"Medical Group Employment and Physician Peer Review: Oil and Water?"

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1. **Introduction**

This presentation has been developed for:

(1) Medical group leaders who are responsible for devising suitable employment agreements with the physician members of the medical group (and also with independently contracting physician members of the medical group).

(2) Hospital and health system leaders who are responsible for creating all manner of agreements with physicians (employment, recruiting, coverage, clinical department leadership, and the like).

(3) Practicing individual physicians who enter into employment agreements and other agreements with the medical group and with the hospital/health system.

Following the nomenclature of the times, the two principle "take always" are:

How to prepare agreements that address both the medical group's need for fair and efficient employment decisions and the physician's expectation of collegial peer review.

How to prepare medical group-physician agreements that do not contain three, four, or five inconsistent and probably mutually-exclusive termination and review opportunities.

2. **Past, Present, and Future: The World of Physician Employment**

In the past, physicians often practiced alone, or in close-knit or loose partnerships with colleagues. Now, employment has come closer to being the norm, particularly in the medical group setting. Physician employment is therefore not just the wave of the future. It is also the wave of the present.
The shifting, or at least evolving, physician practice environment has been aptly described by the leadership of the American Medical Association as follows:

"With the ongoing economic reorganization of health care, more newly-graduated and established physicians are becoming employees in established medical groups, managed care organizations, health care institutions or group practices that they form with other physicians. As a result, physicians are increasingly covered by employment contracts." See, e.g., "Annotated Model Physician Employment Agreement," American Medical Association (2008 ed.) at Page iv.

"Physician employment is an integral part of the practice of medicine. Many physicians today are employed by small group practices, multi-specialty group practices, medical faculty practice plans, hospitals or other institutions. With more medical students than ever entering the workforce this trend is likely to continue and accelerate. At some point in their careers, most physicians will likely be party to an employment agreement." See, e.g., "Annotated Model Physician Employment Agreement," American Medical Association (2008 ed.) at Page ii.

The range of common physician employment settings presently includes the following:

- Medical groups.
- Health maintenance organizations.
- Post-graduate training programs.
- Academic medical centers/faculties.
- General acute care hospitals.

And, for the future, it is reasonable to expect the following settings or employers:

- Medical groups.
- Insurers.
- Patients' employers.
- The State.
- National Health Service.
These developments are without regard to, or not affected by, the bars to the "corporate" or unlicensed practice of medicine that are still in effect, if not rigorously enforced, in a number of states. See, e.g., California (California Business and Professions Code Section 2400); Massachusetts (Massachusetts General Laws Chapter 112, Section 6); Pennsylvania (Pennsylvania Medical Practice Act, 63 Pennsylvania Statutes Sections 422.1 et. seq.).

These prohibitions of the practice of medicine by those who have not been licensed to do so do not directly affect the ability or inability of a medical group to employ a physician, for the medical group is typically organized as a professional corporation or other entity, and licensed as such. Nonetheless, the dwindling number of states in which the practice of medicine by a non-medical corporation is barred is some indication of how the environment is shifting, for good or for bad.

3. The World of Employment and the World of the Professions

Medical group-physician agreements are often laden with internally inconsistent and sometimes mutually exclusive provisions concerning the evaluation of physician performance, possible remediation, potential termination, and opportunities for challenge. This is by no means the result of poor draftsmanship. But, it also is not by happenstance. It is because of the as-of-now not fully consummated marriage between the physicians' world of professional peer review and the newer medical group-physician relationship of employment.

The source of the clash is found in the philosophical chasm that separates the physician as "employee" and the physician as independent, if not supreme, professional, and the consequent friction between "employment law" and "credentialing and peer review law."

And, the medical group organizational structure is a made-to-order battleground for this clash.

As a rule, physicians expect the best. They expect the best of themselves. And, this colors their expectations of their fellow physicians and colleagues, who, in the medical group setting, may well be employees. To the contrary, and at the risk of over-emphasis so to make a point, employers in our society, in a number of job settings, have come to expect the worst in employees, or at least prepare for it. And, unfortunately, certain employees do not disappoint them.

The "job descriptions" employers create are, to some extent, based on that premise, as are many personnel procedures. And, notably, the personnel and human resources setting acknowledges the possibility that someone who is not qualified for a job, or who is qualified but has no interest in applying himself diligently to the job, can nonetheless be offered the job. Therefore, the human resources and personnel departments are designed, to some degree, to identify that person and address the unfortunate consequences of his or her presence.

To the contrary, peer review law, and physician peer review itself, are based upon the premise that physicians know best, and will act in the best interests of their patients. Physicians view themselves as uniquely suited to not only provide a service (that being medical care) to the
patient, but to ascertain what services are needed by the patient. Consequently, the fact that the patient refuses the service may rule it out, but the fact that the patient requests the service does not mean it will be provided.

These two distinct mindsets, of physicians/professionals on the one hand, and human resources/personnel managers and executives on the other, carry over to physicians when they are engaging in personnel credentialing and peer review, and to executives when they are making hiring, firing, and other significant human resources decisions.


With that introduction mind, what are the features of the ordinary medical group-physician agreement that are most vulnerable to this unresolved clash between the employment mindset and the mindset of the professional? They are:

- Will the medical group have any formal, written policy or procedure for the review of concerns about the physicians' care or conduct, or will this be left to the good judgment and inherent fairness of the medical group leadership?

- If there is a policy and a process, will it be rigid and procrustean, or will it allow for the flexibility that professionals ordinarily expect? Stated otherwise, will there be some degree of required procedure, to be invoked whenever there is a significant concern about physician practice or conduct, or will any suggested process merely consist of an option? Will it be a sequence of mandatory notices, deadlines, meetings, interviews, and reports, or will it take the form of guidelines?

- If there is to be a favored process, or certainly a mandatory process, will there still be an option for a "without cause" termination.

- If there is both a "with cause" and a "without cause" termination option, what factors should be taken into account by the medical group in choosing one or the other? This is not to say the factors that should be taken into account before wishing that the physician would absent himself or herself, but rather the factors that should guide the decision to characterize the termination as "without cause" or "with cause."

- Will there be an "opportunity to cure" that might be exercised by the physician? And, if so, how might the physician exercise any "opportunity to cure" the unstated reason or dereliction that will soon lead to the "without cause" termination?

- More fundamentally, can an agreement contain a "without cause" termination provision and also embody the peer review fairness that the modern physician expects and most of us believe deserves?

- More practically, there may be occasions when one must wonder what caused an agreement to be entered into, but is an agreement ever terminated "without cause?"
• If the agreement has been terminated "without cause," what might the medical group state in response to a credentialing inquiry should a medical staff or another medical group inquire? And, if the medical group responds by stating the agreement was terminated "without cause," does that not create an impression about the physician that is probably even worse than whatever concerns prompted the action?

• Will the agreement provide an opportunity to the physician for some form of meeting with a medical group committee to discuss the action, and possibly to request reconsideration? And, if there were a termination "without cause," what is the agenda for that meeting, and what are to be the bases for any reconsideration?

• Will the agreement, either because of its terms or in accord with state law, provide a right to a hearing? If there were a termination "without cause," what is the content of the notice provided to the physician, a notice that is probably required by law? And, with that transparent or at least diaphanous notice in hand, what is the physician to then present at the hearing? Or, for that matter, what is the leadership of the medical group to present at the hearing in explanation of the proposed termination?

• Will the agreement contain a commitment to submit all disputes regarding performance of the terms of the agreement to arbitration? And, as is ordinarily the case, does that arbitration clause not only encompass disputes about the performance of obligations and covenants, but also about the state of the agreement itself, which is to say the likely disagreement about whether the agreement should be terminated? Does this arbitration proceeding occur before, after, or during the medical group hearing? And, is it the authoritative dispute-resolution process, or simply a very important prelude to litigation?

In our experience, many of these discordant notes in a medical group-physician agreement are the result of the well-intentioned and well-informed contributions by a number of specialists with differing areas of expertise: most notably, the employment law specialist and the health law/peer review specialist. These fascinating divergences matter little when life and practice are proceeding tranquilly, but matter greatly when the time for possible corrective action has arrived.

5. **Examples [and Exemplary] Contractual Provisions.**

In the quest to provide a representative and an exemplary, model agreement, where better to look but to the American Medical Association? See, e.g., "Annotated Model Physician Employment Agreement," American Medical Association (2000 ed.). That model agreement, while since updated, has provided the starting point for untold numbers of medical group-physician agreements, and therefore serves as a useful and meaningful reference point. That model agreement offers the following:

1.2 **Employment**
Employer employs Physician and Physician accepts employment with Employer under the terms and conditions set forth in this Agreement. The purpose of Physician's employment shall be to provide professional medical services on a [full or part]-time basis in the specialty of _________________, which should also include _________________. The Physician's duties are set forth . . . below. . . It is agreed that the Physician is an employee of Employer, not an independent contractor.

2. **Term**

2.1 **Initial Term**

The initial term of this Agreement shall commence on _____________ ("the Effective Date") and shall continue for __ [months or years] thereafter subject to earlier termination (Paragraph ___) or to extension (Paragraph ___). . .

10. **Termination**

10.1 **Automatic Termination**

This Agreement, and Physician's employment by Employer, shall be terminated as follows:

1. Automatically, with cause:
   
   a. Upon Physician's loss, restriction or suspension of his or her professional license to practice medicine in the State of _________________.
   
   b. Upon Physician's suspension or exclusion from the Medicare Program;
   
   c. Upon Employer's inability to obtain malpractice insurance on behalf of the Physician, or if the cost of obtaining such insurance exceeds by [__% or $_____] the cost of obtaining such insurance for other physician employees;
   
   d. If the Physician violates the State Medical Practice Act; or
   
   e. If the Physician's professional practice jeopardizes imminently the safety of patients.

10.2 **Termination Without Cause by Either Party**

Without cause, upon _____ days’ prior written notice by either party;

10.3 **Termination With Cause by Either Party**
In the event of a material breach of this Agreement by either party upon ___ days prior written notice. If the breach is "cured" or corrected within the notice period, the Agreement remains in full effect. If the breach continues, the Agreement terminates upon the expiration date of the notice period.

12. Remedies

12.1 Arbitration/Mediation

Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

6. The Legal Environment.

The differing and sometimes inconsistent provisions in medical group-physician agreements are a source of concern not only for reasons of purity of draftsmanship. They can also lead to confusing legal consequences, usually peculiar to the world of health care. For example:

- Does the Health Resources and Services Administration of the Department of Health and Human Services care if the medical group labels a termination of a physician’s agreement as being “without cause”? That is, does the label “without cause” unilaterally defeat the key terms that are found in the NPDB Guidelines and common state board of medical examiner reporting requirements. See, e.g., 42 U.S.C. Sections 11133(a)(1) and 11151 (3) (definition of "clinical privileges" to include "other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity") and 11151 (4)(A) (defining "health care entity" to include "a "group medical practice . . . that provides health care services and that follows a formal peer review process . . . "); Cal. Bus. & Prof. Code Section 805 (West Supp. 2012).

- Should a physician always be allowed to terminate without cause, only being required to provide a certain number of days' notice?

- Termination of an important medical employment relationship might now effectively block the physician’s access to a significant number of patients, and therefore hamper the ability of the physician to practice his specialty, even outside of the employment relationship. See Potvin v. Metropolitan Life Insurance Company, 22 Cal. 4th 1060 (2000). Further, the fact that employment is terminated must ordinarily be disclosed in any application for medical staff membership and in any application for professional liability insurance. Therefore, termination of an employment relationship may reverberate throughout the
physician’s practice and career, and it may therefore be analogized to the physician-hospital-
medical staff relationship as perceived by the courts in the 1950s and 1960s when the doctrine
of "fair procedure" took hold, meaning some modicum of notice and an opportunity to respond.
See Ascherman v. Saint Francis Memorial Hospital, 45 Cal. App. 3d 507 (1975).

- As noted, the termination of an employment relationship that is preceded by
some form of meaningful peer review and that is based on concern about practice or
professional conduct is likely reportable to the National Practitioner Data Bank, thereby
qualifying the medical group leadership for the immunities held out by the Health Care Quality
Improvement Act. This is not an anomaly. It is just another example of an instance in which
society concludes we would be benefited if we were to learn of an adverse conclusion regarding
a physician’s quality of care that was the product of a thoughtful review process.

- However, if the medical group terminates the physician in an expeditious
fashion, perhaps based simply upon a decision by the chief executive officer or the chief
medical officer, this would not be reportable to the National Practitioner Data Bank, for there
would not be the same basis for thinking that it was a thoughtful and well-founded decision
(which is not, of course, to say that it was not). However, the medical group would then not
enjoy the ordinary peer review immunities. However, the medical group would likely not need
them, as all that would be necessary is that the agreement with the physician were followed.

All of these factors tug, in various directions, often not complementarily, and have to be taken
into account in devising medical group agreements with physicians, programs for review,
procedures for making decisions regarding employment and possible termination, and whatever
opportunities will be presented for review and reconsideration, towards the ends of creating a
healthy organization, making it an attractive contracting party, assuring that its decisions
withstand any challenge, and meeting accreditation requirements.

7. The Path Forward.

For a suitable professional/collegial employment agreement, the author respectfully
recommends:

- A peer review policy allowing for thoughtful reviews of concerns regarding
conduct or care, embodying procedural guidelines, not rules.

- A process that might then yield a recommendation of corrective action, up to and
including termination of the agreement.

- No formal "right to cure," for this possibility is implicit in any decision-making
process should the physician be interested and should the medical group be willing.
• A formal peer review hearing or a formal reconsideration, described in a separate, referenced code, and characterized as an available and mandatory administrative remedy.

• No "without cause" terminations of the agreement. Of course, an agreement may expire, but that is not a “termination” of the agreement, merely a termination of the relationship, for unlike the residency and medical staff setting, there is not a reasonable presumption of renewal.

• The requirement of arbitration, not as an alternative to the peer review process, but as a post peer review process mandatory alternative to any contemplated litigation. Of course, there is the Association's extremely mediation resource, which can always be invoked by willing parties.