



BUYING CRAZE: LIABILITY PROS & CONS OF HOSPITAL EMPLOYMENT

by **Starlett M. Miller**

Physician-owned-and-operated medical practices appear to be on the decline. Across the United States, hospital systems are buying out private medical practices at a rapid pace. Between 2005 and 2008, the percentage of medical practices owned by hospitals soared from 25.6 percent to 49.5 percent, according to the Medical Group Management Association's 2008 *Physician Compensation & Production Survey*. In 2010, for the first time, the number of new physicians who joined hospital-owned practices exceeded the number of first-year practitioners who became employees of medical groups owned and operated by physicians.

Smaller physician practices have been struggling under the strain of the current economy and a rapidly evolving regulatory climate. Facing reductions in government reimbursements, an increase in the number of patients who are unable to afford their medical bills, uncertainty over the healthcare reform law and the impending expense of the federal government's urging providers to purchase electronic health records systems, many physicians in private practice are succumbing to hospital systems' offers of economic certainty, reduced hours, more resources and the ability to devote more of their time to patient care.

Hospital systems are on a private practice buying binge in anticipation of healthcare reform and the resulting need for an increased supply of doctors as more people obtain health insurance and seek primary care. Financial incentives created in the reimbursement scheme also support an integration of primary care physicians and hospitals. For example, the payment system for hospitals incentivizes efficiency because payment amounts are based on diagnostic codes, not necessarily the duration and scope of a hospitalization; however, the fee-for-service payment system for physicians does not necessarily induce the same amount of prudence. Hospitals have an improved ability to eliminate duplicative tests and provide patients with faster care when they control the physicians managing that care.

While employment in a hospital system may carry financial incentives and provide overall cost-saving benefits to the U.S. healthcare delivery system, it does not come without new liability risks. Following is a look at the pros and cons from a liability perspective.

IMPACT OF ELECTRONIC HEALTH RECORD SYSTEMS

On the advent of electronic health records (EHR) systems' major role in healthcare management, physicians and hospital risk managers need to remain cognizant of the threat of lawsuits and the importance of thorough and defensive documentation. Plaintiffs' lawyers are seizing the opportunity provided by the rapid adoption of electronic health records systems—along with the associated risks and challenges—to argue that doctors are letting these electronic sys-



tems perform the evaluation in lieu of the physician's more thorough clinical analysis.

RISK RELATED TO HOSPITAL REFERRAL POLICY

As hospitals reduce their independent contractor physicians and employ growing numbers of in-house physicians, hospital systems should use caution with their policies and procedures.

Federal anti-trust laws prevent a hospital from having policies that require its employee doctors to refer patients to their fellow in-house physicians. There has also been at least one lawsuit alleging that a hospital failed to call in an outside physician because it did not want to lose the business to a competitor. In *Burchett v. Carilion Roanoke Memorial Hospital*, the plaintiff suffered a burst colon and alleged that the Virginia hospital failed to bring in an outside gastroenterologist because it did not want to share business with a competitor and thereby failed to provide the plaintiff with the best possible care. The hospital denied that it had a policy to prevent "leakage" of its business to competitors. Regardless of the outcome in *Burchett*, the takeaway is that hospitals should be wary

of policies that could appear to encourage their physicians to direct patients within the hospital system. As with any shift in corporate structure, the trend toward hospital systems directly employing their own physicians will inevitably be exploited by plaintiffs' attorneys to create new avenues for liability.

EFFECT ON A HOSPITAL'S LIABILITY UNDER THE OSTENSIBLE AGENCY THEORY

Historically, in most states, hospitals were only vicariously liable for the medical malpractice of their employed physicians. In certain cases, hospitals could be liable for the malpractice of their independent

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VERMONT GOV. SHUMLIN RECOMMENDS EARLY DISCLOSURE, SETTLEMENT MODEL SIMILAR TO THE UNIVERSITY OF MICHIGAN HEALTH SYSTEM MODEL

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of 40 percent of all claims filed annually, and reimbursement for lost earnings includes weekly compensation of 80 percent of the claimant's earnings at the time of injury, up to a set maximum.

The Shumlin report recommends against the no-fault medical liability system because economic damages are not compensated in full, and the New Zealand model advocated by Hsiao would be impossible to replicate in the United States.

According to the Shumlin report, "the disadvantages of unfair compensation to patients injured by medical negligence, increased systemic costs, or both, are quite substantial. Moreover, the New Zealand model exists in a very different legal, social and economic milieu. The more limited social safety net in the United States as compared with some of these other countries exacerbates the potential inequity of adopting a New Zealand style system."

Rather than a no-fault system, the Shumlin report recommends one similar to the University of Michigan Health System's early-resolution model, which is: When faced with an adverse outcome,

apologize and learn when wrong, explain and vigorously defend when right, and view the court as a last resort.

According to the Shumlin report, after the University of Michigan Health System implemented its policy of early disclosure and settlement of claims, the monthly rate of lawsuits against the University of Michigan Health System dropped from 2.13 per 100,000 patient encounters before the program was implemented to .75 per 100,000 patient encounters after the program was implemented—or from 38.7 lawsuits per year to 17 lawsuits per year after program implementation. The time from claim to ultimate resolution dropped from more than 20 months in 2001 to about 10 months a decade later, and UMHS' total liability costs have dropped dramatically to 41 percent of the average monthly liability cost before implementation.

The Shumlin report also noted that medical malpractice insurance premiums and claims payouts in Vermont are among the lowest in the nation. The report has been submitted to the Vermont General Assembly for review.

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contractor physicians for policy reasons based on ostensible agency. For example, in Pennsylvania, the two factors required for a finding of ostensible agency are: (1) whether the patient looks to the hospital, rather than the individual physician, for care, and (2) whether the hospital "holds out" the physician as its employee by act or omission, which in some way leads the patient to a reasonable belief that he is being treated by the hospital or one of its employees. Pennsylvania courts permit the subjective determination of whether the patient sought care from the hospital instead of the physician to be established through inferences derived from the evidence. With regard to the second factor, a "holding-out" by the hospital can be found when the evidence establishes that the hospital acted or failed to act in a way that would give the patient a reasonable belief that she was receiving care from the hospital or one of its employees. As the number of independent contractor physicians working in hospitals decreases, it will become more reasonable for patients to assume that the physician treating them was an employee of the hospital.

EFFECT ON POTENTIAL FOR HOSPITAL LIABILITY FOR CORPORATE NEGLIGENCE

Hospitals should experience at least one benefit by utilizing employee physicians instead of independent contractor physicians. In addition to the availability of vicarious liability and apparent agency, many states have adopted a private cause of action against a hospital for corporate negligence, under which a hospital may be held directly liable to a patient for an independent contractor physician's malpractice if the court finds that the hospital breached one of its non-delegable duties (such as providing non-negligent anesthesia services). One of the difficulties created by this emerging doctrine is that hospitals have increased liability for the actions of others, but no greater control over the conduct of the independent contractor physicians. Under the new model where hospital systems are integrated with employed physicians, hospitals will benefit from having more control over employee physicians—and the physician's legal defense in the event of a lawsuit.

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MISCONCEPTIONS OF AN EARLY BREAST CANCER DIAGNOSIS

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the disease. We know that some cancers spread while virtually undetectable by conventional means. Is this really a delay in diagnosis or is it a failure of technology?

Patients (and jurors) are not always aware of these limitations. The limitations of current detection and treatment methods are seldom discussed with patients or even understood by all physicians. Discuss these limitations during the informed consent process and document the patient's understanding.

RISK MANAGEMENT TIPS FOR RADIOLOGY AND SURGICAL PROVIDERS

- Repeat mammograms when films are of poor technical quality.
- Check film quality while the patient is still in the mammography center, if possible.

- If the mammogram results are equivocal, recommend a repeat study, additional views, follow-up studies, etc.
- Compare findings to the results of the physical exam when needed.
- Compare the results of mammography studies to previous studies.
- Promptly report your findings to the referring physician.
- The self-referred patient should be advised of any abnormality and referred to her PCP or OB/Gyn.
- Promptly report consultation and biopsy results to the referring physician.
- Remember that the referring physician may not be the only provider who should be notified.

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