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**Sarah:**  Hi there and welcome today to the Traps in Physician Employment's Agreements. We have with us Dennis Hursh who has spent the last 35 years working with physicians helping them get the best agreements possible. In fact, he wrote the book on a physician's guide to negotiating a fair employment agreement, The Final Hurdle. Thank you, Dennis, for joining us today.

**Dennis Hursh:**  Oh, it's my pleasure, Sarah. It's funny you mention the book but the reason I wrote the book was really because I have done so many physician employment agreements and I see some traps that just continually keep trapping physicians over and over again. So I thought today I'd talk about the three biggest traps that you need to avoid in physician employment agreements.

 The first trap that I find is physicians signing a contract where the start date can get pushed back. Now for a lot of physicians, they figure after they've come out of all the training they've gone through, that first position is really just a reward from the universe for all their hard work. But unfortunately, the employer has kind of a different perspective. The employer's actually hiring you so that you can generate revenue. So to protect the employer there's frequently a lot of conditions that can push back the start date. Now some of these are very reasonable. Obviously you need to have a license to practice medicine. You need DEA and state equivalent registrations.

 Getting those things usually is not much of a problem. The DEA and the state boards of medicine usually process applications very expeditiously. But there's gonna be a few things that are out of your control. And the two things that trip people up the most are participating provider agreements and getting privileges at a hospital.

 Now it depends on the timeframe that you're looking at. I get contracts from time to time from people that have start dates more than a year away. Obviously in a year, there shouldn't be any issue getting hospital privileges or participating provider privileges. The problem is once in a while, I'll get a contract signed in July, with an expected start date of September, and that can be a really big problem.

 Hospitals notoriously move slowly. And folks in the hospitals call summers the slow period. Part of their problem is hospitals want what they call "primary verification." And that's an actual copy of your medical school diploma or transcripts, maybe fellowship and residency transcripts. They may need letters from fellowship and residency directors. And that can take months to pull together.

 The way this usually works is there's a paid staff at the hospital that organizes all the documents and gets everything ready to go. But then frequently, the physicians who review the documents are unpaid and here's where the problem lies. For a lot of people in training, it's a foreign concept but physicians out in practice have a concept that they call vacation. And at vacation, they frequently hit little balls with expensive sticks at exotic locations. The problem for you in that is during a physician's vacation, they're not available for these credentialing meetings. And on top of that, there's no dean of vacations at hospitals so the physicians are all taking vacations at different times. The upshot of this is if you don't have hospital privileges and that's a condition of beginning employment, you may very well have moved to town, signed a lease and be ready to go but you can't start and you can't start earning income.

**Sarah:**  But Dennis, there's something that physicians can do, right, to get around this within their contracts making sure that they're protected, right?

**Dennis Hursh:**  Yeah. And it's the same thing with managed care. What you can do is you just need to be flexible on both sides. For instance, if the physicians don't have hospital privileges sometimes you can do a work around on that because you can just say, "Well if somebody needs to be admitted, one of the other physicians can do it, some of the other physicians can do rounds." The thing is you have to be flexible too. And negotiating these provisions can be really tense because there's a lot of money on the line. You obviously don't wanna be sitting in town, unable to work but the employers want to be able to get revenue from you. So it takes a lot of flexibility.

 There's a few things that I say shouldn't be in those agreements. They shouldn't provide for automatic termination if you're not credentialed. There shouldn't be a unilateral right to terminate for the employer and it shouldn't just be suspended til we get it together. Also, there needs to be a difference between a failure to be credentialed versus a denial of credentials. The employer should always give you administrative assistance and as far as managed care payers, typically I try to get only major payers. So if you're on the east coast, Mutual of Omaha may not be a major payer for you. If there's only one payer that hasn't credentialed you, maybe we can schedule patients with other physicians. And obviously the payer mix is gonna make a big difference. If you're not credentialed for Medicare, that's gonna make a big difference for a geriatrician, not such a big deal for a pediatrician.

 When I said the physician has to be flexible, you've gotta realize that the employer is kinda jumping through some hoops for you so you may have to agree to reduced hours or even reduced pay until you're fully credentialed.

 Another big trap that I see physicians getting caught in is restrictive covenants. What happens is I'll get a call, somebody wants to leave and has a great offer, and then and only then, she looks at her current contract and sees there's a little something in there that she can't work within 15 miles of her current location. Well in a lot of towns, 15 miles is gonna cover not just your new employer but also maybe all three of the local hospitals. So the upshot of that is that physician won't be able to practice medicine in this town if she quits. When you're starting out, it may not be a big deal, but after you've been there a while, you might have kids in school and you might have a really nice practice built up. A restrictive covenant can force you to give it all up, move out of town and basically start your practice over again.

 Physicians always ask me if they c an enforce a restrictive covenant. And the answer is yes.

These things can have a huge impact on you. A lot of physicians look at it and say "Oh, I expect to retire here." There's actually a lot of reasons why you might wanna leave that employer. Sometimes that lovely Dr. Jekyll interviewer turns out to be Mr. Hyde when you're working with them. Sometimes that hospital gets a new brutal cost-cutting CEO or sometimes your circumstances change and you didn't mind putting in the long hours for the big bucks when you got out of training but maybe now you don't wanna do that anymore. So the key is you have to be able to earn a living here at this location if you quit.

 I hear "Well, there's a physician shortage. How can they do that? It's not fair. It's public policy." But you have to look at the employer's perspective here. Those first few patients you're seeing probably came to see another physician. You know, they called up and said, "I wanna see Dr. Smith." And they were told, "Well, Dr. Smith can't see you for three weeks but we have a new physician that can see you tomorrow." So they kinda reluctantly came to see you.

 Now eventually, obviously, you're gonna build your own practice. There's gonna be people coming to see you and referral sources will be referring to you. But at the beginning, basically all that time and money that the employer spent to introduce you to patients and referral sources, it's probably not unreasonable that they want something to prevent you from taking patients . But, you need to protect yourself and make sure it's reasonable. There's really-

**Sarah:** It's like starting a relationship. You wanna make sure that you definitely have a way to get out if you, if something goes awry.

**Dennis Hursh:**  Right. And not just get out but stay in town and get out.

**Sarah:**  Yeah for sure. I mean imagine five years into it and you've built your own practice and you might have kids in school and then just having to leave 'cause you cannot work there anymore.

**Dennis Hursh:**  Yeah.

**Sarah:**  And-

**Dennis Hursh:**  It's terrible.

**Sarah:**  I mean we've talked about it before if there's two doctors that are vying for the same new position and one doesn't have a restrictive covenant and the other one does. Who are they gonna pick? It's just an easier choice.

**Dennis Hursh:**  Yeah. True story in my book. I represented a very senior physician. He wanted to change positions and he had a 65 mile restrictive covenant. And I talked to the general counsel of the hospital and we both agreed the other hospital would be crazy to try and enforce that. His new employer was 63 miles away. So right at the edge. Obviously an unreasonable covenant. But long story short, they ended up hiring somebody else because they just didn't want to get into litigation.

 Now there's two components to a restrictive covenant. There's a geographical area and a time period that you're restricted. I personally think the geographical area is a lot more important. If you're out of the market for a year and you can't treat patients, I'm not sure that that's significantly different than if you're out for two years. Either way, you're probably gonna have to start over and rebuild your practice. I always try and get either the lesser of one year or the time you worked at that employer. But as I said, I think the geographical restriction is much more important.

 My kinda go to restriction is five miles around an area where you spent most of your time. I say kind of go to because it does vary. If you're in a rural area of Montana and your patients are driving 35 miles for groceries, obviously a five mile restricted covenant probably isn't reasonable for the employer. In downtown Manhattan, a couple of blocks would be reasonable, and five miles may not be reasonable. It also makes a difference between specialists and sub-sub-specialists. So if you're a pediatric cardiologist specializing in electrophysiology, probably you're gonna have a bigger restrictive area than a cardiologist or a pediatrician.

 The radius should be drawn around where you spent most of your time in the year before the termination. That's important because a lot of them put restrictions on every office of your current employer. And again, the radius should be drawn from your new office, not every office or location of the new employer. So the language of that restriction is very important. It should be based on your location but a lot of them say the practice of medicine. That can be very significant for a primary care physician in particular that maybe is seeing patients in nursing homes and so on, even though their new office is outside the radius , or for specialists if the hospital is within the restricted radius. Again I think you should be allowed to admit patients and see patients in the hospital just as long as your office is out of the area.

 A lot of times they will have a restriction in there which you have to resign privileges and I usually try to resist that. It's appropriate if it's an exclusive arrangement. Sometimes radiology groups have an exclusive arrangement with a hospital. Something like that is reasonable. But generally,I think you should be able to maintain hospital privileges, just as long as your new office is outside of the prohibited area.

 These provisions also generally have anti-solicitation provisions. They say that you can't directly or indirectly solicit patients or employees. So it's always important to make sure in those provisions that something like a Yellow Page ad or website presence isn't indirect solicitation. Virtually any hospital for example, and most practices now are going to put up a little blurb about you up on the website saying, "Taking new patients." So I wouldn't want an argument that you're somehow violating that. At the same time, obviously, you shouldn't be hiring that awesome nurse that your current employer took ten years training. But again, you should be able to do help wanted ads in the paper.

 There's usually a few reasons that you can get a restrictive covenant invalidated, in the agreement. And that's for example if the employer terminates you without cause, then they ought to release the restrictive covenant. Ideally, also if the employer breaches the agreement, you should be out. Sometimes I get that but it's a little tricky because you know how creative lawyers can be and the employer is always concerned you will come up with some tricky cause of action that says you breached. "You know you looked at me funny so that's constructive termination or something." So that's hard to get but I think it's worth trying to get.

 Sometimes I can negotiate a specific list of grounds where it doesn't apply. For example, if you leave because they didn't pay you, I think it's pretty reasonable to say you oughta be able to go. Hospitals will often waive a restrictive covenant as long as you don't work for a competing health system. So if you go work for a private practice within the area, that's usually fine for them.

 Sometimes you can also buy out of a restrictive covenant but it's always expensive. It's usually about a year's salary. Sometimes I'm able to get that reduced. I have two reasons for asking. The first, as we talked about, is the first year or so you're basically taking their patients that wanted to see one of their physicians but kinda got stuck with you. But after a year or two, those are your patients. People came to see you, referral sources referred to you, so I think it's reasonable to reduce the amount of the buyout. And also, the employer had pretty significant costs of recruitment and credentialing. And probably had some loss from delays in payment from managed care so they were paying you your salary but there was a lag until they were getting paid for your services. So maybe it's reasonable to have a high restrictive buyout at the beginning but less so at the end.

 But here's the bottom line. I talked about the physician that was 63 miles away in a 65 mile covenant. Even though a court would almost certainly have not enforced that, the market will enforce it. So you should always assume that a restrictive covenant will be enforced. Maybe not by a court but by the market. Nobody wants to hire you if they think they're going to court. So don't just blow it off and say, "That's so unreasonable. I know they'll never enforce that."

 Then the last trap that I see people getting stuck in is having to pay for tail coverage in malpractice insurance. This has happened more times than I can count. Some physician out of training signed the contract that was given to her and now she's moving out of town. I just spoke to somebody moving from Seattle to Philadelphia. So the restrictive covenant was no problem at all. The employer said, "By the way, you gotta arrange for tail coverage." And she said, "Okay." The broker informed her that by the way, you need to pay for this tail coverage. And it was many thousands of dollars. Very embarrassing for her. She actually had to go to her family to get the money to buy out.

 Typically I look at it and I'll ask the physician if her current employer has a tail. And actually [laughs] had one physician tell me she was pretty sure her current boss had horns but she'd never seen a tail. So what a tail coverage is, is insurance that covers you after you leave a job. You don't always need tail coverage. It kinda depends on the type of insurance they have. But you have to be very careful because a lot of the first drafts of contracts require you to pay for the tail. That's big because it can be up to a third of a year's salary. So the bottom line is you may not be able to afford to leave that employer. You're effectively stuck there for life.

 Now as I said, there's two types of malpractice insurance and you only really need a tail for the second kind. The first kind is occurrence based policy. And occurrence will cover claims that occur during the policy period. So no matter when the lawsuit is filed against you, you're covered if it alleges that you did something or failed to do something during the period that you were at the employer.

 But the second type of insurance coverage is claims made. And claims-made coverage covers claims that are made in the policy period. So if you leave on December 1st and January 2nd, a lawsuit is filed, claims-made coverage would not cover you. So what you do is to buy what's called a tail to cover you after you leave. A lot of people say, "Well, why doesn't everybody just buy occurrence insurance?" And the reason is that A, it's really expensive and B, from time to time, the litigation climate gets so bad in a state, that you literally cannot buy occurrence insurance. So it's very possible that the employer had no choice. Even if they did have a choice, you can pretty much bet that they're not gonna change your insurance coverage for you.

 I always say you should negotiate for tail coverage even if they currently have occurrence. The reason is they may switch to tail coverage later. So you want to make sure that you're protected no matter what. In the good old days, pretty much everybody paid for a tail. But unfortunately, those days are gone now. Most hospitals will pay for a tail but a lot of private practices are becoming less likely to. You can usually convince some to pay under some circumstances if you appeal to their sense of fairness. For example, if the employer terminates you without cause, I usually try to get them to pay for the tail. Or if the agreement is terminated because of your death or disability, then the employer should pay for that tail.

 Sometimes I'm able to negotiate a portion of tail payment based on years of service. So let's say they'll pay a third of the cost of the tail for every year of service. So if you hang on for three years, they'll pay for the cost of tail. The good news in private practice is that most of those pay for the tails for the owners. So if you stick around, become an owner, probably your tail will eventually be covered. But I think the thing to remember here is that malpractice issues can really trap you in a job.

 Before I sign off, there's something I'd really like to emphasize and that's that you have to get into the right frame of mind about signing a contract. Physicians coming out of training are so competitive. They've always competed. In high school, they had to be the top of their class to get into a good college. At college, they had to be the top of their class and have really good grades in the important courses to get into med school. Even after med school, getting into the residency or fellowship program you wanted was very competitive. And I know sometimes you talk about jobs and you go into this room and you see everybody sitting around you is just as qualified as you are, but you've gotta realize it's a very big country out there. So yeah, you may have 200 other fellows in your specialty but if you think about it, that would still only be four people per state in this country.

 And so the thing you have to remember is once a job offer has been made to you, you're not competing anymore. At this point, you're the prize. They've invested significant time and money before they made the offer to you. So don't feel that you're stuck with what they hand you and don't feel that there's 10 other people waiting behind you because as I said, you're what they want so don't sell yourself short.

**Sarah:**  That's awesome. And I think it's important to understand that, even if they hand you a contract and say, "This is our standard contract," there's definitely room for negotiation. Even if it's their standard contract, they do have some flexibility most of the time.

**Dennis Hursh:**  Right. I actually did a blog post with a picture of a unicorn talking about the standard contract.

**Sarah:**  [laughs]

**Dennis Hursh:**  They, they really don't generally exist. Even very large health systems maybe have a standard contract that they use but they all put addendums and exhibits to that contract. So-

**Sarah:**  Absolutely.

**Dennis Hursh:**  And the other thing is the person that handed you the contract may very well truthfully tell you, "I can't change this." You know, the practice manager can't change it. What he or she doesn't tell you is it has to go to legal and then we can change it. So-

 Yeah.

 Don't fall for the myth of the standard contract. Virtually everything is negotiable. And remember they want you and they want you badly.

**Sarah:**  That's awesome. So if you have any feedback for Dennis, you can email him directly at Dennis@PaHealtLaw.com and he's put together a checklist to go through, just to make sure that all of the hot topics are hit. This obviously does not replace a full legal review by an attorney , but something to at least get you started thinking about what should be in your contract. We'll post the link, but it's PaHealthLaw.com/checklist. And we hope this helps you. You've done all the work and now this is the final hurdle in your journey. So we're excited and hopefully helped make it a little more clear. Thank you so much.

**Dennis Hursh:**  Thank you everybody.