Evolving changes in health care in the United States are causing new graduates and self-employed physicians to consider employment with large groups and health systems. Familiarity with the principles, proper conduct, and mechanics of negotiating an employment agreement will be important for vascular surgeons making such a decision. The various components of compensation packages and contract language need to be critically evaluated. To facilitate an understanding of the complexities involved in employment contracts, strategies to avoid making negotiating mistakes are discussed. (J Vasc Surg 2014;60:253-9.)

Although a comprehensive discussion of negotiating tactics or employment agreements is beyond the scope of this report, we wish to discuss basic principles and strategies that will allow the relatively inexperienced VS to avoid fundamental mistakes. We also advise and expect that the reader will seek expert legal and other professional assistance before signing any employment contract.

**BASIC PRINCIPLES OF NEGOTIATIONS**

There are some basic assumptions when two parties begin negotiations. Although a basic conflict of interest exists, both parties should believe they could get a better deal by negotiating. Because neither side should expect to get everything it wants, the parties should be prepared for compromise.

Lewicki and Hiam⁴ point out that there are four main concerns in any negotiation: being clear about your goals, being aware of emotional goals, recognizing the desired outcomes that are consistent with those goals, and being attentive to the relationship with the other party. In the relatively small world of vascular surgery, the VS must take into consideration one’s reputation, especially if one is contemplating adopting a combative approach. It will not be unusual that the negotiation will take place with someone, or their acquaintance, that the VS will have to deal with in the future and perhaps even regularly. If negotiations are performed in bad faith, there may be short-term advantages, but there may be disadvantages in the long-term. Accordingly, the VS is advised to seek a principled negotiation that uses objective and professional standards and guidelines rather than arbitrary demands.

Negotiations are also more likely to be successful when staged over time rather than attempting to accomplish the entire deal in one session. This often allows trust to develop among the key parties.⁴ For instance, when negotiations involve a hospital and a surgical group, sequencing negotiations to strengthen internal stakeholders (physicians or others within the existing group) first may make sense. This will allow allies to develop that will facilitate the smooth conclusion of the negotiation.

Another important stratagem is to try to imagine being the other party in the negotiation and then consider several questions:

- What are their objectives?
- What is their reputation as far as negotiating style strategy and known tactics?
- What are their needs and alternatives?
• Does the person on the other side have the authority to finalize the agreement?

In other words, try to anticipate and avoid the car salesman scenario where the other negotiating party has to constantly check with the “boss.”

In most cases, the outcome comes down to preparation. The VS must be productive in the breaks between negotiations to gain more information and also to reassess the situation. Fully prepared, successful negotiators are honest, exhibit integrity, have the ability to put themselves in the other party’s shoes, and are good listeners (Table I).

**CONTRACTS AND AGREEMENTS**

Although rarely jobs will be taken on a “hand-shake,” this can lead to significant misunderstandings and ultimate ill feeling that could end the association. Depending on the job opportunity, the VS will be required to sign an employment contract. Most initial employment agreements are for a limited period of 1 to 2 years and automatically renew for an additional time period. Both sides usually think of the period of employment as a probationary period. For the employed VS, this offers an in-depth look at the culture and work ethics of the practice or health system because this is one of the main reasons physicians leave a practice.  

Most contracts also include a “termination without cause” clause, which means either party may give written notice to end the agreement without reason, usually 90 to 180 days in advance of the requested termination date. When a “for-cause” provision is outlined in the contract, it may be due to failure to maintain a medical license or board certification, felony convictions, inability to collect Medicare or Medicaid reimbursement due to debarment, loss of hospital privileges, failure to fulfill contract obligations to the practice, and recently, quality measures or practice guidelines.

Employment contracts may specify a certain time limit and then be followed by another contract, the partnership agreement. The latter only applies when the VS is joining a community practice or group.

Suppressed material needs and loans may make the VS focus on the first or second year compensation in the employment agreement. However, long-term income is much more important and should be the prime basis for consideration. Because the partnership agreement may last for the lifetime of a private practice, it is essential that the VS analyze not only the employment contract but also the partnership agreement. Many of the same factors that are included in the employment contract will be found in the partnership agreement. The partnership agreement will, in addition, include details on sharing income and practice expenses. It should also include specifics on how the partnership could be disbanded and which party will bear the cost of the dissolution. Partnership agreements will explain what, if any, financial responsibilities may accrue to the new partner when he or she becomes a full member of the partnership. These may involve acquisition of new debts or refinancing of established debt. Some agreements may require the new partner to buy-in to tangible assets, such as equipment, supplies, accounts receivable, buildings, and cash. Others may require buying-in to intangible assets such as the reputation of the practice or doctors, favorable relationships with patients, referring doctors, and insurance companies. This is often referred to as “goodwill,” with the term implying that the new VS is gaining monetary value from the reputation and prior performance of the practice. However, such a buy-in to intangibles is becoming anachronistic because this does not guarantee any consistent future income in surgical practices.

**THE NEGOTIATION**

The VS needs first to establish professional and lifestyle goals. These should include but are not limited to a preference for an academic or a nonacademic career, practice location, spousal employment opportunities, vacation time, schooling opportunities for children, and desired leisure activities. Only after these issues have been carefully elucidated should the actual opportunity be analyzed.

The initial contact with the potential employer is ideally accomplished by electronic mail and less commonly by teleconference to minimize time away from work. It is suggested that the VS’s goals be discussed even at this original interview. This initial interview may not result in a firm decision but rather a subjective analysis of each party’s goals and ambitions. If both parties are agreeable, an on-site visit can then be arranged. If the applicant will be moving with a spouse or significant other, that person should also participate in the visit. This usually occurs on the second visit or subsequent to the applicant having decided to take a serious look at the opportunity.

An employment offer may be made at the original visit. It is recommended that it should almost never be accepted at that time. Applicants should also avoid the temptation to negotiate during the initial visit. If the position is of interest, the applicant and the employer should both agree on a timeline for further communication. Unless the employer mentions compensation, it is best not to bring it up but rather concentrate on the job opportunity. A nonbinding letter of intent or memorandum of understanding stating that both parties are interested in pursuing a legal contract should suffice until negotiations have been completed. This may prevent the employer from conducting further interviews while deliberations are ongoing.

Negotiations should only begin once the employment contract is received. After reviewing the contract, the VS should have it reviewed by a peer, a mentor, and especially, an attorney expert in physician employment agreements (Table II). Selecting the key concerns and instructing the attorney accordingly will keep the process from dragging out. The legal counsel’s main task should be to minimize risk and maximize revenue. The adage “if it is not in writing, do not count on it,” is appropriate.

**COMPENSATION**

For most VSs starting practice or changing employment, compensation is the most important part of contract...
Table I. Concerns and questions to answer in preparation for negotiations

<table>
<thead>
<tr>
<th>Concern</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tactical</td>
<td>What is the protocol for this negotiation?</td>
</tr>
<tr>
<td>Preparation, goal setting</td>
<td>What do we (if negotiating for a group) want?</td>
</tr>
<tr>
<td>Preparation, role reversal, strategy</td>
<td>What does the other side want?</td>
</tr>
<tr>
<td>Preparation, strategy and preparation</td>
<td>What are my “walkaways” and alternatives (and what are theirs)?</td>
</tr>
<tr>
<td>Strategy</td>
<td>What are going to be the issues in the bargaining mix? Which issues are</td>
</tr>
<tr>
<td></td>
<td>likely to be the most contentious?</td>
</tr>
<tr>
<td>Goal setting</td>
<td>What type of strategy is likely to give me (us) the best outcome?</td>
</tr>
<tr>
<td>Strategy</td>
<td>Where do I start and how will I know when I have achieved most of my (our) goals?</td>
</tr>
<tr>
<td>Strategy</td>
<td>Who will make the first offer? If I am, what will it be?</td>
</tr>
<tr>
<td>Tactical</td>
<td>When do I (we) stop negotiations and retreat?</td>
</tr>
</tbody>
</table>

Table II. Key components to negotiate in a physician contract

1. Academic promotion/partnership track description
2. Compensation: component, formula, definition of bonuses and productivity
3. Death and disability: details on qualifying for disability, when salary stops and policy starts
4. Work related: hours, time off, vacation and sick time, meeting time
5. Expenses: how calculated; continuing medical education, licensure, society membership and dues, hospital staff dues, examinations, books and journal expenses
6. Details of any buy-in for partnership track
7. Malpractice: responsibility for “tail coverage”
8. Retirement plan: type, vesting period, qualified or nonqualified
10. Exit strategy: realistic and reasonable restrictive covenant and liquidation clauses, confidentiality and nonsolicitation covenants, definition of termination with and without cause, dispute resolution provisions

Negotiations. This can often be the most appealing aspect of the new practice opportunity or a deal-breaker if the amount falls below an expected threshold. In reality, many other long-term factors should be taken into account during the negotiation process, and these will be discussed below. However, an appropriate base salary depends on fair market value and is influenced by the experience level of the physician, community need, special talents or skills, need for specialty coverage at the institution, and geographic region of practice. Salaries offered are generally within a range suggested by objective, independently published surveys and benchmarks in the same specialty.

As described above, there will be two contracts when a VS joins a group practice. The first will be the employment contract with its compensation package. Ultimately, there should also be a partnership agreement with its compensation offer. The method of compensation in the employment agreement and partnership agreement will be different, and accordingly, must be clearly stated and understood. Employment contract compensation may also include moving expenses, signing bonus, benefits (medical, dental, malpractice, etc), marketing expenses, and start-up office expenses.

Partnership compensation is often more complicated and many formats are used. All take into account income to the practice after all expenses have been paid. Thus, it is important to be aware of which practice expenses (eg, malpractice insurance, automobile, and practice-related entertainment) will be the responsibility of the individual VS. Some of these, in addition to general overhead expenses (ie, accounting and billing, credentialing and application fees, facility rent, and uniform fees) may be attributed to the partnership and divided equally amongst the physicians.

There is usually an operating agreement, separate from any compensation plan agreement for a corporation, which lays out the framework of the business. This agreement contains details about ownership percentages, voting powers, fiduciary duties of the members, management roles, and allocation of profits and losses. Business associates, banks, and lenders may request this document.

Compensation will often depend on the type of practice that the VS is joining because it may differ considerably depending on whether the VS is joining a community practice, a single vs a multispecialty group, or a private or academic institution. In the most recent American Medical Association 2012 Practice Benchmark Survey, the dominant compensation method for nonsolo employee surgical subspecialists is salary (66.8%), followed by personal productivity (26.4%) and practice financial performance (3.4%). For nonsolo owner-physicians, personal productivity is the dominant compensation method (55.7%).

In a recent Society for Vascular Surgery member survey, almost 70% of respondents (two-thirds of whom were in private practice) stated that some of their compensation was based upon productivity, and 48% of the latter group reported that productivity determined between 76% and 100% of their compensation. Incentives are usually tied to clinical productivity and may include producing relative value units (RVUs), either total or work-related RVUs,
that achieve a certain percentile of a benchmark, such as Medical Group Management Association, American Medical Group Association, or Faculty Practice Solutions Center (FPSC), or net collections.

In general, however, three common methods are used to compensate the physician: fixed salary, productivity, or salary with productivity bonus. Fixed compensation by a straight salary may often be found in public or academic institutions and can provide protection from potential risks in account collections (ie, private payers and nonpayers) and changes in the revenue cycle (ie, reimbursement cuts).

A common example of pure productivity occurs in surgical groups when they allow the new employee to draw a salary of his or her choosing, which is a loan to be repaid from future revenues after expenses have been deducted. The expenses include not only the salary but also the cost of the benefits as well as costs incurred by bringing in the new VS (eg, increased office space, hiring new nurses, office equipment, etc).

Another variation is the combined model or salary plus productivity bonus. The latter will be based on a percentage of revenue that is in excess of a predetermined threshold. This threshold is usually an amount the physician must generate in order for the practice to cover the expenses incurred in employing the new VS.

A hospital or university may base a productivity bonus on intangibles such as promoting quality standards, achieving appropriate patient satisfaction benchmarks, or being productive in research. Current evidence suggests that between 2% and 3% of physician pay is based on quality measures.

Physician compensation has fared better than inflation in recent years and has had steady increases of between 1% and 7% annually during the past decade. Decreases in compensation, adjusted for inflation, have been rare and primarily targeted to certain procedurally intense specialties, such as vascular surgery. Nevertheless, the cost of caring for patients has increased by >20% while Medicare payments for physicians have been nearly unchanged since 2001. One reason for overall compensation staying steady, despite decreasing reimbursement by government and commercial payers, is revenue from technical charges, in-office procedures, directorship salaries, or salary support from hospitals. A survey conducted by Deloitte found that 64% of surgical specialists felt that as a result of health reform, their net income will decrease. A survey of VSs in fellowships showed an increase in expected salary in their first 5 years in practice, with a decline in expectations thereafter (Fig). Knowledge of compensation standards and benchmarks is important to making sense of salary based on fair market value (Table III).

MISCELLANEOUS ITEMS FOR NEGOTIATIONS

The practice or institution may allow for “carve out” income, which the physician is permitted to keep and may include legal reviews, honoraria, and royalties from intellectual property generated by the physician.

Vacation and paid time off (for medical education or illness) should be negotiated during the contract conversation.

Malpractice insurance should also be discussed. Claims-made professional liability policies cover the physician against malpractice claims only during the period of time that the physician is insured under that policy. Protection against claims brought after a physician leaves a practice necessitates the purchase of “tail coverage,” which can be extremely expensive and is typically covered by the practice or shared with the physician. Occurrence policies cover the physician’s actions made during the policy period even after the physician is no longer employed by the practice. Because of the high costs, these policies are seldom offered. The practice, institution, or state often sets a required minimal amount of malpractice coverage: $1 million/$3 million is common, with the $1 million representing the maximum allowable amount of coverage for a single lawsuit and the $3 million representing the maximum coverage during the policy term, which is usually 1 year.

Contracts will typically also delineate physician responsibilities to the practice or institution. These may include maintenance of state medical licensure, hospital privileges, and board certification. Some will require timely completion of medical records, billing forms, and on-call obligations. Employment agreements may also

Fig. Salary expectations of vascular surgery fellows. Adapted from Nair D. Used with permission from the Florida Vascular Society (http://www.fvs.org/pdf/940_Nair.pdf).
Table III. Resources related to physician compensation

<table>
<thead>
<tr>
<th>Physician Compensation Information Resources</th>
<th>Web site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cejka; physician compensation data</td>
<td>cejkasearch.com/compensation-data/physician-compensation-data/</td>
</tr>
<tr>
<td>Merritt Hawkins (organization recruiting physicians)</td>
<td>merrithawkins.com</td>
</tr>
<tr>
<td>Medical Group Management Association</td>
<td>mgma.org</td>
</tr>
<tr>
<td>American Medical Group Association (aka McGladrey)</td>
<td>Amga.org</td>
</tr>
<tr>
<td>Sullivan, Cotter and Associates—reflects all W-2 earnings of hospital-employed physicians including academic teaching hospitals</td>
<td>Sullivancotter.com</td>
</tr>
<tr>
<td>University Hospital Consortium (academic practice plans)</td>
<td>uhc.edu</td>
</tr>
<tr>
<td>Faculty Practice Solutions Center run by University Hospital Consortium and Association of American Medical Colleges</td>
<td><a href="https://www.facultypractice.org/">https://www.facultypractice.org/</a></td>
</tr>
</tbody>
</table>

Table IV. Main differences between academic and private practice employment contracts

<table>
<thead>
<tr>
<th>Variable</th>
<th>Academic practice</th>
<th>Private practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial term of employment</td>
<td>1-3 years with termination without cause upon 60-90 days notice; longer for subspecialty</td>
<td>Generally 2-year initial term but without cause; termination is usually 90 to 180 days.</td>
</tr>
<tr>
<td>Ownership</td>
<td>No ownership in bricks and mortar or goodwill of practice</td>
<td>Opportunity to buy into the practice and building or other hard assets if the physicians own them</td>
</tr>
<tr>
<td>Compensation</td>
<td>Driven by relative value units production, but is changing to performance metrics. Split between academic, which will be % of full-time equivalent fixed, and clinical, which will have a base salary plus bonus and incentive. Usually compensation is at 50% of Association of American Medical Colleges and not exceeding 75th percentile.</td>
<td>Usually base compensation plus bonus based on production measured by cash collections from professional fees. Usually a sliding percentage applied after a threshold level of production is met. Then will move to pure productivity model with expenses of practice defined and withheld after which the physician keeps the difference.</td>
</tr>
<tr>
<td>Malpractice insurance</td>
<td>Usually (but not always) occurrence-based so no “tail coverage” on termination.</td>
<td>Almost always claims made. Physician pays the cost if he or she is terminated without cause; practice pays if it does so. Sharing expenses usually.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Almost always richer, from ability to set aside money in a variety of qualified plans to health benefits, paid time off.</td>
<td>Basic benefits and usually physician can purchase better benefits. Retirement plan often basic 401K with some match.</td>
</tr>
<tr>
<td>Noncompete clause</td>
<td>Now being expanded by the larger health systems and term of 2-3 years and a radius of 20 miles from medical center not unusual. Some opportunity to purchase the right to compete. Price depends on importance of physician to medical center and costs invested in the physician.</td>
<td>Usually 1-2 years in restricted territory defined by a radius of 5-10 miles from any site where physician practices. Some opportunity to purchase right to practice; very fact-specific to the practice employer.</td>
</tr>
<tr>
<td>Practice support</td>
<td>Taxes imposed on divisions and departments (Dean’s tax, Chair’s tax, etc) may cause a negative bottom line and result in salary support by the hospital.</td>
<td>Added compensation for directorship or other administrative roles for private practice and also academic physicians.</td>
</tr>
</tbody>
</table>

include confidentiality clauses in order to protect any proprietary information.

One of the more difficult negotiating points in an employment agreement is the existence of a noncompete or restrictive covenant clause should the employee be terminated or leave on his or her own accord. The departing surgeon will usually be prohibited from practicing for a defined period and from a defined radius from the current practice or facilities. In some cases, a physician may negotiate a buy-out price, which enables the physician to compete with the practice.\(^{15}\) Noncompete clauses may not be enforceable in certain states and under some circumstances, especially in areas where the population may be underserved.

Compensation agreements must also adhere to state and federal legislation, the most significant of which restrict the potential for financial gain through self-referral to a physician-owned facility. The Stark Law prohibits a physician from referring a Medicare or Medicaid patient to a designated health service if the VS (or a member of the VS’s immediate family) has a financial relationship with the health care entity that provides the designated health...
service. Specifically, it can effect ownership agreements as well as prohibiting compensation related to the vascular laboratory or outpatient endovascular suites based on the number of self-referrals. For a practice to legally generate income from these sources, one of the exceptions to the Stark regulations must apply.

There are significant legal barriers in hospitals satisfying some demands made by physicians considering employment. Hospitals have to be careful to avoid incentives that could lead to withholding necessary services or that are tied to the volume of referrals to the hospital, even if accompanied by improvement in quality. Compensation and benefits offered must be in line with appropriate benchmarks lest the arrangements be seen as a kickback for patient services. Some of these prohibitions, such as Stark laws, may apply even after full-time employment.

If the VS is joining a practice that has a vascular laboratory or endovascular suite, he or she may or may not share in the technical fees generated by these services as part of the original employment agreement. On the other hand, the VS should negotiate to be part of the partnership agreement compensation.

ACADEMIC PRACTICE

Although general principles of negotiations apply to any job opportunity, the goals and objectives for an academic VS are different. Employment contracts may be more complicated, depending on how the division or department is governed, whether it is part of a multispecialty service line, if part of the compensation comes from the state, and whether there is support for research time. The main differences in contracts, other than strictly academic issues, are summarized in Table IV.

A typical academic compensation plan for a VS will be split between an academic part, which is fixed, and based on a percentage of a full-time equivalent appointment. Clinical salary will have a guaranteed base salary based on benchmarks such as the EPSC and academic rank plus a bonus or incentive part. The rapidly changing health care environment, including a decrease in state funding at academic medical centers, has led to an increasing percentage of faculty compensation based on clinical productivity and work RVUs. More VSs in physician-owned groups in the SVS survey report that 50% of their compensation was based on productivity compared with VSs employed full-time (P < .007).

Strategies to avoid fundamental mistakes.

1. Take a hard look at the cultural fit. The most common reason for unhappiness for physicians is a culture misfit. What is the employer’s philosophy related to financial and practice management, quality of care, ethics, patient satisfaction, employee relations, and the vascular disease service line? Talking to physicians who have left the practice or the hospital about their experiences with their previous employer may be worthwhile. There is a documented link between workplace culture and retention.

2. Delve deeply into what “integration” really means in a future health system employer. Are there “meaty” roles in governance, whether they are in clinical or nonclinical departments? Does the physician have opportunities in getting involved with strategic planning or marketing, for instance?

3. Investigate essential metrics before you start negotiating. Large groups and hospitals are at a definite advantage in knowing almost every financial metric of their employed physicians. Prepare and obtain information related to productivity measures such as total RVU or work RVU production, revenue, and expense per RVU, and how this contrasts with appropriate benchmarks.

4. It is also important to get some idea of the expense side of the ledger, which if excessive will decrease net income and, hence, compensation. General overhead in academic departments of surgery is in the range of 40%, not counting physician salaries and benefits. As an example, The Ohio State University Department of Surgery reports surgeon salaries and benefits are in the 65% range and general overhead in the 35% range of overall expenses (Christopher Kaiser, personal communication, February 10, 2014).

5. Leave a backdoor open. If a VS is in practice and brings his or her practice to the hospital, the patients and their medical records then belong to the employer. Negotiations must allow the VS some leeway in contacting previous patients (if not all of the patients) if and when the VS decides to leave. It is best to avoid signing a noncompete clause, but if necessary, the restriction must be reasonable in scope and duration.

6. You get what you pay for. The complexities of employment contracts between health care systems and individual physicians demand an attorney specializing in this area. Pay the going rate for this advice, because a mistake made by a generalist attorney may be irreversible and expensive in the long run.

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REFERENCES


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