behaviors within **<u>two years</u>** after the physician-patient relationship ends

And then the regulations go even further – they specify that you cannot engage in any of the listed behaviors even if more than two years has passed since the patient-physician relationship was terminated if:

There is a significant likelihood that the patient will require additional treatment from you; or

There is an imbalance of power, influence, opportunity, and/or special knowledge

Who is a <u>key third party</u>?

Immediate family members and others who could reasonably be expected to play a significant role in the patient's health care decisions, such as a spouse, domestic partner, sibling, parent, guardian, or child

So you are prohibited under the regulations from asking out or dating or engaging in the other listed behaviors not only with your patients, but also your patients' family **members**

It is not a defense if the patient initiates or consents to the conduct.

B.3. MANDATORY REPORTS TO MEDICAL QUALITY ASSURANCE COMMISSION:

Under the Uniform Disciplinary Act, you must report to MQAC:

1. Any finding that a practitioner committed Unprofessional Conduct or

2. Any information that a practitioner is Unable to Practice with Reasonable Skill and Safety

Exceptions to Reporting Obligation:

1. A report is NOT required by a licensed hospital or appropriately designated professional review committee during the **Investigative Phase** in connection with possible Unprofessional Conduct or Impairment IF the investigation is completed in a timely manner.

2. Another exception to the Washington reporting obligation applies to health care providers providing **Treatment** to impaired or potentially impaired physicians.
A report is NOT required by a physician giving treatment to another physician currently involved in a treatment program IF:

   The Physician Actively Participates in the treatment program, AND
   The Physician Does Not Present a Clear and Present Danger to the Public.

3. The Requirement of a Mandatory Report to the Washington Medical Quality Assurance Commission may be satisfied by reporting to the Washington Physicians Health Program.

B.4. WASHINGTON PHYSICIANS HEALTH PROGRAM

Washington Physicians Health Program:
Chris Bundy, MD, MPH, FASAM, Executive Medical Director
Laura Moss, MD, Associate Medical Director
1200 6th Avenue, Suite 850
Seattle, WA 98101
206.583.0127
http://www.wphp.org

A report to the Program allows the physician to be evaluated by professionals and receive help if necessary and also allows the reporting professional or organization to avoid the decision of whether to report the physician to the Medical Quality Assurance Commission.

Once referred to the Program, the physician is evaluated and the Program makes the decision of whether treatment is necessary, whether the physician may continue to work while receiving treatment, and whether a report to the Commission is required.

In most cases, a report to the Commission will not be required.

The Washington Physicians Health Program is required to report to the Commission ONLY IF:

(1) Physician Presents Imminent Danger to the Public
(2) Physician Fails to Comply with Treatment Program
    Fails to Submit to Evaluation
    Fails to Sign Contract with Program
    Fails to Comply with Contract
(3) Physician Fails to Respond to Treatment

Immunity for Reporting:
Under Washington Law, anyone who makes a **Good Faith Report** to the Washington Quality Assurance Commission or Washington Physicians Health Program is immune from civil liability.

A **Good Faith Report** means providing information that is true to the best of your knowledge and making the report with good faith intent in light of all of the circumstances, as opposed to providing information that you know is false for malicious purposes.

CONCLUSION

I will leave you with parting comment from the book Blink by Malcolm Gladwell. His book is about the concept of thin-slicing and interestingly, he applies the concept to medical malpractice.

He poses a fascinating question and I will do the same here. Suppose you wanted to figure out which physician in this room was most likely to be sued for medical malpractice. You have two choices, you can examine the physicians' training and credentials and analyze their records to see how many errors they have made. The other option is to listen to very brief snippets of conversation between each physician and his or her patients. Which method would you think would be most likely to tell you who will be sued? The latter method because the risk of being sued for malpractice has very little to do with how many mistakes you make. Believe it or not, analysis of malpractice suits show that there are highly skilled doctors that get sued a lot and doctors who make lots of mistakes but never get sued.

Also, the overwhelming numbers of people who suffer an injury due to malpractice never sue at all. Patients don't file lawsuits because they've been harmed. Patients file suits because they've been harmed and they don't like the way they were treated by their doctor on a personal level. In other words, patients sue the doctors they don't like.

A medical researcher recorded hundreds of conversations between a group of physicians and their patients. Roughly half had never been sued and the other half has been sued at least twice. She easily found clear differences in the way the two groups of physicians communicated with their patients. But it wasn't how much details they provided. There was a slight difference in how much time they spend, with the doctors who had never been sued spending a few extra minutes with their patients, but the real difference was found to be in the way they communicated.

The physicians who had never been sued used "orienting statements" indicating what they will be doing and why and engaged in "active listening" and responded to their patients' questions. Also, the doctors who had never been sued were much more likely to laugh and be funny. There was no difference in the amount or quality of information they gave their patients: the difference was entirely in how they communicated with their patients.

Tone of voice was found to be important. Whereas physicians with dominant tones were in the group that had been sued, physicians with a concerned, caring tone of voice were found to be in the group that had never been sued.

The key to avoiding lawsuits then is to use a tone of voice that conveys respect and compassion for your patients.

Chapter 246-16 WAC
STANDARDS OF PROFESSIONAL CONDUCT

Last Update: 11/30/15

WAC

246-16-010 Purpose of chapter.
246-16-020 Definitions.

SEXUAL MISCONDUCT

246-16-100 Sexual misconduct.

MANDATORY REPORTING

246-16-200 Mandatory reporting—Intent.
246-16-210 Mandatory reporting—Definitions.
246-16-220 Mandatory reporting—How and when to report.
246-16-230 Mandatory reporting—License holder self reports.
246-16-235 Mandatory reporting—License holder reporting other license holders.
246-16-240 Mandatory reporting—Reports by professional liability insurance carriers.
246-16-245 Mandatory reporting—Reports by health care institutions.
246-16-250 Mandatory reporting—Reports by health service contractors and disability insurers.
246-16-255 Mandatory reporting—Reports by professional review organizations.
246-16-260 Mandatory reporting—Reports by courts.
246-16-265 Mandatory reporting—Reports by state and federal agencies.
246-16-270 Mandatory reporting—Reports by employers of license holders.

SANCTIONS

246-16-800 Sanctions—General provisions.
246-16-810 Sanction schedule—Practice below standard of care.
246-16-820 Sanction schedule—Sexual misconduct or contact.
246-16-830 Sanction schedule—Abuse—Physical and emotional.
246-16-840 Sanction schedule—Diversion of controlled substances or legend drugs.
246-16-850 Sanction schedule—Substance abuse.
246-16-860 Sanction schedule—Criminal convictions.
246-16-890 Sanctions—Aggravating and mitigating factors.

WAC 246-16-010 Purpose of chapter. The rules in this chapter define certain acts of unprofessional conduct for health care providers under the jurisdiction of the secretary of the department of health as provided in RCW 18.130.040 (2)(a) including persons licensed or certified by the secretary under chapter 18.73 RCW or RCW 18.71.205. The rules also provide for sanctions. The secretary may adopt rules applicable to specific professions under RCW 18.130.040(2). These rules also serve as model rules for the disciplining authorities listed in RCW 18.130.040 (2)(b).

[Statutory Authority: RCW 18.130.050 (1), (12) and 18.130.180. WSR 06-18-045, § 246-16-010, filed 8/30/06, effective 9/30/06.]

WAC 246-16-020 Definitions. (1) "Health care information" means any information, whether oral or recorded in any form or medium that identifies or can readily be associated with the identity of, and relates to the health care of, a patient or client.

(2) "Health care provider" means an individual applying for a credential or credentialed in a profession listed in RCW 18.130.040 (2)(a).

(3) "Key party" means immediate family members and others who would be reasonably expected to play a significant role in the health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client.

(4) "Legitimate health care purpose" means activities for examination, diagnosis, treatment, and personal care of patients or clients, including palliative care, as consistent with community stand-

ards of practice for the profession. The activity must be within the scope of practice of the health care provider.

(5) "Patient" or "client" means an individual who receives health care from a health care provider.

[Statutory Authority: RCW 18.130.050 (1), (12) and 18.130.180. WSR 06-18-045, § 246-16-020, filed 8/30/06, effective 9/30/06.]

SEXUAL MISCONDUCT

WAC 246-16-100 Sexual misconduct. (1) A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes but is not limited to:

(a) Sexual intercourse;

(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis and treatment and within the health care practitioner's scope of practice;

(c) Rubbing against a patient or client or key party for sexual gratification;

(d) Kissing;

(e) Hugging, touching, fondling or caressing of a romantic or sexual nature;

(f) Examination of or touching genitals without using gloves;

(g) Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient or client a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient, client or key party;

(j) Removing patient or client's clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;

(k) Encouraging masturbation or other sex act in the presence of the health care provider;

(l) Masturbation or other sex act by the health care provider in the presence of the patient, client or key party;

(m) Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;

(n) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;

(o) Soliciting a date with a patient, client or key party;

(p) Discussing the sexual history, preferences or fantasies of the health care provider;

(q) Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;

(r) Making statements regarding the patient, client or key party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;

(s) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or key party;

(t) Photographing or filming the body or any body part or pose of a patient, client, or key party, other than for legitimate health care purposes; and

(u) Showing a patient, client or key party sexually explicit photographs, other than for legitimate health care purposes.

(2) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.

(3) A health care provider shall not:

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;

(c) Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.

(4) A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client or key party within two years after the provider-patient/client relationship ends.

(5) After the two-year period of time described in subsection (4) of this section, a health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section if:

(a) There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care provider; or

(b) There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

(6) When evaluating whether a health care provider is prohibited from engaging, or attempting to engage, in sexual misconduct, the secretary will consider factors, including but not limited to:

(a) Documentation of a formal termination and the circumstances of termination of the provider-patient relationship;

(b) Transfer of care to another health care provider;

(c) Duration of the provider-patient relationship;

(d) Amount of time that has passed since the last health care services to the patient or client;

(e) Communication between the health care provider and the patient or client between the last health care services rendered and commencement of the personal relationship;

(f) Extent to which the patient's or client's personal or private information was shared with the health care provider;

(g) Nature of the patient or client's health condition during and since the professional relationship;

(h) The patient or client's emotional dependence and vulnerability; and

(i) Normal revisit cycle for the profession and service.

(7) Patient, client or key party initiation or consent does not excuse or negate the health care provider's responsibility.

(8) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or

(c) Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client.

[Statutory Authority: RCW 18.130.050, 18.130.062, and Executive Order 06-03. WSR 15-24-087, § 246-16-100, filed 11/30/15, effective 12/31/15. Statutory Authority: RCW 18.130.050 (1), (12) and 18.130.180. WSR 06-18-045, § 246-16-100, filed 8/30/06, effective 9/30/06.]

MANDATORY REPORTING

WAC 246-16-200 Mandatory reporting—Intent. These mandatory reporting rules require certain reports about license holders and are intended to address patient safety. These rules are not intended to limit reports from any person who has a concern about a license holder's conduct or ability to practice safely.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-200, filed 3/31/08, effective 5/1/08.]

WAC 246-16-210 Mandatory reporting—Definitions. (1) "Approved impaired practitioner or voluntary substance abuse program" means a program authorized by RCW 18.130.175 and approved by a disciplining authority listed in RCW 18.130.040.

(2) "Conviction" means a court has decided a person is guilty of any gross misdemeanor or felony. It includes any guilty or no contest plea and all decisions with a deferred or suspended sentence.

(3) "Determination or finding" means a final decision by an entity required or requested to report under this chapter. This applies even if no adverse action or sanction has been imposed or if the license holder is appealing the decision.

(4) "License holder" means a person holding a credential in a profession regulated by a disciplining authority listed in RCW 18.130.040(2).

(5) "Unable to practice with reasonable skill and safety due to a mental or physical condition" means a license holder who:

(a) A court has declared to be incompetent or mentally ill; or

(b) Is not successfully managing a mental or physical condition and as a result poses a risk to patient safety.

(6) "Unprofessional conduct" means the acts, conduct, or conditions described in RCW 18.130.180.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-210, filed 3/31/08, effective 5/1/08.]

WAC 246-16-220 Mandatory reporting—How and when to report. (1) Reports are submitted to the department of health. The department will give the report to the appropriate disciplining authority for review, possible investigation, and further action.

(a) When a patient has been harmed, a report to the department is required. A report to one of the approved impaired practitioner or voluntary substance abuse programs is not a substitute for reporting to the department.

(b) When there is no patient harm, reports of inability to practice with reasonable skill and safety due to a mental or physical condition may be submitted to one of the approved impaired practitioner or voluntary substance abuse programs or to the department. Reports of unprofessional conduct are submitted to the department.

(c) Reports to a national practitioner data bank do not meet the requirement of this section.

(2) The report must include enough information to enable the disciplining authority to assess the report. If these details are known, the report should include:

(a) The name, address, and telephone number of the person making the report.

(b) The name, address, and telephone number(s) of the license holder being reported.

(c) Identification of any patient or client who was harmed or placed at risk.

(d) A brief description or summary of the facts that caused the report, including dates.

(e) If court action is involved, the name of the court, the date of filing, and the docket number.

(f) Any other information that helps explain the situation.

(3) Reports must be submitted no later than thirty calendar days after the reporting person has actual knowledge of the information that must be reported.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-220, filed 3/31/08, effective 5/1/08.]

WAC 246-16-230 Mandatory reporting—License holder self reports. Each license holder must self report:

(1) Any conviction, determination, or finding that he or she has committed unprofessional conduct; or

(2) Information that he or she is unable to practice with reasonable skill and safety due to a mental or physical condition; or

(3) Any disqualification from participation in the federal medicare or medicaid program.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-230, filed 3/31/08, effective 5/1/08.]

WAC 246-16-235 Mandatory reporting—License holder reporting other license holders. A license holder must report another license holder in some circumstances.

(1) The reporting license holder must submit a report when he or she has actual knowledge of:

(a) Any conviction, determination, or finding that another license holder has committed an act that constitutes unprofessional conduct; or

(b) That another license holder may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition.

(2) The license holder does not have to report when he or she is:

(a) A member of a professional review organization as provided in WAC 246-16-255;

(b) Providing health care to the other license holder and the other license holder does not pose a clear and present danger to patients or clients; or

(c) Part of a federally funded substance abuse program or approved impaired practitioner or voluntary substance abuse program and the other license holder is participating in treatment and does not pose a clear and present danger to patients or clients.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-235, filed 3/31/08, effective 5/1/08.]

WAC 246-16-240 Mandatory reporting—Reports by professional liability insurance carriers. Every institution, corporation or organization providing professional liability insurance to a license holder must report:

(1) Any malpractice settlement, award, or payment in excess of twenty thousand dollars that results from a claim or action for damages allegedly caused by a license holder's incompetence or negligence in the practice of the profession.

(2) Award, settlement, or payment of three or more claims during a twelve-month period that result from claims or actions for damages allegedly caused by the license holder's incompetence or negligence in the practice of the profession.

(3) Reports made according to RCW 18.57.245 or 18.71.350 meet the requirement.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-240, filed 3/31/08, effective 5/1/08.]

WAC 246-16-245 Mandatory reporting—Reports by health care institutions. (1) This section applies to:

(a) Hospitals and specialty hospital defined in chapter 70.41 RCW;

(b) Ambulatory surgery facilities defined in chapter 70.230 RCW;

(c) Childbirth centers defined in chapter 18.46 RCW;

(d) Nursing homes defined in chapter 18.51 RCW;

(e) Chemical dependency treatment programs defined in chapter 70.96A RCW;

(f) Drug treatment agencies defined in chapter 69.54 RCW; and

(g) Public and private mental health treatment agencies defined in RCW 71.05.020 and 71.24.025.

(2) The chief administrator or executive officer or designee of these institutions must report when:

(a) A license holder's services are terminated or restricted because a license holder has harmed or placed at unreasonable risk of harm a patient or client; or

(b) A license holder poses an unreasonable risk of harm to patients or clients due to a mental or physical condition.

(3) Reports made by a hospital according to RCW 70.41.210 meet the requirement.

(4) Commencing July 1, 2009, reports made by an ambulatory surgical center according to RCW 70.230.110 meet the requirement.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-245, filed 3/31/08, effective 5/1/08.]

WAC 246-16-250 Mandatory reporting—Reports by health service contractors and disability insurers. The executive officer of health care service contractors and disability insurers licensed under chapters 48.20, 48.21, 48.21A, and 48.44 RCW must report when the entity has made a determination or finding that a license holder has engaged in billing fraud.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-250, filed 3/31/08, effective 5/1/08.]

WAC 246-16-255 Mandatory reporting—Reports by professional review organizations. (1) This section applies to every peer review committee, quality improvement committee, or other similarly designated professional review organization operating in the state of Washington.

(2) Unless prohibited by state or federal law, the professional review organization must report:

(a) When it makes a determination or finding that a license holder has caused harm to a patient or placed a patient at unreasonable risk of harm; and

(b) When it has actual knowledge that the license holder poses an unreasonable risk of harm due to a mental or physical condition.

(3) Professional review organizations and individual license holders participating in a professional review organization do not need to report during the investigative phase of the professional review organization's operation if the organization completes the investigation in a timely manner.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-255, filed 3/31/08, effective 5/1/08.]

WAC 246-16-260 Mandatory reporting—Reports by courts. The department requests that the clerks of trial courts in Washington report professional malpractice judgments and all convictions against a license holder.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-260, filed 3/31/08, effective 5/1/08.]

WAC 246-16-265 Mandatory reporting—Reports by state and federal agencies. The department requests that any state or federal program employing a license holder in Washington reports:

(1) When it determines a license holder has harmed or placed at unreasonable risk of harm a patient or client; and

(2) When it has actual knowledge that the license holder poses an unreasonable risk of harm due to a mental or physical condition.

[Statutory Authority: RCW 18.130.070 and 18.130.060. WSR 08-08-066, § 246-16-265, filed 3/31/08, effective 5/1/08.]

WAC 246-16-270 Mandatory reporting—Reports by employers of license holders. (1) Every license holder, corporation, organization, health care facility, and state and local governmental agency that employs a license holder shall report to the department of health when the employed license holder's services have been terminated or restricted based on a final determination or finding that the license holder:

(a) Has committed an act or acts that may constitute unprofessional conduct; or

(b) May not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition.

(2) Reports under this section must be submitted to the department of health as soon as possible but no later than twenty days after a final determination or finding is made. The report should contain the information described in WAC 246-16-220(2).

(3) Reports made by a hospital according to RCW 70.41.210 and reports by ambulatory surgical facilities according to RCW 70.230.120 meet the requirement of this section.

(4) If a license holder fails to submit a report required by this section, a civil penalty of up to five hundred dollars may be imposed and the disciplining authority may take action against the license holder for unprofessional conduct.

[Statutory Authority: RCW 18.130.080. WSR 09-04-050, § 246-16-270, filed 1/30/09, effective 3/2/09.]

SANCTIONS

WAC 246-16-800 Sanctions—General provisions. (1) Applying these rules.

(a) The disciplining authorities listed in RCW 18.130.040(2) will apply these rules to determine sanctions imposed for unprofessional conduct by a license holder in any active, inactive, or expired status. The rules do not apply to applicants.

(b) The disciplining authorities will apply the rules in:

(i) Orders under RCW 18.130.110 or 18.130.160; and

(ii) Stipulations to informal disposition under RCW 18.130.172.

(c) Sanctions will begin on the effective date of the order.

(2) Selecting sanctions.

(a) The disciplining authority will select sanctions to protect the public and, if possible, rehabilitate the license holder.

(b) The disciplining authority may impose the full range of sanctions listed in RCW 18.130.160 for orders and RCW 18.130.172 for stipulations to informal dispositions.

(i) Suspension or revocation will be imposed when the license holder cannot practice with reasonable skill or safety.

(ii) Permanent revocation may be imposed when the disciplining authority finds the license holder can never be rehabilitated or can never regain the ability to practice safely.

(iii) Surrender of a credential may be imposed when the license holder is at the end of his or her effective practice and surrender alone is enough to protect the public. The license holder must agree to retire and not resume practice.

(iv) Indefinite suspension may be imposed in default and waiver of hearing orders. If indefinite suspension is not imposed in a default or waiver of hearing order, the disciplining authority shall impose sanctions determined according to these rules.

(v) "Oversight" means a period of time during which respondent must engage in on-going affirmative conduct intended to encourage rehabilitation and ensure public safety. It also includes active compliance monitoring by the disciplining authority. The passage of time without additional complaints or violations, with or without payment of a fine or costs, is not, by itself, oversight.

(c) The disciplining authority may deviate from the sanction schedules in these rules if the schedule does not adequately address the facts in a case. The disciplining authority will acknowledge the deviation and state its reasons for deviating from the sanction schedules in the order or stipulation to informal disposition.

(d) If the unprofessional conduct is not described in a schedule, the disciplining authority will use its judgment to determine appropriate sanctions. The disciplining authority will state in the order or stipulation to informal disposition that no sanction schedule applies.

(3) Using sanction schedules.

(a) Step 1: The findings of fact in an order or the allegations in an informal disposition describe the unprofessional conduct. The disciplining authority uses the unprofessional conduct described to select the appropriate sanction schedule contained in WAC 246-16-810 through 246-16-860.

(i) If the act of unprofessional conduct falls in more than one sanction schedule, the greater sanction is imposed.

(ii) If different acts of unprofessional conduct fall in the same sanction schedule, the highest sanction is imposed and the other acts of unprofessional conduct are considered aggravating factors.

(b) Step 2: The disciplining authority identifies the severity of the unprofessional conduct and identifies a tier using the sanction schedule tier descriptions.

(c) Step 3: The disciplining authority identifies aggravating or mitigating factors using the list in WAC 246-16-890. The disciplining authority describes the factors in the order or stipulation to informal disposition.

(d) Step 4: The disciplining authority selects sanctions within the identified tier. The starting point for duration of the sanctions is the middle of the tier range.

(i) Aggravating factors move the appropriate sanctions towards the maximum end of the tier range.

(ii) Mitigating factors move the appropriate sanctions towards the minimum end of the tier range.

(iii) Mitigating or aggravating factors may result in determination of a sanction outside the range in the tier. The disciplining authority will state its reasons for deviating from the tier range in the sanction schedule in the order or stipulation to informal disposition. The disciplining authority has complied with these rules if it

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

FACT SHEET ON THE NATIONAL PRACTITIONER DATA BANK

Background of the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established through Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986* (the Act), as amended. Final regulations governing the NPDB are codified at 45 CFR Part 60. Responsibility for NPDB implementation resides in the Bureau of Health Professions, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS).

The intent of Title IV of P.L. 99-660 is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.

Interpretation of NPDB Information

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. Eligible entities should use the information contained in the NPDB in conjunction with information from other sources when granting clinical privileges or in employment, affiliation, or licensure decisions.

The information contained in the NPDB is intended to direct discrete inquiry into and scrutiny of specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. NPDB information is an important supplement to a comprehensive and careful review of a practitioner's professional credentials. The NPDB is intended to augment, not replace, traditional forms of credentials review. As a nationwide flagging system, it provides another resource to assist State licensing boards, hospitals, and other health care entities in conducting extensive, independent investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant clinical privileges.

Settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician, dentist, or other health care practitioner. Thus, a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred.

The information in the NPDB should serve only to alert State licensing authorities and health care entities that there **may** be a problem with a particular practitioner's professional competence or conduct. NPDB information should be considered together with other relevant data in evaluating a practitioner's credentials (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, health status, verification of training and experience, and relationships with patients and colleagues).

Confidentiality of NPDB Information

Information reported to the NPDB is considered confidential and shall not be disclosed except as specified in the NPDB regulations at 45 CFR Part 60. The Office of Inspector General (OIG), HHS, has been delegated the authority to impose civil money penalties on those who violate the confidentiality provisions of Title IV. Persons or entities who receive information from the NPDB either directly or indirectly are subject to the confidentiality provisions and the imposition of a civil money penalty if they violate those provisions. When an authorized agent is designated to handle NPDB queries or reports, both the entity and the agent are required to maintain confidentiality in accordance with Title IV requirements.

For each violation of confidentiality, a civil money penalty of up to $11,000 can be levied. In any case in which it is determined that more than one party was responsible for improperly disclosing confidential information, a penalty of up to the maximum $11,000 limit can be imposed against each responsible individual, entity, or organization.

Eligible Entities

Entities entitled to participate in the NPDB are defined in the provisions of P.L. 99-660 and the NPDB regulations. Eligible entities are responsible for meeting Title IV reporting and querying requirements, as appropriate. Each eligible entity must certify its eligibility to the NPDB in order to report to or query the NPDB. Refer to the *Fact Sheet on Entity Eligibility*, available at *www.npdb-hipdb.hrsa.gov*.

The NPDB is available to State licensing boards; hospitals and other health care entities, including professional societies; Federal agencies; and others as specified in the law to provide information on the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners. The NPDB collects information on medical

malpractice payments and adverse licensure, clinical privilege, professional society membership actions. The NPDB also contains information regarding practitioners who have been declared ineligible to participate in Medicare or Medicaid under the *Social Security Act*.

Querying

The NPDB is a resource to assist State licensing boards, hospitals, and other health care entities in conducting investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant membership or clinical privileges.

Eligible entities may query as follows:

- **Mandatory Querying:** Hospitals **must** query when a practitioner applies for privileges and every 2 years on practitioners on the medical staff or holding privileges. Hospitals are also required to query the NPDB when a practitioner wishes to add to or expand existing privileges and when a practitioner submits an application for temporary privileges.

- **Voluntary Querying:** Hospitals **may** query at other times as necessary for professional review activity.

  Other health care entities that provide health care services and have a formal peer review process, including professional societies, **may** query when entering an employment or affiliation relationship with a physician, dentist, or other health care practitioner, or in conjunction with professional review activities.

  State licensing boards **may** query at any time on physicians, dentists, and other health care practitioners.

  Health care practitioners **may** self-query at any time.

  Plaintiff's attorneys or a plaintiff representing himself or herself (pro se) **may** query under certain circumstances.

The NPDB is prohibited by law from disclosing information on a specific practitioner to a medical malpractice insurer, defense attorney, or member of the general public.

Sanctions for Failing to Query the NPDB

Any hospital that does not query on a practitioner (1) at the time the practitioner applies for a position on its medical staff or for clinical privileges at the hospital, and (2) every 2 years concerning any practitioner who is on its medical staff or has clinical privileges at the hospital, is presumed to have knowledge of any information reported to the NPDB concerning the practitioner. A hospital's failure to query on a practitioner may give a plaintiff's attorney or a plaintiff representing himself or herself access to NPDB information on that practitioner, for use in litigation against the hospital.

Fees for Requesting Information

Fees are charged for all queries to the NPDB and are announced in the *Federal Register*. Query fees are based on the cost of processing requests and providing information to eligible entities. The NPDB only accepts payments for query fees by pre-authorized Electronic Funds Transfer (EFT) or credit card (VISA, MasterCard, Discover, or American Express). To establish an EFT account, complete an on-line *Electronic Funds Transfer Authorization* form. You may obtain the form from the NPDB-HIPDB Web site. For information on Data Bank querying fees and acceptable payment methods, see the *Fact Sheet on Query Fees*.

Practitioner Self-Queries

A practitioner may self-query the Data Banks at any time by visiting the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. All self-query fees must be paid by credit card. For detailed instructions about self-querying, see the *Fact Sheet on Self-Querying*.

Reporting

The information required to be reported to the NPDB is applicable to physicians and dentists and, in some cases, other health care practitioners who are licensed or otherwise authorized by a State to provide health care services.

The NPDB is committed to maintaining accurate information and ensuring that health care practitioners are informed when medical malpractice payments or adverse actions are reported concerning them. The NPDB cannot edit any information contained in a report. Reporting entities are responsible for the accuracy of the information they report to the NPDB.

When the NPDB processes a Medical Malpractice Payment Report or an Adverse Action Report, notice is sent to the reporting entity and to the subject. Both parties should review the report for accuracy. Subjects may not submit changes to reports. If any information in a report is inaccurate, the subject must contact the reporting entity to request that it correct the information.

The subject of a Medical Malpractice Payment Report or an Adverse Action Report may add a Statement to the report, dispute either the factual accuracy of the information in the report or whether the report was submitted in accordance with NPDB reporting requirements, or both.

If the subject and the reporting entity cannot resolve the issues in dispute, the subject may request that the Secretary of HHS review the disputed report.

Medical Malpractice Payments

Each entity that makes a medical malpractice payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or a judgment against that practitioner, must

report certain payment information to the NPDB. A payment made as result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable.

Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services. A written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

Medical malpractice payers must report medical malpractice payments within 30 days of the date a payment is made. The report must be submitted to the NPDB. Once processed, a copy of the report must immediately be sent to the appropriate State licensing board in the State in which the malpractice claim occurred. Reports must be submitted regardless of how, or if, the matter was settled (for instance, court judgment, out-of-court settlement, or arbitration).

Adverse Licensure Actions

State medical and dental boards must report certain disciplinary actions related to professional competence or conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State medical and dental boards must also report revisions to adverse licensure actions. Adverse licensure actions must be reported to the NPDB within 30 days from the date of the action.

Adverse Clinical Privileges Actions

- **Mandatory Reporting**: Hospitals and other eligible health care entities **must** report professional review actions that adversely affect a physician's or dentist's clinical privileges for a period of more than 30 days. They must also report the acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting an investigation or professional review action. Revisions to such actions must also be reported.

- **Voluntary Reporting:** Hospitals and other health care entities **may** report adverse actions taken against the clinical privileges of licensed health care practitioners other than physicians and dentists. Revisions to such actions must also be reported.

Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. The health care entity must print a copy of each report submitted to the NPDB and mail it to the appropriate State licensing board for its use. The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB must be used for submission to the appropriate State licensing board.

Adverse Professional Membership Actions

- **Mandatory Reporting**: Professional societies must report specific information when any professional review action, based on reasons related to professional competence or conduct, adversely affects the membership of a physician or dentist. Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Revisions to such actions must also be reported.

- **Voluntary Reporting:** A professional society of health disciplines other than medicine and dentistry may similarly report adverse actions taken against the membership of their health care practitioners. Revisions to such actions must also be reported.

Medicare/Medicaid Exclusion Reports

The NPDB currently includes information regarding practitioners who have been declared ineligible from participating in, or have been reinstated to participate in, Medicare or Medicaid. Hospitals, managed care organizations, and other providers are prohibited from billing Medicare and Medicaid for any services that might be rendered by these practitioners.

Medicare/Medicaid Exclusion Reports were added to the NPDB through a collective effort and Memorandum of Understanding among the HRSA, OIG, and the Centers for Medicare & Medicaid Services (CMS). This information is released in accordance with the *Social Security Act* and the *Privacy Act*. CMS retains full responsibility for the content and accuracy of Medicare/Medicaid Exclusion Reports; the NPDB acts only as a disclosure service. Notification of exclusion from Medicare and Medicaid programs is made by CMS.

Sanctions for Failing to Report to the NPDB

Medical Malpractice Payers

The HHS OIG has the authority to impose civil money penalties in accordance with Sections 421(c) and 427(b) of Title IV of P.L. 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. Under the statute, any medical malpractice payer that fails to report medical malpractice payments in accordance with Section 421(c) is subject to a civil money penalty of up to $11,000 for each such payment involved.

Hospitals and Other Health Care Entities

If HHS determines that a hospital or other health care entity, including a professional society, has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the entity will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years, commencing 30 days from the date of publication in the *Federal Register*.

State Boards

State medical and dental boards that fail to comply with NPDB reporting requirements can have the responsibility to report removed from them by the Secretary of HHS. In such instances, the Secretary will designate another qualified entity to report NPDB information.

Attorney Access

A plaintiff's attorney or a plaintiff representing himself or herself (pro se) is permitted to obtain information from the NPDB under limited conditions:

- A medical malpractice action or claim must have been filed by the plaintiff against a hospital in a State or Federal court or other adjudicative body.
- The practitioner on whom the information is requested must be named in the action or claim.

Obtaining NPDB information on the specified practitioner is permitted only after evidence is submitted to HHS demonstrating that the hospital failed to submit a mandatory query to the NPDB regarding the practitioner named by the plaintiff in the action. This evidence is not available to the plaintiff through the NPDB. Evidence that the hospital failed to request information from the NPDB must be obtained by the plaintiff from the hospital through discovery in the litigation process. Defense attorneys are not permitted to query because the defendant can self-query.

Coordination with the HIPDB

The Healthcare Integrity and Protection Data Bank (HIPDB) was established through the *Health Insurance Portability and Accountability Act of 1996*, Section 221(a), Public Law 104-191. The HIPDB is a national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, and civil judgments related to health care, and other adjudicated actions or decisions.

To alleviate the burden on those entities that must report to both the HIPDB and the NPDB, a system has been created to allow an entity that must report to both Data Banks to submit the report only once. This Integrated Querying and Reporting Service (IQRS) is able to sort the appropriate actions into the NPDB, the HIPDB, or both. Similarly, entities authorized to query both Data Banks have the option of querying both the NPDB and the HIPDB with a single query submission.

All final adverse actions taken on or after August 21, 1996 (the date Section 1128E was passed), must be reported to the HIPDB. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

NPDB-HIPDB Assistance

For additional information, visit the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. If you need assistance, contact the NPDB-HIPDB Customer Service Center by e-mail at *help@npdb-hipdb.hrsa.gov* or by phone at 1-800-767-6732 (TDD 703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

RCW 18.130.180

Unprofessional conduct.

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter **9.96A** RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by *RCW **18.130.345**, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter **9.96A** RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter **19.68** RCW or a pattern of violations of RCW **41.05.700**(8), **48.43.735**(8), **48.49.020**, **48.49.030**, **71.24.335**(8), or **74.09.325**(8);

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards;

(26) Violation of RCW **18.130.420**;

(27) Performing conversion therapy on a patient under age eighteen;

(28) Violation of RCW **18.130.430**.

[**2021 c 157 § 7**; **2020 c 187 § 2**; **2019 c 427 § 17**. Prior: **2018 c 300 § 4**; **2018 c 216 § 2**; **2010 c 9 § 5**; **2008 c 134 § 25**; **1995 c 336 § 9**; **1993 c 367 § 22**; prior: **1991 c 332 § 34**; **1991 c 215 § 3**; **1989 c 270 § 33**; **1986 c 259 § 10**; **1984 c 279 § 18**.]

NOTES:

***Reviser's note:** RCW **18.130.345** was repealed by **2015 c 205 § 5**.

Conflict with federal requirements—2021 c 157: See note following RCW **74.09.327**.

Findings—Intent—Effective date—2019 c 427: See RCW **48.49.003** and **48.49.900**.

Intent—Finding—2018 c 300: "(1) The legislature intends to regulate the professional conduct of licensed health care providers with respect to performing conversion therapy on patients under age eighteen.

(2) The legislature finds and declares that Washington has a compelling interest in protecting the physical and psychological well-being of minors, including lesbian, gay, bisexual, and transgender

youth, and in protecting its minors against exposure to serious harms caused by conversion therapy." [**2018 c 300 § 1**.]

Construction—2018 c 300: "This act may not be construed to apply to:

(1) Speech that does not constitute performing conversion therapy by licensed health care providers on patients under age eighteen;

(2) Religious practices or counseling under the auspices of a religious denomination, church, or organization that do not constitute performing conversion therapy by licensed health care providers on patients under age eighteen; and

(3) Nonlicensed counselors acting under the auspices of a religious denomination, church, or organization." [**2018 c 300 § 2**.]

Intent—2010 c 9: See note following RCW **69.50.315**.

Finding—Intent—Severability—2008 c 134: See notes following RCW **18.130.020**.

Application to scope of practice—Captions not law—1991 c 332: See notes following RCW **18.130.010**.

Severability—1986 c 259: See note following RCW **18.130.010**.

Finding Physician Employment and Negotiating Strategies.

- Tony Pedroza, MD
- Program Director, Valley Family Medicine Residency
- UW Medicine/Valley Medical Center


KEEP
CALM
AND
GET
A JOB

Finding your first job as a physician:

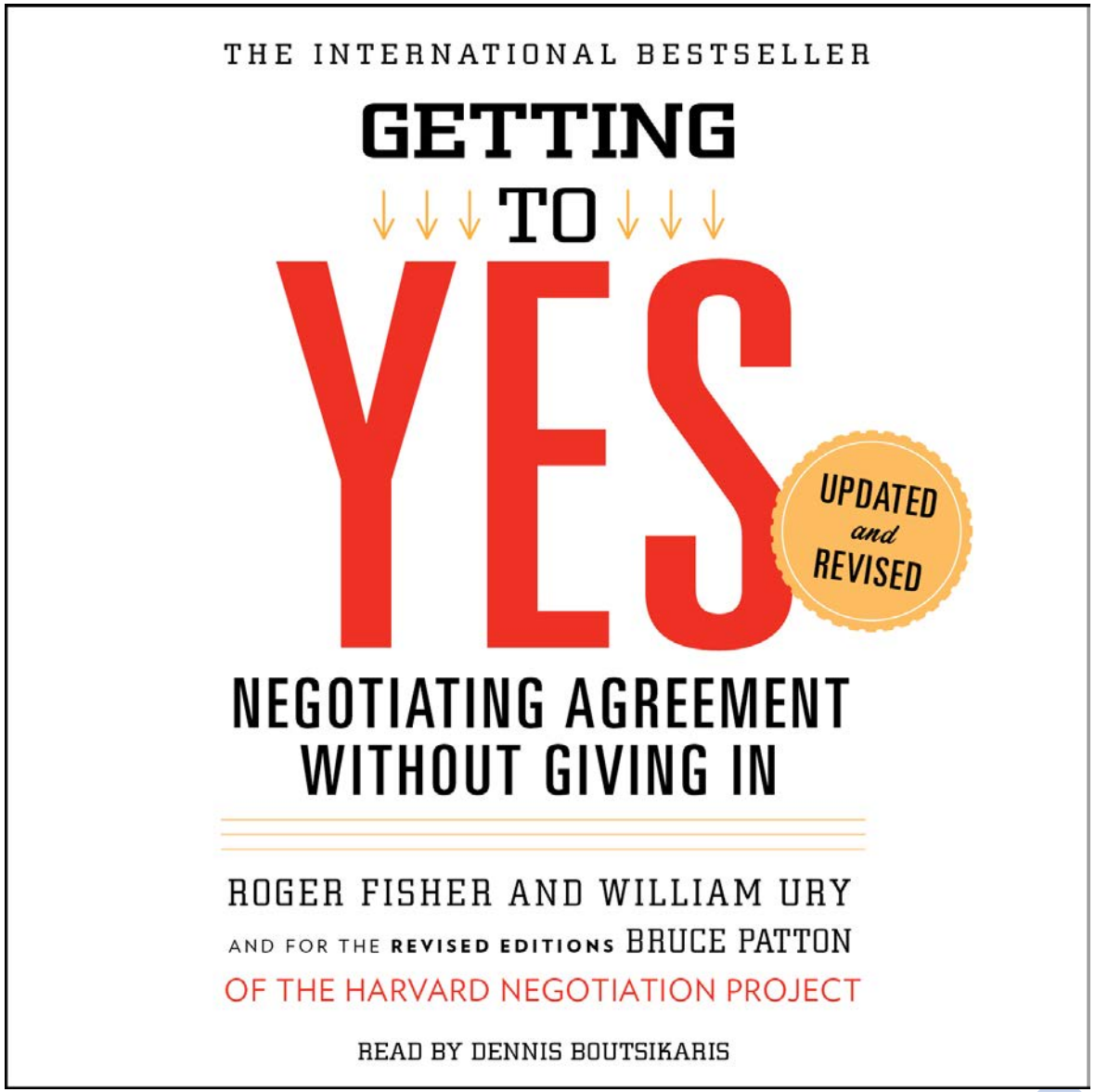
- For most this is your first job as a physician
- For most of you this is your first job requiring an employment contract
- For most this will be your first go at negotiating terms of employment

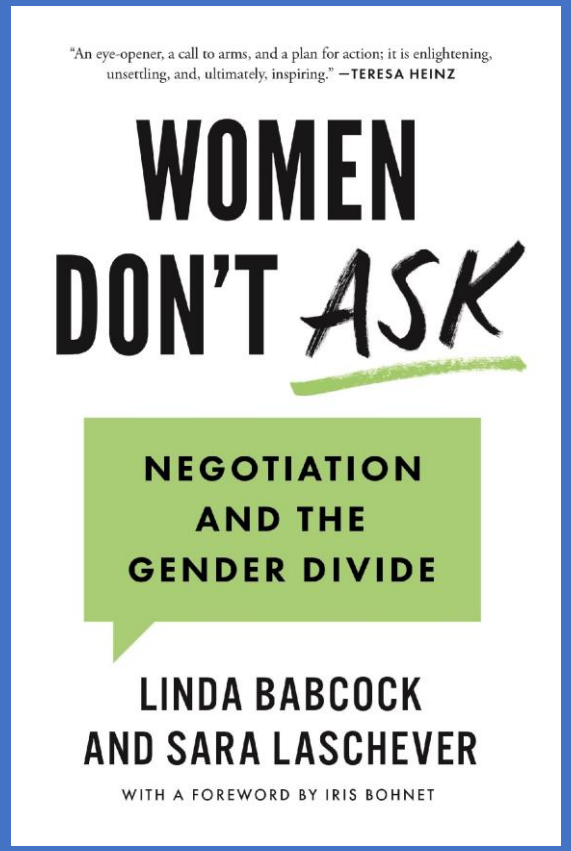
Finding your first job as a physician:

- First step in the process, take a deep breath, take inventory of what you have accomplished, your value.
- Family physicians continue to be in high demand—you are all in an excellent position.
- FIRST job, not your LAST job for most new graduates.

Goals for this presentation:

- Know what you need to know…to find, evaluate and negotiate most effectively
- Know what to expect from the job search and interview process
- Know what the employer expects from the physician: how will they measure your "worth"→quality measures, production measures, patient experience……
- Know what YOU want, what YOU need from this job, what are your goals, what are the goals for you and your family
- Through this be able to approach the process with hopefully an improved sense of calm, sense of control.


THE INTERNATIONAL BESTSELLER
GETTING
TO
YES
UPDATED and REVISED
NEGOTIATING AGREEMENT WITHOUT GIVING IN
ROGER FISHER AND WILLIAM URY
AND FOR THE REVISED EDITIONS BRUCE PATTON
OF THE HARVARD NEGOTIATION PROJECT
READ BY DENNIS BOUTSIKARIS


"An eye-opener, a call to arms, and a plan for action; it is enlightening, unsettling, and, ultimately, inspiring." —TERESA HEINZ
WOMEN DON'T ASK
NEGOTIATION AND THE GENDER DIVIDE
LINDA BABCOCK AND SARA LASCHEVER
WITH A FOREWORD BY IRIS BOHNET


"When you got your offer, did you attempt to negotiate?"
7%
of women
57%
of men
Source: Linda Babcock, Women Don't Ask

Interviewing and negotiating for your first physician job:

- You are likely to have have multiple job offers, multiple interviews.
- So, before you start interviewing, do your homework, prepare…
- Knowledge about positions is your most effective negotiating tool.
- Know contract basics, what is negotiable, what is less likely to be negotiable, **can vary depending on type of employer**.
- Check your data, current salaries, current benefits for the type of job you are looking for.
- Where to find reliable data→faculty, graduates, Google, MGMA.
- KCAFP Fall Professional Development Seminar for Washington family medicine residents.

Your first physician job:

- You need to do your research prior to sending out your CVs as well as some soul searching and meditating…..
- What is your perfect job, what are your ”non-negotiables”
  - Full-time, part-time, urban, rural, inpatient, outpatient, OB, academic.
  - Patient population you want to work with.
  - Funding models for the job types you are looking at, so you can make an intelligent decision about whether the job will be there in the future.
  - Starting date!! Your next opportunity for significant time off may be in the future, so take advantage of this, you have earned it.
- What is the most current data for the jobs you are hoping to find
  - Current up to date salaries, benefits, contract templates.

Concepts to know or make yourself aware of:

- RVUs—Relative Value Units, wRVUs, what are the expectations for new physicians?
- Production expectations→are they reasonable, when do they kick in?
- Scheduled work hours→what does this mean, what does it include?
- How much time do the clinicians need for administrative time, how much time do they spend outside of work on work?
- Clinical support, what does that look like→ 1:1, 2:1, who/what is your support team?
- Clinical facilities, does it have what is needed to be successful?
- Are you doing obstetrics→how are you supported for this, how is call shared, is is shared?

Please keep in mind, negotiations start as soon as you contact the potential employer…

- Phone calls to the practice, be prepared, know who they are.
- Sending in your CV, writing a cover letter, consider it part of the interview, be intentional.
- Keep your references informed of your job search process….otherwise they can inadvertently say the wrong thing….

CV, cover letter, and references:

- Your CV→ Start creating a template in advance of job search.
  - You may have more than one CV, customize for each job you apply for.
- The “cover letter”→usually an email to the potential employer is current process; there is no such thing as one standard cover letter, each one is specific for the job in question. Make it PERFECT, you are introducing yourself.
- References→ your faculty are always good choices, employer almost always contacts the residency program director, so be aware. Faculty and program director are your advocates , make good use of this.
- Who to send your info to, how to make contact. Recruiter vs medical director for example.

How to find info on potential positions:

- Your faculty are excellent resources or know excellent sources.
- Network → former residents/graduates, use your connections.
- What does your spouse/SO/family need in terms of job location, job demands, work hours →be sure to have these critical conversations before you start your search. Urban, rural, full-time, part-time, OB, inpatient for example.
  - Once you know this then start your search.

Is there really a job, are they actually hiring?

- Helps to understand where the employer is in making a decision about if they are actually hiring—not you, are they hiring anyone, does the position exist?
- Fudge it, budget, judge it stages.
- Often the case for jobs that you are applying for far in advance of the employers fiscal or budget year.
- When does the employer’s budget year start?

"Fudge-It"

- If the company sees something that they really want, they will begin fudging the numbers. For organizations with more money, they will begin to fudge the numbers to justify getting you. For organizations without much money, they will begin to think about other perks they can offer you in order to attract you to their organization.

“Budget”

The Budget process is exactly what it sounds like. The clinic will be thinking, we have this much money to pay a new provider when they come to our clinic. We do not want to deviate too much from this figure.

“Judge-It”

- The judge-it stage is when the organization has gone from “maybe” to “yes.” They see the purchase not as a liability but but as a money-making asset. The company sees you as that asset. Once the organization has reached the judge it stage, this is when you have the power to negotiate what you want.

Negotiating, let’s review…..

- Remember, knowledge about the position is a critical negotiating tool, know as much about any position first: payment structure, contract structure, average compensation for new hires, signing incentive, production expectations.
- Who is hiring, who is the employer, what is their mission, does it align with your personal mission, when do they want you to start working?
- Examples: Employed physician, FQHC position, academic position, loan repayment possibilities, etc.
- ***Do your prep work.***

Negotiating Rule # 1

- Q: When should I discuss what I want?

Q: When should I discuss what I want?

- Answer: When the hiring manager/medical director has reached the “judge-it” stage.
- Pointless to negotiate prior to this.

So when should you discuss what you want?

After the company has decided that you are the one that they want to hire and are willing to do more to get you. Let's think about this for a minute. If you come in with all your salary and perk demands up front, the company is going to say, who is the prima-donna? If you make these demands too late after you have accepted the job and signed the contract, they will not give you what you want because they already have you.

Negotiating Rule #2

- Once you have the hiring manager in the “judge-it” stage, and it’s time to talk about salary and perks, who should be the first person to name a figure?
- “What will it take to bring you aboard?”
- “Are you offering me the job?”
- “Yes”
- What do you say?
- Let’s look at some scenarios...

Negotiating Rule #2

- Q: Who goes first?
- A: The hiring manager should always go first.

- Negotiation Rule #2 is let them go first! Never say exactly what you want up front. This goes for salary or any perks you are trying to negotiate. Why is this?

You did your research, you are well-prepared.

- What are current salaries and benefits for the physicians at this job?
- They know, you should know as well, not knowing puts you at a negotiating disadvantage.
- What is the job structure for physicians at this practice, salary, signing bonus, quality metric compensation, benefits, vacation, etc.?
- How long do new physicians stay with the practice…if they do not stay, why not, and how can you use this information to negotiate?
- FTE possibilities, work-day and work-week schedule possibilities.
- Sign on incentive/bonus.

Negotiating Rule #3

Q: What should your first response be?

A: Repeat the idea and then be quiet for 30 seconds.

A: When you hear the number or idea, repeat the idea with a contemplative tone in your voice as if you are at a multinational summit meeting… and then shut your mouth. Keep it shut for 30 seconds or until the interviewer speaks again.

Silence is “Gold”-en

- Most interviewers fear you are disappointed
- >60% will raise/change the original figure before you say another word
- Let silence negotiate for you.

- A word about Silence: No one is comfortable with silence—let it work for you.

- The majority of interviewers will raise that figure immediately if you are silent.

- Congratulations→ You just got your first perk without uttering a single word!

Negotiating Rule #4

Q: How do I make a counter-offer?

A: Answer truthfully...

...then counter-offer with your researched response.

When You Cannot Agree

- Don’t say “no” in the room
- Get a commitment
- Give a commitment

- What if you cannot reach an agreement? Sometimes you cannot find common ground or both parties need time to think things over. Remember: you still have the job if you want it.

- Never say no in the room. You risk having other candidates come in take the position,

- Stay positive about the offer and try to get them to commit to it, to hold the position with the perks that they have offered.

- You will have to make them a commitment, too. “We seem far apart at the moment. I don’t want to decline the offer because I think the fit is good. Why don’t I take a day to look over the package and see if I can accept it. You see if there is anything we have overlooked that might make it better. Then if I can accept the offer, I’ll give you a firm “yes” and if I cannot feel good about the deal, I’ll say so and suggest that you find another candidate who will fill the bill for you. Does that sound fair?”

- If you don’t offer this reassurance, they may rescind the offer even if they told you they would hold it.

- By being willing to have hard conversations about what you want from you job up front you are demonstrating that you take yourself seriously.

- You are also demonstrating your willingness to be a sincere partner in making important decisions for the company.

- Shoot for something that is fair and keeps you committed.

- Remember, we are discussing these things when the offer is already on the table. You have nothing to lose and everything to gain.

- If they demonstrate anger or unreasonableness, you might consider what kind of partners/employer they will be in the future.

Aim for the “Sweet Spot”

Final thoughts…

- First job, not last job, make them all good jobs.
- Negotiate wisely, use strategies that work, lots of negotiation articles available
- Know key concepts of structure of any job you are looking for, salaried, FQHC, RVUs, production, call requirements.
- Know as much about the job before you interview for the job, not after you start the job.
- ***Remember that you want to work with this entity, these are your future work partners, so negotiate with that in mind, specifically that you are reasonable, intelligent, and reflect characteristics that you will be a good colleague, a good partner.***


KEEP
CALM
AND
GET
A JOB

FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

NAVIGATING PHYSICIAN EMPLOYMENT CONTRACTS

September 2021

This guide provides information about physician employment contracts by defining common terms, offering advice about specific provisions, and providing key steps to follow before signing a contract.

AAFP

Introduction

Physician employment contracts and agreements can seem complex and daunting. Some legal considerations and issues are difficult to understand, but physicians need to consider them before signing a contract. All agreements between physicians and employers should be included in the written contract between the parties, rather than relying on verbal promises, emails, or letters. A thorough review of a contract is essential and should be done with an attorney and financial advisor with physician employment contract experience.

Definitions

Term and Termination: A valid contract has a date it starts and a date it terminates. A physician employment contract should identify when employment begins and any conditions that must first be satisfied, such as receiving licensure in the practicing state(s) and obtaining medical staff privileges. Contracts can often be terminated or voided if conditions are not met by the designated start date, so it's ideal to account for potential delays. Once an employment agreement takes effect, it can usually be terminated in several ways. The termination method is significant since enforcement of non-compete restrictions, malpractice tail-policy obligations, and compensation payments can be tied to how termination occurs.

Expiration: Some employment agreements simply expire on a fixed date. Often, it is the intent that the parties will renegotiate or enter into a new agreement upon expiration. However, expiration dates are often forgotten or missed, leaving a physician with no enforceable agreement and little job security. Therefore, it is advisable for an agreement to automatically renew and remain in place until specifically terminated based on its terms or replaced with a new contract signed by all involved parties. If the contract does not automatically renew, physicians should start searching for new employment before the expiration of their current contract to ensure job security.

Automatic Termination: Grounds for automatic termination typically include death, total disability, or an event, such as loss of license, prescriptive authority, or medical staff privileges, or a similar occurrence that prevents a physician from performing their job.

Termination for Cause: Termination for cause provisions can cover a wide variety of events, such as committing a felony or not maintaining board certification. Most termination for cause provisions are within the discretion of the employer to enforce. Physicians need to be cautious of termination for cause provisions that are subjective, such as those related to the employer's reputation or general reference to the physician's professionalism or personal habits. Ideally, subjective provisions are subject to a good faith and reasonable standard on the employer's part. Most physician employment contracts also contain a catchall provision that allows each party to terminate the agreement for cause if the other party has breached the agreement and does not rectify the breach after written notice.

Without Cause Termination: Almost every physician employment contract contains an opportunity for the parties to terminate the agreement without reason, simply by providing notice. A typical notice period is 90 days. Ideally, both parties should have the same right to without cause termination with the same notice period. Employers sometimes prohibit a notice to terminate the agreement until the physician has worked a certain length of time (e.g., one year). Physicians should read their contract carefully, so they don't miss this requirement. Pay close attention to any provision that allows an employer to accelerate the termination date once proper notice is given. This can sometimes include immediate termination. Instead, physicians should insist the agreement include a provision that compensation and benefits will be paid to the physician for the entire notice period—even if the employer elects not to allow the physician to work.

Non-renewal: Some physician employment contracts can be terminated by notice of non-renewal before each annual renewal date. For employment contracts in which this is the only way the agreement can be terminated without a breach, it can be frustrating and difficult for a physician to leave employment. The process can become more complicated when one or both parties miss the period for notice of non-renewal before the annual renewal date. Do not allow this to happen to you.

Provisions of Contracts

Location: An important provision of the physician employment contract is the location of the physician's work. A location may include an office, surgery center, hospital, nursing home, or other site. Defining exactly where a physician works offers control for the physician over day-to-day life, limits work travel occurrences, and impacts a non-compete provision. If an employer does not want to specify an exact location, a mutual agreement on multiple work locations or limitation of travel to a specific number of miles during a given period can be an acceptable alternative.

Schedule: A physician's schedule impacts their job satisfaction. Ideally, you'll want to negotiate and specify your schedule with the employer, including shift details (night versus day), rounding, and weekly work schedules. Schedule details may include patient care, administrative duties, research, and teaching. The schedule should include days of work, including evening and weekend hours. Availability for block time or other assignments should be captured in the agreement document, as well.

On-call Commitment: On-call commitment varies among specialties, but physician agreements should at least provide for call to be shared equally if no other details are offered. The agreement should describe the maximum amount of required on-call time, or it should clarify when additional on-call time becomes voluntary (regardless of whether it is paid or unpaid). If call is paid, the agreement should include specific on-call payments. Ideally, it is important to understand precisely which locations are covered when on call and when shared or backup call is needed. Physicians may be required to provide call for their patients. In such cases, make sure there is a coverage plan during physician absences.

Professional Liability Insurance: Physicians must understand the type of professional liability insurance that will cover their clinical services and who will make those insurance payments. Insurance coverage provided by an employer will typically cover only the services a physician provides as an employee and will not extend to outside professional activities. If a physician is covered under a claims-made policy, the employment agreement should specify who will obtain and pay for a tail policy (i.e., an addition to a claims-made policy). If the physician is responsible for a tail policy, negotiate a cost-sharing arrangement if employment is terminated for certain reasons or specify that the employer should cover the cost. Reasons might include an employer breach of the agreement or termination by the employer without cause.

Non-compete Clause: The state in which a physician practices will determine whether there are restrictions on their ability to compete following termination of employment. Review these provisions carefully to ensure the length of time, geography, and scope of practice are reasonable. Properly written non-competes are enforceable in most states, and many contracts will shift legal and enforcement-related expenses to the physician. Ideally, negotiate a release from the non-compete for reasons that might include employer breach, termination of the physician without cause, or non-renewal of the agreement by the employer.

Compensation: There is no single payment structure by which physicians are compensated. Physicians should understand the formula they have agreed upon and that other changes to compensation may occur over time. When changes to compensation are possible, they should require the agreement of both parties. Employers are restricted to fair market value when compensating physicians, so physicians should use data to know the salary range by region and specialty. A substantial part of a physician's compensation may also include payments for productivity (i.e., relative value units [RVUs], collections), as well as value-based bonuses tied to meeting specific targets. The timing of, and reason for, termination in an employment agreement can impact payments.

Physicians often receive signing bonuses, retention bonuses, and/or relocation or recruitment bonuses. These payments can be tied to a physician remaining employed for a certain period. Carefully review the terms of these payments and seek out pro rata forgiveness of the payments over a fixed amount of time, as well as complete forgiveness in certain events, such as death, total disability, breach by the employer of the agreement, or termination of the physician without cause.

Steps to Review Contracts

When reviewing a physician employment agreement, follow these key steps:

- Hire an attorney and financial advisor with physician contract experience.
- Ask reasonable questions and be respectful of the hiring and contract negotiation process.
- Before signing a contract, talk to your attorney and financial advisor to identify and understand the advantages and disadvantages of the agreement being offered and plan what you will say in negotiations. Be prepared to walk away from the agreement if you cannot live with the terms and provisions.
- Understand the termination provisions and formulate an exit strategy before the contract is even signed so that you can protect and maintain your career options.

AAFP Resources

The American Academy of Family Physicians (AAFP) has developed resources to help you learn more about employment contracting (www.aafp.org/employment-contracting) and understand the credentialing and privileging process (www.aafp.org/hospital-privileging).

Author: Ericka L. Adler, JD, specializes in regulatory and transactional health care law and devotes a large portion of her practice to advising professionals and practices about contracts and compensation arrangements.

FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

ENSURING YOUR EMPLOYMENT CONTRACT WORKS FOR YOU

September 2022

AAFP

INTRODUCTION

A majority of family physicians practice as employees—chances are, you're one of them. Starting a new position is exciting, and you're probably eager to get started. But it is essential to take time to thoroughly review the terms of an employment contract before you sign. For employed physicians, the contract plays an important role in career success. If a misunderstanding emerges during your employment, you cannot rely on verbal promises and written correspondence (e.g., letters, emails). Only the terms spelled out in your contract matter.

Involving an attorney with expertise in physician contracts is also an important step in the process. Your knowledge and your attorney's advice can help ensure all the key aspects of your employment relationship are addressed in a thoughtful, constructive manner as you negotiate your contract's terms. The American Academy of Family Physicians (AAFP) developed this supplement to explain contract provisions and terms that are especially important to watch for and understand to protect your best interests. Other AAFP resources to help you navigate your career pathway, including employment contract negotiations, are available online at www.aafp.org/employment-contracting.

AAFP Employment Contracting Resources

- Employment Contracting: **www.aafp.org/employment-contracting**
- Navigating Physician Employment Contracts: **www.aafp.org/fpm/2021/0900/p17.html**
- *A Family Physician Guide to Employment Contracts*: **www.aafp.org/physician-contract-guide**
- Employed Physician Compensation Updates Letter Template: **https://tinyurl.com/2j5m7n3t**
- Making Sense of MACRA: A Guide for the Employed Physician: **https://tinyurl.com/2866wzct**

DUTIES

Physicians typically have a specific idea of what their employed role will entail, but these details rarely make it into the written contract. A contract should spell out the job for which you are hired. For example, it should specify the number of clinical face-to-face hours per week you're required to provide. It is also essential to understand whether the specified workweek allows adequate time to complete records, fill prescriptions, make patient-related phone calls, and handle similar administrative work. A 40-hour "clinical care" requirement that excludes administrative time should not be accepted.

Other key considerations and questions to ask include the following:

- Are you required to see a certain number of patients per hour?
- Is the role inpatient or outpatient based?
- Are you expected to perform certain specific procedures or defined activities?
- Have you negotiated not to perform certain services (e.g., obstetrics)?

One particular consideration is if you are comfortable serving as a supervising physician for one or more midlevel providers. The employer may specify a maximum number to be supervised or agree that supervision will not be required at all or will not be required for a certain period of time. These expectations and any compensation for supervision must be part of the contract.

In addition to stating specific job duties, the contract should specify where and when those duties will be performed, as well as any call or administrative obligations. In order for you to enforce promises made prior to executing the employment agreement, the written contract must contain all agreed-upon details. If an employer will not include information about factors such as work location, schedule, or call, try to obtain contract language that provides for collaboration or mutual agreement on these points.

OUTSIDE WORK

Almost every physician contract contains restrictions on a physician's ability to engage in outside work, whether clinical or non-clinical (e.g., moonlighting, serving as an expert witness, consulting, speaking, writing, serving on physician association committees or boards). Typically, such restrictions are intended to ensure full commitment to the employer in terms of loyalty and efforts. However, language prohibiting participation in outside opportunities—especially those that don't conflict with the employer's interests—can be frustrating.

If you already engage in outside work or have a firm opportunity, seek to carve out such positions in writing. You can expect to share details about the job, your time commitment, and malpractice insurance coverage. Watch for language allowing an employer to retract permission for approved outside work. This could force you to breach an outside contract.

If you don't yet have any outside opportunities lined up, it is essential to understand the employer's policies and conflicts of interest, as well as the process for seeking permission. Policies should spell out types of work that are permitted or not permitted. Be aware that restrictions are not always tied to whether outside work is compensated.

Many employers allow outside work but require the physician to turn over any revenue to the employer. This is true in both academic and non-academic settings. Ideally, in addition to allowing for approval of outside work, the contract should state that you will retain income from approved activities. However, this may be non-negotiable based on the employer's policies.

TERM AND TERMINATION

Every physician contract has a date on which it starts and a date on which it ends or a method for termination.

CONTRACTS THAT EXPIRE

Employment contracts with an end date are considered to expire on that date. It is ideal to include language stating the employer will offer either a new contract or an extension by a certain date (e.g., six months prior to expiration). If an employer rejects your request to include this contract language, mark your calendar to request a new contract six months prior to the expiration date. Additionally, start a job search at that time to ensure you're not left without a contract. An expired contract becomes an "at-will" contract. Its terms may be difficult to enforce and it can be terminated without notice, which creates job insecurity.

EVERGREEN CONTRACTS

Contracts that automatically renew without expiring are called "evergreen" contracts. One way to terminate an evergreen contract is by providing notice of non-renewal. Physicians may find this frustrating because notice can only be provided during a specified period prior to the contract's renewal date. For example, you might sign a three-year contract that can be terminated by providing 90 days' notice of non-renewal. This contract will automatically renew from year to year until the end of the initial three-year term. Therefore, the first time you can provide notice of non-renewal is 90 days before the renewal date. If you miss this notice period, you're locked in until the next notice period, unless there is another means of terminating the contract. To avoid being locked in by renewal provisions, be sure the contract specifies other grounds for termination.

GROUNDS FOR TERMINATION

Grounds for termination of an employment contract may include the following:

- Notice of non-renewal
- Automatic termination (e.g., death, disability, loss of license)
- "For cause" termination (e.g., breach of contract, failure to show up at work, patient safety concerns)
- "Without cause" termination (no reason needed)

Physicians must carefully review the grounds for termination in their contract. Look for language that gives you the right to be informed of any potential breach of contract and to cure a breach that is reasonably curable. Vague grounds for termination (e.g., failure to meet unspecified productivity goals, conduct impacting the employer's reputation) must be clarified or deleted, when possible. Language allowing for your immediate termination in the event of the employer's liquidation, closure, sale, or similar occurrence also should be deleted or tied to a notice period requirement. Additionally, be sure you have the right to terminate the employment agreement for cause if your employer breaches the contract.

The ability to terminate a physician contract without cause is a key provision. This allows either party to terminate the agreement by simply providing proper notice. You should seek language giving both parties the same right to without cause termination and the same notice period, and be sure the notice period is reasonable, allowing for potential relocation, credentialing, and other factors. The most standard notice period for physician contracts is 90 days. If the contract only allows you to give notice once you have worked a certain amount of time, ensure the contract puts the same restriction on the employer for notice of termination.

TERMINATION PROCESS

The ability to terminate a contract is the first element of a physician's employment exit strategy. Most contracts end when the physician provides notice of termination without cause in order to relocate or take a new position. Pay close attention to any language that allows an employer to accelerate the termination date once you give proper notice but does not require them to continue paying you during the notice period. This provision can jeopardize your planned departure and create financial insecurity.

It is essential to understand exactly what will happen when a contract terminates. The following are key considerations.

Interference With Work

Most physician contracts permit an employer to decide if you will work during the notice period. Be sure the employer is required to continue paying compensation and benefits during that period, regardless of whether you are allowed to work. If your compensation is tied partially or fully to production, the contract should include language defining how compensation will be calculated during the notice period if you are not allowed to work. It is also ideal to include language stating that the employer will not interfere with your work during the notice period by changing staffing, reallocating patients, or otherwise materially interfering with your ability to produce in the same manner.

Repayment Obligations

Employment contracts commonly require the physician to repay the employer for certain expenses upon termination. This may include signing or retention bonuses, advances, training stipends, relocation fees, education loan payments, and similar incentives. Repayment requirements and the amount the physician must repay may be tied to when termination occurs. For example, a contract can require you to remain employed for a period of time—typically between 12 and 36 months—in order to "earn forgiveness" on incentives. Some employers will require repayment of incentives in full if you are terminated for any reason, but you should try to negotiate for forgiveness on a prorated monthly basis. Ideally, you should also request language requiring complete forgiveness of incentives under certain circumstances (e.g., termination without cause by the employer, employer breach of contract, business sale/closure, death or disability).

Malpractice Tail Coverage

Physician contracts always address professional liability insurance and whether acquisition of a tail policy is required upon termination. Claims-made policies require a tail policy, but occurrence policies do not. If a tail policy is required, it is important to note who is responsible for payment, what type of tail coverage must be acquired (e.g., limits, duration), and the acquisition timeframe. Try to negotiate for alternatives to a tail policy, such as the ability to continue the same insurance policy after termination or the opportunity for a new employer to acquire a nose policy.

If an employer will not cover a tail policy's cost, it is advisable to at least seek payment by the employer under certain circumstances (e.g., termination without cause by the employer, employer breach of contract, business sale/closure, death or disability). Some employers may be willing to share the cost of a tail policy over time, pay part of the cost based on how long you are employed, or cover the entire cost once you have worked a certain amount of time.

Competition Provisions

Provisions that affect a physician's ability to compete with the employer following termination are standard in most employment contracts. Employers often consider the competition provisions or non-compete terms as non-negotiable. The majority of states will allow non-compete clauses if the length of time, scope, and geography are reasonable. However, some states apply very specific criteria for non-competes or do not allow such restrictions.

ELEMENTS OF A NON-COMPETE CLAUSE

TIME: Most non-compete terms apply while the physician is employed and run for one to two years following termination.

SCOPE: The non-compete scope should be tailored to the services and specialty the physician provided for the employer.

GEOGRAPHY: Most non-competes specify a radius intended to reflect the region from which the employer draws the majority of its patients and in which it has a protectable interest. The non-compete area's size can vary greatly based on the practice location, with larger areas common in more rural regions.

Before you sign a contract, be sure you could live with the terms of its competition provisions if you were terminated. It can be expensive to fight a non-compete. Additionally, your new employer will not want to be drawn into litigation, which could leave you unemployed.

If an employer won't reduce the radius or length of time, focus on tying the location provision only to where you spent most of your time. Additionally, it can be worthwhile to argue the circumstances in which the non-compete will apply. Employers can be compelled to agree the non-compete should not be enforced if the contract expires or if the employer breaches the contract or terminates the physician without cause.

You may also be able to negotiate for release from a non-compete if the practice is sold or you are terminated due to force majeure. Force majeure is a provision that allows the contract to be terminated or excuses a party's non-performance due to unexpected events beyond the control of either party (e.g., war, pandemic, natural disaster). It has only recently become common in physician contracts, largely because of the COVID-19 pandemic. Employers can also use force majeure to alter the physician's schedule, compensation, location, and other contractual provisions. Review the provision carefully for fairness.

Other restrictions on competition commonly include prohibitions on solicitation of employees, referral sources, patients, and others. Most physicians are not concerned about such restrictions. However, it is important to watch for language that can actually prohibit you from treating or rendering services to anyone who was previously the employer's patient. You may not necessarily know if someone is the employer's former patient, but such language can require you to turn away a patient, even if you made no effort to solicit or contact that patient. This type of language is likely against public policy in most states and should be deleted from the contract.

In most cases, non-competes are enforceable, and contracts will include language allowing the employer to seek injunctive relief (i.e., court action) or damages (i.e., money) from a physician if a violation occurs. The employer may also shift the burden of all legal fees and costs to the physician, regardless of the outcome. Such one-sided provisions should be deleted and replaced with language that either requires the non-prevailing party in any action to pay the legal fees and costs of the prevailing party or eliminates the requirement for any party to be responsible for the other party's legal fees.

ARBITRATION

Arbitration is a system that uses arbitrators to resolve a dispute between parties. Most physician contracts contain provisions that require disputes—other than issues covered under state laws—to be handled using arbitration rather than going to court. The arbitration language will also typically carve out certain issues (e.g., non-competes, non-solicitation, confidentiality, non-disparagement) for which the employer wants to use the court system for more immediate legal results.

The following are the most important questions to ask about arbitration provisions:

- **Is arbitration required and for what type of claims?** Know when you may use the court system and when you are prohibited from doing so.
- **Where will arbitration be held?** The contract will usually specify a state and city as the arbitration site. This is significant because it may not be where the employer is located or where you live.
- **Which arbitration approach will be followed?** There are many associations with arbitration guidelines, including the American Bar Association, JAMS, and the American Health Lawyers Association. Different approaches may have different rules to follow.
- **Who pays the legal fees?** Employers may try to shift legal fees to the physician or may indicate that the prevailing party's legal fees will be paid by the non-prevailing party. In some cases, the parties pay their own legal fees or allow the arbitrator to decide.

While many attorneys feel resolving disputes in a court of law is preferable, arbitration can be faster, less expensive, and more private, and may better suit both parties' needs. Most employers uniformly apply arbitration provisions to their contracts and may consider them non-negotiable. However, even if the contract prohibits parties from resolving a dispute in court, it is important to have language stating the parties can enforce any judgment of the arbitrator in a court. For example, if you are awarded monetary damages by an arbitrator and your employer refuses to pay, you should be able to ask a court to legally enforce the arbitrator's award against your employer.

It is advisable to have your contract reviewed by an attorney with expertise in physician contracts. You can locate attorneys through your state medical society, your state bar association's health law section, or national organizations such as the American Health Lawyers Association. Asking your chapter, mentors, and physician colleagues to recommend attorneys is also a great idea. Choose someone who will work collaboratively with you and the employer to reach an agreement. An overly aggressive attorney can frustrate efforts to achieve desired contract changes and may harm your future relationship with the employer.

CONCLUSION

In many cases, it is possible to improve physician employment contract provisions to better protect you, so understanding a contract before you sign should be your primary goal. Also, remember that the contract only comprises the terms written in its pages. You cannot rely on verbal promises, written correspondence, and other outside information.

Your relationship with an employer starts during the negotiation process. Employers may react poorly to receiving a revised contract from a physician's attorney when no prior discussion has been initiated by the physician. To encourage productive discussion and exploration of possible solutions, consider approaching the employer with questions and concerns as an initial step. By asking thoughtful questions, understanding the employer's position, and respectfully requesting changes that are significant to you, you can help build the foundation for a healthy, long-term employment relationship.

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CME

Negotiation for Physicians: Practical Strategies to Improve Bargaining Success

The right style and tactics make it easier to effectively advocate for yourself, your patients, and your team and reach "win-win" agreements.

Negotiation is an ever-present part of our lives, impacting physicians both personally and professionally. Often, when we think of negotiation in our professional lives, we imagine high-stakes situations like negotiating a salary with an employer or a business deal with a new partner or vendor. But it can take many other forms, such as negotiating with leadership to change a policy or process that affects patient care, to influence investment priorities to better support the primary care team, or to improve aspects of your employment contract (e.g., protected time for administrative work) so you can carry out your professional responsibilities more effectively. ➤

ABOUT THE AUTHOR

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Certain negotiation strategies can improve your odds of success, meaning the agreement not only meets your needs but leads to better outcomes for everyone involved. This article provides an overview of the five different negotiating styles, describes two tools that lay the groundwork for negotiation, and outlines five steps to reaching successful agreements.

FIVE BARGAINING STYLES

When you enter a negotiation, you may encounter — and exhibit — five different bargaining styles:[1]

- Competitive (focused on winning),
- Collaborative (focused on win-win or best net gain),
- Compromising (focused on finding a middle ground),
- Avoiding (focused on minimizing high-pressure interactions),
- Accommodating (focused on maintaining the relationship).

Although each of us tend to gravitate toward one style, we can draw on others as we need them, provided we understand and practice the styles that are less intuitive. Knowing our default style, as well as the style exercised by the other party, can greatly improve our success.

Each style prioritizes the importance of the relationship and the importance of the outcome differently. (See "Bargaining style descriptions" on page 12.) For example, the *competitive* style puts high value on the outcome and low value on the relationship. Thus, it is more aggressive, focusing primarily on results and prioritizing the best deal for one party at all costs. This style often achieves short-term results quickly, but the results can come at the expense of the negotiating parties' relationship. The *collaborative* style tends to focus on finding win-win outcomes and identifying mutually beneficial solutions to complex problems. This style may take more time, but often results in better long-term relationships and agreements that maximize the benefits to both sides. The *compromising* style prioritizes finding middle ground that can meet the needs of all parties; however, rather than focusing on a true "win-win" with a more complex solution, it tends to sacrifice part of what each side wants to come to an agreement. The *avoiding* style involves remaining neutral and minimizing tense or high-pressure interactions. Individuals who use this style are less aggressive at pursuing their goals and more focused on rapidly reaching an agreement to end the negotiation process. The *accommodating* style prioritizes the relationship between parties over the outcome of the negotiation, often sacrificing the optimal deal to maintain strong relationships.

Popular culture often depicts negotiation as a zero-sum game with a winner and a loser. This is known as "distributive negotiation"; it assumes there is a fixed amount of resources and the negotiation is all about how they're distributed. "Integrative negotiation" is different. It approaches negotiation not as a win-or-lose dichotomy but rather a process that adds value for both parties. Strong integrative negotiators can often find creative, mutually beneficial outcomes and build positive relationships that lead to better future negotiations and more value creation. It's a virtuous cycle, and the collaborative bargaining style is the easiest way to get there.

TWO NEGOTIATING TOOLS

Once you understand the common bargaining styles, two tools can help you lay the groundwork for effective negotiation.

1. Zone of possible agreement. This is the overlap of acceptable outcomes for both parties in the negotiation. While it is rarely possible to know the other party's precise zone of possible agreement, certain clues during the negotiation (such as starting offers and counteroffers) can help you determine what the boundaries might be so you can lead the bargaining to an endpoint within that zone. If there is no zone of agreement overlap at the outset, you can

KEY POINTS

- Negotiation is often more fruitful if you know your own bargaining style and, if possible, the other party's bargaining style.
- Keeping in mind your "best alternative to negotiated agreement," or BATNA, helps you know when walking away from a negotiation is better than accepting a negotiated outcome.
- For the best outcome, start by asking for more than you want and be prepared to make concessions as talks progress.

BARGAINING STYLE DESCRIPTIONS

Style	Characteristics	Importance of outcome vs. relationship
Competitive	Aggressive, focused on winning, willing to sacrifice relationships	High outcome, low relationship
Collaborative	Complex and time consuming, focused on win-win or best net gain	High outcome, high relationship
Compromising	Willing to sacrifice goals to find middle ground	Moderate outcome, moderate relationship
Avoiding	Willing to sacrifice goals to minimize high-pressure interactions	Low outcome, low relationship
Accommodating	Focused on maintaining the relationship	Low outcome, high relationship

Source: Lewicki RJ, Hiam A. *Mastering Business Negotiation: A Working Guide to Making Deals and Resolving Conflict.* John Wiley & Sons; 2010.

often help shape the zone by highlighting mutual benefits, offering concessions, and using other means of persuasion.

Here's an example:

Dr. Fredrick is a practicing clinician with 10 years of experience working for his organization. While practicing clinical medicine has been fulfilling, he now wants to diversify his career with protected time for teaching. He believes 20% of his time would be ideal, but he would accept 10%. Thus, his zone of possible agreement is 10% to 20%.

Dr. Fredrick senses that his administrators are reluctant to reduce his clinical time at all. To move them into the zone of possible agreement, he tries to get them to see a mutual benefit. Dr. Fredrick mentions the considerable challenges in physician recruitment and points out that creating opportunities for students to engage with the health system could create a pipeline for future recruitment. This reframes the discussion so the investment in teaching time is no longer simply to retain Dr. Fredrick but also addresses long-term strategic goals for the health system, creating value for both parties. The administrators ultimately agree to set aside 15% of Dr. Fredrick's time for teaching.

2. Best alternative to a negotiated agreement (BATNA). This tool helps you evaluate whether continuing a negotiation is in your best interest.[2] Put simply, BATNA is your fall-back option if the parties cannot reach an agreement and the negotiation fails. For example, your BATNA might be leaving your current employer and accepting an offer from another organization, or it might be giving up on changing your organization's overall policy and making smaller changes at the practice level instead. Clarifying this helps you know how hard you should negotiate to improve the terms of the agreement. If your BATNA is acceptable, you will have little to lose in the negotiation and may be more willing to push harder than if your BATNA is unsatisfactory.

Here's an example:

Dr. Taylor is a third-year resident considering career options. She is interested in teaching medical students and publishing on medical education. She already has an offer from a community health system for a full-time clinical role at a guaranteed salary of $235,000. She is currently talking to a recruiter for a local academic health system about another position with 80% clinical care, 10% teaching time, and 10% time to support academic output, which offers a guaranteed salary of $220,000. The academic job is more ideal for her, but knowing that she has the BATNA of the full-time clinical job to fall back on, Dr. Taylor pushes the academic health system hard in salary negotiations and they agree to increase her guaranteed salary to $240,000.

Having a clear BATNA also helps you know when to walk away from a negotiation rather than accept unfavorable terms. Here's how that might have looked in Dr. Fredrick's example:

Dr. Fredrick is feeling increasingly burned out and is prepared to quit and seek part-time employment if his health system cannot give him at least 10% protected time

for teaching. Early in the negotiation, his administrators suggest that he can teach on his own time and would not need protected time to do it. Dr. Fredrick indicates that he needs protected time for it to be viable to engage with learners and that this added scope is essential to a sustainable career. The administrators refuse to budge. Dr. Fredrick says there is no room for further discussion if protected time is not possible and ends the negotiation. He went into the negotiation with a clear BATNA: It is better for him to quit and work part-time for a while than to accept a negotiated outcome that does not include at least 10% protected time for teaching.

These examples involve dedicated time for teaching, but the same principles apply whether you're asking for dedicated time in your schedule for administrative work, the addition of a scribe to your care team, support to add a new procedure to the practice, etc.

STEPS TO SUCCESSFUL NEGOTIATION

There are five basic steps in the negotiation process.

1. Research. Do your homework on the topic. For example, if the negotiation involves money, productivity, or other measures, identify some industry benchmarks or baseline data. If the negotiation involves a change in process or policy, identify best practices from similar organizations or from the literature so you have some evidence on your side. Do your homework on the other party as well. If possible, get a sense of their bargaining style, discussed earlier. Are they going to be open to collaboration, or are they more of the competing type determined to emerge as the "winner"? Speaking with colleagues who have negotiated with the other party in the past can help you gauge their style. You should also consider how much leverage you have with them, which will influence your goals and starting position.

2. Goals. Clearly establish your goals, including your desired outcome and your minimum acceptable outcome (i.e., your zone of possible agreement) as well as your BATNA, discussed earlier. Each of these elements will help you define your starting position.

3. Opening. It is best to anchor at a high starting position to begin a negotiation. You want to find the maximum plausible position — not unrealistically high, but high enough to allow you to make concessions while still achieving an outcome that meets your goals. There is no perfect way to identify the maximum plausible position, but it is generally higher than you think. If you are negotiating a contract, choosing a salary number slightly greater than specialty-specific benchmarks can be a good starting position. If you are negotiating with health system leadership to make a non-salary change (e.g., EHR functionality, change in work expectations, or protected time for nonclinical work), ask for more than you want. By anchoring high, you position yourself to achieve the goals you set prior to the negotiation, and you may even get more than you expected.

4. Counteroffers. After the initial request or offer, there will be a series of counteroffers. Be prepared to make concessions as the bargaining process progresses. Early on, larger concessions may be appropriate, but as the negotiation continues, moving to smaller concessions is best.

5. Reaching agreement. When agreement seems near, keeping an additional, small concession in reserve can be beneficial as a good-faith gesture that may improve the final position on which the other party is willing to settle. It also helps you end the negotiation on a positive note that supports future relationships.

Here's an example:

As Dr. Taylor begins the negotiation with the local academic health system, she knows the benchmark pay for her position

MORE RESOURCES

Cognitive biases

Neale MA, Bazerman MH. Negotiating rationally: the power and impact of the negotiator's frame. *The Executive.* 1992;6(3):42-51.

Gambits

Dawson R. *Secrets of Power Negotiating: Inside Secrets From a Master Negotiator.* 2nd ed. Career Press; 1999.

General negotiation

Voss C, Raz T. *Never Split the Difference: Negotiating As If Your Life Depended On It.* Harper Business; 2016.

is $245,000. As a new graduate, she is not sure she can get a benchmark offer, but knowing the relative shortage of family physicians, she decides to start with an initial request of $255,000. While it feels uncomfortable to request such a high salary, as the discussions continue she is able to offer concessions on items such as vacation time and on-call work to get other things she values, such as protected time for nonclinical work, while the two sides go back and forth on salary. Ultimately, she ends up agreeing on a salary of $240,000 — below the benchmark for her position, but above the offer from her second-choice position at the community health center. The salary is within her zone of possible agreement, and she also gets protected time to pursue her nonclinical interests.

STRIVE FOR WIN-WIN AGREEMENTS

Negotiation is an important skill that helps you achieve your goals with agreements that ideally are mutually beneficial for both parties. (For advanced topics in negotiation, see "More resources" on page 13.) Finding a "win-win" solution helps build relationships, which makes the next negotiation more likely to produce another win-win.

Negotiation can involve compensation and salary discussions, time allocation, scope of responsibility, process, policy, and many other facets of work in health care. Understanding the parties to the negotiation and your goals are critical. Careful planning around your starting request and subsequent discussions can help you achieve your desired outcome. Finally, keeping in mind a clear BATNA can help you walk away from a negotiation when it becomes clear that any negotiated outcome will be less desirable for you than leaving with no agreement. FPM

1. Shell GR. *Bargaining for Advantage: Negotiation Strategies for Reasonable People*. Viking; 1999.

2. Fisher R, Ury WL, Patton B. *Getting to Yes: Negotiating Agreement Without Giving In*. 3rd ed. Penguin Publishing Group; 2011.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

CME

Travis Singleton and Phillip Miller

EVALUATING PHYSICIAN EMPLOYMENT CONTRACTS: How Do Your Benefits Measure Up?

From signing bonuses to relocation and continuing education allowances, your employment contract needs to provide more than a competitive salary.

The primary feature of most physician employment contracts is, of course, a base salary. A standard contract will typically stipulate a guaranteed amount that the physician will be paid and may also include a production bonus formula. Most production bonuses are based on relative value units (RVUs) or other volume-related metrics, although a growing number may include value-related metrics such as patient satisfaction scores, adherence to treatment protocols, or use of electronic health records (EHRs). Between the base salary and the production bonus outlined in the contract, physicians should be able to determine both the minimum amount they will earn during the contract period and the maximum they could achieve through the bonus.

Beyond the basic financials, physician employment contracts also generally include a range of other benefits, which we will describe in this article. It should be noted that this information is derived mostly from larger employers such as hospitals, health systems, large medical groups, and community health centers working with our search firm. The employment terms offered by smaller groups may vary from what is described.

Signing bonuses

Physician recruiting has become highly competitive because of an emerging physician shortage that is particularly acute in primary care. Seventy percent of physicians receive 51 or more job solicitations during the course of their training, and 50 percent receive 100 or more. For primary care residents, the numbers are even higher, with 78 percent receiving 51 or more job solicitations and 55 percent receiving 100 or more.[1]

For the 11th year in a row, family medicine was the most requested type of search for our firm,[2] and most family physicians are the focus of continuous recruiting activity.

To differentiate themselves, employers such as hospitals, medical groups, and others often offer physician candidates a signing bonus. Signing bonuses are

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Physician recruiting has become highly competitive because of an emerging physician shortage that is particularly acute in primary care.

intended to create a sense of urgency and commitment, and they can prove to be the extra impetus physicians need to put their name on a contract. Signing bonuses also provide physicians with a short-term financial infusion that can make a move more feasible and appealing.

A dozen years ago, fewer than half of our firm's search assignments featured a signing bonus. That number now stands at 76 percent.[2] It would be higher, but some service sites that have proliferated rapidly in recent years, including urgent care centers and Federally Qualified Health Centers (FQHCs), usually do not offer signing bonuses. The average signing bonus for all physicians is currently $32,636.[2] (See the range offered in "Signing bonuses, all physicians.")

Family physicians are a top target for health care recruiting firms, giving them room to negotiate good benefits.

Signing bonuses are offered to create a sense of urgency and commitment.

Relocation allowances are typically fixed except for physicians with unusual moving needs.

SIGNING BONUSES, ALL PHYSICIANS

Low	Average	High
$2,500	$32,636	$125,000

Because signing bonuses are often based on salary, high-earning surgical and diagnostic specialists usually receive higher signing bonuses than more moderately earning family physicians and other primary care doctors. For family physicians, the average signing bonus is currently $22,050.[2] (See the range offered in "Signing bonuses, family medicine.")

Signing bonuses are negotiable within a few thousand dollars of the offered amount, and it is not inappropriate for physicians to ask for some flexibility on this and other benefits. Physicians leaving established practices and relocating may be particularly justified in requesting a more robust signing bonus.

SIGNING BONUSES, FAMILY MEDICINE

Low	Average	High
$5,000	$22,050	$75,000

Relocation allowances

Approximately 12 percent of family physicians relocate in the course of a year.[3] Most of these physicians are moving to new practices. To make relocation easier and encourage physicians to accept their job offers, employers typically include a relocation allowance in the employment contract. Relocation allowances are featured in 95 percent of physician contracts and average $10,072 for all physicians.[2] (See the range offered in "Relocation allowance, all physicians.")

Relocation allowances typically do not vary by specialty but may vary in special circumstances. For example, if a physician owns multiple vehicles, must relocate from a long distance, or has other unusual moving needs, he or she may be able to negotiate a higher relocation allowance.

RELOCATION ALLOWANCE, ALL PHYSICIANS

Low	Average	High
$2,500	$10,072	$44,000

Continuing medical education allowances

Physicians are obligated to keep up their skills and knowledge through CME, and most employers are willing to help defray the cost. CME allowances are offered in 95 percent of physician employment contracts with the average amount being $3,613 per year for all physicians. (See the range offered in "CME allowance, all physicians.")

Like relocation allowances, CME allowances generally do not vary by specialty, and the average amount has hovered around $3,000 to $3,600 for more than a decade with little room for negotiation. An exception may be made for those seeking to learn or maintain skills in complex procedures.

In most cases, physicians are contractually allotted five days annually for CME. This may vary occasionally, usually for subspecialists, but because CME can often be earned online rather than through travel, employers are less inclined to increase the days allotted to CME.

CME ALLOWANCE, ALL PHYSICIANS

Low	Average	High
$500	$3,613	$30,000

Additional benefits

The great majority of physicians today are being hired as employees of some type of health care facility. This is significantly different from the past when a health care facility, such as a hospital, would establish a newly recruited physician in private practice and front the physician's expenses with a loan or income guarantee. About 95 percent of physician contracts today feature a true employment arrangement offering a salary, rather than an independent practice arrangement offering a loan or income guarantee.[2] As a result, physicians today typically are offered a range of benefits similar to those offered to other employed professionals. Health insurance, malpractice insurance, disability insurance, and some form of retirement plan, such as a 401(k) or (very rarely) a pension, are standard benefits found in physician employment contracts. (See "Other benefits offered, all physicians.")

One quarter of physician employment contracts feature educational loan forgiveness, in which the recruiting hospital or other facility agrees to pay the physician's medical school loans in exchange for a commitment to stay in the community for a given period of time. The loan forgiveness term is usually three years, although two-year and one-year terms also are offered. The average amount of loan forgiveness offered to physicians is $80,923, with a low of $10,000 and a high of $260,000.[2] The amount is negotiable, but usually only facilities in underserved areas that have experienced extraordinary difficulty in recruiting doctors will offer the higher amounts.

OTHER BENEFITS OFFERED, ALL PHYSICIANS

Health insurance	98 percent
Malpractice insurance	98 percent
Retirement plan	95 percent
Disability insurance	91 percent
Education loan forgiveness	25 percent
Miscellaneous other benefits	Less than 1 percent

Certain state and federal programs, such as the National Health Service Corps, offer educational loan forgiveness to physicians willing to practice in rural areas – arrangements in which the physician bears no tax burden. When educational loan forgiveness is offered directly to physicians by hospitals rather than government programs, the payments are considered taxable income. In addition, if the physician chooses to leave the employer before the end of the term, the contracts generally require that the physician pay back any loan repayment monies they received, sometimes with interest.

Beyond the salary

Physicians considering employment contracts often focus a great deal on the salary and the bonus structure. These are two critical components of the contract, but you should consider other aspects, including benefits, to ensure the contract is fair and competitive. FPM

1. *2017 Survey of Final-Year Medical Residents.* Dallas: Merritt Hawkins; 2017.

2. 2017 *Review of Physician and Advanced Practitioner Recruiting Incentives.* Dallas: Merritt Hawkins; 2017.

3. Healthcare provider move rates. SK&A website. http://www.skainfo.com/page/infographic-provider-move-rates. Updated October 2016. Accessed July 25, 2017.

Send comments to **fpmedit@aafp.org**, or add your comments to the article at **http://www.aafp.org/fpm/2017/0900/p9.html**.

The average continuing medical education allowance hasn't changed in more than a decade.

Employed physicians are receiving benefits similar to other employed professionals.

Loan forgiveness terms are usually three years.

PHYSICIANS INSURANCE

Medical Professional Liability and Risk Management For Family Practice Physicians

Svetlana Sedukhin, Lauren Haley, and Shelley Knick

October 20, 2023

Physicians Insurance A Mutual Company

Physicians Insurance Risk Retention Group, Inc.
Serviced by Physicians Insurance Member Services, LLC

phyins.com
601 Union Street, Suite 500
Seattle, WA 98101 | (800) 962-1399

Agenda

Physicians Insurance Background

- Mutual Company

Policies and Coverage

- Claims Made, Tail, Step Factors and other Claims-Made Terms

Claims and Risk Management

- Family Practice claims and risk management
- Documentation and Data

Physicians Insurance Background

Background

PHYSICIANS INSURANCE, A MUTUAL COMPANY

National Insurance Company

- Our Purpose is to protect, defend, and support our Members
- Our Values are aligned with our purpose:

People First

Expertise

Commitment

Visit our website www.phyins.com

Physicians Insurance A Mutual Company (PI)
A- (Excellent) rating from AM Best

Delivering Solutions to our Members

POLICY TYPES

Occurrence Policy

- Covers an incident made during the policy period regardless when the claim is reported
- Rarely offered in medical professional liability

Claims-Made Policy

- Covers only an incident reported while the policy is in-force

Limits of Liability

- Expressed as Per Claim and Aggregate
- Most common in WA $1 million/$5 million

Policies and Coverage

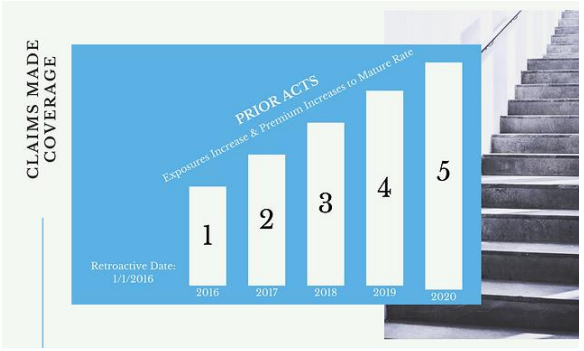
Claims Made Terms

Retroactive Date:

- The retroactive date is the specific date shown on the declaration page or on an endorsement
- It signifies the earliest date from which the policy will provide coverage for claims or potential claims
- Claims and potential claims that occurred before retroactive date are not covered by the policy

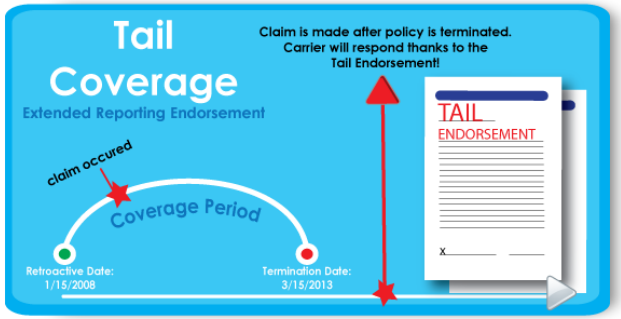
Claims Made Step Factors:

- Associated with how premium is calculated and matures over first five years



Prior Acts and Tail:

- Extended Reporting Period Endorsement or Tail



Family Practice Rates and Classifications

Specialty Rates/ Classifications

- Different rates by the venue (state)
- Different rates by the specialty: Family Practice (no surgery), Family Practice (minor surgery); Family Practice (major surgery)
- Family Practice including obstetrical care
- Rates determined by how invasive a procedure physician performs
- Neurosurgeons pay roughly 7X higher premium than Family Practice Physicians

Applying for Coverage

Application Process:

- Information provided on the application is treated as confidential
- Underwriters review applications to assess the risk and provide the best coverage solution for presented exposure:
    - Risk Characteristics
    - Claims History
    - Risk Management Policies and Procedures (especially for large groups and hospitals)
- Underwriting Guidelines:
    - Insurance Company Policies: Underwriters follow the guidelines, which includes specific criteria for risk acceptance and pricing

Claims and Risk Management

Claims 101

What is a Claim?

- A claim is a request for monetary compensation that is brought by a patient of their family member
- Oral or in writing

What is a Lawsuit

- Formal paperwork filed with Court
- Generally, patient/patient's family has an attorney ve – Third bullet point – Four indents

Major Causes of Claims/Lawsuits

Three top causes of claims:

- Delay in diagnosis
- Failure to diagnose
- Delay in treatment

> The most prevalent medical misadventure for **Family Practitioners** was diagnostic error

Claims and Risk Reduction

We use a data-driven approach to reducing risk and promoting physician resiliency

- According to a recent report from RAND Health and the RAND institute for Civil Justice, most physicians (75-99%) can expect to face at least one malpractice claim in their career
  - Our own research suggests that 26% of all **General Practice** claims and 30% of all **Family Practice** claims turn into a lawsuit

- Based on data shared amongst all PIAA companies, the average indemnity paid for **General and Family Practitioners** was over $300,000.

- Anupam Jena, Seth Seabury, Darius Lakdawalla, and Amitabh Chandra, "Malpractice Risk, by Physicians Specialty," *Research Brief,* RAND Institute for Civil Justice and RAND Health, 2011, accessed February 24, 2014, Malpractice Risk According to Physician Specialty - PMC (nih.gov).
- Physicians Insurers Association of America, *Risk Management Review: 2013 Edition, General and Family PRactice, January 1, 2006-December 31, 2015* (Rockville, MD: Physician Insurers Association of America, 2016).

Breakdown of Payments – Washington State Specific

Indemnity Payments are Increasing

- In 2022 the average indemnity payment increased 65% from 2021
  - Average of $875,375 paid per claim
  - For Claims over $1 million the average payment increased 29.5% to $3,030,099
- What is driving increase indemnity payments?
  - Economic damages were an average of $598,645 paid per claim
    - Increase of 83.6%
  - Economic damages accounted for 68.4% of total indemnity payments in 2022.

- Kreidler, Mike, *2022 Medical Malpractice Statistical Summary, June 2023,* Office of the Insurance Commissioner of Washington State, June 2023, accessed October 9, 2023, 2022 medical malpractice summary for insurers (wa.gov).

Fast Facts About Physicians Insurance

Claims closed for $1 million or more					
Year closed	**2018**	**2019**	**2020**	**2021**	**2022**
Number of indemnity payments	50	46	46	42	66
Total paid indemnity	$123,626,292	$146,253,121	$118,499,537	$98,294,568	$199,986,543
Average indemnity payment	$2,472,526	$3,179,416	$2,576,077	$2,340,347	$3,030,099

- Kreidler, Mike, *2022 Medical Malpractice Statistical Summary, June 2023,* Office of the Insurance Commissioner of Washington State, June 2023, accessed October 9, 2023, 2022 medical malpractice summary for insurers (wa.gov).

The Best Philosophy

Identify, mitigate, and manage risk exposures.

- Relationship centered
- Proactive and reactive
- Customizable and collaborative solutions

Risk Management Approach

Reduce Risk. Raise Standards.

Communication difficulties are the most significant patient safety risk.

Likewise, those errors can lead to claims.

Communication errors have been identified as the second most frequent allegation against physician practices.

Communication errors that put patients at risk often occur:

- From provider to patient or provider to provider
- As a result of verbal, non-verbal, or electronic communications.
- Within teamwork communications
- Medical record documentation

Reduce Risk. Raise Standards.

Provider to Patient

- Failure to adequately educate when delivering informed consent.
- Over assuming health literacy.
- Significance of mutual trust.

Provider to Provider

- Miscommunication of the patient's condition.
- Failure to adequately complete the referral.
- Hesitation to "stop the line" when a safety concern is identified.

Communication

Communication comes in many shapes and sizes.

Verbal

- Telephone communications
- Informed consent or decline
- Patient education
- Apology and disclosure
- Communication with family members.
- Non-verbal communication matters too!

Written

- Record all electronic communications in medical record.
- Beware of copy and paste risks.
- Document diplomatically, especially with difficult patients.

MetaData

- Everything we touch digitally can leave our fingerprint.
- This information is often requested in the event of an adverse event.
- Mobile devices, medication dispensing machines, and point of care testing machines can tell a story in addition to the electronic health record.

TEAMWORK COMMUNICATION TOOLS

Patient Handoffs

- From PCP to Specialist
- After or before hospitalization
- When covering for a provider

Close Loop Communication

- When relaying verbal or telephone orders.
- When requesting or receiving medication or instruments during in-office procedure.
- When clarifying what team member will be relaying information or instructions to a patient.

Speaking Up For Safety

- Empower team to "stop the line" for safety
  - Example- Pain out of control after surgery
  - Example- Medication dosing concerns.
  - Example- If a physician or co-worker is demonstrating concerning behaviors.
- Learn about professional "jousting" and never accept it as a professional practice.

How Risk Management Works For You

Consultation	**Education**
Collaboration	**Advocacy**

KEY TAKEAWAYS:

- Know your policy type, language, and coverage options. Connect with your insurance carrier for questions.

- Claims are a matter of when, not if. Strong communication, patient engagement/understanding, meticulous consent forms and stellar documentation- significantly enhance defense in the event of a potential claim.

- Your insurance carrier is your partner with a clear and simple mission: to protect, defend and support you.

PHYSICIANS INSURANCE

Contact us

Physicians Insurance

FINANCIAL PLANNING

For the “Doctor Doctor” World

Introduction

- Univ. of Washington – MHA 2015, MBA 2014
- Univ. of Virginia – BA 2005

- Director of Finance – Providence St. Joseph Health
- Financial Advisor – 2010 – 2013

Disclaimer: I am no longer a practicing financial advisor. My intent is to give you the tools and theories necessary to approach your own financial choices. When in doubt contact a professional.

Session Overview

- Guiding Principles
  - How to prioritize
  - What to do with student loans
- Retirement Savings
  - How much
  - Which investments to use
- Insurance
  - Is it necessary (Yes)
  - Where to get it
- Questions/Extras

Guiding Principles

- Spend less than you make
- You will make more money than you need to be happy
- There are many solutions to financial wellbeing, pick the one that works for you
- A good way to prioritize:
  - Future You
  - Current You
  - Everything Else

Guiding Principles

- Average annual starting salary: $209,000
- Average loan debt post residency: $200,000

	10 Year Repayment	30 Year Repayment
Loan Balance	$200,000	$200,000
Interest Rate	6.5%	6.5%
Monthly Payment	$2,271	$1,264
Percent of Gross Inc.	13%	7.2%
Total Interest Paid	$72,515.15	$255,088

Guiding Principles

Non-Negotiable

- Retirement Savings
- Short-term Savings
- Insurance

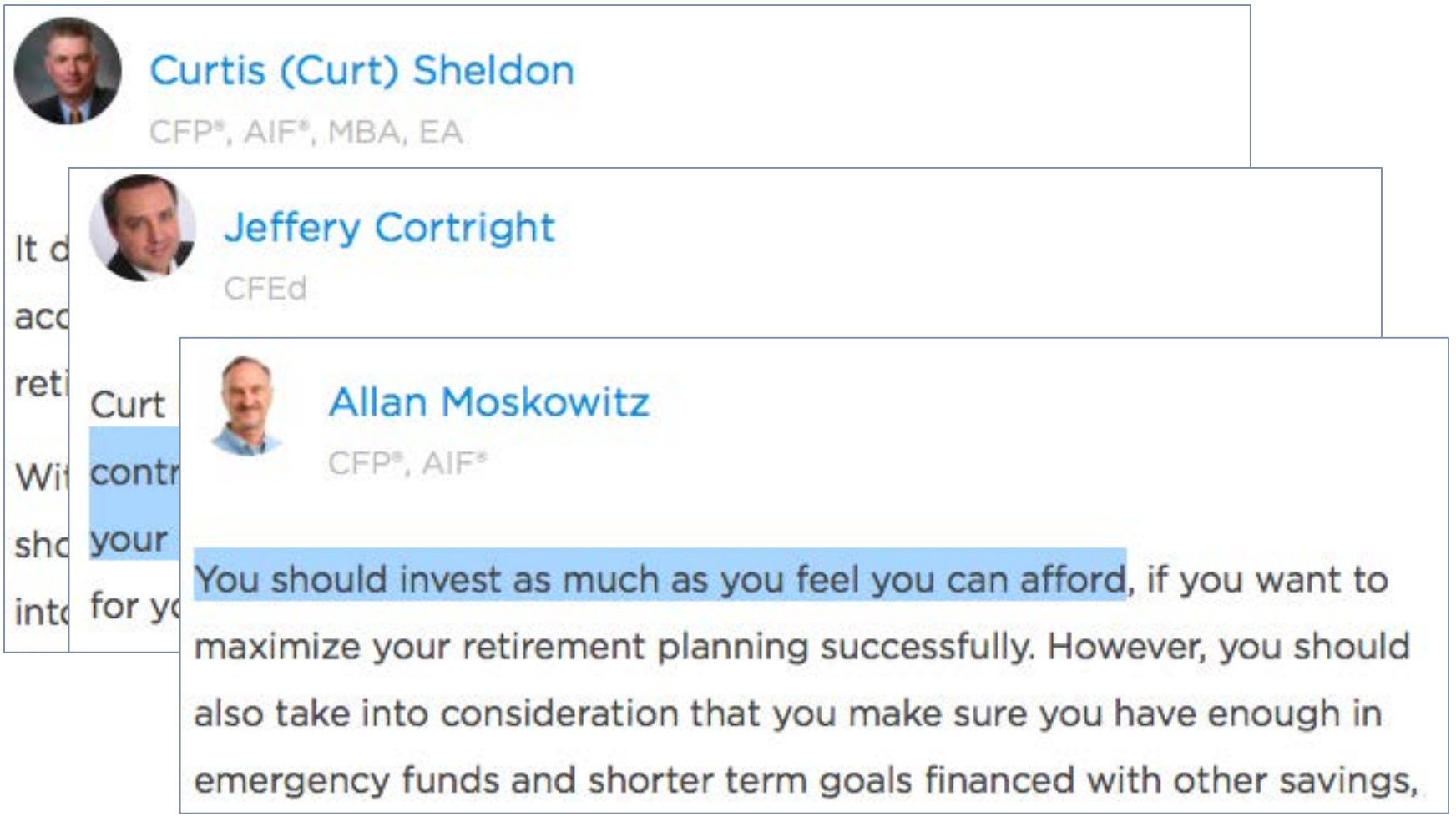
Negotiable

- Housing
- Consumer Debt
- Daily Expenses

RETIREMENT

15% in a Roth* 401(k), in a target date, index fund

15% of Income in a Roth* 401(k)…



Source: Nerdwallet.com

15% of Income in a Roth* 401(k)…

- This is a safe guess. Everybody's rate is different
- Some factors affecting the savings rate are:
  - Retirement age and lifestyle
  - Current money saved
  - External factors
- Three ways to get to 15%
  - Right now
  - With a pay raise
  - Over time

15% of Income in a Roth* 401(k)…

	Traditional	Roth
Work	401(k)/403(b): $20,500 annual employee limit Pre-tax contributions	Roth 401(k)/403(b): $20,500 annual employee limit Post-tax contributions
Personal	Traditional IRA: $6,000 annual limit Pre-tax contributions Income limitations	Roth IRA: $6,000 annual limit Post-tax contributions Income limitations

IRA – Individual Retirement Account

15% of Income in a Roth* 401(k)…

- *Traditional* retirement accounts do not tax the money when it goes into the account. But everything is taxed when it is taken out

15% of Income in a Roth* 401(k)…

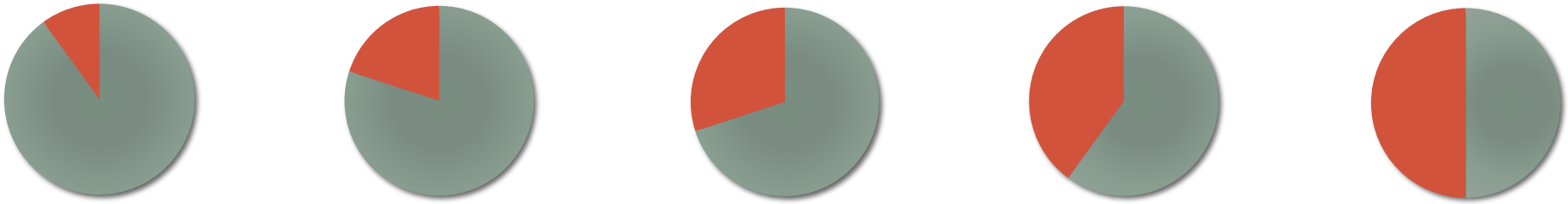
- *Roth* accounts require income tax to be paid on the money going in, but the money coming out is income tax free

15% of Income in a Roth* 401(k)…

- Roth accounts are good when
  - You do not intend to withdraw the money for at least 10 years
  - You are in a low tax bracket, or expect to be in a higher tax bracket in the future
- Traditional accounts are good when
  - You expect to withdraw the money in less than 10 years (approx.)
  - You are in a high income tax bracket
- Roth accounts also tend to have more flexibility for withdrawals

in Target Date, Index Funds

- Target Date Funds – An investment that adjusts the level of risk with the expectation of using the funds at a predetermined time



- Good for people who:
  - Don’t want to rebalance their accounts regularly
  - Those who are prone to making emotional investment choices

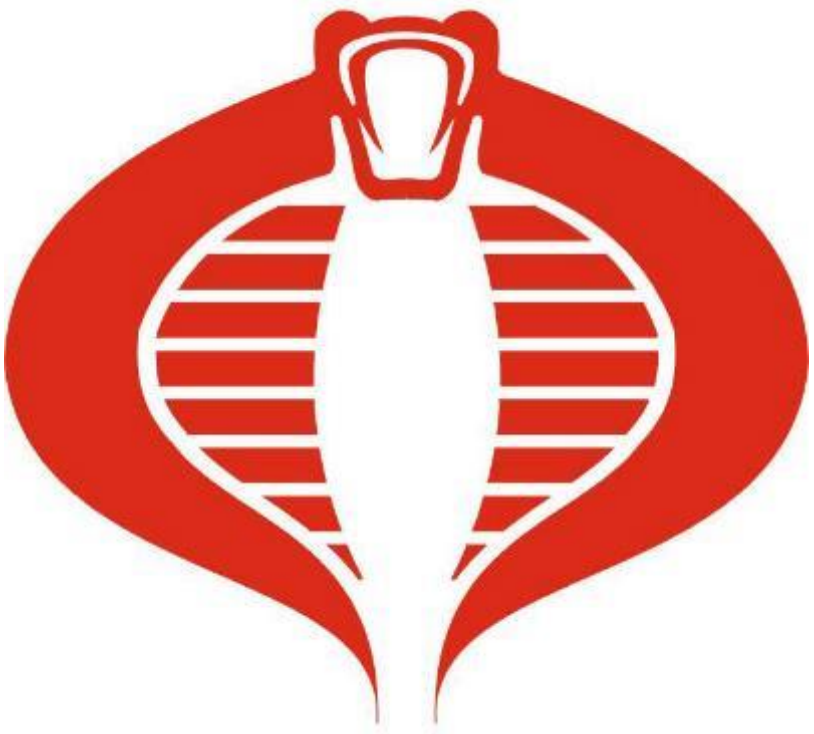
in Target Date, Index Funds

- Index Funds – Mutual funds that attempt to track a broad market index, such at the S&P 500. In other words it tries to be average
- Index funds tend to have lower fees which usually makes them a better investment than similar, **actively managed** funds
- Charles Schwab, Fidelity, and Vanguard are good organizations

INSURANCE

Life & Disability

Health Insurance



- Keep your employer insurance for up to 18 months after leaving
- You pay the entire premium
- 60 days to enroll

Life Insurance… Just Get It

- You will rarely spend that extra dollar on something more worthwhile
- Purchase only what you need
- Some life insurance should be temporary (term), some should be permanent (universal, whole life)
- Insurance can be a useful investment tool (used to mitigate taxes), but you probably aren't rich enough to worry about that… yet

Disability Insurance

- Disability is not as uncommon as you think. Chances of a disability occurring:
  - 3 months or more – 1 out of 3
  - 1 year or more – 1 out of 5
  - 5 years or more – 1 out of 7[1]

- Disability is more than just on-the-job injuries:
  - 90% due to illness, 10% due to injury[2]

1. Burke, J. Christopher. "What Every Physician Should Know About Disability Insurance." *AMA Insurance Agency*. January, 2011. http://www.amainsure.com/static/cms_workspace/AM213-WhitePaper-v2.pdf
2. 2. "What You Need to Know About Disability Insurance." *The Life and Health Insurance Foundation for Education*. 2011. http://www.lifehappens.org/pdf/printable-consumer-guide/disability-pcg.pdf

Disability Insurance

- Covers 40 – 60% of pre-disability income
- Most employers provide some coverage
  - Short-term: first 2 weeks
  - Long-term: weeks 2 – 12
- Three sources of additional coverage
  - Employer plans
  - Professional organizations
  - Private insurance

Disability Insurance

What to look for in a plan:

- Elimination Period: 90 days
- “Own occupation” coverage
- Inflation protection
- Portable
- Renewable

QUESTIONS?

Carlton.Wilson@gmail.com

APPENDIX

Financial Advisors

- Useful if…
  - You don't want to do your own research
  - You want to combat your own bad financial behavior
  - Couples want to mediate their differences of opinion
- Good sources for financial planning:
  - Your work
  - NAPFA – fee only planners
  - Garrett Planning Network
- It is never too early to start

Financial Advisors

- To find an advisor I recommend looking on the NAPFA website. From the profiles I've seen, I would suggest these:
  - Columbia Financial Planning
  - IJD Evergreen

Note: I have no relationship with these advisors, and have never worked with them. This is just my suggestion for a starting point in your search for a good match.

Short-term Savings

- Cash on hand – money to handle normal expenses (car repairs, weekend getaways, etc.) $2,000 - $5,000
- Emergency savings – this is your rainy day fund, to be used for job transitions and major emergencies
  - Should equal 3 – 6 months of expenses (not income)
  - The riskier the job, the more months this fund should cover
- A signing bonus is a great way to achieve this quickly
- Going forward, put half of all bonuses and raises towards your financial plan. Or try to put away 5% of your monthly income

Housing

- Typically you should spend no more than 25% of take-home pay (18% of gross) on housing
- Homes are a poor investment
  - Overtime they keep pace with inflation. Think of it as forced savings
  - Purchase a home because you want to live there for several years
- If you can't afford a fixed rate mortgage you probably should not buy the home
- Think of renting out your home like running a small business with thin margins… because it is

Consumer Debt

- Ideally no more than 5% of gross pay (excludes housing)
- Paying down debt vs. investing
  - 7% rule – if the debt interest rate is more than 7%, it is better to pay off the debt
  - It's a matter of personal preference
- Mathematically, it is best to pay off debt with the highest interest rate first. But do whatever works best for you
- In most cases you should start some cash savings *while* paying off debt

College Savings

- Saving for your child's college comes after saving for your retirement
- Your children would rather have student loans than have you living in their basement
- Typically 529 plans are the best way to save for college (use target date funds…always)
- For a newborn $500/mo will be enough to put them on track for the best in-state, public school
- Savingforcollege.com is a great resource

Parents

- You need to know if your parents are planning on you supporting them
- Spouses should be on the same page about how their parents are going to be supported
- Long Term Care Insurance is a great, but an expensive option

Washington State Department of Health

LOAN REPAYMENT PROGRAMS & RESOURCES FOR FINDING A JOB

Rural Health Workforce

Presenters

Claire Horton (she/her)

Primary Care Office Manager

Health Workforce, State Office of Rural Health

Claire.Horton@doh.wa.gov

Faith Johnson (she/her)

Workforce Advisor

Health Workforce, State Office of Rural Health

Faith Johnson@doh.wa.gov

Today's Agenda

- **State Loan Repayment Program**
  - Washington Health Corps
- **Federal Loan Repayment and Forgiveness Programs**
  - National Health Service Corps
  - PSLF
- **DOH Workforce Advisor**
  - 3RNET

Audience Questions

- Do you plan to practice in Washington State?
- Where do you want to practice (rural/urban)?
- Do you plan on applying for loan repayment programs?

State Loan Repayment Program

WASHINGTON STUDENT ACHIEVEMENT COUNCIL
EDUCATION · OPPORTUNITY · RESULTS

Washington Health Corps
Loan Repayment Programs

WASHINGTON STUDENT ACHIEVEMENT COUNCIL
EDUCATION · OPPORTUNITY · RESULTS

Washington Health Corps

Phone: 888-535-0747, option 5
Email: health@wsac.wa.gov

wsac.wa.gov/health

Washington Health Corps helps the state attract and retain licensed health professionals to serve in critical shortage areas in Washington State by providing educational loan repayment assistance.

Three programs—with different requirements—provide educational loan repayment assistance.

Requirements	Federal Health Program (FHP)	State Health Program (SHP)	Behavioral Health Program (BHP)
Funding source	Federal funds matched with state dollars	State funds only	
Maximum award	$70,000	$75,000	
Minimum service obligation	2 years	3 years	
Minimum work week	40-hour work week	24-hour work week, service obligation is prorated	
Default penalty	(months NOT served x $7,500) + interest Minimum $31,000 payback	An amount equal to the unsatisfied portion of the service obligation, or the total amount paid by the program on participant's behalf, whichever is less.	
Days away from clinic	Approximately 35 days per contract year	40 days per contract year	
Eligible sites *See program reference guide for full details.*	Required: • Federal Health Professional Shortage Area (HPSA) designation. • Nonprofit. • Posted and implemented sliding fee schedule.	Optional: • HPSA designation. • Nonprofit. • Posted and implemented sliding fee schedule.	
Eligible providers	DDS or DMD, Registered Dental Hygienist, MD, DO, Physician Assistant, Nurse Practitioner, Registered Nurse, Pharmacist, Certified Nurse Midwife, Substance Use Disorder Professional, Licensed Clinical Psychologist*, Licensed Independent Clinical Social Worker*, Licensed Marriage and Family Therapist*, Licensed Mental Health Counselor*	All same eligible providers as FHP PLUS Licensed Midwife, Naturopathic Doctor (ND), Licensed Practical Nurse, Chiropractor	ONLY Substance Use Disorder Professional, Nurse Practitioner specializing in mental health, Licensed Clinical Psychologist, Licensed Independent Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Mental Health Counselor

*For FHP only, indicated provider types require a full independent license. Individuals with the associate level, restricted credential are not eligible.

Three-Step Process

1. **New sites** apply and request pre-approval status.
2. **Health providers** apply when the application cycle opens.
3. **Sites** certify and provide information.

Note: Site preapproval application is now open year-round.

2022 Timeline

Federal Health Program (FHP)

- Awards use federal funds matched with state dollars
- Maximum $70,000 award
- Minimum two-year service obligation
- Minimum 40-hour work week
- Maximum 35.7 days per contract year allowed in leave away from site
- Default penalty: months not served x $7,500 per month, plus interest (minimum of $31,000 payback)

State Health Program (SHP)

- Awards use state funds only
- Maximum $75,000 award
- Minimum three-year service obligation
- Minimum 24-hour work week (service obligation period prorated to three-year, full-time equivalency)
- Maximum 40 days per contract year allowed in leave away from site
- Default penalty: amount equal to the unsatisfied portion of the service obligation, or the total amount paid by the program on their behalf, whichever is less

National Health Service Corps (NHSC) Loan Repayment Programs

NHSC Loan Repayment Program Benefits

NHSC helps to remove financial barriers for providers, enabling them to provide care in high-need areas.

Benefits include:

- Loan Repayment for professionals;
- Recruitment and retention tool for employers;
- Increases access to care for communities served by NHSC providers

General NHSC LRP Eligibility Requirements

U.S. citizen or U.S. national

Currently work, or applying to work, at an NHSC-approved site

Have unpaid government or commercial loans for school tuition, reasonable educational costs, and reasonable living expenses, segregated from all other debts

Licensed to practice in state where employer site is located

Must be licensed in one of the following eligible disciplines:

- Physician (MD or DO)
- Nurse practitioner (primary care)
- Certified nurse-midwife
- Physician assistant
- Dentist (general or pediatric)
- Registered dental hygienist
- Psychiatrist
- Psychologist (health service)
- Licensed clinical social worker
- Psychiatric nurse specialist
- Marriage and family therapist
- Licensed professional counselor
- Registered nurse
- Pharmacist
- Substance use disorder counselor
- Nurse anesthetist

HRSA NATIONAL HEALTH SERVICE CORPS

WHICH ONE IS RIGHT FOR YOU?

PROGRAM TYPE	NHSC Loan Repayment Program	NHSC SUD Workforce Loan Repayment Program	NHSC Rural Community Loan Repayment Program
DISCIPLINES ELIGIBLE FOR ALL PROGRAMS	Physicians (DO/MD) • Nurse Practitioners (NP) • Physician Assistants (PA) • Certified Nurse Midwives (CNM) • Health Service Psychologists (HSP) • Licensed Clinical Social Workers (LCSW) • Psychiatric Nurse Specialists (PNS) • Marriage and Family Therapists (MFT) • Licensed Professional Counselors (LPC)		
DISCIPLINES ELIGIBLE FOR SPECIFIC PROGRAMS	+ Dentists (DDS/DMD) Dental Hygienists (RDH)	+ Substance Use Disorder (SUD) Counselors Pharmacists (PHARM) Registered Nurses (RN)	+ Substance Use Disorder (SUD) Counselors Pharmacists (PHARM) Registered Nurses (RN) Certified Registered Nurse Anesthetists (CRNA)
AWARD AMOUNT	UP TO $50K full-time / UP TO $25K part-time	UP TO $75K full-time / UP TO $37.5K part-time	UP TO $100K full-time / UP TO $50K part-time
SERVICE COMMITMENT	2 YEARS	3 YEARS	
NHSC HEALTH CARE SITE	✓ Any NHSC-approved site	✓ Any NHSC-approved SUD site	✓ Any rural, NHSC-approved SUD site

All programs use one application, **but you can only apply to one program.**

NHSC Approved Sites

- NHSC-approved sites are outpatient facilities providing primary care medical, dental, and/or mental and behavioral health services.
- The facility can be located in a rural, urban or Tribal community.
- To become an NHSC site, the facility must meet program requirements.
  - Non-discrimination policy, including seeing all patients regardless of their ability to pay
  - Located in a Health Professional Shortage Area (HPSA)

Eligible Site Types

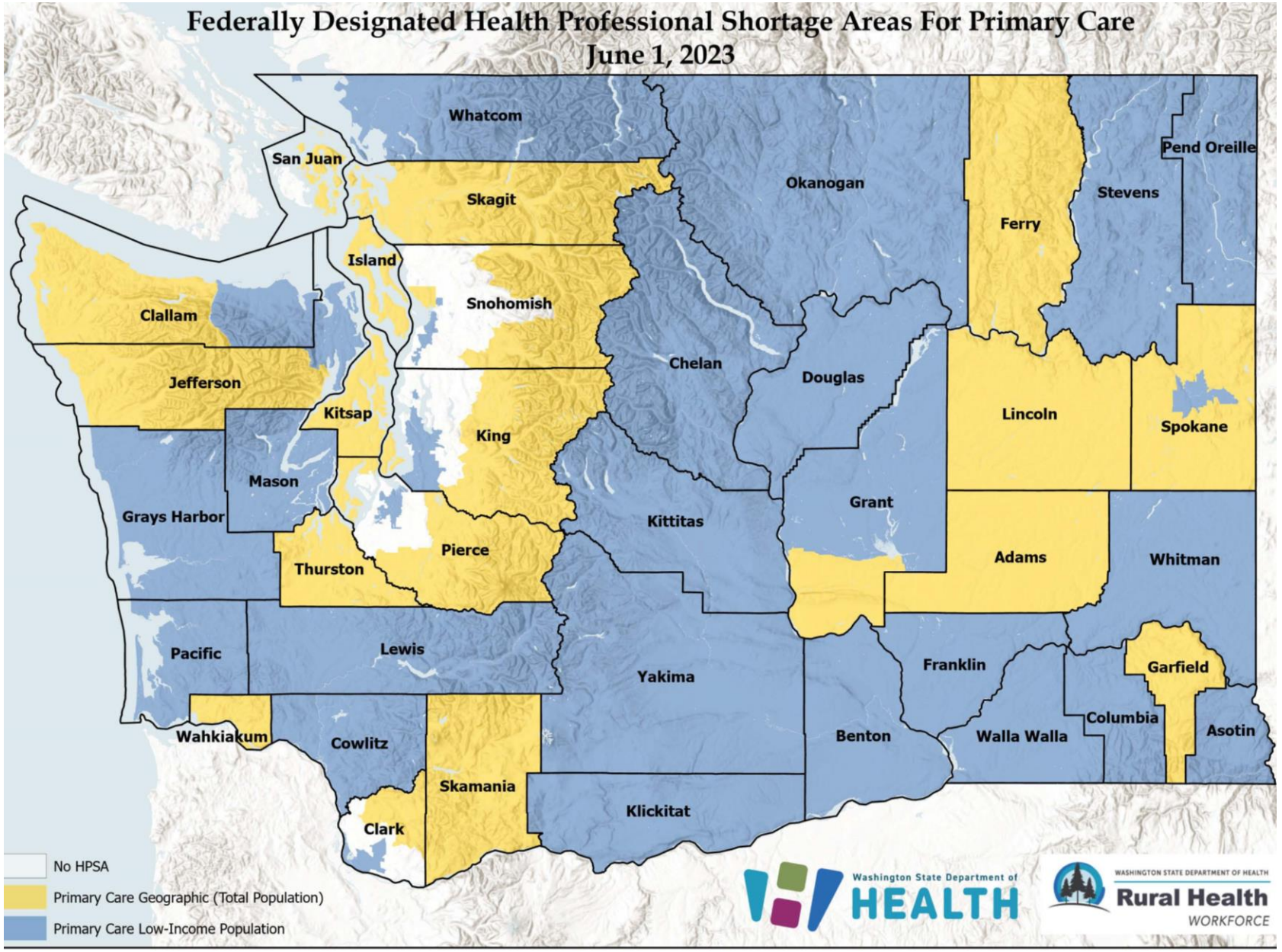
- Federally Qualified Health Centers
- Indian Health Service Facilities
- Certified Rural Health Clinics
- Correctional or Detention Facilities (Federal/State/Immigration and Customs Enforcement)
- Critical Access Hospitals
- Free Clinics
- Substance Use Disorder Treatment Facilities
- Private Practices
- Community Mental Health Centers

Health Professional Shortage Areas (HPSA)

Designations are for areas and populations

Certain types of facilities are also able to receive a HPSA

- Tribal Clinics, Rural Health Clinics, and Community Health Centers



Look up HPSA Scores

Find Shortage Areas by Address: https://data.hrsa.gov/tools/shortage-area/by-address

- Use this tool to check the HPSA score of current or potential employers
- Look for the Primary Care HPSA score, and double check the status is “designated”
- This website only shows the designations for populations and geographic areas.

Additional Government Loan Repayment Options

Indian Health Service Repayment Program

Veterans Administration Education Debt Reduction Program and Student Loan Repayment Program

Public Service Loan Forgiveness

- Forgives balance on direct loans after 120 qualifying payments while working for qualifying non-profit or government employer

- PSLF Waiver 2.0 – Get a Second Chance with the Income Driven Repayment plan (IDR) Recount

- Additional permanent program changes on the way.

Washington has a Student Loan Advocate

- https://wsac.wa.gov/PSLF

Errors to Avoid

Consolidating eligible educational loans with ineligible loans

Accepting employment with a non-approved employer

Application errors

Overlapping service obligations

Working in Rural Health (video)

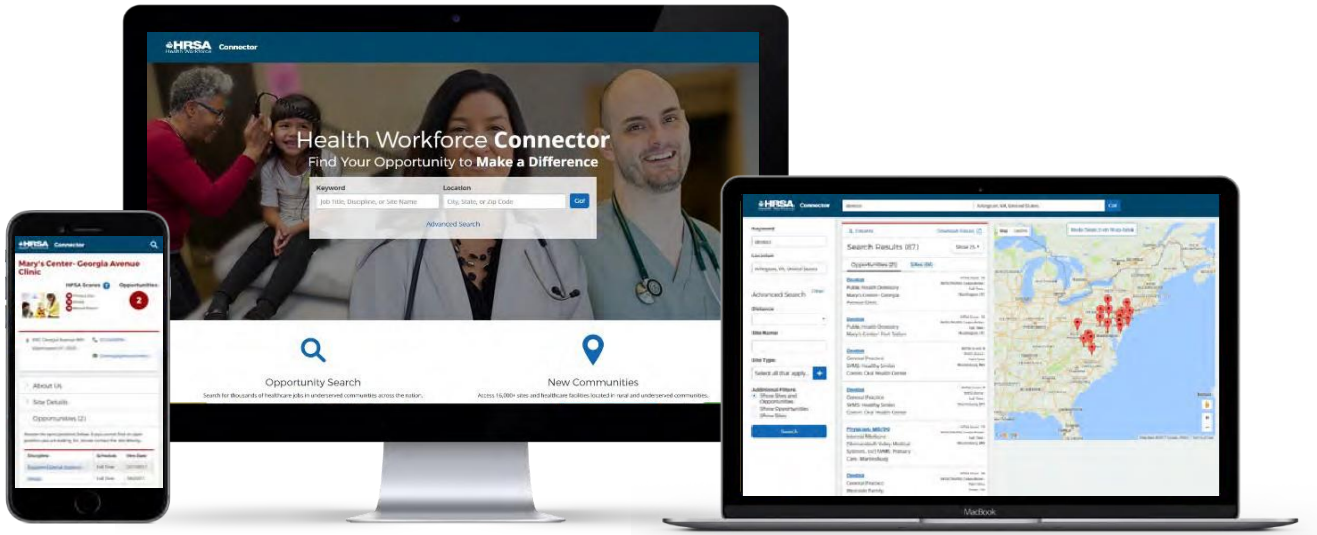
Support & Resources to Aid in Your Job Search

Workforce Advisor Resource

- The Rural Health office is committed to providing access to care to all rural and underserved communities in WA State. Helping to fill healthcare positions in these communities with medical professionals like yourselves helps to address access.
- Direct Recruitment

Health Workforce Connector

- View job vacancies at thousands of NHSC and Nurse Corps approved sites nationwide.
- Google Maps technology allows users to view the surrounding community
- Narrow your job search by:
  - Field of Practice, Specialty, HPSA Score, and Site Name



3rnet.org

3 R N E T

The Nation's Most Trusted Resource for Health Professionals Seeking Careers in Rural and Underserved Communities.

Job Seeker | Network Coordinator | Employer

- Receive email notifications for new jobs
- View full job details
- Access compensation information
- Save jobs to your profile
- Get contact information
- Obtain individualized help

Next steps to work with an advisor:

1. **Register on 3RNet.org**
   I will reach out to you

2. **Think about your criteria**
   - ✓ Region of the state
   - ✓ Proximity to family
   - ✓ Loan repayment site
   - ✓ Work culture
   - ✓ HPSA Score if applicable

3. **Update your CV/resume**

→ Faith.Johnson@doh.wa.gov

Questions?

Contact us

Washington Health Corps (State Loan Repayment):

- health@wsac.wa.gov

National Health Service Corps or HPSAs:

- Claire Horton, PCO@doh.wa.gov

Public Service Loan Forgiveness:

- Washington Student Achievement Council - Loan Advocate, loanadvocate@wsac.wa.gov

Assistance with 3RNET or finding a job in rural or underserved areas:

- Faith Johnson, faith.johnson@doh.wa.gov

We appreciate feedback!

- Anonymous
- Only 3 questions
- Takes less than one minute

Washington State Department of Health is committed to providing customers with forms and publications in appropriate alternate formats. Requests can be made by calling 800-525-0127 or by email at civil.rights@doh.wa.gov. TTY users dial 711.

Get Ready! Preparing Your CV, Cover Letter and Interview

Natalie Nunes, MD
David Evans, MD
October 13, 2023

Educational Objectives:

- Preparing Your CV
- Importance of a Cover Letter
- Interview Tips

Before you start…


HELLO
i'm
Awesome

"Yes, I received your resume. In fact, I'm getting ready to send it around the office right now."

Presentation Matters

- Make it easy to read
- Simple formatting
- White paper
- Clear font that copies/scans well

Self Marketing

Simple Outline

Use discretion

Keep it relevant

Your Complete Name, MD/DO

Accurate current address

Phone

Email (personal v work)

Check for typos!

Education

- Reverse chronological order – most recent first
- School name, location, dates & degrees
- List any honors
- Don’t include high school

Post Graduate Education (Residency and Fellowship)

- Separate heading or part of education section
- Month & Year of Graduation
- State affiliation “University of Washington School of Medicine, Family Medicine Residency Network.”

Honors and Awards

- List relevant honors and awards that are not previously mentioned

Professional Service

- List professional memberships and year joined (AAFP, WAFP, WSMA, etc.)
- Include any offices or committees in which you participate
- Use action words (developed, planned, organized…)

"The years 1966 through 1995 are blank because I was on tour with the Grateful Dead."

Employment Experience

Employment Experience

- Most recent listed first. Place, position, and time employed.
- Residents should only list those that are meaningful to your employer, and that inform your medical practice.
- For future CVs, leave no time holes: account for years since residency

Other Skills and Qualifications

- Medical
  - Procedures
  - EMR
  - Clinical leadership
- Languages spoken
  - Include level of fluency
- Include pertinent non-medical qualifications

License and Certificates

Medical license for each state & date of expiration

ABFM/ACOFP Board Certification date. “Board Eligible” fine until exam results are available

DEA date of expiration

BLS, ACLS, PALS, NRP, ALSO and expiration dates

Publications

- Less important to positions in clinical practice: Make it brief
- For faculty and academic posts, this should be fully fleshed out
- May include relevant publications in the lay press

Community Service

- Non-medical community activities, such as charitable organizations
- Advocacy groups

References

- Have two STRONG references
  - Let them know that you are using their names
- List their names and contact info
  - Email and phone number
  - Or “references available upon request”

Things to leave out

Personal information:

- marital status
- number of children
- DOB, SSN, DEA #
- religion
- test scores

Optional: sports, hobbies

Most common mistakes

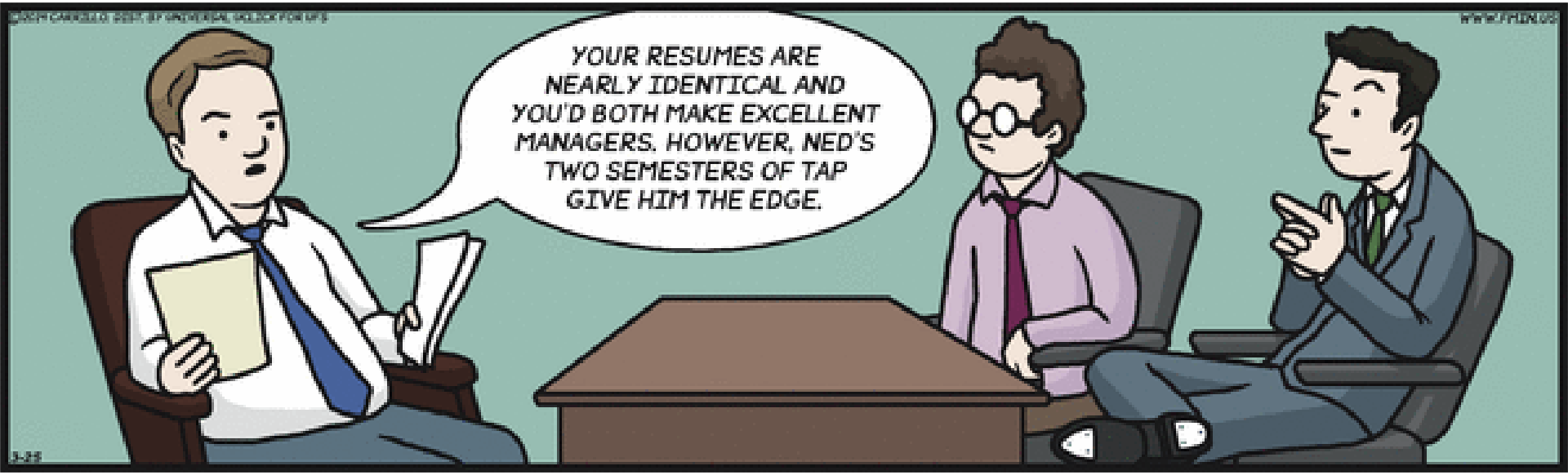
- Spelling and Grammar issues
- Not tailored to the job
- Too long (>2-3 pages)
- Poor work history
- Poor format
- No accomplishments
- Contact info issues
- Lying

Style Tips

- Fonts (sans serif) – easier to read on screen
  - Arial
  - Verdana
  - Lucida Sans
- Not – Times New Roman or Cambria
- 11 or 12 pt font
- **Bold** for subheadings rather than underline

More Style Tips

- Be concise, honest and positive
- Highlight leadership and employability skills
- Advertise you!


YOUR RESUMES ARE NEARLY IDENTICAL AND YOU'D BOTH MAKE EXCELLENT MANAGERS. HOWEVER, NED'S TWO SEMESTERS OF TAP GIVE HIM THE EDGE.

COVER LETTER

Write a specific cover letter for EVERY JOB

It may be the ONLY THING your interviewer will read

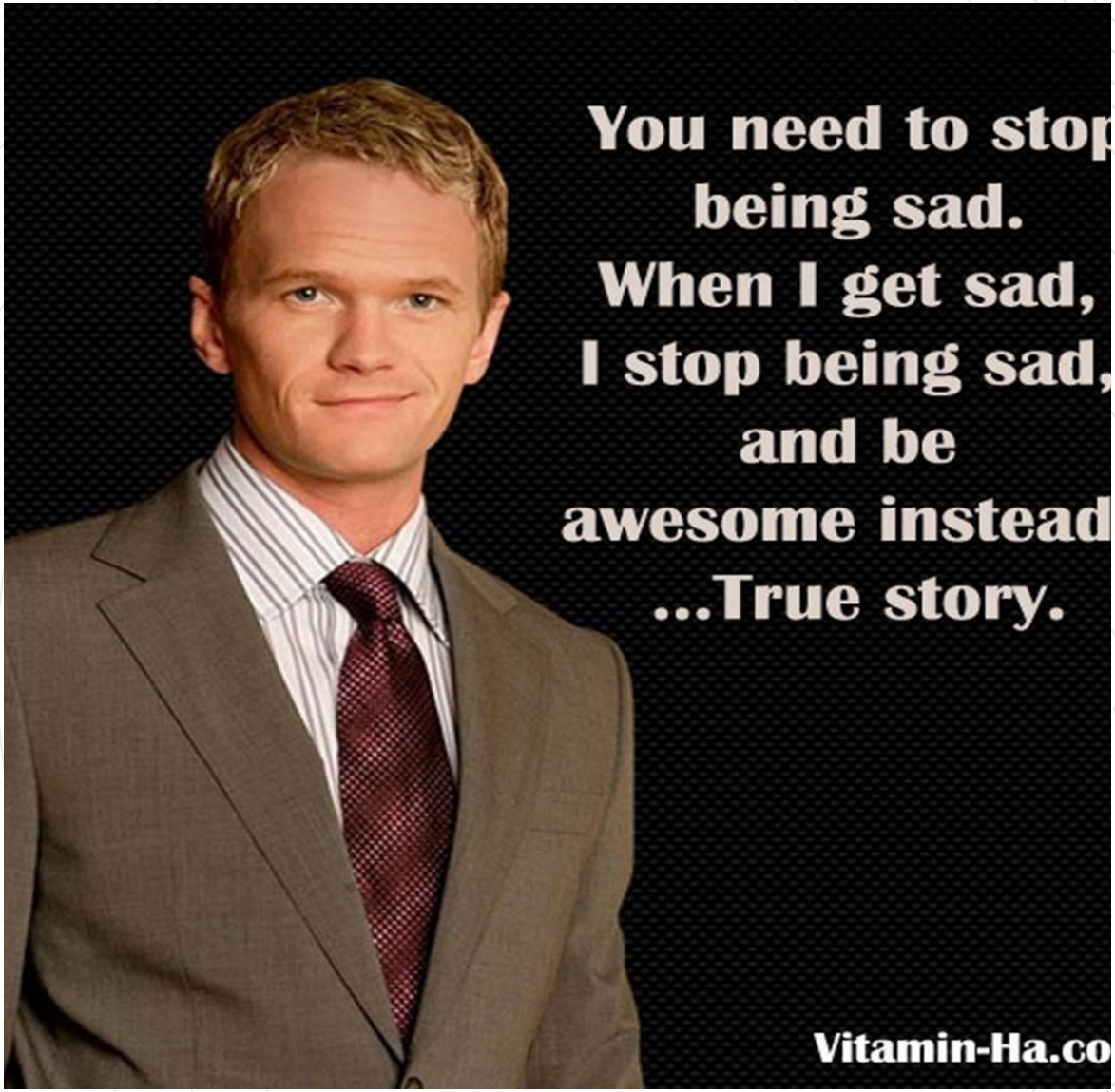
Short and sweet! (1 page)

It should be SPECIFIC to the particular director & to that unique position

COVER LETTER

TELL THEM WHY YOU ARE PERFECT FOR THE JOB

- Special skills
- Interest in particular demographics/communities



INTERVIEWING: CALM DOWN

Traditional	Business Casual	Business Casual/Casual
		

Getting Ready


Coca
Coca

Interview Questions

- Standard
  - Targets education, work experiences, and goals
- Behavioral
  - Focus on actions and behaviors in other settings
    - TIP: think of a couple of good patient stories and have them ready to use as examples for behavioral questions
- Inappropriate/unethical
  - Private life or personal background

When to disclose?

You get to ask questions, too!

General Strategy Tips:

"My short-term goal is to bluff my way through this job interview. My long-term goal is to invent a time machine so I can come back and change everything I've said so far."

- Be ready to talk about yourself.
- Tell a story!
- Breathe! Think before speaking.
- If you don't understand the question, it's okay to ask for clarification.
- Stay calm. Be yourself! You are awesome!


Thank You!

Practice!

Write down a list of possible questions and think about your answers

Stand in front of a mirror and rehearse your answers

Do a mock interview with your advisor.

Final Thoughts

BE YOURSELF.

You offer valuable skills and services.

Hold out for something that is right for YOU.

Your time is valuable. Don’t let anyone sell you short.

SAMPLE PHYSICIAN CV

Sally Smith, MD

Family Medicine

1234 Address Lane • St. Petersburg, FL 12345

123-456-7890 • sally.smith@email.com

Education and Medical Training

Family Medicine Residency 07/2014 – 06/2017
Bayfront Health – St. Petersburg, FL
- Chief Resident

Medical Degree 08/2010 – 05/2014
Baylor College of Medicine – Houston, TX

Bachelor's Degree in Science 08/2006 – 05/2010
University of Tennessee – Knoxville, TN
- Summa cum laude

Licensure and Certifications

TN State Medical License — Pending
American Board of Family Medicine – Board Eligible — As of 04/2017
BLS/ACLS, PALS, etc. — Expires 2019

Experience

Urgent Care Physician 12/2015 – present
The Urgent Care Clinic – St. Petersburg, FL

Volunteer Physician conducting Sports Physicals 09/2015 – present
Local High Schools – St. Petersburg, FL

Leadership/Committees

Member of Quality Care Committee 2015 – 2016
Bayfront Health – St. Petersburg, FL

Secretary of AMA Texas Chapter 2013 – 2014
American Medical Student Association – Houston, TX

Professional Affiliations/Memberships

American Academy of Family Physicians — As of 2014
Florida Academy of Family Physicians — As of 2014

Community Service

Habitat for Humanity – St. Petersburg, FL — 2014 – present
Big Brothers Big Sisters – Knoxville, TN — 2008 – 2010

Additional Skills

Fluent in German and conversational in Spanish; EHR proficient in Epic, Cerner, and Athena.

Personal Information

I enjoy outdoor activities such as running and biking. I also enjoy spending time with my husband and traveling abroad.

First Name Last Name, MD / DO / PhD
(Area code) phone number
email@address.com

Education

Fellowship, University/Institution, City, State	MM/YYYY–MM/YYYY
Residency, University/Institution, City, State	MM/YYYY–MM/YYYY
MD, University, City, State/Country	MM/YYYY
PhD, (Field), University, City, State/Country Thesis Title: Advisor:	MM/YYYY
MA/MS/MPH/MBA, University, City, State/Country (*for each degree)*	MM/YYYY
BS/BA, Major *(include Honors)*, University, City, State/Country	MM/YYYY

Board Certifications

Certification, Certifying Board	Year

Licensure/Certifications

State, License	MM/YYYY–Present
Certification	Expires MM/YYYY

Professional Memberships and Activities

Society Name Member, Committee (Years)	Years
Society Name Member, Committee (Years)	Years

Awards and Honors

Organization, name, description	Year
Organization, name description	Year

Educational Activities and Leadership Positions

Chief Resident University/Institution, City, State	MM/YYYY–MM/YYYY
Committee Leadership /Membership University/Institution, City, State	MM/YYYY–MM/YYYY

Teaching Activities in Programs and Courses

Course Name, Role, Number of Students, Session Titles	Years
Course Name, Role, Number of Students, Session Titles	Years

Research and Scholarly Activity

Clinical Innovations, Safety, and Quality Improvement Projects

Brief description of project and outcomes, Location of project	Years
Brief description of project and outcomes, Location of project	Years

Updated: Date

Publications

Peer-reviewed publications

1. Authors. Title. Journal Vol: pp–pp (year).
2. Authors. Title. Journal Vol: pp–pp (year).

Books & Chapters

1. Authors. Title. in Book Title (Eds.) pp–pp. Publisher (year).
2. Authors. Title. in Book Title (Eds.) pp–pp. Publisher (year).

Other Presentations, Posters & Abstracts

Authors, title of presentation. Meeting Name. (Abstract reference if published) Date

Authors, title of presentation. Meeting Name. (Abstract reference if published) Date

Other Positions and Employment

Employer, City State MM/YYYY–MM/YYYY

Rank, Service, City, State

Volunteer and Community Involvement

Organization, description MM/YYYY–MM/YYYY

Organization, description MM/YYYY–MM/YYYY

First Name Last Name, MD / DO / PhD
(Area code) phone number
email@address.com

Education

Fellowship, University/Institution, City, State	MM/YYYY–MM/YYYY
Residency, University/Institution, City, State	MM/YYYY–MM/YYYY
MD, University, City, State/Country	MM/YYYY
PhD, (Field), University, City, State/Country Thesis Title: Advisor:	MM/YYYY
MA/MS/MPH/MBA, University, City, State/Country (*for each degree)*	MM/YYYY
BS/BA, Major *(include Honors)*, University, City, State/Country	MM/YYYY

Board Certifications

Certification, Certifying Board	Year

Licensure/Certifications

State, License	MM/YYYY–Present
Certification	Expires MM/YYYY

Professional Memberships and Activities

Society Name Member, Committee (Years)	Years
Society Name Member, Committee (Years)	Years

Awards and Honors

Organization, name, description	Year
Organization, name description	Year

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Chief Resident University/Institution, City, State	MM/YYYY–MM/YYYY
Committee Leadership /Membership University/Institution, City, State	MM/YYYY–MM/YYYY

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Course Name, Role, Number of Students, Session Titles	Years
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Clinical Innovations, Safety, and Quality Improvement Projects

Brief description of project and outcomes, Location of project	Years
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Authors, title of presentation. Meeting Name. (Abstract reference if published) Date

Authors, title of presentation. Meeting Name. (Abstract reference if published) Date

Other Positions and Employment

Employer, City State MM/YYYY–MM/YYYY

Rank, Service, City, State

Volunteer and Community Involvement

Organization, description MM/YYYY–MM/YYYY

Organization, description MM/YYYY–MM/YYYY

First Name Last Name, MD / DO / PhD
(Area code) phone number
email@address.com

Education

Fellowship, University/Institution, City, State	MM/YYYY–MM/YYYY
Residency, University/Institution, City, State	MM/YYYY–MM/YYYY
MD, University, City, State/Country	MM/YYYY
PhD, (Field), University, City, State/Country Thesis Title: Advisor:	MM/YYYY
MA/MS/MPH/MBA, University, City, State/Country (*for each degree*)	MM/YYYY
BS/BA, Major *(include Honors)*, University, City, State/Country	MM/YYYY

Board Certifications

Certification, Certifying Board	Year

Licensure/Certifications

State, License	MM/YYYY–Present / expiration
Certificate Programs / Title	Year

Professional Development

Program/Course (Organization), Location	Year

Clinical Positions and Employment

Employer, City State	MM/YYYY–MM/YYYY
Rank, Service, City, State	

Leadership Positions

Committee Leadership / Membership University/Institution, City, State	MM/YYYY–MM/YYYY
Chief Resident University/Institution, City, State	MM/YYYY–MM/YYYY

Professional Memberships and Activities

Society Name Member, Committee (Years)	Years
Society Name Member, Committee (Years)	Years

Academic Appointments

Community Preceptor Department, University, City, State	MM/YYYY–MM/YYYY

Updated: Date

Instructor MM/YYYY–MM/YYYY
Department, University, City, State

Awards and Honors

Organization, name, description Year

Organization, name description Year

Educational Activities

Teaching Activities in Programs and Courses

Course Name, Role, Number of Students, Session Titles Years

Course Name, Role, Number of Students, Session Titles Years

Clinical Education

Responsibility, Location, Level of Effort Years

Responsibility, Location, Level of Effort Years

Research Education

Responsibility, Location, Level of Effort Years

Member, Program or Committee Years

Research and Scholarly Activity

Clinical Innovations, Safety, and Quality Improvement Projects

Brief description of project and outcomes, Location of project Years

Brief description of project and outcomes, Location of project Years

Investigation and Grants

Leadership Positions

Director, Core Years
University/Institution, City, State

Director, Core Years
University/Institution, City, State

Grants

Agency Grant Number Principal Investigator (PI) Years
Title
Description (1 sentence)
Total, direct & indirect costs
Role: (% effort)

Publications

Peer-reviewed publications

1. Authors. Title. Journal Vol: pp–pp (year).
2. Authors. Title. Journal Vol: pp–pp (year).

Books & Chapters

1. Authors. Title. in Book Title (Eds.) pp–pp. Publisher (year).

2. Authors. Title. in Book Title (Eds.) pp–pp. Publisher (year).

Presentations, Posters & Abstracts

Authors, title of presentation. Meeting Name. (Abstract reference if published) Date

Authors, title of presentation. Meeting Name. (Abstract reference if published) Date

Other Relevant Employment and Activities

Employer, City State MM/YYYY–MM/YYYY

Rank, Service, City, State

Volunteer and Community Involvement

Organization, description MM/YYYY–MM/YYYY

Organization, description MM/YYYY–MM/YYYY