**The 3 Biggest Traps in Physician Employment Agreements (Podcast Summary)**

-Dennis Hursh

I wrote a [book on physician employment agreements](https://pahealthlaw.com/book-on-physician-employment-agreements/) (*The Final Hurdle - A Physicians’ Guide to Negotiating a Fair Employment Agreement)* because I have reviewed so many physician employment agreements with the same traps that keep ensnaring young physicians over and over again. Below are three traps that young physicians need to avoid in physician employment agreements.

**Trap #1 - When do you start work?**

The first trap is signing a contract where the start date can get pushed back. Many physicians feel that after all the training they've gone through, that first position is a reward from the universe for all their hard work. But unfortunately, the employer has a different perspective. The employer is hiring you so that you can generate revenue. Therefore, there are frequently many conditions that can push back the start date.

Some of these conditions are very reasonable. Obviously you need to have a license to practice medicine in that state, and you need DEA and state equivalent registrations. Getting licensure and DEA registration is usually is not much of a problem. The DEA and state boards of medicine usually process applications very expeditiously. But there are a few common conditions to starting work that are out of your control. The two conditions that trip up physicians the most are becoming a participating provider in the managed-care plans of the employer, and getting privileges at a hospital.

Of course, the likelihood of this trap becoming a problem depends on the time between the execution date and the anticipated start date. I frequently review contracts that have start dates that are more than a year away. There shouldn't be any issue getting hospital privileges or participating provider privileges over the course of a year. The problem arises when a contract is presented in July, with an expected start date of September, for example.

Hospitals notoriously move slowly, and hospital administrators call summers the “slow period.” Part of the problem is that hospitals want "primary verification" - an actual copy of your medical school transcripts, and fellowship and residency transcripts. They may also require letters from fellowship and residency directors. These documents can take months to pull together.

There is generally paid staff at the hospital that organizes all the documents and gets the physician’s credentialing file complete and ready for review. However, the physicians who review the documents are frequently unpaid – so scheduling credentialling meetings can be difficult. Although it may be a foreign concept for physicians in training, physicians in practice have a concept that they call “vacation,” where they frequently hit little balls with expensive sticks at exotic locations. During vacation the members of the credentialing committee are not available for credentialing meetings. There is no “Dean of Vacations” at hospitals, so the members of the credentialing committee are frequently taking vacations at different times. This can result in delays of several months before a physician can obtain privileges.

Many physician employment agreements provide that the physician cannot start work until privileges are obtained. In some cases, the physician may have moved to town, signed a lease (or possibly purchased a house) and is ready to go to work, but he or she can't start employment, or earn any income.

I occasionally see the same issue with credentialing for managed care companies. Thankfully, it is somewhat unusual for insurance companies, since they generally have paid staff doing all the credentialing.

Because of the potentially huge impact on the physician, it is important that the contract provides some flexibility if you are not fully credentialed at the anticipated start date. For instance, if you do not have hospital privileges, perhaps a patient that needs to be admitted can be admitted by another physician. Similarly, perhaps some of the other physicians in the practice can do rounds until you get privileges.

There are a few provisions that you should not agree to. The agreement should not provide for automatic termination if you are not credentialed. There should not be a unilateral right to terminate the agreement if you are not fully credentialed at the anticipated start date, and your employment should not be “suspended” pending full credentialing.

The agreement should differentiate between a failure to be credentialed and a denial of credentials. If credentials are denied, that could be evidence of a serious quality problem on your part, and the employer might reasonably refuse to wait to see if you can fix it. In contrast, if you diligently completed applications, you should not be penalized because credentialing took longer than expected. The employer should always give you administrative assistance in completing credentialing applications.

I believe that credentialing should only be required for major payors. If a relatively minor payor has not credentialed you, that should not be grounds for delaying your start date. Patients can be scheduled with other physicians without too much of a disruption if it is not a major payor. Obviously, the payor mix is going to drive this decision. For example, if you are not credentialed for Medicare, that's a huge problem for a geriatrician, but not such a big deal for a pediatrician.

Both sides (the employer and the physician) need to be flexible. The employer needs to be willing to allow you to start even though you’re not fully credentialed, which may cause strain and additional work on the other physicians until you are fully credentialed. At the same time, you may need to accept reduced hours and compensation until you are fully credentialed.

**Trap #2 – Restrictive Covenants**

Another big trap that I see young physicians getting caught in is restrictive covenants.

I can’t tell you how many times I’ve gotten a call from a physician who wants to leave her current position. She has gotten a great offer and only then does she pull out her current contract. She tells me that the contract “seems to say” that she can't practice medicine within 15 miles of her current location. She tells me that a 15-mile radius covers her prospective new employer, and all of the local hospitals. The effect of this restrictive covenant is that the physician won't be able to practice medicine in this town if she quits.

When you are starting out, this may not seem to be a big deal, but after you've been there a while, you might have kids in school, and a nice practice established. A restrictive covenant can force you to give it all up, move out of town and be forced to start building your practice over again if you want to leave that employer.

Many physicians say "Oh, I expect to retire here." But there are many reasons why you might want to leave that employer. Sometimes the lovely Dr. Jekyll interviewer turns out to be Mr. Hyde when you're working with him. Sometimes the hospital gets a new brutal cost-cutting CEO, or perhaps your circumstances change, and you no longer want to put in long hours. You have to make sure that you will be able to earn a living at this location if you quit working for this employer.

Physicians often tell me "There is a physician shortage. How can they do that? It's not fair. It's against public policy." And some states *have* prohibited restrictive covenants for physicians. But, you have to look at the employer's perspective. When you first started out, the patients you were seeing probably came to see another physician. They may have called the practice and asked to see Dr. Smith. But they were told, "Dr. Smith can't see you for three weeks, but we have a new physician that can see you tomorrow." So those first patients probably came to you somewhat reluctantly.

Eventually, you're going to build your own practice. There's going to be patients coming to see you and referral sources will be referring to you. But at the beginning, given the 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. However, you still need to protect yourself and make sure practice restrictions are reasonable.

There are two components to a restrictive covenant - the geographical area and the time period that you're restricted. I personally think the geographical area is more important. If you are out of the market for a year and you can't treat patients, I'm not sure that's significantly different than if you're out for two years. Either way, you're probably going to have to start over and rebuild your practice. I always ask for 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.

I generally ask for a restriction of five miles around the place where you spent most of your time in the year before termination. I say “generally” because it does vary. If your patients are driving 35 miles for groceries, a five-mile restrictive covenant probably isn't reasonable for the employer. In downtown Manhattan, a few blocks would be reasonable, and five miles may not be reasonable. Your specialty also makes a difference. A pediatric cardiologist specializing in electrophysiology is going to have a bigger restrictive area than a cardiologist or a pediatrician.

The radius should be drawn around the place where you spent most of your time in the year before termination. Some first drafts put restrictions based on every office of your current employer. Similarly, the radius should be drawn from your new office, not every office or location of the new employer. The language of the restriction is very important. Many restrictive covenants prohibit the practice of medicine in the restricted area. That can be significant for a primary care physician that sees patients in nursing homes, even though their new office may be outside the radius, or for a specialist if the hospital is within the restricted radius. I think you should be allowed to admit and treat patients in the hospital as long as your office is outside of the restricted area.

I try to resist provisions that require the physician to resign privileges upon termination. However, if a practice has an exclusive arrangement with a hospital (frequently radiology, pathology and sometimes hospitalist private practices have these arrangements), then resigning privileges is appropriate. But generally, I think you should be able to maintain hospital privileges within the restricted area, as long as your new office is outside of the prohibited area.

These provisions also typically have anti-solicitation provisions, which provide that you can't directly or indirectly solicit patients or employees. Obviously, you shouldn't be hiring that awesome nurse that your current employer spent ten years training. But you should ensure that something like a Yellow Page ad or a website presence is excluded from the definition of “indirect solicitation.” Most employers are going to put up a blurb about you on the website saying, "taking new patients." I wouldn't want an argument that you're somehow violating a non-solicitation provision because of that blurb.

The agreement should provide a few conditions for waiving a restrictive covenant. For example, if the employer terminates you without cause, or doesn’t renew the agreement, then they should release the restrictive covenant. Ideally, if the employer breaches the agreement, you should also be released from the covenant. Getting a waiver because of a breach is a little tricky because the employer may be concerned that you will come up with some dubious claim of a breach by the employer such as "You looked at me funny so that's constructive termination” or something similar. Getting the restrictive covenant waived because of a breach can be difficult, but I think it's worth trying. In employment agreements with a private practice, I try to get the restrictive covenant waived if you are not offered ownership.

Sometimes I can negotiate a specific list of grounds where the restrictive covenant doesn't apply. For example, if you leave because they didn't pay you, I think it's reasonable to say that the covenant should not apply. Hospitals will often waive a restrictive covenant as long as you don't work for a competing health system.

Sometimes you can buy out of a restrictive covenant - but it's always expensive (usually about a year's salary). Occasionally I'm able to get that buyout reduced over time, based on two arguments. The first argument, as we discussed, is based on the fact that the first year or so you're basically taking a senior physician’s patients who wanted to see “their” physician, but instead were assigned to you. But after a year or two, those are *your* patients. Patients came to see you, and referral sources referred to you, so it's reasonable to reduce the amount of the buyout. Secondly, the employer initially had significant costs of recruitment and credentialing, and probably had some loss from delays in payment from managed care companies - so they were paying you your salary but there was a lag until they were getting paid for your services. After some period of time, however, those costs should have been recouped, and the employer presumably was earning income from your services.

Physicians always ask me if a restrictive covenant can be enforced. And the answer is that the market will enforce a restrictive covenant that a court almost certainly would not enforce.

For example, I once represented a very senior physician who wanted to change positions. He had a 65-mile restrictive covenant in his contract with his current employer, and his new prospective employer was 63 miles away. I talked to the general counsel of the hospital that wanted to hire him and we both agreed the other hospital would be crazy to try and enforce that restrictive covenant, which was obviously unreasonable. If his current employer tried to enforce it in court, they would almost certainly lose. Nevertheless, his prospective employer ended up hiring somebody else, because they didn't want to risk potential litigation. Nobody wants to hire you if they think they might end up in court. Don’t ignore a restrictive covenant thinking that it is so unreasonable that a court will never enforce it.

**Trap #3 – Malpractice Tail Coverage**

The third trap in physician employment agreements is being required to pay for tail coverage in malpractice insurance. I once spoke to a physician moving from Seattle to Philadelphia. Obviously, the restrictive covenant was no problem. The office manager informed her that she had to arrange for tail coverage, and the insurance broker informed her that the cost of the tail coverage was many thousands of dollars. The physician and her husband had saved money for a down payment on a house in Philadelphia, but that money went to pay for tail coverage instead.

When I review a physician employment contract I'll ask the physician if her current employer has a “tail.” A physician once told me that she was sure her current boss had horns, but she'd never seen a tail. Tail coverage is insurance that covers you after you leave a job. You don't always need tail coverage - it depends on the type of insurance the employer has. Many first drafts of employment contracts require you to pay for the tail, which can be as much as a third of a year's salary. If you are required to pay for tail coverage, you may not be able to afford to leave that employer. You're effectively stuck there for life.

As I said, there's two types of malpractice insurance and you only need a tail for one type. The first type is occurrence-based insurance, which will cover claims that *occur* during the policy period. No matter when a lawsuit is filed against you, you're covered if the lawsuit alleges that you did something or failed to do something during the period that you were at the employer.

The second type of insurance coverage is claims-made insurance, which only covers claims that are *made* in the policy period. If you leave your position on December 1st and a lawsuit is filed January 2nd, claims-made coverage would not cover you. This means that you are required to purchase a “tail” to cover you after you leave.

You should negotiate for tail coverage even if the employer currently has occurrence-based insurance, because they may switch to claims-made coverage later. Most hospitals will pay for a tail, but private practices are less likely to pay for a tail. You can often convince an employer to pay for the tail under certain circumstances by appealing to its sense of fairness. For example, if the employer terminates you without cause, I feel the employer should pay for the tail. Similarly, if the agreement is terminated because of your death or disability, then I believe the employer should pay for the tail.

Sometimes it’s possible to convince the employer to pay a portion of the cost of tail coverage based on your years of service. For example, you could ask the employer to pay a third of the cost of the tail for every completed year of service.

The above traps have ensnared many physicians. I hope that you are now forewarned of the dangers of these provisions.

To obtain a complete checklist of all the items to review in a physician contract, go to <https://pahealthlaw.com/physician-employment-agreement-checklist/>

Dennis Hursh is a [physician’s attorney](https://pahealthlaw.com/physicians-attorney/) based in Pennsylvania who reviews physician employment agreements in all 50 states. His proprietary Physician Prosperity Program® provides a fixed fee [physician contract review](https://pahealthlaw.com/) and compensation analysis utilizing Medical Group Management Association (“MGMA”) benchmarks. He has helped thousands of physicians who were confused by their contracts with his contract review and compensation analysis, so they could get a fair deal.