**EPISODE 182 How to Negotiate Like A Boss! Advice From An Expert with guest Kyle Claussen**

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KC: “We wish every physician in the country did this. Most of them put the pen to paper, sign it, and hope for the best. We know that that doesn't work. Half of new physicians leave their first job early. We're seeing a lot transition out of medicine. If you take some preventative medicine up front and get your contract right, then maybe we can prevent some of those bad outcomes.”

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hi there, and welcome back to the Doctor's Crossing Carpe Diem podcast. I'm your host, Heather Fork, and you're listening to episode number 182. We have a hot topic today, and I'm super excited about sharing it with you. We're going to be talking about how to negotiate your employment contract like a boss.

But before we get started, I wanted to let you know about a webinar I'm doing next week. It's going to be next Wednesday afternoon and evening, depending on your time zone. In the webinar, I will be showing how to use AI to rock your career transition. I'll be specifically using ChatGPT to show you how to research nonclinical jobs, how to customize your resume for a specific job description, also how to use ChatGPT to help you in your interview prep, and network on LinkedIn and customize your profile.

The webinar will be Wednesday, May 22nd at 06:00 PM Eastern Standard Time or 03:00 PM Pacific Standard Time. You can sign up at doctorscrossing.com/aiwebinar or go to the link in the show notes. I hope to see you there next Wednesday, May 22nd.

All right, on to our episode for today. My expert guest is attorney Kyle Claussen, who is the CEO of a physician-founded and physician-focused contract review company called Resolve. The stated mission of Resolve is to empower physicians and support and assist them as they transition in their careers. I solicited a number of questions about contract negotiations from a physician Facebook group, which I will be asking Mr. Claussen, as well as some that my coaching clients have asked over the years.

So, let's get started. I am truly honored and delighted to welcome attorney Kyle Claussen to the podcast. Hi, Kyle. How are you?

KC: I'm doing great. How are you?

HF: I'm really happy to have you here because these are burning questions, if I may say, because we're not trained how to negotiate. We often just want to sign that contract and get it over with, but we shouldn't. And I think you can really help empower us as stated in your mission.

KC: Yeah, I'm looking forward to the conversation and all the things you just talked about are fairly common concerns and personality traits of a lot of clients that we have. So, I’m happy to get into it.

HF: All right. Well, I'd love to hear how you got into this area to begin with and a little bit about the company.

KC: Yeah. Resolve was, as you mentioned, founded by a physician who was doing this kind of educational content and helping his residents with contracts and business and medicine conversations and realized that there was a bigger market for this and a bigger need in the physician community for this education. So, that's where Resolve came from.

I was lucky enough, my wife is a physician, so she was doing her training at the same institution as the physician that founded the company. And they were in need of an attorney, and I just happened to be an attorney. And so, that's how I got involved in this.

We've transformed a lot in the last 10 years, as most businesses probably do, but where we hang our hat is trying to empower. And that's why it's in our mission statement. We just feel like there's so much information that's missing from the physician business world that's not being taught in residency programs. And it's such an important part of career satisfaction and making sure you're not bouncing from one job to the next. And so, that's what we're passionate about. That's what we do all day. We have technology and tools and people that help on that topic.

HF: That's really interesting. I'm curious, Kyle, what kind of law were you practicing before getting involved with this company?

KC: Yeah, I thought I was going to be a tax attorney. That was going to be my career. Really exciting. But I went on and got a tax LLM from Boston University and thought that was going to be where my career headed. But having a spouse who's in medicine, being around it, living in it, lots of friends and colleagues of hers watching careers transition and happen, yeah, I couldn't be happier about where we're at.

HF: This does sound a lot better to me than taxes. The tax code is so incredibly frustrating.

KC: I agree.

HF: Well, let's start with you giving the listeners an idea of what is the cost to them if they don't negotiate, starting with the bigger picture here.

KC: Yeah, I think there's different ways to quantify the cost of not negotiating a contract. The easy thing to think about is how much compensation did I give up? Am I short $10,000 or $20,000 a year? And if I'm short that amount over a career, a 30-year career, it's probably $2 million to $3 million with interest on those things if you could invest that money. So, just the monetary value is huge.

But there's other things that have importance in these contracts, things like non-compete so we can get into the different topics that are out there. But on the non-compete specifically, what that does is it reduces your leverage. It pulls away from your ability to renegotiate down the road once you have family and spouses and kids and reasons where you don't want to move anymore. If you then pile a non-compete on top of that, it makes it really difficult.

And so, there's a lot of discussion by the FTC on this, but they think that potentially a 37% reduction in comp happens if you have a non-compete because you lose that leverage and ability to renegotiate. There's a ton of value in it. We wish obviously every physician in the country did this. I think most of them still do what you mentioned early on is just put the pen to paper, sign it and hope for the best.

We know that that doesn't work. The statistics show that half of new physicians leave their first job early. We're seeing a lot transition out of medicine, which I know is what you talked about. And we hope that if you take some preventative medicine upfront and get your contract right, then maybe we can prevent some of those bad outcomes.

HF: I love that you're using this metaphor of preventative medicine because it's true. You have the most leverage before you sign. And this is when people sometimes have this perception that if I try to negotiate, people are going to think that I'm being difficult and may not even want to hire me, which is actually one of the first questions that I wanted to address that came from Facebook. The woman physician asked, “How do I negotiate and not be viewed as difficult?” And I think women especially have more of an issue with this.

KC: Yeah. And I think some of that comes from just the process of getting into medical school, getting into residency. It's never your choice. You hope to get in, you hope to match. And then finally you're coming out and now it's your chance to have some leverage. We know that there's a physician shortage. We know that you are in high demand in almost every market. And so, if you go into that mindset, I think that should help you with asking those questions.

I also think that what we do and what your listeners hopefully are doing, if they're going to negotiate a contract, it shouldn't be viewed as me versus you. It shouldn't be always adversarial. What we're trying to find is terms that fit so you can be there long-term. If we do our job right, hopefully you don't have to come back to us every year. It should be a once every so often type of thing. And if employers kind of understand the conversation in that frame as well, you're hopeful that are open to those conversations too.

I think you should really try to, for all your listeners, remove that fear, remove that thought process that you're going to be viewed as difficult or demanding and just know that this is part of business and healthcare is a big business in our country.

HF: Do you have some recommendations on the actual logistics of negotiating in terms of questions I often hear are, “Should I schedule a meeting to talk to somebody? Should I put my requests in an email? How do I even finesse these conversations to come across this more collaborative versus demanding?”

KC: Yeah, I think it depends on the personalities and what they're willing to do. Some people are better at drafting an email because they're going to be more concise and more direct on what they want versus face-to-face, they're non-confrontational and they'll just cave. I think you have to decide on the outcome you want along with the communication style.

And I also think it depends on what you're asking for. If it's call, for example, things that are linked to the practice to the day in and day out. I think those are good things to talk about. If it's a colleague that you're working with and you're saying, “Hey, how is call handled? How do we hit satellite locations? How does all that stuff happen?” You should be wanting to talk to your colleagues on that and the practice managers and the administration. If it's things like language in the contract or maybe compensation details, things that are more objective, sometimes that's okay to be done via email or having somebody else step in and help you out with that too.

HF: Do you have any suggestions for how to come across and show that you're thinking about them as well? Because that's something I remember reading about negotiations is that to think about what are their needs, because we're often thinking about what are my needs and think about what's in it for them and how to come from that perspective. Is that something that can enter into these conversations?

KC: Yeah, absolutely. I think if the reason they're hiring is because they have a need and that's the default reason why they're posting a job and you're going to drive more revenue than they're going to turn around and pay you back. And that's just the reality of the situation.

Understanding that you want to have that happen. You want to see patients. You want to fill the need that they have. You want to take the call that they're currently maybe having a locum company handle, which is costing them an arm and a leg. There should be a win on having them make that hire or do the renegotiation.

But you also need to be treated fairly in that process. When we talk about things like fair market value and what that should look like, there's a range of what's fair market value. It's not just a set number. And that's where the negotiating, the bargaining happens.

I do think it can be a win-win. I do think recruitment and retention is really hard and it's really expensive for organizations. And so, I think you can view it as yes, I may be asking for more or asking for different terms, but I'm also solving a solution or problem for you.

HF: Can you give us an example, Kyle, of how not to ask? Let's say, for example, pretend I am the employer and you are looking at this contract and you want to ask for, say, $20,000 more, a certain amount. And you also want more vacation and maybe a little more CME. Let's give an example of how not to ask me about that.

KC: Yeah. Well, the first thing I would not do is, I wouldn't piecemeal it. We do have clients that have come to us at the end of their negotiating process. And they've said “I need my CME to be $5,000 instead of $2,000.” Without any justification around it. And then the employer says, “Well, we can get you to $4,000. We can get you somewhere in between.” And then the very next email is, “And I need a signing bonus of $30,000, even though you didn't offer one.” And then they maybe make the adjustment on that. And then they come back and they say, “And I need $280 instead of $250 for my comp.”

And at that point, the employer is wondering “When is this going to end? How many issues are there?” And so, I think not giving any context around the ask, not supporting data with an ask. If you're asking for more to ask for more, they don't like that. And also piecemealing is really not a preferred tactic. I think if you can come in with reference points and be objective on it and also do it concisely all at once, that's really helpful.

HF: I love that. That's a really great recommendation because some people might think, “Well, if I just put one thing out there, then it won't seem like I'm asking for the world.” And so then I'll dribble another one and then another one, but I can see how that would be annoying and frustrating.

One thing that often comes up is this area of non-competes, which you mentioned. And I'd love to hear your advice when someone sees that in a contract, and that can be number of years, length of time. It can also be distance.

KC: Yeah. Non-competes are a major issue. And we know that there's some states that don't allow them for physicians, which is great, but that's a minority position. Most states still honor them and will still enforce them if they're reasonable. And I do think there's a lot of discussion in the physician communities, online and elsewhere, that they just think that these are unenforceable. And so, sometimes they gloss over them. I think that's really bad advice. I think you need to be very careful on that.

What a non-compete does is it says you can't work for a certain time period and in a certain geographic area post-termination. If you are moving to your hometown and all your family is there, and your spouse has a job there, and your great school's picked out for kids, and there's a 20-mile non-compete on you, and that wipes you out of the entire city, that probably should be issue number one for you. And so, I think pushing down on time limits, pushing down on mileage, very important. But there's also other things to think about like what happens if there's a merger? What happens if the private practice I join gets bought out by private equity? Can I get released from the non-compete in those situations? You can also build in these exclusions and these carve-outs to still give you some protection and some out while giving the practice what they need or what they deem to need with that protection.

HF: How successful have you seen people get out of their non-competes? Because that was one of the questions, which was, how can I get out of my non-compete?

KC: Well, you can buy out of them, usually. If your next employer, so to speak, is willing to pay to get you out of it, that's likely what it's going to take, because there's what's called a tortious interference with a business claim. Not only can the practice that has the non-compete on you file an action against you and say, “Hey, you're breaching the contract”, but they can also file an action against your next employer, which your next employer doesn't want.

Usually what we see is a requirement in the contract to confirm that you've either got it waived already or that you're not bound by one, because they want to remove the liability for themselves as well. It's likely going to be something where, unless they're in breach of contract or unless they did something wrong, you're going to have to come to the bargaining table and find out what it's going to take to have that released or go through the process of getting a deck action and going in front of a judge and saying this is unreasonable and I need to wipe it out, both of which are going to be expensive.

HF: What kind of value have you seen on these non-competes?

KC: Usually when we see buyout language, it's about one year's compensation. That obviously varies if you're an orthopedic surgeon versus a pediatrician versus anybody else. And so, if it's more than a year's comp, that's too much. But obviously it's in your benefit to try to drive those as low as you can regardless of specialty.

HF: Okay, what about the requirement to give notice? I have seen everything from nothing in the contract, which is great, to 18 months, which to me sounds incredibly unreasonable.

KC: Yeah. When you talk termination, there's different types. There's for-cause termination, which means you did something wrong or the employer did something wrong. Those are more immediate, usually either right now or within 30 days if they don't fix a breach. But what's most common is what you're referencing, which is called without-cause. And so, it's just I changed my mind or the group changed their mind, they want to go a different direction.

Most common is two to four months, 60 to 120 as far as the number of days. But yeah, we see even longer, we've seen three-year contracts with no ability to get out. That's a really tough situation because life often does happen and you need to have a mechanism to get out of the contract if you need to.

Our recommendation is always usually the shorter the better with some understanding that business transition takes time, you may have to get licensed in a new state. And so, two to four months is a pretty good number to think about.

HF: Right. Because I see when people have six months, I'm always wondering, “Well, if they had negotiated their contract, would they have been able to have gotten that down a bit?” Because it is really hard when you're trying to get a new job for an employer to hire you with that amount of lead time.

KC: Right. Yeah, I agree. I think six months is definitely on the upper end of what you should be accepting.

HF: Since we're talking a bit about leaving, what about tail coverage? Because I often find that people don't even know exactly who is paying or what they would need to pay, and they might be getting ready to leave. This is a scenario often here. I'll say “What's in your contract?” And I'll say, “Well, I kind of remember I sort of signed and I thought I put it in this folder, but I can't find it. And now I don't want to go as HR because then they're going to think I want to leave. I don't want anybody to know. So what do I do, Heather?”

KC: Right. Well, it's a really important term. You have to have coverage. You don't want to go without insurance post-termination. And so, I think your listeners know what that means, but essentially patients have a certain amount of time to file a suit. Sometimes that's going to happen after you've left the employer where maybe the malpractice occurred.

And so, you need a tail policy. If you have a claims made policy to begin with, the contract should be defining who pays for that. If it doesn't, you need to have that in there and have an understanding of that. You can solve it different ways. It's either the practice pays for it or you pay for it. Those are the two ends of the spectrum, but you can also have partial payments, based on either time that you've been there or based on who terminates the contract. There's different ways to kind of meet in the middle, but certainly you want to have as much of that paid for by the employer as possible.

HF: What would you say to a physician who is afraid to ask for their contract because they don't want people to think that they're thinking about leaving, but they want to know what the terms are?

KC: Yeah. You may need to find a different paragraph to reference as far as why you're asking for it is “Hey, I can't remember what the CME policy was. Can you send me my contract? Or I need to double check my call requirements or something.” I don't know that there's a great way to get around it though, without just asking for it. I probably wouldn't give a reason initially, just I'd like to collect my files and see where everything's at. That would be one reason to use an attorney as well because you could go back to them. They'll have a file with a copy that's signed. And so, you could be talking to somebody who's independent without having to go back to the employer.

HF: There's an advantage to using an attorney for sure. And that brings us to another question, which I think is a great one. And this centers around, “Should I try to do this myself? Should I engage an attorney? And if I have an attorney, can they be on the backend or are they going to be maybe negotiating for me? And could that put people off?” I'd love it if you could weigh in on this one.

KC: Yeah. Well, clearly biased to start out with. I am an attorney. This is our practice area, but I'll tell you that there are certain times when we have clients that come in that are extremely well-versed on this stuff. They may have had two or three contracts. They've looked them over. If you have access to market data, if you know what's normal in the market and you are 100% sure that you've read everything and you understand it and you've corrected the issues.

Do I always think you have to have an attorney? No, but I think that's a minority position. I think most physicians are not well-trained in this. They don't understand either the legal language that's in the document and or some of the objective kind of business metrics that are going along with it. They don't understand the definitions of net collections. They don't understand the work RVU conversion factors or what's fair on those things or not.

And so, I think you can engage an attorney and still not have them interact with the employer. About half of our clients will keep us in the background. And just use us as kind of an advisor or a coach to help them along with that process. And then the other half wants somebody to interface and handle those hard conversations, both of which are okay.

Personality fit matters on that. If I told you, you're going to have a contract that's worth a million plus dollars, which most physician contracts are over the course of two or three or four years. You'd likely would take that and have it evaluated by somebody. But for some reason because they think it's just this non-negotiable thing that they sign off on it and don't have it reviewed. I think there's a lot of risk if you don't do that.

HF: I really like what you said, Kyle, about putting the value on the contract, because it's funny how we can sometimes buy stocks. We hear a stock tip in the doctor's lounge and we might go plunk down $10,000, $20,000, $50,000 on a stock. But we don't really research it. Whereas if we're going to give a patient a new medication, we would definitely do a lot of research.

KC: Yeah. And your contract is a guaranteed return. It's not a stock that may go up or may go down. Every two weeks you get a paycheck and we're talking about it going up instantly if you do it right. I think you're right. I think the more education on this, the better. I think the more data that's out there and that people see, the more empowered they're going to be as well.

HF: Right. It's good. When you think of it in dollar terms for your investment, it's such a small percentage that it makes sense to get that help. Unless, like you said, you're very well-versed and you don't have any questions. I want to go back for a minute to salary. One of the physicians had a question and she asked, “When I meet all of the requirements for the job, should I negotiate from the highest range of the salary or should I increase the ask by a certain percentage?” And I know you had mentioned it's good to have data on what actually this position should be offering, but I'd love it if you could speak to this one.

KC: Yeah, we don't get to pick where they start. If you have an offer and it's really a lowball offer, if the general rule maybe is that you're going to ask for 10 or 15% more, let's say, because that's a normal range to negotiate from, the problem with that thought process is that if they really lowballed you, you shouldn't be asking for 10% more, you should be asking for what's fair. And so, sometimes that means 10%, sometimes it means 50%, sometimes it means double where they started. And we see that happen all the time where there's huge increases because the employers started at the wrong position.

I think having access to the information and having the thought process that I need to be treated fairly for what I'm doing really matters. If you're in a renegotiation, I certainly would encourage you to look at your data. What have I done in the past? How many patients am I seeing? What are my work reviews? Where are my collections? Because you can then take that and say, “Oh, okay, I'm actually producing at the 80th percentile. Why am I not earning the 80th percentile as well?” And so, there's not a set number for anyone. It's very specific to the location and to your practice and what the volumes are.

HF: That's interesting, Kyle. You've seen a very lowballed salary be increased, maybe even doubled because someone negotiated it?

KC: Correct.

HF: Wow, that's very interesting. Wow.

KC: Yeah, it's shocking. And we see 20, 30, 40 percent increases all the time. Doubling would be an outlier, but it's certainly 10 percent as a rule should not be what you go in thinking about.

HF: Just coming from my perspective, I might think if I am asking double, they're going to just laugh me all the way to the door, I'm going to insult them.

KC: I'll give you an example of how this happens. We had a contract this morning, I was talking with a client on, and it's the exact same specialty and it's the exact same city. And these practices are about a mile and a half apart. And there's one that has a guarantee at $250,000 and the other practice has a guarantee at $400,000. And their collection metrics on production when you bonus are relatively the same, collection percentages are about the same. And so, that's not quite double. But it's very close.

And so why would there be a difference of $150,000 a mile apart? The answer is there's not. I just think most practices, health systems, private practice, private equity, I don't want to come across as saying that they're bad people, but their job is to get as much labor as they can for as low a price point as they can. And so, if there's a range there and they can get somebody to sign for 10 or 20% less than what market tells them is fair, that's their goal. That's the objective of some of these companies.

HF: Well, I appreciate you sharing that information because it's very eye-opening, and unfortunately not super surprising. Now this next question is on a slightly different topic, but it's something I see as well, which is if you're working for an employer, there might be a clause in there about how anything that you do, and it could be completely unrelated to the job, it could be on your own time, is the intellectual property of your employer, and they own the rights of everything you do and even potential income.

KC: Yeah, it's becoming more and more of a problem with the physician population wanting to have side gigs outside nonclinical type work, maybe in addition to what they're doing. Through that process, there's intellectual property that's created, and your contract should be defining, one, if you're even allowed to do those outside activities, but then two, what happens to the revenue from that and the IP from that.

And so, the default position is most contracts start out saying, you can't do that unless we tell you it's okay, and we get to retain all the rights to those things, again, unless you can show us that we've approved it and you didn't use any of our time or any of our resources, and it doesn't relate to the practice of medicine, which for physicians doing outside activities, almost everything is going to relate to the practice of medicine somehow. So you really need to correct that in the documents if you have that interest.

HF: When someone wants to get that removed or modified, how successful do you see them being?

KC: We see it modified frequently. I think it depends on priority. There's some people that care about it, but not that much. And so in those situations, if the employer says no, they'll just let it go. But if it's absolutely priority one or two for you, we see employers, either one, making the adjustment on that, or two, adding an addendum that says, “This category that's important to you, we'll waive that one and keep the rest of it in place.”

HF: Well, it's interesting because the podcast that I did recently with a physician who started an aesthetic business, which became very successful, was doing it a little bit on the side of her full-time job. And I don't know what the terms were in her contract, but she got called in and she was fired when she was eight months pregnant, shown the door. And she said it was super hard at that time, but it ended up being the best thing that happened to her. But there's an example of where, no, you can't do that, or we decided you can't do that after the fact.

KC: Yeah, that's right. Yeah, you got to be extremely careful on that.

HF: The next question is, what is a reasonable sign-on bonus or what factors into what I can ask for in a sign-on bonus?

KC: This is a category that has a really, really big delta. If you look at surveys, MGMA or some others that are out there, they'll give you medians for your specialty, as far as what a normal signing bonus looks like. Oftentimes, it's about 10% of what your total comp would be. If you're earning $250,000, you'd expect a $25,000 signing bonus, for example.

That being said, there are some markets that don't offer them at all. You're going to see a zero. And there's some markets where they can be six-figure plus. If you look on our site, you can look through some of these other contracts that are out there, you'll see signing bonuses of $200,000, $250,000 at times. Now, those are going to be tied to years of service. If you leave early, they want it paid back. But it can be anywhere from zero to $250,000 is my answer on that. And it's really dependent on geography and practice type of where you're going.

HF: Do you do many nonclinical contracts, or are most of them for clinical employment?

KC: Most of them are for clinical, but we do have clients that have both, or are currently working and get offered something else that they're considering transitioning to, which I know is a lot of your clients that are out there. We do handle both. Obviously, there's some distinctions and differences on terms of what's going to be important to you in a nonclinical role, very specific by industry, kind of what that role would be.

HF: And now we have one that's about providing resources or guidance for the topic of maternity or parental leave.

KC: Yeah, this one, it's a tough one, because most contracts are not going to address it at all. When we look at documentation, there's almost 0% chance that they're going to have that in there. You may have to ask them to bring it in. I think there's also confusion on when the state law protections are in place and FMLA, that those only apply to certain employers and after you've been there for a certain amount of time.

And so, I think understanding that and talking with their HR benefits team, do they have short-term disability and does that apply for pregnancies and type of deliveries matter on that as far as how long they're going to pay or make partial payments. Definitely a topic that's important, definitely a topic that you should be asking on, not generally discussed in the contract, usually going to be in the benefits side of the document. That said, we have had clients push for certain details or exceptions to that to be brought into their full contract.

HF: Do you feel that when people start asking about that, it starts making the employer be more hesitant about hiring someone wondering, “Well, are they planning on coming on board and then pretty soon going on maternity leave? And if we have an equally qualified candidate, maybe we really shouldn't go with you.”

KC: Yeah. We don't have employers tell us that. I think for obvious reasons, they don't want to not hire someone who's pregnant or considering being pregnant for discrimination reasons. But I do think it's also with the shift of number of females that are coming out, and the percentage of the population of physicians that are female, it's very common. And so, I don't think that they should be making hiring decisions on a year or two's timeframe. It should be hopefully a long-term commitment by both you and the employer.

And so, I wouldn't be afraid to ask on that item and make sure you've got that clear. Because if you're trying to plan family things, you want to have a good picture on that. Because if this job is not going to offer you the same benefit that another one does, that might be your decision making factor. And so, you have to know the information.

HF: That's an excellent point. Now, this next area is something that I don't know if you deal with a lot in the physicians who come to you, but it's about this area of a physician wanting to do wellness coaching. As a coach, not offer medical advice per se and not use their medical license. I've seen this question asked in Facebook group with everybody giving us rather different kind of opinion from, “No, you can't do it, they're always going to defer to your highest license and agree” to “Well, you just need a contract that states that you're not offering medical advice.” Yada, yada, yada. So, can you help us out here, Kyle?

KC: I think both of those things that you just said are partially true. And so, I think you do want to make sure whatever you're doing right in the wellness area, that it is well-defined, it is disclosed, you're not acting as a physician in that capacity. And hopefully, if you have a dual role, where you are seeing patients clinically still, that you're not seeing the same patient in both roles. I think that's where it gets really confusing.

But I also think that if there's ever a claim that comes in, you need to be prepared for them going after your highest level of license. And so, I think that's going to be very location-specific, very state-specific on what you were doing and when and how.

And so, I don't think there is a general rule, which is probably why you haven't seen a great answer on it yet. But I would encourage you to have documentation and disclosures to those clients to make sure that they're clear on what your role is.

HF: Have you personally seen it work well where a physician is practicing as an MD, and then they have a separate wellness practice on the side where they're functioning as a coach?

KC: I have not seen that. The folks that we've talked to have usually been one or the other, where if they're going into wellness, they're doing that as kind of their transition or their full-time gig moving forward. I think the middle ground, though, is the really tricky part, and you need to be really careful on that.

HF: Okay. Thank you. We're getting close to time here, but I have just a few more I wanted to ask you. This physician wrote in, most primary care docs take either small or no lunch breaks. Why is it standard to demand nine hours per workday and only pay for eight?

KC: It shouldn't be. You should have a break. I also think that most contracts are structured with a base plus production. And so, I think the employer's position would be that, “Well, if you're seeing those patients over lunch, we are paying you for that through your production bonus.” The problem would be is that they're not on that structure. So, if that's a situation that you're in, either one, negotiate for protected time for things like that and or increase your compensation to adjust for that additional time and or patient volume that you're seeing.

HF: And it is the unfortunate situation. As you know, you have a wife who has a position that so much of what we do is really not paid for. It's done at night after the kids go to bed. It's done early in the morning. It's done on the weekend. So, it's so much more than not getting a lunch break, unfortunately.

KC: Yeah, I agree with you on that. And we do see physicians start to ask for things like protected admin time for charting, and to try to remove that kitchen table late at night type of thing. But it's certainly not the majority rule. I think you're going to have to ask for those benefits.

HF: Now, the last thing I wanted to ask you, Kyle, is I had a client who got a job offer and he was given a letter of intent. And he looked at the letter of intent and then we are waiting for the contract. But the contract never came. And they said, we don't really have a contract. It's a letter of intent. Is that a common practice?

KC: In some organizations, it is. And especially with nonclinical work and in the patient facing world, academics, they tend to have things that look like letters or offer letters and not actually have a full blown contract. The definition of a contract just means an agreement between two parties. And so, you have to be very careful on if what you're signing is legally binding or if this is just supposed to be a start to the process. And some will actually say that some will say this is a non-binding document at the bottom versus others that are silent on it. Those are the ones you need to be careful on and make sure you get the terms where you need it before you sign.

HF: Okay. Well, this has been a terrific conversation. I could ask you questions for a whole another couple hours, I'm sure. But this has been really, really helpful. I'd love it if you could share a bit about how folks can reach you and what you offer from the company.

KC: Yeah. If any of your listeners go to resolve.com, that's our company, that's our website. What we do is we provide technology and tools and data for physicians to make sure you guys know what's normal in a contract, what's not, what your market value should look like, if you're being lowballed or not. And then also, if you need access to expert health care attorneys, folks that specialize in this and do this every day, that's there for you as well. We're big on transparency. All of our pricing is flat feed, so you can go check that out and we'd be happy to work with you if you think it's a good fit.

HF: All right, wonderful. I will make sure to put resolve.com in the show notes. You can easily find Kyle Claussen. And before I go, I just wanted to remind you that I am doing a webinar on May 22nd. That's a Wednesday at 06:00 PM Eastern time for an hour.

I will be going over how to use ChatGPT to help in your career transition. And that's from how to even know what nonclinical options are there for you, how to research a specific one, and then taking steps to customize your resume, prepare for interviews, customize your LinkedIn profile and more. There will be a link in the show notes for the AI webinar or you can go to doctorscrossing.com/aiwebinar and sign up.

And as always, don't forget to carpe that diem, share the podcast, and I'll see you in the next episode. Bye for now.

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Podcast details

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