Wearing Two Hats at Once: Employed Physicians and Medical Staff Rights

Staying Well Within the Law

June 2012

Hospitals and health systems now employ between 20 percent and 25 percent of all physicians according to a recent American Hospital Association survey, representing a 34 percent increase over the past decade. Reasons for the trend vary -- among them are hospitals' desire to legally lock in physicians' patient referrals; physicians' frustrations with decreasing reimbursement and payor headaches, the increasing cost and complexity of private practice; the evolution of larger, more fully integrated provider entities; generational differences in attitudes about entrepreneurship and work/life balance. Employed physicians may gain a measure of financial security and lifestyle advantages, but the tradeoff is a reduction in autonomy. Employment relationships are generally defined by detailed contractual provisions, but employed physicians are also members of medical staffs whose governance is defined by bylaws and determined by committees of peers. It is important for employed physicians to understand how those two roles interact and which system takes precedence, and to address these issues to the extent possible when negotiating the employment relationship.

Medical staff membership and clinical privileges are granted under hospitals' bylaws as required in Pennsylvania and most other states by hospital licensure requirements. Pennsylvania Department of Health regulations require a hospital's medical staff to be organized to provide for the election or appointment of its officers, and to establish the bylaws, rules, and regulations of the medical staff. The medical staff must define in its bylaws the requirements for admission to staff membership and for the delineation and retention of clinical privileges. The bylaws must set forth qualifications for membership and clinical privileges and a system of due process including fair hearings and appeal mechanisms for medical staff decisions. Due process protections are also required as a condition of the immunity from lawsuits provided under the federal Health Care Quality Improvement Act and are required for accreditation by the Joint Commission. The model is quasi-judicial and intended to be impartial and objective.

In contrast, an employer-employee relationship usually tilts more heavily in favor of the employer's rights, as set forth in written agreements when they are present (as is almost universally the case with hospital-employed physicians). Employment contracts may be terminable by one or both parties without cause, or may be only terminable for breach or upon the occurrence of specific events, with or without an opportunity to cure the alleged breach. One of those events is usually the loss or suspension of medical staff privileges.

Similarly, termination of employment frequently requires the employed physician to relinquish his or her staff membership and clinical privileges and forgo any hearing,

appeal or other due process rights. This may be coupled with a restrictive covenant prohibiting the former employee from continuing to practice in the hospital's service area following termination, and may also prohibit the physician from reapplying for privileges for the duration of the noncompete.

Hospital administrators understandably prefer to avoid having to prove the reasons for a physician's termination in a court-like setting before a potentially unsympathetic "jury" of physician peers. This may be particularly applicable when the reason for the termination is based on allegations of "disruptive" behavior which may be difficult to document. Disruptive physician disputes have increased in recent years, in part because the Joint Commission has adopted a zero-tolerance approach to such behavior by both physicians and administrators. Nevertheless, physicians should not routinely agree to surrender their due process rights upon becoming employed without determining whether any other protections may be preserved.

As a physician considers an offer of employment from a hospital or hospital affiliate, the contract should be carefully reviewed to consider not just what triggering events may cost the physician his or her job, but how, and by whom, the decision is to be made. Hospitals and health systems employ physicians through a variety of methods including directly through the hospital itself, through a (usually nonprofit) subsidiary of the hospital or its holding company parent, or through a stand-alone practice entity owned and controlled nominally by a physician-insider of the health system (a so-called "friendly" or "captive" PC). These subsidiaries and affiliated entities may include employed physicians on their governing boards, but are not required to do so. Some health systems employ all their physicians through the same corporate entity while others set up or acquire separate entities for each specialty or even for individual physicians. The determination of exactly who is the "employer" and how that employer makes termination decisions is critical. It may be possible to negotiate terms under which a physician may not be terminated except with a majority or supermajority vote of the physician representatives on the governing board, or to develop other protections against arbitrary action by the administration. The success of such negotiations will be driven by traditional bargaining power considerations and the relative flexibility of the hospital. Smaller community hospitals are likely to be more willing to offer concessions to secure desired physician practices.

A hospital may not always want to remove a former employee from its staff. Given the frequently illogical economics of physician employment, a hospital may want to shed a physician's salary obligations to save money but still want to keep that physician as an independent member of the staff and retain his or her patient base. This cycle has occurred in prior waves of practice acquisition and divestiture and may happen again.

Note that termination or other reductions in clinical privileges for reasons related to clinical quality or professional conduct are reportable to the National Practitioner Data Bank, as are physician resignations or voluntary reductions during an investigation of such allegations. However, if under a physician's employment contract the physician is required to forfeit staff membership and privileges upon termination of employment,

even if for cause, there may not be any reporting requirement. Data Bank reports can be formidable obstacles to future employment, licensure and managed care contracting, so there are times when being “fired” by a hospital employer may be preferable to seeking your day in court in a medical staff hearing and losing your case. In some cases it may be possible to negotiate a mutually-agreed upon separation that avoids a Data Bank report as well as the blot on a physician’s employment record associated with an involuntary termination.

If you are considering hospital employment, or if you are currently employed by a hospital or health system affiliate, it is important to understand your rights as an employee and a staff member, and how those rights may vary depending on which hat you are wearing and the terms of your employment.

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