



Physicians as Employees: HR/Workplace Law Pitfalls and Best Practices

Presented by:

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Our Presenters

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Overview

- Trends in Physician Employment—Supply and Demand
- Increased Use by Hospitals of Employed Physicians and HR Pitfalls
- Navigating the Complex Legal Landscape and Avoiding Legal Pitfalls Involving Physicians as “Employees”
- Best Practices to Avoid HR and Workplace Law Pitfalls and Achieve Physician Alignment

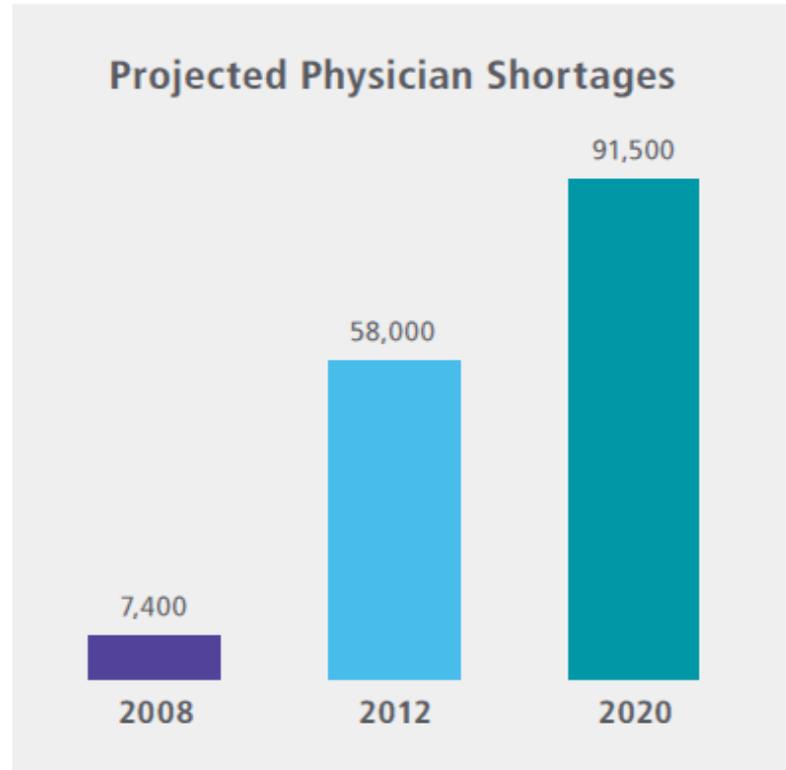
Statistics and Trends

The Physician Workforce in 2013



Source: AMA Physician Master File (2013)

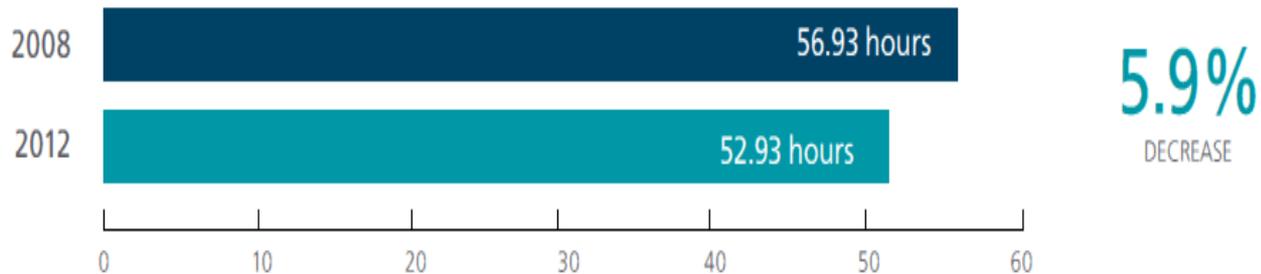
Projected Shortage of Physicians



Source: AAMC Physician Workforce Policy Recommendations, September, 2012

Fewer Hours Worked¹

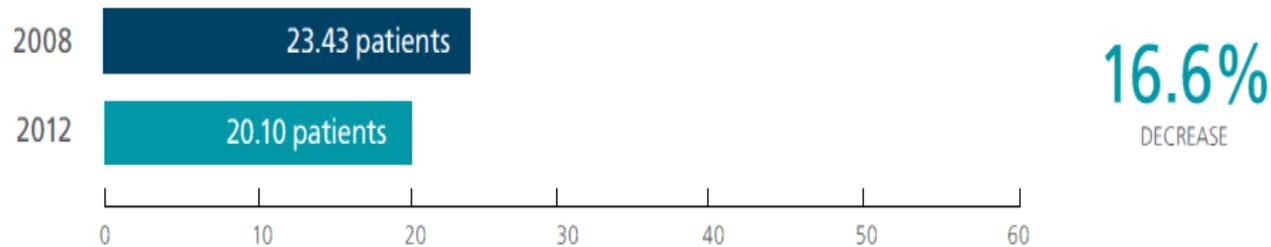
How Many Hours Do You Work Per Week?



¹ Graphs and survey data were provided by Merritt Hawkins from its *2013 Review of Physician and Advanced Practitioner Recruiting Incentives* and were reprinted with their express permission.

Fewer Patients Seen²

How Many Patients Do You See Per Day?



Source: A Survey of America's Physicians: Practice Patterns and Perspectives. The Physicians Foundation/Merritt Hawkins. September, 2012.

² Id.

Increased Demand Leads to More Direct Employment

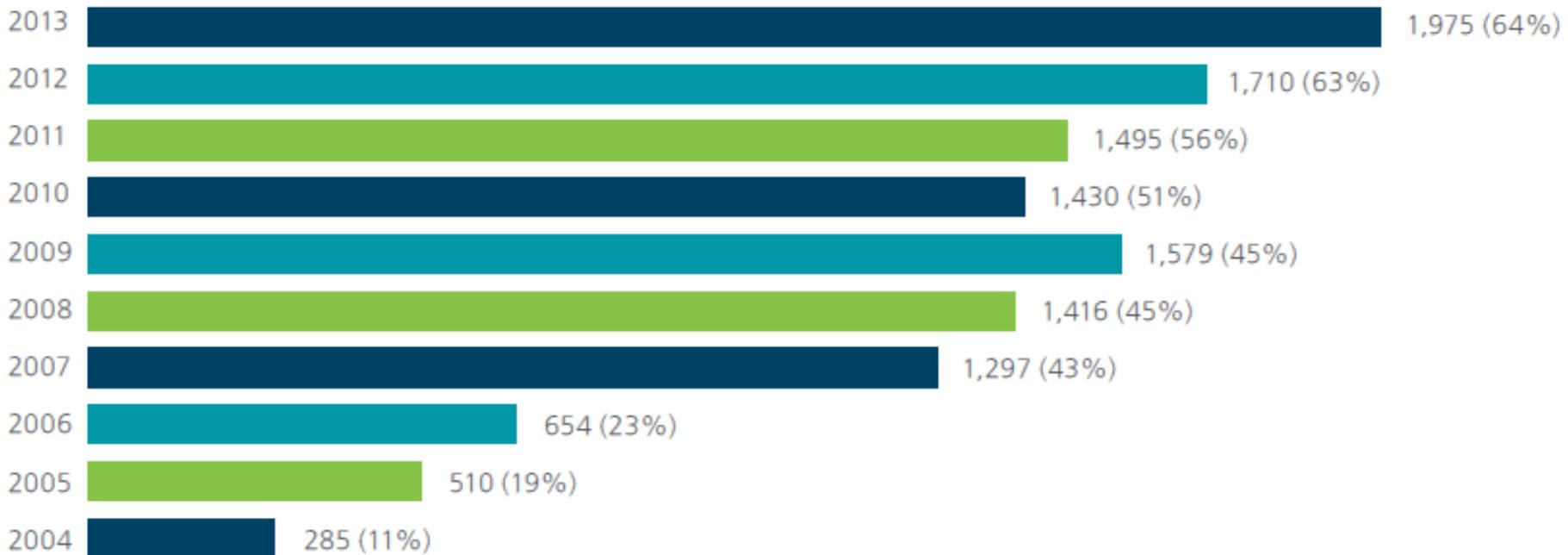
- Expansion and consolidation of healthcare systems has increased the demand for physicians especially given anticipated shortages
- Wanting to ensure continuity of in-demand specialties and drive admissions hospitals are bringing specialists in house
- Hospitals seeking to qualify as ACOs want to offer integrated networks with large panels of physicians
- Emphasis on more healthcare access has led to a proliferation of sites needing physicians to staff them
- Some hospitals hoped to enhance physician integration/alignment by making them “employees”

Why Physicians Are Seeking Hospital Employment

- Newer physicians want work/life balance and are less interested in high income and building their own practices
- Many practices are having difficulty surviving without the resources a hospital can provide
- For independent practices, millennial medicine means less financial reward, more management responsibility, costly technology, greater risk and the headaches of employing their own staff
- Hospitals are perceived as a safe haven

Growth in Hospital-Employed Search Assignments³

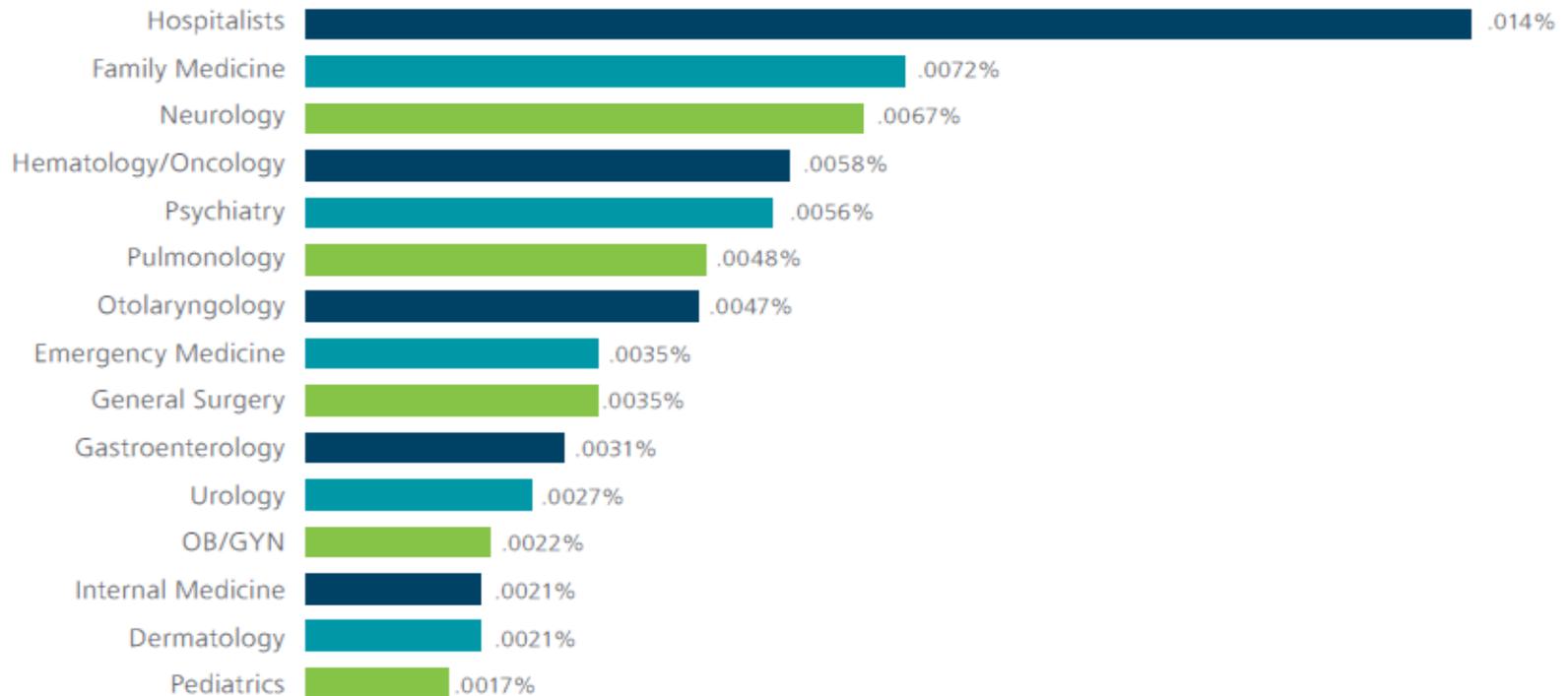
Merritt Hawkins Hospital-Employed Search Assignments



³ Id.

Top Searches by Specialty⁴

Merritt Hawkins' Top Physician Search Assignments as a Percent of All Physicians Per Specialty (patient care only)



⁴ Id.

Summary of Trends

- Shortages exacerbated by decline in productivity and physicians leaving patient care
- Medical school graduates will increase, but shortage of residency slots
- Greatest demand is for primary care docs (e.g. general internists, family, pediatrics) and hospitalists
 - ✓ Only one third of all physicians are primary care
 - ✓ Healthcare reform demand for greater access and integration reinforces need for primary care “quarterbacks” or “gatekeepers”
- Hospitals and institutional providers now the largest employer of physicians

HR Pitfalls: Expectations Conflict with Reality

Making physicians “employees” often has not met the hospital’s expectations:

- Since other hospitals were also hiring their own docs, no competitive advantage was gained by hiring specialist
- Hospitals have not realized gains—especially when productivity falls short of expectations—this stresses relationship between the hospital and physicians
- Sheer volume of employed physicians is difficult to manage--some hospitals have built out new HR infrastructure just to deal with them
- Employed physicians are different from other employees and create complex HR and legal problems
- Integration or alignment issues persist notwithstanding employment status

HR Pitfalls: Expectations Conflict with Reality

Many physician employees' expectations have not been met creating frustration and cause for conflict:

- Some hospitals say employed docs are the “least happy” and have the highest rate of EAP referral
- Employed physicians never thought of themselves as “employees” and expected greater independence “as physicians”
- Some bristle at “performance management” and being told “you’re not meeting productivity/quality expectations”
- Frustration may leads conflict, resistance to changes in care models, nonalignment with strategic plan, changes in care models, workplace disputes, litigation and possible unionization

Potential Interest in Unionization

DOCTORS COUNCIL
The Union for Doctors, The Voice for Patients

SEIU
Stronger Together

Doctors' Union
Patients' Voice

DOCTORS COUNCIL
SEIU
Stronger Together

**Physicians as Employees-
Many Challenges:
One Voice**

Doctors Council SEIU
50 Broadway, 11th Floor, Suite 1101
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Barry Liebowitz, M.D., President – Frank Proscia, M.D., 1st Vice President/Executive Director

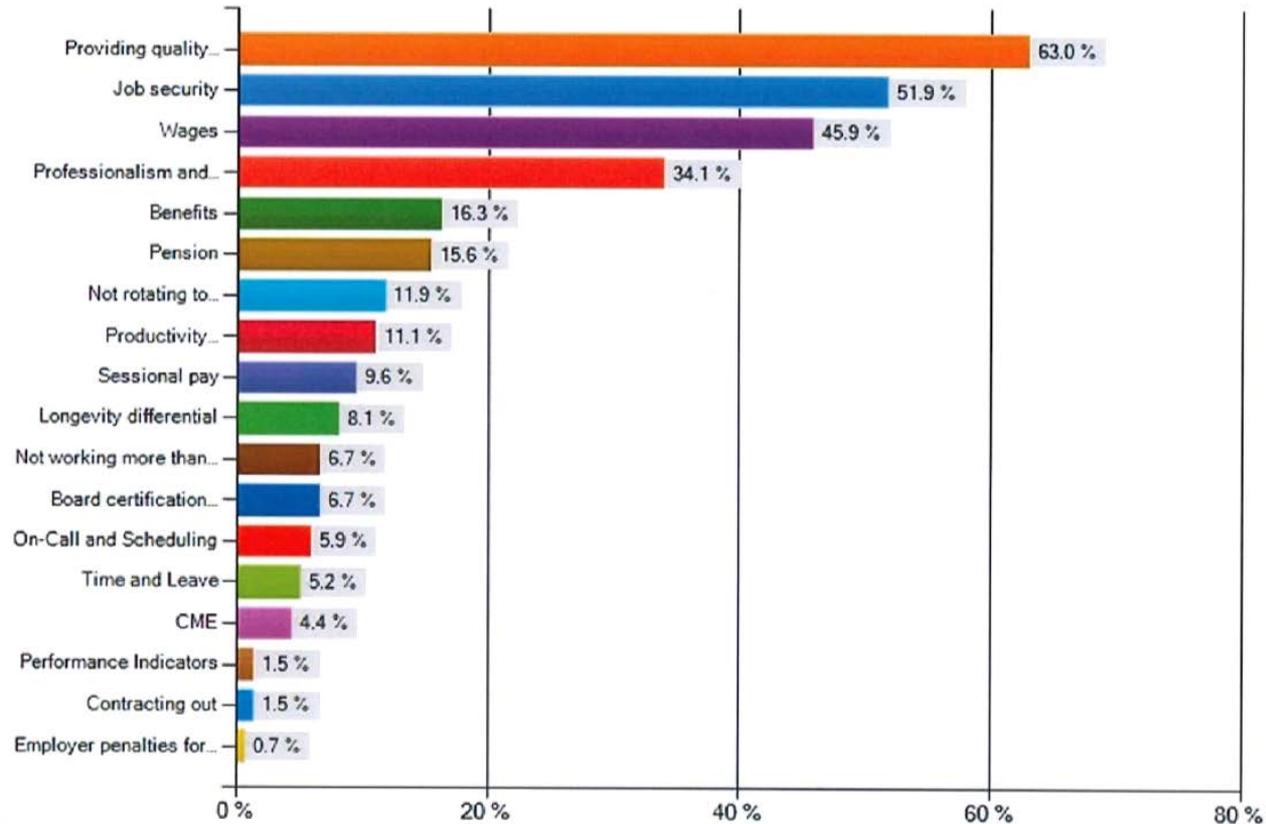
Doctors' Union
Patients' Voice

DOCTORS COUNCIL
SEIU
Stronger Together

Physician Reasons for Wanting a Union

(SEIU Doctors Council Survey and Presentation at Cornell Program Fall 2013)

From this list of issues, pick the 3 that you believe to be the most important.



Growth in Physician Unionization

- While still at a low level, union membership has increased by 25% over past 5 years from about 40,000 to 50,000
- By 2013, union membership was 6.6% of all physicians
- 9.5% now covered by union contracts

Union Membership and Coverage Database from the CPS ([Unionstats.com](http://www.unionstats.com)) Barry Hirsch, Georgia State University; David Macpherson, Trinity University. See <http://www.unionstats.com/>

New Legal Landscape of Employment Status

- Contractual Rights and Obligations Not Common to Most Employees:
 - ✓ Individual Contracts
 - ✓ Employment Policies
 - ✓ Medical Staff Bylaws
 - ✓ Possible Labor Contracts
- Employment Laws Now Apply
- Fewer Privileges and Immunities
- In addition, many of the same old issues—Whistleblower Protection/False Claims, etc.

Contract Terms—Pitfalls or Solutions

- Fixed Contract Term or “At Will”
- Compensation, Benefits and Insurance Coverage
- Scheduling, On-Call and Outside Interests
- Education and Training
- Professional Judgment and Independence
- Institutional Support
- Arbitration—Pros and Cons
- Termination Upon Notice With or Without Cause
- Severance, Continued Health Insurance and Tail Coverage, Executed Release
- Termination/Non-Renewal Leads to Loss of Privileges and Vice Versa
- Non-Compete, Non Solicitation

Employment Laws—Now Apply to Physicians, “as employees”

- **Title VII and State and Local FEP Laws**
 - ✓ No immunity
 - ✓ None or diminished peer privilege
 - ✓ Jury trials
 - ✓ Compensatory and Punitive Damages
 - ✓ Class Actions
- **Age Discrimination in Employment**
 - ✓ OWBPA

HR Professionals are well-verse in these employment laws, but the application to employed physicians may be challenging. In addition, the Medical Staff Executive Committee’s independent decisions and actions can complicate matters and they may insist upon independence and their own counsel.

Pitfalls: Federal, State and Local Disability Laws (ADA)

Discrimination—Prohibits discriminating against a qualified individual (applicant or employee) with a disability or perceived as having a disability.

Reasonable Accommodation—Hospital must engage in an interactive dialogue with the individual to determine the nature of limitation and offer a reasonable accommodation if one can be made without an undue hardship. One accommodation may be a leave, but it does not foreclose or preempt other forms of reasonable accommodation.

Both HR and MEC may be involved in determining “reasonable accommodations that may impact patient care. In addition, it also may affect staff privileges which only the MEC may decide.

Pitfall/Best Practice The interplay of the Medical Staff process and the HR process may frustrate a timely resolution of many employment issues. A strategic way to manage these conflicts is to negotiate a process agreement between the Hospital and MEC.

Pitfalls: Disability Laws

Credentialing—Under the Medical Staff Bylaws, the Medical Staff Executive Committee is responsible for credentialing physicians. This includes a medical assessment of fitness for duty which often begins with a questionnaire regarding the applicant’s physical and mental history and condition.

Some of the questionnaires in use now make unjustifiable and illegal inquiries regarding an individual’s disabilities. These forms should be reviewed by counsel. See Medical Society of New Jersey v. Jacobs, 2 AD Cases 1318 (Dist. Ct NJ 1993)(State Board subject to ADA)

Privileges- MEC also determines whether to grant, deny, suspend or limit privileges. Courts have held that an denial or loss of privileges allegedly based on “disability” did not violate Title I of the ADA relative to independent contractors. However, it surely applies to employed physicians.

Federal Family and Medical Leave (FMLA)

Under federal law an employed physician, as any other employee, is entitled to **up to 12 weeks of unpaid, protected leave** if they are unable to work due to their own serious medical condition or to care for a newborn or newly adopted child or an immediate family member with a serious medical condition, as long as they have been continuously employed for **at least a year and have worked at least 1250 hours within the prior year**. Some state laws are more generous.

If the employee returns within the 12 week period, he or she is entitled to reinstated to their former position.

HR Professionals are well-versed in the FMLA, but the application in the case of employed physicians may be challenging especially in dealing with intermittent leaves.

Other Employment Laws

- Federal and State Wage and Hour Laws
 - ✓ Overtime and salary basis test and class actions
- Federal Contractor Employer Obligations
 - ✓ Affirmative Action
 - ✓ Executive Orders Promoting Unions
- Federal and State Fair Credit and Reporting
- Federal Immigration Laws/IRCA
- Veterans Rights Laws (USERRA)
- Workers Adjustment and Retraining Notice (WARN)
- Whistleblower Protection Laws

Case Study: Competence/Fitness versus Discrimination

- Employed physicians aged 40 and older are protected by the ADEA against discrimination based on age.
- They also are covered by other anti-discrimination laws such as the ADA and FMLA. There are a growing number of senior physicians.
- Under the medical staff bylaws, the competence of any physician is a concern and subject to review by the Medical Staff Executive Committee and yet the Hospital's responsibility through its HR Department to ensure compliance with the ADA and FMLA and other applicable laws.
- What is the issue and who decides it?
- **Case Study: Stern v. St. Anthony's Health Center, 2013 WL 596746 (S.D. Ill. Nov. 8, 2013)(ADA & ADEA)**

Unionization and Protected Concerted Activity

- Employed physicians have long been covered by Federal and State Labor Laws
- Under the National Labor Relations Act, as amended, employed physicians within the private sector have the following rights in order to promote their mutual aid and protection:
 - ✓ To join, support and assist a union or refrain therefrom
 - ✓ To engage in protected concerted activity or refrain therefrom
 - ✓ To strike or boycott

This right is not limited to union activity—it covers a growing number of cases where non-union represented employees engage in **protected, concerted activity for their mutual aid and protection** where no union is sought or involved, “union-like” activity (e.g. social media cases)

Case Study: Protected or Unprotected Activity?

Family Medical Practice employed a number of physicians under employment contracts for a fixed term. The contracts were similar and expired at the same time. Near the end of the contract, the practice manager announced the terms of the new contracts.

One of the physicians had concerns and spoke to her colleagues about proposing better terms. They all agreed they should demand these better terms. This physician then met with the practice manager and said she was speaking for the group. She informed him that they wanted these changes to the contract. When the time came for the new contract to be issued, she was told her contract would not be renewed.

What legal issues are presented? Did the employer have the right to not renew the group leader's contract?

Family Healthcare, Inc. 354 NLRB No. 29 (2009)

Workplace Law Pitfall: Interplay of Medical Staff and HR Processes in Dealing with Disruptive Physician

- Clinical Issues v. Bad Behavior and the overlap
- Issue of who complains and over what
- Patient, staff and colleague complaints
- Investigations and peer review issues

Case Study: Bad Behavior in Patient Care Area

Physician Smith is a senior member of the surgery department. He is respected in his field and has been recognized by a news magazine as a “Best Physician.” However, Dr. Smith “suffers no fools” and is erratic and manic when under stress.

Last week, in the surgery suite, he became unglued when a surgical nurse misinterpreted his directions and she began a procedure prematurely on the patient. Dr. Smith screamed and threw a scalpel across the room and it stuck in the wall. He then ordered the nurse to get out and threatened to tell everyone what an idiot she was.

After the surgery, he still continued by taunting the OR nurses and angrily throwing mints, paper clips and other office supplies at the nurses. The Chief Nursing Officer immediately called the Chief of Surgery and then VP of HR requesting corrective action. The Chief requested to meet with X in the morning. The HR VP initiated an investigation. Who should handle this and how?

Privileges and Immunities and National Practitioners Data Bank

- **Health Care Quality Improvement Act (HCQIA)**

In 1986, HCQIA was enacted in response to the incredible volume of suits filed by physicians against hospitals and peer review committees following their loss of privileges and/or employment due to the recommendations or actions of a professional review committee.

- **Limits on Peer Review Privilege**

- **National Practitioners Data Bank**

- ✓ Mandatory Reporting to NPDB
- ✓ Providers Required to Request Data on Physicians
- ✓ Providers Required to Recheck Data on Physicians

Best Practices to Avoid HR/Workplace Law Pitfalls and Promote Physician Alignment

- Create a structure that promotes physician integration and alignment from the Top Down
- Orient all physicians to the organization's strategic vision, culture, values and mutual expectations
- Educate physicians, leaders and managers on code of conduct, corporate compliance, employment law issues, human resources policies and the practical application of them

Best Practice Contracts

- Promote your “best in class” physician contracts, mutuality, balance and terms that align with hospital’s mission, quality care, institutional support, professional development and support for community activities
- Incorporate by reference hospital and medical staff bylaws, code of conduct; condition continuation of employment with continuation of privileges and vice versa, arbitration with due process and confidentiality, terminations with notice, with release and reasonable non-compete/non-solicitation based on the facts

Dedicated HR Support for Physicians

- Dedicated Physician HR Manager with staff to provide HR services re: compensation, benefits, counseling, problem-solving procedure and EAP
- Liaison with Medical Executive Committee with a process sharing agreement to reconcile different roles and use existing HR assets and process for routine HR Matters (e.g. leave management)

Communications and Climate Surveys

- Create and implement ongoing communication (e.g. in-person, social media, web-based, physician led), recognition and social programs to draw physicians into the organization and its culture
- Consider focus groups and periodic climate surveys to monitor and assess engagement and detect issues requiring correction



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