CONTRACT TALK

Three health care lawyers provide tips for understanding employment contracts and their potential pitfalls.

BY CHRISTOPHER M. ADERMAN, MD; FERHINA ALI, MD, MPH; AND KATHERINE TALCOTT, MD

Throughout training, we are presented with various contracts, but there is little room for negotiation once the binding residency or fellowship match list has been submitted. Many of us would sign a contract for our first job out of training without hesitation, yet few of us have taken the time to comb through the legalese in an attempt to understand the nuances of these contracts.

Employment contracts can be highly variable; thus, close inspection and even review by an attorney are advised before one commits to a potentially career-long partnership. Right now, many second-year fellows around the country are entertaining offers from private practices or academic medical centers. We asked three lawyers who specialize in health care contracts to explain some commonly covered items and identify some red flags and potential areas for negotiation.

What basic items should be listed in an employment contract? How detailed should a contract be?

Jeffrey B. Sansweet, Esq.: Most contracts include the term of employment, termination provisions (with cause and without cause), location, salary, bonus, outside activities, malpractice and tail insurance, continuing medical education (CME) allowance, paid time off, benefits, a noncompete agreement, and potential partnership opportunities. The amount of detail varies significantly, and sometimes vague terms in a contract are more advantageous than clearly defined terms.

Philip M. Sprinkle II, Esq.: Employment contracts can be as long or as short, as detailed or as plain as the two parties prefer. From the contracting physician's perspective, the common or core issues to be addressed include salary and benefits, bonuses (how they are computed and when they are paid), length of commitment, commitment to consideration for ownership, noncompete clauses, malpractice insurance coverage, call coverage, vacation, and, occasionally, specific equipment or staffing needs. Timing and methods of termination are also included. For the contracting physician, inclusion of objective reasons for termination should be preferred (eg, loss of licensure or US Drug Enforcement Administration license), and subjective reasons eschewed (eg, actions that negatively affect the goodwill or reputation of a practice).

For a physician interested in an academic position, the concept of a tenured position would also be a core component of a contract. Less commonly, physicians may want contracts to address side businesses, publishing rights or inventions (about one in 15 physicians, in my experience), specific equipment or staffing needs, maternity or paternity leave, or specific commitments to subspecialties.

All potential employees should remember, however, that it is they who are seeking a position from an employer. The more esoteric or unique the desired contractual arrangement, the less likely it is that the physician employee will find a match.

Richard C. Koval, MPA, CMPE: The primary issues addressed in most contracts are the employment term and termination provisions (start date and how the contract can be ended), duties of the parties, compensation (usually a combination of guaranteed salary plus incentive-based compensation), benefits (eg, vacation, CME leave, health insurance, retirement plan), professional liability coverage (including responsibility for tail costs upon termination), professional expenses to be paid by the practice (eg, dues, licenses, CME, interoffice mileage, etc.), restrictive covenants, and relocation assistance.

Future co-ownership is normally not addressed in the employment contract because such an arrangement is based on mutual agreement; thus, neither the offer nor its terms is guaranteed. However, a side memo or letter should outline expected provisions regarding anticipated timeframe for offer, percentage of ownership, method used to determine pricing, payment terms, income distribution formula for co-owners, and method for redemption of ownership interests.

Are there differences in contracts for academic versus private practice jobs?

Mr. Koval: The primary differences arise in the nature of compensation, given that various sources will likely be combined between teaching, research, and clinical work. Institutional contracts tend to be professionally prepared because they apply to a wide number of faculty members,

but that sometimes limits the willingness of the institution to negotiate contract provisions.

Mr. Sprinkle: Tenured positions have become more dear, and academia has developed multiple employment tracks—from pure clinical performers who are paid based on productivity with little or no chance of research or a tenured position to a pure tenure track. Academic contracts are less complicated but less negotiable. Most are short term (ie, year to year), and most are dependent on annual commitments on both the academic side and the clinical side. Some issues are still negotiable, however, such as productivity bonuses for physicians on a clinical track and research time for physicians on a tenure track. Other issues such as malpractice insurance do not even exist in academia, as all such contracts involve occurrences-based coverage that provides complete insurance coverage for the physician employee.

Mr. Sansweet: Academic institutions obviously do not offer partnership opportunties. They also typically have better benefits than private practices. Academic institutions may also offer signing bonuses and medical school tuition loan reimbursements. Also, many institutions have simple contracts, with many policies set forth in separate documents. As Mr. Sprinkle mentioned, academic contracts also tend to be less negotiable than private practice contracts.

What are some of the biggest red flags you have encountered while reviewing employment contracts?

Mr. Sprinkle: Examples of common red flags include a salary that cannot be changed unilaterally by the employer, terms of the agreement that do not match the terms of the alleged commitment (eg, employer hires physician for a 3-year commitment and provides a signing bonus that is repayable if the employee departs before 3 years, yet the contract indicates that it is a year-to-year agreement), and vague references to shareholder-partner opportunities.

Mr. Koval: Several red flags are worth mentioning:

- Compensation based exclusively on a percentage of productivity, which leads to nominal earnings in the first few months of practice.
- Compensation based on a share of practice overhead, over which employed physicians have little or no control.
- Vague provisions regarding future co-ownership, leaving no clear idea as to how the process might work.
- Unreasonable limitations on reimbursement for professional expenses, resulting in unnecessary tax costs for the associate, as those amounts are paid out of pocket from taxed wages.
- Excessively broad termination provisions allowing the practice unfair latitude in canceling the contract.
- Insufficient disability leave (usually unpaid) to allow for maternity.
- Indemnification clauses that protect only the practice, rather than both parties.

Mr. Sansweet: Other red flags may include notice and termination nuances, requirements for tail malpractice insurance, and details of the noncompete clause.

Tail malpractice insurance has been mentioned several times. What is it, and why is it important?

Mr. Sprinkle: Besides actual salary, the next biggest dollar item in physician employment is the payment of tail insurance. With a few rare exceptions, professional malpractice insurance consists of two types: occurrences-based, which provides coverage (both indemnity and defense) for any real or alleged act of malpractice that occurs during the term of employment, and claims-made, which provides coverage (both indemnity and defense) for any real or alleged act of malpractice that occurs and for which a claim is made during the term of employment. The latter is significantly cheaper, as it limits coverage to any claims that have been asserted before the employment ends for any or no reason.

In order to expand the claims-made coverage to be equivalent to occurrences-based coverage, the physician employer would have to purchase an additional binder or contract at the end of the employment period. That additional binder is called an extended reporting endorsement, but it is colloquially named a *tail*. Depending on the state in which the physician finds himself or herself, and depending on the specialty, the tail coverage is usually expensive (approximately $25,000, but sometimes greater for some

specialties such as neurosurgery or pediatrics and less expensive for others such as pathology).

Although the physician employee had no role in the selection of the type of insurance used by the private practice and did not enjoy one penny of savings from choosing the cheaper tail insurance, many private practices attempt to shift the cost of the tail insurance to the employee. This economic shift is illogical. Nevertheless, it has become common, and physician employees should attempt to avoid this obligation. A good compromise position is that the physician employee is responsible for the cost if, but only if, he or she terminates the agreement prematurely without cause or the group terminates the agreement prematurely for cause. In all other situations, including death, disability, termination by the employer without cause, termination by the physician employee for cause, or successful completion of the term by the employed physician (the completion of the "benefit of the bargain"), the employer would bear this cost.

What parts of an employment contract are typically negotiable?

Mr. Koval: Willingness to negotiate will vary from one practice to another, but each contract should be approached on the assumption that everything is negotiable. The worst that can happen is that the practice will not agree to negotiations. On rare occasions, a practice will withdraw an employment offer in response to attempted negotiation, but such actions should be viewed as a preview to subsequent co-ownership negotiations. It is better to know that a practice is inflexible before dedicating 2 or 3 years to the relationship. All that being said, restrictive covenants will often be the most difficult aspect to negotiate.

Mr. Sprinkle: In academia, little is negotiable other than salary, clinic days, and research days. In private practice, more may be negotiable depending on the group. Some groups will simply not modify their employment agreements but will make email commitments to the interpretation of clauses, which are just as effective as formal amendments. For what it is worth, I have been successful in getting modifications to approximately 95% (maybe more) of the contracts that I have negotiated when I have been told 80% of the time that the contract is not negotiable.

Mr. Sansweet: A typical lawyer answer: "It depends." Some employers are willing to negotiate almost everything, and others (usually larger practices and institutions) will negotiate nothing.

What are some mistakes physicians commonly make when they receive a contract?

Mr. Koval: Not getting qualified advice is certainly the biggest mistake. It is always sad to hear from an employed physician who signed a contract in good faith but without advice, only to discover that the document had provisions that later came back to hurt him or her. It is important to remember that most contracts are prepared by counsel for the practice, and their main priority is to protect their client's (ie, the practice's) interests. They are not paid to be fair.

Mr. Sansweet: One common mistake physicians tend to make is to try to negotiate some terms on their own and/or to have a lawyer look over the contract without informing the prospective employer. Other mistakes include signing a letter of intent before having a lawyer look at it and signing an agreement of sale to buy a house before getting a signed employment contract.

Mr. Sprinkle: Getting a health care lawyer to review an employment contract is a huge help. Such attorneys know the contractual limits under federal and state laws and understand the profession. In many cases, they will have a sense of what changes are necessary and which are simply matters of style. At a minimum, the attorney will, even if no changes are made, help the physician identify and plan for issues that may become exposures for the physician. ■

Section Editor Christopher M. Aderman, MD
- second year vitreoretinal surgery fellow, Wills Eye Hospital, Philadelphia, Pa.
- caderman@midatlanticretina.com

Section Editor Ferhina Ali, MD, MPH
- second year vitreoretinal surgery fellow, Wills Eye Hospital, Philadelphia, Pa.
- fali@midatlanticretina.com

Section Editor Katherine Talcott, MD
- second year vitreoretinal surgery fellow, Wills Eye Hospital, Philadelphia, Pa.
- ktalcott@midatlanticretina.com

Richard C. Koval, MPA, CMPE
- principal/senior consultant, BSM Consulting
- financial interest: none acknowledged

Jeffrey B. Sansweet, Esq.
- shareholder and attorney, Sansweet, Dearden, and Burke, Ltd., in Wayne, Pa.
- financial interest: none acknowledged

Philip M. Sprinkle II, Esq.
- senior partner, Akerman LLP, in Miami, Fla.
- financial interest: none acknowledged