

# Part Time Employment for Physicians

## 2017

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## Part-Time Employment for Physicians

Part-time physicians can be a boon to a practice—if you do it right. Part-time physicians can be just as satisfied and efficient as full-time physicians, and they may even help generate revenue when they are not in the office. How you set up such arrangements -- e.g., job-sharing or a single physician -- depends on how the practice works together as a team and on the needs of both the part-time physician and the practice as a whole. The bottom line is that “where there’s a will, there’s a way.”

Female physicians are taking the lead in reduced work hours, although part-time is increasing for men too. Over one third of internists are women (many of whom are married to other physicians) and about twice as many women as men work part-time. One study found that 25% of all physicians in large groups work part-time in 2011 – up from 13% in 2005. That same study found that 44% of female and 22% of male physicians worked part-time in 2011, which is roughly triple what it was in 2005. Over 50% of medical school entrants today are female. As more women enter residency programs and then go into practice, it is safe to assume that desire for part-time opportunities will continue to increase.

While medical groups may be eager for the patients that flock to female physicians, these practices need to figure out how to accommodate part-time practitioners. Studies show that young physicians, or “Gen-Xers,” are, in general, searching for more balance in their personal and professional lives. That the practice of medicine is becoming more prone to burnout suggests an increased need for more part-time practitioners of both sexes.

This guide is for employers and employees as they consider how to make part-time arrangements a win-win for both parties.

### Why Part-Time?

An employed physician may seek part-time employment or an owner/partner may decide to cut back to part-time. There are myriad reasons for physicians wanting to work part-time.

- A senior partner physician approaching retirement wants to reduce his/her hours and/or call.
- A partner who is burned out simply wants to improve his/her career satisfaction and lifestyle by working less.
- A partner becomes disabled and due to physical limitations or other reasons is no longer able to put in the full number of hours. For instance, a physician who has difficulty walking may need to opt out of rounding at the hospital or taking ER call but can still see patients in the office on a limited schedule.
- A partner wants more flexibility during child-rearing years. Discontinuing work altogether may result in a potentially career-ending disruption. It can be difficult to return after a hiatus of as little as six months, since the break in CME credit accumulation, referral patterns, and so on, is hard to overcome. Working part-time allows continuity with the addition of flexibility.

There are also many reasons why a practice might consider bringing on a part-time provider.

- The practice has been unsuccessful in recruiting a full-time physician. Women are the physicians most likely to want to work part-time and they represent 35% of all internists between the ages of 35 and 44, more than 40% of physicians under 35, and over 50% of medical school entrants. Thus offering a part-time position could dramatically increase the number of interested candidates.
- The practice needs additional help but not enough to support another full-time physician immediately. By sharing current practice income with a half-time rather than a full-time physician, the original physicians may be able to avoid an unintended prolonged dip in their own compensation while the new physician's schedule gradually fills with patients.
- The office needs help on busy days, holidays, and to cover vacations. A part-time practitioner who works Mondays and Fridays, plus more frequently during vacation season, can ease the burden during the high stress, high volume times or when other physicians are not available.

Additionally, part-timers can enhance practice profitability by making more effective use of existing staff and facilities. For example, the profitability of most ancillary testing, such as labs, bone density testing, or x-rays, depends on volume. In addition, the tests ordered by the part-time practitioner may be performed when he or she is not in the office. The part-time physician may also increase the patient base to help fill physician extender slots as well as help the practice make better use of office resources —by eliminating underutilization of staff and exam rooms on days the other physicians take off.

Studies show that patients perceive no difference in quality of care among physicians working over 65 hours per week, 40-65 hours per week, and less than 40 hours per week. However, the physicians who work more than 65 hours per week are significantly less satisfied with the amount of time they can devote to their patients and personal lives. Additionally, studies show that part-time physicians are as productive per hour worked and are more satisfied with their work. The Medical Group Management Association's (MGMA) Physician Compensation and Productivity Survey shows that the compensation to gross charges ratio and ambulatory encounters per physician, both measures of relative productivity, is virtually identical for physicians working 40-60% of full-time and those working full-time.

There are many situations in which part-time employment can be a benefit to both the practice and the physician. A part-timer can improve practice productivity and stability by smoothing out peaks and valleys in the caseload, either weekly or seasonally. With easier recruitment and all physicians more satisfied, future practice success is enhanced.

## Special Issues to Address

Although there are many advantages to part-time physician employment, there are also some special issues that need to be faced to make it successful. Normally they can be resolved by the practice and physician working together. As a general rule, it is wise to keep part-time arrangements as simple and straight forward as possible. Excessive creativity and complexity in their design can bog down negotiations, lead to confusion later on, and/or create tensions with other physicians who may feel disadvantaged. A good theoretical starting point is the premise that all money and time allocations should be pro-rated based on the percentage of full-time employment the physician will be working. Such a working premise helps reduce complexity, make the arrangement seem intrinsically "fair," and resolve most issues. Unfortunately, some issues just can't be resolved quite that neatly; so the two parties should be prepared to depart from the premise, as needed, in order to resolve problems unique to their particular situation. The following issues should be carefully considered and addressed as appropriate.

Benefits: Certain provider benefits are by nature "lumpy" (premiums don't decline with hours worked) and therefore may cost the practice slightly more on a per full-time equivalent (FTE) basis. Will the practice absorb this incremental cost, find a way to split it with the physician, or shift the whole amount to the physician? Other benefits, such as life insurance or retirement plans, can only be made available to full-time employees, or employees who work a minimum number of hours (usually 1000 hours per year.) In that case, will an ineligible part-timer have to get along without such basic benefits, rely on a spouse's coverage, or purchase separate coverage personally -- with or without some offsetting compensation from the practice?

Overhead expenses: Part-time physicians obviously use less overhead than full-timers; yet many practices traditionally divide such expenses equally for income division purposes. Will the part-timer be allocated an equal, proportionate, or no share of overhead expenses?

Rounding and Call: As with the disparities in overhead expenses, the additional patient workloads that part-timers add to rounding and call burdens are not equivalent to those of a full-time physician. Will the part-timer be expected to round on patients even on non-work days? Will he or she share equally, proportionally, or not at all in taking call? What allocation of these practice burdens to the part-timer will also be fair to the full-time physicians?

Community Relations: Patients, referring physicians and others in the community need to be aware that the part-timer will not be in the office on certain days of the week and probably will be less frequently available to handle emergencies than a full-time physician. Typically, patients understand that they cannot always see their own physicians, especially in emergency situations. But there should be no surprises for them, or for referring physicians who may want to get their patients in to be examined stat. How will the community, referral physicians, and patients be educated about the part-time arrangement? What other measures will be taken to mitigate strains on these important relationships? For example, easy and assured access to a familiar, trusted nurse might greatly ease patient anxieties when the physician is unavailable

Patient Base: A part-time physician may find that certain patients place such high value on continuity of care that they will transfer to a full-time physician, possibly outside the

practice. And in some competitive practice markets, referring physicians may tend to send their most challenging cases to full-time physicians. Are the practice and the part-time physician prepared to accept such behavior patterns, or live with them until the growing number of part-time physicians gradually alters attitudes in the community?

Practice culture: Often the most difficult barrier to overcome lies within the practice itself. If the full-timers are not flexible and open-minded about striking a new path, they may resent the fact that the part-timer is only pulling a proportionate share, rather than an equal share, of the load. Will full-time providers question the part-timer's dedication to the practice of medicine or commitment to the long-term success of the practice? If so, can their concerns be overcome? If not, is the atmosphere even conducive to a successful part-time arrangement?

### **Structuring the Deal—Getting to a Win-Win Contract**

There are several types of part-time arrangements. Some are temporary; others permanent. The part-timer may be an employee with the terms written into an employment contract or an outside independent contractor, either of which can be paid on an hourly or daily basis. Job sharing is another option. The deal a practice strikes with a provider will depend on the specific situation.

Temporary part-time arrangements are different and not specifically addressed in this guide, mostly because the longer-term relationship of the provider to the practice does not change. Thus a physician may want to cut back to part-time or take a leave of absence as a bridge during a personal situation. Locum tenens arrangements can be made to cover such cut backs, just as they might for maternity or family leave, a sabbatical, or a medical disability. Since the physician plans to return to full-time soon, the impact on patients and the practice is less and of shorter duration than long term part-time employment arrangements. Hence a relatively simple, even informal, accommodation usually suffices to bridge the temporary period.

### **Job Sharing—The Magic Bullet?**

With the right combination of individuals, a job sharing arrangement can be an excellent solution, one that will reduce problems for the practice and thus enhance the probability that part-time employment will succeed. Nevertheless, this option can represent a more complex recruitment challenge since the two individuals must agree to work opposite schedules and they must work and communicate very well together. However, from the practice's standpoint hiring two part-time people to share one job simplifies call and other issues by mirroring the normal arrangements for a single FTE provider. In addition, patient acceptance is better because at least one of their two regular providers will be in the office. Meanwhile, staff and office space are just as fully utilized as they would be by a full-time provider. And if the job share physicians do not receive some benefits, the overhead expense may actually turn out to be less than for a full-timer. An online resource for women (<https://www.mommd.com/>) offers a variety of information on job sharing and other part-time arrangements. The American Medical Association also has a growing collection of resources on [part-time medicine](#).

## The Compensation Package—Salary and Benefits

Establishing the needs of both the employer and employee from the outset is essential to finding and keeping a productive part-time physician. The purpose of the compensation package is to support those mutual objectives, and it should be adjusted accordingly. For potential partners, it is also important to consider buy-in arrangements.

Because physician compensation includes both salary and benefits, designing the total package can become a complex undertaking. The “Income Distribution and Partner Buy-Ins” guide provides more details about how to distribute practice income and consider buy-in arrangements. When there is a part-timer in the picture there are some additional considerations. For example, equal distribution of income would be unfair and probably unworkable. Most groups that have both full- and part-time providers use a productivity-based formula, but other options are also possible.

### Salary

Salary can be set up several ways:

- An hourly wage, based on local averages, that includes time spent on paperwork and phone calls as well as actual patient time;
- A percentage of a full-time salaried position, based on percentage of time worked;
- Daily, weekly, or monthly fees based on a pre-determined number of days, hours or shifts worked; or
- Profitability based payments calculated as revenue minus overhead (see discussion on dividing overhead under “Deal Breakers”), or some other formula that will facilitate practice objectives.
- Some combination of the above, e.g., fixed wage plus a bonus based on pure production (charges, encounters, RVUs, etc.) against a target.

If the physician’s work hours will flex up and down from one period to the next, an hourly wage may be appropriate, although deciding which hours to count in the calculation can be tricky -- only scheduled patient time, all hours spent in the office, or after hours work as well? A per diem, hourly, or other fee arrangement can work for both owners and employee so long as the formula is set in advance, such as quarterly for x number of days per week during the period. For physicians cutting back from full-time, a compensation agreement based on production and/or profitability may prevent possible resentment from other full-timers. There is no single preferred solution for all situations. As long as everyone understands and agrees on the methodology, any of the above options can be made to work.

Once a general decision has been reached on how to compensate the part-timer(s), the next step is to establish an actual formula for calculating salary. Parity is essential to maintaining satisfaction amongst the part- and full-time providers. Those who take on more of the less desirable tasks (i.e., call, weekends) need to be compensated for these tasks; similarly, compensation should be reduced for those who are assigned less than a fair share of these tasks. There are several options to consider when developing a compensation formula for a mix of full- and part-time providers:

- Percent of total – Part-time physicians may be paid a fixed percentage of the annual

compensation received by those working full-time or they may receive a calculated per diem rate equivalent to what a full-timer would receive on a daily basis. Compensation can be calculated based on total hours worked during the week or some other proportional allocation. Alternatively, some practices place a dollar value on each aspect of the practice, such as evening call, weekend call, hospital rounds, one day in the office, etc., based on the average revenue generated by, or time spent on, each increment. Then they use that factor to determine provider salary. While this approach sounds appealingly precise, its application requires many assumptions and/or an existing cost accounting system, which is atypical of most private practices.

- Productivity or income goals – Compensation may be based purely on productivity. This “eat what you kill” methodology is easy because it is based on how much the physician bills or how much the physician contributes to practice receipts. Thus, if one physician wants to work three days a week while another wants to work five, the compensation formula automatically adjusts based on production. Using this methodology, however, may require a separate calculation for taking call, making rounds, etc. Additionally, it alone won’t take into account disparities in the use of on-going fixed expenses, e.g. when a physician cuts back hours but still retains a dedicated full-time nurse.

Other factors worth considering when planning employment and compensation arrangements for a part-time provider include:

- Technology – Technology can facilitate part-time arrangements (PDAs, computers, cell phones, etc.). A paperless office may help reduce communication and charting complications. Email, cell phones, and digital dictation, for example, can help the part-timer stay in touch with patients during off hours and/or from remote locations. If a part-time provider is expected to be available to answer patient emails and calls or do chart work on “off” days, then compensation should reflect this additional workload.
- Staffing – Some practices have dedicated staff, particularly clinical staff, for each physician, while other groups elect to have all physicians share all staff. Each practice will need to consider carefully how to allocate staff, if at all, and the expenses associated with the staff. Enabling more efficient use of staff may reduce the costs associated with part-time providers, but not without some compromises.

### Benefits

Benefits present a different problem. Benefits, such as retirement and health, life, and disability insurance may have predefined rules set by the insurance company or in some cases by the practice. For pension and profit sharing plans, federal regulations define the number of annual work hours, usually 1,000 hours per year, required to qualify for participation.

Some (but not all) professional liability companies give discounts on premiums to doctors working part-time but not necessarily reflecting the full reduction in hours, for example, a part-time provider may only receive a flat 50% discount for anything less than 20 hours worked per week. Likewise, any increments above 20 hours may require paying the full 100% premium. In general, a practice should purchase liability insurance for the part-time provider, regardless of the discount, to ensure that the practice will be protected in case of lawsuit. In some practices the cost of malpractice insurance for a part-timer is passed along to the physician.

Health insurance is often available through a spouse. However, for the part-timer who does need health insurance its high cost makes it an important part of the equation. Whether the practice pays all or part of a part-time physician's health insurance may depend on several factors. Some group health insurance plans may only insure participants who work a defined number of hours, often close to full-time. On the other hand, self-insured plans (usually only available to companies with a large enough employee base across which to spread the risk) may make their own determination. Another option is to set up a pro-rated medical spending account. An important consideration is that health insurance premiums paid by the employer and employee contributions to medical spending accounts are paid out of pre-tax dollars, thus saving taxes for both the employer and the employee.

CME is optional. Some practices pay for it; others do not. Vacation may be paid, unpaid, or "swapped" for additional work at another time. Licenses usually should be paid by the practice, but some choose to reimburse the part-timer based on the percentage worked.

One way to equalize benefits (and their costs) between full- and part-time providers is to make a part-time provider "cost-neutral." For example, if the provider works 60% of a full-time schedule, they receive approximately 60% of the benefits provided to a full-timer. This balance can be achieved by paying some benefits in full while eliminating others, or by transferring a percentage of fixed costs to the part-time provider. Thus the provider might be expected to pay the 40% additional cost of malpractice and health benefits, while receiving 60% of the full-timer's CME allotment. While this technique may not entirely neutralize the increased overhead costs, it can go a long way towards minimizing cost differences between part- and full-timers.

Another approach that many practices have found effective is to offer higher salaries to off-set the reduced benefits available to part-timers or, conversely, offer full benefits in exchange for an off-setting reduction in salary. (Due to the payroll tax savings a salary reduction can be more financially beneficial to the practice than an equivalent benefits reduction.) Finally, although there are several ways to minimize benefit cost differences between full and part-time employment, in many instances the incremental expense is simply borne by the practice as a cost of doing business.

Because part-time physicians typically are ready to make sacrifices in salary, benefits, and partnership in order to work part-time, they may ease the burdens on other physicians; yet still be as productive and cost effective as full-timers. The trick is to negotiate an accommodation that works for both the part-timer and the practice.

Non-compete clauses are commonly included in all types of physician employment contracts. In the case of part-timers there are a couple of additional twists to consider. Some part-timers are raising families or pursuing outside interests in their time off; others may be employed elsewhere, typically in another capacity, such as administrative or educational. Some practices may not want a physician who initially was satisfied with a part-time income to later negotiate a similar deal with the group across town—even temporarily—to help cover a large personal expense or explore what the other group has to offer. In other cases the opposite may be true: sharing a provider could be a highly cost effective and desirable arrangement for both practices. The important thing is to spell out clearly in advance what is permitted under the contract so there will be no misunderstandings later.



## Potential Deal Breakers

Often the two most difficult issues to be dealt with are call and overhead. Nothing can create more stress in group relationships than perceived inequity in the division of income and personal time.

Although a crucial part of the overall employment agreement, call is so unlike the other negotiable issues that it may best be addressed separately. Patients need coverage full-time whether they see a part-time or full-time physician. Conceptually this requirement presents no problem: the extra patients a part-timer adds to the call workload should equate to the extra physician call time contributed if the part-timer takes call in the same proportionate share as the part-timer's work hours in the office. However, this theoretical proposition may not coincide very well with the part-timer's fundamental objective of maximizing personal time by reducing total work hours. If therefore call will not be shared proportionally, it is reasonable for there to be some financial gain (or loss) associated with taking call (or not).

Again, there are several ways to divide up call. It is not uncommon for physicians in a practice to divide call equally, with part-timers taking as much call as the full-timers. But some practices choose to base call on the same percentage as the part-timer's proportionate share of full-time employment, while others may exclude them altogether from the call rotation and simply reduce salary accordingly. A no-call option may not be feasible in small groups (where one or two full-timers would have to absorb the entire extra burden), but more realistic in larger groups where there are more providers to share in the call schedule. Physicians in job sharing arrangements often share one full slot in the call rotation, thereby simplifying financial calculations and alleviating concerns about "fairness."

No matter how call is handled, it is reasonable to remunerate all physicians appropriately for taking (or not taking) call. If the part-timer is taking no call, incentives can be established to compensate other physicians for taking more than their proportionate share of call. Similarly, a part-time physician taking full call might be compensated extra for that disproportionate share of the work. For example, a practice might assign a dollar or percent of revenue value to weeknight, weekend, and holiday call and then compensate for each accordingly. Thus a 60% part-time work schedule but with full call might result in a 10% salary increase, i.e. an additional 2.5% for every 10% increment over what would otherwise be 60% call. If changes to the amount of call are only made annually, the corresponding salary for each physician can be determined at that time based on the number of times he or she is scheduled to take call in the future. A no-call option may translate into a substantially lower salary, but the smaller the practice the more burdensome coverage then becomes on the other physicians.

Hospital rounding issues can be addressed in the same manner as call. However, rounding tends to be a less significant issue, in part because many practices still follow the tradition of having each physician, regardless of work schedule, take responsibility for rounding on his or her own hospital patients. Hospitalist arrangements may eliminate the issue in other practices.

Depending on the practice's standard compensation formula, overhead can be another tricky issue to address. No practice wants to pay an employed physician more than he/she brings in after expenses. At the same time, it would be unfair to ask a part-time practitioner to

cover the same overhead as a full-time practitioner. For a group that allocates overhead expenses equally in its compensation formula, a real departure from the standard overhead calculation may be required to recognize that a part-timer consumes less resources (staff and otherwise). This issue of course does not arise for the many groups that do not use an overhead allocation in their physician compensation formula. Overhead allocation methodologies are covered in the next section on the division of income division under buy-in and ownership agreements.

### **The Actual Employment Contract**

Once the practice and potential part-time physician employee have worked through and come to a basic understanding about the various issues discussed above, this tentative agreement needs to be incorporated into a formal employment contract. In some cases the practice's existing contract for full-time physicians may serve as a good starting point and require only minor modifications. In other cases an entirely new contract will have to be written. (ACP's guide "Physician Employment Contracts" discusses the basic elements to include in any employment contract. Finally, the employment contract should either be written or reviewed by a qualified attorney with medical practice employment experience.

### **Partnership/Buy In**

Should part-time providers be made partners? There are good arguments on both sides. Part-time owner issues vary depending on the group's philosophy. The level of commitment is key. If the part-timer is as involved in practice decisions and is as committed to the practice's success as any full-timer, then he or she may make a good partner. The same reasons for granting ownership to full-time physicians also apply to qualified part-time physicians. The practice gains from their long-term commitment and contributions to building the practice's reputation and market share in the community. The practice may be at risk of losing an excellent part-time physician who is denied partnership—especially if the part-timer anticipates going full-time at some point in the future, e.g., after children reach school age.

Since employees are free to leave the practice with relatively limited notice, finding an equally qualified replacement may not be easy in today's environment; therefore most practices try to minimize the costs and disruptions of frequent recruitments. On the other hand, a practice is free to let an employed provider go if a more attractive or workable option comes along. For instance, if there are two people sharing one FTE position and one retires, the practice can dismiss the remaining part-time employee and instead find a full-time provider to fill the shoes of both. Once the part-timer becomes a partner, however, that person normally must be accommodated, regardless of other available options.

Partnership also gives the part-time provider an increased voice in the management of the practice, which is another important retention incentive. The degree of influence may depend on how the group defines voting rights. For instance, the part-timer may get a pro rata vote on issues such as major capital expenditures; or the group may choose to assign equal votes to all partners because they will be equally using, paying for, and benefiting from such purchases, while the compensation formula will adjust for productivity differences. Gaining full voting rights may require also accepting a full share of overhead charges, or overhead may not be a factor so long as the part-timer is committed to the long-term success of the practice. Some groups make

most decisions by consensus instead of voting, thus giving the part-time partner in effect a full voice regardless of technical voting designations.

Once the decision has been made to allow a part-timer to buy into the practice, a few practical decisions must be made. One is the length of time to qualify for partnership and another is the percentage of partnership. The number of years to achieve partnership may be the same whether the provider works full- or part-time. Alternatively, “credit” toward partnership can be given for a percentage of each year served based on the part-timer’s share of an FTE work schedule, until the credit for a part-timer equals that required by a full-time partner. For practices that do not allow a part-timer to buy into partnership, the physician should be credited for previous part-time years once he or she elects to go full-time. For example, in a practice that requires two full years of service, this part-time credit might allow buy-in six months after increasing to full-time provided the physician had already served three years at half-time.

Whether the new partner is part-time or full-time, a practice value must normally be computed to determine the price of the buy-in to the new owner. One practice may pay to have the practice valued each time a partner buys in; another may base the buy-in exclusively on accounts receivable; while yet another might simply spread out the buy-in over a fixed period of years using a reduced compensation formula. The practice must decide if the part-timer will buy in at a full share or a reduced percentage based on the share of FTE worked. Making everyone an equal share partner and then using a productivity-based compensation formula to reflect part-time hours can simplify both the buy-in and any future sell-out.

While employment compensation formulas often do not allocate overhead, partner compensation agreements normally must do so in order to arrive at a fair division of income. There are several ways to divide overhead:

- Full-share – Assumes the part-timer costs the same as a full-timer. This division may work for an established provider who is temporarily going part-time, such as the first six months after a new baby is born. Or a senior partner, who benefits significantly from practice profits and spends substantial time in community relations, may be willing to continue shouldering an equal share of overhead in exchange for being allowed to gradually scale back his or her share of the work as an interim step to full retirement.
- Percentage share – Works especially well in larger practices where more providers can spread any extra costs associated with part-time providers. The provider who is only in the office 50% of the time or whose production is 50% that of the average full-timer would thus pay 50% of the standard overhead expenses. The tricky part here is how to deal with individual fixed costs, such as malpractice and health insurance, but the “cost-neutral” benefits approach described earlier may be one solution.
- Profit sharing – May be the simplest approach, where feasible, for dividing income because “net profit” already takes into account the income that is leftover after paying all overhead expenses. Thus a profit sharing formula takes the practice profit (for all physicians) and divides it among individual physicians based on days worked and productivity. It is distributed to physicians on a predetermined formula. For example, 25% of the profit could be divided based on time in the office (e.g., using FTE) and the remaining 75% could be based on productivity (e.g., using RVUs or receipts).

## **Practice Culture**

Can your practice, rooted in the tradition of full-time providers, change to accommodate a physician who wants to work part-time? Is your practice open to the idea? Does it in fact need part-time providers to succeed in the future? These questions must be answered in the full context of the group culture, and a part-time arrangement should only be undertaken if the practice's owners want to make it work. In an environment where part-time providers are becoming increasingly common and satisfaction with the practice of medicine is on the decline, adding a part-time practitioner (or allowing a full-time provider to reduce hours) can revitalize and sustain your practice.

## Appendix: Part-time Agreement Check List

The following factors should be considered in designing a part-time arrangement:

- Define practice and physician scheduling objectives:
  - o Days/week, days/month, weeks/year, or hours/day physician is needed
  - o % of FTE and/or schedule physician is prepared to work
  - o Check minimum hours required to work per year, if applicable (e.g., 1000 hrs), in order to qualify for pension plan or other benefits.
- Call and rounding requirements
- Benefits and who pays for what and how much:
  - o Health insurance
  - o Professional liability coverage
  - o Pension or profit sharing plan or 401(k)
  - o Life or disability insurance
  - o CME
  - o Vacation, sick, professional leave
  - o Other benefits such as medical or childcare spending accounts, auto leases, etc.
- Compensation formula
  - o Hourly/daily/weekly/monthly/annual salary, e.g., “prevailing hourly wage in the local community.”
  - o Compensation calculation: share of salary vs. productivity (if applicable) o Production definition, e.g., receipts, charges, hours worked, RVUs, other o Overhead division, if appropriate, e.g., “cost neutral”, equal share, pro-rata
- Other contract issues—common to both full and part-time physician agreements
  - o Employee vs. independent contractor status (if applicable)
  - o Contract start and end dates
  - o Required compliance with office policies
  - o Work space, staff, and other resources provided by practice
  - o Definition of practice property, e.g., reimbursements and medical records
  - o Non-compete clause (optional)
  - o Termination clause
- Buy-in Agreement
  - o Waiting period to qualify for buy-in for both full- and part-time
  - o Buy-in terms
  - o Valuation methodology
  - o Income division methodology