

# The Neville Chamberlain Analysis: The Legal Consequences of Physician Security at Any Price

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People don't like uncertainty. Sociologists teach us that structural ambiguity motivates individuals to seek security and certainty.

It's difficult to imagine an industry with a more uncertain future than American medicine. Congress passes laws, and agencies issue regulations by the ream. Third-party payers behave more and more like slot machines in the Las Vegas airport. Patients misinterpret the complexity of medical care using Google searches. What a quandary! Who wouldn't want to hit the Staples "Easy Button"?

The sea change in their practice environment has caused many physicians to consider trading the risks and rewards of private practice for the "safety" of hospital or salaried employment. While there are many factors to consider, and no universally correct answer to choosing a career path, physicians must look carefully at the legal consequences of trading private practice for hospital employment.

## Non-compete Clauses

The first and most obvious relinquishment of legal rights comes from the "non-compete" clause. This contractual term prohibits physicians from going back into private practice in the community that is served by the hospital employer. The idea is that the hospital provides patients and helps develop physicians' practices within the hospital system. The hospital then ensures that physicians don't depart from the facility with patients, which the hospital views as its property. Hospitals and insurance companies often act as though they own the patients.

Non-compete clauses have three parts: 1) description of services covered; 2) duration; and 3) geographic area. Description of services is rarely an issue. Most non-compete clauses define services as "the practice of medicine." This means that a physician cannot claim a different specialty and move across town to open a private practice. Next is the length of time after leaving hospital employment a physician must wait to practice in the hospital's area—typically one to two years. Finally, the geographic area is usually determined to be a radius around the hospital of a certain number of miles, not uncommonly 25 to 50 miles.

Typical non-compete clauses effectively force the former hospitalist to relocate to another community to continue to

practice medicine. The non-compete clause is a major downside to becoming a hospital employee. Such clauses intentionally foreclose opportunities that may induce a hospitalist to leave. Trading away potential opportunities for short-term benefits often proves highly disadvantageous in retrospect.

A word of caution: do not discount the likelihood of a hospital enforcing a non-compete clause. Some physicians wrongly assume that they will be able to negotiate their way out of a non-compete clause when exiting hospital employment. They may reason that "the hospital won't fight me on this because I will continue to refer some cases to the hospital." The financial implications for the hospital, however, are larger than any one individual contract, as it is probably a party to dozens of non-compete clauses. If one physician leaves without consequences, it could encourage others to do the same.

Further, non-compete clauses typically use boilerplate language. If one litigant successfully voids a non-compete, others will use that case's arguments against their own contracts. This puts the hospital in the position of having to litigate fiercely to defend the validity of any individual non-compete clause. This means that physicians hoping to get out of a non-compete clause either voluntarily or through litigation should prepare for a long, expensive fight. During the fight, the physician should be prepared to be enjoined (ordered by the court) not to practice in violation of the contested clause. This means the physician will be legally bound by the clause, even while challenging it in court. As one physician in a non-compete fight put it, "This is a total disaster. Even if I win, I still lose."

## Professional Liability Coverage

One of the more problematic areas, which is seldom if ever discussed, concerns professional liability. Employed physicians can expect to receive professional liability coverage as part of their employment benefits. This looks great on the surface. Who wouldn't want to have others worry about the future premium increases for liability coverage? All policies, however, are not the same. Most physicians in private practice have a "consent to settlement" provision in their liability policy. This provision states that a medical malpractice claim pending against the physician may not be settled without the

physician's consent. This prevents a liability carrier from settling a claim at low dollars to avoid costly defense expenses. Policies provided by hospital employers may not contain the "consent to settle" provision, meaning that if a physician employee is sued for a malpractice claim, that claim could be settled without the physician's consent, or even prior knowledge. There are even some policies that require a common defense—i.e. for the hospital and physician to be represented by the same law firm, in order to save costs. If both hospital and physician are sued, and the hospital decides to assign all the liability to the physician, there may be little the physician can do to prevent it.

It really does matter if a defensible claim is settled. All settlements against a physician must be reported to the National Practitioner Data Bank (NPDB). This means that there will be a permanent record of the physician being sued, along with the settlement awarded. The NPDB can be accessed by a number of organizations, including potential future employers and accreditation committees. Also note that any time the physician applies for privileges, new liability coverage, or a medical license in a new state, the settlement will have to be disclosed and explained. The whole idea of the "consent to settle" clause in a liability policy is to allow the physician to have some control over his permanent record. Hospital employment may strip away this right.

Additional liability considerations come with being a hospital employee. Some argue that hospital employment increases the likelihood of being named in medical malpractice actions. Depending upon the type of liability coverage a physician has prior to hospital employment, "tail" coverage may be needed. If the policy is "occurrence based," no additional coverage will be needed when transitioning to a different setting. However, with "claims made" policies, coverage pertaining to the time the alleged malpractice occurred must be in effect at the time the malpractice claim is filed. Therefore physicians should be aware that moving from private practice to hospital employee status might mean that they will need to purchase "tail" coverage for actions that may be filed after the physician has left private practice. Then, should a physician become dissatisfied with employment at the hospital, he may need to purchase "tail" coverage for events that occurred during employment that result in claims filed after termination. All of this equates to a large expense that many physicians do not factor into the cost-benefit analysis of transitioning from private practice to hospital employment.

### Other Contractual Pitfalls

Physician-hospital employment contracts often do not specify where the physician will see patients. With many

hospitals having satellite facilities, physicians may be surprised to learn that they can be legally assigned to treat patients at satellite locations. The physician, who has for some years been on staff at a hospital, may reasonably assume that employment at that hospital would mean a practice based in a familiar setting. Yet he may be informed that he will be seeing patients twice a week at a satellite facility 35 miles away in a community he has never visited. This is symptomatic of the general loss of autonomy physicians experience when trading their private practice for employment with a hospital. It is telling that the law refers to the employer/employee relationship as a "master, server" relationship.

Physicians may be surprised to learn of additional expectations not covered in the recruitment materials. Here is a problem that one physician encountered:

A surgical specialist was recruited to a hospital and provided with a lucrative contract. The hospital had a need for that specific surgical specialty and looked forward to expanding its services and revenue. Upon gaining privileges in the surgery department, the physician was informed that he would be expected to take general surgery backup call in the emergency department. The hospital administration put pressure on the physician to accept general surgery backup call, and when the physician stated that he was not comfortable treating general surgical emergencies that he had not treated since residency, and then failed to bring in the anticipated revenue, the hospital initiated a sham peer review and terminated the surgeon. That surgeon's career is now over.

Yet another potential pitfall of physician employment is that some contracts require the physician to waive any due process (i.e. peer review) should the hospital decide to terminate the physician's employment contract based on quality-of-care concerns or professional conduct. This can result in an adverse action report to the NPDB, which can end a physician's career.

### Conclusions

For many physicians it is seductive to think of transferring administrative duties and financial risks to a hospital, and they already know private practice's downside. They need, however, to weigh carefully the costs of perceived security, in both forgone opportunities and legal risks. They need to read proposed contracts very carefully.

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