CONTRACT ISSUES

EMPLOYEE VERSUS INDEPENDENT CONTRACTOR

There are two basic types of work arrangements an emergency physician may undertake – an employee hired by a hospital/group or an independent contractor secured by a hospital/group. This dichotomy has no bearing on whether the physician works for a hospital, a small local group or a national "mega-group." There are pros and cons to each arrangement that should be considered, and an experienced attorney will provide the most favorable contractual terms when negotiating.

For physicians who are employed by a group that in turn is contracted with a hospital, the (usually pre-existing) contract between the group and the hospital also directly affects the physician. It is advised that (if allowed) this contract be reviewed before considering employment. If considered privileged information, inquire as to its strengths and weakness (e.g., length, criteria for termination). Perhaps more important than the contract is that the group has enjoyed a positive association with a hospital for many years and shows strength in the institution (e.g., autonomous department status, emergency physicians on all major committees and considered for medical staff officer positions).

Many physicians are content as employees, while others prefer more flexibility and are willing to take on the greater fiscal responsibility required of independent contractors. Employees generally receive valuable benefits from their employer including vacation time, medical coverage, disability insurance, education allowances and the option to participate in pension plans. An independent contractor can purchase insurance products to suit his or her exact needs though insurance rates for individuals are higher than for groups. The hospital/group regardless of the type of work arrangement usually provides professional liability insurance.

While, in 2010, employees can shelter $16,500 in tax-exempt retirement accounts (i.e., 401k or 403b plans), independent contractors can contribute 20% of their income (up to $42,000) in a Simplified Employment Pension (SEP) Plan. Further, independent contractors can deduct appropriate business expenses (e.g., car lease, education costs, equipment, etc.) while employees are allowed only a 2% deductible on adjusted gross income. Independent contractors are held completely accountable for income tax reporting and must do so on a quarterly basis. Independent contractors also have to pay the employer share of social security tax and Medicare tax. Those that shirk this responsibility often end up owing large amounts of money to the Internal Revenue Service (IRS) because of back taxes and penalties. Also, there is always a looming

threat to one's pension plan should the IRS declare that the individual should have been considered an employee all along. It is highly recommended that independent contractors consult a qualified accountant or tax attorney to set up their pension plans and tax payment schedules.

While employees may perceive greater job security than independent contractors, either arrangement is subject to the terms of a contract. For example, when a contract comes up for renewal, breaking the relationship may be as simple as issuing a letter of intent to terminate at the end of the contract period. Either type of work arrangement can also end suddenly. This generally requires that one party can demonstrate breach of the contract by the other party. In general, one's long-term job security depends very little on a contract and a great deal on establishing positive relationships with others and providing excellent patient care.

The distinction between employee and independent contractor is critical, especially to the IRS. To this end, the IRS developed a "Twenty-Factor Test" to clarify whether an individual should be defined as an employee or as an independent contractor. Perhaps because tax laws are more favorable to the independent contractor, these criteria favor the definition of an employee. The 20 criteria follow.

Instructions

Independent contractors, upon receiving an assignment, maintain control of how the work results are achieved. They must, however, abide by boundaries established by hospital/group policy, regulatory agencies, medical staff bylaws, etc.

Training

Independent contractors must possess all necessary skills to perform the tasks expected of the hospital/group based upon prior training and experience.

Integration

Independent contractors provide their services independent of hospital/group operations. For instance, independent contractors must cover or provide their own recruiting for assigned shifts after a work schedule has been agreed upon.

Personal Services

The term "personal service agreement" construes an employee-employer relationship. Independent contractors are not required to personally render services. Instead they may utilize other, suitable privileged physicians to render the same results.

Assistants

Provision of support personnel by the hospital/group constitutes an employer-employee relationship. Independent contractors may hire, supervise and pay administrative assistants or physician extenders out of their personal funds.

Hours

Independent contractors have no "set hours," and instead, submit in advance their hours available for scheduling and then mutually agree on a final schedule with the hospital/group.

Full-time

The terms 'full-' or 'part-time employment' indicate an employee-employer relationship. Minimum hours of expected work are more appropriate terms for independent contractors.

Order or Sequence

Independent contractors must determine which patient to see next and what nursing orders are written.

Reports

Reports signify an employer controlling an employee. Independent contractors generally report only on work progress and completion. If more extensive reports are required of independent contractors, an administrative stipend should be given.

Employer's Premises

Contracting exclusively with one hospital, the "owner of the premises," implies an employee-employer relationship.

Payment

Hourly, weekly or monthly payment constitutes an employee-employer relationship. Independent contractors should be paid by the job – i.e., a percentage of collections on their professional fees with or without a "minimum guarantee."

Expenses

Employees may be reimbursed by the hospital/group for business and travel expenses as a benefit. Independent contractors allocate such expenses from their income.

Tools and Materials

Employees are furnished all tools and materials to perform work tasks. Independent contractors must provide their own materials, though exceptions exist regarding hospital equipment.

Significant Investment
Independent contractors must lease any necessary administrative space in the hospital and/or furnish the space themselves.

Profit/Loss Potential
Independent contractors should be compensated based on a "percentage of receipts," and therefore, have potential for profit and loss.

Other Work
Independent contractors may work in more than one hospital.

Availability
Independent contractors should be available to work at any hospital they choose.

Right to Fire
The right to fire (albeit limited by many laws) indicates an employee-employer relationship. Independent contractor contracts contain a term and termination date.

Right to Quit
Termination without liability applies only to employees. Independent contractor contracts require advance notice and premature termination often results in monetary damages.

Continuing Relationships
Independent contractors must be able to renegotiate their contracts should a new management group or administration take control.

When reviewed point by point, it becomes clear that emergency physicians are challenged to comply with many of these IRS rules governing independent contractor status. If the IRS believes an employee-employer relationship exists, the physician may seek Section 530 relief for reconsideration as an independent contractor. This section of the IRS code allows independent contractor status to prevail as long as the hospital has treated all similar physicians the same way since 1978 or its inception.

DRAFTING TERMS
Black's Law Dictionary defines a contract as, "a promissory agreement between two or more persons that creates, modifies or destroys a legal relation." In establishing a legal relationship between a physician and a hospital/group, there must be mutual acceptance of the terms of the contract. While contracts are essential, there is no substitute for excellent rapport between the parties. Maintaining a positive alliance with hospital administration and the medical staff equates to sustained job security since all contracts are time-limited. Other factors that enhance job security include adding

integral services (e.g., an emergency department based observation unit) and becoming involved in the hospital's strategic planning for the future.

To achieve a full legal understanding of the terms, it is strongly advised to have an attorney review the contract and explain or clarify the obligations of both the physician and of the hospital/group. The attorney should ensure that the contract clearly defines the job duties, compensation and benefits without ambiguity. "Fine print" should not be ignored as it may lead to serious long-term consequences. The next two chapters on business practices contain powerful tools to aid in negotiating a fair and equitable contract. Though beginning a job on "a handshake" allows medical staff bylaws and common law principles to prevail should termination be threatened, it is best to have a signed contract promoting due process and devoid of a non-competition clause.

Negotiation involves much more than the salary. For instance, full partnership should be attainable as long as no genuine problems arise during the trial period. Many books have been written on negotiation techniques. Getting to Yes (Fisher R, Ury W, Houghton Mifflin, 1981) explains why principled negotiation, with the goal of mutual understanding and creating a win-win endpoint, is a favored technique. Lawyers may assist in mediating between contractual parties when they are far apart on certain issues.

The typical elements or clauses that constitute the terms of a contract between a physician and a hospital/group are described below.

Introduction

The first clause of the contract, called the recitals, introduces the parties, the reason for entering into the contract and the effective date. These introductory statements usually begin "Whereas…."

Obligations

This section may be termed 'Representation and Warranties' and are assurances given by each party that certain things are true or will happen and these expectations should be reasonable. The physician will be expected to comply with hospital administrative policies and medical staff bylaws, so it is important not to concede unilateral control of their revision. Copies of the bylaws and policies and any other documents referred to in the contract should be provided by the hospital and carefully reviewed by the physician and his or her attorney prior to signing.

Compensation

There is significant regional variation in salary ranges. For employees, compensation includes "straight pay" (i.e., the hourly rate or annual salary), bonus or incentive pay and benefits (i.e., vacation time, medical coverage, disability insurance, educational

allowances, pension plan eligibility, etc.). An hourly differential or stipend may be offered for nights, weekends and holidays. Compensation based on capitation agreements with hospital-affiliated managed care organizations are uniquely challenging and require a fixed dollar amount per year per group enrollee as well as a "stop loss" provision in case there are significant changes in volume or acuity.

Liability Insurance

Professional liability (malpractice) insurance is usually purchased by the hospital/group. A certificate of coverage should be received from the insurance company naming the physician as the insured and typically requiring a 30-day notice of cancellation or change in coverage. "Occurrence" coverage protects all acts committed during the covered period regardless of when suit is brought. The typical monetary limits are $1 million per occurrence and $3 million per year. "Claims-made" coverage usually extends only for the period of employment. Thus, if a suit is brought after a claims-made policy has lapsed, legal expenses and awards are not covered. "Tail" coverage provides retrospective malpractice insurance after a claims-made policy ends, and though expensive, is absolutely necessary.

Scheduling

This section specifies the number of clinical shifts that the physician is required to work and at which facility (if more than one). The physician must be guaranteed a minimum number of hours per month to avoid being effectively "terminated" by simply being removed from the schedule. Night, weekend and holiday requirements as well as any on-call responsibilities (e.g., for unanticipated episodes of extremely high volume or to cover for a sick colleague) must be defined.

Non-Clinical Responsibilities

Administrative or teaching duties exclusive of clinical time should be specified.

Medical Staff Privileges

The Hospital Board of Directors grants physician privileges typically by ratifying the recommendations of the medical staff credentials committee. The AMA and JCAHO support fair hearing policies for physicians requested to terminate their medical staff privileges. Signing a contract requiring automatic loss of medical staff privileges if termination occurs equates to relinquishing due process.

Restrictive Covenants

Non-competition clauses attempt to prevent competitive business situations. Groups often exploit restrictive covenants during contract renegotiations by intimating that the well-liked physicians would have to leave if a new deal cannot be struck. Hospitals

may use non-competition clauses to discourage employed physicians from leaving to work for a competitor. Many states have abolished restrictive covenants altogether. Other states allow them to span a reasonable time period (e.g., no longer than two years) and cover a small geographic area.

Indemnification

This agreement requires the negligent party to pay the other party's expenses incurred in a legal judgment. Such clauses do not favor physicians.

Hold Harmless

This section states that in the event of a lawsuit, neither the physician nor hospital/group will sue each other to recover damages.

Term and Termination

The term is the length of time the contact is in effect. Typical contracts are 1-2 years in length. Longer-term contracts (e.g., 3-5 years) create greater job security though less flexibility. Termination defines the criteria by which the term can be shortened or run out without renewal. Self-renewing means the contract will automatically renew after the end date, usually for one year at a time, should neither party give notice of intent to terminate. Provisions for termination without cause allow either party to end a contract prior to its expiration date after a set period (usually 60 to 90 days) of notice.

Breach and Remedy

When one party fails to live up to the contractual requirements and the other party then experiences damages, a civil suit for breach of contract can be filed. A "liquidated damages" clause defines the exact dollar amount one party would be due from the breaching party (after final judgment).

Termination with cause requires noncompliance with contractual obligations. Often, the offending party must first be given written notice of the repugnant action and an opportunity to remedy (or "cure") it within a discrete period of time (usually one week). "Material breach" is a legal term meaning that substantial and important injuries have been incurred due to contract violations.

Amendments

This section indicates that any part of the contract can be amended by mutual agreement while otherwise maintaining contract terms.

The above explanation of contract clauses is not all inclusive. It is highly recommended that you consult an attorney. Money spent up front for a contract review often saves far more should problems occur in the future. The cost for legal review of an

uncomplicated emergency physician contract with a hospital/group is about $1,000. State medical societies and emergency medicine organizations can often steer you to a law firm expert in this area.

AAEM has put forth the following guidelines that list the essential components of a fair and equitable contract:

- Emergency physicians should be entitled to full due process as accorded other members of the hospital medical staff. Any restriction or termination of clinical privileges of the emergency physician should be accompanied by the opportunity for a fair hearing through the medical staff.
- Emergency physicians should not be subject to restrictive covenants or non-competition clauses that prevent them from continuing to practice in a certain hospital or geographic area. It is in the best interest of the community to allow qualified emergency physicians to remain.
- Emergency physicians should have full access to the books of account. A physician can be held criminally responsible for inappropriate professional fee charges and therefore should have the opportunity to review this information. Also, in order to prevent exploitation through fee-splitting, emergency physicians should have the opportunity to review remittances made on their behalf. The Health Care Financing Administration (HCFA) and AMA have policies and statements supporting open books.
- Each member of a group practice should receive income proportionate to the service rendered to the group. Differential pay for the less desirable shifts is proper, as are pay formulas with fair productivity and quality components. Payment for administrative, educational and other essential activities is appropriate.
- In group practice, each full-time emergency physician should have an equal say in matters affecting the group.
- Professional liability coverage, including the party responsible for payment of “tail” coverage, should be clearly stated.
- A hospital contract should not contain clauses forcing participation with hospital-affiliated managed care organizations at discounted rates without approval of the group.
- Emergency physicians certified by ABEM or AOBEM should not be required to obtain “merit badges” such as ACLS and ATLS recognition. Residency trained emergency physicians have achieved a depth of knowledge far beyond these courses. Moreover, such certification may be misinterpreted as “qualified” to practice emergency medicine.