E-Briefings
Volume 15, No. 4 • July 2018

Employed and Independent Physicians in Integrated Health Systems: The Same or Different?

By Kevin J. Egan, J.D., and Daniel K. Zismer, Ph.D., Castling Partners, LLC

A common question from leadership of health systems pursuing integration strategies with physicians is whether or not employed physicians and independent physicians are the same. An often-heard follow-up inquiry is, "If they are different, what does that mean?"

Let us begin by considering a brief case vignette derived from practical experience. Consider these facts: a physician employed by a health system in its early stages of integration becomes a behavior problem in a clinic setting. Over time, the problem rises to the level of board awareness. During board discussion, the chair asks, "Why isn't the medical executive committee dealing with this issue?" The board is surprised to learn that a problem of this nature is not always the job of the medical executive committee.

While, at times, it is still the duty of the formal hospital medical staff structure to address the practice and behavioral issues of employed physicians, much of the time, the health system (as the employer) is now the first point of responsibility.

Answers to the following questions provide a basis for expanding board understanding of these issues:

1. **Integration of physicians into systems continues; what does this mean for the board?** The world of healthcare continues to march to the beat of integration, with physician integration into health systems continuing at a rapid pace. By all measure, this integration, often driven by practice acquisitions and the direct employment of new physicians, will only accelerate. Accordingly, board members must recognize these changes and view hospital medical staffs in a different light.
2. **What does the term "hospital medical staff" mean today? Are employed physicians members of the medical staff?** Leadership needs to understand what the concept of a medical staff encompasses in a conventional and historical sense, while recognizing that hospital medical staffs are changing. Employed physicians are indeed full members of the hospital medical staff, but employed physicians are fundamentally different from independent physicians because of the contractual link they possess with the hospital or system. Like the independent physicians of the past, the employed physician is attached to the system through hospital medical staff membership. However, an employed physician possesses an additional and often overriding set of important contractual obligations and rights not held by independent physicians.

Key Board Takeaways

As boards contemplate the difference between employed and independent physicians at their organizations, they should keep the following in mind:

1. Health systems will increasingly become the employer of choice for a large proportion of the "medical staff." Employed physicians are, simultaneously, system employees and members of the hospital medical staff. Independent physicians of the hospital medical staff are not system employees.
2. Employed physicians have roles, rights, responsibilities, accountabilities, and obligations that distinguish them from independent physicians affiliated with the hospital medical staff.
3. Boards or leadership of systems should almost never rely solely upon hospital medical staff structure to address performance issues of employed physicians. The system-employer has a direct interest and contractual duty to address any such behaviors itself.
4. Systems need not demonstrate "community need" to recruit and directly employ physicians. Community need justifications pertain solely to a system's extension of financial support to recruit independent physicians to supply provider capacity.

When systems engage physicians directly as employees, related responsibilities, accountabilities, and obligations beyond the traditional physician/hospital medical staff affiliation come into existence. As such, the role of the hospital medical executive committee is confined to matters that apply to all members of the medical staff regardless of method of affiliation with the hospital.

Physician employment creates and defines another level of relationship between the parties, which, in many ways, is primary, as the physician is first an employee of the system and secondarily a member of a hospital medical staff. The system as employer is, by definition, involved in all matters relating to physician-employee conduct and performance even if those matters are covered by hospital medical staff bylaws. Moreover, the system-employer has full access to all facts pertaining to the employed physician's conduct even when medical staff confidentiality rules might otherwise restrict access.

Board members possess a fiduciary duty to recognize and understand this relationship and exercise due care in their oversight of physicians as employees of the organization that they govern.

3. **How should the hospital medical staff handle behavior problems of an employed physician?** Remember that an employed physician possesses a *contractual* link with the system as well as an attachment through hospital medical staff membership. For example, when a physician behavior problem emerges with an independent physician, the only path to address and correct the problem is through the hospital medical staff and its disciplinarily process. With an employed physician, there is a contractual way to correct troublesome behavior or address quality concerns. Depending upon the terms of an employment agreement (which often vary greatly), leadership may choose to utilize the contractual option or the medical staff remedy to correct problems. It is vital that the impact of contractual language be considered carefully as employment contracts are prepared.
4. **Do independent members of the hospital medical staff possess the same rights as employed physicians?** Yes and no. Remember that independent hospital medical staff members possess the same procedural rights arising out of hospital medical staff membership, as do employed physicians. However, as mentioned above, the contractual link between employed physicians and the system or hospital will likely provide additional contractual rights and duties to the employed physician. For example, an independent physician with behavioral problems will only be subject to discipline by the medical staff itself. In contrast, an employed physician will likely also have a contractual duty to behave well and the board would likely utilize the contractual term to discipline or discharge the poorly behaving physician.
5. **Are independent physicians automatically parties to managed care contracts of the system?** Managed care contracting is complex, but it becomes even more challenging when distinctions between employed and independent physicians are considered. Employed physicians are bound contractually to participate in the managed care contracting arrangements of the parent system. This is not the case with independent physicians. Independent physicians will need to seek out desirable managed care linkages on their own or join independent practice associations (IPAs) for these purposes. Antitrust issues lurk in this context and must be carefully respected by independent physicians, who cannot remain independent and simultaneously share market and pricing data.
6. **Can independent physicians compete with the hospital?** Independent physicians can and do constantly compete with hospitals, systems, and employed physicians. Both compete for market share and programmatic dominance.
7. **Do independent physicians have the right to know the strategic plans of the employed physicians?** No. Independent physicians are indeed *independent*. Legally, they are separate economic actors who have separate business goals and strategies. The antitrust laws prohibit the sharing of data that inhibits competition in the marketplace. The antitrust laws are potentially criminal, so all must tread very carefully.
8. **Must the system consider the number of independent physicians in recruiting plans?** Yes. Most community health systems are tax-exempt entities and a series of IRS restraints operate in this setting. One of those rules requires that hospitals prepare medical staff development plans to justify the use of non-profit assets in recruiting independent physicians. The focus of these plans are the overall quality and size of the full hospital medical staff, both employed and independent practitioners. Note that recruitment assistance

for independent physicians is keyed to the presence of established community need. In contrast, a system may directly employ as many physicians in various specialties as it desires; community need does not have to be established for direct employment.

9. **Must compensation be the same for both independent and employed physicians?** No. The salaries of employed physicians are set by the system and must be both commercially reasonable and equal to fair market value. A failure to do so in strict accordance with IRS guidelines exposes both board members and senior leadership to the risk of federal sanctions. The system or hospital does not set salary levels for independent physicians and, consequently, the income of the two groups may vary greatly. Note also that none of the regulatory restraints present when establishing the compensation of employed physicians are present regarding the income of independent physicians; they are free to earn as much as they can.
10. **Must the hospital treat all independent physicians equally when granting clinical privileges and providing access to clinical resources?** No. Systems and hospitals are independent businesses and have their own economic interests to consider when making these choices. For example, a hospital will often contract exclusively with a single group of physicians to provide services like anesthesia or those needed to operate the emergency department. By doing so, the hospital is making a business choice to exclude some independent physicians from performing these services or practicing in portions of the hospital. Boards should treat both groups of physicians equitably but need not do so equally.
11. **Must systems include independent physicians in any branding program or marketing effort?** There is no legal obligation to market independent and employed physicians in the same marketing program. In fact, to do so for independent physicians at no cost may raise regulatory flags. That having been said, there is a fine line separating prudent cooperation from outright exclusion. If independent physicians wish to participate in a system-wide branding project, it may be prudent to allow such an effort as long as the independent physicians pay their share of marketing costs.
12. **Does the medical executive committee of the hospital medical staff have anything to do with employed physicians?** Yes. The committee certainly does have a role in governing, credentialing, and disciplining employed physicians. However, a hospital medical executive committee may not play any role in the contractual or operational relationship between the employed physician and the employer. This may mean that a board finds itself dealing with an employed physician's difficulties, simply because he or she is an employed physician. Further, a board will want to be advised of any proceedings initiated against an employed physician by the hospital medical staff. A well-crafted employment agreement will contain provisions requiring that the employed physician advise the employer-system of the pendency of such an action.

The world of healthcare continues to march to the beat of integration, with physician integration into health systems continuing at a rapid pace.

Governing boards should consider convening a special session that includes senior leaders and legal counsel for purposes of establishing a common understanding and unified position as to how the organization's relationships with employed and independent physicians are, at the same time, both alike and different. Such a session should be organized and facilitated around the issues clarified in this article. Time spent delving into this point has increasingly proven to be well-spent as systems move forward with continuing efforts to integrate with physicians as employees and develop useful structures and business models designed to emphasize the employed physician.

The Governance Institute thanks Daniel K. Zismer, Ph.D., and Kevin J. Egan, J.D., Managing Directors and Co-Founders of Castling Partners, LLC, for contributing this article. Castling Partners, LLC is a premier healthcare consulting firm that often assists system boards in considering and working through challenging integration issues such as the ones described in this article. Dr. Zismer can be reached at daniel.zismer@castlingpartners.com or (612) 850-4545 and Mr. Egan at kevin.egan@castlingpartners.com or (218) 820-1525.