I. Introduction

The enactment of the Affordable Care Act\(^1\) embodied on a national basis, the need for healthcare providers to create collaborative efforts to address patient care, safety and cost. Many hospital organizations reacted to proposed changes to reimbursement by seeking to secure profitable service lines, including cardiology and orthopaedics. Physicians, previously independent, found themselves being recruited to be employed by hospitals or saw the ability of their practice efforts to grow thwarted by hospitals recruiting in competition with the practice. Too often physicians were finding themselves in communities with no options but to become employed or lose patient referrals from primary care or other referral sources that were now employed by the local hospital.

In 2012, the American Medical Association (“AMA”) Board of Trustees, published its *Principles for Physician Employment* (“AMA Principles”). The AMA, in recognizing the increase in the physician employment trend, sought the need to address the particular needs of physicians in these employment arrangements and issued these AMA Principles to address what it perceived as the need to protect a physician’s professional, ethical and financial interests while maintaining the “... inviolability of the patient-physician relationship.”\(^2\) No different than federal regulations such as Stark (42 U.S.C. 1395nn) or the antikickback statute (42 U.S.C. 1320a-7(b)), it has long been a concern that financially influencing a physician may negatively influence patient care.

This paper and its accompanying presentation seeks to assist physicians, hospitals and their legal counsel, with an understanding of how these conflicts occur and how to address these issues. While the actual AMA Principles are fully attached to this paper, they will be discussed in the context of proposed contract terms that appear in many contracts. While it is recognized that the financial investment by an employer in a physician is significant and requires certain performance and financial parameters, it is

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\(^1\) AMA Report of Board of Trustees, June 1, 2012, AMA Principles for Physician Employment (Resolution 724-A-12).

\(^2\) AMA Report of Board of Trustees, June 1, 2012, AMA Principles for Physician Employment (Resolution 724-A-12).
never good when such practice and financial criteria affect patient care.

II. AMA Principles for Physician Employment - In General

The AMA Principles are described in six different sections. These include 1) Conflict of Interest; 2) Advocacy for Patients and the Profession; 3) Contracting; 4) Hospital Medical Staff Relations; 5) Peer Review and Performance Evaluations; and 6) Payment Agreements. The AMA Principles incorporate both related AMA Policies as well as the AMA’s Principles of Medical Ethics. While none of these principles or policies have the effect of law, they are clear indications of policies and views of one of the oldest physician peer organizations in the country.

The AMA states in its prelude to the AMA Principles that they are not intended to be a comprehensive treatment of certain contractual terms such as a description of duties, compensation or the expectation of performance. These issues are actually addressed in other AMA policies and in the AMA’s Model Employment Agreement. Rather, the AMA Principles were developed to address select problems that arise during the employee-employer relationship.

1. Addressing Conflicts of Interest. The AMA Principles addressing conflicts of interest all revolve around the overall principle that a physician’s paramount responsibility is to his or her patient. Knowing that the AMA strongly opposes hospitals’ unilateral coercion of any physician or physician group to enter into an employment agreement, these principles further expound on these concerns.

There are six AMA Principles addressing conflicts of interest which, in summary, address the following:

a. **Principle:** That an employed physician may owe a duty of loyalty to his or her employer which can create conflicts in patient care.

   **Discussion:** These could take the form of financial incentives to over/under treat patients. Legal counsel need to be very aware that such types of incentives can also be considered violations of other laws such as those in Medicare.

b. **Principle:** Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on patient care matters. This includes the ability to exercise independent medical judgment.

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Discussion: Contracts should both avoid and not have terms that allow employers to retaliate against a physician for exercising independent medical judgment. This can be in the form of “required” referrals in a healthcare system to other employed physicians only and paying lip services only to provisions in contracts that state the employer “…allows for the independent medical judgment of the physician.” Violations of such provisions can be considered breaches and clearly define expected professional behaviors – whether good for the patient or not.

c. **Principle:** If the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

Discussion: This principle is rooted in the AMA *Principles of Medical Ethics*\(^4\) which articulate the physician’s responsibility to the patient first. Contract terms that seek to override such principles include “utilization” guidelines and performance criteria seeking to limit care or cost (e.g. types of equipment; implants; inferior care). The physician should have the unfettered right to make care decisions for the patient.

d. **Principle:** A physician’s treatment and referral decisions must be based on the best interests of the patient and agreements should not (whether explicit or implicit) have restrictions or discourage or encourage particular treatment or referral options.

Discussion: As with other State and federal laws, these principles encourage disclosure and transparency of the financial relationship of the physician with the employer. This includes policies which might prohibit a physician from referring to outside physicians or facilities. Patients need to know that a physician may have incentives to refer a certain way and should be part of that decision.

While contract terms may allow a physician such freedom to determine the patient’s plan of care, health systems create internal policies such as controlling referrals to its inpatient or outpatient services by controlling the “schedulers” and dictating how patients will be scheduled once a physician may determine the medical or testing need. Physicians and their legal counsel should address these questions through a thorough “due diligence” and the physicians should continue to monitor this type of practice.

e. **Principle:** A physician with an administrative title, such as a medical director or chief medical officer, does not override their professional ethical obligations.

\(^4\) AMA Principles of Medical Ethics, E-1.001.
Discussion: So often a “hired” physician for a payer or health system, becomes the advocate for limiting patient care; disciplining physicians who do not refer a certain way; or, lead peer review challenges against a physician because the administration thinks they are not “behaving”. The AMA has published Ethical Obligations for Medical Directors\(^5\) which, when determining such issues as medical coverage or appropriateness of care, includes the overriding principle that the patient’s interest must be paramount. Such a medical director should be operating within policies that are fair and objective and any contract that seeks their services, must allow the physician some level of control and oversight of such decision-making rules.

2. **AMA Principles - Advocacy for Patients and for Professionalism.**
This principle addresses the use of financial incentives in managing medical care.

a. **Principle:** Patient Advocacy is a fundamental element of the patient-physician relationship which should not be altered by an employer or by compensation arrangements.

Discussion: It is recommended that all Physician Employment Agreements contain provisions that do not limit or prevent a physician from freely advocating on behalf of his or her patients and delivering good patient care. Again, making referral decisions and determining plans of care for a patient should remain the right of the physician and contract terms that retaliate or are in breach if a physician does not follow what the employer demands, should not be allowed.

b. **Principle:** Employed physicians should be free to do volunteer work outside of, and, which does not interfere, with the duties as an employee.

Discussion: While there is no related AMA policy on volunteer work, the ability to educate, teach and volunteer by a physician is important. Physicians should be aware that such volunteering, if it involves patient care, may not be covered by certain malpractice policies so a physician should always inquire as to coverage. All contracts should clearly identify other professional activities allowed such as expert witness testimony, teaching (grand rounds), or volunteer clinic work.

3. **AMA Principles - Contracting.** The third AMA Principle, “Contracting”, further addresses the specifics of financial conflicts managing patient care. These AMA Principles on “Contracting” include the following:

a. **Principle:** Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, healthcare systems and payers, in accordance with the ethical principles of the medical profession.

\(^5\) AMA Ethical Obligations of Medical Directors, E-8.021.
Discussion: Certainly, physicians operate in a world of contractual relationships whether through employment by a hospital to professional service agreements, or abiding by the Medical Staff Bylaws as a Member of the hospital medical staff. None of these arrangements, per se, presents an ethical issue for a physician. However, hospitals are often large employers or view physicians as competitors that must be “controlled” or “put out of business”. Health systems that close departments, control referrals, or recruit competitive physicians against community physicians can create environments that are so hostile to local physicians or physician groups that they are left with no alternatives but to become employed and enter into contract negotiations already under duress and without any negotiating power. None of these tactics create contracts that are “mutually satisfactory”.

b. **Principle**: Physicians should never be coerced into employment agreements. Such agreements should be negotiated in good faith. It is critical that the Physician have experienced legal counsel to assist with these negotiations.

Discussion: Too often physicians find themselves in very difficult situations and try and handle it themselves, or, do not know or have healthcare counsel who understands the terms of these agreements. Coercion comes in many forms, including rapid (and unworkable) time demands (“We have to have it signed by Friday or the deal is off”); peer pressure (“If you don’t join, we will no longer refer to you”); or administrative retaliation (being taken off boards and important committees), all seeking to marginalize the physician’s negotiating power. These tactics have terrible results on contract terms and leave little room for a physician to be worried about patient care when he or she is worried about financial and professional survival.

c. **Principle**: Compensation arrangements should be clear.

Discussion: Compensation arrangements take many forms in contracts and can include a fixed salary; production based compensation; wRVU compensation; and all other types of formulas. It should be a simple rule that if you don’t understand it, you shouldn’t agree to it. Further, hospitals and health systems use national published benchmarks (eg. MGMA) that may or may not actually be applicable and the physician does not have access to the same information or the skill set to determine what is fair. No compensation, ever, should be based on negative patient indicators such as higher or lower utilization not tied to good patient care.

d. **Principle**: Termination of the employment agreement does not end the patient-physician relationship.

Discussion: It is almost universal in physician employment agreements that patients and their medical information are treated like acquisitions or
products that exclusively belong to the hospital. Termination provisions often require the physician to end all relationships including with employees and patients, and hold medical records as hostage. Notwithstanding the AMA publishing a long-standing ethics position\(^6\) that patients should be notified of the relocation of their physician and how to acquire their medical records, the majority of contracts completely ignore these provisions and will instruct staff to tell patients, “We don’t know where she went”, when the physician is down the street. This needs to be addressed clearly in the agreement.

\(\text{e. } \textbf{Principle}:\) Physician employment agreements should contain provisions to protect a physician’s right to “due process” and should never be automatic grounds for termination from the medical staff.

\(\text{Discussion:}\) For many years hospital-based agreements for radiology or anesthesiology had provisions that automatically terminated medical staff membership as it was tied to the term of the often exclusive hospital-based agreement. This was generally accepted by the healthcare community as the consideration for the exclusive contract and financial arrangement. However, hospitals and health systems have now transposed these same provisions in physician employment agreements and literally stripped away any and all medical staff due process rights. Legal counsel should diligently advocate the removal of such onerous provisions. If not able to be removed, several provisions to try and protect the physician include: 1) language that requires the medical staff record to reflect a termination from the medical staff due to a contract termination, not a patient care issue; and 2) no reporting to the National Practitioner Data Bank. Offers of “buying out” such a provision (such as liquidated damages) has sometimes worked. It is also suggested that if a hospital invested all that capital in employing the physician, and the physician would like to remain on the medical staff, take call, and still be a contributing member, why a hospital would not consider this a reasonable offer.

\(\text{f. } \textbf{Principle}:\) Physicians should not enter into non-compete or other restrictive covenant provisions.

\(\text{Discussion:}\) The AMA is clear in Ethical Policy 9.02 that covenants-not-to-compete “… restrict competition, disrupt continuity of care and potentially deprive the public of medical services.”\(^7\) The AMA discourages restrictive covenants and considers restrictive covenants that are excessive in geographic scope or duration as unethical. Certainly, State law governs questions of valid non-competition agreements, but are troublesome ethically as can they can deny patients, both existing and in the future, access to the physician’s care.

\(^6\) AMA Medical Ethics Records of Physicians upon Retirement or Departure from a Group, E-7.03.

\(^7\) AMA Medical Ethics Policy E-9.02, Restrictive Covenants and the Practice of Medicine.
Principle: Physician employment agreements should have dispute resolution provisions.

Discussion: Conflict resolution policies are required in all medical staff bylaws for JCAHO accredited hospitals. The AMA has published conflict resolution policies that medical staffs can use. Notwithstanding, too often physician employment agreements have nothing that addresses conflict resolution except a venue provision of which state’s law will be used.

Conflict resolution provisions in a physician’s employment agreement should include both patient care and contract term conflict resolution provisions. This should always include a clear representation of the physician’s reporting requirements, whether to an administrative officer or medical officer. Certainly, conflicts regarding performance or patient care should never be resolved by anyone but a medical administrator, or, the medical staff.

Conflict resolution procedures should also include a description of “informal” v. “formal” proceedings. “Informal” conflict resolution includes meetings to resolve or mediation. “Formal” can include court or arbitration, utilizing, for example, the AHLA Dispute Resolution process and arbitrators. While it is not this author’s opinion that arbitration is less timely or costly (neither is necessarily true), it is private and an arbitrator can have healthcare experience where a judge may never have had an opportunity to address the unresolved issue.

4. Hospital Medical Staff Relations. In general, these AMA principles address the role of the physician as a member of the organized medical staff, with rules and regulations, and the role of the physician as an employee of the hospital. Hospitals and their medical staffs are not always in harmony and the employed physician’s loyalty can be put to the test, almost like a child in a bad divorce. These AMA principles, in part, address the following:

a. Principle: Employed physicians should be members of the organized medical staff and subject to its rules and regulations.

Discussion: Physician employment agreements should never diminish or usurp the role of the medical staff. Administration should not interfere in peer review through the use of employment terms nor add or remove physicians without the active participation of the medical staff or the violation of the Medical Staff Bylaws, rules and regulations.

b. Principle: The medical staff remains responsible for patient care and outcomes.
Discussion: Contract terms should not delegate the functions of the medical staff to administration, or, via the contract, deny the medical staff the ability to monitor patient care. Medical staff responsibilities include both the ability and need to assess their members so all physicians, whether employed or not, need to be subject to these rules.

c. **Principle:** Employed physicians should be free to vote, speak, or advocate on any medical staff matter and not be retaliated against by their employer.

Discussion: Too often, hospital administrators expect employed physicians on medical staff matters to act as the surrogates of administration. This causes terrible conflict between the employed physician and the non-employed physician who will always view the employed physicians as “biased”. Physician employment agreement provisions should never restrict a physician’s participation on the medical staff or its committees, nor, in practice, should the hospital use such an employed physician as its “eyes and ears” in the privacy of the medical staff forum.

d. **Principle:** The overall medical staff should participate in the initiation, renewal or termination of exclusive employment agreements.

Discussion: Too often, the medical staff is “the last to know” when an exclusive employment agreement, such as a hospital-based service arrangement, is terminated. As so many of these arrangements are crafted in contract, and approved by Boards, it is often the same Board that has the power to unilaterally terminate. Often this is done for political or financial reasons but does not address the needs of the physicians on the medical staff. The radiology contract may have been expensive but the quality and management of the department was top level. This is the medical staff input that is required and the contract language that is needed.

5. **Peer Review and Performance Evaluations.** These AMA Principles address the overall concern that the terms of an employment agreement will overstep the boundaries of the medical staff relative to peer review. These principles, in part, are as follows:

a. **Principle:** Physicians should promote and be subject to an effective program of peer review to monitor quality, appropriateness or medical necessity.

Discussion: All contracts or employment agreements should defer all peer review activities to the medical staff. Further, contract provisions should abide by the medical staff process for peer review, including summary suspension and other disciplinary matters. Contracts that have “without cause” clauses allowing a hospital to terminate should never allow such if the reason for termination is a peer review or patient
performance issue. This is the sole role of the medical staff and should not be marginalized.

b. **Principle:** Peer review procedures should be the same for all physicians within the same organization.

**Discussion:** Having contract provisions in an employment agreement that do not allow for the effective or similar peer review, are potentially a violation of the existing Medical Staff Bylaws and should not be allowed. As most often an obligation of the employed physician is to remain on the medical staff, the contract, in referring to such medical staff membership, should add that the “...parties agree to abide by the terms and conditions of the Medical Staff Bylaws, whose terms and conditions are incorporated herein...”.

c. **Principle:** Peer review of an employed physician should not be done by the Human Resource Department or a lay administrator.

**Discussion:** Peer review should be conducted by other qualified, non-conflicted, physicians. Performance review should be conducted by a Chief Medical Officer or such other designated medical administrator. Employment agreements should clearly identify these reporting and review requirements, including the positions or names of such individuals.

d. **Principle:** All peer review should be conducted fairly with due process.

**Discussion:** No employed physician should be denied due process rights. All members of a medical staff, whether employed or not, should receive the benefit of notice, a hearing, and all the other requirements of the Healthcare Quality Improvement Act, whose terms are incorporated in the Medical Staff Bylaws. Only after an adverse decision has been made and finalized should an employment agreement be subject to terminations based on peer review.

e. **Principle:** Employed physicians should have fair, objective and regular evaluations.

**Discussion:** Employment agreements should not only discuss how a physician’s performance will be evaluated, but should enumerate the criteria to be used. This could include patient satisfaction surveys, surgery start times, patient complaints and other objective criteria.

f. **Principle:** No physician employment agreement should require the automatic termination of his or her medical staff privileges.
**Discussion:** It is clear that this trend in contracts is an intent to summarily dismiss a physician in contravention of the medical staff and its Bylaws. Legal counsel should advocate very diligently on the removal of such a provision.

6. **AMA Principles - Payment Agreements.** These AMA Principles generally address the employer assuming all contracting, billing and collection efforts on behalf of the employed physician. A physician still has an ethical duty to charge, bill and collect appropriately so without any forum of input or participation, this can place the physician in a financial conflict with his or her patient.

   a. **Principle:** All employment agreements assign all billing, negotiating and collecting to the employer with no or little input from the physician.

      **Discussion:** Employment should never be an abdication of the responsibilities of a physician to know what he or she is billing a patient. Physician employment agreements can request contracts be “mutually” agreed to and that monthly reporting be made to the physician. The books and records relative to billing and collecting, no matter what the compensation arrangement, should always be available to the physician.

   b. **Principle:** Billing should be accurate and employers should indemnify a physician for its or its employees’ mistakes or violations of law.

      **Discussion:** All physician employment agreements should allow the physician access to all billing records and have billing reports made available. Physicians who have relegated, by choice or via the contract, all billing and coding responsibilities, can be liable for inaccurate billing and coding. However, it is almost impossible for a physician to control hospital employed coders or billers who either mistakenly, or with intent, file inaccurate or false billing. It is critical to have an indemnity provision protecting the physician from this kind of conduct.

**Conclusion**

Physicians find themselves in a very different and competitive reimbursement world. As the physician is often the linchpin of the delivery of healthcare, many industry players seek to control the physician market. Some health systems do it through more collaborative efforts while others appear more “heavy handed”. All are seeking the physician referrals, especially to productive outpatient service lines, so have developed and drafted contract terms seeking to protect its enterprise. Unfortunately, too many times these financial controls directly impact a physician’s care and the patient will be lost in that process. These AMA Principles should be used as guidelines and parameters to assure the patient’s voice, through their physician, is heard.