2020 Family Medicine Resident
Professional Development Seminar and Career Fair
October 9 – 10, 2020

Virtually on Zoom
Hosted by the King County Academy of Family Physicians

Faculty Bios

CONFERENCE CHAIRS:

Jeanne Cawse-Lucas, MD
Associate Professor
Theodore J. Phillips Endowed Professor of Family Medicine
University of Washington
Contact Info: cawse@uw.edu, 206-543-9425'

Jeanne Cawse-Lucas graduated from the University of Massachusetts Medical School and did her family medicine residency at Swedish Cherry Hill. She practiced at a hospital-owned community clinic for two years and then joined the faculty at the UWSOM. At the UW, she maintains a clinical practice at the UWNC- Northgate clinic and serves as the UW Department of Family Medicine Associate Chair for Faculty Affairs as well as family medicine academic advisor and director of the Primary Care Practicum.

Tony Pedroza, MD
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 7 years, and oversees the professional development curriculum at the Valley Family Medicine Residency Program.

INVITED CONFERENCE PRESENTERS:

David Kinard, M.Ed.
Senior Vice President Business Development
Physicians Insurance A Mutual Company
Contact Info: david@phyins.com or 206-343-6618

David leads teams involved in providing medical professional liability coverage and related services to physicians, clinics, and hospitals throughout the Pacific Northwest. He regularly meets with physicians and physician leaders to develop solutions that address the challenges facing today's clinical and business sides of medicine.

Tamara L. Roe, JD
Attorney
Montgomery Purdue Blankinship & Austin PLLC
Contact Info: troe@mpba.com (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.

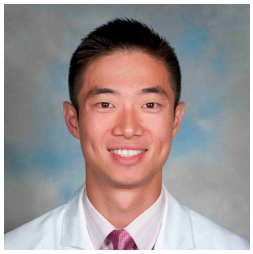
Claudia Shanley , MSW
Rural Health Workforce Director
Rural Health/Office of Community Health Systems
Health Systems Quality Assurance
Washington State Department of Health
Contact Info: Claudia.Shanley@doh.wa.gov (360) 236-2814

Claudia has a Master's of Clinical Social Work degree from Smith College in Northampton, MA and Bachelor's degree in Social Work from the University of Alaska Fairbanks. Her career developed from a social justice lens, beginning with her work serving families of young children from birth-5 years in the Athabascan Villages of the Upper Tanana Region in Interior Alaska. This rural experience that spanned over ten years prepared her for systems development work in the public health, education, and human services fields at the state level in Alaska and Washington, followed by a ten year federal experience in Region X, leading a team of training and technical assistance specialists supporting Head Start programs throughout the Pacific NW and Alaska. Her journey continued by working to support access to health services in rural and underserved populations through directing the Washington Student Achievement Council's multiple health loan repayment programs. She currently serves in a new role as the Rural Health Workforce Director at the Department of Health. In addition to providing oversight to well-established health workforce programs such as the National Health Service Corp and J-1 Conrad Visa Waiver Program, she represents DOH and rural health on various statewide committees and councils, and is responsible for developing new partnerships and opportunities to address rural health workforce shortages.

Carlton Wilson; MBA, MHA
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:



Nelson Chiu, MD
Clinic Chief, UW Neighborhood Northgate Clinic; Clinical Assistant Professor
UW Department of Family Medicine
Contact Info: chiun@uw.edu
Nelson Chiu, MD is the Clinic Chief at the University of Washington (UW) Neighborhood Northgate Clinic as well as a Clinical Assistant Professor in the UW Department of Family Medicine. He completed residency at the UW, where he earned a certificate in Global Health. He graduated from Rutgers-New Jersey Medical School, where he was a Humanism Scholar, and Princeton University.

Patricia Eqwuatu, DO
Family Medicine Physician, Faculty Member
Kaiser Permanente Family Medicine Residency Program, Co Faculty RPrIDE (https://wa.kaiserpermanente.org/html/public/fpr/rpride)
Contact Info: patricia.i.egwuatu@kp.org
I am a first generation Nigerian/Ugandan American who developed a passion for practicing medicine during childhood as I listened to my parents tell stories about health care in their native countries of Nigeria and Uganda. I am a Pacific NW Native. Grew up South of Seattle. Attended University of Washington, Pacific NW University of Health Sciences for Medical School and trained at University of Washington Family Med Residency program. I joined Kaiser Permanente Family Medicine Residency Program as a Faculty Member who co leads our Anti Racism Curriculum. I also practice comprehensive health care for adults of all ages, primary care, women's health, obstetrics, and pediatrics. Outside of medicine I love to spend time with family and friends. I am a huge sports fan and love attending games and heading to concerts.

Jennifer Maxwell, MD MPH
Family Physician
Yakima Valley Farmworker's Clinic
Contact Info: jennifermax@yvfwc.org
Dr. Maxwell received a dual degree MD, MPH from the University of Toledo in Ohio and completed her family medicine residency at the University of Washington. After residency she completed a chief year where she completed a Teaching Scholars fellowship. She is currently fulfilling her National Health Service Corps Scholarship obligation at the Yakima Valley Farmworker's Clinic in Yakima, WA where she teaches nurse practitioner residents and medical students. In her spare time she enjoys hiking, playing board games, and chasing her 3 children.

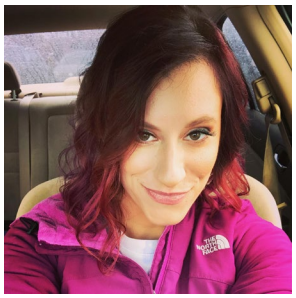
Melissa Weakland, MD
Ballard Neighborhood Doctors
Owner and physician
Contact info: Info@ballarddocs.com
Thirteen years ago I joined an ND in private practice in Ballard. Recently we expanded and relocated to Crown Hill. We have maintained a strong community based practice providing care to all regardless of ability to pay. We thus take all insurance and have a sliding scale for those without insurance. When helpful we will provide pro bono care. With this model we have always been a profitable clinic, have never paid to market our services and continue to have a wonderful quality of life providing we believe high quality care.

Chao-ying Wu, MD (calling me Ying is fine) *he/him*
Family Care Network
Family Physician
Contact info: cywu@fcn.net, (360) 220-2323 (cell, prefer) or (360) 671-3345 (office)
I'm happy to provide the perspective of someone who has worked in two single payer systems, IHS (Navajo Nation) and New Zealand, and in private practice as an employee, and as a partner/owner through cycles of consolidation and fragmentation and consolidation again. I am most excited to share what it feels like to take care of the same patients for 24 years, and the value of really long-term continuity. I can also speak to health related non-profit work if there is interest (Ski patrol 21 years, Chuckanut Health Foundation 6 years, WAFP Foundation Board 2 years).

AMERICAN ACADEMY OF FAMILY PHYSICIAN STAFF:

David Wells, MA
Chapter Executive
King County Academy of Family Physicians (KCAFP)
Contact Info: kcafp@kcafp.net or (425) 780-7898

David started working for the KCAFP in June of 2017 while he pursued a Masters of Transformational Leadership from Seattle University. He graduated in June of 2019 and has continued to support the mission and program needs as the role has evolved. David enjoys trying out new recipes (sweet or savory) and hosting events for friends or family.



Alyssa McEachran
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 Blankinship & Austin PLLC
701 Fifth Avenue, Suite 5500
Seattle, WA 98104
Tel: (206) 682-7090
troe@mpba.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

Washington law: reasonable restrictions enforceable
Reasonable if protects legitimate business interests – must look at various factors
Consider negotiating the scope of the non-compete
- Duration: 1 to 3 years following termination of employment
- Geographic scope: 3 to 15 miles from any practice location
  - *From where does the practice draw patients?*
- Definition of competition:
  - practice of medicine or limited to specialty?
  - Exception for working at hospital or taking academic position?

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 sexual misconduct?

Obvious:

(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

Not So Obvious:

(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 **two years** 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 key third party?

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:
Charles Meredith, MD, Medical Director
Scott Alberti, Clinic Director
720 Olive Way, Suite 1010
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.

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;

(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.

[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:

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.

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.

Chapter 246-16 WAC
STANDARDS OF PROFESSIONAL CONDUCT

WAC

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. 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 standards 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. 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) 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.

(3) 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.

(4) After the two-year period of time described in subsection (3) 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.

(5) 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.

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

(7) 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 (1), (12) and 18.130.180. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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. 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 acknowledges the deviation and states its reasons for deviating from the sanction schedules in the order or stipulation to informal disposition.

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-800, filed 7/22/09, effective 8/22/09.]

WAC 246-16-810 Sanction schedule—Practice below standard of care.

PRACTICE BELOW STANDARD OF CARE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least  greatest	A – Caused no or minimal patient harm or a risk of minimal patient harm	Conditions that may include reprimand, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Caused moderate patient harm or risk of moderate to severe patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
	C – Caused severe harm or death to a human patient	Oversight for 3 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. In addition - demonstration of knowledge or competency.	Permanent conditions, restrictions or revocation.	3 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-810, filed 7/22/09, effective 8/22/09.]

WAC 246-16-820 Sanction schedule—Sexual misconduct or contact.

SEXUAL MISCONDUCT OR CONTACT (including convictions for sexual misconduct)				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** –Inappropriate conduct, contact, or statements of a sexual or romantic nature	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Sexual contact, romantic relationship, or sexual statements that risk or result in patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Sexual contact, including but not limited to contact involving force and/or intimidation, and convictions of sexual offenses in RCW 9.94A.030.	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-820, filed 7/22/09, effective 8/22/09.]

WAC 246-16-830 Sanction schedule—Abuse—Physical and emotional.

ABUSE -- Physical and/or Emotional				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** – Verbal or nonverbal intimidation, forceful contact, or disruptive or demeaning behavior, including general behavior not necessarily directed at a specific patient or patients	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Abusive unnecessary or forceful contact or disruptive or demeaning behavior causing or risking moderate mental or physical harm, including general behavior not directed at a specific patient or patients.	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Severe physical, verbal, or forceful contact, or emotional disruptive behavior, that results in or risks significant harm or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-830, filed 7/22/09, effective 8/22/09.]

WAC 246-16-840 Sanction schedule—Diversion of controlled substances or legend drugs.

DIVERSION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS				
Severity	Tier/Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	A – Diversion with no or minimal patient harm or risk of harm	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, treatment, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, treatment etc.	0-5 years
	B – Diversion with moderate patient harm or risk of harm or for distribution	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc.	Oversight for 7 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc. OR revocation.	2 - 7 years unless revocation
greatest	C – Diversion with severe physical injury or death of a patient or a risk of severe physical injury or death or for substantial distribution to others	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions OR revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-840, filed 7/22/09, effective 8/22/09.]

WAC 246-16-850 Sanction schedule—Substance abuse.

SUBSTANCE ABUSE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least ↓ greatest	**A** – Misuse of drugs or alcohol with no to minimal patient harm or risk of harm	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, treatment, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, treatment, etc.	0-5 years
	B –Misuse of drugs or alcohol with moderate patient harm or risk of harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc.	Oversight for 7 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc. OR revocation.	2 - 7 years unless revocation
	C –Misuse of drugs or alcohol with severe physical injury or death of a patient or a risk of significant physical injury or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions OR revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-850, filed 7/22/09, effective 8/22/09.]

WAC 246-16-860 Sanction schedule—Criminal convictions.

CRIMINAL CONVICTIONS (excluding sexual misconduct)				
Severity	Tier / Conviction	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least ↓	A – Conviction of a Gross Misdemeanor except sexual offenses in RCW 9.94A.030	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-5 years
	B – Conviction of a Class B, C, OR Unclassified Felony, except sexual offenses in RCW 9.94A.030	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	C – Conviction of a Class A Felony, except sexual offenses in RCW 9.94A.030	5 years suspension	Permanent revocation	5 years - permanent revocation

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-860, filed 7/22/09, effective 8/22/09.]

WAC 246-16-890 Sanctions—Aggravating and mitigating factors. The following nonexclusive list identifies factors that may mitigate or aggravate the sanctions that should be imposed in an order or stipulation to informal disposition.

(1) Factors related to the unprofessional conduct:

(a) Gravity of the unprofessional conduct;

(b) Age, capacity and/or vulnerability of the patient, client or victim;

(c) Number or frequency of the acts of unprofessional conduct;

(d) Injury caused by the unprofessional conduct;

(e) Potential for injury to be caused by the unprofessional conduct;

(f) Degree of responsibility for the outcome;

(g) Abuse of trust;

(h) Intentional or inadvertent act(s);

(i) Motivation is criminal, immoral, dishonest or for personal gain;

(j) Length of time since the unprofessional conduct occurred.

(2) Factors related to the license holder:

(a) Experience in practice;

(b) Past disciplinary record;

(c) Previous character;

(d) Mental and/or physical health;

(e) Personal circumstances;

(f) Personal problems having a nexus with the unprofessional conduct.

(3) Factors related to the disciplinary process:

(a) Admission of key facts;

(b) Full and free disclosure to the disciplining authority;

(c) Voluntary restitution or other remedial action;

(d) Bad faith obstruction of the investigation or discipline process or proceedings;

(e) False evidence, statements or deceptive practices during the investigation or discipline process or proceedings;

(f) Remorse or awareness that the conduct was wrong;

(g) Impact on the patient, client, or victim.

(4) General factors:

(a) License holder's knowledge, intent, and degree of responsibility;

(b) Presence or pattern of other violations;

(c) Present moral fitness of the license holder;

(d) Potential for successful rehabilitation;

(e) Present competence to practice;

(f) Dishonest or selfish motives;

(g) Illegal conduct;

(h) Heinousness of the unprofessional conduct;

(i) Ill repute upon the profession;

(j) Isolated incident unlikely to reoccur.

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-890, filed 7/22/09, effective 8/22/09.]

Negotiation Jujutsu

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UW Medicine/Valley Medical Center


KEEP
CALM
AND
GET
A JOB

Negotiating for your first job as a family physician :

- For most of you this is your first job requiring an employment contract.
- You all have been busy “learning”.
- Not many have needed to negotiate contracts

Negotiating for your first job as a family 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 a good negotiating situation.
- FIRST job, not your LAST job for most new graduates.
- Covid pandemic and job searches, impact??

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

WOMEN DON'T ASK

NEGOTIATION and the GENDER DIVIDE

"This book is an eye opener, a call to arms, and a plan for action."
—Teresa Heinz

LINDA BABCOCK and SARA LASCHEVER

Negotiating for your first physician job:

- Likely to have have multiple job offers, multiple interviews.
- So before you start interviewing, do your homework, prepare…
- 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.
- And one last thing→ what job are you looking for?

Negotiating for 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.
- What is the most current data for the jobs you are hoping to find
  - Current up to date salaries, benefits, contract templates.

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.

Okay, you have the interview…..now what happens.

- It all depends, is the employer negotiating, are they sorting out if they have a position, have they made a decision to actually recruit and hire for the position.
- If you are there, most likely the answer is yes, but pay attention to clues from the discussion.
- Before you set up this interview:
  - When do you want to start?
  - What FTE do you want, what do you need, what is not negotiable?
  - Are you undecided → be cautious, keep your cards close…..

Negotiating Rule # 1

- Q: When should I discuss what I want?

“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.

Q: When should I discuss what I want?

- Answer: When the hiring manager/medical director has reached the “judge-it” stage.

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? Let's look at a few examples.

Let's say you want one extra week of vacation. Let's look at what happens if you go first:
You ask for one week. You get what you want, but you are never sure if you want more.
You ask for 6 weeks, they won't give it to you and then you have to come down and you lose your dignity.

Instead plant a seed, or answer the questions with a question.

"I would really like to work here, but one of the important things that I also want is to be able to travel." What can you do to help me with that? Get them to make you an offer first. Maybe you want an extra week of vacation, what if they come out and offer you two weeks more of vacation? By speaking first, you have just lost a week of vacation. Never tell them exactly what you want first. Wait for them to make a suggestion.

Remember→ do your homework…..before you start negotiating!

- 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?

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 the original figure before you say another word
- Let silence negotiate for you.

A word about Silence: No one is comfortable with silence
Most interviewers (who as you remember are in the judge-it stage) are freaking out that they might lose you! They think you are disappointed in what they offered and are scrambling to fix their mistake.
The majority of interviewers will raise that figure immediately.
“Well, we could go as high as….”
“But of course for someone like you…”
Congratulations: You just got your first perk without uttering a single word!
Sometimes you will hear: “Our budget only allows us to go that high” or “We just purchased a new MRI machine that cost a lot of money” or whatever….. But it doesn’t matter because you will now make a counter offer.

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.

What if They Get Angry?

- Self-respect
- Respect for the bottom line
- Partnership

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 continue to be angry with you, you might consider what kind of partner this clinic will be in the future. You can not approach negotiations being afraid of what your company will think about you.

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 books on the negotiation → PREPARE, and be comfortable with these discussions.
- Remember that you want to work with this entity, these physicians, so negotiate with that in mind, specifically that you are reasonable, intelligent, and will make a good physician partner.


KEEP
CALM
AND
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A JOB

American College of Physicians
Leading Internal Medicine, Improving Lives

Physician Employment Contract Guide
2017

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Introduction

Numerous publications, websites, recruiters, and other resources are available to help physicians find employment opportunities. This guide discusses the selection and employment contracting process that follows the identification of a suitable opportunity. It is intended to assist both individual physicians seeking employment and physician groups recruiting a physician.

Starting salary is a relevant but hardly the most important factor in the selection process. A physician's job performance, degree of professional and personal satisfaction, and future career will be heavily influenced by the practice type, location and clinical quality of the group the physician joins, as well as by the fit between the physician's own style of practice and that of the group. It is therefore critically important to both the practice and the physician candidate that they effectively communicate their desires and expectations regarding the position.

Because the employment contract defines the conditions of employment and can therefore greatly impact future professional satisfaction and personal happiness, a physician needs to read carefully and fully understand every aspect of the employment agreement.

A contract's legal terminology, such as 'restrictive covenant' and 'assignability,' can be confusing, and some important contract provisions, if not understood, can lead to problems in the future. Other provisions may need to be negotiated. Thus legal assistance from a qualified health attorney may be helpful.

Physician groups should strive to find a new associate who will work well within the group's existing culture and will get along with existing staff. Groups should look beyond the first clinically well qualified candidate willing to accept the group's salary offer and consider the intangibles that will make the potential candidate a good team player, productive, and a credit to the practice. And it is in the group's interest to be sure the physician candidate fully understands the group's expectations and the conditions of employment before signing any agreement.

Finding the Right Practice

Before a senior resident or fellow begins to think about signing an employment contract, there are a few things he or she should consider. Even a 'grizzled veteran' physician looking for a new employment opportunity should pause to consider the type of practice in which he or she wants to work and the preferred geographic location.

Resources

Professional publications or physician recruiters are two sources to check when looking for a position outside one's immediate geographical area. A physician's local hospital or personal network of colleagues, teachers or medical school and residency training alumni may also be excellent suppliers of information.

Today the Internet has become a major additional tool in the search for career opportunities. There are websites that permit physicians to tailor their searches by specialty, type of practice, and location. Other sites focus on physician management opportunities, and some list opportunities in the managed care, hospital, or pharmaceutical industries. There are a host of resources available; and a physician searching for the best opportunity should make full use of the advantages each source provides.

Group practices should consider the benefits of advertising position openings in several of these resources; however, the cost vs. benefits of advertising in different venues must be considered.

Practice Types

A physician should also consider what type of practice would best suit his or her needs and preferences. Types of practices include, but are not limited to: solo, small group, large group, hospital or health system owned; health maintenance organization -based (HMO); single or multi-specialty; outpatient, hospitalist, or a combination of the two; traditional, direct patient contract, hybrid, or government. Listing the characteristics, pros and cons of each type of practice can be advantageous when trying to make the decision. For example, a physician concerned with independence and primary decision-making may wish to start a solo practice; however, he or she must be aware of the associated financial risk, or even the possibility of failure. A physician who is more risk averse may prefer to join a staff model HMO or hospital owned group, but must be willing to accept reduced autonomy.

Practices hiring a physician should also consider the fit. Does the candidate have experience in your practice environment? Will the candidate's skills and personality fit well into your practice setting? Hiring even a highly qualified candidate who predictably will have difficulty adjusting to your practice or community can lead to unhappiness and disruptions that serve neither you nor the candidate's interests.

Location

When deciding on practice location, consider both the working and the living environments, such as the local school system, places of worship, availability of leisure activities and proximity to the hospital. The cost of living, crime rate, and transportation system may be personal priorities as well. Physician practices hiring a new physician should consider whether or not the candidate has previously worked in the geographic area, or a similar environment, may be an indicator of the physician's willingness to stay long term. Reference checking on a local candidate also tends to be much easier.

Practice Culture

There also are important subjective issues that both parties need to consider before agreeing on an employment contract. The practice's culture and value system should sufficiently correlate with those of the physician. A physician should learn everything possible about the practice make-up by observing practice operations, meeting owners, other employed physicians, staff and patients. Talking with colleagues unaffiliated with the group about its reputation and culture is highly recommended.

A physician may ask to follow one of the group's physicians around for a day. This experience will enable the physician to listen for patient comments that may reveal patient satisfaction, quality and continuity of care. The physician can discover first-hand what kind of system is in place to track patients' test results, how much paperwork the group's physicians have to do, and how the patient flow is managed. Also take advantage of this informal opportunity to ask the physician you are following about the practice's culture and problems as well as his/her own satisfaction and contentment within the practice.

Likewise, a practice hiring a new physician should consider whether or not the candidate fits the practice culture and what impact the candidate's presence will have on the organization. During the hiring process, the interviewer should ask open-ended questions designed to encourage the doctor to respond with in-depth answers that will reveal the physician's character, values, job expectations, and potential personal problems. The group should ask for and investigate references from previous employers and the physician's training program (if it is recent), contact hospitals where the physician previously held admitting privileges, confirm that licensure is current, and check the National Practitioner Data Bank (www.npdb-hipdb.hrsa.gov) for possible malpractice, licensure, or other adverse actions. Finally, a standard police check can provide added comfort in making the final selection.

Practice Economics and Growth

A physician should inquire about the financial condition of the practice as well. Practice stability is very important when deciding on long-term employment. Consider how long the practice has been in business, its expenses, revenue, debt, and financial future. If the financial health of a prospective employer is shaky, working conditions may be poor. Inquiring about the practice's accounts receivable, especially the gross or net collection ratio, will help provide a sense of the practice's collections success and solvency.

Along those same lines, practice potential and market potential are influential factors. Growth, income, status, and mobility are aspects of practice potential that must be carefully considered. Market potential both has to do with community factors (the ratio of physicians to population locally, population growth rates, local per capita income levels, and other demographic factors) and with the practice itself (reputation, size of patient base, number of new patients received annually, etc.)The physician and practice should also discuss the practice's referral network, ancillary providers, hospitals, and payers. To determine the payer mix one can ask the following questions.

- What percentage of revenue comes from Medicare, private insurance and self-pay? Also ask the percentages for capitation and deeply discounted fee for service plans?
- How reliant is the group on specific payers? (Excessive dependence on a few payers increases the practice's vulnerability to downward pressure on reimbursement rates.)Is the practice part of an IPA or PHO that negotiates provider agreements and fees for the practice?

The practice should be prepared to discuss these issues openly with physician candidates and to provide them the basic information they will need about the practice and community in order to make informed decisions.

Compensation

A key issue on the mind of anyone seeking employment is compensation. Although a salary may be negotiated during the hiring process, the compensation methodology for a particular practice usually is not negotiable. Many compensation models exist, including those based on individual productivity alone, share of practice income, salary guarantees, individual productivity less expenses, and multi-variable incentive bonuses tied to practice reimbursement and other objectives.

The practice and physician candidate should each consider how well the practice's compensation scheme matches the candidate's personality, working style, and preferences. For example, a physician wishing to be compensated for team effort may opt for a practice that pays physicians an equal share of practice income–but must recognize that no financial incentives will be paid for extra individual productivity. By contrast, a physician seeking a high degree of autonomy might look for a practice offering an "eat what you kill" arrangement in which physicians are paid strictly on the basis of their individual productivity, less assessments for the practice's overhead and expenses.

In considering feasible levels of physician compensation, it helps if both parties start from a common understanding of basic practice economics. The funds a practice has available to compensate physicians depend on the payments received from patients and payers for patient services rendered by the physicians. Contractual agreements with insurance carriers reduce these payment amounts to levels well below the practice's listed "charges" for the services (e.g., actual collections run about 70% of gross charges for general internists). From its actual receipts the practice must pay staff and other operating expenses (roughly 65% of receipts for general internists). The remaining funds are those available to pay physician benefits and salaries, plus any retained earnings, ownership income, capital investments, etc. These residual funds may increase or decrease depending on the prosperity of the community, the lucrativeness of insurance contracts, the practice's billing success and collections ratio, and its ability to hold down overhead expenses. Regardless of its internal economics, however, a practice must at least match the "going rate" for physician compensation in its geographic area, if it is going to attract and retain good physicians.

Negotiations

Some residents believe they have little choice but to accept "in toto" the contract as it is originally presented to them. Others make the mistake of thinking everything is negotiable. The truth lies somewhere in the middle and will vary depending on individual practice circumstances. While practice economics and the need to be fair to previously hired physicians may limit a group's flexibility, common negotiating ground usually can be found on the issues that are most vital to a reasonable physician.

The Art of Negotiating

Physicians should enter negotiations with a clear idea of what they want and what is minimally acceptable. The goal of negotiation is to create a win-win solution, not to win at the expense of the other party. A physician must negotiate whatever terms he or she feels are truly essential to job satisfaction. A fear that hard feelings might develop even before employment begins sometimes inhibits physicians from saying what's really on their minds. Neither a physician nor an employer will be well served by the physician accepting a position only later to become miserable due to contract terms he or she failed to address during the negotiations. Being forthright without being abrasive or unrealistic is therefore essential to the process.

It is wise for both parties to be creative and flexible in negotiations. A physician can introduce his or her ideas but must be able to accept modification of demands or requirements, since no one realistically can expect to get everything desired. While each party to a negotiation pursues their own interests, each should regard the other, not as a contestant, but as a collaborator in the search for overlapping objectives. Try to generate options that accommodate both sides. Search for an arrangement that assures both parties a fair measure of satisfaction.

Experts believe that the time for a physician to negotiate the best deal possible is the honeymoon period right after the group has made an offer to the physician. A physician however should keep in mind that the posture he or she adopts during the negotiating process will be discussed and remembered for a long time thereafter. Likewise, a physician can gain insight into the likely future relationship with the group from the nature of the give and take in the contract discussions.

Prior to offering a contract, the employer group should decide how flexible they are prepared to be during contract negotiations. Are they willing to make changes to the offer? How many changes and to what extent? The group should have a clear understanding among themselves about the issues on which they are prepared to bend in order to attract a good candidate. They should give clear guidance to the physician (or other practice representative) who will negotiate with the candidate. These instructions should include the specific salary range within which the group's representative is empowered to negotiate. The instructions should also make clear when the negotiator must return to the group for further guidance on particular contract elements.

Involvement of a Third Party

Since an employment contract is one of the most important financial decisions a physician makes, any misunderstandings can cause painful consequences. The contract offered by the group should be carefully reviewed or crafted by the group's attorney to be sure it protects the group's interests. Similarly the candidate physician should seek legal counsel to at least review the contract. Because certain aspects of physician employment are unique, it is important to select an attorney with previous health care experience. A knowledgeable health law attorney may be recommended by colleagues or by the local/state medical society or bar association. Such lawyers can help identify potential conflicts

and suggest alternative contract language. While the cost of hiring an attorney usually is money well spent, physicians must guard against relying so heavily on legal counsel that they do not fully understand the contract provisions with which they alone must comply once it is signed.

Some advisors recommend that a physician employ a consultant to help conduct the actual negotiations. A skilled negotiator can evaluate terms, re-draft contract language, and bring additional negotiating expertise to the table. The right consultant may also help the negotiations build a win/win agreement without creating discord. However, involvement of a third party lawyer or contract negotiator to help the physician can also introduce some tension in the relationship with the group, especially if the practice itself prefers not to employ such outside professional assistance. Since few employment situations absolutely require the added expense of hiring a third party negotiator, most physicians tend to rely on the free negotiating advice available from their attorney, colleagues, or even a search firm that introduced them to the opportunity.

Negotiating Tips for Physicians Seeking Employment

1. **Gather information and be prepared.** Find out as much about the practice in advance as you can. What questions can you anticipate from them? What do you want to know? Determine what you want to accomplish. Similarly the practice should obtain a CV, cover letter, and list of references from each candidate prior to scheduling interviews to screen out those candidates who may not fit the practice's criteria.

2. **Treat people with respect.** From the receptionist to the partners, show courtesy and consideration. It creates a great first impression.

3. **Negotiate from the perspective of mutual benefit and fairness.** Whenever you are seeking a concession, explain why it is fair. If it could benefit patients or the practice, point that out. Always have logical reasons for what you want and why you are asking for it. If it involves financial consequences, be prepared to consider giving up something else in exchange.

4. **Set priorities.** Before you come to the table, review, rank, and list critical factors. What is negotiable? What is not?

5. **Develop a strategy.** Consider how you will obtain your most important points. Are they easy or difficult for this practice to offer? Which other points are easy for the practice to offer or concede? Start with an easy point to negotiate. Get a feel for the process and the people involved. Tackle your hardest issue midway, and conclude with light ones.

6. **Return to unresolved issues after most of the bargaining is done.** At that point, added pressure to find common ground creates a greater bargaining base for both parties, because the success of everything you've done so far hinges on resolving these few remaining issues.

7. **Get it in writing.** When you negotiate a change in the contract, make sure that change is in writing, not simply a verbal agreement.

Understanding the importance of point number 7 is critical. Every material aspect of the contract on which the parties agree should be recorded in writing. Verbal pledges can be made in good faith, but over time memories grow short, details blur, and/or circumstances change. The person making the pledge may leave the group. Oral pledges are hard to prove after the fact. Most employment contracts indicate that only the commitments specified in the contract are considered binding.

Understanding the Contract

The contract defines the employment relationship between the physician and practice. Even if an attorney or professional consultant helped negotiate or review the contract, ultimately the decision to accept the offer rests with the physician. There are specific terms and benefits the contract should address before either party signs on the dotted line.

Compensation and Benefits Salary and Incentive Pay

Salaries vary widely depending on geographic location, specialty, and years of experience. It is up to the physician to convince an employer that he or she will be sufficiently productive and cost-efficient to justify the desired level of compensation. It is very important for a physician to fully understand the compensation formula the group will use to calculate salary and incentive pay.

Pure salary is unusual beyond the first year of employment. Therefore the methodology and variables for calculating incentive payments usually determine the attractiveness of the offer. Most of the incentives that will be tied to productivity are variously defined in terms of RVUs, charges, net or gross collections. Sometimes other performance variables added to reflect patient satisfaction, utilization, quality improvement measures (especially for hospitalists), "citizenship," etc. Too many incentive criteria makes for confusion and frustration on the part of physicians. It is important to analyze which of the incentive variables may, in part, be beyond the physician's control. For example, "net collections" are influenced by the contracts as well as the effectiveness of the group's billing and collections staff-- so how good are they?

While compensation formulas vary considerably, each practice ultimately must agree to provide an overall compensation package that is sufficient to attract and retain its doctors. It is wise for a physician to compare compensation offers to industry norms in order to determine whether pursuit of a higher salary or better bonus structure is worth further negotiation. If a practice is located in a low cost of living community, it should point out and document this factor to perspective candidates, especially when the group's salary structure is on the low side compared to other parts of the country.

Benefits

Benefits play a key role in determining the value of an offer and may include, but are not limited to: health, dental, vision, and malpractice insurance; professional membership dues; CME reimbursement; vacation/sick leave; plus retirement and disability plans. Also sometimes included are enticements such as student loan repayment, signing bonuses, and relocation expenses.

A group should consider offering a signing bonus if the practice is located in a remote area or is facing stiff recruiting competition from other groups in town. Groups usually also pay a percentage of the new hire's relocation expenses or provide a fixed moving allowance.

A candidate may wish to consult a tax advisor to determine the tax consequences of alternative compensation packages involving significantly different elements.

Maternity and family leave are examples of other valuable benefits. Male and female physicians can benefit from the Family and Medical Leave Act of 1993, which allows up to 12 weeks of unpaid leave per year for specified family and medical reasons, such as the birth of a child. However, the act applies only to companies that employ 50 or more people within a 75-mile radius. (See ACP's separate guide "Part-Time Employment for Physicians" for more information on maternity leave options.)

Ownership/Partnership

A physician will want to determine whether the employment contract addresses or allows for future ownership opportunities. These provisions are sometimes stated, sometimes implied, as ownership is often mentioned verbally or covered in vague terms. The actual terms of the ownership buy-in will be stipulated in separate "buy-sell" and/or "partnership" agreements, usually not signed until ownership takes place in subsequent years. Thus a physician planning to stay in a practice more than a few years should make sure that any implied ownership options or assurances discussed during the original employment negotiations are clearly spelled out in the written employment contract. Such provisions may include stipulations regarding the circumstances under which the physician may be considered for or automatically offered partnership, the timing and method by which the physician may acquire ownership in the practice, how the proposed purchase price will be determined, and the period over which the purchase price will be paid. Since large front-loaded buy-ins tend to scare off potential candidates, the trend today is toward smaller front loaded buy-ins, e.g., $5,000-10,000, followed by compensation off-sets for a specified number of subsequent years. The stipulated purchase price often is based on a percentage of the practice's hard assets, accounts receivable, and occasionally goodwill.

If a practice is unwilling to include an ownership commitment and detailed provisions in the initial employment contract, it may be willing to define the conditions under which ownership will be considered later. If a group requires an associate to work for a specific length of time before discussing a buy-in contract, a new hire should ask when to expect such partnership consideration to take place, the criteria for selection, and what the ownership terms might be, generally speaking. The candidate should also ask whether there have been associates who opted not to join or who were not invited to join. The practice should also explain the compensation arrangements for owners, including whether there is any income differential between junior and senior partners. Some groups divide net income equally once a physician becomes a partner. Other groups employ a standard salary formula, such as a base salary plus a productivity incentive that divides the net income remaining after paying practice expenses and physician compensation. As a full practice owner, a physician conceptually shares equally in the practice's net income and governance. However, a new partner's actual impact on decision making may be more limited, both because senior owners can out-vote any individual physician, and one physician often is responsible for the daily management of the practice.

In considering the value of ownership, it is important to recognize that holding equity in a physician practice is unlike owning stock in a commercially traded company. It is an "illiquid" asset with limited market value; yet it imposes an obligation on the owner to help absorb any income shortfalls the practice may experience and to perform certain additional owner duties on behalf of the practice. Thus a physician considering partnership should weigh the potential income gains and personal satisfaction of exercising governance against the added risk and ownership obligations entailed.

Outside Activities

An employment contract should specify whether and under what circumstances the physician is allowed to work outside the practice, including such non-patient care activities as research, publishing articles, teaching, consulting, and directorships. Work outside the group that benefits the group's image or reputation may be compensated through bonuses and honoraria. The employment contract, however, needs to specify explicitly whether money earned from outside sources is to be considered private compensation paid directly to the individual physician or more typically as part of the group's overall income. If treated as practice income, the employment contract should indicate whether and how the physician will be credited for these outside services within his/her compensation formula. If the physician will be allowed to retain income derived from any outside activities, the contract either should

identify the specific activities in question or state how they will be identified in the future. Groups usually preclude physicians from performing outside services that will interfere with their ability to fully satisfy their practice obligations.

Contract provisions sometimes also require a physician to give up any royalties or ownership claims on computer programs or medical devices he or she may have invented while employed by the practice.

Duties and Requirements

The contract agreement should clearly state whether a physician is considered a full or part-time employee, whether the physician will be required to perform administrative or teaching duties, and share in after-hours call schedules. A physician should inquire about the length of the workweek (hours) and how many patients are expected to be seen per hour, per day, or per week. It is also important to define working relationships, such as to whom the physician reports, who reports to the physician, and the physician's role, if any, in hiring support staff.

In certain procedure-intensive specialties, it is extremely important to find out the approximate number and type of procedures expected to be performed. Similarly, a hospitalist will want to learn as much as possible about the group's contract to provide hospitalist services, since this agreement will largely determine the physician's duties and objectives.

A practice should inform the potential hire of any performance evaluation process that will be followed and the potential positive or negative effects such evaluations can have on the physician.

Part-time physician employment has become quite common in recent years. (For additional detail see ACP's "Part Time Employment for Physicians" guide.) The employment contract for a part-time physician should address at least the following special circumstances associated with such employment:

- Work days and hours per week.
- Method of calculating compensation for less than full-time work.
- Compliance with office policies and procedures.
- Shared call responsibilities.
- Work space and support staff to be provided.
- Possible provision to terminate the employee if the part-time arrangement proves unsatisfactory.
- Any negotiated or required adjustments to the standard physician benefit package. (Check to determine what benefits a part-time employee is entitled to under relevant federal and state laws.)

Restrictive Covenants & Non-Solicitation Clauses

Restrictive covenants, often called non-compete clauses or non-competition agreements, can be one of the most important yet least understood and potentially most contentious aspects of an employment agreement. Following termination of employment, these clauses seek to prohibit the physician from practicing medicine for a specified period of time in a specific geographical area. The objective of the covenant is to prevent departing physicians from damaging the practice by taking with them a significant number of patients on which the group's economic well-being depends. Often the group itself originally had acquired or helped the physician to attract these patients. Usually a companion "non-solicitation" clause prohibits the departing physician from actively seeking to attract patients, employees, and health plan contracts away from the former practice.

Consultants advising physicians on contract negotiations often recommend that they try to limit the covenant's geographic restriction to a few mile radius from the office site where the physician actually will be working and to keep the time restriction to no more than 1-2 years; otherwise, the physician could someday be forced to choose between relocating to an entirely different geographic area or going without employment for an extended period of time. The two parties should strive to negotiate a restrictive covenant that is reasonable from both points of view, non-punitive, and seeks only to legitimately protect the practice against damage to its patient base.

The employment agreement should also address the specific "remedies" for violating a restrictive covenant or non-solicitation clause. One enforcement option is for the group to obtain a court injunction: a ruling by the court prohibiting, or "enjoining," the departed doctor from practicing within the restricted area, or violating the non-solicitation clause. A more common remedy is for the employment contract to require the physician to pay specified monetary damages if these contract provisions are violated. Such compensation sometimes is designated as an acceptable means by which the physician may obtain legal release from the restrictive covenant.

The degree of enforcement by authorities of restrictive covenants varies considerably from state to state, with some states going so far as to outlaw them as anti-competitive and illegal restraints of trade, while courts in other states will enforce them as contractual business obligations but only if the restrictive provisions meet certain tests of "reasonableness" with regard to the geographic and time limits. But physicians should not make the mistake of ignoring the covenant as a pro forma matter, since it can ensnare both parties in expensive and disruptive litigation later on. Both parties should investigate enforceability in the state where the practice is located and negotiate reasonable limits in the contract language.

Contract Term

Employment contracts should specify both a starting date and an ending date. Some contracts are written for one year and are automatically renewable while others last longer and have a specific renewal process.

Termination

Termination clauses in a contract may include both termination without cause and termination for cause. In some cases the right to terminate the contract without cause is granted only to the employer, thus giving the group unilateral power. Advisors usually recommend that physicians negotiate to make such rights reciprocal, or at least limit the practice's unilateral termination rights to the first year of the contract. More commonly, contracts state that termination without cause may be invoked by either party following a specified period of advance written notification, such as 90 or 180 days.

Clauses authorizing termination for cause typically are unilateral but the causes should be reasonably and narrowly defined. Loss of medical license or federal DEA registration, termination or suspension of medical staff privileges, violation of a material provision of the agreement, a felony conviction, use of illegal drugs or abuse of controlled substances are normal examples of cause. For some types of cause, a physician may negotiate a provision requiring that the employer provide advance written notice of the complaint that, if uncorrected, will lead to termination, thus allowing the physician adequate time either to change the objectionable behavior or to find new employment.

The practice may include a provision for severance pay under some circumstances. If the physician is terminated without cause during the first year of employment, the practice may agree to waive required repayment of relocation funds—due to the undue hardship on such a physician.

Gap/Tail Insurance

A clause regarding professional liability insurance coverage after the employee has left the practice should be included in the contract. Most employers provide "claims-made" medical malpractice coverage for employee physicians during the time the physician is on the practice's payroll. However, once the physician leaves the practice, the employer will delete the employee from the policy. Thus this kind of policy generally will cover a claim against the physician employee made during the term of employment, but it will not cover claims arising thereafter.

To insure against this gap in coverage, "tail" insurance can be purchased by the physician employee. Appended to the original claims-made policy, the "tail" provides coverage after the physician's termination for any events that may have occurred during his/her period of employment. Sometimes a provision is negotiated in the employment contract for the employer to pay "tail" coverage premiums if the employer terminates the physician without cause, since this coverage could be costly. If, however, the physician is terminated for cause, the contract often stipulates that the physician employee must pay all or a portion of the tail premiums.

Assignability

An assignability clause should be written into the contract to address what will happen in the event of a potential group acquisition, consolidation, or merger. If ownership of the practice changes significantly and the employment contract is assignable, the physician's contractual obligations continue as before. However, if the contract is "non-assignable," the physician is freed from his or her obligation to continue working for the new group – the trade-off being that a physician who prefers to stay with the group must then negotiate and sign a new contract, the terms of which might turn out to be less favorable than the previous contract. If an employment contract provides no assurance of continued employment following an ownership change, the physician may wish to negotiate for a cash settlement or release from the restrictive covenant in the event he or she gets 'bumped' from the practice as a result of the change.

Conclusion

It has been said that signing an employment contract is one of the most important financial decisions a physician makes during a career. Contract language is critically important but can be perplexing to someone without legal training, thus causing the negotiations to be both exciting and intimidating. Consequently, both the physician and the practice may consider engaging attorneys to help them fully understand the contract terms and provisions. Ultimately, however, the process and decisions must be controlled by the principal parties themselves. To assist practices and physicians in successfully navigating this employment process five documents are attached to this guide.

Sample Employment Contract. For background purposes, this hypothetical document illustrates language typically contained in a basic employment contract. Because requirements vary from practice to practice and legal provisions from state to state, the document cannot serve as a model contract; nor should it be relied upon for valid legal language. If a practice wishes to borrow language from the document, any such language should be reviewed by a qualified attorney in that state before being

incorporated into an actual contract.

Self-Assessment Tool. While primarily intended to assist physicians in examining their own preferences and help identify the kinds of practice opportunities they should seek, practices may also find this a helpful list of factors to consider in determining whether a good "fit" exists between the candidate and the practice.

Position Assessment Comparison. This check list of topics will help the physician gather information and make notes on subjective and objective factors so he/she may later assess and compare alternative practice opportunities, both against each other and against the physician's own priorities.

Physician Compensation and Benefits Worksheet. The Worksheet may be used by physician candidates to compare the objective factors of competing employment offers, and used by practices as a checklist of possible benefits to offer candidates.

Time-Table Prior to Practice Entry. This time-table provides a several month schedule of activities that physicians leaving residency and others normally require to find, select, negotiate, and start a new position. An employing practice should assist the physician with activities in the latter stages of this schedule, both to assure a good match and a good start for its new physician.

Sample Physician Employment Agreement

THIS AGREEMENT, made and entered into as of this _____ day of , 20___, by and between, _____ _____("Employer"), and _____ ("Employee").

STATEMENT OF BACKGROUND INFORMATION

1. Employer is a professional corporation with medical offices located in the District of Columbia.

2. Employee is a physician licensed to practice medicine in the District of Columbia and the State of Maryland.

3. Employer desires to employ Employee as a practicing internal medicine physician, and Employee desires to be employed in such capacity, in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants, agreements and conditions hereinafter set forth, the parties hereto agree as follows:

STATEMENT OF AGREEMENTS

1. Employment. Employer hereby employs Employee as a practicing physician, and Employee hereby accepts such employment subject to the supervision of Employer and otherwise in accordance with the terms of this Agreement.

2. Responsibilities of Employer:

2.1 **Annual Compensation.** Employee shall be paid an annual salary of

Ninety-Five Thousand Dollars ($95,000.00), plus fringe benefits as set forth in Paragraphs 2.3, 2.4, 2.5, and 2.6 below ("Fringe Benefits"). Employee shall be paid annual salary on a monthly basis.

2.2. **Incentive Compensation.** In addition to the annual salary and Fringe Benefits provided for in Paragraph 2.1 herein,' Employee shall receive annual Incentive Compensation in cash beginning August 15, 2xxx, equal to forty-five percent (45%) of annual collections from patients and third party payors generated from Employee's professional fees for any collections exceeding Two Hundred Eighty Thousand Dollars ($280,000.00).

All monies, including monthly capitation received by the Employer for health maintenance organization (HMO) enrollees who have been assigned to the Employee or whose care has been exclusively managed by Employee in any given month, shall be included in annual collections from third party payors generated by the Employee.

Any annual Incentive Compensation payable to Employee pursuant to Section 2.2 herein, shall be paid no later than November 15 of each year benefits:

2.3. **Benefits.** Employer shall provide Employee with the following benefits.

(a) Group term life insurance in the face amount of $l32, 000

(b) 80% of group health insurance coverage selected by Employer and approved by Employer; and

(c) Individual disability insurance. Employer shall pay premiums for an individual disability

insurance policy selected by Employer for an aggregate disability coverage of not more than 60% of current annual salary as described in Section 2.1 herein to be reduced by any amount of enforced coverage by the Employer.

(d) Right of Employee to participate in a 401 K or other pension plan set up by the Employer.

Employee's rights with respect to such benefits shall be subject to: (1) the provisions of the relevant contracts, policies or plans providing such benefits, and (2) the right of Employer to amend, modify, or terminate any such plan with respect to all classes of employees covered by a given benefit.

2.4 **Vacation and Personal Leave.** Employee shall be entitled to the following paid leave each year during which the Employee's compensation shall continue to be paid in full:

(a) Employee shall receive three (3) weeks per year of vacation. Employer and Employee shall agree upon the period(s) of vacation to be taken each year. Vacation leave may not be accrued if not taken.

(b) Up to fourteen (14) days of sick leave each year with accrual to a maximum of twenty-one (21) days if carried over to subsequent years.

(c) One week of CME leave

(d) Administrative leave as approved by Employer for extraordinary events including, but not limited to, studying for, or taking of medical board or certification examinations, family emergencies and funerals.

2.5 **Reimbursable Expenses**. Employer shall reimburse Employee for the following approved expenses incurred during the course of Employee's employment:

(a) Fees for admitting staff privileges at Hospital, Hospital Center, Hospital for Women, University Hospital and other hospitals designated by Employer ("Designated Hospitals"). Membership fees in any independent practice association or other care delivery system in which Employer elects to participate as a provider.

(b) Membership fees for the following medical societies: Medical Society of the District of Columbia, and the American College of Physicians, and the District of Columbia Chapter of ACP.

(c) Fees for the following medical journals, The New England Journal of Medicine, and the Annals of Internal Medicine.

(d) Five (5) days of CME expenses, including travel, room and board and registration, not to exceed Two Thousand Dollars ($2,000.00).

(e) Professional licensing fees for the State of Maryland and the District of Columbia.

(f) Other necessary expenses as approved by Employer.

Payments shall be made to Employee for reimbursable expenses upon submission of applicable bills, receipts or other documentation required by Employer and submitted in proper expense report format as set forth by Employer.

2.6 **Professional Liability Insurance Agreement.** During the term of this Agreement, Employer shall obtain and maintain the liability insurance for the practice of medicine by Employee on behalf of Employer. Such insurance shall be for the same amount as provided for all physician employees for Employer who are within the same specialty as Employee.

2.7 **Support Services.** Employer shall furnish to Employee all of the necessary support services, including but not limited to, equipment, facilities, supplies, medical support employees, secretaries and other personne1 reasonably needed by Employee to perform Employee's obligations created by this Agreement. The cost of providing these support services shall be borne solely by Employer.

2.8 **Employer's Authority.** Employer shall exercise direction over and give support to Employee in regard to standards, policies, record keeping, treatment procedures, and fees to be charged; such direction and support shall not interfere with the normal physician-patient relationship nor be in violation of acceptable medical ethics. Employer shall have the right to determine which staff person(s) will render support to Employee and which physician employee will render services to a patient of the Employer.

Employer shall have final authority over acceptance or refusal of any patient. It is understood and agreed, however, that Employer shall discuss the refusal of patients with Employee.

2.9 **Stock Purchase.** Employer shall provide employee with the right to purchase shares of stock in Employer subject to the terms of an applicable stock subscription agreement and a shareholders agreement, upon satisfaction of the following conditions:

(a) Employee has completed a minimum of two and one half years of continuous employment by Employer:

(b) Employee has generated collections from his professional fees which exceed Two Hundred Ninety Thousand Dollars ($290,000.00) for the first year of employment and which exceed Three Hundred Thirty-three Thousand Dollars ($333,000.00) for the second year of employment.

(c) Employee is certified by the American Board of Internal Medicine (ABIM)

(d) Employee is found by Employer to be compatible with Employer's Practice philosophy

2.10 **Employment Outside the Practice**: Employee has the right to all funds generated by the Employee in the performance of non-patient care activities. All employment outside the Employer's physician practice must be approved by the Employer, which approval shall not be unreasonably withheld.

3. Responsibilities of Employee

3.1 **Professional Services.** During the term of this Agreement, Employee shall devote full-time, all his or her professional time and efforts to and for the benefit of Employer and shall not, directly or indirectly, render professional, medical, managerial or directive services to any person, whether or not for compensation, except as an Employee of Employer, unless Employee shall first have obtained the written consent of Employer. Passive and persona1 investments and the conduct of private business affairs by Employee which are not inconsistent with the restrictions of this Paragraph shall not be prohibited hereunder. Employee shall be committed to enhancement of Employer's practice and shall use his or her best efforts to further the goals of and to promote the medical practice of the Employer. The expenditure of reasonable amounts of time for teaching, personal, and charitable and professional activities shall not be deemed a breach of this

Agreement provided such activities do not materially interfere with the services required to be rendered to Employer hereunder.

3.2 **Standards of Practice** Full-time practice is defined as a minimum of (30) scheduled hours per week at the Employers offices. Employee shall have on-call responsibilities one week per month. Holiday assignments are to be rotated equally between Employee and other physicians of the Employer. Employee shall devote his or her utmost knowledge and best skill to the care of Employer's patients, which are entrusted to him or her and shall perform such other duties as may be assigned to him or her by Employer. Employee understands that all patients are accepted by Employer regardless of their race, color, national origin, handicap or age. Dismissal of an established patient from continued care must be justified by a cause for dismissal due to patient noncompliance with physician directives or office procedures, and must be discharged in accordance with established legal protocols.

3.3 **Ethical Conduct.** Employee shall engage in the practice of medicine in accordance with the Principles of Medical Ethics of the American Medical Association, and the customs and rules of ethical conduct prescribed by any Designated Hospital.

3.4 **License.** Employee shall maintain an un-restricted license to practice medicine in the District of Columbia and the state of Maryland. Originals must be presented to Employer and photocopies of all required licenses shall be provided to Employer.

3.5 **Hospital Privileges.** Employee agrees that Employee shall use best efforts to obtain and continue to maintain' admitting staff privileges at the Designated Hospitals. Employee's duties and responsibilities include, but are not limited to hospital rounds and other duties required of physicians attending hospitalized patients.

3.6 **Professional Membership.** Employee shall be required to be a member of the District of Columbia Medical Society.

3.7 **Medical Staff Policies and Procedures.** Employee shall abide by all policies and procedures for the medical staff as may be established from time to time by Employer.

3.8 **Billing.** Employee agrees and acknowledges that Employer alone has the right to bill and receive payment from patients and third-party payors, including all government-sponsored programs, for physician services rendered by Employee hereunder, and Employee shall not bill any patient or third-party payor for such services. All income or fees for physician services rendered by Employee shall belong to, and be the property of, the Employer. Employer will use best efforts to bill for services no later than five (5) working days after Employee has provided information necessary to complete such billing and in the case of rebilling, five (5) working days after negotiation of rejection of original billing information. Paragraph 3.8 herein shall survive termination of this Agreement.

3.9 **Surrender of Books and Records.** Employee acknowledges that all lists, books, records, and any other materials owned by Employer or used by it in connection with the conduct of its business, shall at all times remain the property of the Employer, and that upon termination of employment hereunder, irrespective of the time, manner or cause of said termination, Employee will surrender to Employer all such lists, books, records, and other materials. Paragraph 3.9 herein shall survive termination of this Agreement.

3.10 **Use of Employee's Name.** Employer shall have the right to use Employee's name in connection with Employer's marketing and contracting activities, and in any oral or written communication with patients or third-party payors.

3.11 **Medical Records.** Employee shall prepare and maintain for the benefit of Employer medical records for patients in accordance with accepted standards of practice in the community, applicable laws regarding confidentiality of medical reports, the policies and procedures established by Employer and the terms of any third-party payor agreements. Employee acknowledges and agrees that all such medical records are the property of Employer. To the extent permitted by law, Employee shall cooperate and communicate freely with other health care providers who provide professional services to patients of Employer.

3.12 **Reimbursement Contracts.** In the event that Employer elects to participate as a provider in an HMO, PPO, IPA or other care delivery system, then Employee shall also be required to join.

3.13 **Relationship with Patients.** Employee shall not during the term of this Agreement:

(a) Directly or indirectly induce or advise any patient of Employer to withdraw, curtail, withhold, or cancel the patient's relationship with Employer; and

(b) Directly or indirectly disclose to any person, firm, corporation or any other entity the names or addresses of any patients of Employer.

3.14 **Non-Competition Terms.** Employee agrees and understands that Employer would suffer great loss and damage if for a period of two (2) years immediately following the termination of employment hereunder, for any reason whatsoever, Employee should perform professional services for patients seen by Employee while employed under this Agreement or perform or solicit to perform professional services for any patients within five (5) miles of the Employer's office.

By reason of the foregoing, Employee expressly covenants and agrees that he or she shall not for a period of two (2) years immediately following the termination of employment under this agreement, for any reason whatsoever, perform professional services for any patients within five (5) miles of the Employer's office.

Nor during the same two (2) year period following employment termination shall the Employee solicit to perform professional services for patients formerly seen by Employee while employed under this Agreement, regardless of where said patients may reside.

If any court shall determine that the duration or geographical limits of any restriction contained in this paragraph are unenforceable, it is the intention of the parties that the restrictive covenant set forth herein shall not thereby be terminated, but shall be deemed amended to the extent required to render it valid and enforceable, such amendment to apply only with respect to the operation of this paragraph in the jurisdiction of the court which has made such adjudication.

Employee acknowledges that the restrictions contained in paragraph 3.15 of this Agreement are reasonable and necessary protection of the legitimate interests of Employer, and any violation of them would cause substantial injury to Employer, and that Employer would not have entered into this agreement with Employee without receiving the additional consideration of Employee's binding him/herself to said restrictions. In the event of any violation of the said restrictions, Employer shall be entitled in addition to any other remedy, to preliminary and permanent injunctive relief without the necessity of proving actual damages.

The above Non-Competition terms will not be enforced if Employee is terminated by the Employer without cause.

4. Term and Termination

4.1 **Term.** This Agreement shall commence as of the date hereof, and shall continue for' a period of one (1) year unless sooner terminated pursuant to this Agreement. Thereafter, this Agreement shall be automatically renewed for succeeding terms of one (1) year unless either party shall, at least sixty (60) days prior to the expiration of any term, gives written notice of their intention not to renew this Agreement.

4.2 **Termination.** This Agreement shall be terminated upon the happening of any of the following:

(a) Whenever Employee shall not be duly licensed or otherwise legally authorized to practice medicine in the District of Columbia and/or the State of Maryland;

(b) Death of the Employee or the determination by either the Board of Directors of Employer or the Courts, of the incompetence of Employee;

(c) Termination of Employer's medical group practice;

(d) At any time when there is not medical malpractice insurance in full force and effect with respect to Employee.

(e) At Employer's option, if Employee shall be disabled for one hundred and eighty (180) days or more, provided that such option shall be exercised in writing, delivered to the Employee, and shall be effective on delivery;

(f) The suspension, expulsion or any other disciplinary action finally taken by the District of Columbia, and/or Maryland Board of Medical Examiners or equivalent regulatory body.

(g) At the Employer's option, if Employee failed to obtain or continue to maintain privileges on at least two of the medical staffs of the designated Hospitals;

(h) Employee bills third party payors or accepts funds from either patients or third party payors for Employee's own use. Employee's failure to rectify a breach of any material term which is not specifically enumerated in paragraph 4.2 hereof, within thirty (30) days after written notice thereof from Employer.

(i) Conviction of a felony crime.

(j) Other actions determined by a neutral arbitrator to endanger the professional standing of the practice.

(k) Notwithstanding any of the provisions of this Agreement, upon ninety (90) days prior written notice by either Employee or Employer to the other.

4.3 **Reimbursement of Monies Following Termination**. Employee will not be responsible to reimburse the Employer for any monies previously given or spent on Employee's fringe benefits, after termination has occurred.

5. General Provisions

5.1 **Notice.** Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by registered or certified mail, return receipt requested, postage prepaid, to the addresses set forth herein. Either party may, by notice given as aforesaid, change their address for all subsequent notices, except that neither party may require notices be sent to more than two addresses. Notices shall be deemed given when mailed in the manner provided in Section 5.1 hereof.

5.2 **Severability.** Should one or more of the provisions contained in this Agreement for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement. Such invalid, illegal or unenforceable provision shall, to the extent permitted by law, be deemed amended and given such interpretation as to achieve the intent of this Agreement.

5.3 **Waiver**. Any party hereto may waive any right under this waiver Agreement without invalidating the Agreement or waiving any other rights hereunder.

5.4 **Captions**. The captions used herein are for convenience only and are not a part of this Agreement and do not in any way limit or amplify the terms and provisions hereof.

5.5 **Non-Assignability**. This Agreement for personal services shall not be assignable, except to the parties hereto.

5.6 **Arbitration of Claims**. The parties agree that any claim arising from an alleged violation of this Agreement that is not resolved by the parties within ten (10) days of notice of violation shall be submitted to binding arbitration. If alleged violation is not resolved, each party shall designate an arbitrator and notify the other of that designation within twenty (20) calendar days after the notice of violation. At one time of such designation, each party shall deposit one hundred dollars ($150) in a special account at a mutually agreed upon bank, to be applied to the expenses of arbitration and to the fees of the neutral arbitrator who shall be someone selected by the two (2) arbitrators appointed by the Employer and Employee Expenses of arbitration shall be those approved by the neutral arbitrator. Fees and expenses of arbitration beyond this initial two hundred dollar ($300) deposit shall be paid or provided for by the parties on demand of the neutral arbitrator, one-half (l/2) by Employer and the-half (l/2) by Employee, except that if the arbitrators award one party damages in excess of the highest written settlement offer submitted by the other party prior to the hearing, then the awarded party shall recover, in addition to the damage award, all arbitration fees and expenses he/she has paid.

5.7 **Governing Law**. This Agreement shall be interpreted in the laws of the District of Columbia.

5.8 **Entire Agreement**. This Agreement, and any attachments incorporated herein, constitute the entire Agreement between Employer and Employee with respect to the subject matter hereof and supersede all prior offers and negotiations, oral and written. This Agreement may not be amended or modified in any respect whatsoever, except by an instrument in writing signed by Employer and Employee.

INTENDING TO BE BOUND, the parties hereto have caused this Agreement to be duly executed and delivered as of the day and year first above written.

By: _____
Address: _____

By: _____
Address: _____

Self-Assessment Tool

How would you like to practice? (Designate first choice, second choice, etc.)

Single Specialty Group
Multi-Specialty Group
Hospitalist Group
Hospital Employee
Partnership
HMO
Solo Practice
Association
Government Agency
Academic Institution
Locum tenens
Other (urgent care, outpatient, student health center, etc.)

Ideal practice size:_____ Acceptable practice size:_____

Working Hours: _____ Less than 40 hrs/wk
_____ 40-48 hrs/wk
_____ 48-56 hrs/wk
_____ More than 56 hrs/wk

Professional/Practice Components (What percent of time would you like to assign to each of the following activities in position?)

_____ % Patient Care
_____ % Administration / Management
_____ % Research
_____ % Teaching
_____ % Publications
_____ % Speaking
_____ % Other
100 % Total

Compensation (What general level do you expect in your first practice?)
_____ $50,000 - $75,000
_____ $75,000 - $100,000
_____ $100,000 - $125,000
_____ $125,000 - $150,000
_____ $150,000 - $175,000
_____ $175,000 - $200,000
_____ $200,000 - $225,000
_____ Over $225,000

Strengths, Skills, Opportunities, and Threats to Career Growth

Strengths (List top three strengths that you possess.)
1. _____
2. _____
3. _____

Skills (List top three skills that you enjoy using and that produce high performance.)

1. _____
2. _____
3. _____

(List three skills you have and can perform well, but do not particularly enjoy. Next to each, list the aspect that makes them less desirable. For example, good attention to administrative details – not particularly challenging or creative.)

1. _____
2. _____
3. _____

Opportunities (List top three activities / skills you enjoy doing, but where you could improve your performance.)

1. _____
2. _____
3. _____

(List three activities that you do not do well, but are interested in improving, e.g., management responsibilities or learning about different types of managed care systems and plans.)

1. _____
2. _____
3. _____

Threats to Career Growth (List three activities that you do not do well and do not value their importance, although others have indicated they are important. Next to each list why others consider them to be important, e.g., computer programs – managing the business side of a practice and technology importance in the coming years.)

1. _____
2. _____
3. _____

Opportunity Assessment Tool

Professional Considerations (For each opportunity rank the following as good, fair, or poor)

Opportunities for your specialty
Hospital privileges (opportunities for first choice hospital)
Ancillary services available
Office space and location
Practice colleagues' reputation
Local and state medical associations
Community size (patients, employers in the area)
Referral sources
Types of insurers
Career advancement opportunities

Personal Considerations

Climate
Geographic location
Size of community or its economy base
Family / relatives proximity
Housing / cost of living
Crime rate
Recreational opportunities
Culture
Transportation systems
Children's education
Other family considerations

Market Conditions

Who are the major players?
How is the market affecting practices?
What is the market capacity for your credentials?
Who is the competition?

How will I feel about practicing medicine here?

Physician Compensation And Benefits Worksheet

What is base pay?	$	Does it meet your range?	☐ Yes	☐ No
If not at the high end of your range, what are compensating factors?				
If it is at the high end of your range, are there expenses you will assume, e.g., healthcare coverage, parking, and professional dues?				

Is there a signing bonus?	☐ Yes	☐ No	Is there an annual bonus?	☐ Yes	☐ No

How is annual bonus determined?

When is it paid?

What is the partnership potential?

May you accept other income from speaking engagements, authorships, etc.? Yes ☐ No ☐

Which Sources?

Is there a restrictive covenant? Yes ☐ No ☐

Length of time?
Geographic area?

What benefits are included?	Yes	No
Health Insurance		
Policy/Company _____		
Coverage (single/family) _____		
Cost per month $_____		
Out-of-pocket max. $_____		
Life Insurance		
Policy/Company _____		
Face Value _____		
Optional for dependents?		
Dental Insurance		
Policy/Company _____		
Coverage (single/family) _____		
Cost per month $_____		
Short term Disability		
Benefit begin _____		
% Of Pay _____		
Continues for (# days or weeks)		
Long-term Disability		
Benefit begins _____		
% of Pay _____		
Continues for (# days or weeks)		

	YES	NO
% Of Pay		
Continues for (# days or weeks)		
Pension Plan		
Defined benefit Company match _____		
Defined Contribution Company match _____		
Vesting schedule # of years to 100%		
What benefits are included?		
401 (k) or other Retirement Savings		
Vesting schedule: # of years to 100% _____		
Company match: Percentage?		
Profit Sharing		
Payment of Student Loans		
Percentage or Dollar Amount		
Professional Dues and Licensing		
List Organizations and Dues: _____		
_____		
CME Allowance		
Auto Allowance		
Cell Phone Expenses		
Malpractice Insurance		
Policy		
Occurrence/Claims Made _____		
Coverage Limitations _____	Yes	No
$ _____ Individual		
$ _____ Aggregate Annual Premium $_____		
Tail Coverage		
Previous Carrier		

Non-financial benefits:		
Vacation Pay in Days _____# of days		
Sick Pay in Days _____# of days		
CME/Prof. Dev. Days _____# of days		
Family Leave _____# of days		
Office Physical Environment		
Attractive		
Adequate for Service		
More than Adequate		
Practice Culture		
Share your values: Quality? _____ Integrity? _____ Cooperation? _____		
Relations with Other Physicians - _____Easy _____ Challenging _____ Difficult		
Relations with Staff - _____Easy _____ Challenging _____Difficult		
Relationship with Admitting Hospitals		
Which Ones? _____		

Timetable Prior to Practice Entry

12 – 16 months prior to practice

1. Evaluate your professional and economic needs and desires (location, climate, practice type, desired salary, etc.)
2. Begin contacting personal sources (mentors at you residency, physicians in the community, etc.) for information about upcoming practice opportunities
3. Obtain demographic information on population, economic, employment, and health plan trends in areas where you might wish to locate.
4. Utilize leads and assistance provided by recruitment websites, hospitals, state medical associations, specialty societies, and recruiting firms to begin sending resumes and applying for specific employment opportunities – concentrating on your preferred geographic areas.

6 – 10 months prior to practice

1. Select one or more preferred areas where you would like to practice and begin the interviewing process, if you have not already done so.
2. When interviewing, make sure all you questions are answered, especially issues such as salary, productivity or profit sharing, partnership duties, fringe benefits, and work procedures.
3. Obtain information about the area's average income for your specialty, partnership arrangement trends, and opportunities available. State medical societies can help you obtain this information.
4. Evaluate area real estate and quality of life factors, especially if you would be moving to a new community.
5. When an offer is made, carefully review and negotiate the employment contract provisions, with the assistance of a knowledgeable health care attorney.
6. After accepting a position, inform the State Licensing Board of any proposed address change.
7. Obtain narcotics license from the Department of Justice Drug Enforcement Agency.
8. Apply for hospital staff privileges. Attend a grand rounds at the local hospital.
9. Make sure that the practice has taken the formal stems needed to add you to their provider agreements with local health plans.
10. If moving to a new community, begin the search for a home and the community support arrangements your family will need for a smooth transition (schools, professional services, religious, and other relationships.)

3 months prior to practice

1. As appropriate, purchase or rent a home and complete all moving arrangements.
2. Resolve any last minute questions or ambiguities regarding your employment and role in the practice you will join
3. Confirm that the practice has secured professional liability insurance for you, or obtain it yourself if not offered by the practice you are joining.
4. Confirm that you have been added to all of the practice's provider agreements with health plans.
5. Meet physicians who are potential referral partners. Meet with social agencies and determine if local medical society and / or hospitals will announce your availability.

Included with the PowerPoint presentation are several brief articles on contract negotiation.

There is also a myriad of books on negotiation, negotiating techniques and theory.

Getting to Yes

Women Don't Ask—Linda Babcock

A Shifting Employment Landscape Demands New Negotiating Tactics for Docs

—Are you considering giving up independent practice to work for a hospital or group practice? You'll need negotiating skills you didn't learn in medical school.

By Paul Cerrato
Reviewed by Drex DeFord, Independent Consultant; previously, CEO at Next Wave Connect; CIO at Steward Healthcare (Boston); CIO/Senior VP at Seattle Children's; Chairman, CHIME Board of Trustees

A post on the *New England Journal of Medicine* Career Center site sums up the shifting job market for physicians succinctly: "With increasing frequency, both practicing physicians and those graduating from training are seeking employed positions."

From 2000 to 2010, for example, the number of physicians who worked for hospitals jumped by 34%.

And a survey sponsored by Merritt Hawkins, a recruiting firm, suggests that 61% of residents are looking to take on positions as employees when they finish their training.

That outlook is consistent with the fact that a growing number of hospitals and health systems are buying medical practices, which frequently turns independent practitioners into employees. With this shift in employment status come challenges for physicians who once spent much of their time negotiating with insurance companies but now find they have to also start thinking about negotiating contracts with their new employer.

Take Note

- According to a recent survey, 61% of residents are looking to take on positions as employees when they finish their training.
- The AMA warns job applicants to be wary of unreasonable demands: "Employed physicians should be free to exercise their personal and professional judgment in… any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment."
- If recruiters speak about a "standard contract" that everyone is signing, think twice about joining the organization.

Professional groups like the American Medical Association offer some useful advice on the subject. AMA urges physicians to "obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts."

The association is also concerned about potential conflicts of interest embedded in employment contracts that may prevent clinicians from offering patients good quality care. As it points out in *AMA Principles of Physician Employment,* if a contract offers financial incentive to over- or under-treat patients, these issues need to be addressed upfront. Specifically the association says: "Employed physicians should be free to exercise their personal and professional judgment in… any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment."

The freedom to make independent medical judgements is only one of many issues that physicians need to consider before they sign an employment contract. In fact there are so many complexities involved that the AMA's advice to seek legal counsel before signing on the dotted line makes absolute sense.

Dennis Hursh, a lawyer who is a member of the American Bar Association's Health Law Section, says that when employers offer a new physician a staff position, they may sometimes use language like: "We'll send you our standard contract, which we all have signed."

In Hursh's view, if you hear that "standard contract" line, the recruiter "is either misrepresenting the situation or is misinformed… The secret all experienced attorneys know is that all contracts are negotiable."

So what needs to be negotiated? Compensation and performance requirements are two obvious issues. But also be aware of any restrictive covenants that the contract may contain. Typically these contract clauses will prohibit you from practicing medicine within a certain distance of the employer if you decide to leave the practice or hospital. And they will typically require you to adhere to this restriction for a specific period of time. Hursh has represented more than one physician who found such restrictions put a major roadblock in their career path when they wanted to move to a new practice a few miles from their former employer. "Sometimes the charming Dr. Jekyll who interviewed you turns into a real Mr. Hyde in day-to-day dealings."

Jackie Caynon, a partner at Mirck O'Connell's Health Law Group, concurs. During a recent email exchange, he said: "Noncompete clauses can be dangerous for the newly-employed physician because if they are enforceable against the physician, it may require the physician to move away from the area where the physician has just settled in with his/her family." Caynon also warns physicians about a contract between a physician and a hospital that contains a mutual indemnification clause or hold harmless clause. "These kinds of clauses come into play if a patient sues a physician for a medical malpractice case and alleges vicarious liability against the hospital where a physician is working. If a physician agrees to indemnify the hospital and the jury decides the hospital is liable, the physician may be on the hook to pay the judgment rendered against the hospital as well as its attorney fees and court costs," he added.

When it comes to negotiating salary and benefits, job candidates need to be realistic about the amount of money a practice will have available for compensation. Practice revenue depends on payments from patients and insurance companies, but any agreements with payers require those payments to be well below the amount that the practice lists as charges for its services. Similarly any revenue has to be tapped to pay administrative staff and cover operating expenses.

Nonetheless, you can reasonably expect any salary offer to be at least close to what your colleagues are getting in the same region and with the same credentials.

When it comes to negotiating an equitable employment contract, the American College of Physicians agrees with Dennis Hursh on at least one major issue: ACP believes it would be a mistake for residents to assume they have no bargaining power and must accept any contract offered "in toto."

But on the other hand, ACP takes the position that it would also be a mistake to assume that *everything* is negotiable.

ACP also discussed the pros and cons of hiring a third party to sit in on contract negotiations: "A skilled negotiator can evaluate terms, re-draft contract language, and bring additional negotiating expertise to the table. The right consultant may also help the negotiations build a win/win agreement without creating discord. However, involvement of a third party lawyer or contract negotiator to help the physician can also introduce some tension in the relationship with the group, especially if the practice itself prefers not to employ such outside professional assistance."

References

- 1. Darves B. NEJM CareerCenter: Understanding the Physician Employment "Movement" July 23, 2014.
- 2. American Medical Association. AMA Principles for Physician Employment. 2013.
- 3. Hursh D. The Final Hurdle: A Physician's Guide to Negotiating a Fair Employment Agreement. Advantage Media Group. Charleston, SC. 2012.
- 4. American College of Physicians Center for Practice Improvement and Innovation. Physician Employment Contracts.

Six Contract Negotiation Tips for Physicians, from Physician Recruiters

How to Close the Deal on the Best Possible Offer for You

As a physician, the employment market is generally in your favor - there are likely more physician jobs open, than there are physicians to fill them. However, when you find the one job that is the best fit for you, diplomacy is paramount to ensuring a smooth interview and negotiation process. Even though you are in demand, you still should be careful how you approach the contract negotiation process - how do you clarify questions, and request changes, without breaking down trust or killing the momentum?

The national team of physician recruiters at The Medicus Firm provide several great ideas below, based upon their experiences working with hundreds of physicians and helping them to finalize an acceptable offer that meets their needs for their next career move.

1. Know your worth. Research salary trends and market value for your role prior to negotiating. There is so much information widely available today, there's no reason to be uninformed about the salary range for your profession. "When you do research competitive salaries, be sure to factor in your level of experience, your role, medical specialty, educational background, and even geographic region. Salaries vary by geographic location, and, for physicians especially, salaries can vary widely from one region to the next, sometimes by several thousands of dollars within a 50-100 mile radius," states Jeremy Geer, senior recruiting consultant..

2. **Avoid "going to the well" too often** – "This is a very common mistake, when candidates make multiple requests for concessions throughout the negotiation stage of the process," according to Steve Look, executive vice president of The Medicus Firm. His colleague, Craig Southerland, agrees: "I always advise physicians that they can negotiate back and forth no more than twice. First with the initial questions and requests, then once more with any follow-up concessions or requests. If a candidate tries to go back to the employer with additional requests any more than two times, he or she can easily end up negotiating themselves right out of the offer, and end up with nothing but disappointment."

3. Communicate clearly, and often. The biggest, most common mistake when negotiating salary, is when candidates fail to effectively and pointedly communicate with potential employers. "Without clear, concise communication, the process often gets bogged down and can create frustration and lack of direction, which ultimately leads to negative outcomes," states Jamie Thomas, executive vice president in the Atlanta office. "I have found that the best way to communicate salary expectations is to be honest about your expectations from the beginning, and throughout the process. Once a candidate has interviewed and the negotiating process has begun, it is important for the candidate to have candid, open dialogue expressing their compensation needs, while expressing their true intent, should the client meet those needs. For example, don't tell the hiring manager that you will accept the position if they offer X, and then, not accept the offer after the employer agrees to your request."

4. Be Aware of the Competition. As a physician, it's true that your skills and qualifications are in great demand, but that doesn't necessarily mean that you are the only person in the interview mix. "Clinicians often mistakenly believe that they are the only person a potential employer is speaking to, interviewing, or making an offer to join their program. This is almost never the case. Hospitals almost always have multiple candidates they are considering for any open position. They will often go with the employee candidate who shows the most interest, is the most positive, and who builds and maintains momentum throughout the interview process, by keeping in constant contact with a potential employer, and keep them apprised of your situation," advises Nolan Smith, recruiting principal in Dallas.

5. Timing is Everything. (Avoid Negotiating Salary Details too Soon in the Process.) Not only can this potentially turn off an employer and perhaps even make you seem greedy to your future employer, trying to negotiate salary before the interview prevents you from leveraging the value you bring to the employer as a reason to offer higher pay. Kaitlin Kremer, a recruiting consultant out of the Atlanta office, adds, "you have to make the employer 'fall in love with you' first, then you can make requests or negotiate for more money if appropriate."

6. **Keep the "Big Picture" and End Goal in Sight**: Consider the offer as a whole, and try not to get bogged down in the minute details. Consider all aspects of the offer: Base salary, plus bonuses/incentive, plus benefits, and other perks. Several recruiters, including Brian Nichols, recruiting principal in Atlanta, said that they see many candidates get so intensely focused on negotiating base salary, that they fail to consider the bigger picture. Also, this makes the employer concerned that the candidate is not planning on working hard enough to meet productivity goals and earn bonus incentives. This especially applies to physicians or any clinicians with a compensation structure that includes productivity incentives.

Each job search, interview process, and contract negotiation will include a variety of deciding factors, and involve a different, unique set of circumstances for the physician and his or her family, as well as for the employer. Your physician recruiter is motivated to help you get the best offer and the terms you need to accept, as each recruiter's goal is to bring the hospital (employer) and physician (future employee) together into a lasting, mutually beneficial agreement.

Playing nice: how to handle your first negotiation (with grace)

Yes, you can negotiate your first contract. Follow these tips to make your experience a positive one.

By Teresa Odle | Fall 2015 |

Mario Espindola, M.D., knew he wanted to practice at a federally qualified health center. Through professional conversations and gentle negotiations, both he and his employer found happy outcomes.

As Mario Espindola, M.D., neared the end of his residency in the University of California, San Francisco Fresno Family and Community Medicine program this spring, he began looking for his first practice opportunity. He knew where he and his wife wanted to live and that he preferred a federally qualified health center.

Espindola found just that at Hillside Health Center in Ukiah, California, but his work wasn't over after he landed the job. He still had to negotiate his offer.

Kelly Kesey, the recruiter and training coordinator for Mendocino Community Health Clinic, Mendocino Coast Clinics and Long Valley Health Center in northern California, recruits health providers and executives for Hillside Health Center and a number of other locations. She says Espindola handled his negotiations exceptionally well.

"He knew that the practice wanted someone who was bilingual," says Kesey. "So when it came to negotiations, he said, 'I'm wondering if the agency strongly values that I'm bilingual and if that has a place in these negotiations.'" Espindola wasn't pushy, but he paid attention and balanced his interests with the needs of the employer.

Espindola's example shows physician contract negotiations don't have to be a battle. Both he and Hillside Health Center ended up with happy outcomes. And that's what negotiation is all about: making sure everyone comes out ahead.

Don't fear negotiation

Amber Brake, chief executive officer of Physicians' Negotiators LLC, says new physicians need to know how to negotiate. She believes the first contract builds a foundation for a physician's career and that it's important to begin on good terms. "About 60 percent take terms that are unfavorable," says Brake. "And about 50 percent of physicians change jobs in the first two years."

Some physicians hesitate to negotiate because they don't want to come across as difficult, according to Ryan D. Mire, M.D., FACP, who practices at Heritage Medical Associates and serves as associate chief of medicine at Saint Thomas West Hospital in Nashville.

"There is a natural intimidation factor that exists with an early career physician who feels like they need the job and doesn't want to get into a contentious relationship or conflict from the beginning of the relationship with the practice," he explains. But Mire and other seasoned physicians know that negotiating terms is just part of the process.

Physician recruiters know this, too. As the regional director of physician recruiting for LifePoint Hospitals in Colorado, Utah and Nevada, Bruce M. Guyant, DASPR, has seen good and bad examples of negotiations in his 18 years of recruiting. He says that although some negotiations have wrinkles, LifePoint Health always wants physicians to feel good about the outcomes.

"I speak not only for myself, but all of my esteemed colleagues in the industry, when I say that I truly want a physician to be happy, contented and comfortable with the agreement that they sign with us," says Guyant.

Another reason new physicians don't negotiate is that their first salaries seem large compared to what they made as residents. Espindola, who served as chief resident at UCSF Fresno before joining Hillside Health Center, points out that new physicians are often making more money than they've ever made before. He says that when they talk to practices, they think: "'I'm going to be working five days a week and getting paid two to three times more than in residency, and I'm getting great benefits. Why would I negotiate more?'"

But physicians who don't negotiate may later find out they could have been earning more. Although most employment agreements must keep physicians within a set range, there can be wiggle room. Additionally, compensation varies from region to region and even practice to practice, says Espindola. He emphasizes that physicians have to find out what's out there. The only way to negotiate is to know your own worth and the going rates.

Preparation is key

When negotiating, it's helpful to look past the short term and consider what you want your work life to be several years in the future, recommends Rebecca Miller, M.D.

The easiest way to find out your worth is by thorough preparation. "It's important for a physician to know what his or her fair market value is," says Rebecca Blythe, DASPR, MBA, physician recruiting specialist for St. Vincent's Health System in Birmingham, Alabama. She says a tool such as the Medical Group Management Association's regional salary guide is a good resource. "A physician can also talk to other physicians in their specialty and to new hires," Blythe adds. Consultants such as Brake can also help. Brake says, "We come in, take all of the different salary surveys and distill them down to what's applicable and say, 'Here's what we think you're worth.'"

In addition, it's important for physicians to understand how a potential employer or practice determines compensation. Some base pay on productivity, while others use experience or specific skills to determine salary.

Knowing what matters most to an employer helps physicians gather the right data to estimate a fair starting point. "People respond to objective data," says Brake. In fact, if another party doesn't respect the data you present, it could be a red flag about future dealings.

Asking questions also eases you into the salary discussion. Rebecca W. Miller, M.D., who specializes in internal medicine and pediatrics for St. Vincent's Family Care in Hoover, Alabama, says she was not comfortable negotiating her contract. "When you come to negotiations as a resident physician, you may not feel empowered," she explains. Miller says questions help you start the conversation, establish a relationship and gather information. "I would recommend to ask a lot of questions and consider what you will want out of life not just one year, but many years into the future," says Miller.

10 tips for keeping negotiations positive

1. Worried about how you'll come across if you negotiate your contract? Follow these tips from physicians, recruiters and consultants to make sure your negotiations go smoothly.
2. Timing is everything. Asking about compensation too soon can be a big turnoff to employers, so get to know a practice and its physicians before talking dollars and cents. That said, don't drag out talks. If the hiring process is advancing without a salary discussion, ask your first or most trusted contact when and how to ask about money.
3. It's a myth that everything is negotiable, but don't assume the opposite. Recognize that some terms are flexible, and others aren't. If a practice won't or can't budge on an issue that matters to you, you'll have to make a tough choice between walking away or compromising.
4. Ask questions not only to gather data but also to build relationships. Show interest in the practice, the area and future colleagues. By demonstrating excitement, you'll show you care about more than your own interests.
5. Explain that you want to find the opportunity with the best long-term fit for you and your family. By showing the practice you want to put down roots, you can demonstrate commitment and explain why the contract terms matter to you.
6. If you receive an offer from one employer while negotiating with another, it's OK to let the second employer know about the first. Emphasize that you're still excited about their opportunity and give them your decision timeline. If that employer can accommodate your timeline, it will. Sometimes, a practice simply can't meet another deadline because it's still interviewing prospective candidates.
7. Demonstrate your value. Use objective data to show the employer what benefits you offer. For example, bringing you on board might help the practice offer a new revenue-generating service or expand its patient base.
8. Be persistent but reasonable. You don't want to fold immediately, but you must be willing to compromise.

9. Get help if you're uncertain how to negotiate or gather salary data. Attorneys and consultants can review contracts and arm you with information. And experienced colleagues make great mentors because they know how the conversation looks from both sides of the table.
10. Be open about your hopes and desires. Paint a picture of the future you want in medicine. This is much better than taking a guarded, adversarial approach to negotiating, and it will help the other party feel like you're on the same side.
11. Practice openness, honesty and trust to keep negotiations positive whether or not you accept the job offer. If you do walk away, both parties will understand why, and if you sign the contract, you'll start off on the right foot.

Know what you want

Salary is not the only item on the table. A financial package might include a sign-on or retention bonus, moving expenses and other perks. Physicians may be able to negotiate these amounts or adjust their payment schedule. For example, Espindola worked with the group to negotiate slight changes in his signing and retention bonuses.

Lifestyle factors are also important to many physicians today, says Miller. Schedules and vacation time might be negotiable depending on the practice. "This was not the case when I entered the workforce," she says. Physicians who want additional family time should find out whether those terms are even on the table before negotiations go too far. And if an employer is willing to budge on lifestyle factors, a candidate might need to be more flexible about other terms.

Before negotiating, physicians should determine their priorities. Guyant recommends ranking contract terms from most to least important. "Successfully negotiating requires some preparation ahead of time," says Guyant. "If you go into discussions and shoot from the hip, so to speak, then you will likely not have a favorable outcome."

Guyant adds that physicians should try to understand an employer's perspective. When a practice denies a request, it may be less about winning the negotiation and more about ensuring the practice's viability. To stay in business, practices have to maintain a certain budget while providing a high level of care.

Fully understand your contract

Mire hired an attorney to help with contract interpretation. He advises new physicians to do the same, but to negotiate without an intermediary. "I would hire an employment agreement attorney for the legal understanding of the contract, but handle negotiations on your own," he says. He believes this is more personal and less adversarial.

Blythe agrees. "A physician is his or her best representative," she says. Attorneys help by reviewing contracts and making recommendations, but candidates shouldn't assume their attorneys have the final word. Blythe has seen candidates propose long lists of contract changes

from their attorneys even when "there may be just a few things that are negotiable." Many established practices have standard phrasing and clauses that aren't up for debate.

Similarly, Guyant cautions, "You are not obligated to make legal counsel's gripe yours." He says he's found that "minor parts can become huge sticking points, and all of a sudden, you have a deal-breaker because the physician feels that there is a big issue, when it really is not big to them."

It's important to understand a contract and ask questions, not just nitpick about potentially unfair terms. Often, recruiters and mentors can help explain contract terms so candidates can make their own decisions. As Guyant says, "The contract is for you, and you must be happy with it."

Once you've agreed on terms, nail down the details in your written contract. Play nice

After research comes negotiation. The same rules of professional courtesy apply here as with all other communication. Honesty and openness are important. And although candidates and employers should consider offers carefully, it doesn't help either party to play waiting games. "Hillside Health Center took the time to review every counteroffer that I presented to them and get back to me in a timely manner," Espindola says. "Kelly and Dr. (Thomas) Bertolli were very good about communicating," he adds. Other practices made him wait longer and did not communicate as well.

Poor communication during a negotiation can be a warning sign. As Kesey points out, practices should want providers to feel valued and vice versa. An open, friendly negotiation process creates "an established relationship of trust and of hearing each other, like how to say 'no.'" This sets the stage for open discussions in the future.

Blythe echoes this sentiment. "Be honest and aboveboard with everyone, and try to make it a win-win for all involved. Being comfortable with your relationship with your new employer is as important as anything you will negotiate in a contract," she says.

Choose your battles

Negotiation always involves compromise, and sometimes a practice can't meet a physician's request. For example, some physicians try to negotiate paid time off with Mendocino Community Health Clinic, but Kesey says, "That's just not negotiable with our agency." However, she's willing to work with candidates. She explains the practice's policies to them, saying, "Here's what we can and can't negotiate. How can we make this work for you?"

According to Mire, some physicians are under the false impression that candidates can't negotiate. "While there are times that there is a standard contract for a group, there is always a possibility that you negotiate some aspect of a contract, especially if the group has a high interest in you as a potential candidate," Mire says. "I advise all physicians to ask for what they want. …But understand that it's a negotiation. Pick your battles for those aspects that are most important to you, and realize that you have to compromise on some aspects."

Each party should show respect for the other and be willing to address issues. “It’s important to approach it from a respectful point of view,” says Brake. “So neither party is negotiating from a zero-sum game. They aren’t trying to negotiate everything to their advantage and have the other party walk away with nothing.”

According to Guyant, conceding a little leaves both parties feeling good after the physician signs. “Often, to get a few things that you need or want from your practice arrangement, you need to be willing to give some concessions to the hospital or clinic for whom you are going to work,” he explains. Mire agrees. “I advise all physicians to ask for what they want but understand that it’s a negotiation and they may not get everything they ask for,” he says.

Espindola certainly didn’t get everything he asked for from Hillside Health Center, but he was welcomed and respected. Now he knows that it never hurts to ask. He says, “You want to make sure that you’re being adequately compensated and left with no doubt that you didn’t explore all your options.”

Teresa Odle is a frequent contributor to PracticeLink Magazine.

Tips on How to Negotiate a Contract

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Julie A. Freischlag, M.D., FACS, FRCSEd(Hon)

At the end of medical training, residents know so much about their chosen specialties, but little about negotiating their first job. The process is typically unfamiliar and daunting. As someone who has had many jobs in my career, I can say that being well-prepared — both practically and emotionally — is key.

I did a less-than-stellar job of negotiating my first academic role at UCSD. Since my first husband was doing his fellowship at UCSD, I thought I knew everything about the process. I did not prepare myself as well as I could have, and it turns out, I could have asked for more. This experience served as a good lesson a decade later when I was exploring the role of Chief of Vascular Surgery at UCLA. By then, I had more experience under my belt and was able to negotiate my needs more effectively.

Later in my career, when Johns Hopkins was looking for a Chair of Surgery, I initially declined the call to interview because they also were considering an inside candidate. Based on my experience with three other jobs that had hired inside candidates, I didn’t want to make the effort only to be turned down yet again. But, Johns Hopkins pleaded with me to interview and I gave in

… only to be hired as the first female Chair and Surgeon-in-Chief of the Department of Surgery. I stayed in that position for 11 years. To think that I initially turned down the interview! This experience taught me to face my fears.

Think Beyond the Salary

Although money is always the first thing people think about when exploring new positions, it's the least important aspect of the negotiation. Before you start the negotiation process — indeed, before you even apply for a job — make sure you know what you want and need to ask for. This involves mapping out a clear career plan with goals and a realistic timeframe to achieve them.

While salary, bonuses, housing expenses, and health benefits are typical needs that can be negotiated, there are other factors to consider. For example, moving a family can be challenging, particularly when it comes to employment for spouses and partners. Definitely inquire about spousal and partner hire within the organization. If you want to preserve time with your family, consider negotiating flexible on-call hours. If one of your goals is to build an academic career, ask for protected time to teach or conduct research and time off to attend national meetings. If you will have a research lab, outline the kinds of support you need (e.g., supplies, technology, and equipment). If you will be conducting clinical research, ask about access to databases, statisticians, and epidemiologists.

I also recommend that your contract include specific language about scope of work and expectations. You don't want "other duties as assigned by the employer" to involve daily tasks that do not align with your career goals. A contract lawyer can help you with these types of details. In my opinion, a contract lawyer is a must for negotiating positions in private practice.

The details of contracts can be overwhelming, especially for residents securing their first positions. In addition to contract lawyers, mentors can be excellent resources when considering a particular job and contract. Program directors and division chiefs also can be extremely helpful, particularly if you are looking to move to a different institution.

Practical and Emotional Checkpoints

Whether you are negotiating your first academic role or one later in your career, honestly ask yourself if your vision matches that of the leader above If your visions do not match, determine to what extent, if at all, you are willing to compromise. Will you have sufficient resources to assure your success? If the position does not work out for the long-term, will you still gain great experience? For greatest professional and personal satisfaction, you want to make sure the opportunity matches your intellectual curiosity, passion, and entrepreneurial spirit.

Throughout the negotiation process, keep in mind the following checkpoints:

Practical checkpoints:

- Know why you want the job and what you can accomplish in that position.
- Know who works in the organization.
- Know why you are best suited for the position.
- Know your competition.
- Know what you need to be successful.
- Know when you need to learn something new.

Emotional checkpoints:

- Do not want the job too much.
- Do not assume the job is good or bad.
- Do not eliminate schools, location, or opportunities.

Own the Process

While your credentials, experience, skills, and reputation influence the negotiation process, project your best self by genuinely conveying your passion for your work, creativity, and energy. Attitude has a lot to do with success. Don't be afraid to take chances. If I had given into my reticence about interviewing at Johns Hopkins, I wouldn't have become the first female Chair of Surgery! Don't be afraid to go outside of your comfort zone for your future. As Oprah Winfrey said, "Do the one thing you think you cannot do. Fail at it. Try again. Do better the second time. The only people who never tumble are those who never mount the high wire. This is your moment. Own it."

Dr. Julie Freischlag is Vice Chancellor, Human Health Sciences, and Dean, School of Medicine, at the University of California, Davis.

Everything You Know About Salary Negotiation is Wrong–Part 1

Posted on September 14, 2016 by Drpost — No Comments ↓

Doctors–Are You Prepared to Negotiate Your Salary?

How many of these "negotiation commandments" have you heard?

- **You should never disclose your salary or your requirements first**
- **When your offer is too low, negotiate up**
- **Splitting the difference always works in your favor**
- **Without competing offers, you have no leverage**
- **Always negotiate hard: if you get the offer of your dreams, you can still get more**

They're all wrong!

Some of them all the time; others, some of the time. Let's take a closer look….

Myth #1: You should never disclose your salary or your requirements first

If the practice has a known salary range and you would be happy with that, this *may* be OK. But I personally know of many cases where people went on multiple interviews, spanning multiple weeks, only to receive an offer that's completely unacceptable–far out of their range. All their time has been wasted and they are very angry about it too.

Trial lawyers know a cardinal rule: never ask a witness a question that you don't already know the answer to. If you are looking for a job, the rule is: never waste time pursuing a job when you don't already know what you'll be paid, at least at a minimum.

So how do you handle this practically? If you are invited to an interview, it's absolutely fair to ask, "Can you give me the general salary and bonus range for this job?" If they answer your question, you face three possible scenarios:

- *If the range is too low*, you tell them you really appreciate their consideration, but that you require a range of (and here's where you include your range). Some of them will come back to you and indicate flexibility. Now you are the one with leverage.
- *If it's within your range*, you simply say, "Thank you. And, of course, depending on the candidate, I assume you have some flexibility." That's a statement, not a question. If you ask it as a question, it doesn't work. Rather, you are putting them on notice that your value is higher. That will help you later.
- *If it's higher than your expectations*, there's a good chance that they know it. If you come off as a hard-ass, then you're telling them that you don't know when to quit. You're best off saying, "Thanks for that information. Yes, I'm interested in exploring this opportunity further."

If they don't give you an answer, they may ask you what you are looking for. Never give a single number. *Give them a range with a flexible span*. For example, if you want $190K, something like $205K-$215K works well. Notice that your lowest salary is higher than what you

want, but not so far above it that you can't "save face" if you really want the job – or, better, trade off that salary for a better bonus or benefits. Make no mistake: they will take your lowest number as your real demand. But if they want you badly enough, they may not want to "insult" you by offering you that and so they may very well "split the difference," offering you $210K. If they say that your range isn't "fair or reasonable," but you know it is, thank them for their time and wish them well.

Myth #2: When your offer is too low, negotiate up

You should only negotiate up depending on how low the offer is. If it's close – and the benefits and perks and career opportunities are great – sure. If it's not, you absolutely have to walk away: "Thank you. I think very highly of your company, but I'm afraid we're not close on compensation. So unfortunately, I have to decline."

It's very important not to use "weasel words" like "maybe," "I hope," "could you possibly?" and the like. Put the onus on them – if they want you and can afford you – to come back to you, whether in that communication or later. If and when they do, you will have gained significant leverage.

You also have an "anchor" in such negotiations. If you've actually discussed a range initially, you can say, "As I explained initially, my range for this position is $205K-$215K. I'm disappointed that your offer is not in that range, so it's not possible for me to accept."

Myth #3: Splitting the difference always works in your favor

You should split the difference only when it's to your advantage. So if you would be happy with $190K, but you've told them $210K and they've offered $190K, go ahead and ask, "Why don't we split the difference?" You would be amazed how often this works. In order to use "splitting the difference" to your advantage, you should always ask for more than you would be happy with from the get-go. Now suppose you have told them $190K and they have offered $160K. Is that a difference you want to split? Absolutely not. That's when you reject the $160K flat out and force them, unilaterally, to raise it (And, of course, if you're a neurosurgeon, these numbers are more likely to be in the $600K- $900K range, so adjust for your market value.). Once they have raised it, *then* you can split the difference.

Myth #4: Without competing offers, you have no leverage

While you shouldn't lie about having competing offers, your interviewers have no idea whom else you are talking to. If their imagination wants to run wild, let it. Certainly, you are having "a number of ongoing discussions, including this one." That's true, even if you have only one offer. Or you may be expecting an offer in two more weeks. Expecting an offer isn't the same as having an offer. Not all expectations are met. So if they absolutely want you, what are they going to do to lock you down now?

Also remember that if they've first offered you the job, they want you for some reason. Maybe it's because they think they can get you cheaply. We've already discussed how to counter that – and if they don't come back, do you really want to work for someone that cheap unless there's a separate benefit such as being able to work with a world-leading doctor or researcher? If they don't think you're cheap, they think you're valuable. That is leverage.

Myth #5: Always negotiate hard–if you get the offer of your dreams, you can still get more: You may actually end up with nothing if you negotiate too hard with the wrong person. Know about the party you're negotiating with so you can capitalize on your strengths and the party's weaknesses. If possible, talk to business associates who have dealt with this person before. Many negotiators develop patterns and certain styles that you may be able to use to your advantage .

You should negotiate harder with people who tend to play mind games at the negotiating table. When Donald Trump decides he wants to make a deal with you, he apparently stuffs a few tricks up his sleeve before negotiation time. First, he'll have his staffers warn you that he's very busy, probably won't be able to stay long (5 minutes max) and won't shake your hand (he just doesn't do that). Then when Trump enters the room—you know, the one from *The Apprentice*—you're instantly charmed over by his warm handshake and extensive 40-minute chat. You walk out feeling quite good about yourself. In reality, you were duped into thinking that his standard negotiation courtesies were really flattering. This gives Trump the clear upper hand and makes you feel good about ultimately accepting less than you wanted.

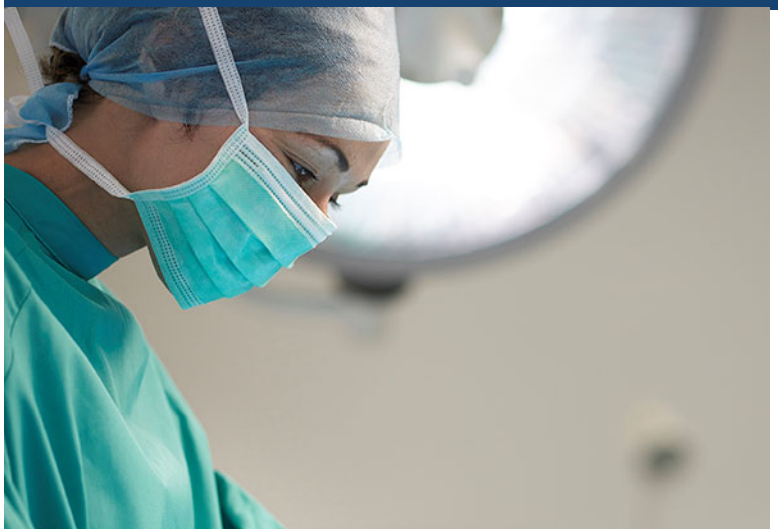
For others, negotiating too hard will be the kiss of death. Other people negotiate by giving one—and only one–offer. This was Steve Jobs' go-to negotiation style at Apple. These negotiators offer you the job and compensation of your dreams because they recognize your talent and ability, so they want to reward you. However, if you turn their offer down, these negotiators walk away and never come back. There are absolutely no second chances.

What you need to know is that you cannot negotiate the same way with different people. If you are talking to a Trump-style "mind-game" negotiator, then you have to be confident and ask for a lot more than you want. If you are talking to someone who is going to make one great offer, take-it-or-leave-it, you will lose the job of your dreams. The lesson is: know whom you're dealing with and adjust your style accordingly.

Steven Mason

Physicians Insurance
A MUTUAL COMPANY

MEDICAL PROFESSIONAL LIABILITY AND RISK MANAGEMENT FOR FAMILY PRACTICE PHYSICIANS



Family Medicine Resident Professional Development Seminar | 2020

OUR VALUES PROTECTIVE | PRINCIPLED | SERVICE ORIENTED
COLLABORATIVE | FORWARD-THINKING

TODAY'S AGENDA

1. A Wee Bit about Physicians Insurance
   - Mutual Carriers versus Stock Companies
2. Policies, and Coverage
   - Policy Types, "Nose", "Tail" and other Claims-Made Terms
3. Claims and Claims Activity
   - Family Practice claims and risk management
4. Documentation and Data
   - Informed consent and charting

FAST FACTS ABOUT PHYSICIANS INSURANCE

- Northwest based mutual company
  - Owned by our policyholders
  - Run by a board of mostly physicians
  - No obligations to stockholders
- Cover and serve more than 8,500 physicians, clinics, and hospitals
  - Write in Oregon, Washington, Wyoming, Alaska, and Idaho
  - Largest insurer of private practice physicians in the Pacific Northwest
  - Largest insurer of critical access hospitals in Washington, Oregon, and Alaska
- A financially strong company with an AM Best A- Excellent rating
- More than $100 million in dividends to our physician policyholders since 1982, with $60 million provided in the last 12 years.

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

CLAIMS-MADE DISTINCTIONS

- Retroactive Date
  - Earliest date for which claims-made coverage applies
- Step Rating
  - How premium matures over first five years
  - First year claims-made only covers claims which both occur and are reported in the first year so premium is much less that year
- Prior Acts
  - Also known as “Nose Coverage”
  - Matches retroactive date from previous policy
  - Can increase step rating to “mature” premium
- Reporting Endorsement
  - Commonly called “Tail” or “Tail Coverage”
  - Converts Claims-made to Occurrence
  - Cost varies by company: 175% – 200% of annual premium
  - Waived for Death, Disability or Retirement

2020 RATES FOR FAMILY PRACTICE PHYSICIANS

- Base Mature Rates for $1M/5M limits (no surgery)
  - WA: $11,268
  - OR: $8,289
  - ID: $6,145
  - Sticker price—discounts may apply
- Regional Differences
  - Different laws and risk exposures = premium differences
- Specialty Rates/Classifications
  - Rates determined by how invasive a procedure physician performs
  - Neurosurgeons pay roughly 7X higher premium than FP

APPLYING FOR COVERAGE

- Coming or going – negotiate your tail
  - Who is paying for it
- Don’t omit information or lie on your application
  - Underwriters have seen it all – you can’t surprise them
  - This information is treated as confidential
  - Underwriters are not there to judge you, but to find a way to provide you insurance
  - They will likely find out anyway
  - You put your policy in jeopardy with misinformation

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 proprietary 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 (of which Physicians Insurance is a leading member), the average indemnity paid for **General and Family Practitioners** was $312,988.

- Anupam Jena, Seth Seabury, Darius Lakdawalla, and Amitabh Chandra, "Malpractice Risk, by Physician Specialty," *Research Brief*, RAND Institute for Civil Justice and RAND Health, 2011, accessed February 24, 2014, http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9610.pdf.
- Physician 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).

MAJOR CAUSES OF CLAIMS

CHIEF MEDICAL FACTOR

Three top causes of claims—errors in diagnosis, no medical misadventure, and improper performance.

- The most prevalent medical misadventure for **General and Family Practitioners** was diagnostic error—cited as the primary issue 33% of the time.

MAJOR CAUSES OF CLAIMS

Chief Medical Factors (by frequency)	Average Indemnity Payment
Errors in diagnosis	$339,937
No medical misadventure	$287,491
Medication errors	$202,298
Improper performance	$239,057
Failure to supervise or monitor case	$245,987
Failure to recognize a complication of treatment	$313,544
Failure to instruct or communicate with patient	$313,936
Failure/delay in referral or consultation	$267,916
Delay in performance	$389,126
Not performed	$290,593

MAJOR CAUSES OF CLAIMS

PROCEDURES

Three top causes of claims—errors in diagnosis, prescription, and general examination.

- Approximately 31% of claims involved prescription of medication. On average, more than $303,453 was paid on behalf of **General and Family Practitioners** involved in this procedure.

MAJOR CAUSES OF CLAIMS

PROCEDURES

Procedures Performed (by frequency)	Average Indemnity Payment
Diagnostic interview, evaluation, or consultation	$267,278
Prescription of medication	$303,453
General physical examination	$382,795
No care rendered	$276,231
Miscellaneous manual examinations and nonoperative procedures	$305,050
Injections and vaccinations	$209,608
Operative procedures on the skin, excluding skin grafts	$131,799
Diagnostic Testing	$474,540
Diagnostic procedures involving cardiac and circulatory functions	$395,123
Operative procedures of gallbladder and biliary tract	$131,146

MAJOR CAUSES OF CLAIMS

PRESENDING PATIENT CONDITION

Three top causes of claims—back disorders, disorder of joint, and symptoms involving the abdomen.

- Between 2006 and 2015, the most prevalent presenting medical condition for which claims were filed against **Family and General Practitioners** was back disorders. Claims involving back disorders resulted in an indemnity payment 37% of the time with an average indemnity payment of 448,318.

MAJOR CAUSES OF CLAIMS

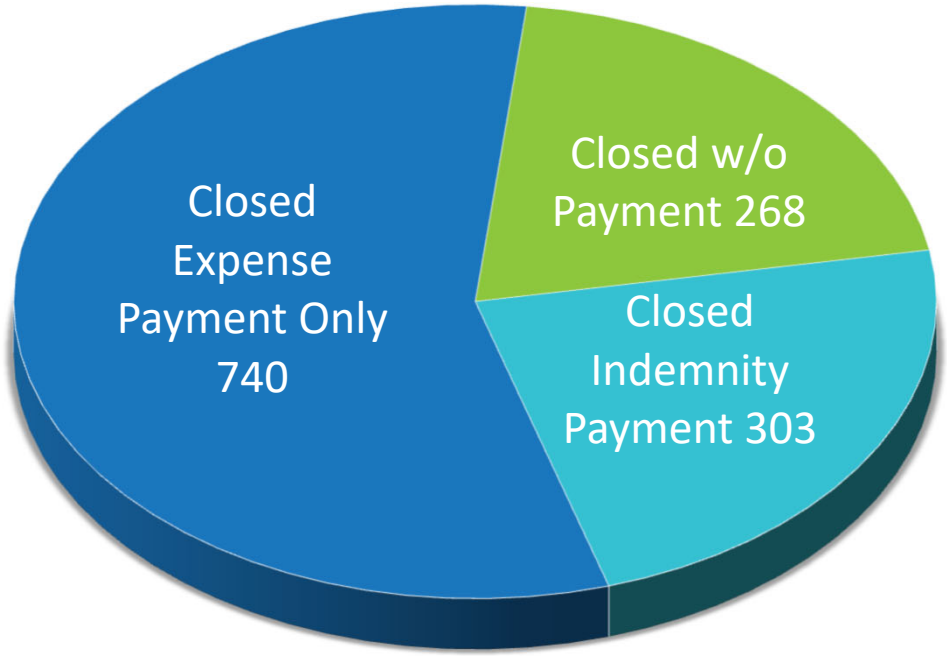
PRESENTING PATIENT CONDITION

Presenting Conditions (by frequency)	Average Indemnity Payment
Back disorders, incl. lumbago & sciatica	$448,318
Disorder of joint, not incl. arthritis	$259,091
Symptoms involving abdomen and pelvis	$323,265
Diabetes	$238,667
Pneumonia	$287,314
Decubitus ulcer	$194,722
Chest pain, not further defined	$335,053
Hypertension	$1,975,000
Heartburn	$262,959
Cellulitis and abscess	$254,650

CLAIM ACTIVITY FOR FAMILY PRACTITIONERS

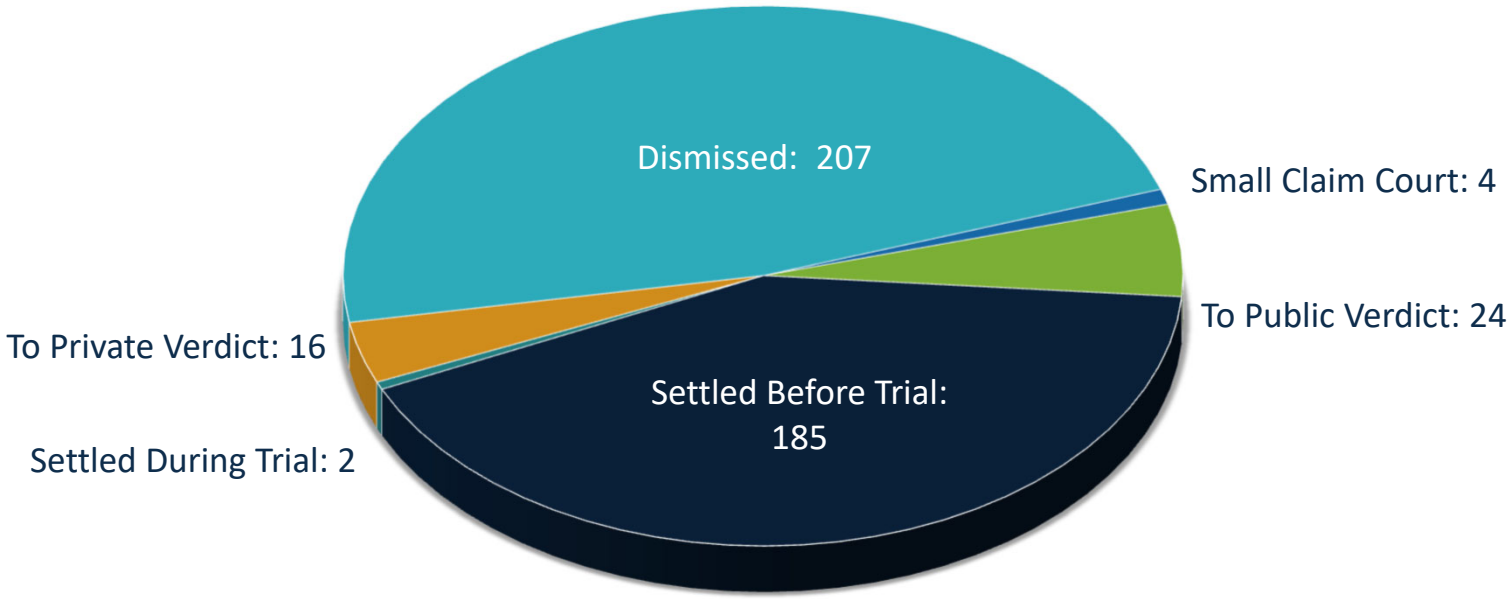
30 year period
All Closed Claims (1,311)

76.8% Closed with No Indemnity Payment (Settlement to Plaintiff)



SUIT ACTIVITY FOR FAMILY PRACTITIONERS

30 year period
Total Suits Closed (435)



CLAIMS FREQUENCY BY SPECIALTY

Family Practice ranks 17th of all specialties covered by Physicians Insurance – with claims turning into suits 29% of the time. Overall range is 18-41%.

It's just a numbers game; there isn't anything I can do to reduce my exposure to a claim.

- Untrue. A key ingredient to reducing exposure is relating well to patients. Honesty, empathy, and compassion promote trust and caring by the patient.
- What you may have heard is true…patients are extremely reluctant to sue a physician that they like.

Specialty	% Claims into Suits[1]
Plastic Surgery	41%
Neurological Surgery	39%
Urgent Care	38%
Neurology	36%
Pathology	33%
Urological Surgery	32%
Otolaryngology	32%
Cardiovascular Surgery	32%
Orthopedic Surgery	32%
General Surgery	31%
Radiology	30%
Emergency Medicine	30%
Anesthesiology *	30%
Cardiovascular Diseases	30%
Colon and Rectal Surgery	30%
Allergy	30%
Family Practice	29%
Obstetrics and Gynecology	29%
Ophthalmology	28%
Hospitalist	27%
Internal Medicine	27%
General Practice	26%
Pulmonary Diseases	26%
Gynecology	24%
Pediatrics	24%
Thoracic Surgery	22%
Dermatology	22%
Gastroenterology	21%
Psychiatry	20%
Physical Medicine & Rehab.	18%

THE FACTS ABOUT CLAIMS

- Do not practice in fear of getting a claim.
  - About 5% of physicians with a claim in a year
  - Changing public perception of patient responsibility
  - New ways to engage with patients before/after adverse events
- The majority of medical liability claims resolve in favor of the physician.
- 10 year public trial defense verdict at 92.3%.
  - Since 2009, 99 public trials with 97 defense verdicts.

FAKE NEWS ABOUT CLAIMS

- It's all about the money.
  - This may be true for the personal injury lawyer but the patient's motivation is often far different.
- Frivolous lawsuits are the problem.
  - This is not the case. Frivolous suits involving minor or non-injury events are infrequent
- A large percentage of cases are won or lost on the basis (quality) of the medical record
  - Document patient instructions and patient noncompliance
  - Alteration of the medical record WILL be discovered and is ALWAYS fatal to your defense

THE FACTS ABOUT CLAIMS

- Document patient refusal of recommended care (informed refusal).
- Labs, consults, X-rays and other studies must be reviewed and marked…have a system in place and consistently use it.
- Document provider/patient notification of study results and recommended follow-up.

REDUCE RISK. RAISE STANDARDS.

- The medical record is often the most important evidence allowing successful defense of a malpractice claim or lawsuit.
- Poor records are the most-cited reason for settlement.
- 35 to 40% of lawsuits are compromised by the medical record.

#1 Rule for Charting

If it isn't in the chart, it didn't happen

REDUCE RISK. RAISE STANDARDS.

- Informed consent is obtained and charted
  - Approximately 40% of medical malpractice lawsuits contain an allegation of “inadequate consent”
- Patient education, instructions and recommendations for treatment, consultations, referrals, and follow-up care are documented
- Return dates are included
- Patient noncompliance is charted
- Information is factual

REDUCE RISK. RAISE STANDARDS.

- Informed consent is obtained and charted
  - **P**rocedure-**A**lternatives-**B**enefits-**R**isks-**C**omplications
  - Extent in direct correlation to potential risks and complications
  - Signed consent for significant procedures
    - Signed refusal forms are equally important
  - Discussion mandatory even when written consent obtained
    - Consider a memo summarizing what was discussed and decided upon as another layer of communication

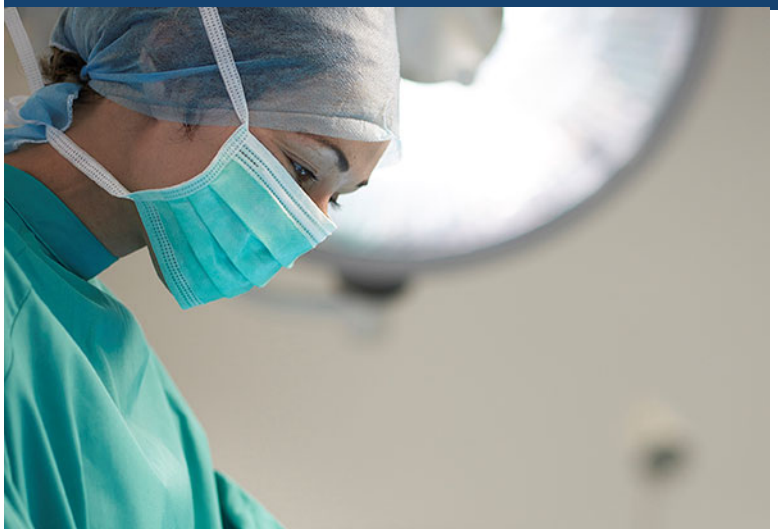
KEY TAKE-AWAYS

- Know your policy type, language, and coverage options. If you don’t know, call your insurer.
- Claims are a matter of when, not if. But they can be reduced if you have strong communication, patient engagement/understanding, and stellar documentation – which all produces better care.
- Don’t worry alone. Physicians Insurance is there to help – we have the same goal.

Physicians Insurance
A MUTUAL COMPANY

THANK YOU

(800) 962-1399 | PHYINS.COM | TalkToUs@PHYINS.COM



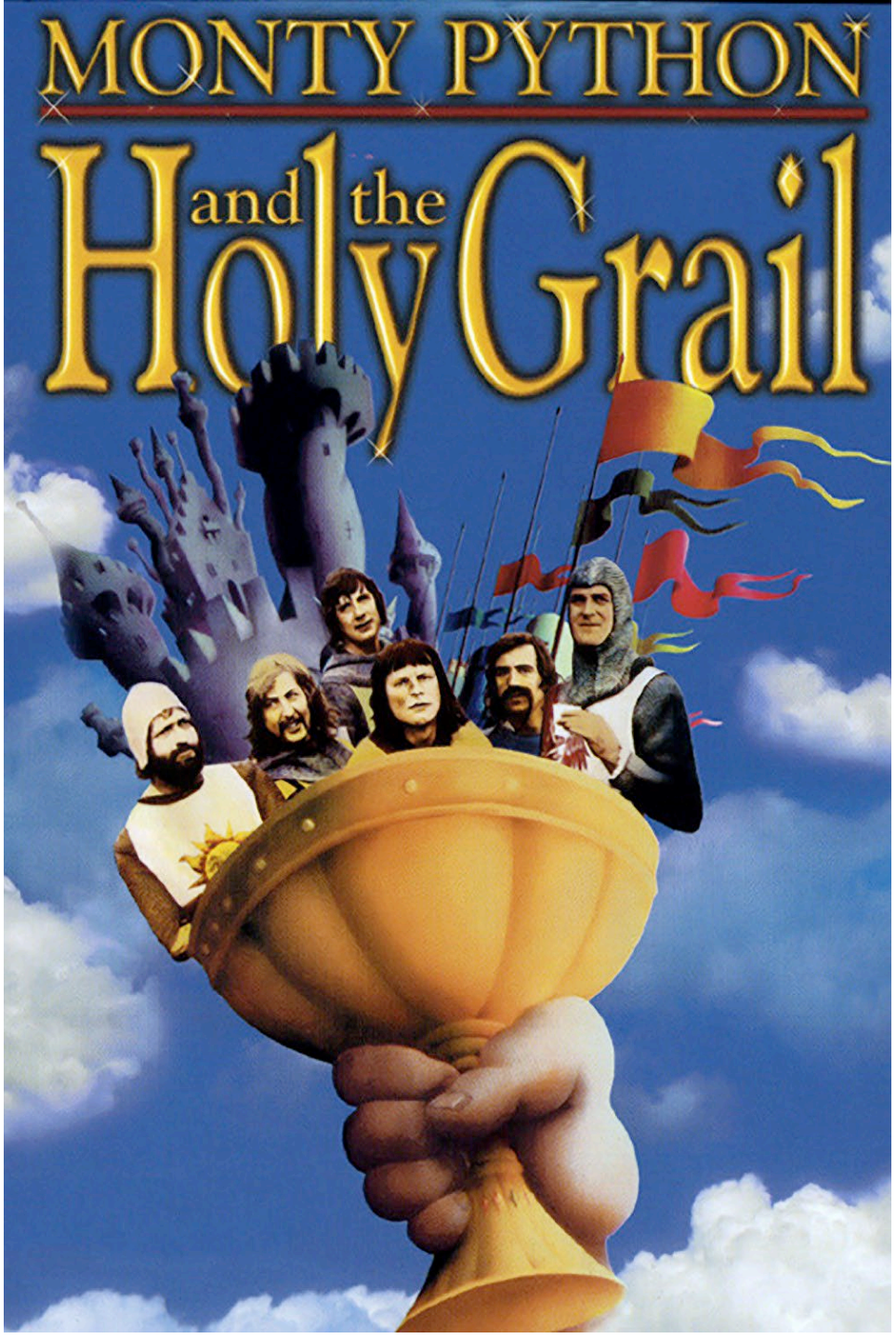
OUR VALUES PROTECTIVE | PRINCIPLED | SERVICE ORIENTED
COLLABORATIVE | FORWARD-THINKING

Get Ready!
Preparing Your CV, Cover Letter and Interview

Jeanne Cawse-Lucas, MD

October 9, 2020

Before you start…




WHAT
YOU LOVE
HAPPY BUT
POOR
JUST A
DREAM
#WIN
WHAT
YOU'RE
GOOD AT
RICH BUT
BORED
WHAT
PAYS
WELL
@eskimon


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

- Simple formatting
- White paper
- Large font that copies/scans/faxes well
- Online CV

Your Complete Name, MD

Accurate, current address

Phone

Pager

Email

Education

- Reverse chronological order – most recent first
- School name, month, and year of graduation, and degree earned
- List honors associated with your degree
- Don’t mention high school

Post Graduate Education (Residency and Fellowship)

- This can be a separate heading or part of the general education section
- Month and Year of Graduation
- State affiliation “University of Washington School of Medicine, Family Practice Residency Network.”

Honors and Awards

- List relevant honors and awards that are not previously mentioned

Professional Service

- List all memberships and year joined
- Include any offices or committees in which you participate

Employment Experience

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

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

License and Certificates

License and Certificates

- Very important: and some authors recommend it after the address section.
- Medical license number for each state and the date of expiration
- AAFP Board Certification date. "Board Eligible" fine until exam results are available
- DEA number and date of expiration
- ACLS, PALS, NRP 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

Languages

- List languages and degree of fluency
- Be accurate
- Citizenship if other than US

Other Skills and Qualifications

- Medical
  - Procedures
  - EMR
  - Clinical leadership
- Include pertinent non-medical qualifications

Community Service

- Non-medical community activities, such as charitable organizations
- Some advocacy groups

References

- Have two STRONG references
  - Let them know that you are using their names
- List their names and contact info
  - Minimum, email and phone number

Things to leave out

Personal information: marital status, number of children, sports, hobbies… save it for the interview or after you have an offer!

COVER LETTER

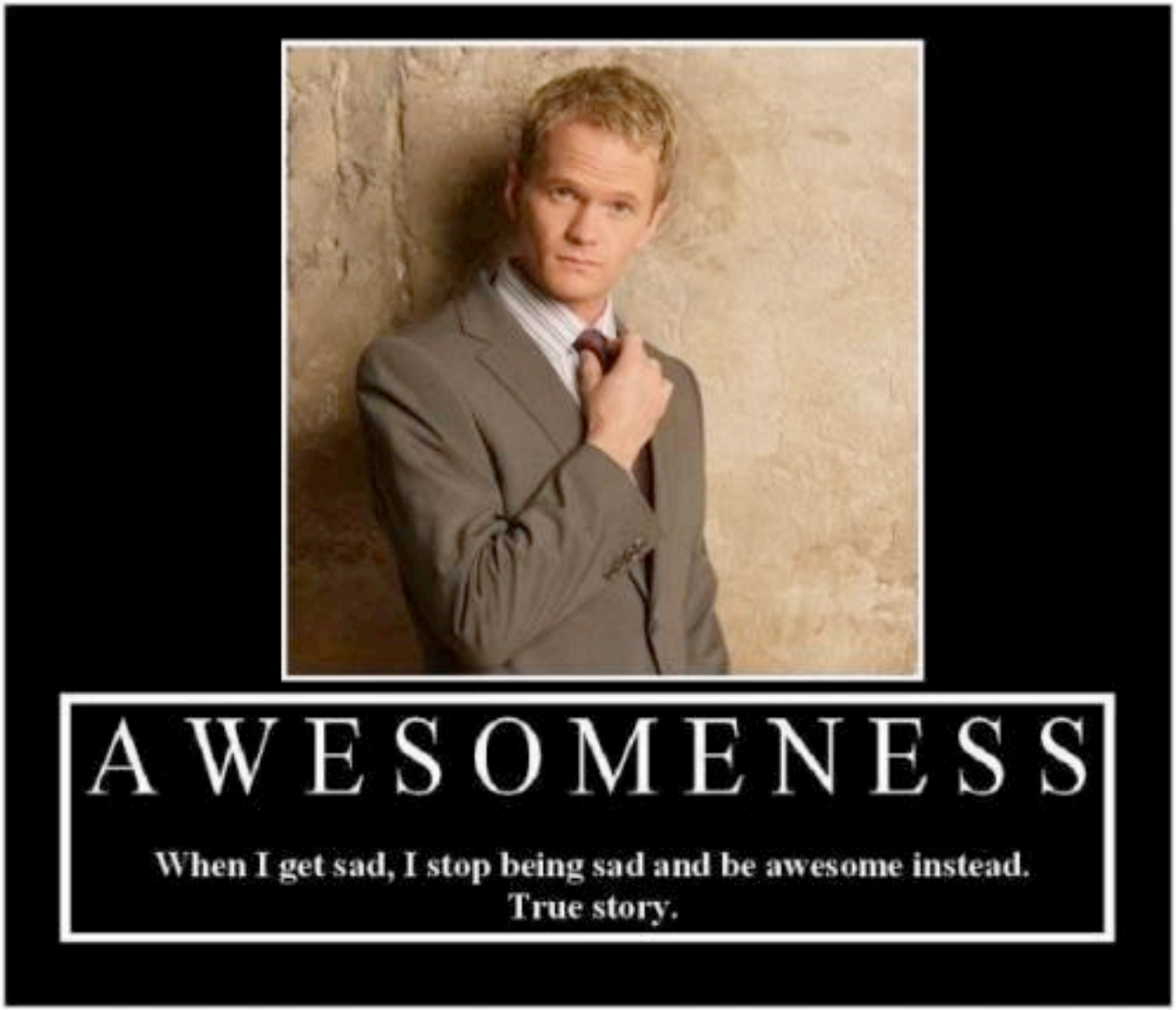
- Write a specific cover letter for EVERY JOB
- It may be the ONLY THING your interviewer will read
- Short and sweet! (1 page)
- It should be SPECIFIC to the particular director, to that particular position

COVER LETTER

TELL THEM WHY YOU ARE PERFECT FOR THE JOB

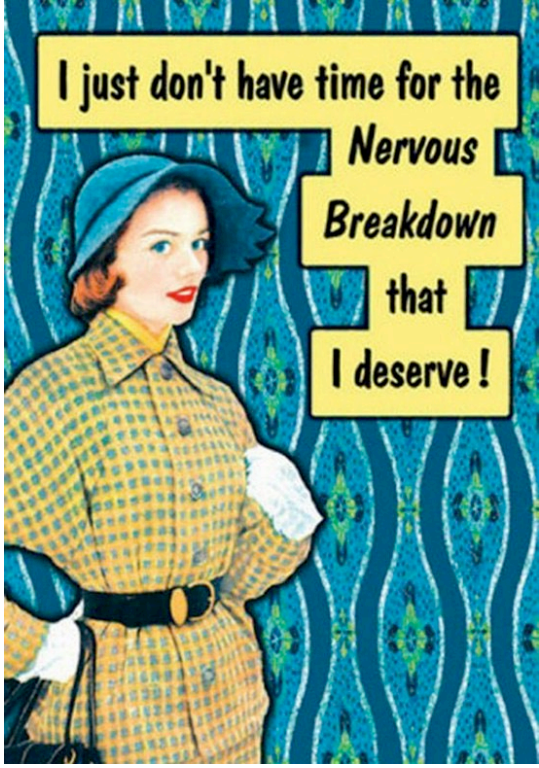
- Special skills
- Interest in particular demographics/communities

INTERVIEWING: CALM DOWN



Getting Ready

Traditional	Business Casual	Business Casual/Casual
		



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 Interviewing Strategies

- 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!

"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."

Follow Up

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.

IDENTIFYING YOUR KEY JOB ISSUES

The following three exercises will help you identify the key issues that can help guide your job search.

1. Your perfect job.

List all the things you are really good at doing (e.g., working with children, performing procedures, teaching or managing staff).

_____

_____

Which of the things listed above do you really like to do?

_____

_____

What kind of job will let you do most of these things most of the time?

_____

_____

2. Your great day at work.

Imagine that you are relaxing with a friend at the end of a great day at work. Your friend asks what made it so great. Write down three things. (For example, maybe your day was great because you were able to spend extra time helping one of your elderly patients, you delivered a baby or you negotiated a better contract with one of your health plans.)

1. _____
2. _____
3. _____

3. Your values and goals.

Think about your personal and professional values and goals.

What would you like to achieve in different parts of your life? _____

_____

What type of practice would allow you to meet these goals? _____

How much time would you like to spend working? _____

How close would you like to live to your family and friends? _____

What parts of the country and what types of communities appeal to you? _____

_____

Describe the standard of living you would like to achieve or maintain. _____

How much job security do you need? _____

Do you prefer treating certain types of patients or performing certain types of procedures? Are there certain things you would rather not do? _____

What types of non-clinical activities interest you? _____

Do your religious beliefs guide your practice? _____

What do you like to do when you are not working? _____

Family Practice Management®

 Valancy J. Finding the perfect job. *Fam Pract Manag.* July/August 2006:37-43; http://www.aafp.org/fpm/20060700/37find.html.

Interviewing 101

An on-site interview is your opportunity to assess how well your values and those of a potential employer align.

Rebecca Ann Beach, MD

Dr. Beach is a family physician at the Union Hospital Health Group in Terre Haute, Ind., and the Union Hospital Family Practice Residency. She is also medical director of the Clay City (Ind.) Center for Family Medicine.

CME
covered in *FPM* Quiz

Finding a job that provides long-term satisfaction takes more than the right connections or good luck. For me, it has required a strategy that takes into account my personal and professional needs and values. In a previous article I shared the framework I've used to identify my values and determine what I can and can't live without in a new position (see "How to Find the Job That's Right for You," November/December 2000, page 30). Knowing exactly what I want enables me to focus my efforts on only those opportunities that best suit me. Plus, it saves me time and stress. I approach a job interview the same way.

KEY POINTS:

- Think of the job interview as an opportunity to determine how well a potential employer can meet *your* needs.
- Interviewing support staff can provide you with valuable insight into an organization.
- Touring the physical space where you might work can tell you a lot about the values and priorities of a practice.

Relax

Most of us treat a job interview as a form of mild interrogation: the employer asks the questions, and we provide the answers. Instead, I would encourage you to consider a job interview another opportunity to see how well the organization fits *your* needs. The truth is, by the time you and a potential employer actually meet for an interview, your motives are well aligned. You want a position at a place where you fit in and can stay a while and where you can see a lot of satisfied patients. That's exactly what employers want. They want the best person for the job, and they're hoping that person is you so they can get back to work. Some will even use the on-site interview to try to "sell" you on their organization. Don't be led astray. Stay focused and ask questions that will help you determine whether your values and expectations align with theirs.

Don't pass up the opportunity to talk to nurses and the front-office staff.

Use lists

It's likely you won't be conducting a job search too many times in your career, so don't invest time and effort memorizing your interview questions. Instead, write them down. This recommendation may go against the grain, particularly for physicians who are trained to memorize questions and take minimal notes during a patient interview, but my personal experience has been that everyone reacts positively to my lists. Most administrators are relieved that I am interested and educated enough to bring a list. Many physicians are unsure about what to ask me and seem quite relieved that I have a list of things to talk about. Nurses and support staff seem ecstatic that I cared enough to prepare questions for them.

I tailor each list of questions to each person who interviews me (see page 39), but as you'll see, there are some questions I ask everyone. Their responses – particularly the inconsistencies in their responses – speak volumes. And, while it's likely you're going to interview with the administration and some potential

BOB SCOTT

What questions should you ask?

The following are examples of questions I have asked during job interviews. Consider them a bank to draw from. Your questions may differ depending on your personal and professional needs and values and on the practice setting you're considering. [A longer version of this list is available at www.aafp.org/fpm/20010100/38inte.html.]

Ask a physician

What's the call schedule?

How many calls and admissions do you handle on a typical call night or weekend?

Does the practice use a nurse triage system?

Do you have evening or weekend office hours?

What hospital(s) are you affiliated with?

What is the business plan for the next five to 10 years?

What is the policy regarding prescribing narcotics and antibiotics over the telephone?

Are patient charts well organized? Are they dictated or handwritten?

What are the weaknesses of your current charting system?

Is the practice computerized? What are the future computerization plans?

How would you describe your level of autonomy?

How many patients do you see per day?

Who decides how much time you spend with each patient?

Do you receive appropriate feedback about performance quality?

Do you receive feedback or education on billing and coding?

How would you describe your relationship with the staff?

What are the staff's foremost concerns?

Are you satisfied with the current compensation package?

How is productivity measured?

How would you characterize the pressure to produce?

How would you describe the organization's overall financial health? How is this clinic doing financially?

Is any expansion, integration or corporate rearrangement currently being considered?

Is the administration responsive to your concerns?

Ask an administrator

How would you describe the organization's overall financial health? How is this clinic doing financially?

What is the business plan for the next five to 10 years?

What is the overhead?

Is any expansion, integration or corporate rearrangement currently being considered?

Are you aware of any specific plans for capital improvements?

How would you describe the practice's relationship with third-party payers?

Is the practice computerized? What are the future computerization plans?

What's the payer mix?

How much autonomy do physicians have in this organization?

Do physicians determine how much time they spend with each patient?

Do physicians work any evening or weekend office hours?

Do physicians receive feedback or education regarding performance quality, billing and coding?

Do physicians receive feedback regarding patient satisfaction?

Do physicians hire and fire their own staff? Do physicians have the authority to hire more staff, if needed?

What is the compensation plan (i.e., salary, benefits, vacation, time off for CME, maternity leave)?

Is compensation tied to productivity?

Are bonuses given?

Ask a nurse

Are patient charts well organized?

What are the weaknesses of your current charting system?

Is the practice computerized?

Is it difficult to get equipment replaced or to get new equipment when needed?

What is the practice's policy for prescribing narcotics and antibiotics over the telephone? How closely do providers adhere to this policy?

How much responsibility do nurses have for telephone triage and patient education?

Do you feel that physicians can effectively address your concerns?

Is the office manager responsive when you have concerns?

Do you have any issues or concerns regarding compensation?

How does the overall organization seem to be doing financially? What about this clinic?

Are you aware of the organization's future plans?

Ask support staff

How manageable is the volume of telephone calls the practice receives?

What are the weaknesses of your current charting system?

How would you describe your organization's relationship with third-party payers?

Is the practice computerized?

Is the computer system easy to learn and to use?

Is it difficult to get equipment replaced or to get new equipment when needed?

How would you describe your level of autonomy?

Do you feel the physicians can effectively address your concerns?

Is the office manager responsive when you have concerns?

Do you have any issues or concerns regarding compensation?

How does the overall organization seem to be doing financially? What about this clinic?

Ask everyone

How long have you worked here?

What do you like best about the organization?

What would you change if you could?

How much turnover has occurred during the past 12 months?

Why have people left?

Have you ever considered leaving?

SPEEDBAR®

➤ **To prepare for the interview, write down questions, tailoring them to each person you interview with.**

➤ **Ask about the financial health of the organization and the clinic with which you may be affiliated. Also ask about strategic planning.**

➤ **Allow yourself time to reflect following an interview and don't hesitate to call a potential employer for more information or clarification.**

➤ **Never accept the first job you're offered and don't accept a job if you're hesitant or still have questions.**

colleagues, don't pass up the opportunity to talk to nurses and the front-office staff. They can also provide you with valuable insight about your potential employer. If the opportunity isn't offered, ask.

I highly recommend asking about the financial health of the organization and the specific clinic with which you may be affiliated. It's a vital question considering the amount of change that's occurred in health care in recent years. Also ask about strategic planning: What is in store for the next year, and the next five or 10 years? While an administrator is the logical source for this information, I also like to ask physicians and support staff. If the administration is planning sweeping changes and your future colleagues are unaware, the work environment might become quite uncomfortable.

Evaluate the facility

The interview process should also include visually inspecting the practice. Again, if no one offers to show you around, ask. What you see will shed light on how the organization views its doctors, staff and patients and is another indicator of whether your values align with theirs. For example, are exam rooms a comfortable temperature? Are they well lit and private? If so, it's likely that patient well-being is a high priority. What about the waiting room? Is it clean, comfortable and stocked with up-to-date reading material? Are check-in and check-out areas well marked and easily accessible? Using the same mind-set, walk by the nurses' stations and peek into physicians' personal offices. I also recommend reviewing a few patient charts. Charts that are disorganized and illegible may be a sign of unhappy times to come.

The interview process should also include visually inspecting the practice.

Interview follow-up

After each interview allow yourself some time to review and reflect. You may want to type up your notes and summarize the information you've received. Review your list of questions to make sure you've filled in all the blanks, and call back for more information or clarification if needed. Then write down pros and cons of the position and talk them over with someone who knows you well to help stratify what's most important you.

Job offers

There are plenty of job opportunities for family physicians, so don't feel pressured to accept the first job you're offered. And don't accept a job without a second interview. You'll be cheating yourself out of another chance to evaluate the organization. Why take chances, especially if it means uprooting your family?

Even when you're really sure this is the right job opportunity for you, don't accept an offer immediately. Give yourself and your prospective employers and co-workers some time for "courtship." You'll learn a lot about them by the way they treat you and, to get you on board, they may grant you a few favors not offered to established employees. Perhaps you've identified a few key issues that would make your workday more productive and enjoyable. For example, the office may need another part-time receptionist or medical records clerk, or a better transcription service. Be selective and polite. If you ask for the right things, even the administrators will be glad you asked.

Whatever you do, don't accept a job if you're hesitant or have any questions. The rationalization that "maybe this one issue won't be problem" will inevitably backfire. Instead, ask the employer to address it. If they know an issue is really important to you, they may be willing to make some accommodations.

Get any verbal clarifications or commitments in writing. Perhaps you've been told that you can select your own nurse or that the organization offers six months of maternity leave. Make sure there are no qualifiers attached. The six months of maternity leave may only apply to people who've been employed for three years. Or you may get one opportunity to choose a nurse. What happens if he or she isn't working out? Ask for details, and you may also want to have a lawyer review the contract.

Assuming the job market is a place you'd rather not be, I'd advise you to do everything you can to get exactly what you want. Be choosy and ask questions that will help you determine which job opportunity is the right one for you. FPM

Editor's note: In an upcoming issue, James Giovino, MD, will explore alternative practice styles available to family physicians looking for a change of pace, whether it's working in the emergency department, in a resort community or on Capitol Hill.

CV format (one option)

Your complete name, MD
Accurate, current address, phone number, pager

Education-

- Reverse chronological order – most recent first, Don't mention high school
- School name, month, and year of graduation, and degree earned
- List honors associated with your degree
-

Post Graduate Education (residency and fellowship)

- This can be a separate heading or part of the general education section
- Month and Year of Graduation
- State affiliation "University of Washington School of Medicine, Family Medicine Residency Network."

Honors and Awards- relevant only, not previously mentioned

Professional Service

- List all memberships and year joined, include any offices or committees in which you participate

Employment Experience

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

Licenses and Certificates

- Very important: and some authors recommend it after the address section.
- Medical license number for each state and the date of expiration
- AAFP Board Certification date. "Board Eligible" fine until exam results are available
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- ACLS, PALS, NRP and expiration dates

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- Be accurate
- Citizenship if other than US

Other Skills and Qualifications

- Medical

Procedures
EMR
Clinical leadership
Include pertinent non-medical qualifications

Community Service

- Non-medical community activities, such as charitable organizations
- Some advocacy groups

References

- Have two STRONG references

Let them know that you are using their names

- List their names and contact info, minimum, email and phone number

LOAN REPAYMENT

CLAUDIA SHANLEY , MSW
Rural Health Workforce Director
Community Health Systems, HSQA, DOH
Claudia.shanley@doh.wa.gov

Washington State Department of Health

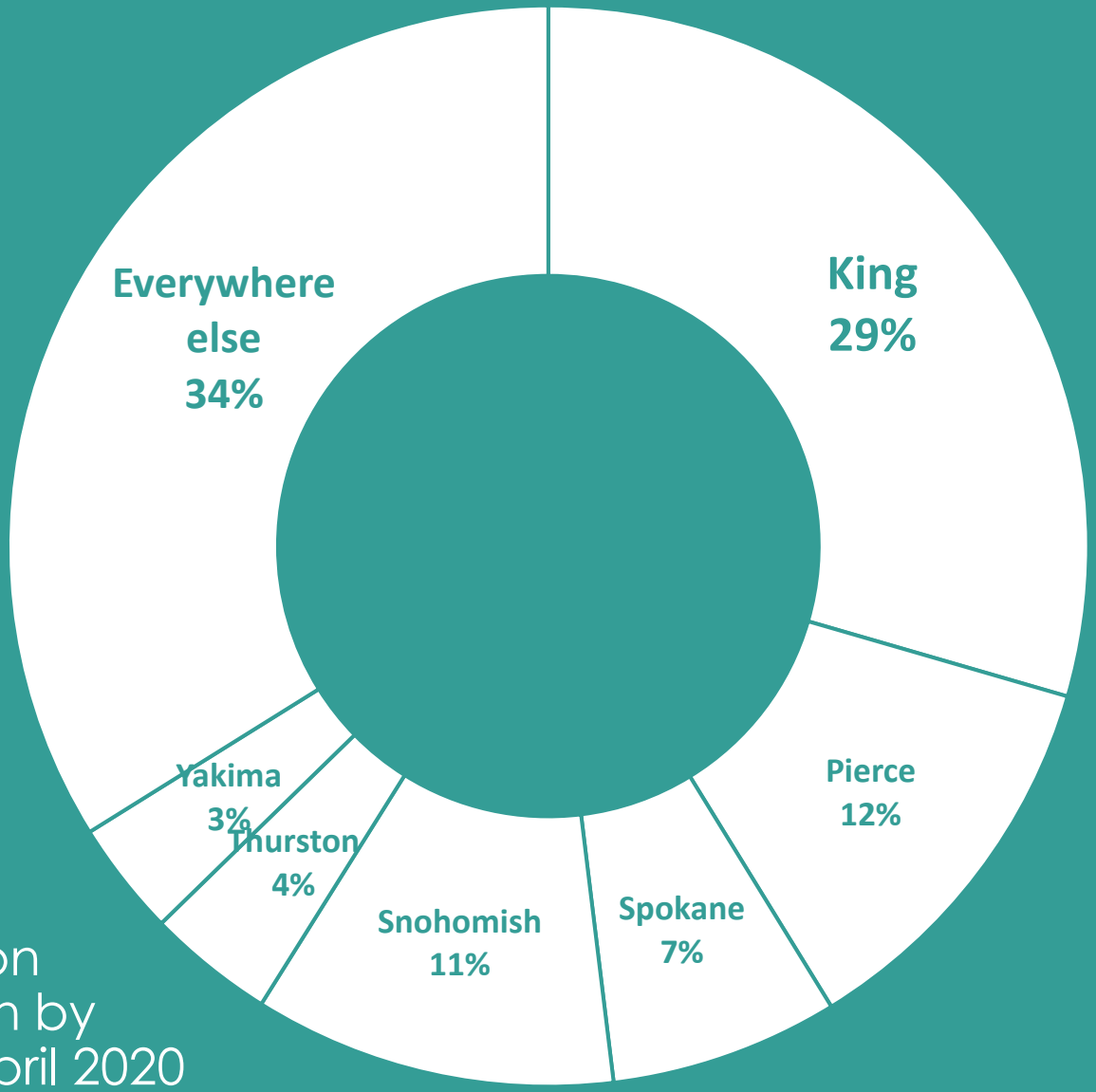
Today's agenda

- **Government loan repayment programs**
- **Employer loan repayment**
- **Public Service Loan Forgiveness**

My agenda

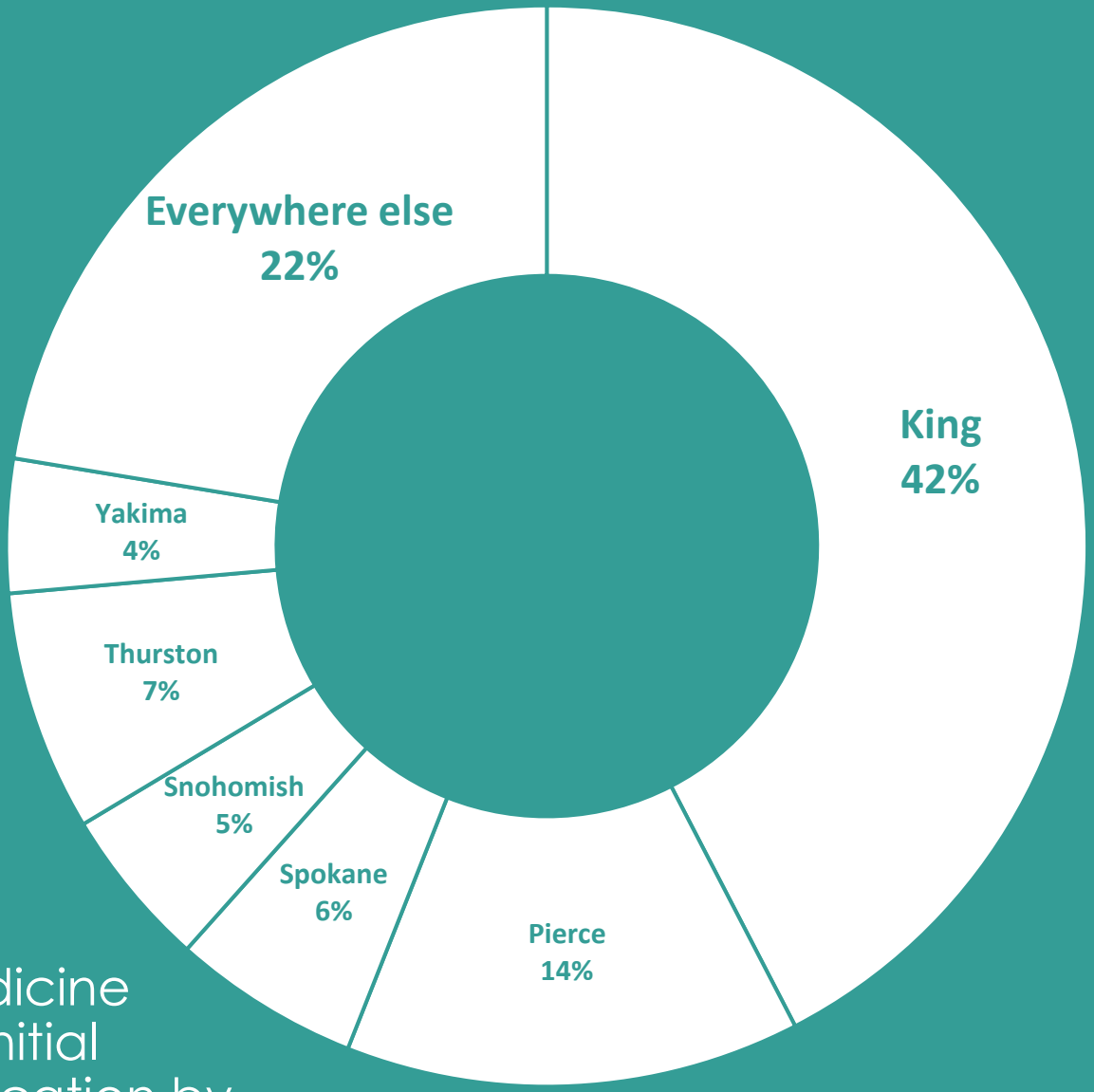
- **Connect communities with physicians**
- **Reduce health disparities**
- **Support rural Washington**

https://www.youtube.com/watch?v=904sZ7ELbb4



Washington population by county, April 2020 estimates

Data Source: Official of Financial Management, April 2020 Population Estimates



Family medicine physician initial practice location by county, classes of 2018 and 2019 (n=126)

Data Source: WWAMI Family Medicine Residency Network

Step 1

Find the right position for you and your family

You're entering an important discernment period

Loans are one consideration, but there are many others that more directly affect your job and life satisfaction

3RNet.org

Rural and urban underserved opportunities in Washington and across the country

Connect with someone like me working in every state

Government loan repayment program

Taxpayer funded

Policy goal is to help ensure access to healthcare for high need populations

Government loan repayment

It's about the facility where you work

Community Health Centers

Rural Health Clinics

Critical Access Hospitals

Tribal Health Sites

Department of Corrections

And the populations you serve

Medicaid clients

Medicare clients

Rural residents

People experiencing homelessness

Migrant workers

Tribal members

Inmates

Several different loan repayment programs

National Health Service Corps (NHSC)

NHSC Loan Repayment Program

NHSC SUD Expansion Loan Repayment Program (2019)

State loan repayment programs

Washington State Health Corps

State Health Program SHP

Federal Health Program FHP

Behavioral Health Program BHP

You can apply to all the programs,
but can only receive funds from one program at a time

Loan Repayment Program

Full time and part time awards:

2 Year Service Commitment

$50,000 award full time

$25,000 award part time

Continuation awards available non-competitively

Award dollars are not taxed as income

Payment is a lump sum

Can be potentially combined with public service loan forgiveness

Loan Repayment Program

In order for you to apply your site must be approved

Provider application typically opens in the winter

Must be employed or have a signed contract to begin work at an approved site by July deadline (it moves a bit each year)

Awards are made by Sept. 30

Annual appropriation $310 million

Substance Use Disorder Workforce Loan Repayment Program

Full time and part time awards:

3 Year Service Commitment

$75,000 award full time

$37,500 award part time

Priority if you

- Have a DATA 2000 waiver
- Serve in an opioid treatment program
- Are certified in SUD interventions

Awarding $70 million this year, included in next proposed budget

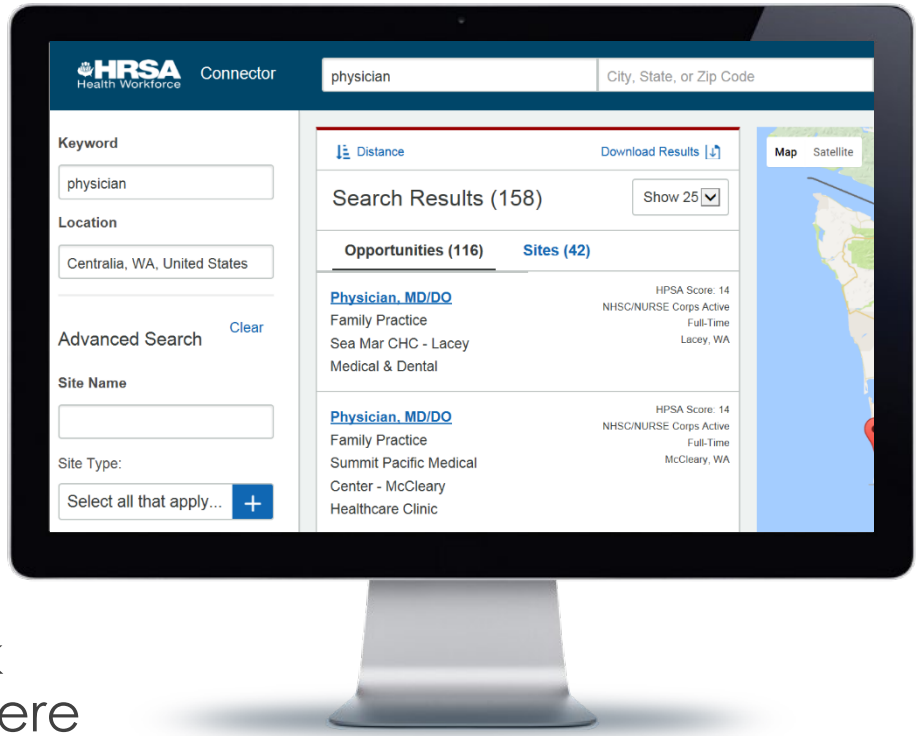
Connector.hrsa.gov

All approved NHSC sites

Search by a variety of criteria

Some sites good about posting opportunities

If interested in SUD LRP ask the site if they opted in, there will be about 115 eligible sites in WA this year, potentially more next year



NHSC awarding process

Regular LRP

Tiered based on Health Professional Shortage Area (HPSA) of your site

Can see a site's assigned HPSA on the connector

Date you apply can also matter (don't procrastinate)

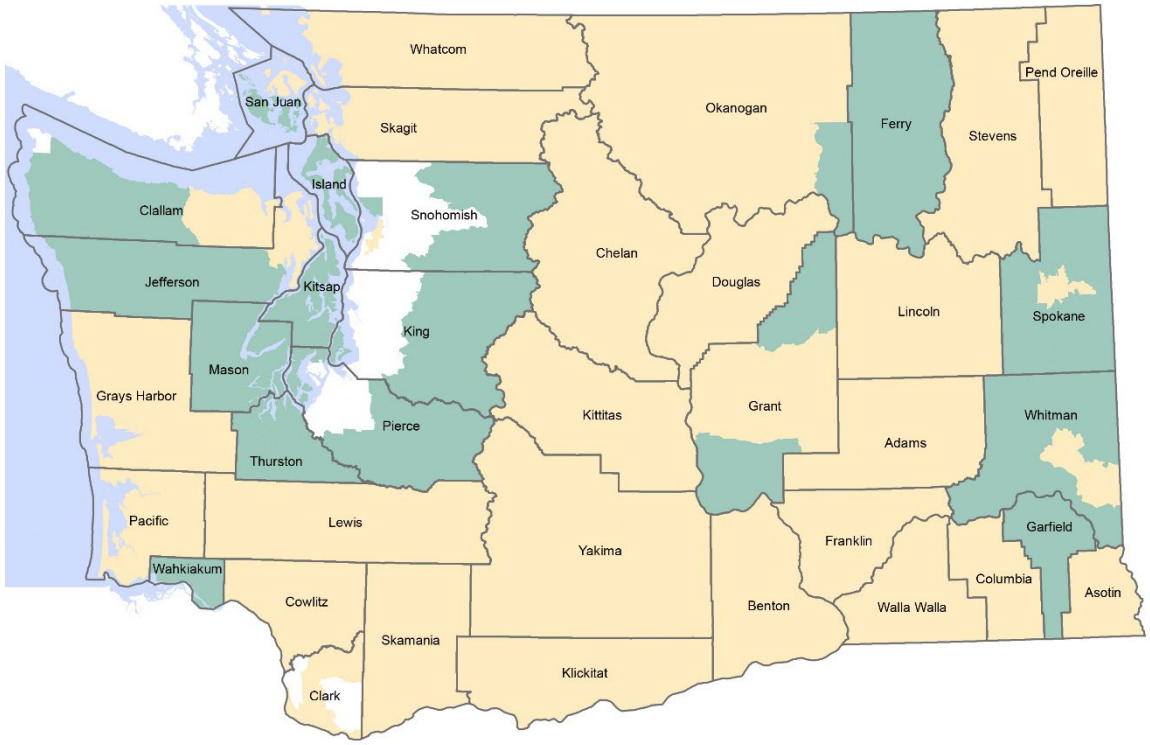
SUD LRP

They will award with priority for higher HPSAs and providers with DATA 2000 waivers

Can use higher of primary care or mental health HPSA

They may award low HPSA sites, need to fully expend funds

Health Professional Shortage Areas



- The gateway to many federal resources including loan repayment
- Most designations are for areas and populations
- Certain types of facilities are also able to receive a HPSA

Washington State Loan Repayment Programs

WASHINGTON HEALTH CORPS

Single application for two programs – FHP and SHP

First screened for Federal Health Program eligibility

If awarded under FHP then:

- 2 Year Service Commitment
- $70,000 award full time

Extension awards may available based on funds available

Award dollars are not reported as federal income

Payment is quarterly after service is verified by site

Washington State Loan Repayment Programs

WASHINGTON HEALTH CORPS

Applications not awarded by FHP are considered for the State Health Program cycle:

If awarded under SHP then:

- 3 Year Service Commitment
- $75,000 award full time

Part time awards also granted; lengthens service obligation rather than decreasing award amount

New default penalties established through legislation

Washington State Loan Repayment Programs

In order for you to apply your site must be approved

Site application opens in Fall

Provider application opens in the winter

Applications finalized in spring with awards being made by July 1 of each year

Must be employed or have a signed contract to being work at an approved site by July 1

Washington awarding process

Scoring system

Site is scored based on several factors including underserved population, health disparities in the area and rurality

Provider is scored based on factors related to likelihood of retention

Total score used for awards

Legislative priority

Currently psychiatrists and psychiatric ARNPs working at the state mental hospitals receive priority

New Behavioral Health Program added for 2020 cycle from legislatively appropriated funds

Common pitfalls to avoid

- Site not applying to be part of the programs
- Paperwork mistakes with your application
- Consolidating eligible educational loans with ineligible debt
- Not applying funds to loans
- Overlapping service obligations

Other governmental loan repayment

- Indian Health Service Loan Repayment Program
- Veterans Administration Education Debt Reduction Program and Student Loan Repayment Program

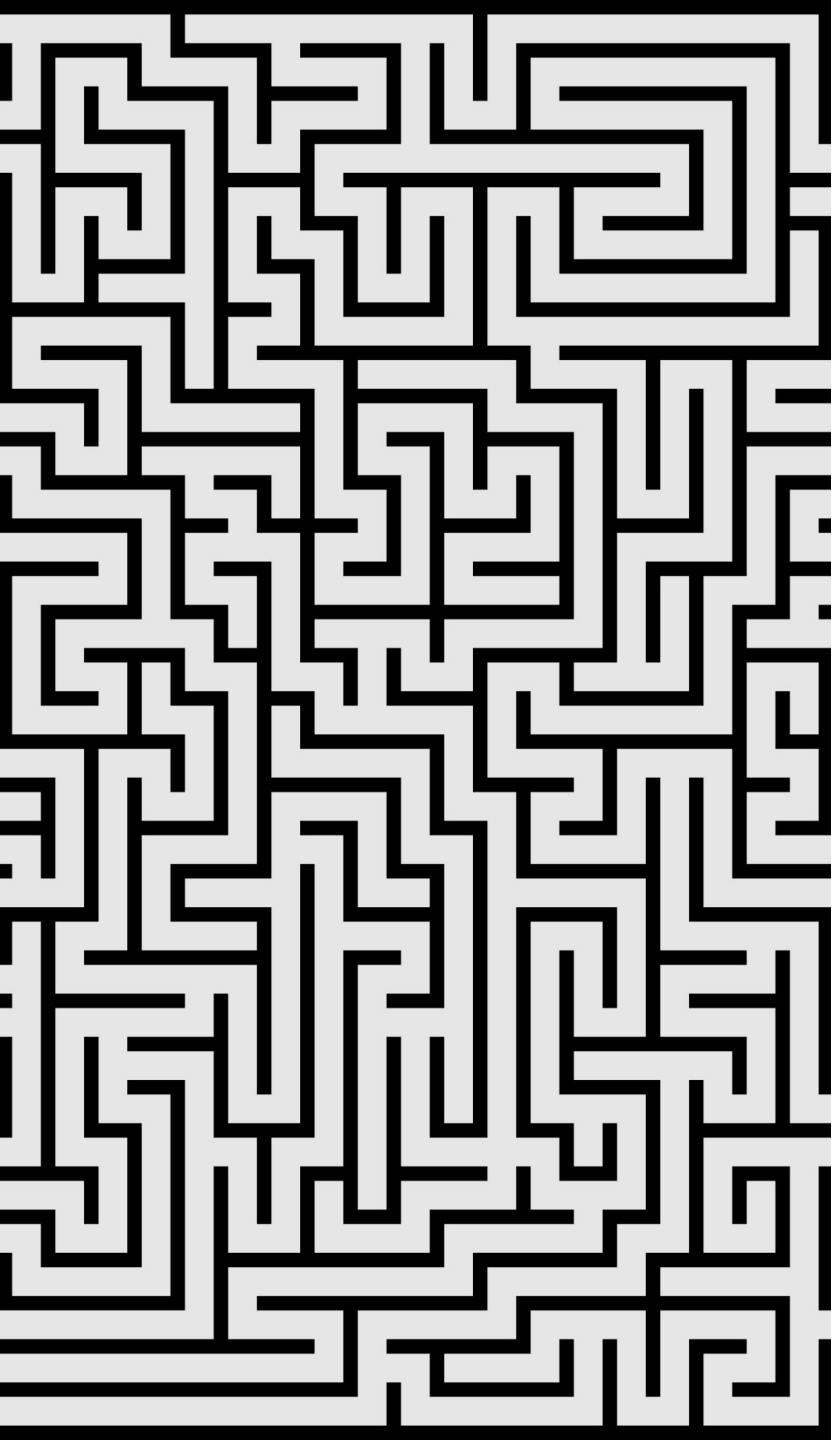
Employer Loan Repayment

Employer funded

Goal is to entice you to choose/stay at a healthcare facility

Again, it's all about where you work

- Many employers now offering this benefit
- Sites participating in government programs may offer short term loan repayment funds as a bridge to NHSC/State program award
- Can be guaranteed via contract
- Variable length of service
- Sometimes funds are on the front end, sometimes not paid until the end of a length of service
- Taxable as income, so remember, net amount to you will be reduced



Public Service Loan Forgiveness

Funding… unclear

Goal is to encourage people to go into public/non-profit careers (and deal with high levels of student debt)

Public Service Loan Forgiveness

- Debt must be Federal Direct Loans
- Enroll in an Income-Driven Repayment Plan
- Work full time at an eligible public or nonprofit employer
- Make 120 qualifying payments (make sure they are being counted)
- Have every employer complete PSFL Employment Certification Form
- When you have made all payments, submit application/documentation to Department of Education

Things to keep in mind with PSLF

- Only Direct Loans are eligible, other federal loans must be consolidated into this category, private are not eligible
- Need to be on an income-based repayment plan, that means a longer repayment period with more interest accruing
- Run the numbers once you're out working and see if it makes more sense to pay down debt aggressively
- You have to advocate for yourself, stay on top of payments to make sure they're being counted correctly

Things to keep in mind with PSLF

- Who is going to control Congress next session?
- As of June, 99% of applicants were denied. Will government be willing to bear cost once greater number of applicants are approved? Will caps come in?
- Letters from loan servicer verifying participation may not be reliable
- Benefits appear to be accruing to those who attended graduate/professional school rather than bachelors gradates
- Creates perverse incentive to incur as high of educational debt as possible (an argument that's out there, not saying it's true)

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.

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: $170,000
- Average loan debt post residency: $200,000

	10 Year Repayment	30 Year Repayment
Loan Balance	$200,000	$200,000
Interest Rate	6.8%	6.8%
Monthly Payment	$2,301	$1,303
Percent of Gross Inc.	19.7%	11.1%
Total Interest Paid	$76,192	$269,386

Guiding Principles

Non-Negotiable

- Retirement Savings
- Short-term Savings
- Insurance

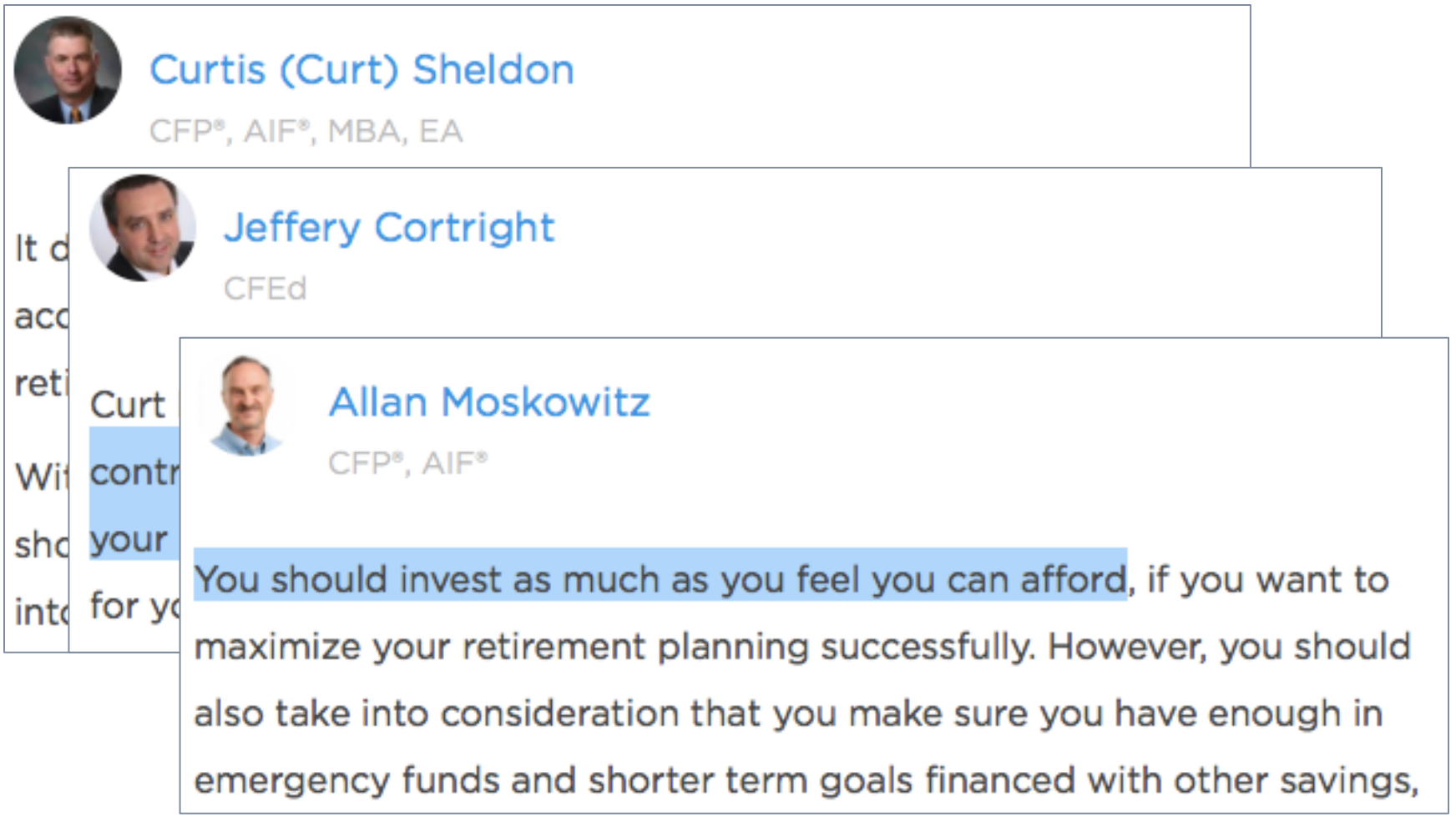
Negotiable

- 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): $19,500 annual employee limit $57,000 annual total limit Pre-tax contributions	Roth 401(k)/403(b): $19,500 annual employee limit $57,000 annual total 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

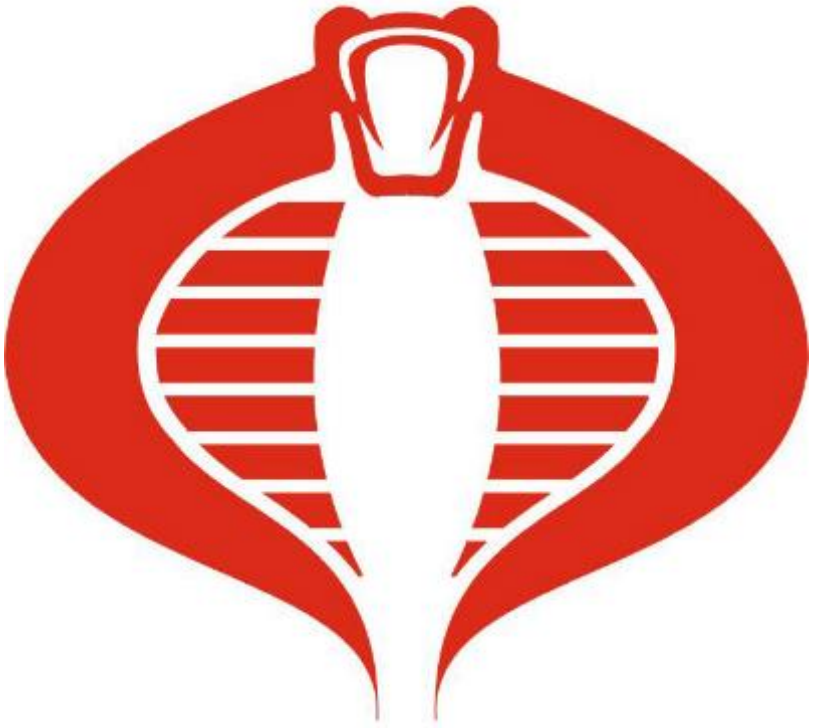
in Target Date, Index Funds

- 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?

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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:
  - 2020 Financial Planning – Stacy comes highly recommended and has experience with the medical world
  - 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