

Career Resources

Job negotiation

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Abstract. A new job is a great opportunity to change and enhance your professional and personal life. Your new position will be defined through negotiation with the parties supporting your new position. Whether your new job is your first or your last, with a large organization or solo, urban or rural, the goal is the same, to define your expectations and communicate clearly to create a situation that you will find professionally and personally fulfilling.

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Preparation is everything

Looking for a new job is a time for reflection. You need to know yourself. What do you want in a practice? Where do you want to be? What are your priorities? What are your spouse's priorities? Your preparation for negotiation starts with considering and ordering your priorities, which could include but are not limited to the following: (1) practice type, (2) income, (3) location, (4) clinical materials, (5) teaching and/or research opportunities, (6) atmosphere, (7) advancement potential, (8) employment for spouse, and (9) lifestyle.

If you have a spouse or other significant person who will be impacted by a job change, you obviously must include them in the process of defining the most important elements

of a new position. Ideally, you have considered your “wish list” before looking at jobs, but whether you have or not, reflecting (or rereflecting) on your priorities after looking at a few positions may result in a reordering (eg, moving the importance of available colleagues ahead of income). Deciding what is most important to you and what is not is critical to preparing for negotiations.

What are you worth? You need to have a sense of your economic value, in general, in the specific geographic market in which you are looking and because of your specific experiences and training. The Association of American Medical Colleges and the Medical Group Management Association both issue detailed annual surveys of physician compensation by geographic area and discipline. Both are expensive to purchase, but through either a recruiter or through contacts in practice business offices and academic administration, you probably can gain access to these datasets. Many business staff members are Medical Group Management Association members and have access to this database, which includes compensation information for both private and academic practices. Faculty affairs professionals and women's liaison officers often have online access to the academic Association of American Medical Colleges' Faculty Salary Survey. A link to less detailed physician compensation information is available at http://www.cejkasearch.com/compensation/amga_physician_compensation_survey.htm.

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After your initial preparation, you will be better able to gather additional important information during your initial contacts with a practice opportunity and later at the time of a first visit. Your priorities should guide your information gathering. If your guaranteed income is your highest priority, it is certainly appropriate to explore the potential salary at a first interview. However, if the practice location and atmosphere are your highest priorities, you might very well want to reserve discussion of the compensation package to a second or even later conversation, after coverage and call have been explored. If the practice environment is a critical consideration, you should certainly try to meet most if not all the other surgeons with which you would be potentially working.

There may be other resources that are essential for you to function in your desired situation such as an endovascular laboratory, dedicated operating room personnel, laboratory space, research technicians, or protected time for grant writing. These might exist or require investment or development as part of your recruitment. Before accepting an offer, you should try to see all the existing resources and personnel that would be important for you to be successful, including the basic office space, clinical staff, and operating rooms.

Compensation can come in many forms including guaranteed salary, an incentive payment based on productivity, or a loan requiring payback that may be forgiven after a defined number of years. Many compensation packages may contain all 3 elements. The most typical salary offers would be a salary guaranteed for 2 years to 3 years, with additional incentive pay if a threshold of productivity is crossed. Typical benefits would include health, life, and disability insurance; retirement fund contributions; vacation, sick and Continuing Medical Education (CME) leave; professional liability insurance; and relocation costs. In addition, sign-on bonuses, cash advances, and loan paybacks may be offered as one-time benefits.

Although benefits are important to consider, the value of the benefit package is often not included in the compensation offer. However, the cost of providing benefits relative to salary may range from 20% to 100% depending on whether the cost of professional liability insurance is included in the calculation. It is critical that you understand whether an offered salary figure does or does not include the value of the benefit package (ie, the specific value of your guaranteed take-home salary).

Evaluating an offer

You are offered a position, but they ask you how much money you need. It is to your advantage to have them make an offer to you first. However, if you have done your homework and have a realistic sense of your worth, you would be prepared to make an initial salary request that is achievable. More commonly you will receive a salary figure and a draft contract (or contracts) to consider.

The larger the organization with which you are negotiating, the more likely that the people with whom you are meeting are not the “deciders,” from both the perspective of what is negotiable and what is not. You should try to assess the roles of the individuals with whom you are dealing and clarify whether you have direct access to more senior levels of management. Even in a small private practice, the senior surgical partner may feel understandably uncomfortable changing the terms of a complex contract he/she paid his/her expensive lawyer to draft.

A counterproposal to the offer you receive does give the other party the opportunity to respond negatively and conclude the negotiation. This is rarely done after a first counterproposal. Completely assessing the initial proposal you receive and making a comprehensive counterproposal are seen as signs of your serious interest. You should have a lawyer licensed in the relevant state review any contracts. The local medical society can recommend attorneys with health care contract experience. You should avoid making multiple reiterative counterproposals, particularly in regard to points beyond salary. A prolonged, volley-like, negotiation can be viewed as evidence that you will be a painful addition to their practice and lead to an abrupt conclusion.

The geographic cost of living is an important factor to consider in assessing any salary offer. Many cost of living calculators are available to compare the relative value of salaries in different regions of the country, such as those at <http://cgi.money.cnn.com/tools/costofliving/costofliving.html> and <http://www.bankrate.com/calculators/savings/moving-cost-of-living-calculator.aspx>.

Most incentive arrangements are based on a calculation of net revenue benefit package i.e. the specific value of your guaranteed take-home salary. The gross revenue is dependent on several factors including your support of the billing process (ie, communicating in a timely way with support staff to let them know what you are doing that needs to be billed for), your payer mix (ie, the proportion of your patients actually paying for your services as well as the relative strength of their insurance coverage compared with the other surgeons in the practice), and the contracts the practice has with payers (ie, how well is the practice compensated per the agreements it has with health insurers). However, the most significant influence on your net revenue, which also might be the most difficult for you to tease out, can be how expenses are charged to you.

Expenses can be general to the practice: rent, employees; equipment; service contracts; or specific to you: malpractice insurance (cheaper for you than older surgeons for the first 3 years of practice), employees that only work for you; your car if leased by the practice, your benefits, CME and journals. Larger organizations often cost shift and charge back nonspecific general “overheads” as an expense. In this way the procedural specialties can indirectly subsidize the primary care physicians. In academic practices, overhead can include the Dean’s tax. General overhead is also often applied in hospital owned practices and this can be substan-

tial, ie, 5% to 25%. Obviously, there are other positive tradeoffs to being a member of a multispecialty group which can mitigate this phenomenon.

Within a surgical practice, general expenses can be divided in the following ways: split evenly in as many ways as there are surgeons to share them (the "country club" model), proportionate to collected revenue, or some combination of both. The practice should explain their system clearly with examples. In a single-discipline surgical practice, the total deductions from revenue for practice costs are typically not greater than 50%. If your incentive compensation is dependent on exceeding a set collected revenue threshold, that point is usually set at the dollar figure where the group is collecting more money for your services than they are spending on supporting you in practice. It is critical that you understand the calculation and the influences on your expense structure.

In some circumstances, money paid to you as a sign-in bonus or an income guarantee is considered a loan, which either needs to be paid back or that will be forgiven if you stay in the recruitment area for a definite period beyond the length of the guarantee. Money advanced for loan paybacks will be reported to the Internal Revenue Service as income on which you will need to pay income taxes. Taking these funds can tie you to a practice or a hospital in a way that can have serious long-term implications as well as expensive tax bills for which you need to be prepared.

Do not sign any documents that you have not had independently reviewed and if you do not understand their purpose. Obviously, the more compensation you can receive that does not involve long-term strings, the better. If you are generally uncertain if you want to have a long-term relationship with an institution or an area, you would be better served by a simple employee relationship rather than be a debtor of the hospital.

In many private practice opportunities, the hospital that is paying is not in control of the other physicians who will cross-cover you. It is obviously essential that you meet these surgeons, that you are comfortable with them, that you can confirm they are actually amenable to cross-coverage, and that they themselves are committed to staying in the area for the short-term. A promise of every fifth night call vaporizes quickly if 2 of the 5 covering surgeons are about to leave the area. If call frequency is very important to you, it is critical to assess the stability of the arrangement.

Closely examine the offered contract for provisions regarding how quickly you can be terminated without cause. Contracts may include language that you can be terminated for no reason in as little as 60 days to 90 days. You should try to limit the ability to fire you without cause and ensure that any specific reason, such as loss of license, felony conviction, or egregious misconduct, is specifically stated in the contract. Especially if you will be relocating, you should try to limit or eliminate provisions that allow you to be terminated without cause for at least the first year or more ideally for the entire term of the contract.

The path to partnership should be clear in your initial negotiations and ideally stated in the initial contract. You should not be expected to buy in to a practice for anything more than your share of the practice's tangible assets including the office building if owned and the actual current value of owned equipment such as furniture, copiers, or computers, not the purchase price or replacement cost. Years ago, an existing practice could guarantee predictable cash flows, similar to stock dividends. The concept that a surgical practice has intangible value, sometimes carried as "good will" on a balance sheet, has passed.

Most modern professional liability insurance (malpractice insurance) is now sold on a claims-made basis. Occurrence insurance, the form of coverage that was once most common, wrote you a policy covering all claims resulting from the care you rendered in a specific year that was effective at whatever time in the future the claim was ultimately made. Claims-made insurance, by contrast, covers the claims made during the year of the policy irrespective of when the care was delivered. Most claims-made policies do not cover claims arising from care you rendered in the previous years you were insured by another insurer, which is similar to the preexisting disease provisions of health insurance.

When you switch from one claims-made policy to another, you need the next policy to retroactively cover the period of your last policy, often termed a "nose." Alternatively, you need a "tail," an extension on your previous policy that covers all the subsequent events that ever arise from the services you provided during the time of that policy. In this case, you are buying occurrence coverage linked to that previous claims-made policy. Claims-made insurance is relatively inexpensive for your first year of practice because it typically takes 12 months to 18 months for a bad result in an angry patient to mature into a malpractice suit. Claims-made coverage annual premiums generally increase over a 3-year period to reach a mature annual premium rate. Tail coverage is generally priced at 2 to 2.5 times the cost of your mature annual premium. That premium will further increase if claims are paid on your behalf or if you shift your practice to a more litigious area, or it may decrease with your moving into a less risky practice area, or with a good loss record, or if your state insurance climate improves with tort reform.

Contracts may assign to the cost of tail insurance coverage to you, either generally or specifically in certain conditions including if you are fired, if you quit, or if you leave before a certain period. This cost, especially if combined with the cost of buying out of a restrictive covenant, could make the cost of leaving a practice prohibitive. Your next practice might be willing to purchase you a "nose." Try to limit your obligation for tail coverage as best you can. Some alternatives would include you are only responsible for tail coverage if you leave before 5 years or you are responsible if you are fired for cause but if you and the practice mutually

agree to end your employment, you would split the coverage.

Although not enforceable in many states or when too broadly written, noncompete and restrictive clauses can present serious problems if you are committed to staying in an area but wish to leave your original practice arrangement. These clauses typically restrict your practice in a distinct geographic area or at specific hospitals for a defined length of time after leaving the group. You will need local legal advice to determine the enforceability of such a clause in the relevant state. If you cannot remove it entirely, the following approaches mitigate the long-term impact of noncompete clauses: adding a buyout to allow your employer to recoup the cost of your employment or restricting the target area to a smaller area, assuming there would be other available practice sites outside that redrawn zone.

In evaluating an academic position, where there are multiple expectations beyond clinical performance, be sure you understand all the expectations for the position, identify all the individuals to whom you would report and who would have input into your evaluation, and assess the probability that the proposed position can be performed. In the ideal situation, you would be receiving formal mentorship to support your academic growth and annual feedback from your Chair or Division Chief on your progress to promotion. Academic positions can involve employment by multiple institutions, and you may be paid separately by each (eg, by both the university and the Veterans' Administration). Try to assure that the position does not consist of simultaneously contracting 100% of your professional effort to more than 1 institution.

In an academic position with a tenure clock, you must be successfully promoted to Associate Professor by a defined date or face either termination or an involuntary switch to a clinical track. Some institutions have provisions to extend the clock for the birth or adoption of children or other life events. If it is not possible to shift to a nontenured clinical position, better known as "up or out," you would have to find another private position to stay in the same area. Information if available regarding the percentage of individuals who achieve tenure within the department are critical out-

come measures of scientific mentorship with in the department. Statistics on promotion and attrition for faculty men and women at every medical school are compiled annually and available at <http://www.aamc.org/members/wim/statistics/stats08/start.htm>. Although not specific for departments of surgery, these can be helpful in documenting the actual experiences of junior faculty in different institutions.

All significant expectations and promises should be documented in writing, either by you or the person to whom you will report. Important points of agreement beyond terms of employment included in the employment contract can be documented in letters or emails exchanged between you and your potential employer. In the long-term, having everything enumerated in your employment contract does not make it all happen. An exhaustive contract can be a solid documentary foundation for expensive litigation, but it rarely starts a new professional relationship off on a constructive footing.

The most important reason to try to express everything of significance in writing is the fallibility of human memory. In the midst of later conflict, parties will genuinely not remember a conversation of a few years earlier. The documentation could be in the form of a memo or letter after a meeting along the following lines: Dear Dr Jones: Thanks so much for meeting with me on Tuesday. I am very excited about my future with your group. I am writing to confirm my understanding of our discussion in regard to . . .

Your preparation, thoughtful evaluation of offers, and clear communication of your requirements, should ensure a successful negotiation for a new job. Additional useful guidance is available through several web sites: Salary.com Negotiation Clinic: http://www.salary.com/personal/layout/scripts/psnl_articles.asp?tab=psn&cat=cat011&ser=ser031&part=par186, Advice from Cejka Search, a leading physician search firm: <http://www.cejkasearch.com/resources/careerdevelopment/default.htm#compensation>, Women in Cell Biology Guide to Salary Negotiation, <http://www.ascb.org/index.cfm?id=1611&navid=112&tcode=nws3>, and National Institutes of Health Guide to Negotiating and Evaluating Job Offers for Junior Faculty, <http://www.training.nih.gov/careers/careercenter/negotiate.html>.