Peer Review and the Hospital Employed Physician

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Employed Physician Trends

- In 1975, 78% of all physicians were in solo or two-person practices
- In 2008, only 25% of all physicians were in solo practice; 21% in groups of 2 to 4
- Over 5-year period from 2005 to 2010, hospital-employed physicians nearly doubled from 23% to 45%

- 2012 survey from AAMC showed 1 in 100 of medical school graduates planned solo practice
- Currently, 80% of medical school graduates want salaried employed positions
- Anticipated that 75% of newly hired physicians will become hospital employees
- Steady increase in proportion of physicians who no longer do any inpatient work
History of Employed Physicians

• In the 1990s many hospitals started employing physicians to create integrated networks to provide care in capitated systems.

• Hospitals largely overpaid for those practices, failed to create effective integrated systems, and the practice stopped.

Current Physician Employment

• Healthcare reform makes increased integration efforts more likely.

• Physician employment likely here to stay.

• This requires looking at the elephant in the room -- how do we address employment-related issues.

The World We Used To Live In

• Physician is independent from the hospital.

• Relationship is defined by the medical staff governing documents:
  • Any limitation on ability to practice is limited to voluntary agreements or formal corrective action.

• Hospital liability is limited to negligent credentialing.
The World We Used To Live In

- Medical staff process is managed by the medical staff
- Medical staff peer review information is not provided to any other internal department or external entity
- Process has attendant procedural due process rights and potential reporting issues

The World We Are Moving Into

- Physician is employed by the hospital
- Relationship is defined by employment law, the employee handbook, and the employment contract
  - Paid (or unpaid) leave is now an option
- Hospital liability includes both vicarious liability and negligent credentialing

The World We Are Moving Into

- Physician may or may not need to be on the hospital’s medical staff
- Information may need to be provided to other internal departments or external entities
- Ability to practice may, at times, be limited without resorting to medical staff procedural due process rights and may or may not create reporting issues
An Example

Dr. Cardio is employed by Heart Hospital
- Poor documentation
- EMR problems
- Has drop kicked a computer monitor in the course of screaming at others

Peer Review’s Purposes

- To foster appropriate critiquing of patient care and of a practitioner’s credentials
- To have an effective educational tool to improve future patient care
- To insure open and candid evaluations without fear the information will be subsequently used:
  - Against the reviewed physician (malpractice)
  - Against the reviewing physician (defamation)
  - Against the entity (antitrust, credentialing)

Peer Review

- A process designed to improve the quality of health care
- Necessary to have participation from doctors, nurses, hospital administrators, and other providers
- To accomplish the goal of improving the quality of care health care, state legislatures have provided statutorily created privileges that protect the peer review process
What the Privilege Gives You (generally)

• Proceedings and records of a peer review committee must be held in confidence and are not subject to discovery in a civil action against the entity or the provider
• Individuals cannot testify as to what he or she said or heard in a peer review proceeding

What the Privilege Does Not Protect

• Because privileges are recognized under state law, federal law does not require a federal court to recognize a state privilege
• Non-peer review purposes (e.g., risk management? employment?)

How To Protect Your Process

• Follow the process outlined in your state’s peer review process
• Educate, Educate, Educate
• Remember that a health care entity that is asserting the peer review privilege will have the burden of establishing the applicability of the privilege
A Few Examples (Ohio)

The Statute’s Requirements:
• A health care entity;
• Conducts, as part of its regular business activities, professional credentialing or quality review activities;
• Involving the competence of, professional competence of, or quality of care provided by health care providers; or
• Conducts any other attendant hearing process.

A Few Examples (California)

The Statute’s Requirements:
• A “peer review body;”
• Reviews the qualifications, staff privileges, employment, medical outcomes, or professional conduct of an individual;
• To determine whether the individual may continue to practice, or assess and improve the quality of care.

A Few Examples (Washington, D.C.)

The Statute’s Requirements:
A process in which health care facilities, group practices, and health professional associations
• Monitor, evaluate, and take actions to improve the delivery, quality, and efficiency of health care;
• Including recommendations, actions, and implementation of recommendations.
The Employment Problem

When primarily dealing with independent physicians…

- Hospital addressed concerns related to those physicians through the medical staff corrective action process with attendant fair hearing rights, which was subject to peer review.

When dealing with employed physicians…

- Hospital may address concerns related to a physician's ability or behavior and some of those may not be subject to peer review.

Employment Pink Elephants

- Termination of employment does not need to be reported to the National Practitioner Data Bank
- Termination of employment does not trigger procedural due process rights pursuant to the Medical Staff Bylaws
- Termination of employment gives the employee the right to go directly to court
- An employment file will most likely not be protected by privilege

Employment-Related Issues

- Human resources may take an active role in managing the physician
- A hospital administrator may be in a supervisory role over the physician (e.g., not only manages the hospital, but also manages the affiliated ‘professional corporation’)

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Triaging Concerns

How do you first capture a concern to decide who should handle the issue?

Who is best qualified to address this issue?
- Claim by physician employee of discrimination
- Claim by hospital employee of discrimination by physician employee
- Quality of care concerns
- Behavior concerns
- Compliance concerns

• May consider establishing a ‘triage’ committee

• This office will review all issues that are presented at all levels of the organization and simply decide the appropriate place to “house” any necessary investigation

• Requires advanced planning and preparation

Advantages of Central Triage:
- Ease of education for managers
- Greater understanding of peer review protection
- More uniformity in how matters are handled
- Better communication between different departments of hospital
Sharing Information Internally

If your hospital consists of more than one entity, do any of these apply:
• Physician employed at provider-based location
• Physician employed at non-provider-based location with appointment and privileges at hospital
• Physician employed and also on PHO panel
• Physician employed and also has privileges at a joint venture ambulatory care and/or surgery center

Sharing Information Internally

Should an action at one location impact the ability of a practitioner to practice at another location?
• Summary suspension
• Termination
• Recommendation to terminate
• Voluntary agreement not to exercise
• Being placed on a quality-focused professional practice evaluation

Third-Party Requests

• Do the same rules for disclosure apply to physicians as would apply to any other employee?
• What about peer review information?
• Do you maintain an employment file and/or a quality file on the physician?
Third Party Requests

For example:

- Hospital A employs Doctor X (a surgeon) in a professional corporation controlled by Hospital A. Quality of care concerns arise at Hospital A. PC terminates Dr. X prior to the quality of care concerns coming before the MEC. Hospital A’s Medical Staff Services receives a reference query from Hospital B. The PC receives a reference query from Hospital B regarding Dr. X’s employment?
  - How should you respond?

Peer Review Employment Process

- Creation of separate peer review process for “employment side”
- Potentially provides “best of both worlds”
- Provides potential ability to share information

Peer Review Employment Process

- Create a peer review committee
  - Should you make it a committee/subcommittee of the Board
- Create a process for capturing complaints when they are first presented
  - Should you designate agents to act by or on behalf of the committee
Peer Review Employment Process

- Create screening quality criteria (clinical and professional behavior)
  - E.g., appropriate completion of medical records (legible, vital statistics, diagnostics, proposed treatment, ordered medications, etc.)
  - E.g., appropriate ordering of medications, protocols

Peer Review Employment Process

- Create remediation process
  - Voluntary
  - Written plan of improvement with timelines and goals
    - E.g., if goals met, plan closed
    - E.g., if goals are not met, human resources advised (but not provided with details)

Peer Review Employment Process

- Determine what information will be disclosed to Human Resources in this era of transparency
  - The more specific you are as to what is being shared and what is being protected, the better chance you have that the courts will agree
Peer Review Employment Process

• Determine what language should go into employment contract regarding reasons for termination
  ▪ E.g., practitioner recognizes and agrees to peer review committee final quality determinations as basis for termination (without access to underlying data)

Case Study #1

Dr. Emma Ployee, has been an employed hospitalist for the last 6 months.
• PRC has 4 cases raising quality concerns.
• 2 incident reports have been filed by nursing involving code situations where Dr. Ployee seemed to be unsure of herself and another physician had to be called to assist.
• PRC decides to put her on focused review. PRC Chair tells Hospital CEO.
• Hospital CEO says, “No need. I’ll take care of this.”

Case Study #1 (continued)

• CEO exercises 60 days without cause termination provision of Dr. Ployee’s contract.
• PRC does not implement focused review because CEO says that there will be a back-up hospitalist available for the remaining 60 days.
• Variation: PRC also does not advise Dr. Ployee of its concerns.
• A code occurs. Dr. Ployee is unable to intubate patient. The “back up” is a physician assistant who is not privileged to intubate patients. Patient suffers an anoxic brain injury.
Case Study #2

A hospital has a separate foundation which employs a group of primary care physicians (including Dr. Proud Mary), all of whom have privileges at the hospital, but who usually admit their patients to the hospitalists.

- Several of the hospitalists approach the Chief of Staff with clinical concerns about Dr. Mary.
- Chief of Staff tells the CMO who is also the Administrator for the foundation.

Case #3

Dr. Heeza Skreemer has held a medical staff appointment and clinical privileges at Hospital Healthy for many years. Because of his age, national origin or religion, he would be able to raise a civil rights claim.

- He has been the subject of many discussions regarding his disruptive behavior—yelling, belittling, inappropriate medical record entries, etc.
- No corrective action to date because he is litigious and has a huge practice.
- Hospital decided to implement a service line strategy that results in Dr. Skreemer becoming an employee of the hospital.
- Incident report filed regarding inappropriate behavior and presented to MEC.
- MEC refers problem to the CEO.

QUESTIONS?

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