EPISODE 4.16 | MAY 2, 2024

NEGOTIATING THE CONTRAT YOU DESERVE WITH ETHAN NKANA, JD, MBA AND DR. ERICA MATHIEU

David Mandell:

Hello, this is David Mandell, host of the podcast. Thanks for joining us. If you're listening on any of the podcast platforms or you're watching us on YouTube, thanks for joining us. I'm excited about today's episode. We've got two interesting guests, and I think the topic -- negotiating and coming to an agreement on your contract as a physician -- is one that I think all the docs listening and watching will be interested in. Because whether it happens often or a couple of times throughout your career, getting a good deal, making sure that you get the best deal you can and be in a position where you feel like you're getting value for what you're bringing is extremely important. And I think a lot of docs, especially young docs today have an issue with that. They don't feel like they're getting their best deal or that some of them may even feel like there's nothing to negotiate, that it's sort of take it or leave it. And hopefully after today will gain some insights that maybe that's not the case.

Let me tell you about both Ethan and Erica and then we'll bring them on. Ethan Nkana is the founder of Rocky Mountain Physician Agency. He began his hospital administration journey as human resources intern after earning a bachelor's degree in Business Administration and Public Relations. Over the following decade Ethan would grow his skill set to include leadership roles in hospital finance, physician contracting and compensation, hospital operations and healthcare strategy. This extensive training and expertise is underpinned by Ethan's legal and business training. He got his Juris Doctor JD and his Master's in business administration, MBA from the University of Dayton. He, like me, is a JD MBA, so that's great.

Dr. Erica Mathieu. I'll give you some highlights from her bio, and of course we'll link to both of their bios or Erica's case, her LinkedIn. She's a proud graduate of the Ohio State University College of Medicine, which will make my business partner Jason O'Dell proud. We can see that behind her. She also went to, well, I guess went to the Ohio State University for both undergrad and to get her MD. She currently has the position of Chief Medical Officer with Primary Health Solutions and she can tell us a little bit about that. And prior to that she was a family practice at a group in Dayton, Ohio. With that, Ethan and Erica, welcome to the program.

Ethan Nkana:

Thank you for having us, David.

Erica Mathieu:

Thank you.

David Mandell:

Excellent. The way we're going to do this is to make it organized, whenever I have two people, I like to be organized in how we go at it. Of course, either of you can chime in as we go through this. But I'm going to start, Ethan with some questions specifically for you. And then we'll turn the mic to Dr. Mathieu and go through some questions from her perspective. And I'll certainly want your input on there. And then we'll wrap back to Ethan. Let's start with you, Ethan. You're playing the role, and I didn't make this clear in the bio, but you can talk about it. Your agency, you're playing the role of a physician agent and people think of that when, think of an entertainment or sports, et cetera. But they haven't really thought of it probably for physicians before. Why would a physician need an agent? What's the need there?

Ethan Nkana:

Yeah, I think the primary reason that doctors need agents and representation and contract negotiations, and really the premise for the business is that doctors make a ton of money. Not that different from professional athletes. But when professional

athletes go pro, they hire an agent to negotiate their contracts for them, make sure they get the best deal, the best terms. But doctors are kind of left on their own to figure it out, find a lawyer who does it, and then hope that they get a good deal with their employer. And so we've really focused on bringing value to the doctors as opposed to billing doctors hourly or in six minute increments. Our focus is on helping make doctors more money. And if we cannot do that, we don't get paid.

David Mandell:

Interesting. And I mean, obviously I think there are probably docs listening to say, "Hey, I don't make the money of a quarterback or NBA players making 25, 35, 45 million dollars a year." But still compared to the average U.S. household, their income is quite high. And even the NFL and I have known a fair amount, people who played et cetera, some from the Ohio State University, some not. But kind of the rank and file there don't make that much more money than physicians. I mean, it could be hundreds of thousands of dollars, could be a million dollars a year, et cetera. But they're still always represented by agents. I think that point is a good one. Now, you mentioned healthcare attorney, you have a JD, so do I. Isn't this something a healthcare attorney would do normally? Or is there something different that you're doing or that you're proposing that docs consider that goes beyond let's say a healthcare attorney just looking at a contract and giving you their two cents? Tell me how this is a little different than what a healthcare attorney might do.

Ethan Nkana:

Yeah, great question. I think the main difference is how we get paid and what we focus on. While we're going to do a comprehensive review and analysis of the doctor's contract, help them make sure that the terms of their employment are fair and competitive for where they are. But at the highest level what we're trying to do is maximize our doctor's compensation. And I believe that everything we do in life comes back to incentives. And so we've built our incentive structure, our compensation structure such that it's tied to the doctor's compensation. So, there's no question about like, "Hey, is Ethan motivated to spend five hours reviewing a

contract?" No, I'm motivated to help you make as much money as possible. That could take five hours, it could take 10 hours, but our focus is on making the doctors more money.

And whereas I think a traditional attorney, whether they make the doctor more money or not, they're going to get their billed hours paid out. I get a bill from my attorney when I send a text message, so it's expensive, but the work that I do is strictly value-based. We want doctors to make a bunch of money and in turn we'll share some of those spoils.

David Mandell:

It sounds like it's a different business model, first of all, in terms of aligning yourself with the client in terms of the fee structure. And then you can tell me, because you've seen this as a hospital administrator and also working in HR. I think there's a fair amount of physicians, and I kind of talked about this at the get-go, and Erica, I certainly when we get to you, want your input on this. But especially younger docs maybe coming out of fellowship or residency, what have you. And they say there's nothing really to negotiate, right? I mean, I just need an attorney to just read, tell me what it says essentially, and that's it. Then I'm going to sign it. Because I don't think that there's, in some ways they believe potentially that you can't get me any more money. Tell me about that mindset. And does it apply in certain cases, in certain circumstances, does it not imply in others or can you say across the board that that's not true with the proper approach to it?

Ethan Nkana:

Yeah, I would love to loop Dr. Mathieu in on this one because I think there's-

David Mandell:

Okay, do that.

Ethan Nkana:

... things that I don't fully understand about why this happened. For my part as a hospital executive for 100% certain I told first time attendings, "It's a standard contract, it can't be changed."

David Mandell:

You told them? Okay.

Ethan Nkana:

Absolutely, of course I did. That's how we save money because those doctors wouldn't negotiate not knowing if there's a cushion that they could ask for more and we could give them more without having to go to legal for approval.

David Mandell:

Interesting.

Ethan Nkana:

We tell doctors it's a standard contract. They usually just said, "Okay, well I guess I'll sign it." And the thing that I've been, and this is where I'd love to know what Dr. Mathieu thinks. But the idea that I've been exploring recently is like do doctors ... Are they conditioned to do exactly as they're told? Because all the way through training we have the senior doctors and attendings and chief residents who tell us exactly what to do and how to do it. And then coming out of training I think is the first time a doctor gets to say, "This is what I want and what's important to me in my practice." And I think it's a little bit of a shock to come out of that mindset and now say, "Hey, I deserve better." Dr. Matthew, what's your experience or observation?

Erica Mathieu:

Absolutely. I completely agree with that assessment, Ethan. When you're a medical student, you're paying to work in essence. You are not being paid to do the work, and

your schedule might say 6:00 a.m. until 3:00 p.m., but the truth is, and anyone who, whether you're a physician or not, if you've ever dated a physician that the answer or you're married to one like my husband, the answer to that question is, you're done when I say you're done is the answer.

Thinking about something such as, "How much am I going to be paid?" When you go to residency that's handed to you, that's posted clearly on residency websites, "This is what you're being paid." You got the position and when you are told to leave, you show up When you're told to show up, it doesn't matter. And now like you said, this is the first time that you've been in the driver's seat at all. And it makes sense that we'd be a little bit hesitant as a group to not take people, I guess at their word. When they say, "This is what we can offer you, this is all we've got." Well, that's a lot of money compared to what I made as a resident, so sounds fantastic.

David Mandell:

Right. Yeah, it's not only the training that's coming out, which I think is an important point, but it's also more money than they've been paid in the past. It's not like they're used to negotiating six-figure salaries. But I want to drill down into one point that you said, Ethan. Because I really wanted people to hear this. And I think this gets to the fact of your experience and why you're able to do what you're doing today. But you said that when you were on the hospital side that when dealing with first-year docs coming in that there was a cushion. That, let's just say 10%, I don't know, you could give us an idea of it is, but we're going to pay this doc normally 250, that if we could go to 275, without even having to go to legal, meaning there was already built in some acknowledgement that that could be negotiated if they pressed back. Did I hear that right, and is that your experience?

Ethan Nkana:

Absolutely, 100%. And in your last question you also asked about, can first time attendings even move the mark in negotiations? And the answers are resounding

yes. Here's where the strategy of this comes into play. If I'm a first time attending and I only have one offer, how confident am I going to be in pushing back on the numbers that they put in front of me? If that's my big job that I've been working towards and I don't want to do anything that might risk that job and my livelihood. What I encourage doctors to do, and Dr. Mathieu did this in her experience as an attending, is get multiple job offers that you'd be willing to accept. And now you can say, "Okay, I really like offer A, but maybe offer B doesn't quite hit the mark on clinical support or my schedule." And so, you would then have confidence to have a little more of a voice in the conversation. Plastic surgery, we increase an offer. First time attending by 50,000. Family medicine, we increase a first time attending's offer by 40,000. And this is just by asking.

David Mandell:

Let me just drill down on that for a second. I agree totally with your point. It always makes sense, just market economics, if you have more than one offer, whether it's to sell your practice, we've talked a lot, I've done a lot of talks about M&A in this podcast or any kind of, selling your home, right? In those examples you just said a plastic surgeon, there was a family practice, did they have multiple offers, or was it still you were able to get some better terms, even when we were focusing on one?

Ethan Nkana:

It happens in both, but I will say that our success rate is lower when the doctor has one offer.

David Mandell:

Yeah. Makes sense.

Ethan Nkana:

I've had some doctors come back twice even, so they'll ask, they'll get told no, and they'll come back again and say, "Look, I really want to join, but I have this other offer." And so really that's what gives doctors what's called leverage in the conversation. But

what I often hear is doctors think, "Well, I'm a really good doctor, they really want me, so I have leverage." That's not leverage. Leverage is the ability to walk away from the offer with an equally satisfying option.

David Mandell:

Interesting. I like that. That's very insightful. A couple more questions, Ethan before we go back to Erica. Do you see, in my mind there's kind of three scenarios and you could correct me on that. But whether it's a doc coming out or moving laterally, they're either going to be negotiating with or against a large institution. That could be in a hospital, it could be a health system, could be academics, et cetera. They're going to become a W-2 employee. There is a situation where they're joining a private practice, where they are potentially going to become a partner in a couple of years. It's a different scenario, different kind of environment. They're coming into that situation.

And then you've got existing docs who maybe are then up for partnership or moving across at a partnership level from one private practice to another. To my mind there's one against a larger institution, one to a group that could be a large group, and then where you're coming in early and then one you're kind of coming across as a partner, they moving to a new state, but you're 10 years in practice and you're going to join another private practice. How are those different in your mind? Meaning or do you approach them all the same? Are there any nuances depending on the situation based on those three scenarios?

Ethan Nkana:

Yeah, there's an incredible amount of nuance, and I won't bore your audience with all of it. But I often say that the most important thing to consider is, when you're in private practice, you're probably doing a lot more than taking care of patients. You're probably doing hiring and firing, you're probably doing contracting with insurance payers. There's a lot of other, you have to grow your business marketing. There's all of

these other things that are incumbent in that business. Which can impact your lifestyle. Now on the large hospital health system side, you have some of those things taken care of for you. We're negotiating on different points. Now we're talking about support. Now we're talking about making sure that my pay is adequate for the context in which I'm giving and providing care.

I'm thinking a little bit differently about my doctor's priorities and preferences and what they want in their practice. Dr. Mathieu could tell you one of the first things we do is sit down to really prioritize what's important to the doctor. And then we want the employment opportunities that we identify to reflect those priorities. If a doctor says, "I want to practice in," let's just say a federally qualified health system, FQHC, you don't want to then bring them private practice opportunities. Because those are completely incompatible, not just from your daily life, but from your values and how you give care. And so I always approach it from the perspective of, "What matters most to my doctor?" And the levers that I pull are different, but the language is all the same, the context is the same, and the players are all the same, just sitting in different context.

David Mandell:

One more question before we get to Erica, so follow up on that, which is that, I've heard, and I don't know who I heard this from. It might've been from the fellow doc, etc. I don't even think it was on the podcast. But they had an opinion about, and I can't even remember what the opinion was. I think it was that when you're taking a new job or considering it, don't, or try not to negotiate with a doc on the other side. Meaning you're going to come to the new practice, don't be negotiating with one of your potential new partners.

Ethan Nkana:

Interesting.

David Mandell:

Find ideally HR if it's big enough, or the CEO or the CFO, someone who's not a fellow physician who may have other issues, emotions about bringing in a doc and in terms of, "Oh, I didn't get paid that when I was that age." Or whatever the issue is. That it's a little tougher to have that business mindset when it's also the doc who took you out to dinner and recruited you to the practice who you're going to be in the OR with, that kind of thing. Better to do it with a business person that your relationship will almost always be business. Even if you join that practice. CEO, you might become friendly with them, but it's not going to be like one of your fellow docs where you're consulting on cases. Does that seem reasonable to you? Is that something you've thought about yourself, or tell me about that?

Ethan Nkana:

Yeah, that's a really interesting perspective. I had not considered that myself. The rule of thumb that I use is, don't negotiate with people who cannot make a decision. I often think about, depending on the hierarchy in the organization ... That's a really interesting, I want to think on that because that's a really interesting perspective. I would throw my rule of thumb into the ring as well, which is, if you're going to negotiate, don't do it with the recruiter. Don't do it with the first person you got a phone call from. Do it with the people who have the power and influence in the organization to make that change.

David Mandell:

That makes sense. Yeah, that makes a lot of sense. And yeah, he wasn't, and I'm trying to even think who was a client of mine. But it made sense to me. But some circumstances there isn't any other opportunity. It might be a small practice where there's a practice manager, but the practice manager is not the one making the deal. The larger the practice, the larger the institution, obviously you're going to deal with a business person.