Practice Pitfalls in Drafting Physician Employment Agreements and How to Avoid Them

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Though physician employment agreements have become rather standard in many ways, practices still make significant and costly mistakes in a number of key areas when negotiating and drafting these agreements. Poorly defined and ill-fitting compensation packages often lead to disputes and sometimes result in litigation. Non-competition clauses that fail to meet the legal requirements, or provide less protection than expected, challenge practices regularly. Failure to understand the actual differences between a physician employee and physician contractor have potentially significant tax and benefits issues. Practices also regularly fail to adequately protect themselves in common term contracts leading to difficulty terminating the agreement. This article should help to raise awareness of key issues and provide information for addressing them.

Compensation

Physician compensation varies widely among practices and certainly even more between traditional physician practices and hospital-affiliated practices. A short book could be written on the development of physician compensation and current models, especially in light of the many federal and state laws that can come into play. That said, there are a few universal and avoidable issues.

Practices often fail to properly incentivize physicians or to realize the unintended consequences of the compensation structure they choose. Moreover, practices often bind themselves in these structures, which the physician may find very lucrative but are ultimately detrimental to the practice. In an employment agreement for a specific term of years, with no way to amend the agreement and without cause to terminate, this can be a problem for practices. In a hospital-physician employment agreement, where assessing "fair market value" and "commercially reasonable" compensation must be evaluated regularly, it is an even larger concern. Yet, it is easily resolved if the practice maintains the right to review and revise the compensation structure from year to year based on the physician's performance and the goals of the practice. Alternatively, the practice can make sure it retains a right to terminate without cause on a relatively short term to limit the time it must suffer under a program that does not work.

Another key area of compensation that has created litigation is defining the physician's trailing compensation in a fee-for-service based model dependent upon collections. Disputes arise concerning the timing of, and accounting for, payment. Practices are well advised to very carefully think out what compensation it may agree to pay at the conclusion of the agreement and set forth a reasonable mechanism for accounting for the payment. Additionally, the timing of such trailing payments should be well defined to avoid doubt.

Finally, an issue that still arises is the ownership of receivables. Practices sometimes assume that they own all of the fees for services of the physicians they retain without clearly obtaining an assignment in the employment agreement. The language to obtain such an assignment is not complicated.

Non-Competition and Non-Solicitation

Almost every practice and physician are now familiar with the concept of non-competition agreements, which prohibit physicians leaving a practice and soliciting their former patients or opening up a competing practice within a defined geographic region for a certain period of time. In some states, such provisions are barred for all employees (California[1]) and in others (Massachusetts,[2] Colorado,[3] and Delaware,[4] for example) the provisions are prohibited just against physicians. Still other states permit non-compete agreements for physicians, but place limitations on them. Texas, for example, allows for such restrictions on physicians, but the agreement must include provisions permitting the physician to buy-out, access patient's records, and see the patient in certain circumstances. A compendium of state law is beyond the scope of this article so it will be necessary for you to check the law in your state, but here are a few key pointers for practices in states that permit such agreements:

1. With almost no exception, a practice must carefully define the geographic area in which it will seek to enforce the non-compete and should consider the shortest possible period for the restriction to help with enforceability. Some states limit the period to one year and others find that a two-year restriction is generally acceptable. Practices commonly over reach in this area, demanding long periods that are not reasonable

and defining the geographic area too broadly. To help ensure enforceability of a particular geographic area, practices should carefully look at the area from which they draw the largest number of their patients and retain that analysis. This process will provide evidence for practice counsel to use when attempting enforcement (which often happens on an urgent basis, and would not otherwise allow time to gather such evidence). When defining the length of limitation, practices should keep in mind that a restriction of a year, and perhaps even less, generally will be deemed reasonable and often are effective. The departing physician is unlikely to wait six months to a year before opening a competing practice and more unlikely to move into the restricted area once established in a new location.

Non-competition provisions are enforced, at least at the initial and critical stages, based on what the judge assigned believes is reasonable and consistent with the state's law in most jurisdictions. Those judges often wield a lot of power over the potential success of a practice claim under a non-compete. Reasonableness may be the difference between enforcement and rejection.

2. Practices should also consider non-solicitation provisions in conjunction with, or as an alternative to, a non-competition clause. Under a non-solicitation provision, physicians are not prohibited from opening a practice within a certain geographic area but they are prohibited from soliciting their former patients. A request for a patient's file is a very clear indication to look out for a violation of a non-solicitation provision for physicians.
3. Finally, drafting concerns are still prevalent in states that permit non-compete buy-outs. Be careful to select a buy-out number that is rationally related to the patients the practice will lose because of the physician's exit. Choosing an unrealistic number will often create an issue with a court when attempting to enforce a buy-out. Also consider setting a short deadline for the physician to exercise the buy-out option and complete payment. Agreements that have no deadline or time to complete the payout may create a strategic advantage for the physician.

Contractor v. Employee

Practices often mistakenly think treating a physician as a contractor reduces some of the downside of having an employment relationship without any significant consequences. In almost every case, however, these practices fail to follow the legal requirements for having a true contractor relationship. They treat the "contractor" as an employee—providing insurance coverage, 401(k), paid vacation, a place to work, equipment, consumables, and mandating the physician work only for that practice, work at certain offices and facilities, and require a non-compete.

The test for whether an individual is an employee or a contractor varies from state to state and with the federal government, but the simplest way to analyze it is to compare it to a true contractor relationship. For example, you wouldn't provide benefits to your pool contractor, let him use your tools to build your pool or prevent him from building pools for other people. Doing those things for your "contractor" physician likely means that the physician will not be viewed as a contractor in the eyes of the law.

So, what is the consequence? If the state or federal government conducts an audit and determines that the practice has mischaracterized the physician as a contractor, the practice can be liable for penalties, interest, and additional tax of around 40% of the physician's earnings for the last three years. It is possible to properly treat a physician as a contractor, but many practices choose not to when they realize they will have to give up their non-compete and much of their control over the relationship just to have the convenience and save on tax withholding and benefits.

At-will v. Term

In a true at-will employment relationship, the practice or the physician can terminate at any time without notice. Most states permit this type of relationship, but practices often want at least some notice to find a replacement. With new physicians, a practice may also want certainty that they will not lose the value of their investment in training the physician and seek a term contract for a number of years.

In addition, practices almost always want to preserve the right to terminate an agreement for cause immediately in certain circumstances. Drafting mistakes in these "termination for cause" provisions can result in unfortunate and costly lawsuits and settlements. First, practices often define what constitutes "cause" too narrowly. Physicians are usually so focused on negotiating compensation that practices can get away with at least one cause for immediate termination that is broad enough to apply in any situation. Strangely, practices rarely take this opportunity. Practices, or lawyers unfamiliar with health care law, also fail to take into consideration true health care issues that would merit immediate termination, such as a physician failing to become credentialed with all of the practice's payers or at hospitals or facilities important to the practice. Other causes a practice needs to consider are debarment, loss of privileges or credentials, loss of or suspension of license, discrimination toward an employee, malfeasance, violation of practice policies, and malpractice claims against the physician.

When writing such provisions for immediate "cause" termination, a practice should also consider a second "without cause" option with a notice of two to four months. The provision will provide a simple and reasonably short period to terminate the agreement without too much pain. Additionally, a "without cause" termination provision can be cited as an alternative basis of termination when terminating with cause and limit the potential damages arising from an incorrect "for cause" termination. When used together, damages can potentially be limited to the sum the physician would have received under the longer term without cause termination provision, thus making litigation unlikely.

Another thing practices often forget to retain when preparing extended notice termination provisions is the right to take the

physician out of the practice during the notice period and simply pay out the remaining time. Providers may maintain the position that they need to be at work to find replacement employment creating an uncomfortable environment if the practice would prefer the physician not be in the office.

Additional Considerations

1. Practices sometimes fail to address whose responsibility it is to purchase gap or tail coverage and what carriers may be acceptable to provide such coverage.
2. Call coverage should be very carefully addressed so that all involved understand their responsibilities. While this issue does not regularly result in litigation, a number of practice-physician relationships have been disrupted because of it.
3. Outside activities, including volunteer work, serving on boards or as a medical director, and expert witness services are often overlooked. Practices should consider what time constraints are appropriate for such activities and retain the right to restrict physician involvement in such activities. Practices must also keep in mind the potential malpractice claims that may arise from such activities, in the event the physician is covered through the practice. Additionally, practices should consider who owns outside income the physician generates. Serving as an expert witness, for example, takes away from regular work and can generate quite substantial revenue.
4. In the same vein, practices sometimes find themselves at odds with a physician employee over an investment in a related business. Reserving the right to approve physician investment in related health care businesses can help prevent these issues and ensure continuity with practice investments.
5. Employment and compensation during credentialing sometimes can be an issue when a physician cannot, or is slow to obtain, privileges at a much-needed facility. Practices may want to reserve the right to terminate or reduce pay in this situation.
6. The location where a physician may be required or expected to provide services can become an issue if not clearly addressed by practices that have multiple offices and may need a physician to fill in at another location.
7. Time off to attend CME and coverage of CME costs is sometimes overlooked at the beginning of a contract. To avoid a physician requesting additional and unanticipated compensation, this should be addressed from both a time off and reimbursement standpoint.
8. Intellectual property rights in works of authorship and the occasionally developed patentable device often escape consideration. Practices may be surprised that they have less ownership rights in intellectual property than they thought and should address the issue with counsel for inclusion in employment agreements.
9. Overlap and continuity between the employment agreement and employee handbook is also often overlooked. Some employee handbooks purport to create a contract and include confidentiality obligations and other provisions that might contradict the physician employment agreement. Physicians have attempted to defeat non-competition and other provisions in employment agreements using the employee handbook. The simple fix is to provide that the employment agreement supersedes any provision in an employee handbook or other code of conduct.
10. Whether to arbitrate or not is debated even among lawyers. Often, the desire to avoid the potential publicity of a dispute—a discrimination or harassment claim, for example—guides some practices towards arbitration. Whether a practice chooses arbitration or not, such a decision should be considered with the benefit of counsel and the law in the applicable state. New York[5] and Washington[6] have, for example, limited arbitration of sexual harassment claims (but a dispute is brewing about whether these laws may be circumvented using the Federal Arbitration Act).
11. Finally, a number of problems arise when practices include equity ownership provisions that set out in much detail when and how a physician will be considered for ownership. Too often, practices that think a candidate will work out wonderfully are surprised by a change in circumstance within the practice or their relationship with the physician. These changes often make the originally outlined terms problematic. Keeping it vague in the employment agreement gives the practice more latitude to adjust to these changes without hurting or destroying the relationship with the physician.

Conclusion

The cost of lawyers and litigation are just two of the harms that can befall a practice dealing with poor contracts. Sometimes the business consequences can be just as costly. The loss of trust associated with hashing out the finer points of a poorly written compensation structure, finding a locum tenens to fill the void when a physician leaves with no notice, and the loss of patients associated with an unenforceable non-competition agreement often hurt just as much or more. Consult with your legal counsel to make sure your practice agreements are up to date and cover all the areas addressed here to mitigate the risks discussed in this article.

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1 Cal. Bus. & Prof. Code § 16600.
2 Mass. Gen. Laws ch. 112, § 12X.
3 Col. Rev. Stat. § 8-2-113(3).
4 6 Del. Code Ann. § 2707.
5 N.Y. C.P.L.R. 7515(a)(2), 7515(a)(4)(b)(i)-(iii).
6 Wash. Rev. Code § 49.44.085 (Prohibiting confidential arbitrations).