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Terminating the Hospital-Physician Employment Relationship: Navigating Conflicts Arising from the Physician's Dual Roles as Employee and Medical Staff Member

Gayland O. Hethcoat II*

In an effort to meet the challenges of the post-health reform marketplace, hospitals have accelerated the practice of employing physicians. Despite this trend, many hospitals require their employed physicians to also maintain membership and privileges on the medical staff—the self-governing entity comprised of fellow physicians that oversees the practice of medicine within the hospital setting. Recent case law identifies at least two salient issues that will likely arise from physicians' dual roles as hospital employee and medical staff member and be a point of negotiation and litigation: (1) the applicability of “due process” rights, which are typically afforded in medical staff peer review actions, to employment termination actions, and (2) the obligation to report employment termination actions to the federal government's National Practitioner Data Bank, a central database for information about medical staff peer review actions and other incidents that may reflect on physicians' competence and quality of care. This article examines how and why these issues may become points of contention and proposes various practical solutions to avoiding or mitigating such conflicts.

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Five years after passage of the federal Affordable Care Act (ACA),¹ hospital employment of physicians remains one of the most frequently cited strategies for hospitals and physicians to meet the challenges of the post-health reform marketplace. Many health industry analysts opine that the employment relationship offers a template for hospitals and physicians to align their operations and financial interests and thus position themselves to meet greater demand for high-quality, cost-efficient care, as reflected in various initiatives in the ACA, such as its Medicare reform measure involving "accountable care organizations" (ACOs).² Although the full impact of hospital employment of physicians is unseen, one observation is readily apparent: The increase in hospital employment of physicians further hastens the demise of the voluntary medical staff model—the traditional paradigm of hospital-physician relations.³

Under the voluntary medical staff model, private-practice physicians, aggregated together as the medical staff, operate on a mostly independent basis within a hospital's confines, subject to the rules in the medical staff's bylaws and administrative oversight by the hospital's governing body. By definition, the employment model confers hospitals with a degree of control over physicians—control they would not otherwise have under the voluntary medical staff model. Nevertheless, many hospitals preserve the traditional medical staff structure and require their employed physicians to also maintain membership and privileges on the medical staff. This overlap naturally invites questions about the

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

² See EZEKIEL J. EMANUEL, REINVENTING AMERICAN HEALTH CARE 224–30 (2014) (discussing Medicare-participating ACOs).

³ See Lawrence P. Casalino et al., *Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model*, 27 HEALTH AFF. 1305, 1311–12 (2008).

interrelationship between the physician's roles as hospital employee and as member of the hospital's medical staff.⁴

For all its potential, the continued growth of hospital employment of physicians will inevitably bring with it a greater share of relationships that do not work out and end in termination. Recent case law identifies at least two salient issues that will likely be a point of negotiation and litigation regarding physician employment arrangements: (1) the applicability of "due process" rights, which are typically afforded in medical staff peer review actions, to employment termination actions, and (2) the obligation to report employment termination actions to the federal government's National Practitioner Data Bank (NPDB), a central database for information about medical staff peer review actions and other incidents that may reflect on physicians' competence and quality of care.⁵ These issues have long been major points of contention within medical staff peer review law, but the overlay of the employment relationship on the medical staff affiliation requires looking at them anew.

This article examines how and why termination of a physician's employment with a hospital may trigger conflicts regarding due process and NPDB reporting and proposes various practical solutions to avoiding or mitigating these conflicts. To put this discussion in context, this article begins with an overview of the market forces that are driving more physicians to become hospital employees and more hospitals to become physician employers. An analysis of the legal disputes over due process and NPDB reporting that may emerge from physicians' concurrent roles as hospital employee and medical staff member follows. Finally, this article suggests how hospitals and physicians alike can minimize these disputes by ensuring clarity and precision in negotiating and drafting physician employment agreements and in carrying out termination decisions.

I. THE EVOLVING PHENOMENON OF HOSPITAL EMPLOYMENT OF PHYSICIANS

Physicians have historically enjoyed a level of respect and prestige that few others in society command. Such reverence, however, does not come free, premised as it is on the notion that, as licensed professionals who have undergone years of rigorous training, physicians will always act independently in the best interests of their patients, regardless of their self-interests or the interests of others who stand to benefit from the

⁴ See *infra* Part I.

⁵ See *infra* Part II.

patient-physician relationship. Numerous sources of law codify and make explicit this implicit promise, as, for example, the doctrine in many jurisdictions that prohibits the “corporate practice of medicine” (subject to the common exception that hospitals may employ physicians without violating this prohibition, as discussed below).⁶ Likewise, protection of physician independence undergirds many laws regulating hospital operations, such as state hospital licensing laws and the Medicare conditions of participation requiring hospitals to maintain a self-governing medical staff, which adheres to a set of bylaws.⁷

Traditionally, under the voluntary medical staff model recognized by law, the local community hospital was the “physician’s workshop.”⁸ That is, the hospital was a place where physicians could access equipment and staff to perform procedures and provide services not otherwise available in their private offices.⁹ In exchange, physicians would serve in leadership roles on the medical staff and take emergency department call coverage, usually without pay.¹⁰ For some physicians, contributing their time and energy to their affiliated hospital was more than just a work requirement; it was a civic duty.¹¹

As with so many aspects of healthcare delivery and finance, however, the nature of hospital-physician relations has not been static. In the 1990s, many hospitals acquired large numbers of primary care physicians’ (PCPs) practices and employed the physicians, thinking a managed care model of capitation payments, based on PCPs acting as “gatekeepers” for the rest of the healthcare system, would become the national standard.¹² For physicians, the uncertainty and lower payment rates offered by managed care organizations, combined with the generous terms proposed by hospitals, made hospital employment enticing.¹³ But when the capitated model failed to take off as anticipated, many hospitals divested their employed primary care practices because they were losing money.¹⁴

Although hospitals’ experiences in the 1990s provided a cautionary tale, they ultimately did not curb the practice of employing physicians.

⁶ See *infra* Part II.A.

⁷ See, e.g., 42 C.F.R. § 482.22 (2014) (requiring hospitals, as a condition to participation in Medicare, to “have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital”).

⁸ Casalino et al., *supra* note 3, at 1306.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

Indeed, hospital employment of physicians continued into the 2000s, during which many hospitals began to employ specialists in addition to PCPs.¹⁵ Now, more than half of practicing physicians in the United States are employed by hospitals or integrated healthcare delivery systems.¹⁶ With its incentives for hospitals, physicians, and other healthcare providers to further integrate themselves in an effort to cut costs while improving the quality of their care,¹⁷ the ACA has been a major contributing factor to the increase in hospital employment of physicians in more recent years. One such initiative under the ACA involves recruiting ACOs into the Medicare program with the prospect of sharing in the cost savings that are anticipated to result from tighter coordination among providers and an accompanying reduction in duplicative and unnecessary interventions.¹⁸ By design, the ACO concept is intended to be a flexible one, and, as such, hospital employment of physicians is one model that may be conducive to achieving its goals, through such measures as “incentive-driven compensation linked to productivity and clinical behavior” and reductions in “excess costs associated with unnecessary practice variation and unnecessarily expensive supplies selected by physicians.”¹⁹ Although the ACO program and the risk-based payment approaches codified in the ACA technically apply only to Medicare and other public payers, they are poised to be adopted by private payers as well.²⁰

While the ACA has no doubt fostered an environment favorable to hospital employment of physicians, other, more local factors have played an important role, too. For hospitals, employing physicians is, at bottom, a competitive measure, allowing them to reinforce their place within an existing hospital market or enter into a new one, or preempt competition from specialist-owned ambulatory surgery centers (ASCs), specialty hospitals, and imaging facilities.²¹ Relatedly, employing physicians may

¹⁵ See *id.* at 1307–08.

¹⁶ Robert Kocher & Nikhil R. Sahni, *Hospitals’ Race to Employ Physicians—The Logic Behind a Money-Losing Proposition*, 369 NEW ENG. J. MED. 1790, 1790 (2011).

¹⁷ See generally EMANUEL, *supra* note 2, at 224–30 (discussing various cost-control measures in the ACA).

¹⁸ See *id.* at 224–28.

¹⁹ Kocher & Sahni, *supra* note 16, at 1792.

²⁰ See, e.g., Press Release, U.S. Dep’t of Health & Human Servs., Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value (Jan. 26, 2015), available at <http://www.hhs.gov/news/press/2015pres/01/20150126a.html> (noting the creation of the Health Care Payment Learning and Action Network, through which the U.S. Department of Health and Human Services “will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs”).

²¹ See Casalino et al., *supra* note 3, at 1308.

allow hospitals to improve their operations by filling a shortage in a particular specialty or a gap in emergency department call coverage or availability for consultation that would otherwise exist.²² For physicians, relinquishing the responsibilities of a private practice and becoming a hospital employee promise “more regular work hours and less frequent call responsibility, and . . . shelter from an increasingly complex and unstable market.”²³ In short, hospital employment of physicians can be both individually and collectively beneficial.

To be sure, not all physicians are opting for hospital employment. Many physicians have taken the opposite course and become competitors with hospitals, increasing their ownership in ASCs, specialty hospitals, and imaging facilities.²⁴ For physicians—mostly specialists, often in markets that lack a consolidated hospital presence—ownership in these facilities enables them to increase their efficiency and profitability by providing a narrow range of procedures and reaping the “facility fee” payment that hospitals would otherwise receive.²⁵ Accordingly, these physicians “may rarely set foot in the hospital.”²⁶ Even private-practice PCPs and other physicians whose practice is not procedure-based are becoming more detached from their community hospitals, using hospitalists (who may be hospital employees) to admit and treat large numbers of patients rather than assuming call coverage responsibilities.²⁷ Thus, as one study concluded, a dichotomy is emerging such that “physicians will increasingly choose the path of hospital employment or of separation from hospitals, with the two paths coexisting in some communities, while one path or the other predominates in others.”²⁸ The ramifications of this divergence are not yet fully realized, but it at least appears “[t]he voluntary medical staff model, traditionally the foundation of physician-hospital relations, [is] entering a period of decline.”²⁹

II. NAVIGATING TERMINATION-RELATED CONFLICTS ARISING FROM THE PHYSICIAN’S DUAL ROLES AS EMPLOYEE AND MEDICAL STAFF MEMBER

For most hospital-employed physicians, the employment agreement and medical staff bylaws are the primary authorities that govern their

²² *See id.*

²³ *Id.* at 1309.

²⁴ *See id.* at 1310.

²⁵ *Id.*

²⁶ *Id.*

²⁷ Casalino et al., *supra* note 3, at 1310–11.

²⁸ *Id.* at 1313.

²⁹ *Id.* at 1305.

practice within the hospital. In many ways, the hospital employment agreement may resemble previous employment agreements to which the physician was a party, addressing such matters as compensation, benefits, insurance, and scope of responsibilities. Typically, the agreement will also require the physician to be a member of the hospital's medical staff and maintain appropriate privileges for his or her practice, and to abide by the medical staff bylaws, rules, and regulations. Depending on the particular arrangement, the agreement may provide that termination of employment will result in automatic termination of the physician's medical staff membership or privileges, or vice versa.

By contrast, the medical staff bylaws act as a charter that sets forth the medical staff's system of governance and the rights and duties of all medical staff members vis-à-vis the hospital governing body.³⁰ The requirement to have medical staff bylaws and to ensure certain content therein stems from various regulatory sources, including state hospital licensing laws, federal conditions of hospital participation in Medicare, and rules from accrediting organizations, such as The Joint Commission.³¹ Although courts have held medical staff bylaws to be enforceable contracts in some cases,³² they generally have not held them to be enforceable *employment* contracts.³³ Nevertheless, reference to and incorporation of medical staff bylaws in *employment agreements* raise questions as to how the agreement, bylaws, and the laws underlying them interrelate and which controls in the event of a conflict. Having an answer to these questions is especially important when the hospital-physician relationship breaks down and is terminated, and will clarify both hospitals' and physicians' rights and responsibilities.

A. *The Applicability of Medical Staff "Due Process" Rights to Employment Termination Actions*

To appreciate why contentions regarding due process may arise from a hospital's termination of a physician's employment, it is helpful first to understand why the procedures for terminating, suspending, or taking other adverse actions against a physician's medical staff membership or privileges are themselves the focus of so many legal disputes. As noted, multiple sources of law and regulation govern the organization and operation of medical staffs and their bylaws, including the procedures for

³⁰ See KAREN S. RIEGER ET AL., HEALTHCARE ENTITY BYLAWS AND RELATED DOCUMENTS: NAVIGATING THE MEDICAL STAFF/HEALTHCARE ENTITY RELATIONSHIP § 1.1, at 2 (3d ed. 2011).

³¹ See *id.* §§ 2.1–2.3, at 5–9.

³² See *id.* § 3.3, at 26 nn.17–18 (collecting cases).

³³ See, e.g., *Engelstad v. Va. Mun. Hosp.*, 718 F.2d 262, 267 (8th Cir. 1983) (noting that "[s]taff privileges do not establish an employment contract with the hospital").

peer review actions. One such source is the federal Health Care Quality Improvement Act of 1986 (HCQIA).³⁴ To “balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action,”³⁵ HCQIA immunizes hospitals and their medical staffs from liability for damages resulting from a determination that adversely affects a physician’s standing on a medical staff, but only if minimum safeguards are in place (usually as set forth in the medical staff bylaws) to ensure fairness to the physician.³⁶ Thus, in lawsuits in which physicians seek damages arising from peer review actions (often on contractual, tortious, and statutory theories, such as theories of defamation and violation of antitrust laws), the steps taken by the medical staff in implementing the action are a significant point of analysis because they are the *key* to HCQIA immunity.

As a relatively new form of hospital-physician alignment, hospital employment of physicians is not subject to the same degree of regulation as hospital-physician affiliation through the medical staff.³⁷ To the extent the law specifically addresses hospital employment of physicians, it usually does so within state law doctrines pertaining to the “corporate practice of medicine.” In *Berlin v. Sarah Bush Lincoln Health Center*,³⁸ the Illinois Supreme Court aptly summarized the corporate practice of medicine and its restrictions on employment of physicians:

The corporate practice of medicine doctrine prohibits corporations from providing professional medical services. Although a few states have codified the doctrine, the prohibition is primarily inferred from state medical licensure acts, which regulate the profession of medicine and forbid its practice by unlicensed individuals. The rationale behind the doctrine is that a corporation cannot be licensed to practice medicine because only a human being can sustain the education,

³⁴ Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660 (codified at 42 U.S.C. §§ 11101–11152 (2013)).

³⁵ *Freilich v. Upper Chesapeake Health*, 313 F.3d 205, 211–12 (4th Cir. 2002) (quoting *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1322 (11th Cir. 1994)); *see also* 42 U.S.C. § 11101 (2013) (describing the congressional findings relating to HCQIA).

³⁶ *See* 42 U.S.C. §§ 11111–11112 (2013) (limiting damages for “professional review actions” where requirements for notice, hearing, and governing standards are met).

³⁷ Not to be overlooked, employment laws of general applicability, such as anti-discrimination laws, do impose legal requirements onto the hospital-physician employment relationship. These laws, however, are not unique to this type of employment relationship.

³⁸ *Berlin v. Sarah Bush Lincoln Health Ctr.*, 688 N.E.2d 106 (Ill. 1997).

training, and character-screening which are prerequisites to receiving a professional license. Since a corporation cannot receive a medical license, it follows that a corporation cannot legally practice the profession.

The rationale of the doctrine concludes that the employment of physicians by corporations is illegal because the acts of the physicians are attributable to the corporate employer, which cannot obtain a medical license. The prohibition on the corporate employment of physicians is invariably supported by several public policy arguments which espouse the dangers of lay control over professional judgment, the division of the physician's loyalty between his patient and his profitmaking employer, and the commercialization of the profession.³⁹

Critics contend that the complexities of delivering and paying for health care in the modern era have rendered the legal doctrine an outdated relic from "when health care was 'a cottage industry, made up of independent professionals operating as solo practitioners.'"⁴⁰ As the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) concluded in a report on state laws prohibiting hospital employment of physicians:

[T]he debate over the corporate practice of medicine doctrine is an argument over who will control the delivery of medical care. This contention focuses on whether physicians should make decisions free of external constraints or whether outside parties (a hospital administrator, for example) should be able to exert control over physician behavior.⁴¹

Notably, many states' corporate practice of medicine doctrine includes an exception for hospitals to employ physicians. The rationale for this exception differs from jurisdiction to jurisdiction; where courts have taken up the issue, some have reasoned that the public policy arguments against the corporate practice of medicine—for example, the commercialization of medicine—do not apply to hospitals organized as

³⁹ *Id.* at 110 (citations omitted).

⁴⁰ OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., STATE PROHIBITIONS ON HOSPITAL EMPLOYMENT OF PHYSICIANS, OEI-01-91-00770, at 2 (1991), available at <https://oig.hhs.gov/oei/reports/oei-01-91-00770.pdf>.

⁴¹ *Id.*

charitable institutions, while others have opined that hospital licensing acts and other laws expressly allow hospitals to offer medical care to patients.⁴² Likewise, the source of these exceptions varies—be it statutes,⁴³ court opinions,⁴⁴ or state attorney general opinions.⁴⁵

Even in these states, however, there may be constraints on the manner or circumstances in which hospitals may terminate their employed physicians. This is particularly so in states that regulate hospital employment of physicians legislatively. For example, in Colorado, a hospital statutorily may not “limit or otherwise exercise control over the physician’s independent professional judgment concerning the practice of medicine or diagnosis or treatment or . . . require physicians to refer exclusively to the health care facility or to the health care facility’s employed physicians.”⁴⁶ Violation of this prohibition may subject the hospital to regulatory penalties or any resulting liability to patients or the physician.⁴⁷ Moreover, a physician who believes he or she has been the subject of such a violation “has a right to complain and request review of the matter” pursuant to the

⁴² *Berlin*, 688 N.E.2d at 111–112 (discussing cases). A small minority of states still prohibits hospital employment of physicians on corporate practice of medicine grounds. California is one such state. To achieve the benefits associated with employment of physicians, such as greater clinical integration and joint contracting with insurers, California hospitals have pursued various approaches tailored to California’s regulatory environment. One such approach, for example, involves the operation of clinics by medical foundations—often hospital affiliate or subsidiary entities which engage physicians on an independent contractor basis to provide professional services and which manage the administrative aspects of those physicians’ practices. *See* DEBRA A. DRAPER ET AL., CAL. HEALTHCARE FOUND., A TIGHTER BOND: CALIFORNIA HOSPITALS SEEK STRONGER TIES WITH PHYSICIANS 3–4 (2009), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/T/PDF%20TighterBondCAHospitalsSeekTiesWithDocs.pdf>. Another, somewhat similar approach entails the structuring of clinics as outpatient hospital departments, where independent contractor physicians render their professional services, and the hospital furnishes the “necessary infrastructure and support for operating the clinics, including the physical space, management, support staff, equipment, supplies, medical records, patient registration, and facility billing.” *Id.* at 4. One analysis of these strategies suggested that while they may offer hospitals a proxy for directly employing physicians, they “may ultimately add costs to the health care system because of the additional infrastructure required to operate them.” *Id.* at 7.

⁴³ *See infra* note 46.

⁴⁴ *See, e.g., Berlin*, 688 N.E.2d at 106.

⁴⁵ *See, e.g.*, 1992 Op. Att’y Gen. Va. 147.

⁴⁶ COLO. REV. STAT. § 25-3-103.7(3) (2014). Other states impose similar statutory conditions on hospital employment of physicians. *See, e.g.*, 210 ILL. COMP. STAT. 85/10.8(a)(3); N.D. CENT. CODE § 43-17-42; S.D. CODIFIED LAWS § 36-4-8.1(1); TENN. CODE ANN. § 63-6-204(f)(1)(A); WIS. STAT. § 448.08(5)(a)(1).

⁴⁷ COLO. REV. STAT. § 25-3-103.7(3); *see also, e.g.*, 210 ILL. COMP. STAT. 85/10.8(c)–(d) (containing similar provisions).

hospital's medical staff bylaws or policies, which "shall ensure that the due process rights of the parties are protected."⁴⁸ From these provisions, one can infer that a hospital may not lawfully *terminate* a physician for exercising his or her "independent professional judgment" and that if a termination action appeared to be a smokescreen for restricting such exercise, the physician would be entitled to minimum procedural safeguards to validate the basis for the termination.⁴⁹ The statute does not, however, presume that no one can stand in judgment of an employed physician; it implies that any void created by restrictions on hospital action will be filled by the medical staff, which, as an independent body comprised of other physicians, *can* review the propriety of a fellow physician's "independent professional judgment."

Absent these types of statutory protections, the scope of a hospital-employed physician's termination rights will depend on the content of the employment agreement and its relationship to the medical staff bylaws, as illustrated by the recent Hawaii case of *Woodruff v. Hawaii Pacific Health*.⁵⁰ In that case, a hospital system terminated a pediatric hematologist/oncologist in connection with an investigation of the physician's billing practices.⁵¹ Because of violations for false billing claims, the hospital system was a party to a corporate integrity agreement with the OIG and accordingly had to report to the agency and other interested parties overpayments and "material deficiencies" in billing practices.⁵² To comply with Medicare regulations, the system's billing office instituted a policy prohibiting physicians from billing for certain invasive procedures performed by a nurse practitioner in the outpatient

⁴⁸ COLO. REV. STAT. § 25-3-103.7(7); *see also, e.g.*, 210 ILL. COMP. STAT. 85/10.8(a) (containing similar provisions).

⁴⁹ This inference is supported by reference to Illinois' statute authorizing hospital employment of physicians. It contains review procedures that are similar to those under the Colorado statute but goes further than that statute by prohibiting "retaliat[ion] against any employed physician for requesting a hearing or review" under the statute. 210 ILL. COMP. STAT. 85/10.8(e). By contrast, although state peer review protection statutes generally do not directly regulate hospital-physician employment arrangements, at least one court has held that a state statute recognizing the confidentiality of peer review proceedings impliedly prohibits a hospital from terminating an employee physician because of the physician's conduct as a peer reviewer of another physician's care. *See Yedidag v. Roswell Clinic Corp.*, No. 34,286, 2015 N.M. LEXIS 51, at *39-41 (N.M. Feb. 19, 2015) (holding that New Mexico's peer review confidentiality statute, N.M. STAT. ANN. § 41-9-5, which impliedly "prohibits an employer from retaliating against a physician who participates in a peer review because the unlawful acquisition and utilization of peer review information is a factual prerequisite to such retaliation," is a "mandatory rule of law incorporated into physician-reviewer employment contracts").

⁵⁰ *Woodruff v. Haw. Pac. Health*, No. 29447, 2014 Haw. App. LEXIS 26 (Haw. App. Jan. 14, 2014).

⁵¹ *See id.* at *1-2.

⁵² *See id.* at *5.

hospital setting.⁵³ The plaintiff physician expressed resistance and disagreement over the application and interpretation of the policy and, as an audit and investigation found, had submitted numerous billing claims that did not meet the standards in the policy.⁵⁴ After disclosing these findings to the OIG and offering to accept the physician's resignation (which the physician did not tender), the hospital system terminated the physician's employment.⁵⁵ The physician's medical staff privileges were unaffected by the termination, but shortly thereafter the chief executive officer of the hospital where she practiced suspended them.⁵⁶ On review, however, the hospital's medical executive committee ruled that the suspension was unwarranted and therefore lifted the suspension.⁵⁷

Among the various causes of action the physician alleged in litigation following her termination, she argued the hospital bylaws "were incorporated into [her] employment agreement . . . and therefore she was entitled to a hearing before her employment was terminated."⁵⁸ For support, the physician cited her employment agreement, which required her to maintain in good standing medical staff membership and appropriate privileges, and to comply with the medical staff bylaws and all other rules, regulations, policies, and procedures.⁵⁹ The agreement

⁵³ See *id.* at *10.

⁵⁴ See *id.* at *11–14.

⁵⁵ See *id.* at *14–17.

⁵⁶ See *id.* at *17. The opinion does not specify the grounds for suspension of the physician's privileges, but the short gap between termination of the physician's employment and suspension of her privileges suggests the underlying reasons for both actions may have been the same.

⁵⁷ See *id.* at *17–18.

⁵⁸ *Id.* at *46–47. Where an employer hospital is a public hospital, an employee physician facing termination may argue that he or she is owed a pre-termination hearing and other procedural rights as a matter of constitutional due process. For instance, in the recent case of *Winger v. Meade District Hospital*, No. 13-1428-JTM, 2015 U.S. Dist. LEXIS 28234 (D. Kan. Mar. 9, 2015), the employee physician asserted that the employer public hospital violated his right to constitutional due process when it revoked his temporary medical staff privileges because of a finding of substandard care and then subsequently terminated his employment. The court rejected this argument on the ground that the medical staff bylaws and employment agreement did not create "a constitutionally protected liberty or property interest such that the due process protections were applicable . . ." *Id.* at *13 (quoting *Couture v. Bd. of Educ. of Albuquerque Pub. Sch.*, 535 F.3d 1243, 1256 (10th Cir. 2008)). As the court noted, the employment agreement explicitly incorporated the bylaws, which "provide[d] that temporary privileges, such as those held by [the physician], could be revoked at any time, without any procedural rights." *Id.* at *16. Thus, even for physicians employed by public hospitals, the scope of termination-related procedural rights available to them will generally turn on the provisions of the medical staff bylaws and the employment agreement, as it does for their private-sector counterparts.

⁵⁹ See *Woodruff*, 2014 Haw. App. LEXIS 26, at *49–50.

also provided that loss of medical staff membership was “grounds for automatic and immediate termination of employment”⁶⁰

On appeal, the court held that the employment agreement did not confer to the physician rights associated with peer review actions under the medical staff bylaws.⁶¹ To the extent the agreement incorporated provisions of the bylaws, it did so one-sidedly, in favor of the hospital system; it conditioned the *physician’s* employment on compliance with the bylaws but did *not* require the *hospital system* to comply with the bylaws.⁶² Nevertheless, the court went on to note that the hearing procedures under the bylaws did “not apply to employment terminations, but only to adverse actions relating to staff membership and clinical privileges.”⁶³ Although the employment termination “may have ended the increased access to hospital facilities [the physician] had as an employee,” the court concluded “it did not affect the access to and privileges at [the hospital] she enjoyed as a medical staff member.”⁶⁴ Suspension of the physician’s privileges did follow her employment termination, but she was afforded—and was vindicated by—the medical staff review process in that action and did not otherwise challenge it in the litigation.⁶⁵

As *Woodruff* shows, while a hearing and other related procedural rights may be standard course in medical staff peer review actions, such rights are much more likely to be the exception, and not the norm, in physician employment termination actions. In those jurisdictions that prohibit the corporate practice of medicine, or authorize such practice by hospitals, but subject to certain restrictions, hospitals run the risk of violating the prohibition—and incurring all the liabilities that come with doing so—if they terminate or take other adverse action against a physician’s employment as a means to retaliate against or impinge on the physician’s independent professional judgment. Otherwise, any parameters to a hospital’s ability to terminate a physician’s employment must appear in the employment agreement. *Woodruff* demonstrates that a mere citation in an employment agreement to the hospital’s medical staff

⁶⁰ *Id.* at *50.

⁶¹ *See id.* at *51–52.

⁶² *See id.* at *50–51.

⁶³ *Id.* at *51–53; *see also* *Bryant v. Glen Oaks Med. Ctr.*, 650 N.E.2d 622, 630 (Ill. App. 1995) (making similar observations where a pathologist argued the hearing and appellate review provisions in the medical staff bylaws applied to the termination of his medical directorship).

⁶⁴ *Woodruff*, 2014 Haw. App. LEXIS 26, at *53; *see also* *Bryant*, 650 N.E.2d at 630 (noting the plaintiff physician’s “fail[ure] to appreciate the distinction between his medical staff privileges and his ability to provide pathology services with the free and unfettered right to use the pathology laboratory”).

⁶⁵ *Woodruff*, 2014 Haw. App. LEXIS 26, at *53.

bylaws is not sufficient to extend the rights therein to employment termination actions. If a physician is to receive notice, a hearing, or any other rights with respect to termination of employment, the employment agreement must enumerate them with specificity.

B. Reporting Employment Termination Actions to the National Practitioner Data Bank

The availability of a process to challenge medical staff peer review actions is important to physicians because it provides a mechanism to preserve the status quo and stave off losing, in whole or in part, their medical staff membership or privileges. Insofar as a physician is able to avail him or herself during such review process, he or she may be able to avoid an outcome that, in the longer term, may be even worse than losing his or her medical staff membership or privileges at a particular facility: a report to the NPDB. As a corollary, one would expect physicians to advocate fiercely for a hearing and other rights in employment termination actions if the outcome of the action were reportable to the NPDB. The question, then, is whether physician employment termination actions are, in fact, reportable to the NPDB.

The NPDB is a creation of HCQIA. Complementing the immunity provisions under HCQIA, the NPDB is intended to bolster the integrity of the peer review process by “accumulating and disseminating data pertaining to adverse peer review actions which have an impact on the clinical privileges of physicians and other medical staff members.”⁶⁶ In relevant part, HCQIA requires hospitals and other “health care entities” to report to the NPDB “professional review actions” that “adversely affect[] the clinical privileges of a physician for a period longer than 30 days.”⁶⁷ HCQIA’s definition of “professional review action” is particularly dense, “but the essence of the definition . . . is that it is a recommendation or an action based on an assessment of ‘the competence or professional conduct of a physician’ that will have an adverse effect on such physician’s clinical privileges or membership/appointment in a professional society.”⁶⁸

In the context of analyzing reporting obligations regarding physician employment termination actions, identifying the potentially reportable

⁶⁶ RIEGER ET AL., *supra* note 30, § 2.4, at 16.

⁶⁷ 42 U.S.C. § 11133(a)(1)(A) (2013); *see also* 45 C.F.R. § 60.11(a)(i) (2014). HCQIA also requires reporting of a physician’s surrender of his or her clinical privileges “while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding.” 42 U.S.C. § 11133(a)(1)(B) (2013); *see also* 45 C.F.R. § 60.11(a)(ii) (2014)).

⁶⁸ RIEGER ET AL., *supra* note 30, § 2.4, at 10 (quoting 42 U.S.C. § 11151(9) (2013)).

“professional review action” is an important threshold task. Is the employment termination decision *itself* the potentially reportable action? Or, where termination of a physician’s medical staff membership or privileges occurs in tandem with termination of the physician’s employment, is the termination of the physician’s *medical staff membership or privileges* the reportable action (or both)? The first question generally has been overlooked, which is curious considering that HCQIA defines “clinical privileges” as not only medical staff membership and privileges in the ordinary sense, but also “the 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.”⁶⁹ Arguably, this definition is broad enough to encompass a physician’s status as a hospital employee as an “other circumstance” to render care in the hospital setting, especially in light of the fact that so many physicians are opting for employment over affiliation as an independent practitioner on the medical staff as the “credential” for practicing medicine within the hospital environment.⁷⁰

Perhaps it is assumed that because termination of a physician’s employment tends to be initiated by hospital administration or human resources personnel, the employment termination action is not an action performed by what HCQIA describes as a “professional review body” engaged in “professional review activity.”⁷¹ If these terms referred only to *medical staff* review bodies engaged in *medical staff* review activity, then such an assumption would have support. But HCQIA is not so limited; it specifically includes hospitals and their governing body and other committees in the definition of “professional review bod[ies]” that may conduct “professional review activity.”⁷² Thus, when one construes these terms more robustly, and interprets HCQIA’s definition of “clinical privileges” to capture a physician’s employment status in relation to a hospital, one could reasonably conclude that HCQIA casts a wide enough net to require reporting of physician employment termination actions where the action is “based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients)”⁷³ Because termination of a physician’s employment *without cause* could meet this

⁶⁹ 42 U.S.C. § 11151(3) (2013); *see also* 45 C.F.R. § 60.3 (2014).

⁷⁰ *See supra* Part I.

⁷¹ *See* 42 U.S.C. § 11151(10)–(11) (2013) (defining quoted terms); *see also* 45 C.F.R. § 60.3 (2014).

⁷² *See* 42 U.S.C. §§ 11151(10)–(11) (2013) (defining quoted terms); *see also* 45 C.F.R. § 60.3 (2014).

⁷³ 42 U.S.C. § 11151(9) (2013).

basis,⁷⁴ even without-cause employment termination actions could be reportable under this interpretation.

Despite its theoretically broad scope, in practice, HCQIA's NPDB provisions have been analyzed more narrowly to discern whether termination of a physician's *medical staff membership or privileges* is reportable, to the extent it is connected with termination of the physician's employment by a hospital. On this issue, conventional wisdom holds that termination of the physician's medical staff membership or privileges is *not* reportable, at least where the termination happens automatically following the employment termination action. Proponents of this view have traditionally pointed to a passage in the 2001 version of the *National Practitioner Data Bank Guidebook*—a compilation of guidelines on reporting to and querying from the NPDB published by the Health Resources and Services Administration (HRSA) within HHS—that describes the example of a hospital that has a “system of professional review established under its bylaws” and an “employment termination procedure,” the latter of which the hospital uses “to end a practitioner’s employment without use of the professional review process,” resulting in revocation of the practitioner’s clinical privileges.⁷⁵ According to this version of the *Guidebook*, a report on the revocation of the practitioner’s privileges would be voided “since the professional review process had not been followed in terminating the practitioner’s privileges” and “[t]he termination was not a professional review action.”⁷⁶

In April of 2015, HRSA released a much-anticipated updated version of the *Guidebook*, in which the agency essentially reiterated its position from the 2001 iteration. The new *Guidebook* maintains the distinction between a “system of professional review established under [a hospital’s] bylaws” and an “employment termination procedure,” concluding like the 2001 version that as long as revocation of a practitioner’s privileges is “not a result of a professional review action,” the revocation is not reportable.⁷⁷ But the *Guidebook* now clarifies that “if the hospital had

⁷⁴ See *Langenberg v. Warren Gen. Hosp.*, No. 1:12-cv-175-NBF, 2013 U.S. Dist. LEXIS 166183, at *31-32 (W.D. Pa. Nov. 22, 2013) (describing the purpose of a without-cause provision in a physician’s employment agreement as “not to guarantee that no cause exists for termination of the contract but, rather, to ensure that each party has the ability to unilaterally terminate the contract without the need to state a cause. Such circumstances do not foreclose the possibility that the terminating party might have reasons for its decision to invoke [the without-cause provision]”).

⁷⁵ HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., NPDB GUIDEBOOK, at F-9 (2001).

⁷⁶ *Id.*

⁷⁷ HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., NPDB GUIDEBOOK, at E-40 (2015) [hereinafter 2015 GUIDEBOOK].

performed a professional review of the practitioner's privileges as a result of the review, the professional review action would have been reportable, *even if the action started as an employment termination.*"⁷⁸ This added commentary suggests that a direct connection between an adverse privileging action and a finding regarding a practitioner's competence or professional conduct is necessary to give rise to a reporting duty; if the privileging action is merely a formality that follows from an employment termination action, the privileging action is not reportable, even if the employment termination action itself was related to the practitioner's competence or professional conduct.

In an era of increased employment of physicians, where physicians' employment status and medical staff membership and privileges often overlap such that termination of employment will cause automatic termination of medical staff membership and privileges, HRSA's continuation of its policy in the 2001 version of the *Guidebook* should come as a welcome development for hospitals and physicians alike. Indeed, prior to issuance of the revised *Guidebook* in 2015, one reasonably could have surmised that HRSA might change its enforcement posture, as the agency has indicated that underreporting of professional review actions by hospitals is the "next compliance effort"⁷⁹; to the extent more physicians are trading traditional medical staff affiliation for employment, and such underreporting is attributable to hospitals not reporting employment-related actions, physician employment termination actions conceivably could have become an area of renewed interest for HRSA.

The risks of litigation that a hospital may assume in *not* following HRSA's now years-long guidance on reporting employment termination-related actions are on full display in the recent Pennsylvania federal district court case of *Langenberg v. Warren General Hospital*.⁸⁰

⁷⁸ *Id.* (emphasis added).

⁷⁹ See HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK 2012 ANNUAL REPORT 38 (2014), <http://www.npdb.hrsa.gov/resources/reports/2012NPDBAnnualReport.pdf> (noting "a robust plan to conduct educational outreach activities targeted at specific audiences associated with hospital compliance involving querying and reporting to the Data Bank"); see also *Hospital Reporting—The Next Compliance Effort*, THE DATA BANK (Aug. 2012), <http://www.npdb.hrsa.gov/enews/Aug2012enews.jsp> (noting "the next phase of our compliance initiative—the Hospital Compliance Effort"). According to HRSA data, at the start of 2011, forty-seven percent of hospitals had never reported revoking or restricting a physician's clinical privileges to the NPDB. See Peter Eisler & Barbara Hansen, *Thousands of Doctors Practicing Despite Errors, Misconduct*, USA TODAY, Aug. 20, 2013, <http://www.usatoday.com/story/news/nation/2013/08/20/doctors-licenses-medical-boards/2655513/>.

⁸⁰ *Langenberg v. Warren Gen. Hosp.*, No. 1:12-cv-175-NBF, 2013 U.S. Dist. LEXIS 166183 (W.D. Pa. Nov. 22, 2013).

Following complaints the physician had raised about patient safety and quality of care, the hospital in that case terminated the employment of a vascular surgeon only months into the employment, citing the without-cause provision in the employment agreement.⁸¹ Pursuant to the hospital's medical staff bylaws, the physician's medical staff membership and privileges terminated automatically and immediately upon termination of his employment.⁸² A month later, the hospital filed a report with the NPDB "stating that [the physician] had been terminated because, *inter alia*, he 'often lacked civility and was demeaning to Hospital staff,' which had a 'disruptive and detrimental effect on the Hospital's working environment.'"⁸³ The NPDB report further stated that the bases for the report were the physician's "'failure to comply with corrective action plan,' 'abusive conduct toward staff,' and 'disruptive conduct.'"⁸⁴ During the course of the physician's employment, however, the hospital never disciplined him for any misconduct or provided him with any corrective action plan.⁸⁵ After submission of the NPDB report, the physician struggled to obtain other employment.⁸⁶

In the federal lawsuit that ensued, the physician asserted a litany of causes of action, all of which were premised on the hospital's allegedly improper filing of the NPDB report.⁸⁷ Among them, the physician asserted three breach-of-contract claims that were rooted in the hospital's failure to afford the physician any procedural rights before reporting to the NPDB.⁸⁸ The governing "contract" for these claims was the employment agreement and the bylaws. As to the bylaws claims, the physician first argued that the hospital breached by submitting the NPDB report despite language in the bylaws stating that automatic termination of a physician's medical staff membership and privileges resulting from the expiration or termination of a "contractual relationship" with the hospital was not an "adverse action," which would implicate the fair

⁸¹ See *id.* at *2–7.

⁸² See *id.* at *3.

⁸³ *Id.* at *3 (citation omitted). The opinion is not entirely clear as to whether the hospital reported the employment termination action or the consequent termination of the physician's medical staff membership and privileges to the NPDB. But the court's characterization of the physician's legal assertions suggests the hospital reported the latter. See *id.* at *20 (noting the physician "maintains that the Hospital breached the Bylaws by treating his automatic termination of staff membership and clinical privileges as an 'adverse action' for NPDB reporting purposes").

⁸⁴ *Id.* at *3.

⁸⁵ *Id.*

⁸⁶ See *id.*

⁸⁷ See *id.* at *6.

⁸⁸ See *id.*

hearing plan in the bylaws.⁸⁹ Relatedly, the physician contended that the hospital breached the bylaws by “failing to afford him due process procedures ‘pursuant to a professional review action,’ including notice of the charges against him, a hearing at which he could contest the charges, and an opportunity to appeal any unfavorable ruling.”⁹⁰ With respect to the employment agreement, the physician argued that the hospital breached the covenant of good faith and fair dealing implied therein by submitting the NPDB report “in the absence of due process measures and after having informed [the physician] that his termination was on a ‘non-cause basis.’”⁹¹

On a motion to dismiss, the court rejected all the physician’s breach-of-contract claims. The defect in his first count was that there was “no ambiguity in the Bylaws concerning the fact that the automatic and immediate loss of clinical privileges and staff membership which results from a termination of the physician’s employment contract (as was the case here) [wa]s not an ‘adverse action’ giving rise to due process hearing procedures.”⁹² The physician apparently attempted to equate the bylaws term “adverse action” with the HCQIA term “professional review action”—so as to implicate the HCQIA procedures associated with the latter term—but by doing so he necessarily had to look outside the “operative contractual document” and therefore could not state a viable claim for breach of contract.⁹³ For the same reason, the alternative bylaws breach claim “fare[d] no better.”⁹⁴ As the bylaws were clear that termination of a physician’s employment would prompt the loss of his or her medical staff membership and privileges, the physician was “unwarranted” in his “attempt to infuse meaning into the Bylaws’ use of the term ‘adverse actions’ by referencing the HCQIA’s definitions”⁹⁵ In a similar vein, the court held that the hospital could not have violated an *implied* duty under the employment agreement when it exercised its *express* right to terminate the agreement without cause.⁹⁶ Any contention of the physician with the NPDB report that followed from the termination was, according to the court, an effort to “(once again) conflat[e] [the hospital’s] statutory responsibilities and reporting requirements under the HCQIA with its contractual obligations under the

⁸⁹ See *id.* at *13–15.

⁹⁰ *Id.* at *7.

⁹¹ *Id.* at *8.

⁹² *Id.* at *7.

⁹³ *Id.*

⁹⁴ *Id.* at *8.

⁹⁵ *Id.*

⁹⁶ See *id.* at *10–11.

Employment Agreement and thereby graft[] additional obligations onto the Employment Agreement that do not appear in that document.”⁹⁷

Although *Langenberg* does not speak to whether employment termination actions against physicians *are* reportable to the NPDB, it at least shows that the practice of hospitals reporting such actions is not unprecedented, even where the hospital did not extend HCQIA’s procedural safeguards to the physician who is the subject of the report. Like *Woodruff*, the case further reinforces the primacy of the employment agreement and medical staff bylaws in governing disputes arising from a hospital terminating a physician’s employment. Ultimately, if a physician is to be afforded any procedural rights to challenge an action that may generate an NPDB report, the employment agreement or medical staff bylaws must ensure that those rights are available.

III. PRACTICE POINTERS

The success of hospital employment of physicians as a form of hospital-physician alignment will turn, in no small part, on the contingencies hospitals and physicians have in place to resolve potential conflicts. It may seem somewhat counterintuitive and adversarial to make issues regarding termination a particular point of focus, but by reaching common ground on these issues at an early stage, hospitals and physicians can better avoid confusion about their rights and obligations, and mitigate the likelihood of disputes escalating like those in *Woodruff* and *Langenberg*.

At the outset, hospitals and physicians considering the employment model should identify and articulate their negotiating positions on due process rights related to termination and where on the continuum they can compromise. One might expect physicians to advocate for as many procedural rights as they can get, while hospitals, wanting maximum flexibility, would push for the opposite. But the negotiation need not be so partisan and polarized. One potential middle-ground approach is to demarcate rights associated with “with-cause” termination from those rights associated with “without-cause” termination.

As to the former, the parties may consider enumerating the grounds for with-cause termination by the hospital to include issues involving quality of care or patient safety. If the hospital desires to terminate on one of these grounds, it could provide the physician a notice of its intent to terminate and an opportunity for the physician to respond in some type of review forum. The review forum could be conducted through the

⁹⁷ *Id.* at *10.

medical staff, as the American Medical Association (AMA) proposes in opining on with-cause termination of physician employment agreements, with the physician receiving “full due process under the medical staff bylaws” and a stay on the termination until after the “governing body has acted on the recommendation of the medical staff.”⁹⁸ Alternatively, the review process could be a scaled-down version of a peer review proceeding, perhaps entailing a combination of medical staff and hospital human resources functions. As one commentator suggests: “[E]ven if a full-blown, formal peer review process never occurs, hospitals can at least attempt to approximate one by offering a review by the medical staff, and some opportunity for physicians to present their sides of the story.”⁹⁹

Contrary to what they might expect, hospitals could reap a number of legal benefits by affording their employed physicians an opportunity to challenge a termination action for quality-of-care or patient safety concerns. For one, if the process and resulting decision are structured to fit within HCQIA’s statutory terms—that is, the outcome is a “professional review action” that meets the statute’s notice, hearing, and governing standard requirements, taken by a “professional review body” during the course of “professional review activity”¹⁰⁰—then the hospital and review process participants could arguably receive immunity from damages. Thus, the hospital could mitigate its liability stemming from allegations that a termination action was wrongful or gave rise to other contractual or tortious causes of action. Plus, the hospital could much more definitively conclude that the termination action was a reportable “professional review action.”¹⁰¹ In similar fashion, by conducting review

⁹⁸ See AM. MED. ASS’N, AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT § 3(e) (2014).

⁹⁹ Susan O. Scheutzw & Sean P. Malone, *No-Cause Terminations and Data Bank Reports: Does a No-Cause Termination Mean No Lawsuit?*, MEDSTAFF NEWS (Am. Health Lawyers Ass’n. Wash., D.C.), Nov. 2014, at 7.

¹⁰⁰ See 42 U.S.C. §§ 11151(9)–(11) (defining quoted terms) (2013); see also 42 C.F.R. § 60.3 (2014). As with reporting of physician employment termination actions to the NPDB, immunity from damages for such actions would turn on a finding that the physician’s employment status constitutes “clinical privileges” under HCQIA. See *supra* Part II.B.

¹⁰¹ See *supra* Part II.B; see also *supra* note 100. To be sure, compliance with HCQIA’s due process provisions is *not* a prerequisite to reporting a professional review action. See *Leal v. Sec’y, U.S. Dep’t of HHS*, 620 F.3d 1280, 1287 (11th Cir. 2010) (explaining that 42 U.S.C. § 11112, “which sets out standards that professional review actions must comply with in order for those who participate in them to be immune from liability for money damages in suits brought by disciplined physicians, . . . does not govern when a summary suspension, which is a type of professional review action, is reportable”); Robert R. Harrison, *Reporting the Summary Suspension of Medical Staff Privileges: Requirements, Sanctions, and Interpretive Challenges*, MEDSTAFF NEWS (Am. Health Lawyers Ass’n. Wash., D.C.), Mar. 2015, at 4 (“For NPDB reporting purposes, hospitals

activity through bodies that act as peer review committees, the hospital could, depending on the applicable state law, privilege from discovery or admissibility in litigation the communications and documents that are generated during the review process.¹⁰² Finally, a review process that removes the hospital from directly passing judgment on a physician's provision of medical care could shield the hospital from charges of engaging in the corporate practice of medicine.¹⁰³

By contrast, negotiating physician rights relating to without-cause termination may be more challenging because without-cause termination is inherently supposed to be hassle-free. The AMA looks upon without-cause termination with some skepticism, advising physicians to "carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions" and to ensure that these provisions are not a vehicle for the employer hospital to terminate for reasons relating to "quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff."¹⁰⁴ For hospitals, however, the ability to terminate a physician's employment without cause is often critical, providing a mechanism "to part ways with allegedly trouble-making physicians with no questions asked, without a costly peer review process,

have relied on an underlying HCQIA function—the granting of immunity for professional review actions—to support the interpretation that no report is required in the absence of a professional review action, but the guidance has not been explicit on that point.”). In *Langenberg*, the physician argued to the contrary—that, by deeming automatic revocation of a physician's privileges following termination of an employment agreement with the hospital as outside the ambit of an “adverse action” subject to a hearing, the hospital's medical staff bylaws expressed the position that such revocations lack the indicia of a “professional review action” that satisfies the procedural standards for immunity under HCQIA and therefore were not reportable to the NPDB. See *Langenberg*, U.S. Dist. LEXIS 166183, at *15–22. The court did not rule on the merits of whether the hospital properly reported to the NPDB, instead limiting its conclusion only to the determination that the hospital did not breach the terms of the medical staff bylaws by making the report. See *id.* at *20–22. The ruling leaves open the possibility that the physician could initiate HCQIA's administrative procedures for challenging the substance of the hospital's NPDB report. See 45 C.F.R. § 60.16 (2014) (enumerating procedures for disputing the accuracy of NPDB information). Indeed, it appears the physician did take this course, as the court later stayed the proceeding while the physician moved forward with an administrative proceeding and subsequent district court action against HHS involving the NPDB report. See *Langenberg v. Papalia*, Civil Action No. 12-175 Erie, 2014 U.S. Dist. LEXIS 133941 (W.D. Pa. Sept. 14, 2014).

¹⁰² See RIEGER ET AL., *supra* note 30, § 2.4, at 9 n.12 (collecting state statutes). Federal law, however, would provide no analogous peer review privilege. See, e.g., *Agster v. Maricopa County*, 422 F.3d 836, 839 (9th Cir. 2005) (noting that HCQIA “granted immunity to participants in medical peer reviews, but did not privilege the report resulting from the process”).

¹⁰³ See *supra* Part II.A.

¹⁰⁴ AM. MED. ASS'N, AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT § 3(f) (2014).

and without having to make a [NPDB] report that can generate lawsuits for defamation, interference with business relationships, or bad-faith peer review.”¹⁰⁵

Short of scrapping without-cause termination rights altogether, there are a number of aspects of the without-cause termination provision that hospitals and physicians could negotiate. The period of any notice prior to such termination would be an obvious target. Linkage of the physician’s employment status with his or her medical staff membership and privileges—such that termination of the employment triggers termination of the physician’s medical staff membership and privileges—may be another point of deliberation. As a practical matter, a physician’s medical staff membership and privileges may be meaningless after termination of employment, but by decoupling them from the physician’s employment status, the hospital could effectively put the physician on notice that his or her employment status and medical staff affiliation are distinct and that termination of employment will implicate only those rights under the employment agreement.

Severing the connection between the physician’s employment status and medical staff affiliation could also ward off the quandary of the hospital having to determine whether to report to the NPDB termination of the physician’s medical staff membership and privileges automatically occurring because of termination of the physician’s employment.¹⁰⁶ Even in those arrangements where the physician’s medical staff membership and privileges and employment status remain synchronized, the parties could bargain for a representation that the hospital will not report to the NPDB an automatic termination of the physician’s medical staff membership or privileges. While it is generally correct, as the hospital argued in *Langenberg*, that a hospital’s “reporting requirements under the HCQIA are not a matter that could be altered, waived, or otherwise bargained away through a contractual arrangement between [a h]ospital and a physician,”¹⁰⁷ HRSA’s guidance in the *Guidebook* suggests that such a representation would be acceptable because the automatic termination of the physician’s medical staff membership or privileges would not be a “professional review action” that would implicate the statute.¹⁰⁸

Ultimately, whatever terms the parties agree to, they should make sure to draft them with precision in the employment agreement. This may seem like an obvious point, but it warrants emphasis given the

¹⁰⁵ Scheutzow & Malone, *supra* note 99, at 5.

¹⁰⁶ See *supra* Part II.B.

¹⁰⁷ *Langenberg v. Warren Gen. Hosp.*, No. 1:12-cv-175-NBF, 2013 U.S. Dist. LEXIS 166183, at *21-22 (W.D. Pa. Nov. 22, 2013).

¹⁰⁸ See 2015 GUIDEBOOK, *supra* note 77, at E-40; *supra* Part II.B.

“[m]ultiple layers of contractual relationship between the parties”¹⁰⁹ References to the medical staff bylaws and related rules, regulations, policies, and procedures will be particularly important and should prompt review of the specific documents or provisions being referenced and determination of whether they track the terminology from relevant laws, such as HCQIA (as was not the case in *Langenberg*, to the physician’s detriment). Uses of “[l]anguage such as making the employment agreement ‘subject to,’ ‘except as otherwise stated,’ or ‘except as otherwise permitted’ by the bylaws” may create the situation, intentionally or unintentionally “where the terms of the employment agreement are superseded.”¹¹⁰ Yet, as *Woodruff* cautions physicians, even broadly worded requirements in the employment agreement for the physician to comply with the medical staff bylaws are generally insufficient, on their own, to render the procedures for medical staff peer review actions applicable to employment-based actions.¹¹¹

Finally, the impetus is on hospitals to think through the propriety and consequences of terminating a physician’s employment before doing so. Termination is a drastic measure, and as such, it may not be the appropriate response to remediate a problem with a physician. Particularly where a hospital has clinical concerns, the hospital may find that the medical staff framework—with all the corrective action powers at the medical staff’s disposal, such as the authority to convene investigative committees and subject a physician with deficiencies to peer supervision—may be more conducive to resolving the problem. As noted, moreover, going the medical staff route may have the added benefits of ensuring certain legal protections are in place and accruing physician buy-in toward the employment model. On the other hand, a quick, clean severance may sometimes be appropriate, such as where the physician is creating a disruption for other staff. Termination of the physician’s employment, potentially along with the physician’s medical staff membership and privileges, may be proper then.

In addition to the operational factors that will shape employment termination decisions, larger market forces will also critically affect the contentiousness of these decisions. For physicians in the post-health reform system, “it will be harder to revert to private practice if relationships sour, since new payment structures and care models will make it increasingly difficult for traditional private practices to remain

¹⁰⁹ Patrick D. Souter, *Hospital-Physician Employment Agreements and Medical Staff Bylaws: Potential Issues Resulting from Overlapping Contractual Obligations*, MEDSTAFF NEWS (Am. Health Lawyers Ass’n. Wash., D.C.), May 2014, at 1.

¹¹⁰ *Id.* at 2.

¹¹¹ See *Woodruff v. Haw. Pac. Health*, No. 29447, 2014 Haw. App. LEXIS 26, at *50–51 (Haw. App. Jan. 14, 2014).

profitable.”¹¹² Indeed, “[e]mployment choices that physicians make today may not be able to be undone.”¹¹³ Acknowledging this reality, hospitals should likely anticipate more challenges to their employment termination decisions, leading to the types of assertions in *Woodruff* and *Langenberg* that various procedures must be exhausted before the termination decision can take effect. As a spillover effect for hospitals, messy employment termination actions could undermine among already employed physician staff the very sense of collaboration and coordination that the employment relationship is meant to engender, and deter employment of other physicians. Clearly, termination of the hospital-physician employment relationship is not a matter to be taken lightly.

IV. CONCLUSION

Hospital employment of physicians continues to take further root in the healthcare landscape, yet the voluntary medical staff structure remains intact. Hospitals and physicians accordingly will have to confront questions about the physician’s dual roles as hospital employee and medical staff member, and the rights and responsibilities that attach to one role and carry over to the other. The pre-employment negotiation will be the best opportunity for the parties to sort through and reach consensus on these issues, including the applicability of traditional peer review protections in the medical staff context to employment termination actions and the duty to report such actions to the NPDB. Although the employment model is intended to give hospitals greater flexibility and control of physicians’ practice, hospitals are well advised to consider some type of pre-termination review process for their employed physicians, particularly in circumstances that involve clinical practice issues. Doing so could have a number of longer-term legal advantages and shore up goodwill among physicians. Once they have agreed to a set of terms, the parties should draft them carefully in writing in the employment agreement, avoiding vague, overly broad references to extra-contractual documents, such as the medical staff bylaws, which could muddle the parties’ understanding about which document supersedes the others. If and when the time comes to terminate a physician’s employment, hospitals should make sure a thorough decision-making process is in place, requiring due consideration of the reasons for the termination; any available alternatives, including disciplinary action initiated through the medical staff; and the risks of

¹¹² Kocher & Sahni, *supra* note 16, at 1790.

¹¹³ *Id.* at 1792.

liability. Taken together, these steps could go a long way toward facilitating the spirit of partnership the hospital-physician employment model is supposed to promote.