MANAGING EMPLOYED PHYSICIAN CLAIMS

This article addresses claim management for employed physicians by the hospital risk management or claim department through either a captive program or a self-insured retention.

HYPOTHETICAL

Competent Care Health System, an integrated delivery system, purchased a medical group and decided to roll the physician liability insurance into its captive insurance company. Dr. Jones just received a summons and complaint for a medical malpractice action alleging lack of informed consent, intentional battery and negligence. He put the summons aside because the medical group risk manager was no longer there and he was unsure how to report the claim to the hospital risk management staff. Months later, he saw the hospital risk manager in the hallway and told him about the claim. The risk manager assigned counsel from the captive panel; the attorney was able to have the default judgment set aside. The claim progressed slowly. Dr. Jones complained he was not kept informed on the progress of the case, did not agree with the choice of expert witnesses and that his best interests were not represented. The hospital/captive reserved its rights against the doctor for intentional acts and battery that were alleged in the compliant. He claimed that there was a conflict of interest and demanded separate counsel, which was hired at a cost of $300 per hour. An offer to settle came in from the plaintiff’s attorney for $100,000 (above NPDB reportable limits). The doctor refused to settle unless he was dismissed from the case. The settlement was then made on behalf of the hospital; no report was made to the National Practitioner Data Bank (NPDB).

THE NEW PARTNERSHIP: PHYSICIANS AND RISK MANAGERS

As delivery systems shift from a volume-based fee-for-service model to a value-based care delivery system, primary and specialty physicians are seeking employment with various provider systems or networks in ever increasing numbers. Chances are good, therefore,
that hospital risk managers will be involved in some aspect of managing physician claims. Whether the employer is a hospital, a hospital system, ACO or other entity, the relationship between physician and the risk management department is crucial in obtaining the best claim resolutions. In short, the better the relationship – the better the outcome.

Recent statistics show that physician employment could hit 75%, eclipsing private practice, in 2014. According to Merritt Hawkins, a physician recruitment firm, hospitals will employ three-quarters of physicians by 2014.¹ The reason for this migration to an employed rather than independent status is multifaceted and includes improved quality of life with schedules and time off, less administrative management responsibility, decreased medical malpractice insurance costs and improved benefits.²

As risk manager of an entity that employs physicians, your risk and claim management strategies are also changing. Physician claims are personal, because a physician’s reputation or license may be at stake. Doctors are accustomed to physician insurance carriers fully managing these claims and providing risk management education. A physician carrier’s management of a claim may be quite different from that of the entity’s risk manager. Physicians are not always convinced that the hospital or other entity has their best interests in mind when resolving claims. They are also used to having a degree of control throughout the life of the claim. Trust must be established between the physician and the hospital risk management staff in order for claim management to be optimal.

**SOME OF THE ISSUES**

**CLAIM MANAGEMENT AND CLAIM REPORTING**

Physicians rolling into the hospital’s program as employed physicians come from many different orientations on claim and incident reporting. Claim management will now likely be done under the direction of the hospital’s risk management department. Confusion can develop on how the incident and claim reporting process should work. Incidents and claim reporting will likely take a new track and the risk of non-reported claims can increase. A clear and concise incident and claim reporting policy consistent throughout the organization must be developed. Training and dissemination of incident reporting forms should be done early in the physician’s employment, preferably during orientation. Risk managers should strive for a policy that allows them to receive incident, claim and lawsuit information within 24 hours of an occurrence.

**DETERMINING COVERAGE**

The claim handler for physician claims must determine whether or not the physician has coverage, whether the dates of the claim and notice provisions are met, and whether the employed physician is practicing within the scope of his/her employment.

The entity is responsible for the acts of the employee practicing within the scope of their employment. Sometimes the scope of employment is not clearly defined by the employment agreement and issues such as moonlighting and board involvement for other entities are not addressed. It is important to determine that the act giving rise to the claim occurred within the scope of the physician’s employment or there may be no coverage for the physician. This issue should be addressed in employment contracts and insurance policy language. Although, there is more flexibility with a captive insurance program to provide coverage, in some situations some entities may choose not to cover a claim of this nature. This determination should be made as early as possible in the life of a claim.
The general rules on whether an employer will be held responsible for the acts of the employee are:

- Employer is ALWAYS DIRECTLY LIABLE for its own negligence in hiring, training or supervising employees.
- An employer is ALWAYS VICARIOUSLY LIABLE for the wrongful acts of an employee within the scope of his or her employment.
- An employer MAY BE VICARIOUSLY LIABLE for the wrongful acts of an employee outside the scope of his or her employment.³

Any decision made as to whether an act or omission is within the scope of employment can be seen as a pattern of action for future claims that give rise to this same issue and should, therefore, be treated consistently.

Further complicating the issue of who is vicariously responsible for the acts of the employee are the many points of potential liability due to the various health care delivery models. Health care reform and the development of ACOs and other care entities might blur the picture. Any potential codefendants in the claim must be identified. The degree of participation or potential liability on the part of the codefendant will determine whether the entire matter should be tendered to the codefendant or apportioned between them.

CHOICE OF DEFENSE COUNSEL

Physicians may ask to select their own defense counsel. However, even most physician carriers have a panel of law firms from which to select. It is easiest to address this issue up front at the time of employment so that all parties agree on how to proceed when a claim comes in. Most organizations retain the right to select counsel from their panel and involve the physician in selecting from that defined panel.

RESERVATION OF RIGHTS

Typically, captive insurance companies do not reserve their rights in a medical malpractice matter. However, situations may occur where the entity’s policy specifically excludes an act or omission by the doctor, such as allegations of fraud or criminal acts, which could cause the entity to issue a reservation of rights letter to the physician, advising that full coverage is not available for a particular claim. Although this sounds like a good idea on the surface, there are a few things to consider. First, it will likely alienate the physician who may not be particularly cooperative as the claim moves forward; it may deter other physicians from becoming employees; or it could give rise to an actual conflict of interest and a right to independent counsel in some jurisdictions. Although most captives rarely reserve their rights, the manner in which these potential conflicts are managed is important; managing expectations early is key to an optimum outcome on the claim.⁴
CONFLICT OF INTEREST AND RIGHT TO INDEPENDENT COUNSEL

The entity that holds the captive insurance policy is now the insurance company in most respects and must afford such rights as due to the insured physician under state laws. One of these laws might be the right to separate counsel when there is a conflict between the insurance company and the doctor. These conflicts can occur when all of the acts or omissions alleged in the complaint are not covered and a reservation of rights has been made as described above. If all allegations are not covered under the captive policy, the defense of the employed physician might conflict with the interests of the captive/entity. In some jurisdictions, this may trigger the right to independent counsel for which the insurance company (captive) will have to pay reasonable attorney fees.\(^5\)

When other hospital employees are involved, physicians may deem it necessary to implicate them in defense of their claims. Because both the physician and the other implicated employees are employed by the same entity, the defense of the matter would probably not give rise to a conflict of interest, as the defense is aligned. However, it has been argued that if there is a reporting requirement to the NPDB, the defense may not be aligned and a conflict exists.\(^6\)

CONSENT TO SETTLE OR TRY A CLAIM

Who makes the decision to try or defend the case, or, if it is to be settled, for how much? Physicians have a personal interest in the outcome of their claims not only for reputation’s sake but also for reporting to state and national medical practice data banks.\(^7\)

The first thing to look at is the captive policy. Is there a settlement clause in the policy and does it clearly state who has the authority to settle a claim? This needs to be viewed in light of state statutes. With most captive policies, the consent to settle lies with the hospital; however, a few states take the position that the physician has the ultimate right of settlement and give the physician a statutory right to consent to settle a medical malpractice claim. These states require that the physician give consent before the insurer can settle a professional liability claim on his or her behalf. The California Business and Professions Code, § 801.1(j), for example, states, “Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured. ... The requirement of written consent shall only be waived by both the insured and the insurer.”\(^8\)

If the state has such a statute, the law must be followed regardless of what the captive policy says. If the captive policy is silent on the issue, the position taken must be consistent over time in similar circumstances.

Physicians are accustomed to consent to settle language from their medical malpractice policy. The issue becomes: Who has the right to consent or prevent settlement if the physician is an employee? Usually the
entity would have the consent unless the policy or a contract specifies something different in an employment situation. Physicians are typically not pleased with no right to consent to settlement because they think that it is their reputation at stake and that they have limited, or have lost, control of the process. They are not always convinced that the entity has a doctor’s best interests in mind when settling a case.

The best way to deal with consent issues is to address them before a claim occurs and delineate this in the captive insurance policy or the employment contract so that expectations of all parties are aligned from the start.

Assuming that the physician agrees to settle a particular claim, the amount of the proposed settlement becomes very important because it may trigger state and federal settlement reporting requirements.

SETTLE ON BEHALF OF AND THE NPDB

A technique often used by defense counsel is to dismiss the doctor from the case and settle the claim on behalf of the hospital. Is this a good technique or are there ramifications to this approach?

A case settled on behalf of a physician must be reported to the NPDB. So removing the doctor from the action is seen as a way for the hospital to protect the doctor. Also known as “shielding,” this technique has been known for years but has recently become more prevalent.

The data bank is a federally run register that is supposed to record all serious disciplinary actions taken against doctors and any payments made on behalf of doctors, because of either a verdict or a settlement, in a medical malpractice case.

The purpose of the data bank is to protect consumers by providing information to make decisions on whether to hire or discipline a doctor.9

If a practitioner is dismissed from a lawsuit prior to the settlement or judgment, any payment made to the plaintiff is not reportable. Also, payments made by the practitioner in a personal capacity are not reportable. However, if the dismissal from a lawsuit is a condition of a settlement or release, then the payment is reportable. Thus, it is important for physicians to monitor all malpractice litigation (even if payments are to be made by the hospital or insurance carrier) and to obtain early dismissal before settlement negotiations are undertaken.10

In addition, the regulation in the data bank’s guidebook says in bold face that “if the practitioner is dismissed from the lawsuit in consideration of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care practitioner and must be reported to the NPDB.”11 However, patients’ lawyers maintain that regulation still depends on the hospital, or the hospital’s insurance carrier, admitting to the data bank that the doctors were removed as a condition of the settlement – which, they say, almost never happens.12

Although settling on behalf of the hospital or entity instead of the physician appears to defeat the purpose of the NPDB, whether or not to use this technique is a decision for the entity and its attorneys.
PLAYING NICE IN THE SANDBOX – RISK MANAGEMENT TECHNIQUES

Physicians are used to having control over their medical malpractice claim process, so they will need to trust the claim management changes inherent in the employee arrangement. Techniques for fostering this trust are simple and go a long way to eliminating some of the issues above.

- Involve the physician employee, group or representative in the claim process as much as possible by allowing active participation in claim management policy and education.

- Develop a clear claim reporting process (i.e., a written policy for claim and incident reporting) and advise physicians on any changes from their prior process and experience.

- Establish a working relationship between the employed physicians and the risk manager. The risk manager should be visible and available to physicians providing education and process development in claim and risk management activities.

- Risk management should provide continued support and peer resources for strong provider reaction to malpractice claims.

- Consider developing a claim management committee where physicians are represented and involved in claim decisions.

- Determine where settlement authority lies. Often this is a matter of how much money is anticipated to settle the claim and settlement authority would be granted in a specific amount. Do this in advance of a claim, ideally at the time of employment.

- If there is a settlement, inform the physician what is being reported to the NPDB or state data banks.

- Manage expectations of choice of counsel in advance by developing a defense attorney panel with physicians.

- Keep the physician informed on the progress of the claim by copies of correspondence and input from expert witnesses.

- Involve physician in all aspects of settlement negotiations and seek his/her input.

- Address in advance the need for the physician to be available for trial and settlement negotiations.

- Thoroughly prepare the physician to understand the implications of body language, vocal tones and message when testifying if a trial seems inevitable.

- Review employment contracts for the presence of consent issues.

- Closed claim reviews should be mined for information for future risk management loss prevention educational offerings.
CONCLUSION

Handling medical malpractice claims for an employed physician requires attention to the unique interests and concerns of individual doctors as well as employing best practices in claim management. Communication and managing expectations at the start of a physician’s employment are vital. Another key component in obtaining optimal claim outcomes is the involvement of employed physicians in all aspects of claim management policy development that might affect them. When changing policies and loss prevention education, risk management should include physicians whenever possible. Physicians should be strongly encouraged to take an active leadership role in risk management issues.

The ancient adage, “united we stand and divided we fall”, aptly describes the relationship between an employed physician and a captive insurance company. The success of a captive claim management program depends on a committed, coordinated effort among all parties.

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