American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships

An Information Paper

The concept of "due process" is complex and often confusing. Its multiple components present us with an array of problems that may require varying solutions. Failure to distinguish and better understand these component issues impairs the focus necessary for emergency physicians to pursue creative, productive resolutions.

This information paper will identify 1) the issues relevant to emergency medicine, their origins and manifestations, and 2) external factors affecting the issues.

I. Fundamental Issue

For many emergency physicians, "due process" appears to be a catch phrase for "fairness in dealing." A definition and discussion of due process and related issues appears in Section III.

Since the parties who are dealing have different needs and goals, there is inevitably tension in their relationships. What seems reasonable and fair to one party may appear to be unreasonable and unfair to another. Some examples are provided in Part V below.

II. Background

A. Practice Relationships

Emergency medicine practice situations are generally comprised of several key entities joined in varying relationships: 1) hospital, 2) ED contract group, 3) individual emergency physician and 4) managed care organization (eg, IPA, PPO, HMO). Each entity must relate to the others. Interests and incentives may be aligned or at odds.

Security is of great importance to each of the parties involved in an emergency medicine practice situation. The various relationships may or may not be subject to prevailing law, regulations, customary practice, applicable codes of professional ethics, and mutual agreement. The fact that the provision of medical services is a business is not always recognized by advocates of due process as it applies to emergency medicine. "Closed departments" such as hospital emergency departments add yet another element of complexity to the discussion of due process. Unique considerations, outlined below, characterize the various emergency medicine practice relationships.

1. Hospital/Practice Group

In this relationship, the hospital is engaging in a business arrangement with a group or individual that will provide emergency physician staffing. The prime concern of the hospital is that its interests be preserved, and its concerns protected. Usually, the hospital will want a single

accountable contact person on the contractor side through whom it can deal. Rarely does due process apply to hospital/group relationships; most such contracts contain "termination without cause" clauses that allow separation at the sole discretion of the hospital. This reflects the fact that hospital/group relationships are primarily business in nature.

2. Hospital/Physician

This relationship involves the hospital relating to the individual emergency physician through the organized medical staff and physician credentialing process. The hospital's main goal in this relationship is to ensure that the physicians practicing within that institution are adequately trained and licensed and that quality of medical care is maintained. Except in those departments the hospital decides to maintain as "closed departments," a physician meeting credentialing requirements and maintaining quality care generally is allowed to join the medical staff, enjoying the rights, privileges, and responsibilities of practicing medicine within that environment.[1] Physicians generally may not be denied privileges in an "open" department unless they fail to meet announced credentialing criteria or practice in an unsafe or unprofessional manner. They generally must be accorded a *bona fide* due process review before being terminated from the medical staff. Ultimately, the medical staff bylaws define and provide the due process rights. Of course, the bylaws should reflect applicable law and accreditation standards.

The hospital is also concerned about how the physician affects the hospital's business. A hospital may be particularly concerned about controlling hospital-based physicians because such physicians may substantially affect the hospital's business. A hospital-based physician often interacts with many hospital patients and may, as an ostensible agent, create liability for the hospital. For example, a hospital could be liable for the malpractice of an independently contracting emergency physician if the patient looks to the hospital, not the individual doctor, for care and accepts whichever physician is assigned to his case.[2] Business problems are usually raised with the practice group rather than the individual physician.

3. Group/Physician

The group holding the ED contract and the individual practicing emergency physician have what is primarily a business relationship. Due process may or may not apply and depends largely on whether it is specifically dealt with in the contract binding the physician to the group. Many contracts between these parties include a "termination without cause" clause for the same reason that hospital/group relationships do: from a strictly business standpoint it makes sense to "mirror" the analogous concept in the hospital/group contract. However, many variations of contract entities exist (partnerships, single owner corporations, multiple owner corporations, etc.), and whether due process exists depends on agreed-upon terms that bind the parties.

4. Group & Physicians/Managed Care

As emergency physicians increasingly become involved in managed care arrangements, another due process issue will arise: decertification by the managed care organizations (MCOs). An MCO can and will drop a physician from its provider list for a variety of reasons, including

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[1] There may be other legally acceptable reasons for denying a physician staff membership. For example, some jurisdictions allow a hospital to deny membership to an applicant because the hospital already has too many physicians in that specialty or the physician does not meet other economic criteria.

[2] See, e.g., Stipp v. Kim, 874 F. Supp. 663, 665 (E.D. Penn. 1995); contra Coleman v. McCurtain Memorial Medical Management, Inc., 771 F. Supp. 343 (E.D. OK la. 1991).

over-utilization of services, poor quality of care, and excessive patient complaints. Decertification or deselection often occurs without an explanation and almost always without any due process rights or any right to challenge the decision other than by a request for reconsideration. However, some jurisdictions are now directly or indirectly (e.g., through state regulation of the MCO or case law) providing some due process protection to physicians. (See, e.g., Texas HMO Act; Potvin v. Metropolitan Life Insurance Co. Calif. Ct. App. # B/0D17, 4/30/97.)

In summary, these relationships that typify an emergency medicine practice create a complex set of contractual interactions. Due process considerations may apply to all or just one of these relationships. Generally, due process considerations must apply to relationships where strictly professional and licensing rights are being discussed. Due process may apply to business relationships, but if it does it generally is spelled out as a negotiated aspect of the contract.

III. Components

Emergency physicians are often concerned about aspects of their business and career relationships.

A. Decision-Making Criteria

One aspect is the fairness of criteria used for taking action and making decisions. An emergency physician who is unfairly terminated may be substantially harmed, perhaps because the physician's professional relationships are interrupted or, given the limited number of EDs, the physician must relocate his or her personal residence to another city. Some emergency physicians believe the items listed below exemplify unreasonable criteria for a hospital to terminate a practice group or a group to terminate a physician, while others believe it may be appropriate to terminate a relationship on the basis of one or more of these criteria:

1. Failure to reduce ancillary service utilization for capitated patients. (There is usually disagreement about the appropriateness of the utilization.)
2. Abrasive personality or dislike by the medical staff, neither of which interfere with the quality of medical care.
3. Excessive patient complaints about issues not related to quality of care.
4. Transfer of an exclusive contract to another emergency practice group.
5. Refusal to follow patient triage or other clinical protocols whose scientific basis is questioned, at least by the terminated party.

B. Due Process

Due process refers to the fairness of the means (the procedure) used to implement the criteria for taking action and making decisions. Consider, for example, an emergency practice group that terminates an individual physician pursuant to a "no cause" termination provision in their contract. Some physicians believe that fairness requires the group to give the individual an opportunity, perhaps a hearing, to challenge the termination.

Although some emergency physicians argue that they are entitled to "legal" or "constitutional" due process, under the law they typically do not have due process rights unless such rights are specifically included in the physician's contract.

Due process generally includes these elements:

1. A statement or listing of the charges made against the physician.
2. Adequate notice of the right to a hearing and a reasonable opportunity to prepare for the hearing.
3. A responsible hearing body that conducts a fair, objective, and independent hearing pursuant to established rules.

4. Rules of procedure that clearly define the extent to which attorneys may participate.
5. The opportunity to be present at the hearing and hear all the evidence.
6. The opportunity to present a defense to the charges.
7. A decision by the hearing body that is based on the evidence produced at the hearing.
8. The right to provide a written statement at the end of the hearing.
9. Recognition that in any hearing the interest of the patient and the public must be protected (See AMA Policy "Guidelines for Due Process" last modified in 2018.)

It is uncertain, though doubtful, that most emergency physicians believe all these steps should be rigidly followed when a hospital terminates a practice group, or a practice group terminates a physician.

IV. Parties Involved

As previously discussed, various relationships are generally involved: hospital/practice group, practice group/physician, hospital/physician and group and physician/MCO, with each relationship having conflicting needs and goals. For example, a practice group may resist a "clean sweep" provision (described below in part V.B) in its contract with the hospital but insist on including the provision in its contract with the individual physician. Without a "clean sweep," it is more difficult for a hospital to terminate a group and attract a replacement, since the terminated group could stay on and compete. With a "clean sweep, "it is easier for a group to terminate a physician. The physician could not stay on and compete.

V. How the Issue Is Manifest -- And Why

There are many ways to limit due process for a group and/or its physicians, including the following:

A. Termination Without Cause

Some hospitals may insist that their contracts with emergency practice groups allow termination without cause on 30 to 90 days notice. The provision deprives a group of any right to challenge the real basis of the hospital's decision or the means by which the hospital reached it. Perhaps the real basis is unreasonable. Perhaps the hospital made its decision with incomplete or inaccurate information. The provision gives a hospital powerful leverage over a group and its physicians: Do what is requested or be terminated. Termination becomes easy.

For the same reasons, many emergency practice groups also insist on "no cause" termination provisions in their agreements with individual physicians, but individual physicians raise the same objections in their contracts with the groups as groups raise in their contracts with the hospitals. Some individual physicians believe that the interruption to their practice and personal lives is so great that a group's decision to terminate should not be based on incomplete or inaccurate information. Others believe that a physician who can challenge a "termination without cause" does not really have a "cause only" termination.

B. "Clean Sweep" Provisions

A "clean sweep" contract provision requires a physician to relinquish his or her medical staff membership and privileges -- without the right to a medical staff hearing -- when the professional relationship at a hospital is terminated.

This provision makes it difficult for (i) a terminated group to create problems for a hospital by competing with a successor group and (ii) a terminated physician to create problems for a group (or

the hospital). For example, without a clean sweep, a well-respected and popular terminated group could strike a deal with many of the staff's physicians to manage their private patients who present to the ED.

This provision can also save a hospital a substantial sum of money. Assume the following: A physician's professional competence is problematic. Pursuant to the physician's professional services contract with the group, the group may terminate the physician without cause on 30 days notice. If the group attempts to remove the physician from the ED by asking the medical staff to suspend or revoke the physician's privileges, the physician would be entitled to a fair hearing to challenge the staff's action. The hearing would probably cost the hospital and/or medical staff thousands of dollars. However, the group avoids this cost -- and avoids impairing its relationship with the hospital and staff -- simply by terminating the physician without cause. Without due process, the terminated physician has no opportunity to defend against what the physician might perceive as an attack on his or her professional knowledge and skills.

C. Contractual Non-Compete Provisions

An emergency practice group often insists on non-competition provisions in its contract with an individual physician. The provisions expressly or effectively prohibit the physician from working in the ED after the group-physician or the hospital-group contract ends.[3] Physicians often complain that these provisions are unfair.

These provisions help the group preserve its contract with the hospital. Since a medical staff generally desires continuity in its ED, a hospital will be less inclined to terminate a group if the hospital cannot negotiate with and retain at least some of the group's physicians. But this is exactly what the non-competition provision would prevent. The hospital would have to find an entirely new, outside entity to take over the department.

A physician usually has many objections to these non-competition clauses. Some physicians believe a marginal group should not stay ensconced because a hospital is reluctant to contract with an entirely new outside entity; a physician should have the opportunity to acquire an emergency services contract himself if he or she can offer better administration, service, and financial terms; a physician should not have to work -- and perhaps move -- elsewhere simply because a group is terminated; and a physician's ability to acquire an ED contract should not be limited once it is clear the group is on the way out.

Much of the disagreement about non-competition provisions reflects legitimate, conflicting business needs. However, some emergency physicians believe they will always lack the bargaining power to

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[3] There are a variety of ways to preclude competition, including by (i) prohibiting a physician from working in a department for a fixed time, (ii) prohibiting a physician from disclosing a group's "trade secrets" or "confidential information," (iii) requiring a physician to pay a "recruitment fee" to offset a group's costs for arranging his job, and (iv) requiring a physician to pay a "liquidated" amount to compensate a group for acknowledged, though difficult to evaluate, damages. Even if a group will no longer provide services at a hospital, the group may want to prohibit an individual physician from remaining at the facility. If a hospital must replace a group and all physicians, the hospital may be reluctant to terminate the group. Non-competition provisions are generally disfavored, and their enforceability varies by jurisdiction. Some states have enacted legislation specifically limiting the use of restrictive covenants in contracts with physicians and other health care providers.

eliminate these provisions from their contracts. These physicians believe they have to accept the prohibition if they want to work. They also believe the prohibition is unethical.

VI. External Factors Affecting the Issue

A. Hospital Control Over the Practice Group - Physician Relationship

Hospitals can exhibit different levels of control over the issue of due process. Groups holding ED contracts may place restrictions on due process in their contracts with the physician.[4] For example, a physician may be restricted from a due process procedure in his or her contract, or the contract may contain specific mechanisms, some of which may be limited in scope, for dispute resolution. Hospitals may not know about these restrictions unless they specifically request this information from the group.

The hospital may request a copy of the physician contract prior to engaging a group to hold its ED contract. The hospital may choose not to enter into a contract with a proposed contract holder because of the stipulations in their contract. The hospital may require certain due process clauses or a mechanism that is consistent with the hospital bylaws.

The hospital or medical staff could have a stipulation in the bylaws stating that all physician contracts with the hospital or a hospital-based contract group must contain certain due process procedures. They could go on to stipulate the language or mechanism of due process for all physicians who work at the hospital or the group.

There are no studies on the number of hospitals or medical staffs that require a group to have the aforementioned provisions. It is unlikely that many hospitals request a copy of the physician contract or enforce hospital bylaws requiring due process procedures prior to signing an ED contract.

B. State and Federal Law

Each state varies in its approach to issues of physician due process. The practitioner is advised to contact an attorney in his or her locale to determine the laws governing contracts in that state. These laws may extensively explain the rights for due process, or the state may be silent on this topic.

The National Practitioner Data Bank states that any professional review action based on reasons related to professional competence or conduct and adversely affecting clinical privileges for longer than 30 days must be reported. If a physician were terminated for contract issues and not for professionally-related activities, the termination is not reportable. The law also stipulates that the practitioner has the right to dispute the accuracy of the Data Bank information by contacting the Secretary of the US Department of Health and Human Services. The law implementing the Data Bank provides protection against antitrust damages if certain procedural due process is followed.

C. Accreditation Standards

The Joint Commission's 2019 standards address the issue of due process procedure in healthcare institutions. MS. 10.01.01 states, "There are mechanisms, including a fair hearing and appeal process, for addressing adverse decisions regarding reappointment, denial, reduction, suspension or revocation of privileges that may relate to quality of care, treatment, and services issues."

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[4] Some jurisdictions may make a contractual waiver of due process unenforceable if the waiver precludes a physician from challenging an action that will be reported to the state medical board.

D. Professional Society Policies and Ethics

In addition to the "Guidelines for Due Process" policy previous noted, as of July 2019 the American Medical Association had a number of policies that address due process. Policy 225.985, Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract, states that the AMA believes "the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed actions." This policy is permissive, not mandatory.

AMA Policy 225.992 - "Right to Relevant Information" states 1. The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to him or her for inspection, and supports inclusion of these provisions in hospital medical staff bylaws. 2. Triggers that initiate a peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied to all cases and physicians. 3. A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures and faced with potential peer review action shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond. 4. All relevant information pertaining to a potential peer review action should be obtained promptly from the subject physician and other relevant sources. Relevant information includes, but is not limited to, pre-event factors, names of other health professionals involved in the care of the patient, and the contributing environmental factors of the health care facility/system. 5. All material information obtained by the peer review committee regarding the subject of the peer review should be made available to the physician under review in a timely manner prior to the hearing. 6. The investigating individual or body shall interview the practitioner, unless the practitioner waives his/her right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process.

AMA Policy 230.987 - "Hospital Decisions to Grant Exclusive Contracts" specifically addresses the issue of exclusive contracts. "The AMA supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body." This deals with closing a previously open department, not termination of a physician by a group.

As with statutes and accreditation standards, the professional societies really do not deal with due process when privileges are curtailed because an exclusive contract is terminated.

ACEP's policy statement "Emergency Physicians Rights and Responsibilities" states that "emergency physicians should be accorded due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges."

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