Disciplining the Difficult Doctor

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INTRODUCTION

Physicians with performance or behavioral issues pose unique challenges for employers. These materials provide an overview of those challenges, state and federal employment law implicated by such challenges, and practical strategies for dealing with difficult employed physicians. This outline will focus on employed physicians in the clinic and group practice setting and not, for example, hospital or medical staff privileges.

I. THE CHALLENGES/RISKS OF DEALING WITH PROBLEM PHYSICIANS

A. Increased Stakes

Physicians with performance or behavioral issues pose particular problems for employers, given the increased stakes involved in dealing with physician employees.

B. Overview

When it comes to disciplining or terminating a physician employee, the process is often more complicated and the stakes higher.

1) **High Income Profiles**: High compensation means physicians are going to have a significant amount to lose and disposable income to obtain legal counsel and engage in a dispute over the termination or disciplinary process.

2) Reputational Concerns: A physician's ability to seek other employment relies substantially on the respect of peers and health care institutions. A physician is likely to be particularly sensitive to investigations, actions, or terminations that he or she views as negatively impacting their reputation.

3) Large Egos: Physicians, likely due to their education and status, may have large egos. Regardless of whether the size of their ego is well-founded, the implications of that ego mean a dispute is more likely, as a physician is not likely to take well to being told that a behavior, whether a matter of professional competence or social grace, is not appropriate.

4) Intelligent/Aggressive: A physician's intelligence may also lead to a more combative interaction, given the physician's desire to disprove allegations or prove professional competence.

5) Likely to Fight: The characteristics noted above make the possibility of a dispute more likely than the standard employment setting and the standard employee.

C. All the Usual Employment Law Risks

Physician-employees may raise unique issues, but the following fundamental employment law risks apply equally in cases of physician disciplinary actions and terminations. The following "Big 4" are common employment-related claims that can result from any disciplinary action or termination.

1) Discrimination Claims

a) Title VII of the Civil Rights Act.

i. Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex and national origin. 42 U.S.C. § 2000e et. seq.

ii. Federal appellate courts are divided, but the Equal Employment Opportunity Commission and some appellate courts have taken the position that Title VII also prohibits discrimination based on sexual orientation and transgender status or gender identity. EEOC v. R.G. & G.R. Harris Funeral Homes, Inc., 2018 WL 1177669 (6th Cir. 2018); Zarda v. Altitude Express, 855 F. 3d 76 (2d Cir. 2017); Hively v. Ivy Tech Community College, 853 F.3d 339 (7th Cir. 2017); Evans v. Georgia Regional Hospital, 850 F.3d 1248 (11th Cir. 2017).

iii. The Pregnancy Discrimination Act of 1978 amended Title VII to "prohibit sex discrimination on the basis of pregnancy." 42 U.S.C. § 2000e(k).

b) Age Discrimination in Employment Act of 1967 ("ADEA"). The ADEA protects certain applicants and employees 40 years of age and older from discrimination on the basis of age in hiring, promotion, discharge, compensation, or terms, conditions or privileges of employment. 29 U.S.C. § 621.

c) Americans With Disabilities Act ("ADA"). The ADA prohibits discrimination based on disability against a qualified disabled person, a person who is regarded as disabled, and a person who associates with a disabled person. 42 U.S.C. § 12112(a).

d) Family and Medical Leave Act ("FMLA"). Although not strictly a discrimination statute, the FMLA grants eligible employees the right to job-protected leave for certain family, medical, and military reasons and prohibits interference or discrimination based on such leave. 29 U.S.C. § 2615.

e) Minnesota Human Rights Act ("MHRA"). Under the MHRA, it is an unfair employment practice to discriminate against a person with respect to hiring, tenure, compensation, terms, upgrading, conditions, facilities or privileges of employment based upon race, color, creed, religion, national origin, sex, marital status, familial status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation, or age. Minn. Stat. §§ 363A.03, 363A.08.

2) Whistleblowing and Retaliation Claims

a) A number of laws prohibit disciplining or terminating an employee in retaliation for engaging in legally-protected activity. For example:

i. Minnesota Whistleblower Act, Minn. Stat. §§ 181.932-181.935, prohibits an employer from discharging, disciplining, threatening, discriminating against, or penalizing an employee who engages in a variety of protected activities, including, for example, an employee who:

1) in good faith reports a violation, suspected violation, or planned violation of any federal or state law or regulation or common law to the employer, a governmental body, or a law enforcement official;

2) is requested by a public body or office to participate in an investigation, hearing, or inquiry;

3) refuses an employer's order to perform an action that the employee has an objective basis in fact to believe violates any state or federal law or regulation, and the employee informs the employer the order is being refused for that reason; or

4) in good faith reports a situation in which the quality of health care services provided by a health care facility or provider violates a standard established by federal or state law or professionally-recognized national, clinical, or ethical standard and potentially places the public at risk of harm.

ii. The anti-discrimination laws prohibit retaliation against any person for engaging in protected conduct.

1) The MHRA prohibits reprisal against any person who is associated with a person in a protected class, opposed a discriminatory practice, filed a charge of discrimination, or testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under the MHRA. Minn. Stat. § 363A.15.

2) Title VII. Title VII provides that: "It shall be an unlawful employment practice for an employer to discriminate against any of his employees or applicants for employment … because he has opposed any practice made an unlawful employment practice by this subchapter, or because he has made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this subchapter." 42 U.S.C. § 2000e-3(a). A plaintiff must

establish that the desire to retaliate was the "but-for" cause of the challenged employment action, not simply a motivating factor. Univ. of Tex. SW. Med. Ctr. V. Nassar, 133 S.Ct 2517 (2013).

3) The ADEA, ADA, and the Equal Pay Act ("EPA") contain anti-retaliation provisions similar to Title VII. 29 U.S.C. § 623(d); 42 U.S.C. § 12203(a); 29 U.S.C. § 215(a)(3). The ADA further provides that it is unlawful "to coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by this chapter." 42 U.S.C. § 12203(b).

iii. The Minnesota Workers' Compensation Act, Minn. Stat. § 176.82, prohibits terminating or threatening to terminate an employee for seeking workers' compensation benefits.

iv. The FMLA, 29 U.S.C. § 2615, prohibits terminating any person for opposing any practice made unlawful by the FMLA, filing a charge or proceeding, giving information in connection with an inquiry, or testifying.

v. The Minnesota Parenting Leave Act ("MPLA") provides eligible employees with up to twelve weeks unpaid leave for the birth or adoption of a child. Minn. Stat. § 181.941. The MPLA prohibits retaliation. "An employer shall not retaliate against an employee for requesting or obtaining a leave of absence as provided by this section." Minn. Stat. § 181.941, subd. 3.

b) Whistleblowers can prevail on their claims even if their original complaint had no merit as long as the original complaint was brought in good faith.

3) Breach of Contract/Promissory Estoppel

a) Failure to abide by promises may lead to breach of contract and promissory estoppel claims.

b) Physicians may have protective agreements, including, for example, employment agreements and shareholder agreements.

c) Employment policies may create enforceable unilateral contracts. Pine River State Bank v. Mettille, 333 N.W.2d 622 (Minn. 1983).

d) Before terminating, review the personnel file and all applicable documentation, including employment agreements, shareholder

agreements, offer letters, employee handbooks, personnel policies, disciplinary warnings, and compensation plans.

4) Torts

a) There are a number of tort claims, but the most common tort claim in the employment setting is defamation (libel or slander).

b) A statement is defamatory if it (a) is communicated to someone other than the plaintiff, (b) is false, and (c) tends to harm the plaintiff's reputation and to lower him or her in the estimation of the community. Stuempges v. Parke, Davis & Co., 297 N.W.2d 252, 255 (Minn. 1980).

c) In Lewis v. Equitable Life Assurance Society, the Minnesota Supreme Court recognized "self-publicized defamation," meaning that in certain circumstances a plaintiff may prove defamation even if the plaintiff is the one communicating the defamatory statement. 389 N.W.2d 876, 886 (Minn. 1986). The Court held that the "publication requirement [of a defamation claim] may be satisfied where the plaintiff was compelled to publish a defamatory statement to a third person if it was foreseeable to the defendant that the plaintiff would be so compelled." Id. at 888.

d) With self-publicized defamation, truth is still a defense. True statements, however disparaging, are not actionable as defamation. Stuempges, 297 N.W.2d at 255.

e) Even with self-publicized defamation, the employer may enjoy a "qualified privilege."

i. "[A] communication, to be privileged, must be made upon a proper occasion, from a proper motive, and must be based upon reasonable or probable cause. When so made in good faith, the law does not imply malice from the communication itself, as in the ordinary case of libel. Actual malice must be proved, before there can be a recovery, and in the absence of such proof the plaintiff cannot recover." Stuempges, 297 N.W.2d at 256-57 (citation omitted).

ii. "Malice" means the defendant "made the statement from ill will and improper motives, or causelessly and wantonly for the purpose of injuring the plaintiff." Id. at 257 (citation omitted).

D. Magnified Challenges for Physicians

1) Protective Employment Contracts

a) The Problem: Physician employment contracts are more likely to have protective, physician-friendly, terms. These terms may include: (a) lengthy advance notice requirements for without cause termination; (b) definitions of "cause" that establish a high bar; and (c) board of

director or shareholder voting approval requirements. This is particularly true for physician shareholders, whose exit is likely to trigger buy-out requirements, may pose financial strain on the practice, and could raise additional disputes.

b) Practical Tips: Make sure to review the applicable documents that govern any potential disciplinary action or termination, including the employment agreement and shareholder documents. Make sure the disciplinary action or termination conforms to contracts/documents:

i. If for cause, determination of cause requires careful legal analysis.

ii. Know exactly what the employment contract provides and how the clinic will manage the situation without creating a breach.

iii. Follow any notice, meeting, quorum, and voting requirements of the Bylaws and Shareholder Agreement if applicable, as well as the procedural requirements of the Employment Agreement.

2) Physician Shareholders

a) The Problem:

i. Minority shareholder protections. Minn. Stat. § 302A.751 gives Minnesota courts significant discretion to fashion a remedy when minority shareholders are treated in an unfairly prejudicial manner. The Minnesota Court of Appeals has held that an employee-shareholder may have a reasonable expectation of continuing lifetime employment. Pedro v. Pedro, 463 N.W. 2d 285 (Minn. App. 1990), 489 N.W. 2d 798 (Minn. App. 1992).

ii. Owner vs. employee. A shareholder may or may not be considered an "employee" for purposes of seeking protection under anti-discrimination statutes. Courts will look at various factors to consider whether the individual is a "servant" under common law and assess various factors to determine whether their work is controlled or subject to a right to control by a master. Clackamas Gastroenterology Associates, P.C. v. Wells, 538 U.S. 440, 444 (2003).

b) Practical Tip:

i. The reasonable expectation of lifetime employment for minority shareholders can be overcome by proper documentation of the intent of the parties in the form of a shareholder employment agreement. Gunderson v. Alliance of Computer Prof., 628 N.W.2d 173 (Minn. Ct. App. 2001).

ii. To determine whether an individual is an "owner" or an "employee," look to the following factors:

1) Whether the organization can hire or fire the individual or set the rules and regulations of the individual's work;

2) Whether and, if so, to what extent the organization supervises the individual's work;

3) Whether the individual reports to someone higher in the organization;

4) Whether and, if so, to what extent the individual is able to influence the organization;

5) Whether the parties intended that the individual be an employee, as expressed in written agreements or contracts; and

6) Whether the individual shares in the profits, losses, and liabilities of the organization.

Bluestein v. Central Wisc. Anesthesiology, 986 F.Supp.2d 937, 943 (W.D. Wis. 2013) (citing Clackamas, 538 U.S. at 449-50).

3) Protective Policies

a) The Problem: Practices may develop disruptive physician or general disciplinary policies to outline procedures for dealing with discipline or difficult physicians. These policies tend to be very limiting and may fail to be implemented or strictly followed in the disciplinary process. Failure to abide by policies can create grounds for disputes and potential breach of contract claims.

b) Practical Tips:

i. Discourage the adoption of restriction discipline and conduct policies.

ii. If drafting such policies, avoid rigid requirements. Instead, provide for flexibility and include disclaimers allowing discretion.

iii. Review existing policies to ensure policies provide a practical process for the employer and are not overly restrictive or unduly protective of the physician employees.

iv. Make sure policies, if any, are carefully drafted and that any disciplinary action is done in accordance with the policies.

4) Peer Review

a) The Problem: Peer review statutes allow physicians and other providers to evaluate each other's performance in a candid and, importantly, confidential manner without fear of malpractice claims. A formal peer review process has many benefits, but operates within a complex system of state and federal laws and imposes specific obligations on the employer to maintain peer review privilege during the process. Moreover, a physician, who can view a privileges or licensing-related peer review process as a career-threatening accusation, is likely to dispute the process, potentially claiming that unlawful motives tainted the process.

i. Minnesota's peer review statute, Minn. Stat. §§ 145.61-145.66, protects a "review organization," including clinics, from disclosure of information acquired "in the exercise of its duties and functions."

ii. The peer review statute permits the creation of review organizations "to gather and review information relating to the care and treatment of patients" for a number of purposes, including "evaluating and improving the quality of health care." Minn. Stat. § 145.61, subd. 5.

iii. The peer review statute prohibits the review organization from making unauthorized disclosures of peer review information. Minn. Stat. § 145.64, subd. 1. Unauthorized disclosure is a misdemeanor. Minn. Stat. § 145.66.

iv. In Minnesota, there is an exception to the peer review privilege which allows the physician reviewed by the peer review committee to have access to peer review privileged information through discovery in a lawsuit between the physician and the organization conducting the peer review. Minn. Stat. § 145.64, subd. 2. In such lawsuits, the court is usually asked to issue a protective order limiting the disclosure of the privileged information so that a third party (e.g., a news reporter, plaintiffs' malpractice attorney) does not have access to the peer review information.

v. The Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11101 et seq., is a federal law containing (1) provisions relating to immunity from damages for those involved in professional review activities; (2) requirements that health care entities (as defined in Section 6(a)(iv)(2)) and insurance carriers report information relating to the competence of physicians to the National Practitioner Data Bank ("NPDB"); and (3) requirements that healthcare entities request information from the NPDB on all physicians who apply for appointment to the medical staff or for privileges at the healthcare entity.

vi. HCQIA provides peer review participants and healthcare entities with significant immunity from claims arising from peer review actions, including antitrust, breach of contract, defamation, invasion of privacy claims, etc. If a professional review action meets all HCQIA standards, the review body and any person acting as a member of or staff to the body shall not be liable in damages under federal or state law with respect to the "professional review action." Discrimination claims, however, are a significant exception to such immunity. Notably, these include claims under Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Age Discrimination in Employment Act. 42 U.S.C. § 11111(a)(1)(D).

b) Practical Tips:

i. Adopt a legally-compliant peer review policy and process.

ii. For quality-of-care issues, conduct a thorough investigation using a peer review committee established under the peer review policy.

iii. Certain matters are appropriate for peer review and others are more appropriately treated as employment matters. While there are some overlapping issues, the peer review process ordinarily should be used for issues related to the practice of medicine, the provision of care by a physician or other practitioner, and standards of care. Issues related to employer-employee policies which are administrative or are not directly related to the practice of medicine ordinarily should be treated as employment matters. Failure to keep a license to practice medicine, repeated unexcused absenteeism, misuse or personal use of clinic or hospital equipment are examples of issues that are not generally reviewed as peer review matters.

iv. Minnesota law requires that the peer review committee must take reasonable steps to guard the confidentiality of the peer review information. All members of the review committee, all individuals interviewed or consulted with in the course of a review, and any outside experts should be reminded that they are obligated to keep the information confidential and privileged under peer review. Information should only be shared with those on the peer review committee or those who need to know in order to meet the purposes of the review.

v. Physicians on the review committee and board should be careful not to discuss the matter in open areas, as this is often the source of a breach of confidentiality that results in the privilege being "waived" inadvertently.

5) State and Federal Privacy Laws (e.g., HIPAA and the Minnesota Health Records Act)

a) The Problem: Part of proper documentation is telling the story for an outside audience. State and federal privacy laws require the protection of a patient's protected health information ("PHI") and makes telling a compelling story trickier.

i. Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA permits a covered entity to use PHI for "health care operations" without patient consent. 45 C.F.R. § 164.506. "Health care operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, which are limited to the activities listed in the definition of "health care operations" at 45 C.F.R. § 164.501, include reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing, or credentialing activities.

ii. Minnesota Health Records Act, §§ 144.291-144.298, requires patient consent for the release of information outside the health care entity.

b) Practical Tips:

i. Take caution when using PHI and identities of patients to justify employment decisions or disciplinary actions.

ii. Be mindful during all stages of the process (e.g., investigation, disciplinary action, termination) that a third party or the physician at issue may need to read and draw conclusions from the documentation.

iii. Consider pro-active redaction or de-identification of PHI. Information compiled for "health care operations" may later be used for other purposes and not a permitted disclosure under HIPAA.

iv. If an outside lawyer is engaged for a dispute, make sure there is a Business Associate Agreement ("BAA") in place between the covered entity and the lawyer.

6) Reporting

a) The Problem:

i. Physician disciplinary actions and terminations may also trigger reporting requirements to state licensing boards or the NPDB.

ii. Reporting obligations exist at both the state and federal level in order to prevent incompetent physicians from moving from one entity to another or from one state to another without disclosure or discovery.

iii. Minnesota Board of Medical Practice Required Reporting:

1) *Facility Reporting:* Under the Minnesota Medical Practice Act, health facilities, including clinics, are required to report to the Minnesota Board of Medical Practice "any action taken by the institution or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition a physician's privilege to practice or treat patients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action." Minn. Stat. § 147.111, subd. 2. Clinics must also report the resignation of any physicians prior to the conclusion of any disciplinary proceeding, or prior to the commencement of formal charges but after the physician had knowledge that formal charges were contemplated or in preparation.

2) *Other licensed professionals:* A licensed health professional and individuals holding residency permits are required to report to Minnesota Board of Medical Practice "personal knowledge of any conduct which the person reasonably believes constitutes grounds for disciplinary action [under the Medical Practice Act] by any physician or person holding a residency permit . . . including any conduct indicating that the person may be medically incompetent, or may have engaged in unprofessional conduct or may be medically or physically unable to engage safely in the practice of medicine." Minn. Stat. § 147.111, subd. 4.

3) *Self-reports:* A physician is required to self-report to the Minnesota Board of Medical Practice any personal action which would require that a report be filed with the board by any person, health care facility, business, or organization as specified in Minn. Stat. § 147.111. Minn. Stat. § 147.111, subd. 7.

4) *Reporting Timeframes:* All required reports to the Minnesota Board of Medical Practice must be submitted no later than 30 days after the occurrence of the reportable event or transaction and failure to report may

result in civil penalties. Minn. Stat. § 147.111, subd. 8, 10.

iv. National Practitioner Data Bank ("NPDB") Reporting:

1) A clinic meeting the definition of a "health care entity" has a duty to report if it (i) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days or (ii) accepts the surrender of clinical privileges by a physician (a) while the physician is under investigation by the entity relating to possible incompetence or improper professional conduct, or (b) in return for not conducting such an investigation or proceeding. 45 C.F.R. § 60.12.

2) A clinic is only a mandated reporter to the NPDB under HCQIA if it meets the definition of a "health care entity," i.e., that it follows a formal peer review process, involving notice and an opportunity for a hearing, to further quality health care. Thus, a clinic may opt out of becoming a reporter by not implementing such formal peer review processes that are required to include certain due process requirements, including notice, a hearing and appeal process. 45 C.F.R. § 60.3.

3) Note that the Minnesota peer review statute is more flexible than the definition of "formal peer review" under HCQIA and does not require hearings or appeals.

v. There may be concurrent investigations and reporting by the clinic, peer review organizations, hospital medical staff, and state or federal authorities.

b) Practical Tips:

i. Don't wait on others' investigations. The clinic should follow its own process and draw its own conclusions. Evaluate any reports made by other organizations, but do not let another organization's investigation control or drive the clinic's disciplinary process.

ii. Evaluate whether the clinic has an obligation to report under any state or federal laws. Whether or not reporting is required will be a facts-and-circumstances based analysis.

iii. If the disciplinary or termination action triggers a self-reporting obligation by the physician, the clinic may choose to remind the physician of such obligation, but should leave the reporting itself to the individual.

7) Partners and Privileges

a) The Problem: The physician may be on staff at an affiliated hospital or ambulatory surgery center ("ASC"). Accordingly, the physician may be subject to other organization's third party policies, medical staff bylaws, and peer review process. The clinic employer may not learn of the disciplinary proceeding or underlying issue until the hospital or ASC has made its own independent determination.

b) Practical Tips:

i. If a clinic is made aware of an investigation, ordinarily it should not simply wait on the other organization's investigation.

ii. The clinic should continue to manage the employment relationship during the third party's investigation.

iii. Ordinarily, the clinic should investigate and gather facts on its own and decide on its own employment action.

iv. If possible, the clinic should get information from the hospital or ASC.

v. The clinic should review its employment agreements to determine its rights as employer as a result of another organization's determination (e.g., the restriction or termination of privileges at a hospital is often a terminable offense under an employment agreement).

vi. If the clinic has a professional services agreement with such organization, there may be a contractual obligation for the partner to provide the clinic with notice of an issue related to professional competence or other complaints.

8) Whistleblower and False Claims Act Risks

a) The Problem: Additional risks in disciplining and terminating physicians arise as a result of health care fraud and abuse laws, most notably the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, and its accompanying prohibitions on retaliation. The FCA allows individuals to file suit for violations of the FCA on behalf of the government. Disgruntled employees (including employed physicians) are more likely to file FCA complaints, whether or not meritorious. FCA claims are made particularly enticing by the financial reward for successful claims.

i. The FCA imposes liability upon any person who, among others:

1) "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;"

2) "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;"

3) "conspires to commit a violation [the FCA];" or

4) "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1).

ii. The key elements of a viable FCA claim are falsity, intent (scienter), materiality, and causation.

iii. The number of whistleblower actions has been steadily increasing in recent years. Private citizens ("relators"), including physicians, may file complaints alleging violations of the FCA. These suits are called "*qui tam*" actions. Initially, a *qui tam* complaint is filed under seal (i.e., the case is confidential), even from the named defendant. Once the seal is lifted, the complaint is served on the defendant. Once a whistleblower files an FCA action, the Department of Justice ("DOJ") must decide whether to "intervene" (i.e., take over and prosecute the action).

iv. If the DOJ intervenes in the *qui tam* action, the relator is entitled to receive between 15 and 25 percent of the amount recovered by the government through the qui tam action.

v. An employee's protected activity must be the "but for" cause (and not just a "motivating factor" of the adverse employment actions) to support a retaliation claim under the FCA. DiFiore v. CSL Behring, LLC, No. 16-4297 (3d Cir. Jan. 3, 2018).

vi. There is a three-year statute of limitations for retaliation suits under 31 U.S.C. § 3730(h) of the FCA.

vii. This is in addition to whistleblower protections under Minnesota law as noted above, Section I.B.2.

b) Practical Tips:

i. Employers should carefully investigate all claims of fraud (even by apparently disgruntled employees), follow their existing compliance policies and code of conduct, document their actions at all stages of the proceeding and apply their disciplinary provisions fairly and uniformly to all employees.

Failure to do so may result not only in an employment lawsuit but also a FCA claim.

ii. Be aware of the risk.

iii. Run a tight ship.

iv. Have and follow a compliance program.

v. Whenever disciplining or terminating a physician, conduct a thorough investigation and document the existence of a compelling lawful business reason for the action.

II. TWO SCENARIOS

A. Case Study: The Difficult Doctor

1) Case Study No. 1[1]

a) Dr. Hagen was a doctor of obstetrics and gynecology and a partner in a group practice.

b) The other owners of the practice had concerns regarding Dr. Hagen's behavior, including concerns regarding his anger, alcohol use while on call, and poor behavior towards staff. He allegedly yelled at staff, belittled nurses, and threw surgical equipment at staff. Referring providers found him confrontational.

c) In November 2009 there was an incident in which one of the other partner's patients was admitted to a hospital with a condition that threatened her 34-week-old fetus. The hospital contacted Dr. Hagen when his partner was unavailable, and when he arrived, he was told the baby was dead. He then reportedly cursed at nurses and accused them of letting the fetus die. Dr. Hagen told the hospital he was reporting himself for cursing at nurses, reporting the nurses for not treating the patient well, and reporting his partner for not coming to see the patient. He also said he may report his partner for malpractice and told his partners that he was going to get the patient to sue the hospital.

d) The hospital suspended Dr. Hagen for 10 days for yelling at nurses.

e) The partners of the group practice terminated Dr. Hagen for willfully violating professional ethics and his employment agreement.

[1] Based on Hagen v. Siouxland Obstetrics & Gynecology, 799 F.3d 922 (8th Cir. 2015). Facts based on district court's order on defendant's motion for summary judgment. *See* Hagen v. Siouxland Obstetrics & Gynecology, 934 F.Supp.2d 1026 (N.D. Iowa 2013).

f) Dr. Hagen sued the practice, claiming, among other things, that his partners fired him in retaliation for mentioning he might report one of the partners for malpractice.

g) At trial, the partners testified that Dr. Hagen was erratic and abusive when in the office. After an eight-day trial, the jury upheld Dr. Hagen's public policy tort claim and awarded him $1.05 million.

h) The Eighth Circuit later reversed the jury's judgment, holding that Dr. Hagen could not assert a tort claim for wrongful discharge for violation of Iowa public policy because the claim is limited to at-will employees and, because Dr. Hagen had an employment agreement that protected him from wrongful discharge, breach of his employment agreement was his exclusive remedy.

2) Process

a) Plan. Develop an investigation plan. Consider obtaining legal advice.

b) Documentation. Gather and review all relevant documents that will govern the investigation and potential actions: employment agreement, conduct and disruptive physician policies, peer review policies, and contracts with other hospitals and ASCs.

c) Fact-Finding. Gather and review facts from employees, including those who have formally complained as well as those who may have knowledge of the alleged behavior. Interview complainants, key witnesses, and the accused physician; review relevant documentation; and consider other sources of evidence (e.g., computer data, email, surveillance tapes).

d) Investigate.

i. Be thorough and neutral.

ii. Consider using an independent investigator.

iii. Consider referring the matter to the peer review committee.

iv. Be discreet but do not promise confidentiality (if peer review, remember confidentiality obligations).

v. Get physician's side of the story and provide opportunity to respond to complaint allegations.

vi. Factual detail is critical.

vii. The investigator should carefully and factually document the investigation. Keep the documentation in a separate, confidential investigation file (and not, for example, in the physician's personnel file).

e) Formal Review. (Peer Review or Board)

i. Consider discussing investigation results and options with legal counsel.

ii. Typically, the peer review process should be used for issues related to the practice of medicine, the provision of care by a physician, and standards of care. If the physician's issues do not cross into professional competence categories, ordinarily the process should be treated as an employment matter, reviewed by human resources and decided by the Board.

f) Consider Remedial Measures. If investigation proves the allegations are merited but remediable, consider appropriate response:

i. Disciplinary action, such as written warning, performance improvement plan, demotion, and/or unpaid suspension.

ii. Coaching.

iii. Other actions such as limiting contact, removing duties, or changing work situations.

iv. Prohibit retaliation.

v. Termination.

g) Determine Reporting Obligations. Review findings and remedial measures to determine whether or not the conduct requires reporting.

h) Termination. If termination is an option, consider:

i. Employment Agreement:

1) Consider available bases for termination and pros and cons of the various termination bases (e.g., terminating with "Cause" vs. "Without Cause").

2) Review and follow any employer notice obligations. Using a without cause termination provision within the contract may be desirable to prevent a breach of contract dispute.

3) Review restrictive covenants, including any non-solicit restrictions.

4) Confirm any severance requirements or other applicable termination provisions.

ii. Strategies to reduce risk:

1) Documentation

2) Coaching

3) Negotiated resignation or mutual separation: Consider negotiating with the physician to craft a transition and termination that would be considered a win by both parties. For example, the parties can negotiate a transition period, a mutually-agreed public announcement, and the terms of a Separation and Release Agreement.

4) Separation and Release:

1. There is no law requiring Minnesota employers to pay severance to terminated employees. Absent an employment agreement or severance policy or plan, an employer need not pay severance to a terminated employee.

2. Consider offering terminated employees severance in exchange for a full release of claims.

3. This may help (i) avoid litigation and potential losses (a legally-compliant release will bar most, though not all, possible legal claims); (ii) make the physician less angry; (iii) provide closure (legal and psychological); and (iv) provide a "win-win" outcome.

4. Almost all problematic potential claims can be released. The following claims can be released as part of a valid severance agreement and release:

    a. Discrimination lawsuits. Pilion v. University of Minnesota, 710 F.2d 266 (8th Cir.1983)), ADA claims (Kujawski v. U.S. Filter Wastewater Group, Inc., 2001 U.S. Dist. LEXIS 17578 (D. Minn. Aug. 7, 2001)), ADEA claims (Warnebold v. Union Pacific Railroad, 963 F.2d 222 (8th Cir. 1992)), and MHRA claims (Somora v. Marriott Corp., 812 F. Supp. 917 (D. Minn. 1993)).

    b. Discrimination charge damages. EEOC Enforcement Guidance on non-waivable employee rights under Equal Employment Opportunity Commission (EEOC) enforced statutes (Apr. 10, 1997), citing EEOC v. Cosmair, Inc., 821 F.2d 1085, 1091 (5th Cir. 1987) (although an employee cannot waive the right to file a charge with the EEOC,

employee can waive the right to recover in his/her own lawsuit as well as the right to recover in a lawsuit brought by the EEOC on the employee's behalf).

c. FMLA. Paylor v. Hartford Fire Ins. Co., No. 13-12696 (11th Cir. Apr. 8. 2014).

i) Close the Loop. Close the investigation loop by informing complainants, ordinarily in writing, that the matter has been investigated, remedial action has been taken and retaliation will not be tolerated.

B. Case Study: Competence Complaints

1) Case Study No. 2[2]

a) Dr. Aluru was a licensed anesthesiologist who was employed by an anesthesiology group practice. Shewais a member of several protected classes: female (sex); of Indian descent (race and/or national origin); Hindu (religion); and over the age of 40 (age).

b) She began working at the group practice in 2001 and received good reviews from 2001 to 2005. Sometime around 2006, the practice began receiving complaints from surgeons regarding Dr. Aluru's professional competence and timeliness.

c) The group did not document any specific performance review or the communication of those complaints to Dr. Aluru. Instead, the group's president used more passive and indirect methods, including intervening to make sure she was assigned less complex cases and encouraging her to seek out additional training.

d) The group's president believed Dr. Aluru's proficiency was continuing to deteriorate (although she was given a raise during the same period).

e) The group lost a major hospital contract. Shortly thereafter, the group terminated Dr. Aluru based on her inability to handle complex cases, as well as the financial pressures faced by the group as a result of the lost contract.

f) Dr. Aluru filed suit alleging various discrimination claims based on race, religion, national origin, and age, related to adverse employment actions including denial of vacation requests, less favorable scheduling, and termination.

[2] Aluru v. Anesthesia Consultants, Professional Corporation, 176 F.Supp.3d 1116 (D. Colo. 2016).

g) The group was able to show that it had a legitimate, non-discriminatory reason for terminating Dr. Aluru as a result of the financial pressures and her performance was, relatively-speaking, unsatisfactory.

h) "It may be bad personnel practice for an employer to silently harbor doubts about an employee's performance, rather than to inform the employee about those concerns, but . . . the Court does not sit in judgment on whether [the group's] business management decisions we appropriate."

i) The court granted summary judgment in favor of the group practice.

2) Process

a) Initial Investigation. Follow the same steps set forth above.

b) Formal, Professional Competence-Based Review. A matter that deals with professional competence typically is best investigated by a peer review committee following the clinic's peer review process.

c) Report to the Board of Directors. Ordinarily, the role of the peer review committee is limited to investigation, fact finding, and making a recommendation of an action to improve patient care. Typically, the peer review committee should report its findings and make a recommendation to the Board of Directors, meeting as a review organization. This allows the discussions and investigation of the review organization to be privileged and confidential from discovery in a medical malpractice lawsuit.

d) Maintain Privilege. The recommendations of the peer review committee are privileged, but once the Board or governing body takes an action (or no action), the action or no action is not privileged (although it may still be confidential).

e) Considers Steps to Help/Remedial Measures. Consider implementing various steps, including:

i. Peer review or supervision systems.

ii. Coaching or proctoring.

iii. Training.

iv. Process changes to accommodate physician's needs.

v. Third-party assessment and education.

vi. Restrict practice.

f) Document. Thoroughly document the process in writing: factual details, but be cognizant of protection PHI, as the documentation may end up being used externally.

g) If Medical Related. If the behavior or conduct is a result of a medical condition (i.e., due to disability or health condition), the employer likely will want to seek job-related medical information and will have to evaluate whether it is required to make reasonable accommodation.

h) Disciplinary Documentation. Consider whether to give the physician a written warning or performance improvement plan.

i) Consider Remedial Measures. Consider appropriate remedial measures based on the outcome of the investigation:

   i. Disciplinary action, such as written warning, performance improvement plan, demotion, and/or unpaid suspension.

   ii. Coaching.

   iii. Other actions such as limiting contact, removing duties, or changing work situations.

   iv. Prohibit retaliation against complainants and witnesses.

   v. Termination.

j) Determine Reporting Obligations. Review findings and remedial measures to determine whether or not the conduct or actions require reporting.

k) Monitor. Monitor physician's progress after steps above are implemented; document progression or regression.

l) Separation. If concerns are serious, persistent, or non-remedial, steps are insufficient or patient care concerns persist, consider separation strategy, noted above.