# Have You Sold Out Your Future for Stipend Support?

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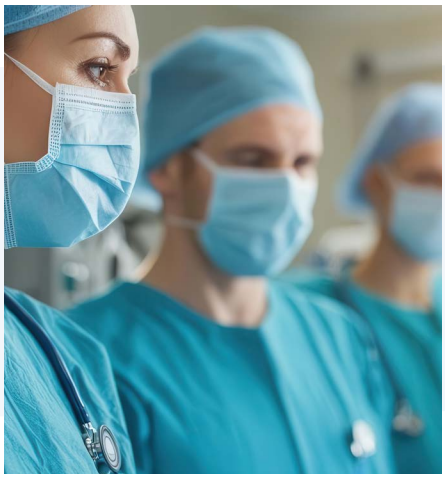
No one who understands the current shortage of anesthesiologists and CRNAs, the increased compensation demands that flow from the shortage, and the whipsaw effect of lower "reimbursement" from commercial and governmental payers questions the fact that nearly every anesthesiology group requires some form of financial support from the hospital.



But in fighting for vital financial support, many anesthesiology groups make the dual mistakes of confusing the deal for dollars with negotiating the exclusive contract of which it's a part, and of ignoring the interplay between exclusive contracting and overall group strategy.

Sometimes this occurs through naivete. Sometimes it occurs because someone played lawyer. Sometimes it occurs because of a mistaken belief that you're stuck negotiating from the hospital's so-called "standard" document. And, well, sometimes the money just looks too good, and the relief of apparent financial stability is so tempting that the contract just gets signed.

But here's the question every physician leader should be asking: *At what point does a stipend stop being support and start being the functional sale of your group without a purchase price?*

## THE SHORTAGE AND THE LEVERAGE

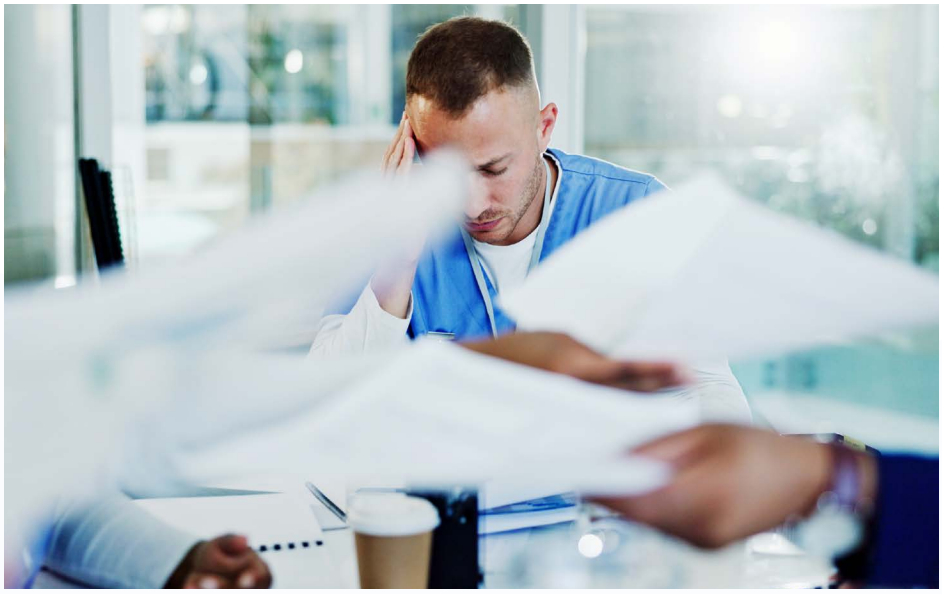
To be sure, the growing shortage of anesthesiologists, fueled by the needs of an aging patient population, the impact of an equally aging anesthesiologist workforce sailing into retirement, and the limited capacity of residency programs training new specialists, has given anesthesia groups substantially more negotiating leverage vis-à-vis hospitals than they've had in decades.

But it's essential that anesthesia group leaders appreciate the fact that leverage in this context is extremely different from, say, the ability of many other sorts of businesses to leverage a shortage, real or manufactured, into increased *profits* by extracting more from the customer.

Think, for example, of the way that Ferrari dealers leverage off the intentionally restricted availability of limited productions models, requiring already great customers to buy multiple "lesser" models before even being considered as a potential buyer of a coveted model such as a LaFerrari. Call it rent-seeking or call it smart thinking, the leverage is used to extract pure profit for the business.

In the anesthesia group financial support context, leverage isn't used to line the pockets—it's used by the group to bridge the financial gap between what's being collected and what must be paid out to its professional staff to meet fair market value compensation expectations, i.e., to retain and recruit. Sure, the staff members' compensation, whether measured by the hour or the unit or the month or the year, will increase due to the support dollars, but the group, not those anesthesiologists and nurse anesthetists, is the party bound by agreement. None of the individuals, unless they are fools (. . . and I have seen it happen), are personally bound to perform the group's obligations to the hospital.

The kicker is that, for the group, even in the face of that elevated negotiating power, when a significant chunk of your revenue comes from the hospital, you are no longer just a contractor. You are its appendage.



## TO WHAT DID YOU AGREE TO GET THOSE DOLLARS?

In that context, to what extent did you as a group leader agree to the group becoming bound so tightly to the hospital that it achieved appendage status?

Did you permit the power dynamic to shift, such that your "independent" group is now, or with the short passage of time will be, functionally no different than a passthrough form of hospital employment, just without any benefits?

Among the dozens of common mistakes are ceding to the hospital virtual operational authority over the group (exclusivity without control), failing to conceive of how timing (termination, renewal, etc.) births control for the hospital, sloppy thinking as to staffing limits and dealing with change in demand, the related failure to build in adjustments to financial support, not understanding the array of rights of first refusals and first negotiation, and even permitting the actual decapitation of the group via traps such as "national search" or the similarly named, but very different, "search firm" ruse.

Even though anesthesiologists think that their bargaining strength is at an all-time high, financial support comes at a cost. I'm certainly not telling you to forego negotiating for financial support—I've been representing groups in that context for decades, and the significant financial support that we negotiate is, in today's anesthesia economy, the life blood of nearly all groups.

Instead, I'm telling you that the issues are far more complex and intertwined with the other provisions of the related exclusive contract as well as with your group's overall business strategy.

After all, inadvertently ceding control over your group's operations at a particular facility has an indelible, and potentially irreversible, impact on your overall business, potentially reverberating outside of your group's operations at that facility to impact its operations at others, for example, in the most common form, at ambulatory surgery centers at which it also provides service. It also impacts the ability to expand to new sites of operation. And, last, it potentially sets your group up to have its existence made moot.

One more point on overall business strategy. Understand that the less reliant you are on any deal, meaning that your group's entire existence is not wedded to one facility or even to one system, the more actual bargaining strength you have. At the end of the day, if you can't walk away and continue as a viable entity, your power is far feebler than you imagined.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