the REPORTER

2-HOUR CME

ANATOMY OF A PHYSICIAN'S CONTRACT:

WHAT TO KNOW BEFORE YOU SIGN

CLOSED CLAIM STUDY
IMPROPER PERFORMANCE OF COLECTOMY

CLOSED CLAIM STUDY
FAILURE TO TREAT PROSTATE CANCER

TMLT
Texas Medical Liability Trust

Quarter 4, 2025

2-HOUR CME
ANATOMY OF A PHYSICIAN'S CONTRACT:
WHAT TO KNOW BEFORE YOU SIGN

by Karin Zaner, JD

OBJECTIVES

Upon completion of this educational activity, the learner should be able to:

1. identify and explain issues crucial to physicians in contracts;
2. recognize certain legal concepts and language raised by such issues;
3. identify certain physician-specific issues, like the Texas physician non-compete law;
4. define other important legal concepts, like "integration" and "indemnity"; and
5. evaluate the effect of typical contract language and whether to negotiate.

COURSE AUTHOR

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TARGET AUDIENCE

This 2-hour activity is intended for physicians of all specialties who are interested in physician contract negotiation and compliance.

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It should take approximately two hours to complete this course.

RELEASE/REVIEW DATE

This activity is released on November 24, 2025 and will expire on November 24, 2028.

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INTRODUCTION

As a practicing physician, you may have contractual relationships that determine how you provide and are compensated for your professional services. Whether new-to-practice, mid-career, or end of career, you need to understand your contractual duties not only before you sign but also during your workday to avoid breach of contract, poor decisions, and/or strategic mistakes.

Keep in mind: when faced with a new contract or employment opportunity, you are in control of what you choose to sign or not to sign. Before executing any employment contract, take the necessary time to carefully review it. Remember, you hold more power than you may realize to negotiate terms.

Most contract details are negotiable — from compensation and call schedules to non-compete clauses and benefits. Do not hesitate to ask questions about any terms, clauses, or provisions you do not fully understand or agree with. As a physician with years of training and experience to offer, you have earned the right to be frank and straightforward about contract terms that do not align with your needs or expectations.

Contract types vary and carry their own differences to consider. Examples include:

- an **employment contract** under which you are an employee with an exclusive relationship;
- a **professional services contract** under which you are an independent contractor with a non-exclusive relationship;
- an **income guarantee agreement** that allows possible future forgiveness for amounts loaned to you as an employed physician;
- a **physician administrator or employer contract**, that puts you on the "other side" of these relationships; and
- a **partnership agreement** for equity and/or share ownership, meaning you may contractually be on "both sides."

In all these circumstances (and more), it is crucial that you fully **read and understand** the contractual provisions that underlie these types of obligations. You are making a significant professional decision, so take time to thoroughly consider each aspect of the agreement — there's no rush, and your potential employer will likely respect your due diligence.

This article examines various types of contractual provisions (mostly using an employment relationship as a basis, although the discussion points can appear in a variety of agreements), with the goal of enabling you to make the best decisions in both negotiating and complying with your specific contract.

Further, some of the most important contractual provisions are only triggered once the contract terminates (such as non-compete covenants and other restrictive covenants). These post-termination obligations are discussed as well.

Finally, consulting with a health care attorney who specializes in physician contracts can help you identify red flags, explain industry standards, and help you negotiate more favorable terms.[1]

Again, you are ultimately in control of what you choose to sign or not to sign. This contract may shape your career, so advocate for yourself at every stage of negotiation.

TYPES OF PHYSICIAN PROFESSIONAL SERVICES CONTRACTS

Physician employment

In a physician employment relationship, a physician is employed by a medical group, a clinic, or other appropriate employer. Or, a physician may be employed by a professional association,[2] a hospital district, a nonprofit charitable health center (NPCHC),[3] or a nonprofit health organization (NPHO).[4] Although there are exceptions, these types of relationships tend to be exclusive; limit "outside activities"; and generally require full-time efforts by the employed physician.

Physician income guarantees

If a physician is employed by a hospital or medical system, they may be subject to an income guarantee that ensures a specific income, with various contractual obligations to both the employer and the third-party hospital that pays you.

It is a common recruitment incentive for a hospital to guarantee a specified level of income to a physician for a specified period upon relocation to an underserved area. The guaranteed payments, often structured in the form of a loan, are forgiven if the physician fulfills the commitment and continues to practice medicine in this underserved area. However, if the physician leaves before the period is completed, they may be required to repay the remaining balance of the "loan" back to the hospital.[5] A physician should be very careful to understand this arrangement and the risks involved.

For example, the income guarantee agreement will almost always require the physician to sign a promissory note and a security agreement that will obligate the physician to personally pay back any funds that are not forgiven. And while the employer will also likely be jointly liable for such amounts under the income guarantee, the employment agreement will likely contain an indemnity provision[6] that will obligate the physician to personally reimburse the employer for any funds that are not forgiven.[7]

Physician as shareholder

A physician may have partnership agreement for equity and/or share ownership in a professional association, a health care facility, or another appropriate entity. In this relationship, a physician's contractual obligations may include complying with certain conditions (e.g., restrictive covenants[8]) that benefit the entity and the other physician partners.

The same physician is likely to also be an entity partner who benefits from the enforcement of such restrictive covenants against their other physician partners. There also may be other contractual obligations in these types of agreements that can affect the physician's status as a "qualified physician" or similar defined term that links to the physician's ability to continue to be an equity owner or shareholder, receive distributions, or be bought out for fair market value (FMV).

For example, if the physician has a licensing or peer review privilege investigation, restriction, or adverse action, this may take them out of "qualified physician" status, which can negatively affect their investment.[9]

Physician as independent contractor

A physician may enter into a professional services contract as an independent contractor with a non-exclusive relationship. Such flexible relationships may be on an hourly basis, be less than full-time, require the physician to pay for malpractice insurance, and have no or minimal benefits compared to being a regular employee.[10]

Also, these arrangements can have restrictive covenants (like non-competes) or other obligations that more typically exist for an employed physician. A physician should understand these provisions to determine whether such an arrangement is equitable; can be negotiated to something less burdensome given the likelihood that benefits are more limited for an independent contractor; or whether such an agreement is worth the obligations.

Corporate practice of medicine prohibitions

Most states have laws that prohibit the corporate practice of medicine (CPOM) by non-physician entities, such as corporations.[11] These types of prohibitions, if they exist, will almost certainly affect the provisions in these types of agreements.

For example, in Texas, there is a strong CPOM protection that ensures "physicians are able to exercise professional medicine judgment relating to a patient's health care needs without financial or other outside pressures." However, despite the statutory and administrative CPOM framework in Texas, whether the physician or the corporation is controlling the medical decisions is "perhaps the greatest consideration when [Texas] courts try to draw this line."[12]

When Texas courts attempt to determine whether a contract violates COPM prohibitions, they may consider such issues as fee structure; how the non-physician entity is using and/or marketing a physician's license; whether there are transfer restrictions against the physician; and whether the non-physician entity makes decisions regarding physician hiring and termination, staff administration, and business functions (e.g., billing, office and equipment leases). To help prevent a CPOM violation, most contracts will have a provision stating that the physician will

maintain their independence in making medical decisions for patients in accordance with the standards of good medical practice.

BASIC CONCEPTS IN PHYSICIAN CONTRACTS FOR PROFESSIONAL SERVICES[13]

Determination of duties
The contract should establish what the physician's duties will be and where they will be performed. The contract will likely include a broadly written description of what the employer expects of the physician, to allow for more practical flexibility in carrying out these duties.

A physician should perform all possible due diligence to adhere to the employer's practice policies, protocols, and procedures. Typically, a contract clearly states that the physician will observe and comply with rules, regulations, and policies, as the employer may institute from time to time. That said, if a physician is concerned about including a specific term of employment not found in the determination of duties, the physician should consider having such term explicitly stated in their contract.[14]

Practice location and resources
Ideally, the contract will identify a specific primary office location and address. However, the employer may want some discretion and flexibility in assigning a physician to various locations if needed, and so may insert provisions to this effect.

The physician may then want to limit the employer's unilateral ability to assign them to new locations to limit regular, distant travel and to protect against possibly enlarging the radius of any non-compete covenant effective after contract termination. While a physician may just want to "trust" that the employer will not force them to staff any unwanted or impractical locations, requiring the employer to gain the physician's consent before any changed or added location in the contract seems like a small concession for the employer to make.[15]

As for resources, the contract will likely state that the employer will furnish such facilities, equipment, supplies, and administrative and clinical personnel as the employer deems necessary for the physician to adequately perform their professional duties and services. If there are any specific and substantial resources that have been promised, a physician could request those specifics be mentioned in the contract.

Physician independence
As discussed above, the contract should distinguish between an employer's ability to direct tasks to the physician (such as scheduling and assigning patients) and the physician's right to medically treat a patient that they independently deem professionally appropriate as protected by any applicable CPOM doctrine.

Physician extenders
A physician may be required to supervise physician extenders (advanced practice providers) in the contract. If so, the contract should fully describe the physician's supervisory duties that follow state law for physician supervision of advance practice providers, including any prescriptive authority. The physician should understand and comply with these duties under applicable state law.[16]

Work schedule, call coverage, vacation, and sick leave
Often, an employer's office policies and procedures govern the normal work schedule and operations protocol. The contract may mention these details, but if it does not, a prudent physician will obtain and review these policies and procedures to understand how this employer operates and what protocols they are expected to follow.

The contract may also specify some of these details. For example, as to call coverage, the contract may require that after hours, weekend, and holiday coverage assignments be rotated equally among physician employees. Ultimately, it will be the physician's obligation to secure their individual coverage, although the employer may help identify physicians to provide coverage.

The employer is prohibited from making any decisions relating to office operational protocols based on federally impermissible grounds (such as race, ethnicity, age, disability, and other reasons), which is normally also stated in the contract.

Outside work
In an employment contract, there may be a prohibition against any independent work done by a physician "outside" their employment contract duties. Other contracts may allow reasonable time for such outside work or activities as teaching or charitable, professional activities, but only if they are approved by the employer and provided that such outside activities do not materially interfere with the physician's employment duties.

Many employers prohibit a physician from engaging in any outside activity competitive with or adverse to the employer's business, as well as providing any legal expert testimony against the employer. Even if an employer consents to outside activities, a physician usually must obtain separate malpractice insurance to cover their participation in them.

Payment of salary, bonus, and expenses
Compensation and how it may change throughout the term of the contract should be clearly defined in the contract or in an attached exhibit. If the employee is strictly salaried or paid by the hour, as long as applicable state payday laws are followed by the employer, clear and simple provisions for how and when the employee will be paid should be described.

Things get more complicated when a bonus structure is added, or when the compensation model either starts with or transitions to a Work Relative Value Units (wRVUs) model. In this model, a physician's pay is tied to their productivity, with a physician earning a certain number of wRVUs for each service or procedure they perform.

In either case, the calculation algorithm must be as clear as possible and account for a wide variety of possible circumstances. Providing specific examples of productivity levels and showing how certain bonus calculations result can greatly help clarify what may otherwise be subject to interpretation. To avoid future disputes, all reasonable efforts on the front end to achieve mutual understanding and clarity between the employer and the physician are recommended.

Any compensation provisions for physicians that are subject to regulatory restrictions (such as state and federal anti-kickback laws) must comply with such regulations so that they fall into any necessary employment "safe harbors," which also require that any compensation not exceed "fair market value" and be "commercially reasonable."

Most contracts also provide a unilateral right for the employer to adjust a physician's compensation if these "safe harbors" are not met (thereby ensuring regulatory compliance), which is usually balanced by other provisions of the contract that allow for early termination if mutual agreement of the parties cannot be achieved.

Payment of professional dues and CME

Under the contract, the employer may agree to pay certain professional expenses such as the physician's annual state medical licensure fee; dues in local, state, and national medical societies and associations; subscriptions to professional publications and/or other similar fees; and appropriate costs to maintain the physician's licensure and professional standing. The employer may also agree to pay directly or reimburse the physician for reasonable expenses (including tuition, lodging, meals, and travel) to attend continuing medical education (CME) programs.

Reimbursement for these expenses usually requires that the physician submit appropriate reporting consistent with the record keeping requirements of the employer, as well as the Internal Revenue Service (IRS). The contract may provide that such reimbursement may not be carried over from year-to-year, so a physician should request all reimbursement on a timely basis and in strict accordance with employer's policies and procedures.

Representations and warranties

A physician should pay particular attention to the representation and warranties (R&W) section of the contract. The accuracy of each one is likely a material, continuing condition to the contract itself.

For example, a contract for a Texas physician may include R&W that the physician:

a. maintain a valid and unrestricted license to practice medicine in the State of Texas;
b. maintain in good standing an appropriate category of medical staff membership and clinical privileges at a specific hospital, health care facility, or location designated by the employer;
c. comply with and provide professional services in accordance with applicable law, the ethical standards of the medical profession, and the requirements of any accrediting bodies;
d. maintain specific board certification or eligibility;
e. maintain status as a Medicare and Medicaid provider physician;
f. hold and maintain registration by the federal Drug Enforcement Administration to dispense and administer controlled substances;
g. obtain and maintain the status of a provider physician as required by the employer;
h. is not bound by any agreement or other impediment, whether oral or written, including any non-competition covenant, with any third party that would restrict the physician's ability to become employed by the employer, and perform the services required by the contract; and/or
i. will not breach any agreement to keep in confidence proprietary information, knowledge, or data acquired by the physician in confidence or in trust prior to employment with the employer, and will not disclose to the employer, or induce the employer to use, any confidential or proprietary information, knowledge, or data belonging to any previous employer or others.

Again, the importance of the accuracy of each and every R&W at signing and throughout the employment term cannot be overstated. If any particular R&W is not accurate, the physician should disclose the specifics of the issue in writing (and include such disclosure as an exhibit to the contract) so that the employer has notice and accepts the exception to the R&W.

The contract may also require that the physician promptly inform the employer of any facts that develop in the future that make any of the R&W inaccurate as well as any other concerning professional developments (such as the imposition of a restriction, limitation, or modification of the physician's medical licensure, certification, credentials,

hospital medical staff membership or clinical privileges, controlled substance registration, or anything else that affects their ability to render medical services under the contract).

PATIENT BILLING RIGHTS AND OWNERSHIP OF PATIENT RECORDS

An employment contract may state that all medical services and other professional services performed by the physician are services performed as an employee; therefore, all revenues from the physician's services are the property of the employer, whom shall be wholly entitled to collect and receive all such revenues.

In this situation, the employer may include assignment rights or even a power of attorney for the physician to sign. The contract will likely also state that all patient medical records, case histories, x-ray films, files, and documents shall belong to and remain the property of the employer. That said, the contract will likely grant the physician appropriate access to and the right to copies of such medical records to perform their duties under the contract, as well as upon termination of the contract as required by law.[17]

Continuity of care for patients

The contract may also attempt to ensure continuity of care for patients if and when the contract terminates. But this is a tricky issue for physicians, especially given the need to avoid any claim of patient abandonment. Generally, a physician ending the physician-patient relationship should give the patient reasonable notice of the patient's current status, the patient's present and future needs, explanation of the consequences of non-treatment, recommendation to continue care with another physician, and a clear statement that the physician remains available to provide any necessary treatment during a reasonable period.

If that physician is a Texas physician departing from an employer, the required notice to patients under Texas Medical Board (TMB) Rule 163.4 will likely suffice.[18] Although the employer can offer to aid in a physician's compliance with these notice requirements (which includes physical posting at clinical location, direct written notice to patients seen in the last two years, and posting on the group's website at least 30 days prior to leaving the practice), the employer should not take any action that might be construed as interfering with this notice.

A physician is responsible for complying with state law or requirements related to giving patients notice, even if the contract does not include a provision describing this responsibility and duties surrounding it.

CONFIDENTIAL INFORMATION AND TRADE SECRETS

The contract will likely contain protections for the employer's confidential information and trade secrets that are disclosed to and used by the physician during the contractual relationship.

The contract will also set forth a clear and specific definition of what constitutes "confidential information." This definition tends to be very broad. Use of such confidential information will likely be restricted to the course and scope of the physician's duties and for the sole benefit of the employer. Surrender or destruction of such confidential information by the physician will probably be required when the contract terminates.

A prudent physician will segregate any employment materials (especially confidential information) from their personal information at the start of and for the duration of the employment relationship. This will simplify the surrender process at termination as well as minimize disputes.

Keep in mind that the employer may deem the contract itself as proprietary and confidential, meaning the physician should not disclose the contract or its contents (even drafts) to any third party — other than legal and financial advisors or as required by law — without the prior written consent of the employer.

HIPAA protections
HIPAA protections obviously must be in place by any covered entity.[19] The contract should address the HIPAA responsibilities of a physician depending on the relationship that the physician will have with the covered entity, which may be as an employer or as a contracted party.

If the physician is an independent contractor or otherwise receives protected health information (PHI) from a covered entity, a HIPAA compliant business associate agreement (BAA) must be executed with the covered entity and full compliance followed by each of the parties.

While an employed physician must receive adequate and regular HIPAA training (and comply with the employer's HIPAA policies and procedures) if such covered entity is their employer, there is no specific requirement that a separate BAA be executed by the physician and the employer.

Use of physician's name and likeness
A contract may provide that the physician will not, without the express prior written consent of the employer, engage in any promotional activity for professional services other than on behalf of and for the benefit of the employer. If a physician does engage in such activity, they should consider whether such activity (such as social media use, advertisements, or other activities) can be construed as falling into this category and requiring consent.

The contract may even contain specific provisions that allow the employer to use the name and likeness (e.g., photographic and/or digital images) on the employer's website and in the employer's marketing efforts. Although a physician may feel strongly about their "personal brand," some consideration of being a "team player" should also be given, especially if the physician is accepting full-time employment.

Intellectual property rights
The contract may also dictate that all intellectual property (IP) rights (e.g., patents, formulae, ideas, inventions, processes, copyrights, know-how, proprietary information, trademarks, trade names, or other developments for future improvements), that are conceived through the physician employee's work while an employee, are the property of the employer.

The contract may further provide that all royalties, fees, or other income attributable to such IP will be the property of the employer. In some cases, the employer may agree to make an exception for any IP developed through the employee's sole effort (i.e., without assistance or resources from employer and outside the employment duties), which, if ever disputed, would allow the issue to turn on the facts of how, when, and with what the IP was in fact created.

In some other cases, the employer may request an actual listing of any such IP from the employee (which the employee may be reluctant to give, or unable to give if the IP is not yet developed). The contract may then contain a statement that any non-listed IP that exists at the termination of the employment relationship belongs to the employer.

There may be an applicable IP policy in effect, to which the contract may require the physician to acknowledge and consent. The employer may also require the physician to enter into and execute other documents and instruments deemed necessary to carry out an IP policy. If a physician employee either has IP that is in any way related to the contract (i.e., medical) or expects to devote time and resources to such IP, they should consult with experienced IP counsel to obtain the best legal strategies for maximum IP protection.

MEDICAL LIABILITY INSURANCE AND TAIL COVERAGE

Payment of professional medical liability/malpractice insurance, including who pays for "tail coverage" when employment terminates is an important issue. While a physician who is an independent contractor may obtain and pay for their own insurance coverage, a physician's employer will typically provide coverage for the physician per the employment contract as the employer deems necessary.

Thus, a physician employee should confirm that their individual policy limits (for a single claim and for an aggregate of all claims) are sufficient to protect them in their role, as well as meet the liability insurance requirements of any hospitals or health care facilities where they have privileges. The contract may also allow the physician to obtain any primary, supplemental, or additional coverage the physician desires — at their expense.

Also important is the distinction between "claims-made" and "occurrence" insurance.

Claims-made insurance protects you during the active policy period, usually one year. If your claims-made policy is not renewed after the policy period, you no longer have coverage for any claims that may arise in the future that are alleged to have occurred during the time your policy was active. To make sure you have coverage after a claims-made policy expires or is not renewed, you will need to purchase tail coverage.

Tail coverage continues insurance protection under your original claims-made policy for claims reported in the future that occurred when your policy was in force. Tail coverage can be expensive because it continues coverage into the future. (Tail coverage is also known as "a reporting endorsement.")

Another option is "prior acts" coverage to cover you for incidents that occurred under a previous claims-made policy; this is also called "nose coverage."

A contract (likely drafted by the employer) may require that any needed "tail coverage" be obtained and the premium paid by the physician. Alternatively, the contract may enable the employer to pay the costs of such tail coverage and deduct the amount from any monies owed to the physician as an offset. Or the employer may instead choose to pay the "tail coverage" if the employer terminates the employee without cause, or if the employee self terminates for cause.

If the contract does not contain such an exception, you may negotiate this point so that you do not have to pay this expense (which can be significant) in the event of a termination not based on performance.

Occurrence insurance provides ongoing insurance protection for events that occurred during the policy period, even if they are reported after the policy is cancelled. Occurrence coverage is ongoing, even if you are sued after your occurrence coverage ends. You do not need tail coverage with an occurrence policy. For this reason, occurrence coverage is more expensive than claims-made coverage.

Notice and waiver of consent to settle claims
If medical liability insurance is provided, the contract may require the physician to provide notice to their employer of any possible claims. On the flipside, the employer may also be contractually required to provide the physician notice of any claims filed against them.

A contract may also provide that a physician authorizes the employer and its insurers to act on behalf of the physician to authorize settlement of any claims against the physician that arise under the contract.

Under these types of provisions, your employer may be required to inform you of the progress and outcome of any claims, as well as the extent of any lawsuit alleging damages in excess of policy limits. If that is the case, the contract will likely allow you to retain separate counsel at your own expense to protect your interests.[20]

NOTICE OF TERMINATION AND GROUNDS

Many physician employment contracts are for a term of one year, with an "evergreen" renewal provision that allows for automatic one-year renewal unless terminated under another contract provision (e.g., "for cause" or "without cause").

The timing and grounds for contract termination must be agreed upon, understood, and clearly set forth by the contract. While a physician may want the "perceived" security of a multiple-year contract, the contract may include various termination provisions that would allow for an earlier termination.

The contract should allow for circumstances in which the employment relationship can be terminated without cause, if proper notice of termination is given, so that the employer can hire a replacement or so the employee has time to find a new position.

Without "no cause" termination clauses, the physician's professional record may be negatively affected if an employer decides to "find" a cause to terminate a physician's employment. Instead, a "no cause" termination clause allows an "escape valve" for either side to voluntarily and respectfully end an employment relationship that is just not working.

Further, certain non-clinical events will almost always result in a "for cause" termination:
- loss or restriction of professional or DEA license;
- loss or restriction of medical staff privileges;
- loss or failure to renew board certification status; or
- felony conviction.

However, the contract may also contain some "looser" and arguably more subjective reasons for termination, such as failure to faithfully and diligently perform the duties required and/or to comply with the reasonable policies, standards, and regulations of the employer.

While the employer almost always has wide discretion in its decision to terminate "for cause," sometimes the contract may provide minimal due process, such as requiring specificity of grounds, possible "cure" rights, a chance to be heard by submission or actual hearing, and/or a heightened requirement for such termination such as a 2/3 vote of partners.

Non-compete covenants
An employment-based non-compete covenant prohibits a former employee from competing with an employer after the end of the employment within a specific geographic area for a specified period of time.

In the past, courts had long viewed these with disapproval as "restraints of trade." While a few states prohibit or severely restrict such non-competes, many other states now uphold them as long as the non-compete protects the employer's legitimate business interests. The legal analyses by various courts usually include a specific case-by-case analysis of how reasonable these restrictions are in order to determine if they are overly restrictive to the employee's ability to make a living and/or go against public policy.

If a non-compete covenant is determined to be overreaching, many courts will alter its terms to make it more reasonable (called "blue penciling") instead of rendering the entire provision unenforceable. A non-compete could prohibit a physician from taking care of patients in a certain geographic area once their employment terminates, including subjecting them to an injunctive lawsuit in effort to force them to stop working and treating patients. Therefore, it is crucial to determine the applicable state law where you practice, including any specific to physician non-competes.[21]

In Texas, for a non-compete "relating to the practice of medicine against a person licensed as a physician by the Texas Medical Board" to be enforced, certain statutory requirements must be met, including an option for the physician to "buy out" the non-compete at a reasonable price.[22]

These requirements include that:
- the non-compete restriction not deny the physician access to a list of patients they have seen or treated within one year of termination of employment;
- the employer provide certain access to medical records for a reasonable fee; and
- the physician is not prohibited from providing continuing care and treatment to patients with acute illness even after employment is terminated.

In practice, however, this statutory framework left physicians with limited ability to contest unreasonable time limits, multiple or overbroad geographic areas, and exorbitant "buy-out" amounts.

In 2025, this statute was revised so that non-competes affecting Texas physicians entered into or renewed on or after September 1, 2025 must:
1. expire no later than one year from the termination of employment or contract;
2. be limited to no more than a five-mile radius from the "primary" location of practice;
3. cap the amount that a physician could opt to pay, so the non-compete "buy out" is not greater than their total annual salary; and
4. otherwise contain terms and conditions that are clearly and conspicuously stated in writing.[23]

Also, if a Texas physician is involuntarily discharged without "good cause," the non-compete is now void and unenforceable. "Good cause" is defined as a "reasonable basis for discharge of a physician from contract or employment that is directly related to the physician's conduct, including the physician's conduct on the job or otherwise, job performance, and contract or employment record." [24]

Depending on their leverage, a physician could ask to eliminate or narrow such provisions, by further reducing the non-compete radius, its duration, and/or the amount of the "buy out" by contractual agreement.

Employee non-solicitation covenants (or "don't try to steal co-workers away from your employer")
A contract may include an employee non-solicitation covenant that is triggered when employment is terminated and typically lasts for a year or two. Such restriction prohibits a physician from certain post-employment activities, such as recruiting or engaging any other current employee of the employer — including, without limitation, other physicians — to leave the employer.

Because these types of non-solicitation restrictions do not affect a physician's ability to practice medicine or treat patients (instead, they only affect the employees they may hire), a prudent physician will choose not to hire these employees until after the covenant expires.

Although the prohibition may only be against "soliciting, inducing, recruiting, or engaging," a better legal strategy is to not rely on the specific wording of the covenant and just not employ a potentially problematic hire until after the covenant expires.

Patient non-solicitation covenants (or "don't try to steal patients from your employer")
In contrast to an employee non-solicitation covenant, a non-solicitation covenant relating to patients, contractors, or referral sources can have a serious impact on a physician's ability to treat patients. Such a provision does not prohibit the physician from practicing in a specific geographic area (like a non-compete) but may intend to restrict the solicitation of patients and sources of future patient referrals (such as contractors or referral sources) outside the non-compete radius.

Employers draft such provisions to be broad and indirect, which may cause a de facto non-compete to exist. This could arguably deprive a physician of the "protections" of the Texas physician non-compete statute — including the "buy-out" option — which could make such a provision subject to court challenge.

As with any non-compete language, a physician could request to eliminate or narrow such provisions before signing a contract depending on their leverage. For example, if a contract must contain such a provision, a physician should request that it only prohibit the solicitation of current patients, contractors, or referral sources, rather than potential ones, and clarify that any such restrictions do not apply to after-acquired locations.

Non-investment restrictions
Sometimes, contracts may contain non-investment restrictions. For example, an employer may prohibit a physician from establishing a financial relationship (i.e., ownership or investment interest) with any hospital, health system, surgery center, imaging center, outpatient therapy center, or other facility that is not affiliated with the employer within a certain mile radius.

The employer may then require that all such current financial relationships be disclosed to the employer in writing upon signing the contract and on an annual basis in the future. The employer may then require the physician to agree that they will not maintain the current financial relationships once the contract becomes effective unless the employer approves the outside financial relationships in writing. If the physician does not receive continuing approval into the future, they may be contractually obligated to divest themselves of the investment, perhaps at a significant financial loss.

OTHER BASIC LEGAL CONCEPTS AFFECTING PHYSICIAN CONTRACTS

Integration provision
A physician may receive oral understandings, representations, and/or agreements from the employer before, during, and/or after the contract is signed. A physician should be aware that they cannot necessarily rely on these.

The contract will almost always include an "integration" provision that will state the parties' agreement that the contract contains the entire agreement and supersedes all prior agreements and/or understandings, whether oral or written. If such agreement is important to a physician, it should be stated in the contract itself.

The integration provision will also likely require any subsequent modification of contract terms be made in writing, signed by the parties.

In the unlikely event that an integration provision is not included in the contract, state common law may nevertheless reach a similar result of precluding enforcement of any extra-contractual agreements. For example, in Texas, unless there is fraud or mistake, contract disputes are governed by the "parole evidence rule," meaning evidence (representations, agreements, understandings, etc.) made before the written contract may not be used to contradict the clear language of the contract itself.[25]

Assignment rights
Given the contract is for the professional services of the physician (which can only be rendered by the physician), it is likely that it will prohibit the physician from assigning, delegating, and/or subcontracting it to any other party without the express written consent of the employer.

However, such an assignment prohibition will typically not bind the employer (i.e., be reciprocal). While the contract may provide some limits on assignment by the employer (for example, limiting assignment to an entity that is wholly owned or controlled by, or affiliated with the employer), such limits can always be modified by pressing the physician for contractual agreement if the employer determines desirable or necessary in the future. In other words, if the employer has the will to assign the contract to another entity, it will likely find a way, despite any existing non-assignment provision in the contract.

Right to offset
Most contracts include a right to offset any amounts due to the employer by the physician, including compensation, whether such debt arises from the employment agreement or any other written agreement between the parties. In doing so (usually at termination), most employers will not ask the physician's permission to make an offset.

For example, a group hires a new physician and provides a $50,000 signing bonus. The contract includes a clause stating the bonus must be repaid if the physician leaves within three years. After 18 months, the physician resigns. How the offset works:

- Amount owed: The physician leaves after 18 of the 36-month period, so they owe half of the bonus ($25,000) back to the group.
- Payments due: At the time of termination, the group owes the physician a final paycheck of $10,000 and an expense reimbursement of $1,500.
- The offset: The group uses the right-to-offset clause to deduct the money owed from the payments due to the physician.
- Total payments owed to physician: $10,000 (final paycheck) + $1,500 (expense reimbursement) = $11,500
- Offset amount: $25,000 (prorated bonus owed)
- Result: The group pays the physician nothing and seeks to recover the remaining $13,500 owed.

Indemnification, or compensation for damages or losses
Indemnification provisions can be tricky, so obtaining legal advice to understand them is extremely important.[26] For instance, a contract may provide a mutual indemnification provision that equally (more or less) burdens and benefits the parties and leaves room for medical liability or other insurance coverage to apply when the contract is breached.

This type of provision shows that both parties intend to cooperate in the defense of a claim (malpractice or otherwise) and to cause their insurers to do likewise but then requires each party to indemnify and defend the other in the event of intentionally wrongful or criminal conduct that is likely not covered by insurance.

However, not all indemnification provisions are created equal. Physicians must be aware that the indemnification provision in the contract (again, likely drafted by the employer) may be one-sided (i.e., burdening the physician for less egregious conduct). For example, an employer may lower the standard of the physician's one-sided indemnification to mere negligent conduct or contractual breach instead of from any intentionally wrongful or criminal conduct (a much higher standard) in the example above.

Indemnification is a serious obligation; therefore, it is important for a physician to fully understand any proposed contractual indemnification provision.

Mediation and arbitration
Typically, to the benefit of the physician, employer, and other parties in the contract, there may be provisions to address how to resolve disputes without litigation. This is done by alternative dispute resolution (ADR) methods, such as mediation and/or arbitration.

Mediation is the process by which a third-party mediator helps parties determine if and under what terms such disputes can be resolved by mutual agreement.

Arbitration, on the other hand, is the more formal submission of evidence and testimony to a third-party arbitrator (a retired judge or experienced lawyer) in a private arbitration process for a decision to be rendered.

A good faith attempt at resolution by mediation could be required before arbitration provisions are triggered. Usually, the provision will confirm that any arbitration decision shall be final, binding, and enforceable in any court (i.e., non-appealable) or it may contractually stop either party from recovering certain types of damages.

Any ADR provisions will likely affect the ability of the parties to sue in a court of law for damages and/or injunctive relief. In fact, a contract may include provisions that require arbitration except in cases where the employer sues for injunctive relief, such as a restraining order, to prevent a physician from practicing medicine in violation of a non-compete covenant after the contract is terminated. In this case, an employer would still be allowed to sue in a court of law for this type of immediate injunctive relief against the physician despite a requirement to arbitrate any other disputes.

Litigation and injunctive relief
If there are no ADR provisions in the contract, then a party will likely be able to bring a lawsuit in a court of law for relief. However, keep in mind that an employer or other corporate entity that contracts with the physician likely has a legal budget (whereas an individual physician may not) as well as an incentive to litigate.

For example, if the physician is alleged to have violated the confidentiality, non-compete covenant, and/or non-solicitation covenants of the contract, the employer will be very motivated to litigate (despite cost) so as to demonstrate to other physicians that such alleged violations will be prosecuted.

These types of lawsuits may even request injunctive relief, which likely threatens a physician's ability to practice medicine in their next employment or contractual opportunity. Tread very carefully and proactively obtain legal advice before any such litigation is filed (or even threatened) by the employer. And certainly, any cease-and-desist letter, demand, and/or notice of lawsuit received by a physician should be addressed immediately.

Payment of attorney fees
As noted above, seldom does the physician draft these contracts. So, a physician should be aware of any contractual provisions that state that the physician will wholly pay for costs associated with litigation or arbitration, including attorney fees. Instead, it is more typical that such provisions be revised more equitably to state that the "non-prevailing party" pay any such reasonable costs incurred by the "prevailing" party.

RISK MANAGEMENT CONSIDERATIONS

The foundation of the employer and the employee relationship is trust. If the contractual relationship is to prosper over the long term, the contract itself should be fundamentally fair and equitable to both parties.

However, employers will almost always set the parameters of the employment relationship, including the initial drafting of the contract. Thus, a physician should always thoroughly read and understand the terms before signing.

It is possible to negotiate some of the terms, especially if a physician has a more "senior" status, has a unique subspeciality, or will be working in a truly underserved area. But, even aside from negotiation, understanding what the contract specifically means and requires is also essential to maximizing contractual benefits and avoiding contractual breaches and their consequences.

Turning to the employer "side," a contract that overreaches may well result in the physician employee going elsewhere. Overreaching provisions (such as an overly restrictive non-compete covenant, one-sided indemnity clause against a physician for mere breaches of the contract, and/or an income guaranty agreement that is not fully explained and agreed to) may eventually be recognized by the physician as fundamentally unfair. By jeopardizing the physician's trust in their employer, the goal of a mutually productive contractual relationship may be defeated.

How can physicians best protect themselves? Consider the following risk management considerations.

Before signing

- Read thoroughly and ask questions about any terms you don't fully understand.
- Take your time to thoroughly consider each aspect of the agreement.
- Remember you are in control of what you choose to sign.
- Consider talking to a trusted colleague about their own contract experience.
  - Do they feel the employer was fair and open to negotiation?
  - Ask about the negotiation process itself rather than specific dollar amounts or terms.
  - Respect if they decline to share details due to contract confidentiality obligations.

Representations and warranties

- Pay particular attention to the R&W section — the accuracy of each one is likely a material condition of the contract.
- If any R&W is inaccurate at signing, disclose this in writing as an exhibit to the contract.
- Promptly inform your employer of any developments that affect any R&W (license restrictions, privilege changes, etc.).

During employment

- Keep a complete signed copy of your contract with all exhibits and amendments accessible throughout employment.
- Segregate employment materials from personal information to minimize any potential disputes in the event job-related materials must be surrendered at the end of the contract.
- Comply with all policies and procedures, including HIPAA requirements and patient notice obligations, even if not explicitly stated in your contract.

Restrictive post-employment covenants

- Know your state's laws regarding non-compete covenants, especially physician-specific protections.
- Negotiate to eliminate or narrow non-compete, non-solicitation, and non-investment restrictions before signing, if you have leverage.
- Refrain from hiring away protected employees or seeing "off limits" patients after leaving an employer until covenant periods expire.

Medical liability insurance

- Verify your coverage is sufficient and meets any group or hospital requirements.
- Understand claims-made versus occurrence-based insurance and who pays for tail coverage when employment ends.
- Negotiate tail coverage payment, if possible, to avoid paying this significant expense for non-performance-based terminations.

Termination provisions

- Ensure "without cause" termination clauses exist for both parties to allow respectful exits without damaging your professional record.
- Understand all grounds for "for cause" termination and exercise any “cure” or other due process rights set forth in the contract as deemed appropriate.
- Know notice requirements to patients and your obligations regarding patient continuity of care under state law.

Income guarantees

- Be extremely careful with these arrangements. You will likely be personally liable for repaying unforgiven funds.
- Understand forgiveness requirements and indemnity provisions that may make you reimburse your employer for unforgiven amounts.

Dispute resolution and legal issues

- Understand ADR provisions and how they affect your ability to sue in court.
- Review attorney fee provisions — negotiate for "prevailing party" language rather than provisions making you wholly responsible.
- Respond immediately to cease-and-desist letters or lawsuit notices. Obtain legal advice proactively.

Other critical areas

- Get everything in writing — integration clauses mean only the written contract counts, not oral or even written promises made outside of the contract.
- Understand IP ownership provisions — anything you develop during employment typically belongs to your employer.
- Obtain required approvals and separate insurance for any outside activities.
- Consider consulting with experienced legal counsel throughout your contract negotiations. The investment in proper legal advice on the front end can prevent significant problems and expenses down the road.

SOURCES AND NOTES

1. Given the complexity of negotiating and complying with these types of professional services contracts (which are almost always initially drafted by the employer), obtaining experienced legal counsel is strongly recommended. While this article will examine various types of contractual provisions that may be set forth in a contract for discussion purposes, the actual terms of any such provisions will depend on the specific language set forth in the physician’s actual contract.
2. Physicians can employ other physicians by forming professional associations such as partnerships or limited liability companies.
3. Such as a federally qualified health center (FQHC) or a migrant, community, or homeless health center.
4. An NPHO can be the employing entity of a hospital or other health care facility.
5. While it is expected that most of these income guarantee arrangements result in forgiveness (a benefit for both physician and employer), a physician may not be able to stay in the underserved area for the required amount of time for a variety of reasons beyond their control (issues with the employer, personal decisions to relocate, inability to become or remain board certified, etc.). Physicians need to understand these possible practical realities and evaluate these risks before they agree to such an arrangement, which the employer may push them to accept given this arrangement benefits the employer’s financial interests as well.
6. *See* Indemnification, or compensation for damages or losses, below.
7. Many of the contractual concepts discussed in this article may appear in income guarantee agreements. However, a detailed discussion of these types of agreements is outside the scope of this article.
8. Such as non-competition, non-solicitation, and/or non-investment obligations, see below.
9. As with income guarantees, many of the contractual concepts discussed in this article may appear in equity and/

or shared ownership types of agreements. Again, a detailed discussion of these types of agreements is outside the scope of this article.

10. For example, the Texas Workforce Commission uses a 20-point guide to determine if a worker is an employee or an independent contractor. *See* https://www.twc.texas.gov/sites/default/files/ui/docs/form-c-8-employment-status-comparative-approach-twc.pdf.
11. 50-state surveys can be helpful in understanding specific prohibitions in each state. *See* The Corporate Practice of Medicine State Guide. Permit Health. April 29, 2025. Available at https://www.permithealth.com/post/the-corporate-practice-of-medicine-50-state-guide.
    Accessed October 27, 2025.
12. The Corporate Practice of Medicine. Texas Medical Association. September 2016. Available at http://www.texmed.org/CPMwhitepaper/.
    Accessed October 28, 2025.
13. Although many basic contractual concepts are covered in this paper, this certainly is not an exhaustive list of issues.
14. Legally, a physician cannot rely on pre- or post- contract representations (like emails, texts, etc.) that contradict the clear language of the contract. *See* Integration Provision, below. So if the term is important enough to the physician (or if the contract itself contradicts the term), such term needs to be clearly stated in (or correction made to) the contract.
15. However, in Texas, this concern appears to have been alleviated by a recent revision to the Texas Physician Non-Compete Statute, which statutorily restricts the allowable non-compete to "no more than a five-mile radius from the 'primary' location of practice." *See* Non-Compete Covenants, below.
16. For example, in Texas, physicians are subject to specific requirements related to the supervision of extenders, including specific prescriptive authority and delegation agreements and complying with them by continuous monitoring. *See* Texas Occupations Code, Chapter 157. Authority of physician to delegate certain medical acts. Subchapter A. General Provisions. Available at https://statutes.capitol.texas.gov/docs/OC/htm/OC.157.htm.
    Accessed October 28, 2025.
17. For example, the Texas Physician Non-Compete statute (Tex. Bus. & Commerce Code § 15.50) requires that, for any non-compete to be enforceable against a physician's practice of medicine, the employer provide certain access to patient medical records for a reasonable fee even after the contract is terminated. *See* Texas Business and Commerce Code. Title 2. Chapter 15. Monopolies, trusts and conspiracies in restraint of trade. Subchapter A. Section 15.50. Criteria for enforceability of covenants not to compete. Available at https://statutes.capitol.texas.gov/Docs/BC/htm/BC.15.htm#15.50.
    Accessed October 28, 2025.
18. Texas Administrative Code. Chapter 163. Rule §163.4. Physician Responsibilities When Leaving a Practice. Available at https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&queryAsDate=10%2F28%2F2025&recordId=223448.
    Accessed October 28, 2025.
19. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HITECH/Enforcement Rule (enacted in 2009), which amended HIPAA, are the main federal laws that protect health information (PHI) of patients. The confidentiality, privacy, and security protections of PHI under HIPAA and HITECH, as well as applicable state patient privacy laws, are outside the scope of this article.
20. Physicians should note that a medical liability settlement and/or judgment made for the physician's benefit may result in a National Practitioner Data Bank (NPDB) report against the physician if they are assigned the responsibility for the negligence despite a decision made only by the employer or its insurer. *See* National Practitioner Data Bank Guidebook. Subsection E: Reporting Medical Malpractice Payments. U.S. Department of Health and Human Services. Last update October 2018. Available at https://www.npdb.hrsa.gov/guidebook.
    Accessed October 28, 2025.

21. 50-state surveys can clarify specific non-compete laws in each state. *See*, e.g.: 50 State Desktop Reference. Seyfarth. 2024-2025 edition. Available at https://www.seyfarth.com/dir_docs/documents/brochures/50-State-Non-Compete-Desktop-Reference-2024-2025-Edition.pdf. Accessed October 28, 2025; and
Katz Banks Kumin. U.S. noncompete agreement restrictions 50 state survey. Updated July 1, 2025. Available at https://katzbanks.com/noncompete-map/.
Accessed October 28, 2025.
22. Texas Business and Commerce Code. Title 2. Chapter 15. Monopolies, trusts, and conspiracies in restraint of trade. Section 15.50(b). Available at https://statutes.capitol.texas.gov/Docs/BC/htm/BC.15.htm.
Accessed October 28, 2025.
23. Texas Senate Bill 1318, effective September 1, 2025. LegiScan. Bill text: SB1318, 2025-2026, 89th Legislature. Available at https://legiscan.com/TX/text/SB1318/id/3122156.
Accessed October 28, 2025.
24. This statutory solution harkens back to prior Texas common law essentially holding that it is inequitable to terminate a physician for "no cause" but then still enforce a non-compete against them (i.e., the equitable defense of "unclean hands"). *See, e.g., In re Jim Walter Homes, Inc.*, 207 S.W.3d 888, 899 (Tex. App.–Houston [14th Dist.] 2006, orig. proceeding) (quoting *Thomas v. McNair*, 882 S.W.2d 870, 880-81 (Tex. App.–Corpus Christi 1994, no writ.)). However, on a practical basis, this may create another problem by incentivizing the discharge of a physician "for cause" so that any non-compete remains enforceable.
In re Jim Walter Homes, Inc., 207 S.W.3d 888, 899. Casemine. Available at https://www.casemine.com/judgement/us/5914b4b3add7b0493476dff6.
Accessed October 28, 2025.
25. *See, e.g., West v. Quintanillo*, 573 S.W.3d 237, 243 & n.11 (Tex.2019). Available at https://case-law.vlex.com/vid/west-v-quintanilla-no-886417435.
Accessed October 28, 2025.
26. A detailed discussion of indemnification is outside the scope of this article. Especially in this area, obtaining experienced legal counsel is strongly recommended to any physician when considering agreeing to indemnification.

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CLOSED
CLAIM
STUDY

IMPROPER PERFORMANCE OF COLECTOMY

by Laura Hale Brockway, ELS, Vice President, Marketing

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

An 80-year-old woman came to General Surgeon A for a colorectal screening. She had a history of irritable bowel syndrome with diarrhea. Three years earlier, the patient had a colonoscopy that showed several polyps; not all of them were removed. The patient's history also included heavy alcohol use and smoking.

PHYSICIAN ACTION

During an office visit on January 10, General Surgeon A recommended an upper and lower endoscopy based on the patient's existing polyps, change in stool color with NSAID intake, and heme positive stool. The surgery was scheduled for January 12.

On January 11, a CRNA performed a preoperative exam. He noted the patient's chest was clear to auscultation and her neurologic system was normal. The patient reported no prior issues with anesthesia.

General Surgeon A performed an esophagogastroduodenoscopy, colonoscopy with biopsies, and a polypectomy using cold biopsy forceps on January 12. The postoperative report documented findings of a tumor in the cecum, rectal polyp, polyps of the right colon, and normal upper gastrointestinal endoscopy. The pathology report indicated a cecum mass "invasive moderately differentiated adenocarcinoma, microsatellite, unstable tumor; rectal polyp biopsy — hyperplastic polyp fragments."

Upon learning that the biopsied specimen was positive for colorectal cancer, the patient wanted to remain in the hospital overnight and proceed with a partial colectomy on January 13. General Surgeon A notified the patient's primary care physician (PCP), who saw the patient the evening of January 12. The PCP also saw the patient on January 13 and noted a normal review of systems and plan for surgery that day. The patient's blood pressure was elevated, thought to be related to anxiety.

The CRNA performed a second anesthesia evaluation on January 13. He changed her ASA score from 3 to 4 and planned for general anesthesia.

General Surgeon A started the laparoscopy at 10:24 a.m. Once the ports were placed and the patient was repositioned ("left tilt, along with some Trendelenburg"), she developed severe hypoxemia, bradycardia, and hypotension. The patient still had a pulse. General Surgeon A stopped the procedure at 10:40 a.m. He removed the ports, began stapling the skin, and placed a right subclavian central line. Resuscitation was carried out and the patient slowly recovered. She was transferred to the ICU intubated and sedated.

The patient's PCP ordered a cardiology consult, who documented that the patient's condition was "suggestive of Takotsubo cardiomyopathy." "However, severe multi-vessel ischemic cardiomyopathy is not excluded. Patient has been under stress since recent colon mass diagnosis."

That afternoon, the patient was transferred to a medical center under the care of a cardiologist. She developed a possible brain injury with left-sided weakness following the cardiopulmonary instability that occurred intraoperatively; her condition improved and she was discharged one week later.

The patient returned to General Surgeon A in March and wanted to proceed with the colectomy. General Surgeon A recommended that she have the colectomy at the medical center where she could receive a higher level of anesthesia care. General Surgeon B performed the colectomy without complication on April 28.

ALLEGATIONS

A lawsuit was filed against General Surgeon A, the CRNA, and the hospital. Regarding the actions of General Surgeon A, it was alleged that he should not have attempted the colectomy the day after the patient's colonoscopy because she

was "fluid deficient." It was further alleged that this action led to the patient's hypoxic brain injury and subsequent lasting mental and physical disabilities.

LEGAL IMPLICATIONS

General Surgeon A's actions in this case were supported by defense experts and the patient's subsequent treating physicians. The patient had an adenocarcinoma of the cecum and resection was indicated. Once the pathology results were received and the colectomy discussed, General Surgeon A required additional testing and work up to ensure it was safe to perform the surgery on January 13.

The patient's PCP — who had treated the patient for 20 years and was aware of her comorbidities — supported the timing of the procedure. She cleared the patient for surgery based on the results of her echocardiogram and stress test.

During the colectomy, General Surgeon A responded appropriately when the severe hypotension occurred by returning the patient to a neutral position and initiating resuscitation. The cardiologist's work-up of the patient upon being admitted to the ICU suggested that the incident was the result of a myocardial infarction and coronary artery disease.

The plaintiff's general surgery expert developed an alternative argument. He testified that the colectomy was non-emergent and should have been delayed to allow the patient to "rehydrate" from the colonoscopy before she prepped for the colectomy.

This allegation was based on documentation that the patient was negative 550 mls on January 12 and negative 1100 mls on January 13. Further, this expert stated that there was no indication that the patient was receiving fluids to balance the bowel prep. However, he did concede that the patient's output of 1300 mls meant that she was hydrated.

Regarding the allegations against the CRNA and hospital, the plaintiff's anesthesiology expert stated that the CRNA should not have been allowed to evaluate the patient independently, without any delegation or supervision from a physician. The expert stated that doing so was a breach in the standard of care, as physician supervision was required by Texas Medical Board regulations.

However, the surgeries took place at a rural, community hospital, which are often vulnerable to a lack of providers and resources. At the time of these surgeries, an on-site anesthesiologist was not available, leaving General Surgeon A to delegate anesthesia selection and administration to the CRNA. It was then argued that General Surgeon A did not properly oversee the CRNA's work.

On January 13, the CRNA did change the patient's ASA score from 3 to 4, indicating she was at high risk for complications that pose a threat to life. Therefore, it was also stated that the patient should not have been cleared for surgery because she was high risk and severely dehydrated.

DISPOSITION

This case was taken to trial, and the jury reached a verdict in favor of the plaintiffs.

RISK MANAGEMENT CONSIDERATIONS

This case highlights the importance of careful preoperative assessment, communication, and adherence to delegation and supervision requirements — particularly in high-risk surgical patients and resource-limited hospital settings. Although the care provided by General Surgeon A was supported by defense experts, the case was lost at trial. This outcome underscores how medical decisions can be vulnerable to juror perceptions when documentation is limited.

One of the central issues in this case was the timing of surgery. The patient underwent a colonoscopy and bowel prep on January 12, followed by a partial colectomy scheduled for January 13. While the decision to proceed was medically supported and the patient was cleared by her PCP, the plaintiff's experts argued that the patient was fluid deficient from the bowel prep and colonoscopy. They claimed the patient's negative fluid balance contributed to intraoperative instability and subsequent brain injury. Documentation of hydration status and fluid replacement was limited, which made it difficult to refute this claim.

A clear note documenting the rationale for proceeding — along with evidence of preoperative fluid and electrolyte evaluation — may have been pivotal in defending the timing of surgery. This documentation is especially important for patients with comorbidities that increase perioperative risk.

An additional area of scrutiny was the anesthesia delegation, supervision, and oversight process. The CRNA performed both preoperative evaluations without a supervising anesthesiologist present. While this arrangement may be common in rural hospitals, hospitals with limited staffing should establish written protocols defining supervision responsibilities, documentation requirements, and procedures for escalating care to other facilities.

Communication among the care team also played a significant role. General Surgeon A, the PCP, and the CRNA each examined the patient, but the records lacked a clear indication of the patient's risk factors, hydration status, and evolving ASA classification. When multiple providers treat a patient, it is essential that all members of the team document consistent findings and communicate any changes that could affect surgical readiness.

Finally, this case illustrates how a medically reasonable course of action can be difficult to defend if documentation leaves room for interpretation. Taking steps to clearly and fully document such details as patient condition, delegation, and physician reasoning can strengthen the defensibility of care should an adverse outcome occur.

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CLOSED
CLAIM
STUDY

FAILURE TO TREAT PROSTATE CANCER

by Wayne Wenske, Senior Marketing Strategist

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

On January 30, 2016, a 62-year-old man came to see Urologist A for continued urinary retention. The patient's history included weak stream, hesitancy, straining, and nocturia. He was being treated with an indwelling urinary catheter.

The patient began catheter use two months earlier, November 2015, when he was hospitalized for acute renal failure and urinary retention.

A CT taken in the hospital revealed a large prostate with large intravesical median lobe as well as an atrophic right kidney with significant hydronephrosis. The left kidney was noted to have mild hydronephrosis and hydroureter. The patient's prostate-specific antigen (PSA) level was 91 ng/mL. A "normal" PSA level for men 60 or older should be at or below 4.0 ng/mL.[1]

PHYSICIAN ACTION

During the January 30 appointment, Urologist A discussed removing the patient's catheter and conducting a void trial. If the void trial failed, a next step of transurethral resection of the prostate (TURP) was also discussed. The catheter removal and void trial were scheduled for February 4.

In the past, the patient declined several treatments for urinary retention due to their cost and his lack of insurance, including use of suprapubic tube (SPT), intermittent catheterization, or prescriptions for alpha blockers or 5-alpha reductase inhibitors.

At the February 4 appointment, the void trial was not successful, and the catheter was replaced. The patient was prescribed tamsulosin and finasteride. He refused to schedule a TURP but was referred to General Surgeon A for treatment of a right inguinal hernia (RIH). The patient did not see the surgeon.

On February 24, the patient returned to Urologist A's office for a catheter replacement. All treatment options were again discussed, including TURP and SPT, and declined by the patient. Urologist A told the patient that if surgery were necessary, he could arrange a payment schedule for his fees and for the hospital fees. Ongoing, monthly catheter changes were scheduled and performed.

On May 17, the patient returned for a catheter change and reported that he was recently seen at a hospital for acute renal failure and urinary retention. A new CT at the hospital again showed a large prostate with intravesical median lobe. In the hospital, the patient refused treatment saying that he would be getting insurance soon and would schedule a TURP when covered. Until then, he would follow up with Urologist A and continue with monthly catheter changes.

Over the next 16 months, the patient returned to Urologist A's office for monthly catheter replacements and multiple void trials. He was unable to void due to the obstructing prostate. At each meeting, Urologist A urged the patient to have a TURP procedure, but the patient declined, wanting to wait until he was eligible for Medicare.

On November 8, 2018, the patient returned to Urologist A and reported that he had gone to the ED on October 25 for clogged catheter, gross hematuria, and flank pain. His catheter was changed in the ED, and dark tea colored urine was drained. He was given ceftriaxone and discharged with a 7-day prescription for levofloxacin, 750 mg.

The patient further stated that his symptoms resolved on antibiotics; he was now on Medicare; and he wanted to pursue a TURP and right inguinal hernia repair. Urologist A planned to perform the TURP after the hernia repair and referred the patient back to General Surgeon A. In the meantime, monthly catheter changes would continue.

In January 2019, General Surgeon A repaired the hernia, but the patient developed significant residual fluid in his right hemiscrotum and blood at the urethral meatus. Urologist A was consulted and arranged for an in-office cystoscopy and catheter change for March 26.

The patient came to Urologist A's office on March 26 but was experiencing gross hematuria; merlot-colored urine in the catheter bag; and lethargy, fever, and chills. The patient was emergently sent to the ED.

The evaluation in the ED revealed obstructive uropathy with bilateral hydronephrosis, extensive widespread bony metastases, and a PSA level exceeding 600 ng/mL. He was diagnosed with metastatic prostate cancer to bone and started on androgen deprivation therapy (ADT).

On March 28, 2019, the patient underwent a left nephroureteral stent placement; on April 2, he began chemotherapy. He continued to be seen by an oncologist and urologic oncologist for cancer treatment and urologic care.

The patient died in February 2020. The cause of death was advanced metastatic prostate cancer.

ALLEGATIONS

A lawsuit was filed against Urologist A alleging failure to properly monitor, assess, diagnose, and/or treat prostate cancer.

LEGAL IMPLICATIONS

Expert consultants for TMLT, the defense, and the plaintiff were mostly critical of Urologist A. More than one consultant expressed that the patient's PSA level of 91 at initial presentation likely indicated advanced disease.

Failing to order a follow-up PSA or to perform a digital prostate exam over three years were noted as significant weaknesses in Urologist A's case. The plaintiffs argued that these actions led to a delay in diagnosis, progression of widespread metastatic cancer, and the patient's death. Failure to biopsy the prostate was also noted as a weakness.

One consultant for the defense pointed out that Urologist A should have been more direct with the patient and told him that he may have prostate cancer and that a biopsy (less expensive than a TURP) was vital to make a diagnosis. Instead, Urologist A used the term "abnormal cells" when discussing test results with the patient. Had Urologist A used the word "cancer," it may have prompted the patient to make alternative treatment decisions.

DISPOSITION

This case was settled on behalf of Urologist A.

RISK MANAGEMENT CONSIDERATIONS

When patients refuse essential care, it is important for physicians to conduct and document these conversations as thoroughly as informed consent. Informed refusal is a critical risk management process that can apply to any situation where patients decline recommended treatment, including refusing medications or testing, missing appointments, or declining surgery. The process requires physicians to fully document that the patient's decision was based on their clear understanding of their condition and the risks of nontreatment.

While Urologist A noted his discussions of treatment options with the patient, there is no evidence that he adequately explained the patient's potentially serious condition to him –nor the consequences of declining treatment.

As one consultant pointed out, there was a critical communication gap between Urologist A and the patient, as he never described the patient's condition in plain language to the patient (as "cancer" instead of "abnormal cells"). For some patients, this might constitute lack of clarity and lead to misunderstandings. Faced with a serious patient condition and noncompliance, it is best to use plain language to ensure their full understanding and comprehension of their condition and options.

Documenting informed refusal should include:

- description of specific treatment(s) offered;
- your clinical reasoning behind the treatment(s) offered;
- potential benefits and risks of the treatment(s) and how and when they were explained to the patient;
- explicit discussion with the patient and, when appropriate, with their family members (if authorized by the patient) of the consequences of non-treatment, including possible adverse effects such as disability or death; and
- a clear statement of the patient's refusal and their reasoning for refusing treatment(s).[2]

To help obtain consent to treatment, consider involving family members in the discussion (with permission from the patient) or asking the patient to obtain second opinions from other providers. A thorough approach helps you to protect the patient's wellbeing and reduces the chances of legal liability in the event of adverse outcomes from declined treatment.

When patients repeatedly refuse essential treatment, physicians may decide to escalate their approach by considering family meetings, sending written communications, obtaining written "informed refusal" signed by the patient, and consulting their medical liability insurer. While full, contemporaneous, and complete documentation does not directly translate to patient compliance, it can demonstrate that you offered appropriate care and advice, but the patient made a fully informed decision to decline your help.

SOURCES

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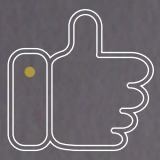

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