

Business and Communication

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Summary:

In this chapter, we explore various aspects of urological business and communication with a focus on transitioning to practice from residency or investigating a job search. We discussed practice decision making, your CV, and interview process. For those in practice we discuss coding, telemedicine and burn out.

Key Words:

Resume, Business, Curriculum Vitae, Job, Interview, Contract, Negotiation

1. Introduction

Our purpose is to provide the graduating and practicing urologist with an understanding of the business of a medical practice. All doctors leave medical school and their postgraduate training with excellent skills for diagnosing and treating medical illnesses. However, nearly every new doctor leaves his or her training with little to no skills to become successful businessmen and businesswomen. In fact, most physicians are now stereotyped as poor business people. Doctors have a reputation for being good at caring for their patients, but poor at managing the business aspect of their practices.

Currently, few medical schools offer any courses or advice on the business of medicine.¹ There are now 65 medical schools that offer a combined MD/MBA program.² However, you do not have to have an MBA to be able to grasp the basic concepts of business that will affect your practice.

If you do not understand the business component of your practice you may not be able to survive in today's marketplace where profit margins are going to be razor thin. You will no longer be practicing medicine and providing the care to the patient that you went to medical school for in the first place.³

The Young Urologist Committee of the American Urological Association has written a manual on the **Transition to Practice**. We encourage you to read this manual and use this AUA Core Curriculum chapter to augment your reading.

2. Applying for a Position

2.1 The Resume

The resume should be a one-page attention getting summary of your background and training. Human resources or office managers receive numerous resumes. The resume must catch the reader's attention so that he or she wants to read it instead of simply moving on to the next one. A good resume opens the door for an interview; a bad resume closes the door. Physicians can increase their chances of getting the job interview by avoiding the top five most common resume-writing mistakes (**Table 1**).

Table 1. The five most-common resume mistakes

	Mistake	Preventative Measure
1.	Spelling Errors, Typos, and Bad Grammar	Always proofread your resume carefully. Do not count on spell check to catch mistakes that you may have made during the resume writing process.
2.	Contact Information is Wrong or Missing	Always double-check your contact information, especially if it has been updated recently. If an employer cannot contact you using the information on your resume, they won't bother contacting you at all.
3.	Employment Dates are Missing	You should always include employment dates (months and years) on your resume. Potential employers need this information to determine your level of experience.
4.	Not Enough Information	When listing your job experience on your resume, try to include information about what you have accomplished.
5.	Too Much Information	

Your resume should feature education and work experience that is relevant to the job you are applying for. Additional information, such as your scrapbooking hobby, can be left off. Most employers and human resource executives like one-page resumes.

It is essential that your resume highlight your skills and expertise as a medical professional. It should also highlight your education, licenses, affiliations and publications that will help your resume stand out as a medical professional and attract the attention of a practice, medical center, or hospital.

2.2 The CV

Doctors use a curriculum vitae (CV) to apply for employment. The CV is typically longer than a resume and provides more detailed, relevant information to those who are seeking more information about you and your achievements as a doctor. A CV is more common than a resume in the academic world and within international medical communities. In order to make it effective, a doctor's CV must be up-to-date and flexible enough to speak to any opportunity for which you are applying. Write a CV by listing your achievements, experience, skills, education and special research and publication credits.

There's a formula you should use when crafting your CV.

(<http://www.wikihow.com/Write-a-Doctor's-Curriculum-Vitae>). This is summarized in **Table 2**.

Table 2. Step-by-step guide to writing a CV

Step	Action
1.	Begin with contact information. On the top of your first page, put your full name, address, phone numbers, pager number, fax number and email address.
2.	<p>Write a brief objective or career statement. This should be a one sentence summary of your current position and your professional goals.</p> <p>Example: <i>I have completed a fellowship in minimally invasive surgery and have extensive experience in robotic surgery and wish to continue in the private practice environment as a urologic cancer surgeon.</i></p>
3.	List any board certifications, including the dates of national examinations that were taken and passed. Include a list of states where you are licensed.
4.	List your educational history and your professional experience. Share your educational credentials by starting with the most recent institution you attended, and list the schools, degrees and years of attendance. Include any relevant activities you participated in while a student/resident/fellow. List all awards and honors you have received.
5.	Include a section on special professional successes. You can list any research you have conducted, publications you have written, teaching you have done and awards you have received.
6.	List the names and contact information of 3 or 4 professional references. It is very important that you ask your references if they can be included on your CV and provide them with a copy of your CV in case they are contacted.
7.	Include memberships of any professional organizations or associations.
8.	If you have any gaps in your education or training, it is recommended that you explain the gaps as it will certainly come up in your interview. Better for you to take control of the gap than to leave it without an explanation.
9.	For first time job seekers, it is suggested that you include information about your residency and any relevant volunteer experience.
10.	Share all languages you speak, including your level of fluency.

2.3 The Cover Letter

This is probably the most important part of the resume as if this letter does not attract the attention of person reading it, the letter, resume, and CV get tossed and no interview will take place. Some tips include:

- i. Address the cover letter to a specific person, i.e. the person doing the hiring.
- ii. Use bullet points to differentiate yourself as someone who knows what the job consists of and what you can—and will—do in the position. Clearly define yourself and your unique skills so that the decision maker will want to meet you and offer you a position.

Example: *As an experienced male infertility and erectile dysfunction expert, I can:*

- Perform microscopic vasal anastomoses
 - Perform penile prosthesis surgery
 - Treat Peyronie's disease with synthetic and auto grafts
 - Work with a reproductive endocrinologist for assisted fertility cases
 - Market and promote Andrology to the community and to potential referring physicians
 - Share with you multiple publications that I have written in peer-reviewed literature on these topics
- iii. Underscore your commitment to seeking the position by including that you will be calling the hiring manager at a specific time, usually within a week of their receiving the letter.
 - iv. In your signature block, along with your name, include the following:
 - Phone number
 - Email address
 - LinkedIn profile link
 - v. Include a "P.S." Considerable marketing research has shown that eight out of ten people who open a direct mail piece - will read the "P.S." first before reading anything else in the letter.

P.S. – I am also an amateur magician and will share some magic with you and I how I can bring a magical addition to your practice.
 - vi. Send the letter to the decision maker by certified mail so you know that the right person received it.

2.4 The Interview Process

In today's medical job market, urologists are in high demand. A tightening workforce in urology, combined with a need for hospitals to attract urologic care physicians (versus losing out to other centers in their geographic area), has caused the demand for well-trained urologists to skyrocket. A graduating urologist can get 9-12 job offers prior to selecting a particular location to practice.

To find a practice location, graduating residents in Urology should begin the interview process as early as possible. There are multiple resources available to search out current urology job openings, from journals to websites.

<https://careercenter.auanet.org/jobs>

2.4.1 IN-HOUSE RECRUITERS

In-House recruiters are employed by and usually work at a given hospital or health system. Sometimes, in large hospital systems such as CHS, HCA, etc., these in-house recruiters may recruit for their hospitals in a given geographical region or for a given service line, such as urology. Regardless, these in-house recruiters are usually very knowledgeable of the hospital, the associated urology practice, the city or town where the job opening is located, etc. You will find that urology practices will often collaborate with the in-house physician recruiting department at their local hospital to help them in recruiting a urologist. This allows the physician or practice manager to focus on their practice and leaves a lot of the recruiting leg work to the professionals.

2.4.2 THIRD PARTY RECRUITERS

Third party recruiters vary from one-man/woman shows to quite large search firms. They are usually hired on retainer or

on contingency by a practice or a hospital. Hospitals without in-house recruiters may use a search firms. Most of the postcards about a urology opportunity in a beautiful place, is most likely sent by a recruiter on contingency. If you reply, use caution in sending your CV, especially when sending your CV out to recruiters at third party firms. You may need to ask if your CV will be shared with other parties.

Take home points:

If you see a job opportunity advertised, do due diligence on the region and Employer, and be careful with your information.

Not all job openings are listed or advertised. Many places are often passively looking. So if you know the type of practice setting in which you would like to work and/or the geographic region where you want to live, get on the phone and start calling. If you are a busy resident you might recruit your partner or family member in the effort to make the calls during business hours. When you call practices or hospitals and say you are a urologist, most times they will stop what they are doing and want to talk with you.

When it comes to looking for an academic job, probably best to reach out directly to the chairperson of the department via email. Additionally, tap into your network to help make more personal introductions. If you are in a fellowship, these are things your fellowship director can help you navigate within your subspecialty, as they often may have an idea of who is looking to hire. Also, the subspecialty organizations, such as SUFU, SUO, GURS, SPU, can be a good resource.

If you don't already have a Doximity and LinkedIn profiles, I would highly recommend you invest a little time into putting one together. It is free and easy to do. When it comes to recruiting and networking, LinkedIn is one of the first places people will look you up. Make it easy to be found by those that may be interested in hiring you.

2.5 Factors to Consider

One of the key decisions for graduates is to choose a geographic location that is also acceptable to the spouse, significant other, and family. Other considerations such as the partner's employment opportunities and their satisfaction with location, is a critical decision that should be made together. However, these decisions can be complicated by those urologists looking to change to a new job and whether this is from self-employed, employed or academic will have unique decision points. ⁴

Finding a city or a practice location where you will be happy is very important. Today's physicians are concerned not only with coding and reimbursement issues but also with lifestyle issues. A harmonious work-life balance is critical to your success. The prospective candidate should be well versed in social opportunities in the vicinity. Dining, night/family life, the education system for your family, and other social activities play a significant role in choosing a place to practice. After you have narrowed down your practice location, there is an exchange of data and practice info, including your residency experience. The interview process has changed significantly over the past few years. This initial process has become more of a "getting-familiar" event rather than something that would be a deal-breaker.

You should practice and strategize your interview process. Once you have narrowed down your future practice location, you must visit the site on more than one occasion. The first visit would be to get familiar with the area and meet the appropriate hospital or future practice managers. A second visit, especially that includes ones' partner and family, is important. Scouting and being familiar with the neighborhoods, renting versus purchasing a home, dining, and social activities, etc., need to be addressed during these visits. After all, this will be your new home.

The interview process is still considered crucial and essential because it gives the two parties the unique opportunity to form first impressions face-to-face and figure out if the proposed relationship is prospective. One of the classic teachings when buying real estate is that the three most important things are location, location, location. Similarly, when interviewing, the three most important things are preparation, preparation, preparation. Nothing will influence the interview more positively or negatively than the preparation or lack thereof of the interviewee. When interviewing, the candidate should know some of the institution's history and be familiar with the individuals already in practice and their area of interest or specialization. You can easily find most of this information online. Do your homework before the interview, especially if the job is high on your list of opportunities.

You can try to anticipate what questions may be asked during the interview. "What can you or your skill set bring to the practice that we don't already have?", or "Why do you think this practice would be beneficial to you"? These are questions that the candidate should have already considered and be prepared to answer. Many times, the most helpful thing is to have three or four talking points on each of these responses rather than a complete or memorized answer so that the response will not seem rehearsed.

Try to connect with the person with whom you are interviewing on some level. The connection could be something having to do with the job or a particular interest in their medical practice. It could be on a personal level such as children, family, hobbies, or time spent outside of work. It could have to do with the region of the country that you come from, places visited, sports enjoyed, etc. Urology is a small specialty so perhaps there are connections related to residency or fellowship training. The bottom line is that a personal relationship will make the candidate stand out more in the interviewer's mind. It will also show your sincere interest in the position and that you have done your homework in preparing for the interview.

This may be obvious, but the candidate should certainly be early to the interview, never show up late, and dress appropriately. If there is a question about the dress, it is better to overdress than appear to be too casual. At times there may be some factor in a candidate's background that is not entirely positive. A DUI citation or arrest may come up. It is important to be truthful and never lie about such incidents. It is much better to address them upfront than to have them surface at a later date. Nearly every practice will do a background check on you and you will not be able to conceal problems, issues, or gaps in your training or work experience. It is far better for you to prepare an explanation and give it positive spin in your direction.

One cardinal rule in the interview process is never to say anything negative about your former institution, colleagues, residents, students, etc. If you are cynical about places you have been in the past, the employer will assume you are likely to be negative about your new institution.

Most of the time, one can get a pretty good idea of the salary and benefits from publicly available documents. The benefits package for most universities will be delineated and likely non-negotiable. In public institutions, salaries are a matter of public record. The applicant can get a good approximation of what their salary would be based on the salaries of those already there. Acquiring salary information may be a little more difficult to ascertain in a private institution where the data is not necessarily publicly available. Still, you can compare salaries at some nearby public institutions to get an idea at least of the salary range. Although salary and benefits are important, you do not want to spend the bulk of your time dwelling on these particular issues. In addition, do not bring up salary as the first question you have about the practice. It is okay, and certainly an employer will expect to answer this question, but don't make it your first question or concern.

One of the most important things that hiring institutions look for is evidence that a candidate is a team player. Positive examples of this would be previous participation in team sports, clubs, or societies. Any leadership positions held in any of these activities are certainly worth emphasizing.

Smile. Sit up and lean slightly forward and act interested. Be enthusiastic. It is desirable to be remembered, but you want to be remembered in a positive light, so don't go too over the top in trying to impress or make a statement. While your past accomplishments are important, your new employer is looking to the future. Provide them with the skills you bring and plans you have for their institution and many business place more emphasis on potential rather than past success.

It is a good idea to practice the interview process before you "go live." If you are in training, have mock interviews with your colleagues who are in the same position. If you work at a hospital, you can go to the human resources department and ask them to practice with you for an interview. Most departments will be happy to accommodate you and help you with the interview preparation.

3. Practice Location Categories

The practice locations that you will have to decide on are divided into two broad categories - hospital based and non-hospital based practice.

3.1 Hospital Based Practice

The hospital under consideration may be a stand-alone hospital or part of a chain such as Kaiser Permanente, an HCA Affiliate, or so on. You need to be familiar with the location's track record of treating hospital-based physicians. One strategy is to contact other hospital-contracted physicians in the hospital such as cardiologists. This will give you the chance to better understand their satisfaction level with their current contracts and also provides you with an opportunity to ask for suggestions that may help you in your negotiations with the hospital.

3.2 Non-Hospital Based Practice

These include locations such as private practice group, large group, multi-specialty, and academic practice.

3.3 Site Visit

During the site visit, the candidate will meet primarily with the physician recruiter. The recruiter will be your liaison during this process. He or she will be walking you through the many steps needed to complete the visit and the negotiations process.

You may also visit with the CEO, COO, CFO, CNO, OR supervisor, OR specialist (urologist), or members of the marketing department. You should be prepared for each of these interactions.

When interviewing for hospital-based opportunities, it is important that candidates do diligent homework on the practice opportunity. *Is this hospital in an urban or rural setting?* This is important because the reimbursements that hospitals receive in rural designations are usually higher than urban locations. Remember that the hospital can bill and collect for the technical component of the urologists' practice and also for the professional portion.

4. Contract Negotiations

After you have visited the potential practice location more than once, now is the time to focus on the contract negotiations. Remember, any contract you sign is a legal document. Thus, it is important to have your own legal counsel (or two) review the contract, line-by-line, so your interests are protected.

4.1 Needs/Requests

(i) List Equipment Needs

- Office-based equipment needs.
- Hospital-based equipment requirement.
- Special equipment, such as robot, intra-op ultrasound equipment, lasers, bipolar generators, specific scopes, etc.
- If research will be a component of your new job, specifically negotiate start-up packages for research space/equipment, acquisition of data, research/lab assistants, statistical support, and programming support.

(ii) List Personnel Requirements

- In your office: adequate nursing and ancillary staff members.
- In the hospital: Will they provide you with appropriate trained personnel for surgical procedures? It's especially important for procedures such as robotic surgery to be staffed with a qualified first assistant or bedside surgeon.
- Who's in charge? This may sound silly for some but for those that have worked in hospital-employed positions or private-equity owned groups this question makes sense. There always needs to be a "captain of the ship." In the OR, it should be the surgeon. When it comes to clinic, physicians should consider playing an active oversight role and have the opportunity, if they wish, to help guide operations. When physicians abdicate this role they run the risk of being treated like a factory line worker and with time this will lead to burn out / "moral injury."

4.2 Understand Compensation

Usually the hospital or department will guarantee your salary for 1-3 years. The suggested length of your initial contract

should be negotiated for 3 years, with frequent evaluations and/or meetings to ensure that you are staying focused and close to target expectations and projections. Your interview process should clearly define your remuneration methodology.

Key questions to consider include: Will you be evaluated on a quarterly basis? What if there is overage? Will you be paid additionally on a quarterly basis?

Will you be reimbursed based on your work RVUs? Though contracts will vary, the RVUs are based on national guidelines with an average RVU production of 9,000-10,000 per year.

If you exceed expectations, then how will you get paid?

One suggestion is that you be paid 75% of any overage of professional fees collected and that the hospital will keep 25%.

Caution: It is important that you are aware of the billing and collections process, since the hospital may have several other physicians in different subspecialties on their payroll. Therefore, you should be mindful of the following:

- Make sure that your billing and collections are handled promptly and appeals to third-party payers are processed in a timely fashion.
- Review and audit your own surgical case logs and RVUs. Meet with the coders/billers and practice manager early on and on a regular basis to ensure your work and value is being measured appropriately.

It is important to understand how you are being measured. Most physicians think they are measured simply on RVUs. But it is often more complex than that. RVUs do not pay the bills, collections pay the bills. Each hospital or group has their own metrics. Learn the “rules” of what you are being measured, and then have awareness to prospectively alter your practices. Most organizations will set a budget and your salary is only a component of that budget. If you understand the other components of the budget then you can better understand ways you can influence your compensation. Learn some basic accounting. The same principles that apply to your home finances apply to your practice finances. Revenue needs to be more than expenses. There are two ways to make more money, grow your top line (revenue) and/or reduce your expenses. Learn to think like the administrators and you can stay one step ahead and be in a position to guide critical conversations and advocate for your patients while being fiscally responsible. Unfortunately, many physicians do not learn this and instead find themselves reacting to decisions made by administrators.

4.3 Contract Renewal

Be aware and review the hospitals’ policy for continuing your contract. Contracts can be terminated based on factors such as performance, professionalism, or surgical outcomes, or a change in business strategy. It is important to have a 90-120 day notice so that you will have enough time to locate and move to a new practice location. Contracts usually suggest a 30-60 day window; this may be inadequate.

4.4 Vacations/Time off

Usually contracts should give you 20 working days and the 5 national holidays as part of your vacation package. Make sure this is included in your contract. Emergency room coverage and in-home consult expectations need to be clearly defined. You should know if these duties will be shared with other urologists on the staff or if you are expected to be constantly on call. Some hospitals do not force urologists to be on call once they have reached 60 years of age. How will this impact your call schedules? (Nearly half of urologists are over 55 yo).

Most states have a maximum number of days a physician can be required to be on call as part of having hospital privileges. Be sure to know what that number is. Consider requesting additional compensation for any call days taken above and beyond that number of days, if you are taking a hospital-employed position. In short, all of this is negotiable. Do not be afraid to ask for what you want and what you think is fair.

4.5 Credentialing Process

Begin the credentialing process for the hospital as soon as possible. Credentialing can take up to 6 months to complete. Be aware that each insurance carrier has their own credentialing process. You should be fully credentialed by the time

you start your practice so that you can immediately treat patients.

4.6 Malpractice Coverage

The hospital should be providing you with insurance coverage as per state or regional guidelines. Learn and understand the differences between claims-made and occurrence-based malpractice insurance. In short, claims-made covers a period of time and will cover you for any claims made during the coverage tie. Occurrence based malpractice insurance will cover claims related to any patient you have treated during that period of time of coverage or employment, even if the claim is made after you leave that practice. Occurrence based coverage is usually more expensive because it essentially has the tail coverage built into it. If your insurance is claims-made then you will need to purchase tail coverage when you leave your practice, so make sure tail coverage is included in the contract in the event you leave the practice.

4.7 Private Group Practice

Details mentioned above, as it relates to hospital-based practice, are very relevant to private practice setup. Thus, carefully review some of the salient features mentioned above.

However, a major difference in private practice ventures these days is that these practice opportunities are decreasing. More and more private practice groups are being bought out by hospitals or are consolidating into larger groups. It is important that you are aware of such possibilities before you decide on joining a private practice group.

More recently, private equity has been moving into urology. So there is additional corporatization of some larger urology practices. The history of private equity in medicine can be seen in other specialties. Private equity buyouts of practices usually benefit only the senior partners that are nearing retirement. It is difficult to make a good financial case for private equity for younger physicians. Some of this is opinion. Time will tell.

The items mentioned above including practice locations, the social setup of a given town, the practice opportunities, equipment available in your private practice office, equipment available in your hospital, etc. need to be reviewed. If appropriate equipment is not available, then you need to have that requirement placed in your contract prior to accepting the offer. Once you move, if it is not in writing, then it may not happen. Additional important questions to ask when considering private practice are listed in **Table 3**.

Some practices share revenue, on-call, etc. while some will let you keep only what you “kill.” Make sure there are no vague statements in your contract. The hallmarks of a successful interview process are knowledge of the proposed practice location, provision of equipment and tools to succeed, and a contract that you can live with and make you a successful urologist.

Table 3. Additional Questions about Private Practice Employment

How soon will you be a partner? 2 years? If not, how long?

What is the buy-in process and cost?

Would you be part of the groups' retirement plan and additional benefits?

If so, how soon can you be part of that?

What is the on-call schedule?

How many of the partners are taking emergency room call?

What is your vacation/time off schedule like?

How is the revenue split/distributed?

Is revenue guaranteed?

What are the sources of revenue?

Is there a production-based bonus schematic?

Is there an opportunity to own ancillary services, surgery centers, or lithotripters?

5. Contracting

Signing a contract can be daunting for any urologist regardless of experience level. Whether or not it is your first contract or if you have been in practice for several years, we suggest the use of a checklist. Most urologists are not familiar with the verbiage and language in a contract with a practice or hospital. Therefore, it is prudent to find a healthcare attorney to review your contract. An attorney's experience with other physician employment contracts gives him or her valuable perspective on what are reasonable terms. It is also prudent that you look at the original contract as a rough draft. Remember that most of the terminology is there to protect the employer's interests, and not your own. Look out for your interests, and remember that most aspects of the contract, and not just salary, are negotiable. It is helpful to look at your job offers side by side and analyze them for pros, cons, and deal-breakers. Do not sign a contract that you are unhappy with, in the hopes that you can negotiate more favorable terms later, as this rarely happens. Be patient. Your position in the negotiation is never stronger than before you sign. Once you sign, you are owed only what is in the contract.

Get it in writing. Many practices will give you verbal reassurances. Administrators and members of a group can often change. Having main points in writing will help assure that the agreement will survive any changes in the group. Take your time. Insist on enough time to thoroughly consider the contract. Do not feel rushed, and perform due diligence. Don't assume. If you don't understand something in the contract, have it explained, or have it used in an example. After all, you are a physician, not a legal professional. It is not unusual for some contracts to have the salary formula used in an example format for better clarity. Make sure all external references to attachments, documents and exhibits are included with the contract.

5.1 Salary and Compensation

The main part of the contract involves understanding aspects of your salary and compensation.

5.1.1 Compensation Based on Productivity

Physician is paid on a formula based on net collections, minus expenses. A simple example of this is when 10K is billed for the month. Collection rate is 60%, so 6K is collected. Overhead is 50%, so the physician is paid 3K. Understand your practice specific variation of this formula, and ask for examples. Understand in detail how expenses are calculated and attributed to each physician. Attribution of expenses/overhead can be a point of contention in groups.

5.1.2 Fixed Salary

A fixed salary typically involves a base salary with a provision for bonuses based on certain metrics. Know these metrics. In many cases, a base salary may be augmented by retirement packages, health insurance, and other benefits, so it is important to understand what the entire financial compensation package amounts to. Also understand salary raises, and expectations, and opportunities to grow over time.

5.1.3 RVU-based Salary

The Relative Value Unit (RVU) concept was introduced by CMS in 1991. The system is blinded to insurers/payers, contracts, etc., and instead assigns a 'value' to patient encounters and procedures. In a typical scenario, 1 RVU equals a certain dollar amount. Every Current Procedural Terminology (CPT) code or office visit (Evaluation & Management code) has an RVU associated with it. Monthly RVUs are then tabulated, multiplied by a dollar amount, and the physician is then paid based on a formula. It is important to understand this formula, and see it used in different typical scenarios.

5.1.4 Physician Recruitment Agreements (PRA)

A PRA is an arrangement that allows for a hospital to recruit a physician to a community with a strictly defined need or shortage for a particular specialty. It is covered under carefully regulated government guidelines, especially federal anti-kickback statutes. Two main types of PRAs exist, an income guarantee and a loan guarantee. An income guarantee typically sets a 'floor' to the income level, which is negotiated. Based on geography, defined need of the specialty, and other factors, there are formulas and limits to calculate the value of an income guarantee. Most income guarantees may

set thresholds of work productivity, sometimes based upon either RVUs or total dollars collected. It is important to know how this is calculated and tracked. It is also important to have the contract define how compensation is calculated should production or collections exceed a certain threshold.

A loan guarantee is a base salary that is structured as a “loan” to the physician. Each year, based on negotiations that the physician remains in a service area (defined in the contract), a certain percentage or amount of the loan is forgiven. However, the loan must be repaid in total, or partially, if the physician breaks the contract prior to completion. A thorough understanding of the contract is important. Advantages include subsidized overhead expenses, reimbursement of relocation expenses, assistance with startup expenses, marketing support, and assistance with student loans. There are often substantial opportunities for negotiation within these contracts, so it is important to ask questions. Having a knowledgeable healthcare contract attorney review prior to signing is crucial.

5.1.5 Bonuses

Bonuses can include sign-on incentives, or productivity related bonuses. Make sure you understand what the bonuses are, how they are achieved, and have them included in the contract. Having the bonus explained in an example is helpful, and can be included in the contract.

5.1.6 W-2 vs 1099

It is worth learning the differences between W-2 and 1099 income. This refers to how the IRS treats income. Most employed physicians are paid as W-2 workers.

W-2: Taxes are withheld and paid by the employer to the IRS, usually on a bi-weekly or monthly basis. As a W-2 employee, one pays for their living expenses after taxes are paid.

1099: A physician can be paid as a 1099 as an individual (independent contractor) or as a separate business entity. For instance, a physician can be paid by a hospital or their group as a 1099 and have that income routed into a separate entity (i.e. LLC) that they may have set up. When paid as a 1099, especially into a business entity, there is more flexibility in how one can deduct expenses and reduce tax liability. In general, businesses usually pay taxes on what is left over after expenses have been deducted.

The above should not be taken as tax advice but only to encourage the reader to learn more. When reviewing an employment contract or new business opportunity one should consult with their accountant to fully understand the associated tax implications.

6. Insurance

6.1 Health Insurance

Understand the degree of premiums that are paid (usually fully) and extent of coverage.

6.2 Disability Insurance

Understand the degree and amount of coverage. Understand the extent and type of coverage. The best coverage is “own-occupation” which covers you if you no longer can perform as a urologist, i.e., you could potentially still work doing chart review as a disabled physician, and still be paid disability. You need to also understand that it is important to carry your own personal disability coverage, including the group’s provided coverage. This protects you if you move on from the position. The costs of disability coverage increase with age and co-morbidities, so it is beneficial to acquire such coverage early in your career. “Own-occupation” disability insurance should be purchased while you are still in residency. It should be separate from your employment. Disability insurance offered by many employers tends to be more generic and not specific to a physician.

6.3 Life Insurance

This is probably the least important insurance to include. Practices will variably include this. Of course, if it is not provided, it is important for you to carry a personal life insurance policy. This is very important to protect your spouse and

children especially if you are the primary income generator in the household. Having a good life insurance policy ensures they will be taken care of and be able to maintain a decent quality of life if something tragic happens to you.

6.4 Retirement or Pension Plans

Most practices will offer a standard tax-deferred retirement or pension plan. Do understand the terms and nature of the plan, as well as maximum contribution, and contribution matching that may be included. It is never too early to start thinking about retirement as well as the power of compounding interest. Consider maxing out your contributions especially if there is an employer matching component. It is important to understand the difference in contribution limits as an employee and an employer. In 2020, the maximum contribution limit for an employee is \$19,500 and the maximum employer contribution limit is \$37,500 for a total max contribution to the 401k as \$57,000/year. If the employer matches you 1:1, for instance, you will max out at \$39,000 in contribution, leaving a potential \$18,000 in contribution potential on the table.

Alternatively, if you are self-employed you could potentially max out at contribution at \$57,000.

The above should not be taken as financial advice but simply to help highlight some concepts that you should discuss with a financial advisor. It is important to have your contract reviewed with not only a healthcare attorney, but also with your accountant and financial advisor to fully understand all the implications of the contract.

6.5 Malpractice

In most cases you will want to insist on malpractice coverage by the group. Make sure the coverage and policy limits are adequate for your state.

6.5.1 Occurrence Policy

Covers events that happened during the policy period, regardless of the date of discovery or when the claim is filed. In some of the better policies, claims are effectively covered for the lifetime of the patient or occurrence.

6.5.2 Claims-Made Policy

Covers incidents that take place and are filed during the coverage period. These policies tend to be less expensive, and increase, then plateau as the potential pool of claimants increases and stabilizes (usually approximately 5 years). The disadvantage is that once the policy is no longer paid (you leave the group) coverage on all patients treated lapses. This policy will often require a "tail-policy."

6.5.3 Tail Policy

Covers, for a fixed amount, all covered lives and procedures performed by a physician over a fixed period of time. It is important to understand who covers this cost, which can be substantial, should you separate from the practice.

7. Additional Benefits

Table 4. Additional benefits to consider

CME allowances including travel to meetings

Monetary compensation/cap

Moving/relocation allowances

Housing or mortgage assistance

Student Loan Repayment Assistance

Medical society dues and licensure coverage

Outside Income Policy (consulting arrangements, call coverage stipends)

Vacation and Sick Leave

8. Interview Timetable

Below is an example of a timeline for the search / interview process. Many would recommend starting earlier and one should think about wrapping up the decision-making process and sign a contract by the end of calendar year prior to anticipated graduation from residency/fellowship. This will then allow sufficient time to get necessary credentialing done so you can start working after graduation without delay

Table 5. Timetable for your chief year in urology

Month	Action
July	Personal assessment period (self-profiling on practice type, location, spouse etc.)
August	Initiate search process based on multiple sources and research
September	Narrow search based on self-profile, likes/dislikes
October	Begin initial set of interviews
November/December	Continue interview process
January	Start Federal/State credentialing process in State(s) of top choice
February	Second look interviews
March	Review contracts/legal consultation
April	Decision process/sign contract, finalize credentialing process
May/June	Hospital-specific credentialing and privileges, coordination of move

9. Transition from Training to Practice

9.1 Reimbursement Basics: RVU and Beyond

Reimbursement typically is tied to Relative Value Unit (RVU) generation, actual dollars generated by services performed, or other formulas that take RVU or dollars generated, along with additional metrics such as patient satisfaction scores, academic productivity (if at an academic medical center), and ancillary services income.

RVU - Established by CMS (Medicare/Medicaid) to assign a unit value to services provided. RVUs capture the following components of care:

- Physician work RVU (50.9%) - The relative level of time, skill and intensity to provide a given service.
- Practice expense RVU (44.8%) - The cost of maintaining a practice (equipment, staff, etc.) to provide a given service
- Professional liability insurance expense RVU (4.3%) - The cost of professional liability for services provided.
- Additional modifiers - Geographic location, Medicare budget conversion factors, etc. are also components of the final RVU computation.

Example:

Laparoscopic prostatectomy, CPT 55866 has the following values for 2018:

Work RVU (26.8) \$964.79

Facility Practice Expense RVU (12.14) \$437.04

Liability Insurance RVU (2.93) \$105.48

Total Medicare Reimbursement \$1507.31

9.2 Amount Billed and Collected

Most groups will set a “rack rate” for all services the organization provides (fee schedule). For example, on the prostatectomy described above, a practice may set this number to 2x Medicare, or \$3014.62. Thus, the amount collected on a Medicare patient would be 50% of the billed amount, or \$1507.31. However, a private payer, which may pay, for example, 1.4 x Medicare rates, or \$2110.23. This would be 70% of the fee schedule amount. It is important to understand what the fee schedule is for a particular group, and what the contracts are with major payers in the area. Knowing the payer mix (private insurers, un-insured, Medicaid, Medicare, etc.) might influence your decision to work in a certain area.

Total Salary would typically involve total collections, minus overhead expenses.

The range of overhead expenses, is subject to considerable variances and it is important to understand how this is calculated. Total Compensation typically involves the total salary, plus ancillary income and benefits. Ancillary income can include group partnerships in research activities, labs and or pathology services, lithotripsy partnerships, imaging and radiation based treatments. Surgical centers or ownership in hospitals can also be components of ancillary income. All are subject to strict Stark legislation-based guidelines. It is important to know how participation in these income streams is possible, what buy-in amounts are, and over what time-frame within each group.

10. Coding Basics

ICD and Beyond by Dr. Ray and Mark Painter (Principals at PRS Coding, www.prscoding.com)

10.1 Introduction to Coding

The process of starting a practice could be compared to buying a new car and driving it down the road. If you use the correct kind of gas, and continue to feed the engine with clean gas, the car continues to run smoothly. Using that analogy, coding would be the gasoline and billing rules are the engine that makes your practice run. If you learn the basics and continue to use the correct codes and billing rules, you will continue to be paid for the work you perform. Coding is the process of identifying the services you provide and the reason for providing those services. The coded

services then have to be reported to third-party payers, as well as others. The accuracy of your coding will determine if you are paid, the amount you get paid, and the credit you receive for the work you have provided.

The majority of physicians entering into practice will have been 'exposed' to coding, but most will not have mastered the process. Learning coding is like learning a foreign language. It is very different in the beginning, but once you have mastered a working knowledge, it's quite easy, and can easily become a second language. The necessary databases and tools to searching and navigating those databases in order to accurately code and report your services will be discussed in this portion of the core curriculum. Reimbursement, RVUs, and other related subjects will be addressed in other sections.

The discussion on coding will be divided into the following three segments: (i) Coding for Services Provided (ii) Coding for the Reason Services Were Provided (Diagnosis Codes) (iii) Reporting of Services

10.2 Coding for Services Provided

The Centers for Medicare and Medicaid Services (CMMS, more commonly referred to as CMS) develop and publish the Healthcare and Procedural Coding System (HCPCS) code set. HCPCS is divided into two principal subsystems referred to as level one and level two HCPCS.

Level one is comprised of Current Procedural Terminology (CPT). Maintained by the American Medical Association (AMA), CPT is a uniform coding system comprised of descriptive terms and identifying codes used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. CPT codes are used to identify services and procedures being billed to public or private health insurance programs. Codes needed to separately report medical items or services regularly billed by non-physician providers are not included in CPT codes. All specialty societies, including the American Urological Association (AUA) have input into the codes developed for their services. The primary CPT codes have five numerical digits, and nearly every service you will provide has its own individual CPT code. The challenge is in finding the correct five-digit code for each service.

Level two of the HCPCS is a standard coding system used primarily for identifying products, supplies, and services not included in CPT codes. The CPT database is most commonly used to identify services provided.

CPT codes are divided into several main categories and then into many subcategories. The key categories used by urologists are:

- Evaluation and Management (E&M)
- Radiological Procedures
- Laboratory Procedures
- Surgical Procedures
- Urinary System
- Male Genital System
- Reproductive System
- Intersex Surgery
- Female Genital System
- Digestive System

In summary, when one provides a service, then one must search the CPT and/or HCPC database to find the five-digit code that most accurately explains the service provided. As an example: You see a new patient in the office, perform a history and physical, and make the decision to go ahead with a cystoscopy. The following steps would be taken to properly code the services provided:

Step 1

Select a database that you plan to use for reference, such as AUACodingToday.com.

Step 2

After signing in, click on "CPT", then "Evaluation and Management", then "Office or Other Outpatient Services", and finally,

“New Patient”.

Step 3

Select the appropriate level of service for the history and physical examination you have performed from the list of five codes, such as 99203.

Step 4

Click on “CPT”, then search for “cystoscopy.”

Step 5

Select the appropriate code for the service you provided from the list, such as 52000.

You have now coded for the services provided:

E & M - 99203

Cystoscopy - 52000

10.3 Coding for the Reason Services Were Provided (Diagnosis Codes)

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), diagnosis codes are used to report the reason a service was provided. This system is based on the World Health Organization’s Tenth Revision, International Classification of Diseases (ICD-10). The National Center for Health Statistics (NCHS) and CMS are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-10-CM.

The ICD-10 consists of:

- List containing a numerical list of the disease code numbers
- Alphabetical index to the disease entries
- Classification system for surgical, diagnostic, and therapeutic procedures (in alphabetic index and tabular list).

On October 1, 2014, the Tenth revision (ICD-10) replaced ICD-9. ICD-10 differs from the ICD-9 in several ways, although the overall content is similar. ICD-10 has alphanumeric codes, rather than numeric codes, and has almost twice as many codes as ICD-9.

In summary, one has to search the ICD-10 database to find the appropriate code that describes the reason that you’re providing a service. Multiple books from any number of sources are available for purchase. However, online databases, such as AUACodingToday.com, are being used more and more, and are the way one should access diagnosis codes. ICD-10 is much more detailed and requires even more dependence on the electronic databases and sophisticated search engines. As an **example**: The patient used in the example above had “gross hematuria”, which was the reason for the visit and the cystoscopy. The following steps would be taken to properly code the diagnosis:

Step 1

Choose a database to be used to research the appropriate code, such as AUACodingToday.com

Step 2

Click on “ICD-10”.

Step 3

Search for “hematuria”.

Step 4

Select the appropriate code from the list – gross hematuria - R31.0.

Most outpatient EMRs have ICD-10 codes built into them so documenting diagnoses will usually pull in the appropriate ICD-10 codes into the note and the charges for the visit.

10.4 Reporting of Services (Payment Rules)

Payment rules, as stated above, could be compared to the engine. There are a lot of moving parts. The rules set the parameters for payment for services. The basic philosophy behind the rules is fairly simple. “Payers are obsessed with

only paying you once for any service that is provided". To complicate matters, all procedures are paid with what is referred to as a "global" fee. A global fee pays you for all services that you provide related to that particular procedure within a window of time.

For example, you have performed a radical prostatectomy. The payment included payment for admitting the patient to the hospital, the surgery, and the postoperative care. For the radical prostatectomy, the payment included all the related care you provided for that patient for 90 days. There are services that you may provide during that 90 days which were unrelated to that surgery and you should be paid an additional payment for those services. The rules allow for that. Some rules apply across all payers, while other rules are payer specific.

In addition to providing the codes, CPT provides rules for reporting those codes. You will find a number of rules in the notes at the beginning of the CPT book, in the beginning of each of the different categories of codes, and in the definitions of the codes. Medicare and private payers develop and publish their own rules. Medicare's rules are published in its carriers' payment manual, transmittals, reference databases, publications, etc. Most Medicare rules are national in scope; however, each Medicare contractor publishes additional rules. Private payers adopt many of Medicare's rules, but also add additional rules of their own.

The best way to understand the hierarchy of payment rules is as follows:

- CPT and ICD-10 codes are the base of the pyramid.
- Payer rules trump CPT rules.
 - Medicare rules are published in detail and are, in part, adapted by private payers.
 - Private payers add their own set of rules, many of which are the same as Medicare.
 - If there is no payer rule that addresses a particular coding issue, CPT rules or ICD-10 rules are followed.

10.5 CPT

You will find a number of rules in the notes at the beginning of the CPT book and the beginning of each of the different categories of codes.

Internet only manuals provide you with **Medicare** payment rules in detail. The National Correct Coding Initiative (NCCI) is the database that provides you with the bundling edits for reporting multiple procedures for Medicare. NCCI is maintained by a subcontractor and available in many publications, including websites. Medicare mandates national coverage for certain procedures through the publication of National coverage decisions (NCDs). Local coverage decision (LCDs) are published by each Medicare contractor to add clarification and detail to the rules set by the national Medicare payment rulebooks.

For **private payers**, rules are provided to urologists in many ways, such as bulletins, websites, other publications, and, most importantly, through contracts. Most payers will follow some Medicare rules. All add additional rules as well. There are many gaps for which there are no published rules, and urologists must revert back to CPT rules. All of these rules can be accessed through the various publications, or the use of various websites that combine all the rules into an easily researchable format, such as AUACodingToday.com.

Bundling Rules are applied to multiple procedures performed at the same encounter and are developed to prevent paying you for a component of another procedure (they are obsessed with not paying you twice for anything). For example: A cystoscopy is a necessary part of performing a transurethral resection (TUR) of the prostate. In the bundling rules, the cystoscopy would be bundled into the TUR and would not be paid separately.

Global Rules are developed to prevent paying for preoperative or postoperative services that were included in the payment for the procedure.

Evaluation and Management (E&M) Services Rules refer to patient evaluation (history and physical examination)

- There are two broad categories - hospital visits and office visits.
- Office subcategories, new patient, established patient, consultation.
- Five levels of service for each type of patient office visit.

- Modifiers transcend all rules and permit reporting exceptions to the rules.

In summary, once you have correctly identified all services with the appropriate CPT and ICD-10 codes, it's time to take a look at the payment rules. First you must identify the payer and abide by their specific rules. For example, the patient from our previous examples (hematuria, office visit, cystoscopy, etc.) was a Medicare patient, and we will have to use Medicare rules. Medicare rules state that you cannot charge a related E&M service on the same day as a procedure. Therefore, if we reported those two codes with the diagnosis of hematuria without a modifier, you would not be paid for the E&M service. Fortunately, there is an exception to the rule. That was the first time you had seen the patient, and you had to perform a history, physical, and medical decision-making in order to determine that you should do a cystoscopy. The exception states that if an E&M service is provided that is significant and separate (distinct) from the procedure, then it should be paid separately. Modifier 25, by definition, notifies the payer that the E&M service qualifies for payment. Therefore, services should be reported as follows:

99203-25 -R31.0

52000 -R31.0

The bottom line is simple. You should spend the time to develop a working knowledge of the coding system and how to search the different databases for the specific codes and coding rules that you need to report your services. Anyone that delegates coding and submission of claims to their office personnel is leaving money on the table and is probably also billing for services that should not be billed. The billing system has a very precise structure. If you do not bill correctly, you do not get paid. Furthermore, if you bill Medicare for the wrong level of E&M code (over or under coding), or you add a modifier to indicate you should be paid when you should not, that is considered fraud. With that in mind, do not make the mistake that many of your colleagues have, by not learning the basics and relying on others to do your coding and submission.

10.6 Telemedicine

The Telemedicine age is upon us.⁵ Thrown into action via the COVID19 pandemic, many organizations and practices had to embrace telemedicine in order to care for their patients and maintain practice. The nuances regarding coding can change by state so providers must stay abreast to their local situations. The AUA provides up-to-date information regarding urology advocate to government payers in the AUA advocacy and policy briefs websites. An article by Badalato and colleagues share thoughts on the future direction of telemedicine in Urology Practice.⁶

11. The Road to Partnership

After a physician has worked with an organization for a period of time as an employee, there may be an opportunity to become a vested 'partner' of the practice. Find out, and understand the duration of time, as well as other metrics that may be required to become a partner. Also, understand what benefits, responsibilities, as well as liabilities that may be associated with becoming a partner. Each practice, depending on size, type (large/small etc.) location, desirability, etc. may have different requirements for a buy-in. It is important to understand what the norm is, and that if you desire partnership, that the barriers are not excessive, be they time, money or other forms of commitments. It is also helpful to talk to the junior members of a practice to understand their experience on the road to partnership. Finally, some practice types are not open to partnership, but instead function to solely employ physicians (i.e. multispecialty, VA, etc.).

11.1 The Buy-In

The Buy in is calculated based on several factors, which may include, but are not necessarily limited to the following. It is important to have the buy-in calculation specifically listed in your contract.

11.1.1 Goodwill

Goodwill historically was a significant portion of the calculated cost of a practice. For example, a physician may have started a highly successful practice in an area 30 years ago, and the practice's value in terms of "charts" (existing patients) and new patient referrals are significant. Certainly, some goodwill may be not unreasonable (sometimes based

on a certain amount per chart), but it is important to make sure the goodwill valuation is not excessive. In the days of modern medical practice, competition between practices, contracts with insurance companies, competition (or cooperation) with local hospitals, governmental regulations and fee schedules, to name a few, can drastically change the operations of a practice. And none of the previous conditions are tied to goodwill.

11.1.2 Fixed Assets

Fixed Assets refer to the hard costs, or physical assets of a practice. Examples include the land and or physical building the practice and or satellite locations of the group and equipment (cystoscopes, ultrasound units, instruments, computers, desks etc.). It is important to understand how the fixed assets are calculated. One method is to have an outside company/auditor value the assets of a practice. Sometimes the number is calculated based upon estimation by the group. It is also important to understand if you are paying (ideally) the depreciated value of assets of the practice. Finally, make sure that the calculation methodology is noted in the contract.

11.1.3 Fixed Value

The benefit of a fixed valuation of the practice is that it is pre-defined. For example, a practice may have a (somewhat) arbitrary value of \$1 million. There are 10 physicians, each of which have paid \$100,000 to join the practice. Your contribution may also be \$100,000 to join, which is then often distributed as \$10,000 to each of the practice members. Regardless of the computational method, it is important to understand the formula and have it in your contract.

11.1.4 The Buy-Out

The Buy-Out is an important component of a well-documented road to partnership, which details what occurs in the event of separation of a partner. This may often be tied to the terms of the separation, i.e. does the partner need to move to an entirely different location (state?) or is the partner setting up a practice as a direct competitor (non-compete issues). In some situations, you may be entitled to having your buy-in refunded, in other situations it may be tied to a new valuation of the company. Also, the buy-in may be forfeited entirely.

12. Understanding the Modern Patient and Consumer

Table 6. The 10C's necessary for patient satisfaction

1.	Competence
2.	Confidence
3.	Comfortable
4.	Careful attitude
5.	Compliance with protocols
6.	Checklists
7.	Courtesy
8.	Calm and controlled
9.	Compassionate
10.	Considerate as well as timely and appropriate communications

It is imperative that we understand the needs and wants of our patients. Our goal as urologists is to maximize patient satisfaction. We can have all the clinical and business skills on the planet, but if patients are not having a positive experience with ourselves and our staff, then we won't be able to put those clinical skills to good use and we won't have a profit and loss balance sheet that will make a lot of difference. Key factors in patient satisfaction are shown in [Table 6](#).

The one "C" that is often the most neglected and also is the one that we have the least training to provide is effective patient communications. Conventional news sources and internet sites influence the modern patient with information of variable quality and potential bias or with a motive for sensationalism. It will be our responsibility to provide credible information to be sure that patients' thirst for medical information is met. Today, it is going to be necessary to use e-mail, internet, and texting to educate, inform, and remain in contact with our patients. An effective and efficient practice is going to be able to book and confirm appointments online and even make referrals to other physicians using these technologies. It will be necessary to conduct patient satisfaction surveys and discover what the patients want and garner their feedback on our practices. Let's not forget it is their expectations, not ours, which are the yardstick by which our patients measure their healthcare experience.

13. Understanding and Managing Stress, Fatigue, and Burnout

13.1 Physician Burnout

Physicians/urologists are experiencing burnout in large numbers. Burnout is a problem that many in healthcare have noticed in the past few years. Perhaps burnout existed previously, but it has now become more prominent and talked about in our profession. In the 2016 AUA Census questionnaire, 38.8% of urologists met the criteria for burnout.⁷ A recent AUA essay competition was dedicated to burnout and I would suggest you read the essays as they are very relatable.⁸ We have seen doctors in the middle of their careers, leaving medicine and retiring at a much earlier age than several decades ago. We should recognize the symptoms, and take appropriate steps to resolve physician burnout. The AUA young urologist committee also mentions physician burnout in their [Transitioning from Residency to Practice Manual](#).

A report from Archives of Internal Medicine published in JAMA indicates that rates of burnout among U.S. physicians significantly exceed those of the general population and other professions.⁹ The results are striking - 46 percent of respondents reported at least one burnout symptom. As a group and relative to other highly educated individuals working similar hours, the report indicates that doctors suffer high levels of emotional exhaustion and struggle to find a satisfying work-life balance.

Burnout is a very serious issue with effects that will ripple throughout our practice, our profession, and our society. It warrants widespread, earnest attention. Signs of burnout include decreased enthusiasm for work, growing cynicism, and a low sense of personal accomplishment. As the name implies, individuals suffering from burnout feel as though a fire of enthusiasm and passion that once burned inside each of us has been snuffed out or, in extreme cases, completely extinguished. In many instances, they report a sense of having "run out of fuel," and feel as though they "have nothing left in the tank." This study points out that the overall rate of burnout among physicians was 38%, as opposed to 28% among other US workers. There also is an associated financial burden to physicians and institutions.^{10,11}

Doctors tend to work longer hours than other workers, on average about 10 more hours per week. This represents an atmosphere for burnout because of the long hours and high workload. Good doctors are inclined to keep giving, to always do whatever is necessary to take care of patients. However, this can lead to compassion fatigue and burnout. Moreover, striking an appropriate work-life balance appears to be a bigger challenge for physicians, in part because they often tend to keep work and personal life more separated than other workers.

Physicians react to burnout in a number of ways. Some doctors withdraw from their practices, reducing their workloads, or leaving the practice of medicine entirely. Others become less engaged with their patients and the profession, resulting in a decline in their work quality. Still, others turn to unhealthy and even self-destructive habits, such as alcoholism, excessive or inappropriate use of prescription drugs, and even illicit substances. The key to combating physician burnout

is not to reduce stress but to promote professional fulfillment. Promoting professional fulfillment is not merely a matter of reducing costs and error rates or increasing clinical efficiency. Medicine is not a job. It is not even a career. At its core, medicine is a calling. When it comes to physician burnout, an ounce of prevention is worth a pound of cure. We must begin early in medical education to help medical students and residents explore and connect with a sense of calling to the profession. Even late in their careers, physicians need to recall that they are summoned to something older, larger, and nobler than themselves. They must never forget that a career in medicine represents one of life's greatest opportunities to become fully human through service to others.

Suggestions for resolving and reclaiming your life include shedding some of your responsibilities and over extending yourself with any additional committee assignments within the practice or at the hospital. It is also helpful to schedule time off and even make a regular date with your partner or family to provide balance in your life. Daily exercise is also helpful as it is often a pleasant distraction from the rigors of practice. Finally, look for other stress-relieving activities.

14. Resources

14.1 Hospital Employment

- Hospital Hiring Of Physicians Picks Up Steam: Health Systems Also Are Looking At How To Hold Onto Their Existing Doctors As Competition For Their Services Heats Up. American Medical News, January 30, 2012
- The Physician As Employee: Pros And Cons. Ian J. Alexander, MD, www.aaos.org
<http://www.ama-assn.org/amednews/site/bio.htm>
- AMA Principles for Physician Employment. ama-assn.org/go/employment, 2012

14.2 Contracting

- An Employment Contract Model for Joining a Medical Practice. Robert Freedman.
<http://www.medscape.com/viewarticle/561958>
- American Health Lawyers Association, <http://www.healthlawyers.org/Pages/Default.aspx>
- Physician employment contracts. <https://www.ama-assn.org/member-groups-sections>
- Annotated Model Physician-Group Practice Employment Agreement. Available from the AMA.

14.3 Advisors

- The Lawsuit Survival Guide: A Client's Companion to Litigation, by Joseph Matthews, Nolo, <http://www.nolo.com/products/the-lawsuit-survival-guide-uncl.html>, \$17.99) Financial Planning Association www.fpanet.org or 800-282-7526
- National Association of Personal Financial Advisors, www.napfa.org or 888-333-6659
- American Institute of Certified Public Accounts/Personal Financial Planning Division www.Aicpa.org or 888-999-9256
- Society of Financial Service Professionals, <https://national.societyoffsp.org/default.aspx> or 888-243-2258
- Certified Financial Planner www.CFP.net or 888-237-6275
- The American College of Trust and Estate Counsel (ACTEC) <https://www.actec.org/>
- AARP www.aarp.com/
- INRA Broker Check <http://www.finra.org/Investors/ToolsCalculators/BrokerCheck> or 800- 289-9999
- North American Securities Administrators Association at www.nasaa.org or 202-737-0900.
- National Association of Insurance Commissioners (NAIC) at www.naic.org
- The American Bar Association (ABA) <https://www.americanbar.org/>
- <http://www.productionmachining.com/columns/choosing-a-professional-advisor>
- <http://www.wikihow.com/Find-a-Good-Insurance-Agent>
- Professional advisors are worth it. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793794/>

14.4 Resources to Check the Disciplinary History of a Professional Advisor

- Certified Financial Planner Board of Standards, Inc. www.cfp.net/search or 888-237-6275
- North American Securities Administrators Association www.nasaa.org or 816-842-3600
- National Association of Insurance Commissioners <https://www.naic.org/> or 816-842-3600
- National Association of Securities Dealers Regulation <https://www.nasdaq.com> or 800-289-9999
- National Fraud Exchange (fee involved) 800-822-0416
- Securities and Exchange Commission <https://www.sec.gov/> or 202-942-7040

14.5 Burnout

- Tait D. Shanafelt, MD; Sonja Boone, MD; Litjen Tan, PhD; Lotte N. Dyrbye, MD, MHPE; Wayne Sotile, PhD; Daniel Satele, BS; Colin P. West, MD, PhD; Jeff Sloan, PhD; Michael R. Oreskovich, MD.
- Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population. Arch Intern Med. 2012;172(18):1377-1385.
- Schattner E. The Atlantic. The Physician Burnout Epidemic: What It Means for Patients and Reform. August 22, 2012
- Baum NH. Balancing Your personal and professional lives, *Ochsner Journal*, 8, 160-163, 2008
- The Modern Healthcare Consumer. Chung CH. The 10 Cs for Emergency physicians. Hong Kong J Emerg Med. 2005;12:1–5
- Patient satisfaction surveys can be found in Marketing Your Clinical Practice-Ethically, Effectively and Economically. Baum N and Henkel G. Chapter 1, pp 3-18. Jones and Bartlett, 2010

14.6 Coding

- American Medical Association. CPT – Current Procedural Terminology. Available at: <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>
- American Medical Association. The RVS Update Committee. Available at: <https://www.ama-assn.org/practice-management>
- AUACodingToday. AUACodingToday. Available at: <http://auacodingtoday.prsnetwork.com/>
- Centers for Disease Control and Prevention. National Center for Health Statistics. Available at: <https://www.cms.gov/Medicare/Coding/ICD10/index.html>
- Centers for Medicare & Medicaid Services. Local Coverage Determinations. Available at: www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html
- Centers for Medicare & Medicaid Services. National Correct Coding Initiative Edits Available at: www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/
- Centers for Medicare & Medicaid Services. National Coverage Determinations (NCDs) Alphabetical Index. Available at: <https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html>
- Medicaid. The National Correct Coding Initiative in Medicaid. Available at: <https://www.medicaid.gov/chip/index.html>
- World Health Organization. International Classification of Diseases (ICD). Available at: www.who.int/classifications/icd/en/

15. Appendices

15.1 Checklist for Contracting

1. Identification of all responsible parties-legal entity names.
2. All licensing requirements/hospital privileges-applicable consequences-clear and concise.
3. Ownership of patients/fees/services, during and post-employment. Assignment of billing rights.
4. Non-complete clauses with reasonable restrictions. If possible, try to exclude restrictive covenants in the agreement. (The American Medical Association discourages the use of restrictive covenants in that they disrupt continuity of care and potentially deprive the public of medical services.).

5. Reasons for termination/"For Cause" definitions and remedies.
6. Ownership of medical records and future access for any board certification applications. Compensation should clearly define the bonus and how the bonus is calculated.
7. Compensation terms, including bonus accessibility and contingencies, as well as reimbursement requirements for business-related expenses/vacation/benefit eligibility, etc. The employer should make clear to the physician the factors upon which compensation as well as the bonus is based.
8. Responsibility for liability insurance/tail issues upon termination. Transition rules upon termination or expiration.
9. Significance of notice, mediation, arbitration, venue, jurisdiction, and governing law clauses.
10. Exclusivity clause. Who receives income derived outside of the practice or hospital such as speaking engagements, expert witness fees, and honoraria.
11. Benefits. Vacation time, educational leave, insurance coverage, payment of professional dues, allowance for educational materials, subscriptions for professional publications, membership fees in professional organizations.
12. Hours demanded of the employee and call responsibilities.
13. Death and disability provisions.
14. Costs of relocation and moving if this is applicable.

15.2 Sample Cover Letter

Dear Dr. X,

My name is X and I am currently a urologic oncology fellow at X. I will be completing my fellowship in the Spring/Summer of 2019 and I writing to inquire whether there will be an opening for a urologic oncologist on your staff in the upcoming future.

I am interested in all aspects of urologic oncology and I am equally comfortable and proficient in both minimally invasive techniques (including robotic) and open surgery. My primary career goal is to be an active clinician but I plan to eagerly continue my academic pursuits. My research interests generally mirror my clinical interests and largely surround minimally invasive approaches to high-risk prostate cancer and upper-tract disease including both urothelial and renal cell carcinoma. I have a great deal of experience with clinical research in the form of outcomes based research, randomized clinical trials and large animal projects.

Attached is a copy of my CV. I have worked very hard to be academically productive both as a fellow and a resident. What my CV may not convey is that I am an enthusiastic team player who enjoys working and collaborating with colleagues from student to attending.

Thank you for your consideration,

[Name]

15.3 Questions To Ask When Selecting a Financial Advisor

1. General Advisor Questions to Ask:
2. What experience do you have?
3. What are your educational qualifications?
4. What services do you offer?
5. What is your approach to financial planning?
6. Will you be the only person working with me or will there be others?
7. How will I pay for your services?
8. How much do you charge?
9. Could anyone besides me benefit from your recommendations?
10. Have you ever been publicly disciplined for any unlawful or unethical actions in your professional career?
11. Will you provide a written agreement for the services to be performed?

12. Do you have any professional credentials? Are these credentials updated?
13. Do you have proper business/operating licenses if required?
14. What is the reputation of the business/individual?
15. What are your presentation and learning styles?
16. Will you present material in a manner that fits my learning style?
17. Will you respect my risk tolerance level?
18. Will you consider my personal financial goals?
19. What kind of clients do you have? Can you relate to me and “where I come from”?
20. What are your ethical standards?
21. What is your mission and vision statement?
22. Do you use confidentiality clauses?
23. Who do you release my information to?
24. Who do you work with? Who will see my information?
25. Who do you associate with? Are there any conflicts of interest?
26. Do you provide a cost estimate?
27. Are you a specialist in this area of work?
28. Will you work with your other professional advisors if needed?
29. Will you show me a sample financial plan that you have produced?
30. Will any of your clients provide testimony about the work you’ve done for them?

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