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Serving Two Masters: Conflicts Between Physician Employment Contracts and the Physician's Duty of Care

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INTRODUCTION

Imagine a potentially lethal contagion of unclear origin wreaking havoc with the U.S. healthcare system. Entering its third year, the rapidly evolving organism has become endemic throughout much of the United States, the mutant strains more communicable but only somewhat less virulent. Spreading at breakneck pace, the disease has caused staffing shortages and generated exorbitant replacement costs. Having now spread to a group of Emergency Department physicians, their employer directs them to avoid testing and continue working, thus knowingly exposing already sick and immunocompromised incoming patients to the potentially deadly virus.

Not the plot of a bad dystopian novel, this scenario is the fact pattern physicians in Houston allege in a lawsuit they filed against their employer.[1] They allege their employer implemented a "4 M's" policy — "Motrin, Mask, Man-up, and Must not test" — for physicians with COVID-like symptoms and that the sick physicians continue to work, putting their patients at undue risk of contracting COVID.[2] These physicians further allege their employer's policies forced them to choose between their employment obligations and their duty to their patients.[3]

The changing physician employment landscape foretells more situations like the above doomsday scenario. In 1963, 81% of practicing physicians not employed by the federal government worked in private

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[1] Gretchen Morgenson, *These ER Doctors Said Profit-Driven Company Officials Pressed Them to Work While They had COVID Symptoms*, NBC NEWS (June 24, 2022, 3:30 AM), https://www.nbcnews.com/health/health-care/er-doctors-said-profit-driven-company-officials-pressed-work-covid-sym-rcna33237.

[2] *Id.*

[3] *Id.*

practices.[4] By 2021, nearly 70 percent of physicians were hospital or corporate employees.[5] In certain specialties the transition has been even more dramatic: in 2008, for example, 90 percent of U.S. cardiologists worked in private practice, but by 2018, only 16 percent of cardiologists remained in private practice.[6]

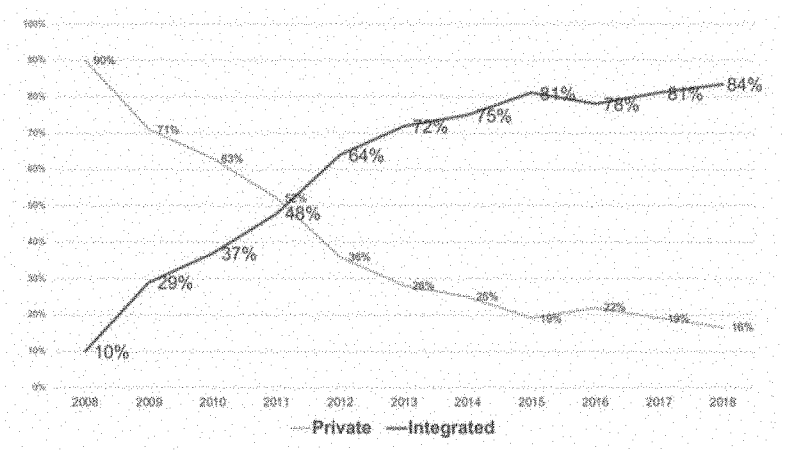

Fig. 1: Cardiologists in private practice and in integrated (employed) positions, 2008–2019[7]

The bases for this shift are multifactorial, and include a combination of administrative burdens, financial incentives, and cultural changes, that, together, have led to an accelerating change in physician-hospital business and legal relationships. These changes in the healthcare environment raise questions regarding how hospital-physician contractual relationships

[4] Maryland Y. Pennell, *Statistics on Physicians, 1950-63*, 79 PUB. HEALTH REP. 905, 907 (Oct. 1964), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1915580/pdf/pubhealthreporig00070-0063.pdf.

[5] *See generally* Nathan Eddy, *Nearly 70% of U.S. Physicians are Employed by Hospitals or Corporate Entities*, HEALTHCARE FIN. (July 13, 2021), https://www.healthcarefinancenews.com/news/nearly-70-us-physicians-are-employed-hospitals-or-corporate-entities (last visited Apr. 23, 2022) (noting that "[t]he COVID-19 trend accelerated the decade-long practice of hospitals and other entities acquiring physician practices, as physicians struggled to maintain private practices.").

[6] *Has Employment of Cardiologists Been a Successful Strategy?- Part 1*, AM. C. CARDIOLOGY (Nov. 6, 2019), https://www.acc.org/membership/sections-and-councils/cardiovascular-management-section/section-updates/2019/11/06/09/49/has-employment-of-cardiologists-been-a-successful-strategy-part-1.

[7] *Id.*

might contravene traditional legal concepts of physicians' duty of care, a duty the basis of which arises from both contractual concepts and from non-contractual historical ethics-based obligations.

This paper proceeds in four parts. Part I discusses the administrative, economic and cultural causes of physician migration from independent practitioners to employees. Part II discusses the ethical roots of physician duty of care to patients and their relationship to the legal duty, considering these concepts. Part III examines how physician-hospital contractual relationships may conflict with the physicians' duty of care, particularly relating to the concepts of relationship termination, withdrawal, and abandonment. Finally, Part IV posits actions that may reduce or eliminate potential problems resulting from the management of these issues.

I. THE GREAT MIGRATION: EXPLORING THE ROOTS OF PHYSICIANS' TRANSITION FROM INDEPENDENT PRACTITIONERS TO HOSPITAL EMPLOYEES

The transition of physician's working as independent practitioners to working as employees is multifactorial in origin, with three main driving forces. First, the administrative burdens of managing a medical practice have grown significantly. Second, physicians face financial pressures that, when combined with hospitals' financial incentives to employ physicians, make transitioning to employment status much more attractive. Finally, substantial cultural changes in American society have altered physicians' priorities in ways that are increasingly inconsistent with private medical practice. When combined and added to the multitude of other factors, these negative forces create a progressively challenging practice environment in which hospital employment is an especially compelling option solution for physicians.

A. Lions, Tigers, and Bears: Regulatory, Statutory, and Other Administrative Requirements Pose Substantial Burdens to Private Practice Physicians

Healthcare in the United States accounted for nearly 20 percent of GDP in 2020, up from just five percent in 1960.[8] Additionally, the federal

[8] *U.S. National Health Expenditure as a Percent of GDP from 1960 to 2020,* STATISTA (Dec. 1, 2022), https://www.statista.com/statistics/184968/us-health-expenditure-as-percent-of-gdp-since-1960/.

government spent nearly $1.5 trillion on healthcare in 2019.[9] The resulting regulatory regime that monitors these funds and shepherds the services provided has, unsurprisingly, grown into a Byzantine maze that private practice physicians find progressively more difficult to manage. Billing rules, electronic medical records and patient privacy are just three areas where the regulatory requirements have burdened physicians.[10] These three concerns, combined with the rigors of general small business management and numerous narrower but still substantial aspects of physician practice management, contribute to an increasingly challenging environment in which to operate a medical practice.

1. Billing and Payment Requirements Have Evolved into a Complex Regime that Can Overwhelm Private Medical Practices

Healthcare payors' need for uniform billing and payment procedures has resulted in a standardized system that can overwhelm private practices. The system is comprised of two key elements: first, the patient's diagnosis, and second, the evaluation or treatment service the physician provided to the patient.[11] To report the patient's diagnosis, the Centers for Medicare & Medicaid Services ("CMS") switched from requiring physicians use the International Classification of Disease ("ICD")-9 system for billing to requiring them to use the ICD-10 system in 2015.[12] This update to ICD-10 increased the number of potential diagnostic choices from 13,000 to 68,000.[13] As an example, there are 40 different diagnostic codes solely for

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[9] The White House, *Historical Table 3.1 Outlays by Superfunction and Function: 1940-2027*, THE WHITE HOUSE OFF. OF MGMT. AND BUDGET HISTORICAL TABLES, https://www.whitehouse.gov/omb/budget/.
historical-tables/ (last visited Apr. 22, 2022).

[10] Len Strazewski, *8 Threats Facing Physician Private Practices*, AM. MED. ASS'N (Feb. 21, 2022,), https://www.ama-assn.org/practice-management/private-practices/8-threats-facing-physician-private-practices.

[11] *Exploring the Fundamentals of Medical Billing and Coding*, REVCYCLE INTELLIGENCE, https://revcycleintelligence.com/features/exploring-the-fundamentals-of-medical-billing-and-coding (last updated Fed. 24, 2022) ("Diagnosis codes are key to describing a patient's condition or injury, as well as social determinants of health and other patient characteristics. The industry uses the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) to capture diagnosis codes for billing purposes. . . Procedure codes complement diagnosis codes by indicating what providers did during an encounter.").

[12] Donna Cartwright, *ICD-9-CM to ICD-10-CM Codes: What? Why? How?*, 2 ADVANCES IN WOUND CARE 588 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865615/.

[13] *Id.*

the treatment of snake attacks.[14] Similarly, CMS now requires physicians to use the Current Procedural Terminology ("CPT") to describe the services they provide; the CPT contains more than 10,000 codes.[15] Further, the CPT made over 300 code changes just in 2021.[16] Each code includes sufficiently detailed criteria, and the CMS estimates the error rate for certain CPT codes was as high as 24 percent in 2018.[17] As coding becomes more complex, this high error rate consumes significant time for medical offices, creating delays in billing, and fear among physicians of potential fraud investigations by creating outlier billing patterns arising from erroneous coding.[18]

2. Statutory Requirements Related to Electronic Medical Record Keeping have Impaired Physician Productivity and Efficiency

Similar issues of regulatory requirements impairing physician productivity arise for private practice physicians in dealing with electronic medical records and patient privacy. The Health Information Technology for Economic and Clinical Health ("HITECH") Act created substantial incentives to convert to electronic medical records ("EMR"), and substantial reductions in payment for physicians choosing not to convert.[19]

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[14] *A Complete List of ICD-10 Codes Related to the Animal Kingdom*, PRAC. FUSION, https://www.practicefusion.com/icd-10/animal-codes-icd-10/ (last visited Apr. 22, 2022).
[15] *CPT® Codes, Then and Now*, AM. MED. ASS'N (Aug. 4, 2015), https://www.ama-assn.org/practice-management/cpt/cpt-codes-then-and-now.
[16] Leigh Poland, *Highlights of the 2021 CPT Code Updates*, J. AM. HEALTH INFO. MGMT. ASS'N (Jan. 11, 2021), https://journal.ahima.org/page/highlights-of-the-2021-cpt-code-updates.
[17] Torrey Kim, *CMS Identifies E/M Codes with High Error Rates*, AM. ACADEMY OF PROFESSIONAL CODERS (Jan. 3, 2020), https://www.aapc.com/blog/49538-cms-identifies-e-m-codes-with-high-error-rates/.
[18] Katherine Drabiak & Jay Wolfson, *What Should Health Care Organizations Do to Reduce Billing Fraud and Abuse?*, AM. MED. ASS'N J. OF ETHICS (Mar. 2020), https://journalofethics.ama-assn.org/article/what-should-health-care-organizations-do-reduce-billing-fraud-and-abuse/2020-03; *see also* Guido van Capelleveen et al., *Outlier Detection in Healthcare Fraud: A Case Study in the Medicaid Dental Domain*, 21 INT'L J. OF ACCT. INFO. SYS. 1, 18, 19 (Mar. 25, 2016), https://capelleveen.org/wp-content/uploads/2021/11/Capelleveen2016-Outlier-detection-in-healthcare-fraud-a-case-study-in-the-medicaid-dental-domain-pre-print.pdf ("However, with upfront engineering and ongoing adaptations, techniques such as outlier detection are suggested as effective predictors.").
[19] HITECH Act, 42 U.S.C. § 300jj–31 (noting Secretary of Health and Human Services may invest funds to promote electronic exchange and use of health information, including promotion of health information technology architecture, training on best practices to integrate health information technology, and promoting the interoperability of such systems).

The legislation also created standards for EMR systems that have significantly limited options, increased costs and created additional infrastructure burdens for private practices including frequent software upgrades, ongoing training costs, hardware, IT security and IT department maintenance costs.[20] Most significantly, EMRs cause significant decreases in productivity by increasing the time physicians spend on recording and administering each patient's care within the system.[21] One study showed physicians actively engage with the EMR for more than fifteen minutes per patient encounter.[22]

3. Compliance with Patient Privacy Statutes Creates both Administrative and Financial Burdens for Medical Practices

Physicians in private practice similarly spend substantial amounts of time dealing with patient privacy issues. The Health Insurance Protection and Affordability Act of 1996 ("HIPAA") created substantial changes in patients' ability to protect personal information which HITECH expanded.[23] For practices, HIPAA requires ongoing education and compliance programming, voluminous paperwork and changes in workflow that create inefficiencies. For example, email must be properly encrypted, and standard communication programs may not be sufficiently secure, thereby requiring the use of special software or applications.[24] At least one report estimates that HIPAA implementation and compliance costs practices about $35,000 per year, with substantial penalties for even incidental unintentional personal health information disclosure.[25]

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[20] *See* Kim-Lien Nguyen, *HIPAA: At What Cost?*, MED. ECON. (Sept. 9, 2019), https://www.medicaleconomics.com/view/hipaa-what-cost (explaining the pitfalls of HIPAA implementation, including rising healthcare costs, lack of interoperability, impeded communication with and inefficient care of patients, rising costs of compliance, and deterred medical research. HIPAA has "also made it much harder for physicians and patients to work with innovators to advance healthcare technology.").

[21] Bruce Lee, *How Doctors May Be Spending More Time with Electronic Medical Records Than Patients*, FORBES (Jan. 13, 2020, 10:40 PM), https://www.forbes.com/sites/brucelee/2020/01/13/electronic-health-records-here-is-how-much-time-doctors-are-spending-with-them/?sh=3536b2475172.

[22] *Id.*

[23] 42 U.S.C. §§ 17931–17941.

[24] 45 CFR § 164.522(b).

[25] Nguyen, *supra* note 20.

4. Medical Practices Must Manage Compliance to all the Regulatory Requirements that Private Businesses Face, in Addition to Specific Health-Industry Requirements

Private practices also function as private business entities. In addition to industry-specific demands, private practitioners must manage the administrative and regulatory burdens of any other business entity. Consequently, physicians find themselves dealing with ever more complex financial, human resourcing, regulatory, tax, information technology and security issues. At least one industry report indicates small business owners spend up to 17 percent of their time managing administrative tasks that are not core business activities.[26]

5. Narrowly Focused Regulatory Requirements Add to Administrative Burden, Creating an Increasingly Untenable Environment in Which to Operate a Private Medical Practice

Over the past two decades, numerous other administrative and regulatory burdens have arisen that impose on private practices. These include health insurance plan documentation and contractual obligations, special requirements for managing biological waste, and reporting requirements for Merit-Based Incentive Payment System adjustments, the system CMS uses to measure performance and adjust physician payments.[27] The regulatory and administrative environment, therefore, strongly disincentivizes the private practice option for many physicians.[28]

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[26] Michael Guta, *Small Businesses Spend Up to 240 Days Per Year Working on Admin Tasks*, SMALL BUS. TRENDS (Sept. 15, 2017), https://smallbiztrends.com/2017/09/administrative-burden-on-small-businesses.html.

[27] *Merit Based Incentive Payment Systems (MIPS) – What is MIPS?*, MDINTERACTIVE, https://mdinteractive.com/MIPS (last visited Oct. 27, 2022).

[28] *See generally* Robert I. Field, *Independent Doctors' Offices Are Disappearing as More Physicians Work for Hospitals and Companies*, PHILA. INQUIRER (Aug. 7, 2021), https://www.inquirer.com/business/doctors-practice-health-corporate-20210807.html#loaded ("New Hampshire orthopedist Charles Blitzer and his seven partners would agree. They sold their practice in 2018 to Wentworth-Douglas Hospital, an affiliate of Massachusetts General Hospital in Boston. Running an independent medical practice has come to require "high-level administrative skills" that Blitzer and his partners "had no desire to acquire. I went to medical school to practice clinical medicine," not to be entrepreneurial, he said.").

B. Money Matters: Current Healthcare Payment Structures Create an Environment that Strongly Supports Physician Employment over Private Medical Practice

Private medical practices face numerous financial pressures that have increased over time.[29] Simultaneously, government and private payor reimbursement structures have created incentives for hospitals to employ physicians. These combined financial conditions have aligned physicians' and hospitals' interests in a way that encourages both parties to seek physician-hospital employment arrangements.[30]

1. Private Practice Physicians Face Significant Financial Pressures that Disincentivize Remaining in Private Practice

Government-funded programs now provide health care coverage to 46% of Americans.[31] CMS sets the reimbursement rate for services provided by physicians. In certain specialties, inflation adjusted reimbursement has declined by an average of 30 percent since 2000.[32] From 2021 to 2022, CMS implemented an across-the-board 3.7 percent

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[29] *The AMA Helps Sustain the Viability of Private Practice*, AM. MED. ASS'N, https://www.ama-assn.org/practice-management/private-practices/ama-helps-sustain-viability-private-practice (last visited Oct. 27, 2022).

[30] Jeff Goldsmith et al., *Do most Hospitals Benefit from Directly Employing Physicians?*, HARVARD BUS. REV. (May 29, 2018), https://hbr.org/2018/05/do-most-hospitals-benefit-from-directly-employing-physicians.

[31] *See CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program (CHIP)*, CTRS. FOR MEDICARE & MEDICAID SERV. (Dec. 21, 2021), https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicaid-and-childrens-health-insurance-program-chip; *see also Department of Veterans Affairs COVID-19 National Summary*, DEP'T OF VETERANS AFF., https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary (last visited Nov. 22, 2022); *see also Military Health Insurance*, MILITARY BENEFIT ASS'N (Sept. 2021), https://www.militarybenefit.org/membership-benefits/get-educated/militaryhealthinsurance/ (noting there are 83 million Medicaid and CHIP beneficiaries and 63.9 million Medicare beneficiaries. There are 6 million VA healthcare beneficiaries and 10 million insureds in the Department of Defense insurance program—Tricare. These total to 163 million. There are 11 million dual beneficiaries—people counted twice because they participate in more than one program. Thus, there are 152 million people receiving healthcare through a government program. When divided by the current U.S. population of 331 million, that result comes to 45.9%).

[32] Jack Haglin et al., *Declining Medicare Reimbursement in Orthopaedic Trauma Surgery: 2000-2020*, 35 J. ORTHOPAEDIC TRAUMA 79–85 (Feb. 2021).

rate decrease to physicians.[33] During the same period the consumer price index rose 7.5 percent.[34] Many non-governmental health insurance plans, which cover about 50% of Americans, now peg their reimbursement rates to some preset percentage of Medicare rates.[35] Consequently, physician practices have little ability to recover declining Medicare reimbursement from other payors.

Additionally, the movement to value-based care, a reimbursement model linked to patient outcomes, requires financial risks and administrative burdens that many small practices cannot handle.[36] Consequently, practices are limited in their ability to participate in reimbursement models that potentially could reimburse them at higher rates. Combined, shrinking reimbursement relative to Consumer Price Index and the inability to manage value-based reimbursement models create substantial financial disincentives for private medical practices.

2. Payment Structures for Health Services Give Hospitals Strong Incentives to Provide Outpatient Physician Services and, Therefore, Employ Physicians

Employing physicians allows hospitals to provide services in outpatient service settings. Payors distinguish between outpatient hospital place of service and physician office place of service.[37] When a patient receives

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[33] *Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule*, CTRS. FOR MEDICARE & MEDICAID SERV. (Nov. 2, 2021), https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule (explaining a 3.75% increase implemented for 2021 was being discontinued for 2022.)

[34] *Consumer prices up 7.5 percent over year ended January 2022*, U.S. BUREAU OF LABOR STATS. (Feb. 16, 2022), https://www.bls.gov/opub/ted/2022/consumer-prices-up-7-5-percent-over-year-ended-january-2022.htm.

[35] *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 5, 2022).

[36] Jacqueline LaPointe, *What Independent Practices Need to Thrive Under Value-Based Care*, REVCYCLE INTEL. (Apr. 11, 2019), https://revcycleintelligence.com/news/what-independent-practices-need-to-thrive-under-value-based-care ("Value-based care promises to improve care quality and lower costs compared to fee-for-service, but providers must overhaul their financial and clinical processes to realize success under the model. Unlike the straightforward fee-for-service model, providers must now fulfill quality reporting tasks, monitor patient outcomes inside and outside of the practice, track financial outcomes, and more.").

[37] Joanna Lion et al., *A Comparison of Hospital Outpatient Departments and Private Practice*, 6 HEALTH CARE FIN. REV. 69 (1985), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191490/.

medical care in the physician's office, each service produces a single charge.[38] Conversely, when that same patient undergoes those same services in a hospital outpatient setting, the service generates two distinct charges, a "clinic" fee and a "professional" fee which, when combined, generate twenty to thirty percent more revenue than the global fee a physician receives when performing the same service in the office.[39]

Hospitals that participate in certain drug pricing programs can leverage their revenues by expanding those pricing incentives to patients in newly acquired outpatient practices. The federal 340B Drug Pricing Program provides qualifying hospitals discounts on the purchase of drugs used in outpatient settings which increases the net income hospitals derive from administering medications in outpatient settings.[40] While the program's goal is to provide resources for hospitals to redirect to other uncompensated care needs, there is no requirement that participating hospital allocate their savings in any specific way.[41] When hospitals acquire outpatient practices that administer large amounts of medications in-office, they can perform those same services at much lower costs, creating a substantial financial incentive to owning physician practices and thus provide care that involves drug administration.[42]

Hospitals also benefit financially by amortizing fixed overhead costs over larger numbers of services, creating economies of scale in administrative management, information technology expenses, and supply chain management. None of these financial incentives are new, but over the past ten to fifteen years hospitals have faced continued downward

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[38] *Medicare Payment Differentials Across Outpatient Settings of Care*, AVALERE HEALTH (Feb. 2016), http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Payment-Differentials-Across-Settings.pdf.

[39] *Id.* at 5; *see also* Donna Rosato, *The Surprise Hospital Fee You May Get Just for Seeing a Doctor*, CONSUMER REP. (June 13, 2019), https://www.consumerreports.org/fees-billing/surprise-hospital-fee-just-for-seeing-a-doctor-facility-fee/ ("Sokol's insurer said there was no error, though. That's because the doctor he saw works for Cedars Sinai Medical Center, a major hospital in LA. Hospitals can charge a facility fee for services provided by any healthcare provider it employs and at any facility it owns, even if the patient never sets foot in the hospital.").

[40] Sunita Desai & J Michael Williams, *Consequences of the 340B Drug Pricing Program*, 378 N. ENGL. J. MED. 539–548 (Jan. 24, 2018).

[41] *Overview of the 340B Drug Pricing Program*, MEDICARE PAYMENT ADVISORY COMM'N, (May 2015), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf.

[42] *Id.* at 14.

pressure on inpatient utilization and reimbursement.[43] To counter this financial change, hospitals have aggressively cultivated their outpatient diagnostic and treatment services.[44] Medicare payments to hospitals for outpatient services grew by nearly eight percent annually from 2007 to 2017.[45] During the same period, payments for inpatient services were essentially flat, growing by less than 0.5 percent annually.[46] Acquiring practices and employing physicians creates a ready pool of referring physicians to these outpatient hospital services such as diagnostic imaging, laboratory, and therapy services.[47]

The result of these reimbursement changes, when combined, is a synergistic effect. Private practice physicians face enormous financial disincentives in the current healthcare finance environment. While hospitals that employ physicians face similar disincentives, unlike physicians, they also have more financially rewarding incentives to employ physicians that are unavailable to private physician practices. The resulting effect is one that accelerates physicians' transition to the hospital employment model.

a. Cultural Changes that are Largely Inconsistent with the Traditional Private Independent Practice of Medicine have Contributed to its Decreasing Appeal

Millennial physicians value work-life balance differently from their predecessors.[48] Over ninety percent of millennial physicians rate work-

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[43] Jennifer Bresnick, *Reduction of inpatient care is challenging hospital revenues*, EHRINTELLIGENCE (Apr. 28, 2014), https://ehrintelligence.com/news/reduction-of-inpatient-care-is-challenging-hospital-revenues.

[44] Wendy Gerhardt & Ankit Arora, *Hospital Revenue Trends*, DELOITTE INSIGHTS (Feb. 21, 2020), https://www2.deloitte.com/us/en/insights/industry/health-care/outpatient-virtual-health-care-trends.html.

[45] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf.

[46] *Id.*

[47] John Britt, *Why Hospital Outpatient Physical Therapy is a Good Revenue Source*, HEALTHCARE FIN. MGMT. ASS'N. (Aug. 1, 2019, 1:31 PM), https://www.hfma.org/topics/hfm/2019/august/why-hospital-outpatient-physical-therapy-is-a-good-revenue-sourc.html.

[48] Robert Nagler Miller, *Millennial Physicians Sound Off on State of Medicine Today*, AM. MED. ASS'N (Mar. 27, 2017), https://www.ama-assn.org/practice-management/physician-health/millennial-physicians-sound-state-medicine-today.

life balance as important.[49] Affirming this trend, the percentage of new physicians who rate work-life balance as their top factor in choosing a new job increased from sixty-three percent to eighty-five percent between 2018 and 2022.[50] In addition, new physicians value the ability to separate their professional lives from their personal lives, which is more difficult to accomplish in private practice ownership roles.[51] These findings comport with a 2017 American Medical Association ("AMA") survey in which eighty percent of millennials reported they were employees which suggests that the percentage of physicians who are corporate employees will continue to increase.[52] The increasing administrative and financial burdens private practice physicians are encountering serve to reinforce millennial physicians' preference for corporate employment over self-employed or private practice.

II. THE HISTORICAL ROOTS OF MEDICAL ETHICS AND THE EVOLUTION INTO A FRAMEWORK FOR THE LEGAL BASIS OF PHYSICIAN DUTY

Examination of physicians' ethical duty reveals some important foundational parallels to modern day concepts of the physician's legal duty of care. This section first examines the historical origins of physicians' ethical duty of care and their evolution into a modern physician code of ethical conduct.[53] From this examination this section then explores the development of the legal duty of care, finishing with examination of enforcement components of legal duty and focusing on components unique to physicians.[54]

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[49] *Id.*

[50] *Growing Number of New Physicians Seeking Work-Life Balance*, PHYSICIAN'S WEEKLY (July 21, 2022), https://www.physiciansweekly.com/growing-number-of-new-physicians-seeking-work-life-balance-3 (noting the average new physician graduated from medical school at 28 and spent 4.5 years in post-graduate training); *see also* Brendan Murphy, *Going Directly from College to Medical School: What it Takes*, AM. MED. ASS'N (Aug. 15, 2019), https://www.ama-assn.org/medical-students/preparing-medical-school/going-directly-college-medical-school-what-it-takes (noting the average age of students entering medical school is 24); *see also Medical Residency Timeline and Length, 2022-2023*, MEDEDITS, https://mededits.com/residency-admissions/timeline-length/ (last visited Oct. 27, 2022). Hence, the study's 2022 cohort likely was predominantly Millennial physicians while the 2018 cohort was more weighted toward Generation-X physicians.

[51] Megan M. Krischke, *How Millennial Physicians Are Creating Work-Life Balance*, STAFFCARE (May 15, 2018), https://www.staffcare.com/locum-tenens-blog/news/how-millenial-physicians-are-creating-work-life-balance/.

[52] Miller, *supra* note 48.

[53] *See infra* pp. 13-15.

[54] *See infra* pp. 15-25.

A. The Hippocratic Oath: The Cornerstone of Modern Medical Ethics

1. The Oath's Origins

The Hippocratic Oath remains the foundational underpinning of modern medical ethics.[55] Although there remains some dispute over the Oath's origin, historians' consensus is that it was written around 400 to 500 B.C.[56] Its authorship notwithstanding, historians consider the Oath the first written guidance on physicians' ethical obligations. While the Oath contains some very directed guidance on matters related to dietetics and the scope of a physician's practice, which have since become obsolete, its writings that address the physician's duty have endured. For example, the Oath states, "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel."[57]

Medical historians disagree over when Hippocratic principles evolved to the now commonplace dictum "primum non nocere" ("first, do no harm"), although most date the transformation to the early nineteenth century.[58] Regardless, the three-word phrase, sometimes augmented with words of beneficence (*"then do some good"*), has come to confirm Hippocrates's belief in the physician's ethical duty to *do*.

2. Others Have Since Updated the Hippocratic Oath to Adapt it to the Modern World

There now exist several contemporary Hippocratic oaths. The World Medical Association (WMA) passed the Declaration of Geneva in 1948, modeling its oath on the Hippocratic Oath.[59] The WMA augmented the Declaration with its "*International Code of Medical Ethics*," drafting both

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[55] Ian Kirby, *The Hippocratic Oath and Professional Ethics*, EMORY U.: ETHICAL ISSUES IN HEALTHCARE (Apr. 24, 2014), https://scholarblogs.emory.edu/philosophy316/2014/04/24/the-hippocratic-oath-and-professional-ethics.

[56] *Id.*; *see* Ludwig Edelstein, LEGACIES IN ETHICS AND MED., THE HIPPOCRATIC OATH 7, 30 (Chester Burns, ed. 1977).

[57] *Hippocratic Oath*, BRITANNICA, https://www.britannica.com/topic/Hippocratic-oath (last updated Sept. 5, 2022).

[58] Thomas Morris, *Do No Harm*, THOMAS MORRIS (Aug. 19, 2019), http://www.thomas-morris.uk/do-no-harm.

[59] *International Code of Medical Ethics,* THE WORLD MED. ASS'N (Apr. 1956), https://www.wma.net/wp-content/uploads/2018/07/Decl-of-Geneva-v1948-1.pdf.

documents largely in response to Nazi atrocities during World War II, and particularly to address widespread distress over revelations that arose during Nuremburg Doctor Trials.[60] The Declaration of Geneva shares with the Hippocratic Oath that "the health of my patient will be my first consideration."[61] The WMA Code of Ethics focuses more on physician duties, with significant increase on physician duty to patients.[62] Notably, unlike the Hippocratic Oath and other subsequent versions, the WMA Code of Ethics extends physicians' duty to include providing emergency care to people where no other physician is providing care.[63]

3. Medical Educators Perpetuate Hippocratic Ideals in Future Physicians Through the Oath's Formal Incorporation into the Medical Education Process

Medical schools instill allegiance to Hippocratic ethical ideals through oath taking ceremonies. The first known incorporation of oath taking into medical school curriculum was at the University of Wittenberg in 1500.[64] One hundred percent of medical schools responding in a study reported oath taking to be part of their commencement proceedings and eighty-eight percent reported that students took an oath more than once during their medical training.[65] The prevalence of taking the oath reinforces the enduring duties of care that Hippocrates described over 2600, years ago.

B. The Modern Code: Incorporation of Abandonment as an Ethical Breach

1. Abandonment as an Ethical Breach is a Modern Concept

The Hippocratic duty of care never expressly included a duty for

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[60] *Declaration of Geneva*, ENCLYCLOPEDIA, https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/declaration-geneva (last visited Apr. 23, 2022).
[61] Tatsuo Kuroyanagi, *Historical Transition in Medical Ethics– Challenges of the World Medical Association*, 56 JAPAN MED. ASS'N J. 220, 226 (2013).
[62] *International Code of Medical Ethics*, *supra* note 59 (noting that in addition to incorporating the Declaration of Geneva, "A DOCTOR MUST OBSERVE the principles of 'The Declaration of Geneva' approved by the World Medical Association," the Code of Medical Ethics adds an entire section entitled "Duties of Doctors to the Sick.").
[63] *Id.*
[64] Rachel Hajar, *The Physician's Oath: Historical Perspectives*, 18 HEART VIEWS 154 (2017).
[65] Shernaz Dossabhoy et al., *The Use and Relevance of the Hippocratic Oath in 2015 – A Survey of U.S. Medical Schools*, 4 J. ANESTHESIA HIST. 139 (Oct. 5, 2017).

physicians to not abandon their patients.[66] Physician professional associations have created ethics guidelines that expressly define an ethical duty not to abandon, including the American College of Physicians, which developed its Ethics Manual originally in 1984 and has updated it since then, most recently in 2019.[67] The American Medical Association (AMA), expanding more specifically on the Hippocratic ideal, developed its first Code of Ethics (the "Code") in 1847.[68] The AMA has revised its Code numerous times since, most recently in 2016, stating, the Code is "rooted in an understanding of the goals of medicine as a profession, which dates back to the 5th century BCE and the Greek physician Hippocrates, to relieve suffering and promote well-being in a relationship of fidelity with the patient."[69]

The 2016 revision starts with the Code's principles, three of which directly address the physician's duty.[70] Expanding on the principles, the Code states,

> The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).[71]

The Code recognizes exceptions to the mutual consent criterion, but reinforces its general importance by incorporating the physician's express consent as to establish the patient physician relationship.[72] Once the physician consents to the relationship, however, the Code provides for the patient's right to receive care.[73] This right translates to a physician's "fiduciary responsibility" to continue the patient's medical care and notify the patient of the physician's decision to withdraw sufficiently far in

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[66] *Hippocratic Oath*, *supra* note 57.
[67] Lois Sulmasy et al., *American College of Physicians Ethics Manual*, 170 ANNALS OF INTERNAL MED. S1, S4 (Jan. 15, 2019).
[68] *History of the Code*, AM. MED. ASS'N (2017), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ethics/ama-code-ethics-history.pdf.
[69] *Id.*
[70] *AMA Code of Medical Ethics,* AM. MED. ASS'N, https://code-medical-ethics.ama-assn.org/ (last accessed Dec. 2022).
[71] *Id.*
[72] *History of the Code*, *supra* note 68.
[73] *AMA Code of Medical Ethics*, *supra* note 70, at 1.1.3.

advance of the withdrawal to allow the patient to establish new treatment and to facilitate the patient's transfer of care.[74]

2. The AMA's Code of Ethics has Limitations that Require Consideration, Including Exceptions to its Universal Application and its Non-binding Nature

Important considerations arise from medical ethical standards for physicians. The Code does not condition the physician's decision to establish or withdraw from care on cause.[75] The Code considers that a physician cannot refuse to consent to establish, nor withdraw from, care in three situations: the physician cannot withhold consent or withdraw based on personal or social characteristics not clinically relevant to the care such as race, gender, sexual orientation or gender identity; the physician cannot decline to treat a patient because of the patient's infectious disease status; and physicians cannot decline to treat patients whom they have become contractually obligated to provide care to.[76] This type of three-party relationship arises in correctional facility health systems, closed health maintenance organizations and among certain hospital based physician specialties such as anesthesiology or radiology where the entity has contracted with two different parties, one to whom it is obligating the care and the other contracted to source the care.

Finally, the AMA Code of Ethics is not binding.[77] The AMA is the largest physician professional association in the United States, yet still contains less than 25 percent of American physicians among its membership, with a more accurate percentage in dispute.[78] The dispute notwithstanding, physicians

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[74] *Id.* at 1.1.5. ("Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients.").

[75] *Id.* ("When considering withdrawing from a case, physicians must: (a) Notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician. (b) Facilitate transfer of care when appropriate.").

[76] *AMA Code of Medical Ethics*, *supra* note 70, at 1.1.2.

[77] *Code of Medical Ethics Preface & Preamble*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-preface-preamble (last visited Oct. 27, 2022) ("Just as the AMA *Principles of Medical Ethics* are not laws, but standards of conduct, so too the Opinions in the *Code of Medical Ethics* are not laws or rules. They are guidance that identifies the essentials of ethical behavior for physicians.").

[78] *AMA Fact Sheet on its Decade of Membership Growth,* AM. MED. ASS'N (2021), https://www.ama-assn.org/system/files/2021-06/ama-10-years-2021-fact-sheet.pdf; *Total Number of Active Physicians in the U.S. 2022, by State,* STATISTA (June 8, 2022), https://www.statista.com/statistics/186269/total-active-physicians-in-the-us; Kevin Campbell, *Don't Believe AMA's Hype, Membership Still Declining*, MEDPAGE TODAY (June 19, 2019), https://www.medpagetoday.com/opinion/campbells-scoop/80583 (noting AMA membership numbers are in dispute).

who join the AMA do not commit themselves to or pledge to comply with the Code.[79] Therefore, the Code's incorporation of fiduciary responsibility does not confer any authority upon physicians.

C. Transformation: Evolution from Ethical Obligation to Legal Duty to Care

1. The Majority Position: The Physician's Duty of Care Does Not Exist if There is No Patient-Physician Relationship

The legal basis of a physician's duty of care lies in the patient-physician relationship. When a physician has no relationship with a patient, there is no duty of care.[80] In *Hurley v. Eddingfield*, the decedent's representative sued the defendant physician, alleging defendant's refusal to care for the patient caused the decedent's death.[81] The Indiana Supreme Court held that "the state does not require, and [Eddingfield] does not engage, that he will practice at all or on other terms that he may choose to accept."[82] Thus, even though the defendant physician treated the decedent previously, was available to treat when the decedent became ill, and no other physician was available, there was no mutual consent,,, therefore, the physician owed no duty to treat the decedent.[83] The duty to treat arises when the patient and the physician both consent to enter into the patient-physician relationship.

However, that mutual consent need not be express.[84] A patient-physician relationship may arise when the physician expresses or implies agreement to provide professional services and the patient expresses or implies agreement to accept those services.[85] In *Rio Grande Valley Vein Clinic v. Guerrero,* a physician's nurse provided laser treatment to a patient in a facility the physician owned and operated, from which the patient sustained burns.[86] In *Rio Grande Valley*, Guerrero, the patient-respondent, did not provide an expert report in her negligence claim against the clinic's physician, as the Texas Medical Liability Act

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[79] *AMA Code of Medical Ethics*, *supra* note 70.
[80] Hurley v. Eddingfield, 59 N.E. 1058 (Ind. 1901); Lownsbury v. Van Buren 762 N.E.3d 354, 358 (Ohio 2002).
[81] *Eddingfield*, 59 N.E. at 1058.
[82] *Id.*
[83] *Eddingfield*, 59 N.E. at 1058.
[84] Rio Grande Valley Vein Clinic v. Guerrero, 431 S.W.3d 64, 66 (Tex. 2014).
[85] *Id.*
[86] *Id.* at 65.

required.[87] Guerrero argued that because her physician had never seen or treated her, the physician had not established a patient-physician relationship,[88] thus negating the expert report requirement. In affirming the trial court's dismissal of Guerrero's claim, the Texas Supreme Court held that a patient-physician relationship existed because the treatment required physician oversight, the physician held himself out as overseeing the treatment, and the patient sought that treatment.[89]

Physicians may also establish implied consent to treat through call coverage obligations.[90] When a physician's on-call obligations are either contractual or to maintain staff privileges, the consent to establish a relationship is presumed.[91] In *Mead v. Legacy Health System*, the plaintiff presented to the emergency department ("ED") with severe low back pain and leg weakness.[92] The ED contacted Dr. Adler, the on-call neurosurgeon who recommended discharging Mead, believing that Mead did not require neurosurgery.[93] Mead's primary care physician admitted her to the hospital and attempted to consult Dr. Adler.[94] Dr. Adler did not return to see Mead for several days, at which point the plaintiff had irreversible nerve damage.[95] Dr. Adler argued there was no patient physician relationship but the Court of Appeals of Oregon disagreed, holding that when a physician's on-call obligation is contractual or a condition for hospital privileges, the on-call physician's consultation is an affirmative action from which one can reasonably infer consent.[96] Conversely, in *Fought v. Solce*, the First Court of Appeals of Texas held that Dr. Solce, whose call obligation was fully voluntary, had no duty of care to a patient about whom the ED contacted him, and who he declined to treat.[97] The court held that Dr. Solce's voluntary on-call service did not impute an affirmative act when the ED contacted him about a patient, even if the patient was "urgently in need of medical or surgical assistance."[98]

Other courts have held that an on-call physician has not entered into a relationship with a patient until the physician and patient have met face-

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[87] *Id.*
[88] *Id.*
[89] *Id.* at 66.
[90] Mead v. Legacy Health Sys., 220 P.3d 118, 122 (Or. Ct. App. 2009).
[91] *Id.*
[92] *Id.* at 120.
[93] *Id.* at 121.
[94] *Id.*
[95] *Id.*
[96] *Id.* at 122.
[97] Fought v. Solce, 821 S.W.2d 218, 220 (Ct. App. Tx 1991).
[98] *Id.*

to-face.[99] In *Wax v. Johnson*, the patient, Wax, had been admitted to the hospital by her internist for a gastrointestinal blockage.[100] Dr. Johnson was on-call and covering while Wax's internist, Dr. Verm, was off duty as Wax's condition deteriorated.[101] However, Dr. Johnson had not learned Wax was a patient until the following morning, and the nurses had not contacted him with any concerns.[102] Wax required major abdominal surgery, losing a substantial portion of her intestine.[103] The court held that being on-call was insufficient to establish the patient-physician relationship until the physician had affirmatively participated in the patient's treatment or care.[104] *Wax* is distinguishable from *Mead*, above, because Mead's physician had already taken an affirmative role in Mead's care though there was some dispute over whether he was aware Mead's physician had admitted her to the hospital, while Wax's physician asserted he was entirely unaware of her condition.[105]

2. The Minority Position: Foreseeability of Injury may be Sufficient to Create a Duty of Care Even Where there is no Patient-Physician Relationship

A minority of courts do not require a patient-physician relationship to establish a duty of care.[106] "A doctor-patient relationship is not required in every legal action against a medical provider. Limited circumstances exist where a reasonably foreseeable third party can maintain a suit against a physician for malpractice."[107] In those jurisdictions, the court will "generally look to three factors to determine whether a physician owed a duty to a nonpatient: "(1) the relationship between the parties, (2) reasonable foreseeability of harm to the person who is injured, and (3) public policy considerations."[108] "A duty arises between a physician and an identified third party when the physician provides medical advice and

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[99] Wax v. Johnson, 42 S.W. 3d 168, 171 (Ct. App. Tx. 2001).
[100] *Id.* at 169.
[101] *Id.*
[102] *Id.*
[103] *Id.* at 170.
[104] *Id.* at 173.
[105] *See* Mead, 220 P.3d at 122; *see also* Wax, 42 S.W.3d at 171.
[106] Warren v. Dinter, 926 N.W. 2d 370, 377 (Minn S.C. 2019) ("Therefore, for 100 years in Minnesota, a physician has had a legal duty of care based on the foreseeability of harm. Although ours is the minority rule, it is by no means unique.").
[107] Oblachinski v. Reynolds, 706 S.E.2d 844, 846 (S.C. 2011).
[108] Plowman v. Fort Madison Cmty. Hosp., 896 N.W.2d 393, 411 (Iowa, 2017).

it is foreseeable that the third party will rely on that advice."[109] In *Warren v. Dinter,* a community-based nurse practitioner sought to have Warren admitted at the nearest hospital.[110] Requiring approval from a hospital staff physician to admit, the nurse practitioner contacted Dr. Dinter, who was on duty that day and who concluded that Warren did not require hospitalization.[111] Warren developed sepsis and subsequently died, her estate filing suit against the physician.[112] Reversing the lower court's summary judgment for the defendant, the Court held that where a physician made a formal decision about a patient's care, the physician should have been able to foresee the potential harm involved, and therefore, even absent an established patient-physician relationship, had a duty of care.[113]

3. Foreseeability Standards Implicate a *Carroll Towing* Approach to Establishing the Duty of Care

The foreseeability of harm basis for duty implicates the *Carroll Towing* factors.[114] Duty to prevent harm is a function of the probability of harm, the gravity of the resulting injury, and the burden of precautions to prevent that harm.[115] In *Helling v. Carey,* the plaintiff alleged that the defendant physician breached his duty of care by failing to perform testing that would have averted the consequences of undetected glaucoma, resulting in blindness.[116] The Supreme Court of Washington held that although the standard of care was not to perform screening on patients younger than 40, and that glaucoma was rare among patients in the plaintiff's demographic, because the screening was simple and harmless and the potential adverse outcome so severe, the defendant did not meet a reasonable standard of care.[117]

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[109] Warren v. Dinter, 926 N.W.2d 370, 376 (Minn. S.C. 2019) (citing Skillings v. Allen, 173 N.W. 663, 664 (Minn. 1919) (holding that a patient's physician had a duty to the patient's parents when the parents relied on the physician's advice about the patient's contagiousness and specifically rejecting a contract basis test for establishing duty of care) and Molloy v. Meier, 679 N.W.2d 711, 719 (Minn. 2004)).
[110] *Warren*, 926 N.W.2d at 372.
[111] *Id.* at 373.
[112] *Id.*
[113] *Id.* at 380.
[114] United States v. Carroll Towing Co., 159 F.2d 169, 173 (2nd Cir. 1947).
[115] *Id.*
[116] Helling v. Carey, 519 P.2d 981, 981–82 (Wash. 1974) (reversing the trial court's verdict because the trial court refused to instruct the jury that the professional standard of care was "inadequate to insulate defendants from liability for negligence.").
[117] *Id.* at 983.

Helling, like *Carroll Towing*, is distinguishable because the foreseeability of harm arose in the context of an undisputed pre-existing relationship. *Carroll Towing*'s application is clear when analyzing cases predicated on breach of duty of ordinary care.[118] Courts have provided little guidance on how to assess when duty of care may arise in the context of foreseeability of harm in the physician-patient relationship, which raises special concerns when addressing cases rooted in a failure to provide care.

4. Abandonment is a Specific Breach of the Duty of Care with its Own Requirements to Establish Breach

Once established, the duty of care creates a correlate duty, the duty to not abandon. A breach of the duty of care by abandonment occurs when there is a "termination of the professional relationship between the physician and patient at an unreasonable time or without affording the patient the opportunity to procure an equally qualified replacement." [119]

The thresholds to establish these elements are less clear. Some courts have held that when a treating physician is able to "secure the patient's acceptance of the substitution" of another physician in their place, the treating physician has not breached the duty of care.[120] Other courts have held that a physician did not abandon the patient if the treating physician arranged for another physician to assume a patient's care, even if the treating physician did not notify the patient or secure the patient's "acceptance."[121] To elaborate, the court in *Stohlman v. Davis,* held that even though the physician, Dr. Davis, had become acutely ill and secured another physician to continue the patient's treatment, Davis' illness was not so severe that he could not have secured the patient's acceptance of the transfer of care.[122] However, the court in *Miller v. Dore* found that the physician, Dr. Dore, by securing another physician to attend to his

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[118] *Carroll Towing Co.*, 159 F. 2d at 174 ("the owner's duty, as in other similar situations, to provide against resulting injuries is a function of three variables: (1) The probability that she will break away; (2) the gravity of the resulting injury, if she does; (3) the burden of adequate precautions.").

[119] Hill v. Metlantic Health Care Group, 922 A. 2d 314, 328 (D.C. Cir. 2007); Anjelica Cappellino, *Patient Abandonment Cases: What You Need To Know*, EXPERT INST. (Apr. 11, 2022) https://www.expertinstitute.com/resources/insights/patient-abandonment-cases-what-you-need-to-know/.

[120] Stohlman v. Davis, 220 N.W. 247, 250 (Neb. 1928).

[121] Miller v. Dore, 148 A.2d 692, 695-96 (Me. 1959).

[122] *Stohlman*, 220 N.W. at 250.

patient's care when he took time off to go fishing, had not abandoned their patient.[123]

5. Not All Courts Agree that Abandonment Requires there First be a Patient-Physician Relationship

Courts have had mixed opinions of whether a claim of abandonment can prevail where no prior patient-physician relationship existed. Some courts have held that a physician cannot abandon a patient if there is no patient-physician relationship.[124] In *Childs v. Weis*, the court held that despite being available and part of the hospital's emergency service, the physician, who declined to treat the plaintiff, did not establish a relationship by instructing the nurse to inform the patient she should contact her primary physician for care.[125] Having not established a relationship, the physician had no duty to provide care and, therefore, did not fail this duty by abandoning the patient.[126]

Other courts have taken a different approach, concluding that when a physician is available to treat and has the requisite training and experience to treat, there is foreseeable risk of not treating the patient and there are no other similarly skilled physicians available, a duty is created and failure to treat is a form of abandonment.[127] In *Noble v. Sartori*, a patient's brother approached the physician in a hospital corridor with concerns that his brother might be having a heart attack.[128] The defendant physician directed him to "get in line."[129] Frustrated, the brothers went to a different hospital whereupon the treating doctor rendered a diagnosis of myocardial infarction, and the patient died the next day.[130] Reversing the lower court's summary judgment for the physician, the Supreme Court of Kentucky held that a jury could reasonably infer an exceptional situation which obviated the traditional patient-physician relationship requirement and from which a refusal to treat could rise to the level of abandonment.[131]

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[123] *Miller*, 149 A.2d at 697.
[124] Childs v Weis, 440 S.W.2d 104, 106 (Ct. Civ. App. Tx. 1969) (stating that "[t]he existence of the duty must flow from the relationship of patient-physician").
[125] *Id.* at 107.
[126] *Id.*
[127] Noble v. Sartori, 799 S.W.2d 89 (Ky. 1990).
[128] *Id.*
[129] *Id.* at 9.
[130] *Id.*
[131] *Id.* at 10.

6. Courts Have Also Found Exceptions to the Mutual Consent Criterion to Establish a Patient-Physician Relationship

Courts have identified exceptions to the mutual consent criterion to establish a patient-physician relationship where they have found the relationship was based on contractual obligations. In *Ricks v. Budge*, 64 P. 2d 208 (Utah, 1937), Dr. Budge, a physician, refused to complete a necessary surgery after he had initiated care for a hand injury several days earlier because patient Ricks owed money for prior treatment.[132] Dr. Budge made no arrangements to transfer care, causing a delay that resulted in a finger amputation.[133] Dr. Budge argued no contract existed between the parties, hence he had no obligation to treat Ricks.[134] The Supreme Court of Utah disagreed, holding that the patient's returning for treatment and the physician's provision of treatment indicated there was a contractual relationship between the parties sufficient to create a duty of care, adding that the contractual obligation continues "as long as [the patient] needs attention, unless [the physician] gives notice of his intention to discontinue his services or is dismissed by the patient; and he is bound to exercise reasonable and ordinary care and skill in determining when he should discontinue his treatment and services."[135]

Other contractual relationships may create an exception to the mutual consent criterion. When a physician is party to a contract that obligates the physician to treat members of a designated group, the contract creates a blanket consent to establish the patient physician relationships with the groups' members.[136] In *Hand v. Tavera*, physician Tavera signed a contract with his employer stating,

> "PHYSICIAN agrees to provide or arrange for covered health care services for ENROLLEES in accordance with Attachment B. [Attachment B specifies various physician responsibilities, including "emergency care of a covered ENROLLEE who has been assigned to PHYSICIAN]."[137]

The patient's contractual enrollment in a health insurance plan provided

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[132] Ricks v. Budge, 64 P.2d 208, 211 (Utah, 1937).
[133] *Id.* at 208.
[134] *Id.* at 211.
[135] *Id.* at 212.
[136] Hand v. Tavera, 864 S.W.2d 678, 679 (Ct. App. Tex. 1993) (Series of transactions refers to the two contractual provisions, first between the health plan and the physician and second between the health plan and the patient.).
[137] *Id.*

for medical care which the patient had purchased "in advance of need."[138] The court found that because Hand sought recovery for tort, not breach of contract, the series of transactions need only create the duty of care.[139] The case held that "when a patient who has enrolled in a prepaid medical plan goes to a hospital emergency room and the plan's designated doctor is consulted, the patient-physician relationship exists, and the doctor owes the patient a duty of care."[140]

Hand and *Mead*, discussed previously, share some attributes. Both identify an implied consent where the physician has a contractual obligation to attend to patients who present themselves. One could consider that entering into a contractual obligation, either with a hospital or a health plan is the affirmative act that establishes the basis for the duty of care, even where the patient is not a party to that contract.

D. Duty of Care: Many States Have Codified, Either by Statute or by Regulation, the Physician Duty of Care as it Relates to Patient Abandonment

Numerous states have now codified termination obligations physicians must meet to avoid allegations and determination of patient abandonment. Twenty-one states plus the District of Columbia have enacted statutes or developed regulations that mandate the physician's obligation, while fifteen offer non-binding guidance.[141] Six states refer physicians to their state medical associations while eight offer no statutory, regulatory, general guidance or reference to other resources.[142] The states delegate authority to their medical boards to enforce these obligations.[143] Where states have codified termination and withdrawal requirements, two general themes emerge:

First, the typical timeline requirement is thirty days in advance of separation. Maine is a notable exception; its guideline for closing a

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[138] *Id.*
[139] *Id.* at 680.
[140] *Id.*
[141] *See infra* Appendix A.
[142] *Id.*
[143] *Understanding Medical Regulation in the United States*, FED'N OF STATE MED. BDS., https://www.fsmb.org/siteassets/education/pdf/best-module-text-intro-to-medical-regulation.pdf (visited Oct. 27, 2022) ("[E]ach of the 50 states, the District of Columbia and the U.S. territories have enacted laws and regulations that govern the practice of medicine and outline the responsibility of state medical boards to regulate that practice within their borders.").

practice suggests ninety days advance notice.[144] While many states require physician practices to directly contact patients by mail when closing a practice, most also suggest publishing newspaper advertisements or notices.[145] Frequency and quantity vary widely. Some statutes do not specify either a frequency or a timeline.[146] Others are more prescriptive: Wyoming's Board of Medicine regulations suggests a minimum of four weekly notices in newspapers in each county the practice serves when a physician practice is closing or relocating.[147]

Second, none of the statutes, regulations, or guidance materials addresses withdrawal or termination from active inpatient treatment relationships.[148] In this respect, administrative law as not kept pace with changes in physician practice since hospitalists, physicians who provide inpatient care only, now provide more than half of all inpatient care.[149] Nevertheless, the currently existing statutes and regulations reinforce the ethical and common law obligations of the physician's duty of care as it relates to withdrawal and termination of care.[150]

E. Beyond Medical Malpractice Actions and Statutory and Regulatory Enforcement Actions, the National Practitioner Data Bank Provides Substantial Consequences to Physicians that Breach the Duty of Care

Like any other breach of physician duty, patients claiming abandonment have a legal remedy through a malpractice action. Similarly, the state can protect its interest in its citizens' well-being through enforcement of

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[144] *Physician's Guide to Closing a Practice,* MAINE MED. ASS'N (2014), https://www.mainemed.com/sites/default/files/content/Closing%20Practice%20Guide%20FINAL%206.2014.pdf (last visited May 5, 2022). These requirements address a withdrawal of care from all of a physician's patients. Nevertheless, they apply because the physician's failure to comply represents improper withdrawal of care from every patient with whom the physician has an established relationship.

[145] *See infra* Appendix A.

[146] *Id.*

[147] Rules and Regulations Chapter 3 § 5(b), WYO. BD. OF MED., (Sept. 10, 2015), https://www.thedoctorpatientforum.com/images/Legislative-Efforts-Images/Documents/Wyoming/WY_Board_of_Medicine_Rules_-_All_Chapters.pdf.

[148] See *infra* Appendix A (displaying a table noting the codification status of termination duty, by state).

[149] *4 Statistics on Hospitals*, BECKER'S HOSP. REV. (July 28, 2014), https://www.beckershospitalreview.com/hospital-physician-relationships/4-statistics-on-hospitalists.html.

[150] 42 U.S.C 117 §§ 11101–11152.

statutes and regulations, not uncommonly in the form of an action upon the physician's license due to a violation. The National Practitioner Data Bank ("NPDB") imposes additional consequences for breaches of duty that substantially magnify the consequences of an actionable breach of duty.[151] Consequently, the NPDB looms large over any legal action or clinical care issue that implicates physicians.

As part of the Health Care Quality Improvement Act of 1986 ("HCQIA"), Congress intended for the substantial limitation of peer review bodies' liability and to create a mechanism for licensing boards and health care entities to better discover practitioners' prior incompetent or dangerous acts.[152] This section explores the NPDB's two primary components, the reporting function and the query function, and discusses key features that both distinguish the NPDB from other remedies and increase its relative importance in physician enforcement actions.

1. The Reporting Function

a. The Primary Reporting Entities are Medical Malpractice Payers, State Medical Boards and Health Care Entities

The HCQIA specifies reporting obligations to the NPDB. Three primary reporters are medical malpractice payers, state medical boards and health care entities.[153] Medical malpractice payers include any entity that settles a claim or satisfies a judgment on behalf of a physician.[154] If the settlement includes the physician's dismissal in consideration of the payment, the paying entity must still report the dismissal in lieu of payment because the payment "can only be construed as a payment for the benefit of the health care practitioner."[155] Additionally, the paying entity must report any dollar amount paid; the federal authorizing bill requires the Secretary to study whether reporting should include "small payments" and

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[151] *What is the NPDB? The National Practitioner Data Bank*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/resources/whatIsTheNPDB.jsp (last visited Nov. 17, 2022).

[152] NAT'L PRAC. DATA BANK, *National Practitioner Data Bank Timeline*, U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/topNavigation/timeline.jsp (last visited May 5, 2022). The Health Care Quality Improvement Act, "HCQIA", comprises 42 U.S.C. §§ 11111–11152.

[153] NAT'L PRAC. DATA BANK, *The NPDB Guidebook, Chapter E: Reports*, U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/guidebook/EOverview.jsp (last visited Oct. 27, 2022).

[154] 42 U.S.C. § 11131(a).

[155] *Reporting Medical Malpractice Payments,* U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/guidebook/EMMPR.jsp (last visited Sept. 26, 2022).

ultimately, the Secretary determined payers needed to report any payment amount.[156]

The NPDB's federal authorizing statute requires state licensing boards to report any action that "revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a physician, for reasons relating to the physician's professional competence or professional conduct."[157] Therefore, a board finding a that physician breached their duty, such as through patient abandonment, would fall within these categories and be reportable under this subsection.

Health care entities are mandatory reporters to the NPDB.[158] They must report any professional review action that adversely impacts a practitioner's clinical privileges for more than thirty days.[159] Entities must also report to the state Board of Medical Examiners, any event in which a physician surrenders clinical privileges either while the investigation is ongoing or in exchange for the entity agreeing not to investigate the alleged unprofessional conduct.[160]

b. The NPDB Confers Broad Protections on Required Reporters with Limited Recourse and Protections for Physicians when Disputes Arise Over Reporting

The NPDB's reporting requirements' breadth, combined with the protections health care entities enjoy regarding their physician peer review processes,[161] raise concerns among physicians.[162] Neither the statute nor

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[156] 42 U.S.C. § 11131(d).
[157] 42 U.S.C. § 11132(a)(1)(A).
[158] NAT'L PRAC. DATA BANK, *supra* note 153.
[159] *Id.*
[160] 42 U.S.C. § 11133(a)(1).
[161] *Legal Protectoins for Peer Review*, AM. MED. ASS'N, https://policysearch.ama-assn.org/policyfinder/detail/H.375.962?uri=%2FAMADoc%2FHOD.xml-0-3167.xml (last visited Dec. 2, 2022) ("The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff. . .Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.").
[162] *Data Bank: Risk Managers Say It Is Not as Helpful or Threatening as Hoped*, HEALTHCARE RISK MGMT. (July 1, 2001), https://www.reliasmedia.com/articles/71413-data-

NPDB's regulations clearly define professional review action, stating only that the review must be "...based on the competence or professional conduct of a physician."[163] Although this process requires the determination result from a peer review process, each health care entity sets the scope of its peer review activities and processes.[164] Title 42 also provides health care entities broad immunity against actions arising from its peer review decisions.[165]

That immunity is contingent upon the entity complying with the statute's notice and hearing requirements, but even then, there are two substantial concerns for physicians contemplating a hearing. First, 42 U.S.C. 11112(b)(3) grants the entity the right to choose among three options for the presiding decision maker: a mutually acceptable arbitrator, a hearing officer that the entity chooses or a panel whom the entity chooses, so long as the hearing officer or panel members are not "in direct economic competition with" the physician.[166] Second, the HCQIA provides for the court to award legal fees to a "substantially prevailing" entity defending against any claim a practitioner makes related to the entity's professional review process.[167] There are also some practical concerns that arise from NPDB's implementation, these being the limitations on who can remove a report and the integrity of NPDB's confidentiality protections.[168]

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bank-risk-managers-say-it-is-not-as-helpful-or-threatening-as-hoped ("The National Practitioner Data Bank (NPDB) was hailed as a step forward in monitoring doctors' errors, but also feared as a central source for information that could be used against health care providers by plaintiffs and regulators.. . . "The OIG report confirmed what we've been saying all along about the NPDB — that it's flawed, incomplete, and it's not reliable," says Robert Mills, a spokesman for the American Medical Association (AMA) in Chicago.").

[163] 42 U.S.C. § 11151(9). my

[164] Marc T. Edwards & Evan M. Benjamin, *The Process of Peer Review in U.S. Hospitals*, 16 J. CLIN. OUTCOMES MGMT., 461, 465 (Oct. 2009), https://www.decof.com/documents/jcom_oct09_peer.pdf ("Our results revealed wide variation in peer review program scope, structure, process and governance across a sample of 339 acute care hospitals (7% of U.S. total), along with associations between program features and perceived reviewer participation, medical staff satisfaction, and impact on quality of care.").

[165] 42 U.S.C. § 11111(a)(1) (The only statutory exception to the immunity provision is for damages "under any law of the United States or of any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981.").

[166] 42 U.S.C. § 11112(b)(3).

[167] 42 U.S.C. § 11113.

[168] NAT'L PRAC. DATA BANK, *What are my options if I want to respond to a report?*, U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/faqs/d5.jsp (last visited Oct.

The threat of economic competitors among the medical staff who comprise peer review panels exists only if the physicians are in private practice and actually competing with a physician who is challenging a peer review process.[169] In that scenario, the health care entity's interest in the outcome relates to assuring the procedural integrity as well as optimal patient care.[170] Further, in 1986, when Title 42 became law, physicians were predominantly private practitioners who, often, were in direct economic competition with other private practitioners.[171] With the shift in physician status from independent practitioners to hospital employees, physicians' economic threat has similarly shifted from direct economic competition to employment status where the hospital's agents comprise both the professional review and the hearing processes, a process many physicians refer to as "sham peer review".[172]

27, 2022) (noting only the reporting entity can change or remove a report from the database); *see Grassley blasts HRSA over data removal after seeing letter exchange with doc*, ASS'N OF HEALTH CARE JOURNALISTS, https://healthjournalism.org/secondarypage-details.php?id=994 (last visited Oct. 27, 2022) ("HRSA officials removed the public file from the data bank website on September 1 because a spokesman said they believe it was used to identify physicians inappropriately.").

[169] James F. Blumstein & Frank Sloan, *Antitrust and Hospital Peer Review*, 51 L. & CONTEMPORARY PROBS. 7, 15 (1988), https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=3948&context=lcp (last visited Oct. 27, 2022) ("From an antitrust perspective, the most potentially negative feature of hospital-based, supply-side peer review stems from the fact that the medical staff peer reviewers are potential competitors with each other and with prospective applicants. The danger lies in the ability of the medical staff to hamper or to exclude other physicians from practicing in the hospital.") (highlighting the relationship between competition and risk of abusing peer review process. Employed physicians do not compete economically, thus its usage to quell competition abates).

[170] *See* Steven R. Edmondson, *Medical Peer Review and Immunity Under HCQIA After Poliner*, HEALTH L. PERSPECTIVES 4 (Nov. 2008), https://www.law.uh.edu/healthlaw/perspectives/2008/(SE)%20poliner.pdf (noting a hospital is interested in the outcome of whether the requirements for immunity can be met. "To meet HCQIA requirements for immunity, an action must either be taken in compliance with the Act's requirements for notice of the proposed action, notice of the hearing, and conduct of the hearing, or it must meet one of the exceptions to those requirements.").

[171] 42 U.S.C. § 11111; *see* Teresa Barker, *More Competition Among Doctors Can Have Positive Side Effects*, CHICAGO TRIBUNE (Jan. 7, 1987 12:00 AM) https://www.chicagotribune.com/news/ct-xpm-1987-01-07-8701020504-story.html ("Increased competition for patients among private physicians and other health-care providers has brought new meaning to the "M" in M.D.").

[172] *Center for Peer Review Justice Homepage*, CTR. FOR PEER REVIEW JUST., http://peerreview.org/ (last visited May 5, 2022) (highlighting hospital corporations' use of the peer review process to "get a physician out of the way. . . because he stands in the way of

Granting the court discretion to award legal fees in certain cases, while meeting Congress's dual intent of facilitating entities' good faith participation in professional review and reducing wasteful litigation, poses certain concerns.[173] The statute limits "substantially prevailing" only by negative inference; the term does not include any claim where the plaintiff obtains an award for damages or injunctive relief.[174] Thus, a court may award fees "if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith."[175] The legal costs of litigating a peer review dispute claim, which at least law firm specializing in representing physicians reports can be as high as several hundred thousand dollars, and the fear of being found liable for them may discourage physicians from pursuing justified claims.[176]

Concerns about the NPDB's limitations on who can remove improper reports and privacy protections also arise. Reports to NPDB are permanent unless *a reporting entity* determines that "the report was submitted in error, the action was not reportable because it did not meet NPDB reporting requirements [or] the action was overturned on appeal."[177] Significantly, the reporting entity may file a Correction Report or a Revision-to-Action Report, but these do not remove the original Initial

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corporate profits. . . although the physician may be acting out of a genuine concern for patient safety and care.")

[173] 42 U.S.C. § 11113.

[174] *Id.* (showing the statute does not provide a mechanism for a court to order the NPDB to remove a report. Courts can order health care entities to submit void reports, but that action is separate from any recourse the physician has through 42 U.S.C. § 11133.); *see* Walker v. Mem'l Health Sys. of E. Tex., 231 F. Supp. 3d 210, 217 (E.D. Tex. 2017) (granting physician-plaintiff's motion to order the hospital-defendant to submit a report to NPDB voiding its prior report despite petitioner's not having exhausted all administrative remedies because, among other factors, "the [NPDB] lacks power to grant effective relief.").

[175] 42 U.S.C. § 11113.

[176] *See* George Indest III, *How Much Will My Legal Defense in a Hospital Medical Staff Peer Review Fair Hearing Cost*, THE HEALTH L. FIRM (Aug. 11, 2021), https://www.thehealthlawfirm.com/blog/posts/how-much-will-my-legal-defense-in-a-hospital-medical-staff-peer-review-fair-hearing-cost.html; *see also Doctor Prevails in Sham Peer Review: How He Did It,* MED. JUST. (Nov. 12, 2020), https://medicaljustice.com/sham-peer-review/ (stating there is an appeals process, but it is generally limited and on occasion, nonexistent); *see also Information on Sham Peer Review*, AM. COLL. OF EMERGENCY PHYSICIANS (Sept. 2011), https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/medical-legal/sham_peer_review_0911.pdf.

[177] NAT'L PRAC. DATA BANK, *Submitting Reports to the NPDB*, U.S. DEP'T. OF HEALTH & HUM. SERVS. https://www.npdb.hrsa.gov/guidebook/ESubmittingReports.jsp#Revision (last visited Aug. 18, 2022).

Report's adverse content from a practitioner's data file.[178] While the NPDB has mechanisms for physicians to contest reports or explain their content, the results of which may append to the report, it does not have discretion to remove a report unless the reporting entity submits a Void Report or a Correction Report.[179] In *Van Boven v. Freshour*, the NPDB was unable to remove an initial report because the Texas Medical Board filed its subsequent report after it dismissed a disciplinary panel's initial findings and temporary restrictions as a Revision-to-Action report, not a Void Report.[180] Thus, while the NPDB has a dispute process, it can only append a report if the reporting entity refuses to remove it.[181]

c. NDPB Has Encountered Difficulties in Maintaining its Data's Confidentiality

Finally, because peer review processes are designed to improve care

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[178] *Id.* ("A Revision-to-Action Report does not replace a previously reported adverse action but rather is treated as a separate action that pertains to the previous action." A reporter uses a correction report to correct errors or omissions in the report and a Revision-to-Action Report to report modifications in the adverse action.).

[179] *Id.*; Van Boven v. Freshour, No. 20-0117, 2022 WL 2015663, at *5 (Tex. June 3, 2022) ("The Data Bank made clear that the nature of the adverse action against Van Boven was to be determined by the Board alone under Texas law, and that determination would dictate which report should be filed.").

[180] *Id.* at *3 (holding that the NPDB's criterion that the "action was overturned on appeal" did not require judicial appeal, and that an administrative board, reversing its own subsidiary panel met the criterion and the Board had acted *ultra vires* in refusing to file a Void Report).

[181] NAT'L PRAC. DATA BANK, *Help Center – Can I have my report changed or removed?*, U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/faqs/d4.jsp (last visited May 6, 2022); *see also* Christine Lehmann, *When Is It Worth Fighting Your NPDB Report?*, MED. ECONOMICS, Nov. 4, 2022, https://www.greensfelder.com/media/news/735_2022-11-04%20Medscape%20-%20When%20is%20it%20Worth%20Fighting%20Your%20NPDB%20Report.pdf. The physician may dispute the report. Not only is this time consuming, and potentially costly because a physician may choose to hire a lawyer to assist in the process, successfully achieving correction or removal is highly unlikely. In 2021, 14% of disputes resulted in corrections and 10% resulted in voiding. To a physician, even an amended report is a bad outcome. If the report is removed, it does not exist and the physician does not have to answer in the affirmative when asked about any reports to the NPDB. And a query to NPDB produces no 'hits'. When a report is corrected, its accompanying original report is removed but "Corrected Reports" refers to corrections of information not related to the adverse action, eg, demographics, etc., meaning that the original report's substantive content remains unchanged. Additionally, the next best option, disputing the report is generally unattractive because of its cost, both financially and time, and the low likelihood of success.

and eliminate incompetencies, they depend on confidentiality.[182] Access to full reporting data is only available to health entities, licensing boards, health plans and peer review organizations.[183] The NPDB makes certain de-identified data publicly available, but previously, journalists have been able to correlate that data with other public records to deidentify reportees.[184] In 2011, the NPDB temporarily shut down its public database to improve the confidentiality protections, but the data integrity concerns continue to present challenges for physicians.[185]

i. The Query Function

When making hiring decisions, hospitals must query the database for each physician on their medical staff.[186] State licensing agencies, peer review organizations and health plans that perform credentialling activities may query the NPDB under Title 42.[187] Multiple state and federal governmental agencies that do not have query authority under Title 42 do have authority under Section 1921 of the Social Security Act, although the information they can receive through the Act's authority is more limited.[188] The query authority poses no specific concerns to physicians because it limits the data these entities can access, although it serves as a reminder of the permanency and confidentiality concerns discussed previously, because numerous entities can access the reports and the adverse permanent information they contain.[189]

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[182] Tanya Henry, *Why Peer Review Confidentiality Is Critical, Must Be Protected*, AM. MED. ASS'N (Dec. 8, 2021), https://www.ama-assn.org/delivering-care/patient-support-advocacy/why-peer-review-confidentiality-critical-must-be-protected.

[183] NAT'L PRAC. DATA BANK, *General Information: Disclosure of NPCB Information*, ,U.S. DEP'T. OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/guidebook/AGeneralInformation.jsp (last visited Oct. 27, 2022).

[184] *Part 1: Malpractice Investigation Has Unintended Consequence*, KCUR (Nov. 9, 2011, 5:26 PM), https://www.kcur.org/health/2011-11-09/part-1-malpractice-investigation-has-unintended-consequence.

[185] Marian Wang, *How Complaints From a Single Doctor Caused the Gov't to Take Down a Public Database*, PROPUBLICA (Nov. 10, 2011, 12:20 PM), https://www.propublica.org/article/how-complaints-from-a-doctor-caused-the-govt-to-take-down-a-public-database.

[186] 45 C.F.R. §60.17 (2013).

[187] *See* Edmondson, *supra* note 170 (exemplifying actions that must be reported to the National Practitioner Data Bank); *see also Chapter D: Queries*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/guidebook/DOverview.jsp (last visited Dec. 3, 2022).

[188] *Section 1921 of the Social Security Act*, NAT'L PRAC. DATA BANK, https://npdb-hipdb.com/legislation-and-regulations/section-1921-of-the-social-security-act/ (last visited May 5, 2022).

[189] *Chapter D: Queries, supra* note 187.

ii. Although the NPDB is Not Independently Operational, its Enabling Statute Confers Substantial Influence of Non-governmental Entities on Data Collected

The NPDB is not independently operational. It cannot act on its own to add information to a physician's record or create an independent consequence. Rather, it relies on other entities to affect its functionality. Prior to the NPDB, remedies and enforcement actions were the outcomes of proceedings overseen by uninterested third parties, namely the courts or executive agencies. The HCQIA confers wide authority to report on malpractice carriers, and, more importantly, health entities such as hospitals with only limited accountability for their actions.[190] This authority creates a distinctly different relationship from a traditional employer-employee relationship or a traditional physician-hospital relationship, the full implications of which are not yet known.

III. THE INEVITABLE CONFLICT: WHERE CONTRACT MEETS DUTY

The duty and abandonment framework that case law and statutory-regulatory regimes reflect are derived from the traditional independent physician paradigm. It is unclear how current law might address the duty and abandonment issue in the employment model[191], but it is clear that real questions exist, and the growing number of employed physicians creates fertile ground for great conflict to arise when physician-hospital contractual agreements do not provide for assuring physicians will have

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[190] 42 U.S.C. §§ 11131–4, 11137 ("No person or entity (including the agency designated under section 11134(b) of this title) shall be held liable in any civil action with respect to any report made under this subchapter (including information provided under subsection (a) of this section without knowledge of the falsity of the information contained in the report."); *see also* Dinesh Vyas & Ahmed Hozain, *Clinical Peer Review in the United States: History, Legal Development and Subsequent Abuse*, 20 WORLD J. GASTROENTEROLOGY 6357, 6359 (June 7, 2014) (citing Nicholas Kadar, *How Courts Are Protecting Unjustified Peer Review Actions Against Physicians By Hospitals*, 16 J. AM. PHYSICIANS AND SURGEONS 16, 17–24 (Spring 2011), https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=2c532edf0f8fac988e847d33311e4e9787353b1d).

[191] Of the cases cited, only one, Warren v. Dinter, 926 N.W.2d 370 (Minn. 2019), establishes that the physician was an employed physician. While some of the other cases cited don't specify the physician-hospital relationship expressly, the facts provided in those cases' opinions are much more consistent with an independent physician and hospital relationship than an employed physician relationship.

the wherewithal to meet their duty of care.[192] This section explores potential conflicts by considering several scenarios based on the terms of the following hypothetical physician employment agreement:

A. Hypothetical Physician-Hospital Agreement[193]

1. *Work Duties*

1.1 Hospitalists: During each 14-day period, the Physician shall work 12 hours daily for seven consecutive days and then will be off for the following seven days. The work hours shall be 7am-7 pm and the Hospital shall pay the Physician an hourly rate in accordance with Section xxx of this Agreement. The physician shall treat a maximum of 15 patients during each 12-hour shift.[194]

1.2 Outpatient Physicians: The Physician shall work from 8:00-5:00 daily, Monday through Friday excluding any Federal, state or hospital designated holidays. The clinic shall not schedule patients between 12:00 noon and 1:00 pm daily or after 1:00 pm on one day per week upon which the Physician and the Hospital shall mutually agree. The hospital shall pay the physician in accordance with Section xxx of this Agreement.

1.3 Paid Time Off: The Hospital shall provide the Physician with twenty days of Paid Time Off ("PTO Days") per year. In accordance with the Hospital's PTO policies, if the Physician does not utilize any of the PTO Days, they may not carry over to the following year and the Physician shall forfeit them.

2. *Medical Liability Insurance:* The Hospital shall provide, at no cost to the Physician, medical liability insurance in the amount of $1 million per occurrence, $3 million annual aggregate. Insurance will be

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[192] Patrick Miller, *Hospital-Physician Alignment: Employment vs. Professional Service Agreement*, XXII, No. 12 IDAHO MED. ASS'N. NEWSL. (Idaho Med. Ass'n., Boise, Idaho), Dec. 15, 2011, https://www.givenspursley.com/assets/publications/articles/imaarticle-hospital-physicianalignment.pdf
(" Under the employment model, the physician becomes a "W-2" employee of the hospital and receives benefits, such as health insurance, medical liability insurance and pension benefits, through the hospital").

[193] Unless a specific statement in this hypothetical employment agreement or the hypothetical scenarios that follow is cited to a published source, these terms arise from contracts hospitals have presented to the author during employment negotiations throughout his medical career or to physician colleagues as they have related to the author.

[194] The actual number, where a contract includes such a provision, is variable and its determination multifactorial.

in the form of a claims-made policy up to and including the last date worked.[195]

3. *Termination:* At any time, the Physician or the Hospital may voluntarily terminate this agreement without cause by giving the other party written notice 90 days before the effective termination date. In the event the Hospital terminates the Physician's employment pursuant to this Section, the Hospital has the right to require the Physician to vacate the Hospital's premises prior to the effective date of this termination; provided that the Hospital shall compensate the Physician as provided in Section xxx of this Agreement for the entire notice period.[196]

4. The Hospital may terminate the Physician for cause, effective immediately upon providing notice of termination. For the purposes of this Section, "for Cause" has the following meaning:

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5. *Non-Contact/Non-Solicitation:* The physician acknowledges that any patients the Physician treats during this Agreement's term are the hospital's patients. The Physician shall not initiate contact with or solicit hospital patients after the effective date of this Agreement's termination.[197]

6. *Medical Staff Membership:* The Physician shall at all times during this Agreement's term maintain all requirements of active membership on the Hospital's medical staff. Dr. acknowledges her medical staff membership will cease concurrent with termination of employment.

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1. Fact Pattern Number 1: Termination by Hospital

Using the hypothetical physician hospital agreement above, the following scenario is posited:

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[195] Hospital-employers usually provide insurance coverage during the time of employment only. In a claims-made policy, liability requires both that the event occurred during the coverage period and that the plaintiff made the claim during the coverage period. Permanent insurance ("occurrence") is available but considerably more expensive. With claims-made, one can purchase an extended reporting endorsement ("tail") to cover any claims arising after the policy period ends. Most physicians do, but not all.

[196] FORMS, POLICIES AND PROCEDURES: PHYSICIAN EMPLOYMENT AGREEMENT, 4 HEALTH L. PRACTICE § C-169 (Thomson Reuters, 2d ed., 2022).

[197] This non-solicitation term is distinct from any restrictive covenant to practice that the Agreement may also contain.

Scenario A: Dr. Smith takes a job as a Hospitalist. After two years of successful employment, Anytown's CEO wants Dr. Smith to change her schedule and take a reduction in pay. Dr. Smith declines and discusses her concerns with the other hospitalists. The CEO decides to terminate Dr. Smith. Having no cause per the contract, the CEO terminates, choosing to remove Dr. Smith that day and pay her for the remainder of the term. Dr. Smith asks to complete her charting and say goodbye to the patients. The CEO says, no, a clean break would be better, and the other hospitalists will assume care of the patients.

Earlier that day, a patient's daughter informed Dr. Smith of an error in the patient's EMR. The mother is allergic to doxycycline, not dicyclomine. Dr. Smith attempts to enter that information into the patient's (EMR), but cannot because, having been removed from the staff, she can no longer access the EMR. The hospital's security staff then escorts Dr. Smith out. Dr. Jones has assumed care, notices the patient has a bladder infection and, seeing no concerns in the EMR, prescribes Doxycycline, causing severe allergic reaction. The patient dies from anaphylactic shock.

a. Did Dr. Smith Abandon the Patient?

Applying traditional case law, Dr. Smith has abandoned the patient because she and the patient had established a patient-physician relationship, the physician discontinued treating the patient while the patient still needed treatment, the withdrawal occurred abruptly, and the patient suffered an injury. Here, however, Dr. Smith would likely argue that her withdrawal arose from circumstances beyond her control and these circumstances created a superseding event that frustrated her ability to effect a safe transition of care, and a court would likely hold she had a valid defense.[198]

Alternatively, had the hospital allowed Dr. Smith to access the patient's EMR, one could conclude that Dr. Smith had no defense to the abandonment claim, even if she no longer was an employee and her

[198] Restatement (Second) of Torts, § 440 (AM. L. INST. 1934) ("A superseding cause is an act of a third person or other force which by its intervention prevents the [original] actor from being liable for harm to another."). Courts have recognized superseding causes as defense to causation in medical malpractice claims. *See generally* Benitz v. Gould Group, 27 S.W. 3d 109, 116 (Ct. App. Tex. 2000) (A "new and independent cause," sometimes referred to as a superseding cause, however, is an act or omission of a separate and independent agency that destroys the causal connection between the negligent act or omission of the defendant and the injury complained of, and thereby becomes the immediate cause of such injury.").

continued involvement in the patient's care would cause her to breach her contract. More difficult, though, is a scenario where Dr. Smith had no access to the EMR, but the hospital did not escort her from the building. Once she was no longer an employee or a medical staff member, how much effort would Dr. Smith reasonably need to exert to a patient belonging to the hospital?

No state's statutes or guidelines address abandonment with respect to inpatients. Whether Dr. Smith breached a duty of care sufficient for a professional board to act is unclear. Physician-to-physician communications are a patient care issue, so a professional board outcome might depend on the degree to which she could, and did, attempt to communicate the vital information.[199]

A report to the NPDB would arise if Dr. Smith's malpractice carrier or the hospital made a payment on Dr. Smith's behalf even if the hospital, without Dr. Smith's consent, made a business decision to settle the claim.[200] An interesting situation arises, however, where Dr. Smith prevails at trial, but the hospital had decided as a business decision to settle both a direct claim against the hospital and a vicarious liability claim under respondeat superior. The NPDB defines a malpractice cause of action as "payment based on a health care provider's furnishing (or failure to furnish) health care services."[201] Under this language, the statute requires the hospital to report and Dr. Smith, having successfully defended herself, would nevertheless still have a negative report in her NPDB record.

Interestingly, even if Dr. Smith could have communicated the critical clinical information and breached professional standards by not having done so, the hospital would not report. The incident occurred when Dr.

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[199] *Communication Between Clinicians*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Sept. 7, 2019), https://psnet.ahrq.gov/primer/communication-between-clinicians ("In a clinical context, maintaining situational awareness requires information sharing and open dialogue among clinicians in order to achieve a shared mental model—the "big picture" of the patient's condition and immediate priorities for care."); *see also Glossary: Mental Models*, AGENCY FOR HEALTHCARE RSCH. & QUALITY, https://psnet.ahrq.gov/glossary (last visited Nov. 14, 2022).

[200] *Reporting Medical Malpractice Claims*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/guidebook/EMMPR.jsp (last visited Dec. 3, 2022) ("Each entity that makes a payment for the benefit of a health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment for medical malpractice against that practitioner must report the payment information to the NPDB." The statute and regulations do not provide an exception for settlements made without the physician's consent.).

[201] 42 U.S.C. § 11151(7).

Smith was no longer on the medical staff and not subject to its peer review process.

b. Did Dr. Jones Breach a Duty of Care to the Patient?

Dr. Jones likely owed a duty of care but likely did not breach that duty. Although Dr. Jones and the patient did not expressly consent to patient-physician relationship, Jones, an employee has a contractual obligation to care for the hospital's inpatients. Therefore, like *Mead v. Legacy Health*, where the physician's on-call obligation provided the requisite implied consent, Dr. Jones has consented to the relationship.[202]

Where Dr. Smith was unable to enter the critical information into the EMR, Dr. Jones would have no way of knowing it existed. Therefore, his ordering the fatal medication was unfortunate but not necessarily a breach of duty. A different outcome might arise if Dr. Smith were able to leave messages and it were the physicians' practice to communicate by some informal message system. In that case, Dr. Jones might well have breached the standard of care, and thus be liable.

2. Fact Pattern Number 2: The Physician with a Fully Committed Patient Load

Again, using the hypothetical physician-hospital employment agreement stated above, this next scenario is posited:

> **Scenario B:** The hospital CEO reduces the physician staffing level down to one hospitalist on duty per shift to contain costs. A competitor announces its closure, but the CEO opts not to re-employ additional physicians or modify compensation to currently employed physicians in anticipation of the increased patient activity. Dr. Williams, who in the past has never taken more than her contractually obligated 15 patients, decides the increased demand is unreasonable and informs her supervisor and the Emergency Department that she will not exceed her obligation.
>
> Dr. Williams starts her shift with 15 patients. The Emergency Department (ED) calls Dr. Williams to inform her of a 35-year-old acutely ill patient who needs admission. Dr. Williams declines the patient. While awaiting on a physician willing to treat him, the patient's medical condition deteriorates with needs well beyond what the ED can address. The patient rapidly deteriorates and goes into cardiac arrest. The ED is able to resuscitate the patient, and he is left

[202] Mead v. Legacy Health System, 220 P.3d 118, 126 (Or. Ct. App. 2009).

with severe brain damage, unable to work and requiring total care for the remainder of his life.

The CEO, furious over Dr. Williams's actions, refers the case to the hospital's Peer Review Committee, who upon finding Dr. Williams deviated from the standard of care and based on mandatory reporting, refers Dr. Williams both to the National Practitioner Data Bank ("NPDB") and the state's medical licensing board.

a. Did Dr. Williams Breach a Duty of Care to the Patient?

The patient's representative would argue here that, like in *Mead v. Legacy Health*, that Dr. Williams had implicitly consented to a patient-physician relationship, thus establishing a duty of care.[203] In *Mead*, the physician, Adler had affirmatively agreed to treating Mead; Mead alleged Adler breached his duty of care by not providing timely care.[204] The court held that Adler had established the requisite relationship to create the duty.[205] Applying that reasoning, having established the duty, and not arranged for another physician to treat, Dr. Williams effectively abandoned the patient. Here, however, Dr. Williams has fulfilled her contractual obligation. Therefore, like the physician in *Fought v. Solce*, who's on-call status was not contractual, and who, therefore, did not consent to the relationship, Dr. Williams would argue she owed no duty here because she had met her contractual obligation.[206]

Alternately, applying a proximity principle such as from *Noble v. Sartori*, one could reasonably conclude Dr. Williams owed a duty and abandoned the patient.[207] Like Noble's physician-defendant, Dr. Williams was present, had the requisite capabilities, no other similarly skilled physician was available, and there was potential risk in not treating. From these facts one could presume Dr. Williams owed a duty to the patient which she breached by not treating. Here, Dr. Williams might argue that her pre-existing duty, at its contractual maximum, precluded her ability to provide the care and therefore, she did not owe the duty. Dr. Williams might be able to prove that her current patient load was so great that she

[203] Mead v. Legacy Health System, 220 P.3d 118, 125 (Or. Ct. App. 2009).
[204] *Id.* at 120.
[205] *Id.* at 124.
[206] Fought v. Solce, 821 S.W.2d 218, 219 (Tex. App. 1991).
[207] Noble v. Sartori, 799 S.W.2d 8, 9 (Ky. 1990) ("Thus, although we recognize that in the usual situation a doctor is under no obligation to treat a person, we also recognize the law implies a duty wherever circumstances put parties in a relationship to each other where one acts negligently it causes injury to the other.")

could not, in fact, provide the necessary care, a contention likely difficult to establish. Consequently, current case law suggests Dr. Williams most likely owed the duty and breached it.

b. How Might Dr. Williams Fare in the Peer Review Process?

A hospital professional review committee would almost certainly consider Williams' actions to have violated professional standards, if only because they violate the Hippocratic standard: "first do no harm, then do good.".[208] Whether a committee would have determined Dr. Williams' conduct merited privilege curtailment is unclear, but if it chose to act and prevailed in a hearing, the hospital would, under Title 42, report the action to the NPDB.

This scenario highlights particular concerns regarding the overlap between human resource concerns and medical liability concerns. Overwork is a growing concern among U.S. physicians, with some speculating physician overwork is part of the business model for hospitals.[209] Causes are multifactorial, studies and experts cite an aging population with multiple complex chronic medical conditions, financial incentives for hospitals to shorten hospital stays, regulatory growth and the documentation demands of electronic medical record keeping as key factors.[210]

3. Fact Pattern Number Three: The Almost Illusory Vacation

The following scenario again relies on the hypothetical physician-hospital agreement outlined above:

> **Scenario C:** Dr. King, an internist, is an outpatient physician working as a full-time employee for Anytown Hospital. He has accrued 80 hours of vacation time which he will lose if he does not

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[208] *See Hippocratic Oath supra* note 57.

[209] Danielle Ofri, *The Business of Health Care Depends on Exploiting Doctors and Nurses*, N.Y. TIMES: SUNDAY OPINION (June 8, 2019), https://www.nytimes.com/2019/06/08/opinion/sunday/hospitals-doctors-nurses-burnout.html.

[210] *5 Causes of Physician Burnout and How to Address Them*, PATIENTPOP (July 13, 2022), https://www.patientpop.com/blog/physician-burnout-causes/; *see also* Kate Rogers, *America's Aging Population is Leading to a Doctor Shortage Crisis*, CNBC (Sept. 6, 2019), https://www.cnbc.com/2019/09/06/americas-aging-population-is-leading-to-a-doctor-shortage-crisis.html ("As America's population ages and demand outpaces supply, a physician shortage is intensifying. . .older patients use two-to-three times as many medical services as younger patients, and the number of people over age 65 will increase by almost 50%, just in the next 10 to 15 years alone.").

take time off before his work-anniversary date. The hospital's clinic manager approves the time and tells Dr. King to find another physician to cover his patients. Unable to find another physician to cover, Dr. King tells the manager she'll need to address coverage.

The clinic manager assigns coverage to Dr. Green and, although physicians receive a substantial portion of patient-related communications through the EMR, fails to redirect any EMR communication from Dr. King's profile to Dr. Green's profile.[211] After leaving for vacation, the lab enters results on a patient Dr. King saw earlier that day who wasn't feeling well; the blood glucose level is five times normal. It is not until the next afternoon that anybody realizes Dr. King's inbox messages are not redirecting. Upon seeing the lab value, Dr. Green tries to contact the patient. Unable to reach the patient, who lives alone, the clinic reaches the patient's emergency contact who, upon checking, finds the patient has died.

When Dr. King returns from vacation and learns what happened he decides to quit his job. He asks the manager for contact information so he can notify his patients. The manager refuses to provide Dr. King the information or place signage in the clinic. Without the information, he is unable to contact his patients and can tell only the patients who visit him in the office after he gives notice.

a. Did Dr. Green Breach his Duty of Care?

Dr. Green likely has no duty to the patient. Like Wax v. Johnson, Dr. Green was an on-call physician with no prior knowledge of the patient's condition.[212] His relationship with the patient begins at the point of first encounter or first awareness because, under the contract obligation theory, that would be Dr. Green's first affirmative act. Unaware of the need to check the lab result, Dr. Green's first affirmative act was to respond to the lab value when he saw it the afternoon after the patient's office visit. Therefore, he did not establish a relationship with the patient until that point in time and owed no duty.

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[211] Sophie Putka, *Are Doctors Drowning in Inbox Overload?*, MEDPAGE TODAY (Sept. 22, 2021), https://www.medpagetoday.com/special-reports/exclusives/94652. Physicians now receive a substantial portion of patient related communications, including laboratory and other diagnostic information, through a dedicated inbox incorporated into the EMR.

[212] Wax v. Johnson, 42 S.W.3d 168, 173 (Tex. App. 2001).

b. Did Dr. King Breach his Duty of Care?

Under traditional case law, Dr. King has breached his duty to the patient. He has abruptly withdrawn from care, albeit temporarily, without providing sufficient time and notification for the patient to procure other care and the patient sustained an injury. Had he found coverage, he almost certainly would have fulfilled his duty of care even if he hadn't informed the patient and had informed Dr. Green of the pending lab testing. Notably, in *Wax v. Johnson*, the court does not opine on the withdrawing physician's liability. The court observes that Dr. Verm, the admitting gastroenterologist, was a named defendant but was not served and did not make an appearance.[213]

Here, however, the question arises as to how Dr. King's contractual relationship with the hospital impacts his duty of care to the patient. In all likelihood, a court would find that Dr. King's duty to the patient did not extinguish just because the physician employment agreement conferred "ownership" onto the hospital. Consequently, Dr. King likely still owed a duty to the patient and breached that duty of care despite his legitimate request for time off, leaving the patient without appropriate coverage.

Conversely, a different result might arise if Dr. King practices in a state with a Corporate Practice of Medicine ("CPM") act that provides exceptions for hospital entities.[214] CPM Acts arise from a concept that individuals, not corporations, practice medicine, and therefore corporations cannot fulfill a duty of care. Many CPM acts provide exceptions for hospital entities, conferring a constructive-physician status to the corporation.[215] Applying that theory to the contract in a CPM jurisdiction, one could argue that the patient-physician relationship was actually between the hospital and the patient, and Dr. King was merely a covering physician. Having completed his coverage and informed the hospital he was not available while on vacation, the duty of care fell to the

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[213] *Id.* at 170.

[214] *Issue Brief: Corporate Practice of Medicine*, AM. MED. ASS'N, https://www.ama-assn.org/media/7661/download (last visited Dec. 3, 2022) ("The corporate practice of medicine doctrine prohibits corporations from practicing medicine or employing a physician to provide professional medical services. . .Most states prohibit the corporate practice of medicine, however, every state provides an exception for professional corporations and many states provide an exception for employment of physicians by certain entities.").

[215] *The Corporate Practice of Medicine in a Changing Healthcare Environment,* CAL. RSCH. BUREAU (Apr. 2016), https://sbp.senate.ca.gov/sites/sbp.senate.ca.gov/files/CRB%202016%20CPM%20Report.pdf.

hospital. On this basis, it is much less clear that Dr. King owed a duty to the patient.

c. Did Dr. King Violate any Statutory or Regulatory Requirements by Improper Notification of his Exit from Practice?

If Dr. King practices in a state with specific statutory-regulatory withdrawal-termination requirements, he has violated those requirements by not providing ample notice to the patient of his departure. None of the statutes or regulations confer the responsibility to the non-physician employer. Likewise, even in states where there are no statutory or regulatory requirements, the accepted standard of practice and best practice is to notify patients when a practice permanently is closing.[216] While Dr. King's failure to properly notify is a per se violation of every existing state statute or regulation, and none provide an impossibility defense, a board is likely to give great weight to Dr. King's circumstances and would be unlikely to take adverse action.

B. COLLECTIVE BARGAINING: WHAT OBLIGATIONS TO PATIENTS WOULD PHYSICIANS HAVE IF THEY CHOSE TO STRIKE OR IMPLEMENT SOME OTHER WORK ACTION?

The next hypothetical is predicated upon a physician hospital agreement that differs from the agreement used above, instead it is based on the collective bargaining agreement described below:

> **Scenario D:** The hospital employs Dr. Brown as a general surgeon. The hospital has a collective bargaining agreement with its physicians and Dr. Brown joins the union. Despite ongoing negotiations, six months after starting her job, the contract between the physicians and the hospital ends without the two sides reaching an agreement on a new contract. The doctors, after some debate, decide they will strike. After complying with all legal requirements, the physicians go on strike.
>
> During this work stoppage, the union agrees to allow two physicians to work each shift and the hospital agrees to go on ambulance diversion, the practice of turning away ambulances

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[216] *See* Rainey Campbell, *Patient Notification Requirements for a Closing Medical Practice*, CARIEND (July 8, 2021), https//www.cariend.com/patient-notification-requirements.

because of limited ability or resources to treat newly arriving patients, to minimize impact on patients.[217]

The hospital CEO, concerned about the hospital's public image of being unable to manage in a crisis, unilaterally lifts the diversion and shortly thereafter an ambulance arrives with a patient reporting nausea and vomiting for the past 24 hours. After testing, the ED physician diagnoses appendicitis. Because neither of the two physicians working that shift is a surgeon, the ED physician contacts Dr. Brown asking for consultation and treatment. Dr. Brown, out on strike, recommends transporting the patient to another hospital. While awaiting the ambulance, the patient's appendix ruptures, despite the hospital providing ongoing care within its capability, he becomes seriously ill and dies from the ruptured appendix.

1. The Health Care Setting Imposes Unique Ethical and Legal Considerations Regarding Unions

Unions raise unique issues in health care. Although historically unions have represented only a small number of physicians, between 1998 and 2019 the number of physicians belonging to unions increased from approximately 15,000 to 67,673, a greater than fourfold increase.[218] This growth trend is notable in light of overall union membership rates in the United States which decreased from 16.33 million in 2000 to 14.25 million in 2020.[219] The American College of Physicians' official position is that any organized work action, including "strikes, work stoppages, slowdowns, boycotts or other organized actions that are designed, implicitly or explicitly, to limit or deny services to patients that would otherwise be available" is unethical.[220]

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[217] Barbara Brody, *'Hospital Diversion' is Perfectly Legal and Putting People at Risk. Here's What You Need to Know*, HEALTH (June 27, 2019), https://www.health.com/mind-body/hospital-diversion.

[218] *Issue Brief: Collective Bargaining for Physicians and Physicians-in-Training*, AM. MED. ASS'N (2021), https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf.

[219] *Number of Union Members in the United States from 2000 to 2021*, STASTISTA, https://www.statista.com/statistics/195339/number-of-union-members-in-the-us-since-2000/ (last visited May 5, 2022).

[220] Lois Sulmasy & Thomas Bledsoe, *American College of Physicians Ethics Manual*, 170 ANNALS OF INTERNAL MED., S1, S21 (2019) ("Physicians should not engage in strikes, work stoppages, slowdowns, boycotts, or other organized actions that are designed, implicitly or explicitly, to limit or deny services to patients that would otherwise be available. Individually and collectively, physicians should find advocacy alternatives, such as lobbying

Organized medicine's ethical stance on physician strikes does not answer the question about a strike's legal implications. Physicians who are non-supervisorial employees may join unions and strike.[221] However, the National Labor Relations Act ("NLRA") does require unions to provide advance written notification to a health care institution of its intent to carry out a work stoppage action at least 10 days in advance.[222] Additionally, the NLRA provides discretionary authority to the NLRB's Director of the Federal Mediation and Conciliation Service to intervene by evaluating the dispute and generate recommendations for resolving the dispute, although the statute does not provide specific authority to end a strike.[223]

Union members do not cease to be employees when their collective bargaining agreement expires.[224] "Following the expiration of a collective-bargaining agreement an employer must maintain the status quo of all mandatory subjects of bargaining until the parties either agree on a new contract or reach a good-faith impasse in negotiations."[225] Therefore, a physician such as Dr. Brown is an employee with a contractual relationship with the hospital even after the collective bargaining agreement expires.

2. What is Dr. Brown's Duty of Care and Did She Breach any Duty of Care?

Does Dr. Brown have a duty to the patient? There is no mutual consent in this case, suggesting no patient-physician relationship exists. However,

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lawmakers and working to educate the public, patient groups, and policymakers about their concerns. Protests and marches that constitute protected free speech and political activity can be a legitimate means to seek redress, provided that they do not involve actions that may harm patients.").

[221] National Labor Relations Act, 29 USCA §155.

[222] National Labor Relations Act, 29 USCA §158(g).

[223] National Labor Relations Act, 29 USCA §173 ("If the Director is not able to bring the parties to agreement by conciliation within a reasonable time, he shall seek to induce the parties *voluntarily* [emphasis added] to seek other means of settling the dispute without resort to strike, lock-out, or other coercion. . . The failure or refusal of either party to agree to any procedure suggested by the Director shall not be deemed a violation of any duty or obligation imposed by this chapter.").

[224] *Collective Bargaining Rights*, NAT'L LAB. RELATIONS BD., https://www.nlrb.gov/about-nlrb/rights-we-protect/the-law/employees/collective-bargaining-rights ("If a contract expires before the next contract is in place, almost all the terms of the expired contract continue while the parties bargain (the exceptions being union security, management rights, no-strike/no-lockout, and arbitration provisions)") (last visited Dec. 3, 2022).

[225] *Richfield Hosp., Inc.*, 368 NLRB No. 44 (Aug. 15, 2019).

a court could consider that, like in *Mead*, Dr. Brown's involvement was based on a contractual obligation.[226] Alternatively, like in *Hand v. Tavera*, Dr. Brown's contract with the hospital to care for its patients created a third-party obligation which formed an implied duty, and thus which Dr. Brown breached.[227] Although this case differs from *Hand* because Hand, the plaintiff-patient, had an actual contract with the health plan, the patient could reasonably argue that his reliance on the hospital's agreement to cancel diversion was sufficient to bind the hospital in which case his reliance on the hospital and Brown's contractual obligation would form the duty of care.[228]

Likewise, if the jurisdiction followed the minority rule in which foreseeability may establish duty of care, Dr. Brown would have a duty of care to the patient.[229] Although the mortality rate after appendiceal rupture may approach forty percent, mortality after treatment for non-ruptured appendix is below one percent and time between onset of symptoms and treatment is a major determinant of rupture.[230] Therefore, it was foreseeable that delaying the patient's care significantly increased his risk of rupture and its associated complications. Having discussed the patient with the Emergency Medicine physician, Dr. Brown both created and breached the duty by abandoning the patient.

The scenario this hypothetical poses is extremely unlikely, both because physicians do not want to strike based on the ethical concerns and because when they have chosen work stoppages, they have used more targeted strategies such as refusing elective and non-emergent care.[231] However, review of a physician collective bargaining agreement from the nation's largest physician union by membership found no provisions for care continuation at its expiration.[232] As physician union representation grows,

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[226] Mead v. Legacy Health Sys., 220 P.3d 118, 123 (Or. Ct. App. 2009).
[227] Hand v. Tavera, 864 S.W.2d 678, 679 (Ct. App. Tex. 1993).
[228] *Id.*
[229] *See* Warren v. Dinter, 926, N.W.2d 370, 372 (Minn. 2019) (showing that although no patient-physician relationship existed, the potential negative outcome from the physician's actions were foreseeable and, therefore, created a duty of care).
[230] Siriwimon Tantarattanaong & Nuraianee Arwae, *Risk Factors Associated with Perforated Acute Appendicitis in Geriatric Emergency Patients*, 10 OPEN ACCESS EMERGENCY MED. 129, 129 (Oct. 4, 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6174914/.
[231] Stephen Thompson & J. Warren Salmon, *Physician Strikes*, 146 Chest 1369, 1369 (2014), https://journal.chestnet.org/article/S0012-3692(15)52405-7/fulltext.
[232] *See* Memorandum of Understanding between Union of Am. Physicians & Dentists and The Cnty. of L.A. (July 30, 2019), https://www.uapd.com/wp-content/uploads/UAPD-LA-325-MOU-07-2019-to-09-2021.pdf (illustrating a physician collective bargaining agreement).

these issues will likely become more emergent.

IV. OPTIONS FOR ADDRESSING THE CONTRACT-DUTY CONFLICT

The hypothetical scenarios presented above demonstrate just a few situations where a conflict between physician employment contract provisions and the physician's duty of care arises. Addressing this issue takes two possible forms: narrowing the traditional scope of the physician's duty of care to accommodate the current and future state of medical practice or changing the current medical environment to alleviate imminent conflicts while preserving the traditional duty of care. Because the current legal duty of care is rooted in centuries-old foundational tenets of physician practice, its modification seems a less plausible approach to resolving the contract-duty conflict. Therefore, this section focuses on approaches that would potentially resolve the conflicts while preserving the underlying duty of care in four areas: (a) contract development; (b) regulatory or statutory options; (c) collective bargaining agreements; and (d) hospital-medical staff governance.

A. Contract Precedent Development

1. Currently Available Model Contracts and Templates Do Not Address Adequately, or at all, the Hospital's Obligation for Facilitating Physicians' Duty of Care Obligations

Current guides for physician contracts do not address mechanisms for allowing physicians to meet their regulatory burdens.[233] While the American College of Physicians ("ACP") publishes a sample contract, for example, its template contains no provisions that discuss or address how the parties will manage patient-physician relationship termination or how the physician's employer will facilitate compliance with legal requirements.[234] State medical association sample contracts might not provide any provisions that address how the parties will manage physician

[233] FORMS, POLICIES AND PROCEDURES: PHYSICIAN EMPLOYMENT AGREEMENT, 4 HEALTH LAW PRACTICE C-169 (Am. Health Laws. Ass'n., 2d ed., 2022).

[234] *Physician Employee Contract Guide,* AM. COLL. OF PHYSICIANS (2017), https://www.acponline.org/system/files/documents/running_practice/practice_management/human_resources/employment_contracts.pdf.

withdrawal when either party terminates the agreement.[235] Commercially available contract precedents also inconsistently contain provisions addressing how the parties will handle these issues.[236] Trade publications targeting hospital administrators have published guides for "essential" provisions in physician employment agreements that do not address managing physician-withdrawal issues at termination.[237]

At least one online legal technology service has incorporated a provision for physician withdrawal.[238] Although the service, Rocket Lawyer, is not necessarily a physician employment contract authority, it claims over 25 million subscribers, making its content a potentially vital resource.[239] Its template contract provision's transition of care provision states,

> Upon the termination of this Agreement, Physician shall take all reasonable steps necessary for the prompt and efficient transfer of Patients under Physician's care to other supervising physicians hired by the Health Care Center. For a period of 30 days after the effective date of termination, Physician shall continue to take such actions as are reasonably necessary to ensure that Patients under supervision continue to receive effective professional care.[240]

This transition of care at termination provision acknowledges the importance of effective physician withdrawal but does not obligate the employer to facilitate the withdrawal. Limiting the employer's obligation is particularly salient because employers control many of the mechanisms

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[235] *Employment Agreement*, WYO. MED. SOC'Y, https://www.wyomed.org/wp-content/uploads/2017/06/Template-Physician-Employment-Agmt-140601.pdf (last visited May 5, 2022) (serving as an example of an agreement in which there is no language to address physician withdrawalwithdraws when either party terminates).

[236] *Sample Three: Physician and Hospital Contract*, DEXFORM, https://www.dexform.com/download/employment-agreement-7 (last visited May 5, 2022) (exemplifying commercially available or downloadable physician employment contract precedents demonstrating no provisions addressing how physicians employee will be afforded resources or support to meet their regulatory obligations).

[237] *Seven Key Provisions for Successful Physician Employment Contracts,* BECKER'S HOSP. REV. (Oct. 12, 2010), https://www.beckershospitalreview.com/hospital-management-administration/7-key-provisions-for-successful-physician-employment-contracts.html.

[238] *Physician Services Agreement*, ROCKET LAWYER, https://www.rocketlawyer.com/business-and-contracts/service-contracts/professional-services-contracts/document/physician-services-agreement (last visited May 5, 2022).

[239] Aaron Pressman, *Exclusive: Legal Tech Startup Rocket Lawyer Raises $223 Million for Expansion*, FORTUNE (Apr. 21, 2021, 8:00 AM), https://fortune.com/2021/04/21/legal-tech-rocket-lawyer-raises-223-million-expansion/

[240] *Physician Services Agreement*, *supra* note **Error! Bookmark not defined.**.

to affect the withdrawal, such as access to patient contact information or signage placement. The provision also doesn't consider termination for cause or other situations where termination does not allow the physician to work for 30 more days after termination. Finally, like the other templates and guidelines for physician-hospital agreements referenced above, the agreement does not indemnify the physician against physician abandonment claims that arise in situations where the employer has impeded proper physician withdrawal, such as by refusing access to patient contact information or refusing to publish notice of the physician's departure.[241]

2. Hospital Constituent Organizations and Physician Professional Associations Should Develop, Collaboratively, Model Contract Language that Addresses Physician Duty of Care Issues

Hospital trade organizations such as the American Hospital Association and medical professional associations such as the AMA and ACP could together develop and promulgate model contract language that addresses physician duty of care requirements. The business provisions should include provisions that obligate the employer to provide resources necessary to allow the physician to comply with legal requirements for physician withdrawal.[242] The model language should also indemnify physicians against third-party claims arising from the employer's breach.[243] Likewise, a provision could obligate the physician to cooperate with an effective withdrawal plan.[244] Delineating these obligations minimizes potential conflicts for physicians and clarifies for hospitals their duties to physicians and patients.

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[241] *Id.*

[242] A sample provision might read "Upon receiving physician's notice of termination as Section x.xx of this agreement specifies, the hospital shall provide all resources the physician requires to meet any regulatory or statutory obligation for physicians to withdraw from their patients' care."

[243] A sample provision might read, "The hospital indemnifies the physician against any claims against the physician that a third party makes if the claim arises from the hospital's failure to provide the necessary resources for the physician to meet the regulatory and statutory obligations for withdrawal from a patient's care."

[244] A sample provision might read, "The physician agrees to perform all necessary steps to comply with statutory and regulatory obligations for the physician's withdrawal from patients' care."

3. Hospitals and Physicians Should Consider Including Provisions that Address Patient Care Coverage, General Work Conditions, and all Additional Documents that the Contract References

Unlike the transition of care at termination provision in the Rocket Lawyer template contract, none of the model contracts, guidelines, or recommendations cited addresses provisions regarding potential abandonment issues that do not arise from termination.[245] Because employed physicians do not have the authority to set their work schedules or enter into agreements that obligate other physicians to provide the coverage, model contracts should include provisions that expressly obligate the employer to provide this coverage.[246] The contract language should also account for how its conditions relate to the employer's general human resources policies and how the parties will resolve situations where the contract and those policies create a burden for the physician, such as a use-it-or-lose-it general policy in the face of insufficient available coverage for the physician to take vacation time. Finally, model language should address a physician's coverage responsibilities for other physicians, including the expected frequency and the scope of coverage.

Medical professional organizations should disseminate strong model contract language to their members to accomplish the primary goal of alleviating potential contract-duty conflict. This collaborative approach would also benefit hospitals by reducing agency liability they might incur as the physician's employer. Further, this collaborative contract development approach would likely increase hospitals' adoption of this language in their physician employment agreements.

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[245] *Physician Services Agreement, supra* note **Error! Bookmark not defined.**.

[246] *Independent Contractor vs. Employee*, CONTRACTS COUNSEL (Dec. 23, 2020), https://www.contractscounsel.com/b/independent-contractor-vs-employee ("Employees are people who work for an employer that controls what the employee does. In other words, the employer controls the how, where, and when the employee performs its work."); *see also* Scott S. Batemen, *You Have Responsibility, But Do You Have Authority?*, MEDIUM: LEADERS & MANAGERS (Aug. 13, 2019), https://medium.com/leading-and-managing/you-have-the-responsibility-but-do-you-have-the-authority-8a28f4b1b32e ("But *authority* isn't automatically available with every job, task or duty. Authority is the power, right or permission to take action. . . It seems logical and obvious that employees should always have the authority to act. . .Anyone who ends up with responsibility without authority — or with limited authority — will find it much harder to succeed and more likely to get in trouble.").

A. Regulatory and Statutory Approaches

1. States Can Modify Existing Regulations to Better Shield Physicians and Potentially Obligate Hospitals Where Contract Obligations Thwart Physicians from Meeting their Regulatory Obligations

Of the thirty-five states with statutes, regulations, or guidance on proper termination without abandonment, none consider situations where the physician cannot independently affect the procedural requirements.[247] Public records do not show any licensure actions for abandonment that implicate a hospital employer which militates against a pressing need for change.[248] Nevertheless, as more physicians move to employment, the likelihood of issues arising grows, and physicians should not depend on a medical board's relative disinterest or the improbability that a board would act against a physician in a situation where the hospital prevented compliance. To the extent that medical licensing boards do not have jurisdiction over hospitals, the boards cannot exert control over hospitals' behaviors. Still, they can build in protections for physicians where hospitals frustrate their compliance.

In states with Corporate Practice of Medicine (CPM) statutes that provide exceptions to hospitals and certain other entities, the boards may have sufficient jurisdiction to effect rules that hold those employer-hospitals accountable. Consequently, where medical licensing boards have jurisdiction over entities exempt from CPM acts, the boards should develop rules that share the responsibility for withdrawal and termination requirements equitably between the hospital and the physician.

2. Changes to the NPDB that Better Address Current Physician-Hospital Relationships Would Help Reduce the Potential for Conflict

Title 42 changes to the NDPB that help maintain the balance between physician-hospital contractual obligations and duty of care obligations

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[247] *See infra* Appendix A: Codification Status of Termination Duty, by State.

[248] Many states maintain public notices of licensure actions, some stating back more than a decade. Review of these lists (performed manually because most have either no search function or the search function isn't sufficiently robust to filter the results meaningfully) in multiple states did not reveal any cases where a board implicated a hospital in a patient abandonment case. The Kansas Board of Healing Arts website provides licensure action information dating to 1972. As an example, *2022 Board Actions*, KAN. BD. OF HEALING ARTS, http://www.ksbha.org/boardactions/22bdact.shtml (last visited Dec. 3, 2022).

include amending reporting requirements so that physicians who surrender clinical privileges must be expressly aware of an active professional review or pending professional review. This could afford physicians the opportunity for a fully independent professional review and appeals process as a condition for immunity and would create a dollar floor for malpractice reporting. The statute also does not adequately consider situations where medical staff privileges are contingent on continued employment.[249] Consequently, a physician unaware of an active investigation who resigns for unrelated reasons unwittingly may cause a permanent report they have little control over.[250]

In addition, the professional review hearing language no longer serves its intended process, and modification would restore integrity.[251] Arguably, when a statute's purpose is to root out incompetence, to give subjects more rights would be counterproductive. However, the statute's historical context suggests that Congress intended the process to ensure fairness.[252] Consequently, amending the law to reflect physician-hospital relationship changes restores the justice Congress intended when it enacted the legislation. Similarly, establishing some monetary floor to malpractice payment reporting would better accommodate the realities of a corporatized physician-hospital environment where physicians have less control over economic decision-making but where the outcome affects them professionally and permanently. The statute recognizes that reporting small payments may not be necessary to its intent, requiring the Secretary to study the issue and report its findings to Congress.[253] Given the changes that have occurred in physician-hospital relationships since

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[249] 42 U.S.C. §§ 11111–11151.

[250] *Examples of Dispute Resolution*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/guidebook/FExamplesofDisputeResolution.jsp (last visited Dec. 3, 2022) ("A hospital must submit a report to the NPDB when a physician or dentist resigns his or her clinical privileges while under investigation, regardless of whether the health care practitioner is aware of the investigation. The hospital provided documentation of an ongoing investigation at the time the surgeon resigned her clinical privileges.").

[251] 42 U.S.C. § 11112(3). The statute provides that the entity, in the case of an employed physician, the employer, can appoint the hearing officer, the only limitation being that the hearing officer is "not in direct economic competition with the physician involved." As an employed physician, other employed physicians are not direct economic competitors. Therefore, the hospital has broad discretion to control this process while still maintaining immunity.

[252] Health Care Quality Improvement Act of 1986, H.R. 5540, https://www.congress.gov/bill/99th-congress/house-bill/5540 (last visited Dec. 3, 2022). The bill provides protections for physicians who participate in peer review process but also sets forth standards for physicians and hospitals to enjoy these protections.

[253] 42 U.S.C. U.S.C § 11131 (1986).

that study's 1988 deadline, a new study may lead to different conclusions.

Modifying the NPDB to incorporate these suggestions requires Congress to amend Title 42 and may be more challenging to implement. Title 42 does, however, give the Secretary authority to promulgate new regulations.[254] Two areas that regulations could shape are defining "competence or professional conduct" and a process independent of hospitals or physicians to remove reports that do not accurately reflect competency or professional conduct. Clearly defining competence or professional conduct gives participants and queriers more predictable and objective parameters to assess the system. An independent report removal process would increase NPDB's integrity by creating a fairer and confidence-inspiring reporting system.

a. Collective Bargaining Agreement Modifications

Although work stoppage actions among physicians are rare, the increasing number of physicians who belong to unions increases the potential for these actions in the future.[255] Collective bargaining agreements should contain specific provisions for post-expiration contingencies if the physicians' union and the employer cannot agree. The provisions should include a mechanism for developing and regularly reviewing an action plan for possible work stoppages. The plan should address physician staffing requirements, patient care obligations, and means to bind the employer to the plan through the labor-management committee or its equivalent. A proactive approach to assuring a safe transition of care would likely reduce or eliminate potential preventable bad outcomes.

3. Institution (Individual Facility) Based Solutions

Hospitals have long been managed under a bipartite operational

[254] 42 U.S.C. § 11114 (1986). To change Title IV, either the Director would need to exercise sole discretion in promulgating new regulations, or there would need to be significant Legislative action.

[255] Paul Sisson, *Doctors Strike Shows Union Push*, SAN DIEGO UNION-TRIBUNE (Jan. 27, 2015, 10:21 PM), https://www.sandiegouniontribune.com/news/health/sdut-uc-doctors-strike-student-health-centers-2015jan27-htmlstory.html ("Doctor strikes have been rare in the United States, largely because most physicians in this country are technically not able to unionize due to their special employment status. . . In the past decade, surveys and reports in the health-care industry have shown that the number of states allowing hospital corporations to directly hire doctors has grown. The trend has led some labor experts to predict that fledging efforts to unionize these practitioners will intensify in years to come.").

structure which essentially separates historically semi-autonomous medical staff governance from more generalized hospital operational management such as the Human Resources function.[256] As more physicians become hospital employees, considerable tension arises between medical staff functions and the Human Resources function.[257] Solutions, therefore, must address both domains.

a. Medical Staff Should Strengthen Their Peer Review Processes and Protections

Medical staff should write or amend their bylaws to provide physicians fully independent notice and hearing procedures for appealing adverse professional review actions. Medical staff can affect the fairness change without statutory change. They should also assure their procedures comply with applicable state law.[258] Insofar as they can implement safeguards or compliance enforcement mechanisms, medical staffs can also reduce their own [as well as the hospital's] liability for a wrongful determination. Non-compliance may also increase the likelihood that a peer review proceeding may become discoverable in personal injury or medical malpractice litigation.[259] Because effective peer review of physician performance depends on open and free exchange of information, the prospect of discoverability could substantially impede a medical staff's peer review efforts.[260]

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[256] *See* Bichai v. Dignity Health, 61 Cal. App. 5th 869, 879 (Cal. Ct. App. 2021), (showing while there is some variability among states, California is representative: "Hospitals are required by law to have a medical staff association which oversees physicians who are given staff privileges to admit patients and practice medicine in the hospital. A hospital's medical staff is a separate legal entity, an unincorporated association, which is required to be self-governing and independently responsible from the hospital for its own duties and for policing its member physicians.").

[257] *Protect Your Peer Review Privilege or Lose Major Protection*, RELIAS MEDIA (Mar. 1, 2016), https://www.reliasmedia.com/articles/137295-protect-your-peer-review-privilege-or-lose-major-protection.

[258] *Legal Risks Abound in Peer Review; Good Process Required,* RELIAS MEDIA (Apr. 1, 2018), https://www.reliasmedia.com/articles/142383-legal-risks-abound-in-peer-review-good-process-required.

[259] *Id.* ("A disciplined physician can fairly easily bring colorable civil claims against a hospital simply by alleging that the process was undertaken in bad faith or with ulterior motive.").

[260] Tanya A. Henry, *Why Peer Review Confidentiality is Critical, Must be Protected*, AM. MED. ASS'N (Dec. 8, 2021), https://www.ama-assn.org/delivering-care/patient-support-advocacy/why-peer-review-confidentiality-critical-must-be-protected; *see also* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970) ("Confidentiality is essential to

b. Hospitals that Employ Physicians Should Create Firewalls Between Their Human Resources Function and Their Medical Staff Function

Peer review or professional review processes serve a specific purpose, which is to assure physicians perform competently and meet professional standards. Imprudent incursion into the process risks legal liability from wrongful termination or a due process claim if a hospital improperly acts on peer review information or improperly uses the peer review process to achieve a Human Resources objective. Information flow emanating from peer review, even within the hospital, may compromise both confidentiality and qualified immunity.[261]

Nevertheless, the Human Resources function exists, in part, to protect hospitals against negligence claims.[262] Therefore, it is reasonable to inform Human Resources of an adverse outcome but only after the physician has exhausted the appeals process.[263] It is particularly reasonable to inform Human Resources of an adverse peer review outcome if the physician employment agreement allows the hospital to terminate the physician "for cause" if the physician is the subject of an adverse peer review action. Without that knowledge, a hospital may have difficulty defending itself against a wrongful termination or breach of contract action if it terminated a physician for cause based on an adverse peer review action. Consequently, separating human resources from the peer review apparatus would likely protect both the physician and the hospital by fostering confidence in the system and allowing the peer review system to

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effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.").

[261] Amy Young, *Limits to Peer Review Privilege*, 5 AMA J. OF ETHICS 423 (Dec. 2003), https://journalofethics.ama-assn.org/article/limits-peer-review-privilege/2003-12.

[262] Jason Newton, *Avoiding Malpractice Allegations with Effective Hiring*, CURI (Nov. 15, 2018), https://curi.com/news/avoiding-malpractice-allegations-with-effective-hiring/.

[263] *Protect Your Peer Review Privilege or Lose Major Protection*, *supra* note **Error! Bookmark not defined.**. Releasing peer review information to Human Resources risks compromising some or all of its protection. However, where the hospital needs to litigate a negligence claim, it may need access to some or all of the peer review information. Because sharing information risks immunity or shielding from discovery, only the minimum information necessary for Human Resources to perform its duties and only the most accurate findings should be disclosed. Waiting until a case has run through its course of procedural activities minimizes the potential compromises to the peer review procedural safeguards.

better serve its primary goal of improving competence and professional standards of care.

V. CONCLUSION

Substantial economic, regulatory and administrative pressures on private medical practice combined with cultural attitudinal changes have accelerated an already existing transition of physicians from private medical practitioners to hospital and corporate employees. This movement is likely to persist. Modern legal duty of care concepts arise from Hipporcrates' medical ethics writings 2500 years ago and now includes a duty not to abandon. This legal duty arises not only from tort case law but from regulatory and statutory regimes including state medical boards of healing arts and the National Practitioner Data Bank.

Physician-hospital contract relationships potentially create situations where conflicts between contractual obligations conflict with or frustrate traditional notions of physicians' duty of care. Issues arising from creating the duty of care and potential abandonment reflect just a small component of the relationship that will likely need further consideration over time. Potential avenues to reduce or eliminate these potential conflicts and the concerns they raise include creating broadly available contract templates that better address duty of care issues, implementing directives to state medical boards to address how they will review abandonment claims and whom they can hold accountable for these claims, amending the NPDB to include full professional appeals rights for physicians in exchange for reporter-immunity and dollar threshold for claim payment reporting.

Appendix A: Codification Status of Termination Duty, by State[264]

STATE	METHOD OR CODE REFERENCE
Alabama	Board Rule 540-x-9-.10
Alaska	GUIDANCE
Arizona	AZ §32-3211
Arkansas	ASSOC.
California	GUIDANCE
Colorado	Mult. Statutes*
Connecticut	Code of Med. Rec. 19a-14-44
Delaware	24DE §1761
Dist. Columbia	17 D.C. §4612
Florida	32FL 456§057.13
Georgia	Rule 360 §3-.02 (16)
Hawaii	NONE
Idaho	NONE
Illinois	IL 84-7
Indiana	Admin Code 844 IAC §5-2-16
Iowa	IA Admin Code 13.7(1)
Kansas	GUIDANCE
Kentucky	NONE
Louisiana	ASSOC.
Maine	GUIDANCE
Maryland	GUIDANCE
Massachusetts	NONE
Michigan	333 MI §16213(3)(b)
Minnesota	ASSOC.
Mississippi	GUIDANCE
Missouri	GUIDANCE
Montana	NONE
Nebraska	ASSOC.
Nevada	NRS 630.304
New Hampshire	GUIDANCE
New Jersey	GUIDANCE
New Mexico	NMAC §16.10.17.9
New York	GUIDANCE
North Carolina	ASSOC.

[264] Campbell, *supra* note 216.

North Dakota	NONE
Ohio	Rule 4731-27-03
Oklahoma	GUIDANCE
Oregon	GUIDANCE
Rhode Island	GUIDANCE
South Carolina	GUIDANCE
South Dakota	SDCL §44:04:09:11
Tennessee	NONE
Texas	TAC §190.8-22:9:190b
UTAH	NONE
Vermont	ASSOC.
Virginia	VA §54.1-2405
Washington	SG OP04-29
West Virginia	GUIDANCE
Wisconsin	Med 10.03.2(o)
Wyoming	WAC Ch. 3; §5

KEY:
SHADED: Applicable Statutory or regulatory reference.
GUIDANCE: State offers non-binding guidance
ASSOC: State refers to AMA or state Medical Association
NONE: State has no code, guidance or referral source.