HOSPITAL PHYSICIAN EMPLOYMENT CONTRACTS

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In the current environment hospitals are increasingly employing physicians and, for various reasons physicians, particularly recent graduates, are increasingly willing to forego their autonomy to become employees. The purpose of this article is to call attention to some important aspects of hospital physician employment contracts, including the utilization of contract language to help elevate a level of employment security and to further physician participation in decision making involving "clinical" issues.

At the outset it is useful to recall the basic definition of an "employment" relationship as one wherein the "[e]mployer has the power or right to control and direct the employee in the material details of how the work is to be performed."[1] Nevertheless, that "control and direction" in contracts involving physician employment should be explicitly modified where there is any impact on "clinical" issues that requires the exercise of physicians' professional judgment.[2] For example, physicians are uniquely qualified to provide direction respecting equipment and/or the personnel needed to support clinical functions.

An organized medical staff is the self-governing association of all practitioners with clinical privileges to treat patients at a given hospital. The medical staff is governed by bylaws that have been said to constitute a "contract" between the medical staff and the hospital.[3]

The intent of this article, however, is to focus on a very different contract, one between an individual employed physician and a hospital. So, it is fundamentally important to firstly

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[1] Black's Law Dictionary (Fifth Edition, 1979).

[2] By contrast, the Joint commission defines a licensed independent practitioner as "any individual permitted by law and by the organization to provide care, treatment and services without direction or supervision." (emphasis supplied).

[3] Joseph v. Passaic Hospital Association, 26 N.J. 557, 564-569 (1958).

recognize the distinction between employment by a hospital and membership on the medical staff at the very same hospital. The rights and obligations of medical staff membership typically derive from a medical staff's bylaws. On the other hand, the terms of employment by a hospital are delineated by a written contract that must be negotiated between the individual employed physician and the hospital or its affiliate. Thus, medical staff bylaws do not directly define the employment relationship - - though medical staff membership is usually a prerequisite for employment by a hospital and hospital employment may be made a prerequisite for medical staff membership. Also, one must be alert not to execute an employment contract which may be construed as a waiver of some right that is otherwise recognized in medical staff bylaws.

Perhaps the first concern of a physician considering employment at a hospital should be: what kind of track record does management at that hospital have for working with physicians in a collaborative way?[4] How much independence and control are afforded employed physicians respecting clinical activities as well as issues that have a direct effect on the execution of those clinical activities? Do physicians have a sufficient voice in governance of the hospital or in matters such as the allocation of practice assets and support services? Put otherwise, what is the culture or employment environment at the hospital? Also, what is the financial condition and the competitive status of the hospital vis-a-vis other hospitals in the area?

The length of the term of the proposed contract should also be initially considered. The usual term is three to five years, three years being most typical. The contract will also describe the mechanics of renewing or extending that term. Physicians should avoid allowing the hospital to have exclusive control over whether or not the agreement will be extended.

Additionally, it is important that the physician's specific hours of work and the hospital's unconditional obligations to provide coverage for the physician during vacation, time off, etc. are

[4] It has been thus appropriately suggested that before they become employees, physicians should do "due diligence," "form interpersonal relationships with hospital administrators and get involved in the medical staff," " understand the decision making hierarchy," " review and assess the goals and objectives of physicians and the hospital," "assess financial impact, especially ancillary revenue," and "assess current agreements."

clearly set forth in the contract document. Consideration should also be given to the hospital's medical staff remaining adequate to provide sufficient coverage throughout the full term of the physician's contract.

Obviously, a primary consideration is also the physician's satisfaction with the available compensation arrangement. Physician employment agreements may generally be expected to embody either a fixed salary, a base salary with a productivity or profitability bonus, or compensation premised exclusively on a measurement of productivity or profitability. In this regard it may be important to consider the nature of the hospital's patient population. For example, Medicaid will afford the hospital with a lesser rate of reimbursement than will Medicare or private insurance. So, for example, if the hospital's income is largely Medicaid based, the physician may want to make sure that his/her compensation is largely premised on a fixed salary and is not primarily in the form of a profitability bonus.

While hospitals, and their affiliates, are bound by Federal laws to pay no more than "fair market value" total compensation to physicians, there is flexibility because there are multiple reputable compensation surveys.[5] Hospitals usually consider a range of compensation utilizing median salaries in a physician's specialty in a given geographical area.[6] However, these may be

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[5] The Antikickback Statute, 42 U.S.C. Section 1320a, provides that "(a)nyone who knowingly and willfully receives or pays anything of value to influence the referral of Federal healthcare program business, including Medicare or Medicaid, can be held accountable for a felony." The Stark Law, 42 U.S.C. Section 1395nn prohibits referrals by physicians who have a financial relationship with the entity receiving referrals. Both laws are intended to de-incentivize financial inducements for unnecessary medical services, which are not in the patient's best interests. To avoid the potential implication of either of these laws, total compensation must be set in advance and must be fair market value.

Internal Revenue Service Rules for tax exempt hospitals also may limit physician compensation to fair market value.

[6] The AMA has said of fair market valuation: "Presently, fair market valuation is a highly subjective exercise cloaked in scientific jargon. The bottom line is that since Medicare reimbursement of physicians and insurance compensation to physicians systematically has been reduced and will continue to be reduced, this fair market value compensation will continue to decline. As a consequence, any compensation structure ... will have to be re-evaluated on a periodic basis to determine whether it comports with fair market value, otherwise the hospital and physician may be held accountable under these federal, and possible corresponding state statutes and their regulations ... In the event the re-evaluation reduces the compensation significantly, the physician may want to negotiate the right to terminate the agreement without the application of any restrictions such as non compete." On the other hand, "[t]he growing physician shortage may have a positive impact on fair market value compensation."

too low, as salaries significantly in excess of a median salary may be justified based on productivity and subspecialty skills. But, any measurement of productivity or profitability must be based only on services personally performed by the physician and not on the volume or value of referrals by the physician that benefit the hospital.

Notwithstanding the foregoing, an employment contract may legally require a bona fide physician employee to refer patients to the employer's services, provided that employee's compensation arrangement is set in advance in a signed, written contract, and it represents fair market value for services individually performed by that physician, not taking into account the volume or value of referrals. Further, the referral requirement may not apply if the patient or the patient's insurer expresses a preference for referral to a different provider and/or the contractually required referral is not in the patient's best medical interests, and the required referrals must relate solely to the physician's services pursuant to the employment agreement and the referral requirement is reasonably necessary to effectuate the legitimate purposes of the compensation arrangement.

Physicians contemplating hospital employment need to also negotiate fair termination provisions in the proposed employment agreement. Generally speaking, termination may be either "for no cause" or "for cause."[7] Termination "without" cause permits either party to end the relationship before its term naturally expires by providing the other party with a certain amount of prior notice of the decision to terminate. Termination "without" cause typically allows either party to end the relationship by giving the other between 30 and 180 days prior notice. This notice must be written and the date of its commencement must be certain. From an employee's perspective, a longer notice period is usually desirable.

See p. 19 of AMA Annotated Model Physician-Hospital Employment Agreement (updated March, 2012), found at www.ama-assn.org.

[7] In negotiating a contract physicians should always be sure to make these termination provisions mutual, so that they identify grounds allowing the physician to quit just as they specify grounds for firing the physician.

At the outset of this article we attempted to draw a distinction between employment by a hospital and membership on a medical staff. Pursuant to a Federal statute and state law, physicians are afforded fair hearing or due process rights to protect their medical staff membership. That Federal statute, the Healthcare Quality Improvement Act (HCQIA), requires that an aggrieved practitioner have at least 30 days from the receipt of a notice of a recommendation of action adverse to the practitioner's medical staff privileges, to request a fair hearing.[8] State law requires that the aggrieved practitioner have copies of all relevant records and reports prior to the hearing. Both Federal and state laws require that the practitioner have a right to counsel to confront and cross-examine all adverse witnesses, among other "due process" rights. However, because there are no comparable statutory rights protecting the physician's employment, it is important that the protections for an employed physician be explicitly written into the employment contract so that the security of employed physicians is not dramatically less than that of a licensed independent practitioner on a medical staff.[9]

Termination "with cause" provisions permit either party to end the contract on the basis of a claimed "breach" of that contract on the part of the other party. What constitutes an alleged "breach" by the physician should be spelled out in the contract and it is important that the contract avoid vague or trivial termination provisions. Examples of unacceptably vague language are terminations for allegedly "unprofessional behavior", "disruptive conduct", or "conduct or behavior damaging to the hospital." One protection that may be incorporated into a contract is to afford the physician the opportunity to correct or "cure" any alleged infraction. Other safeguards may be to specifically require that any alleged infraction be "repeated and

[8] 42 U.S.C. Section 11151.

[9] Physicians must also be alert that nothing that is stated in the contract could be construed as a waiver of the physician's rights as a medical staff member.

serious", "continued after specific written warning", and/or directly linked to, "having a provable affect on patient care" before it can be considered as a ground for termination "with cause."[10]

Physicians should also remain alert that no termination provision subverts their authority to be the exclusive determiners of what medical care is appropriate and that no contractual requirement adversely impacts on the physician's medical judgment.

One issue that is not always addressed in a physician-hospital employment agreement is emergency service coverage or on-call coverage.[11] This is sometimes described in the medical staff bylaws and/or medical staff rules and regulations and/or departmental rules. In fact an effort should be made to assure that the provisions of an employment contract are not more burdensome than the requirements for licensed independent practitioners in the medical staff bylaws. Also, when the employment contract is negotiated, compensation for this work should be addressed.

Physician employment agreements frequently contain provisions containing restrictive covenants barring competition from the physician after he/she ceases employment at a hospital. For example, an agreement may provide that the physician cannot practice medicine within a radius of a specified number of miles from the hospital for an indicated period of time after employment concludes. The general rule is that these sort of post-employment restrictions, if agreed to and written, are valid and enforceable if the times and the distances are deemed "reasonable." According to the New Jersey Supreme Court and Appellate Division, post-employment restrictive covenants of physicians are to be considered on a case-by-case basis to

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[10] The AMA additionally suggests the insertion of a "Due Process" provision such as the following:
"In the event of termination of this Agreement by the Hospital for alleged cause, Physician shall have the full and unwaivable right to notice and a fair hearing before a hearing body and otherwise afforded meaningful due process protections in accordance with the fair hearing plan as proscribed in the Medical Staff Bylaws." See p. 83 of AMA Annotated Model Physician-Hospital Employment Agreement (updated March, 2012), found at www.ama-assn.org.

[11] This is also a subject of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. Section 1395dd, which requires that the hospital maintain a list of on-call physicians from its medical staff that meets the needs of its patients. No physician is to be on-call all the time and senior physicians may be relieved from this duty.

determine if the restrictions are unreasonable or injurious to the public or to the interests of individual patients.[12] Courts have recognized that hospitals should not be able to deprive the public of needed medical services for the hospital's own business reasons. Thus, if the physician can prove that his/her services are unique and needed in a given geographical area, that physician may be able to defeat a non-competition clause.

A physician negotiating an employment contract may logically insist that the non-competition clause not take effect if the physician terminates the employment agreement because the hospital first breached its contract with the physician or because the hospital terminated the employment contract "without cause."[13] Employment contracts may further be structured to preclude non-competition clauses unless and until the physician remains employed by the hospital for a stated minimum period of time.

Hospitals generally require their employed physicians to contract with all payers with which the hospital has agreements. If employed physicians' compensation is based on collections, then the level of reimbursement by payers is significant because the hospital's representative(s) may be negotiating rates for both the hospital and the physicians by inflating facility fees while depressing physician reimbursement.

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[12] Karlin v. Weinberg, 77 N.J. 408, 415-417 (1978); Community Hospital Group v. More, Inc., 183 N.J. 36 (2005); Graziano v. Grant, 326 N.J. Super. 328, 344 (A.D. 1999), and Pierson v. Med. Health Ctr., P.A., 183 N.J. 65 (2005).

[13] The AMA suggests the following "For Cause by Physician" termination provision:

> "Physician may terminate this Agreement effective immediately upon the occurrence of the following:
> "1. Employer's licensure, certification or accreditation expires or is revoked, terminated, limited, conditioned, suspended, restricted in any way or not renewed.
> "2. Employer is excluded, terminated, suspended, or declared ineligible to participate in Medicare, Medicaid, or any governmental program providing compensation for services rendered to patients.
> "3. Employer fails or refuses to perform or fulfill any of Employer's duties, obligations or covenants under this Agreement, which breach is not cured within ten (10) days of Employer's receipt of notice of such breach by Employee.
> "4. Employer files for bankruptcy, is adjudicated bankrupt, takes advantage of applicable insolvency laws, makes an assignment for the benefit of a creditor, or a receiver or its equivalent has been appointed for Employer's property." See pages 80-81 of AMA Annotated Model Physician-Hospital Employment Agreement (updated March, 2012), found at www.ama-assn.org.

With respect to managed care contracts they may have, the physician should understand the terms of reimbursement of each plan and the probable impact that each plan may have on the level of the physician's income, among other concerns. The AMA thus suggests the insertion of the following language respecting managed care contracts, discounted fees and bundled payments:

> "Physician acknowledges and agrees that the Employer will have the right to negotiate and contract for Physician's services at discounted rates with any self-insured employer plan or third party payor plan; provided however, (i) Physicians shall be prospectively involved in any Employer negotiation of managed care contracts (including capitation and global billing contracts); and (ii) all such contracts shall be held in the Employer's name and Physician shall not be a direct party to such contracts. Employer will make all good faith efforts to obtain membership for the Physician in all health maintenance organizations (HMOs), preferred provider organizations (PPOs), physician-hospital organizations (PHOs), independent practice associations (IPAs), accountable care organizations (ACOs), and any other managed care organizations with which the Employer contracts. The Employer will make its best efforts to ensure that the Physician is eligible to participate in all managed care contracts in which the Employer participates. Employer will timely and promptly notify Physician of any agreement as to which fees for Physician's services shall be negotiated and/or bundled; and in such discounted or bundled fee arrangements, under absolutely no circumstances shall Physician be required to accept fees which are discounted at a rate proportionately greater than the discount given to such plans by Employer or take greater risk than Employer."

Malpractice insurance is typically provided by the hospital employer. Physicians employed by a hospital should assure that insurance covering them contains no additional cost tail coverage to avoid their being exposed to personal liability for claims made after employment terminates, but which are based on alleged acts or omissions that occurred during the term of employment. Such tail coverage is very costly and the employment contract should specify who is to pay for it after employment ceases.

Physicians negotiating contracts with hospitals should make sure that they are represented by able counsel. This succinct article is not intended to be a substitute for such

representation. Also, the issues alluded to in this article are far from exhaustive. Other potential contractual provisions include representations and warranties of the parties, a limitation on professional services, the scope of the physician's duties, the hours to be worked, a description of all benefits, contributions to retirement plans, insurance coverage, dues[14] and license fees, vacation, CME and time off, sick leave, family medical leave, loyalty and confidentiality covenants, non-solicitation, patient records and confidentiality, intellectual property and alternate dispute resolution, among many other subjects.

[14] One proposed "Dues and License Fees" provision states: "Physicians shall maintain membership in the American Medical Association, the State Medical Association, the _____ County Medical Society and National Specialty Societies, and the Employer shall pay the dues and assessments to maintain such memberships. Physicians must also maintain active licenses and U.S. Drug Enforcement Administration numbers in the following states: _____ and the Employer shall pay all licensing fees in those states." See p. 58 of AMA Annotated Model Physician-Hospital Employment Agreement (updated March, 2012), found at www.ama-assn.org.