

White Paper



**Quality Metrics, Contractors and the “Right to Control”:
Extending “Employee” Rights to the Independent Medical Staff**

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I. Quality Metrics and the “Right to Control”

Hospitals are becoming increasingly proactive in “managing” the clinical practices of independent staff physicians through, for example, clinical protocols, standard order sets and other evidence-based initiatives driven by quality metrics. Although vital to hospitals from a reimbursement and quality perspective, this increased control of clinical practices is having a negative unintended consequence, i.e., increased exposure for claims under employment discrimination law in connection with adverse privileging actions, for which there is no immunity under the federal Health Care Quality Improvement Act (42 U.S.C. § 11101 et seq.) and no peer review privilege protection.

The Affordable Care Act (“ACA”)¹ is driving major changes in the way healthcare is delivered, through the promotion of population health management, value-based purchasing, and many other initiatives designed to encourage the systemic control and coordination over the delivery of care. Systems-based medicine uses design principles such as: (i) managing care across the healthcare delivery system; (ii) corralling variability through the use of clinical protocols; (iii) reconfiguring the supporting infrastructure and practices² to maximize resource use; and (iv) constant learning from daily care practices. These “systems-based” approaches to healthcare delivery have the dual objective of controlling the spiraling costs of inpatient care and dramatically reducing the exceedingly high rate of medical errors that has remained relatively constant despite a decade of industry reforms designed to improve patient safety.³

ACA embraces and promotes the new systems-based approach, through a variety of reimbursement policies and programs structured to reward coordination, efficiency and improved clinical results. Specific programs include, for example, the Value-Based Purchasing program, which creates a financial reward and penalty system for hospitals based on the achievement of quality metrics established and implemented by the Centers for Medicare and Medicaid Services (“CMS”); the Medicare Shared Savings Program, which creates a set of financial rewards for providers that join together to form ACOs designed to achieve “accountability” for meeting the total healthcare needs of a designated patient population; and the Bundled Payments program, pursuant to which hospitals will, together with other providers, be financially accountable for managing entire “episodes of care” – extending from three days prior to a qualifying hospital admission to thirty days after discharge.⁴ Each of these programs is specifically designed to encourage hospitals to work directly with physicians and other providers in

the healthcare spectrum to coordinate and manage care so as to achieve higher quality at reduced cost.⁵

ACA also requires increased public reporting of the achievement of quality benchmarks, on the HospitalCompare and PhysicianCompare websites.⁶ This increased public reporting of medical error data creates specific challenges for hospitals, as such data can easily be mined and used by plaintiff malpractice attorneys to show hospital notice of quality issues among its physician staff, and a platform for arguing that the hospital should have done more to protect its patients from under-performing physicians.⁷ This, in turn, can increase hospital exposure to corporate negligence and negligent credentialing claims.⁸

Moreover, ACA is not the only government initiative driving more proactive management of physician quality. While ACA uses a financial “carrot and stick” approach to improving quality, the Justice Department has opted for a much more draconian enforcement tool – the federal False Claims Act (FCA).⁹ The FCA imposes civil and criminal penalties on federal contractors that submit “false” or “fraudulent” claims for reimbursement to the federal government. In recent years, federal prosecutors have developed the “worthless services” theory of FCA recovery, pursuant to which healthcare providers can be held liable for the submission of claims for services that were of such inferior quality as to be essentially “worthless” to the patient.¹⁰ Although such suits are generally reserved for cases involving truly egregious failures of care, such as nursing home patients with open bedsores and soiled sheets,¹¹ the federal government has pursued less obvious failures of care, such as, for instance, radiology studies performed on substandard equipment.¹² FCA liability, when it attaches, has potentially huge financial consequences. The FCA’s civil penalties include treble damages and a fine of up to \$11,000 for each individual “false claim” submitted.¹³ Thus, even a small possibility of FCA enforcement can provide strong motivation for hospitals to assert control over the delivery of healthcare services to ensure that quality services are provided at every level.

The Joint Commission (TJC) also has revamped its accreditation standards and processes in recent years in order to address the challenges of patient safety in the hospital setting through a more “systems-based” approach, which TJC describes as “driven by organizational leadership; anchored in the organization’s mission, vision and strategic plan; implemented by directors; integrated and coordinated throughout the organization’s staff; and ...

1 The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 3022 & 10307 (amending Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. by adding new § 1899) (“ACA”).

2 Richard J. Bohmer, “Fixing Healthcare on the Front Lines,” *Harvard Business Review*, 62, 64-69 (April 2010).

3 Belmont et al., “A New Quality Compass: Hospital Boards’ Increased Role Under the Affordable Care Act,” *Health Affairs* 30:7 (July, 2011) (hereinafter “New Quality Compass”).

4 See *New Quality Compass*, at 8-9.

5 ACA articulates its goals in the following specific terms: (i) improving health outcomes, efficiency, and patient-centeredness of care for all populations; (ii) identifying areas with the potential for rapid improvements in the quality and efficiency of patient care; (iii) addressing gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques; (iv) improving federal payment policy to emphasize quality and efficiency; (v) enhancing the use of healthcare data to improve quality, efficiency, transparency and outcomes; (vi) addressing the healthcare provided to patients with high-cost chronic diseases; (vii) improving research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and healthcare associated infections; and (viii) reducing health disparities across populations and geographic areas. ACA, at § 3011 (new 3999HH(a)(2)(B)).

6 www.hospitalcompare.hhs.gov; www.physiciancompare.hhs.gov

7 Peters and Nagele, “Promoting Quality Care and Patient Safety: The Case for Abandoning The

Joint Commission’s “Self-Governing” Medical Staff Paradigm,” 14 *MSU Journal of Medicine and Law* 314, 363-64 (2010) (hereinafter, “Quality Care & Patient Safety”).

8 *Id.*

9 18 U.S.C. §§ 287, 1001; 31 U.S.C. § 3729.

10 See, e.g., *Chesbrough v. VPA, P.C.*, 655 F.3d 461 (6th Cir. 2011); *Zurich Am. Ins. Co. v. O’Hara Reg. Ctr. for Rehab.*, 529 F.3d 916, 918-19 (10th Cir. 2008); *United States ex. rel. Roberts v. Aging Care Home Health, Inc.*, Civ. A. No. 02-2199, 2007 U.S. Dist. LEXIS 92864, at *2-3 (W.D. La. Dec. 18, 2007); see also Press Release date January 19, 2012 announcing \$840,000 settlement in *United States of America ex. rel. Lana Rogers v. Najam Azmat, M.D. and Satilla Health Services, Inc. d/b/a Satilla Regional Medical Center*, Civ. A. No. 5:07-cv-00092-LGW-JEG (S.D. Ga., action filed Nov. 14, 2007) (alleging that hospital violated FCA by submitting bills for endovascular procedures performed by a physician who lacked the necessary qualifications, competence, or credentials).

11 *E.g.*, *U.S. ex. rel. Roberts*, Civ. A. No. 5:07-cv-00092-LGW-JEG.

12 *E.g.*, *Chesbrough*, 655 F.3d 461.

13 31 U.S.C. § 3792.

...continuously re-engineered using proven, proactive performance improvement modalities.”¹⁴ TJC includes within the “systems-based” approach to patient safety the following “sub-processes:”

- Planning and designing services
- Directing services
- Integrating and coordinating services
- Reducing and preventing errors
- Using TJC’s Sentinel Event Alerts
- Achieving TJC’s National Patient Safety Goals (NPSGs)
- Implementing clinical practice guidelines
- Actively involving patients in their care, treatment or services¹⁵

TJC also requires hospitals to participate in the ORYX® electronic performance measurement system for continuous quality monitoring by TJC; this information also is used by TJC to help determine what issues it will put particular focus on during the hospitals’ accreditation surveys.¹⁶

With regard to oversight of physicians, TJC requires proactive monitoring of quality metrics through “Ongoing Professional Practice Evaluation” (OPPE), coupled with proactive departmental intervention in the form of “Focused Professional Practice Evaluation” (FPPE), using such techniques as monitoring of clinical practice patterns, simulation, external peer review, counseling, education and additional skills training.¹⁷ TJC also has identified physician “disruptive conduct” (i.e., verbal outbursts, intimidation, delay in returning phone calls, etc.) as a factor that can undermine patient safety, and therefore has mandated that its accredited hospitals establish a code of conduct and a process for managing disruptive and inappropriate behaviors.¹⁸ Hospitals that fail to implement these proactive quality/safety oversight methods risk sanctions or loss of accreditation.¹⁹

Hospitals are thus moving away from retrospective, arms-length, incident-based peer review, and adopting measures that are more prescriptive, interventional and based on the achievement of quality metrics. The new quality/safety oversight tools include:

- The proactive use of quality metrics and outcomes data to monitor physician quality and safety, and to determine level of adherence to externally imposed standards such as CMS’s benchmarks for Value-Based Purchasing and TJC’s National Patient Safety Goals;
- The adoption and implementation of evidence based clinical treatment protocols (“Clinical Protocols”) applicable to all members of the treatment team (including physicians) that prescribe standardized steps for evaluation and treatment of specific symptoms or disease processes, so that patient care is delivered in a consistent and coordinated manner;
- The implementation and use of Electronic Medical Record (EMR) systems that include “prompts” designed to achieve accuracy, completeness and consistency in the care given as well as the documentation of that care;
- The implementation and use of standard order sets for medications, often implemented through the use of a Computerized Order Entry (CPOE) system;

- The use of surgical checklists and other mechanisms designed to standardize care;
- The adoption of comprehensive policies and procedures for addressing complaints of disruptive conduct and harassment brought against physicians on the hospital’s medical staff;
- The proactive evaluation and monitoring of physicians through the OPPE and FPPE processes mandated by TJC; and Informal interventional measures such as proctoring, monitoring, ongoing chart review, counseling, education and skills training to address specific, identified areas of deficiency.

These measures, designed to increase the hospital’s control over the safety and quality of its services, reduce the latitude that physicians have to exercise “independent medical judgment” in the care and treatment of their patients. For example:

- **Physician A**, who previously was able to choose between several different recognized treatment approaches, now must either follow the hospital’s duly adopted “evidence-based protocol” or provide a specific medical justification for taking a different approach.
- **Physician B**, is notified by his Department Chair that his outcomes data (30-day readmission rate and surgical infection rate) is 15 percent higher than the national benchmark adopted by the hospital, and that, consequently, his surgeries will be observed by a proctor for the next six months.
- **Physician C**, found by the peer review committee to have deviated from the standard of care in a particular case, instead of simply receiving a letter asking him to consider the peer review findings, is now required to attend a counseling session, obtain additional skills training and be monitored for the next six cases.
- **Physician D**, accused by a female nurse of lewd jokes in the operating room and suggestive rubbing of her back, undergoes formal investigation conducted by the Chief Medical Officer and his Department Chair, after which he is required to apologize to the complainant, receives a warning, and must take a course in appropriate workplace conduct.

All of these measures are more interventional than the traditional methods of retrospective, arms-length physician peer review. To one degree or another, each could be seen as encroaching on the physician’s exercise of independent professional judgment, and by the same token, could be interpreted as evidence of greater “control” over the physician’s treatment of his patients (and other employees) by the hospital.

Significant legal implications flow from this increased control.

14 The Joint Commission, *Hospital Accreditation Standards 2014* (hereinafter, TJC HAS), ACC-38.

15 *Id.*

16 TJC HAS, PM-1-3.

17 TJC HAS, MS.08.01.01 (FPPE) and MS.08.01.03 (OPPE).

18 TJC Sentinel Event Alert, “Behaviors that Undermine a Culture of Safety,” July 9, 2008, available online at www.jointcommission.org/assets/1/18/SEA_40.pdf. Although TJC does not address harassment in this Sentinel Event Alert, most would agree that sexual (or other types of)

harassment is a form of disruptive conduct that could undermine a culture of safety.

19 Since many hospitals use TJC accreditation to establish “deemed” eligibility for participation in Medicare and the other federal healthcare programs, the loss of accreditation would not only severely impair a hospital’s reputation and marketability, but also have immediate, severe financial implications in terms of loss of Medicare funding.

II. The Origin of Hospitals “Employment Law” Exposures

As with other employers, hospitals must comply with federal, state and local employment discrimination laws. These laws seek to hold “employers” accountable for discrimination, harassment and/or retaliation against their “employees.” While the coverage of these statutes on the surface might seem clear, courts and litigants have struggled with the contours of these seemingly simple proscriptions for many years. In part, this is because many employment discrimination statutes provide no detailed definition for who might qualify as an employee, and therefore be entitled to the protections afforded by the given statute.

For example, Title VII of the Civil Rights Act of 1964 (“Title VII”), the employment discrimination statute which is the foundation of modern employment discrimination law and the law upon which many state statutes are based, provides that it is “an unlawful employment practice to discriminate against any individual with respect to his compensation, terms, conditions or privileges of employment, because of such individual’s race, color, religion, or national origin.” 42 U.S.C. § 2000e-2(a). While Title VII applies only to “employee[s],” it defines the term “employee” circularly, as “an individual employed by an employer.”²⁰ 42 U.S.C. § 2000e(f). Title I of the Americans with Disabilities Act (“Title I of the ADA”),²¹ which is modeled on Title VII and enacted in 1990, prohibits discrimination against qualified individuals with disabilities and creates affirmative obligations on the part of employers to provide reasonable accommodations to individuals with disabilities. 42 U.S.C. §§ 12112(a), (b). Title I of the ADA provides an identical definition for employee to the definition of employee under Title VII. 42 U.S.C. § 12111(4).²² Similar to Title VII and Title I of the ADA, the Age Discrimination in Employment Act (“ADEA”), first enacted in 1967, defines “employee” as “an individual employed by any employer.” 29 U.S.C. § 630(f).²³ The ADEA prohibits discrimination against workers who are forty years of age or older. 29 U.S.C. § 631(a).

In analyzing a similarly circular definition of “employee” under the Employee Retirement Income Security Act of 1974 (“ERISA”), the Supreme Court in *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992), adopted a common law test for assessing whether an individual qualifies as an employee. The Court in *Darden* borrowed a test that the Court had developed three years earlier in a case under the Copyright Act in *Community for Creative Non-Violence v. Reid*, 490 U.S. 730 (1989), and instructed that because the common law test contains “no shorthand formula or magic phrase that can be applied to find the answer, . . . all of the incidents of the relationship must be assessed with no one factor being decisive.” *Darden*, 503 U.S. at 324 (quoting *NLRB v. United Ins. Co of America*, 390 U.S. 254, 258 (1968)) (emphasis added). The Court’s

“As with other employers, hospitals must comply with federal, state and local employment discrimination laws. These laws seek to hold ‘employers’ accountable for discrimination, harassment and/or retaliation against their ‘employees.’”

Reid test considers the following non-exhaustive list of factors, with any factors not relevant to any given analysis to be disregarded:

- (1) the hiring party’s right to control the manner and means by which the product is accomplished;
- (2) the skill required;
- (3) the source of the instrumentalities and tools;
- (4) the location of the work;
- (5) the duration of the relationship between the parties;
- (6) whether the hiring party has the right to assign additional projects to the hired party;
- (7) the extent of the hired party’s discretion over when and how long to work;
- (8) the method of payment;
- (9) the hired party’s role in hiring and paying assistants;
- (10) whether the work is part of the regular business of the hiring party;
- (11) whether the hiring party is in business;
- (12) the provision of employee benefits;
- and (13) the tax treatment of the hired party.

Darden, 503 U.S. at 323-24; *Reid*, 490 U.S. at 751-52.

Various courts have applied the “*Reid* factors” in analyzing whether an individual qualifies as an employee under various employment discrimination statutes, and in the process have placed particular weight on the right of the hiring party to “control the manner and means” by which the duties are accomplished. See, e.g., *Glascok v. Linn County Emergency Med., PC*, 698 F.3d 695, 698 (8th Cir. 2012); *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 226-27 (2d Cir. 2008); *Weary v. Cochran*, 377 F.3d 522, 525 (6th Cir. 2004) (“The crux of *Darden*’s common law agency test is ‘the hiring party’s right to control the manner and means by which the product is accomplished.’”) (quoting *Darden*, 503 U.S. at 323); *Alexander v. Avera St. Luke’s Hosp.*, CIV 12-1012, 2013 U.S. Dist. LEXIS 92826 (D.S.D. July 2, 2013).

²⁰ Title VII applies to employers “engaged in an industry affecting commerce” that have fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year. 42 U.S.C. § 2000e(b).

²¹ While Title I of the ADA defines employer and employee similarly to Title VII, the application of the analysis set forth herein to the realm of disability discrimination is complicated for two reasons. The first is the prospect that “independent contractor” physicians might be able to sue hospitals under Title III of the ADA, 42 U.S.C. 12181, et seq. (“Title III”), the public accommodation title. One court of appeals has allowed such a claim to go forward. *Menkowitz v. Pottstown Mem’l Med. Center*, 154 F.3d 113, 121-23 (3d Cir. 1998) (“We therefore hold that a medical doctor with staff privileges — one who is not an employee for purposes of Title I — may assert a cause of action under Title III of the ADA as an ‘individual’ who is denied the ‘full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.’”); but see *Bhan v. Battle Creek Health Sys.*, Case No. 1:10-CV-202, 2013 U.S. Dist. LEXIS 58407, at *25-28 (W.D. Mich. Apr. 24, 2013) (dismissing Title III ADA claim of plaintiff-physician, stating that “the most reasonable reading of Title III is that its prohibitions against discrimination extend to customers or clients of the public accommodation, but not employees or independent contractors on the basis of their employment.”). The second is the possibility that privileged physicians can bring claims against hospitals under Section 504 of the Rehabilitation Act, 29 U.S.C. 794 (“Section 504”), which provides that “[n]o otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal

financial assistance” 29 U.S.C. § 794(a). Since hospitals generally are recipients of federal financial assistance in the form of Medicare and Medicaid reimbursements, such claims often are asserted against hospitals, both inside and outside of the employment context. See, e.g., *Evancho v. Fisher*, 423 F.3d 347, 350 (3d Cir. 2005). Two courts of appeals have found Section 504 claims cognizable when brought by “independent” staff physicians. *Fleming v. Yuma Reg. Med. Ctr.*, 587 F.3d 938, 945 (9th Cir. 2009) (holding that anesthesiologist who applied for, but was denied staff privileges at the hospital, could assert a claim under Section 504 because such a claim is “not limited to employers and employees . . . , but rather applies to independent contractors.”); *Menkowitz*, 154 F.3d at 123-25 (reversing district court’s dismissal of Section 504 claim and stating that “appellant has set forth sufficient factual circumstances to permit an inference to be drawn that the hospital suspended medical staff privileges solely by reason of his handicap”). The Eighth Circuit has gone the other way on this issue, affirming the grant of summary judgment on a staff physician’s Section 504 claim because of the “similarity” between Section 504 and Title I of the ADA. *Wojewski v. Rapid City Reg. Hosp., Inc.*, 450 F.3d 338, 345 (8th Cir. 2006).

²² As with Title VII, the ADA applies to employers “engaged in an industry affecting commerce” that have fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year. 42 U.S.C. § 12111(5)(A).

²³ In contrast to Title VII and Title I of the ADA, the ADEA applies to employers “engaged in an industry affecting commerce” that have twenty or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year. 29 U.S.C. § 630(b).

As the Court presciently stated in *Darden*, 503 U.S. at 327, “[t]o be sure, the traditional agency law criteria offer no paradigm of determinacy,” and inexorably lead to fact-intensive analyses which generally render cases brought by independent staff physicians challenging their status not susceptible to disposition on the pleadings and prior to discovery taking place. See e.g., *Uppal v. Hosp. Corp. of America*, Case No. 8:09-cv-634-T-33TBM, 2010 U.S. Dist. LEXIS 101691, at *7-8 (M.D. Fla. Sept. 27, 2010) (stating in a case brought by a physician alleging sexual harassment and retaliation in relation to the curtailment of her privileges that “a determination of a doctor’s employment status in cases such as this must be made after a case specific factual inquiry”); see also *Farzan v. United Parcel Serv., Inc.*, Civ. A. No. 10-1417 (SRC), 2010 U.S. Dist. LEXIS 73969, at *2-3 (D.N.J. July 22, 2010) (“Although it is correct to say that Title VII does not protect independent contractors, the devil is in the details here: the test for independent contractor status is as complicated as anything gets in law, involving the 13-factor Reid analysis This is a fact-intensive inquiry that might be the subject of a motion for summary judgment.”).

In order to prove a claim of employment discrimination, plaintiffs can proceed by pointing to “direct evidence” of discrimination, or in the absence of direct evidence, they can proceed under the burden-shifting framework established by the Supreme Court in *McDonnell Douglas v. Green*, 411 U.S. 792 (1973), and its progeny. To establish a prima facie case of employment discrimination, a plaintiff must present evidence that he or she: (1) was a member of a protected class; (2) was qualified for the job in question; (3) suffered an adverse employment action (or in the context of retaliation claims, a materially adverse action); and (4) the employer treated similarly situated persons outside of the protected class more favorably. *Vakharia v. Swedith Covenant Hosp.*, 190 F.3d 799, 806 (7th Cir. 1999); see *Burlington Northern & Santa Fe Railway Co.*, 548 U.S. 53 (2006). If a plaintiff is able to make out a prima facie case, the burden then shifts to the employer to articulate a legitimate, non-discriminatory reason for its decision. *Id.* The burden then shifts back to the plaintiff to present evidence that the reason articulated by the employer is pretextual, i.e., a court “must evaluate whether the plaintiff has demonstrated such weaknesses, implausibilities, inconsistencies, incoherencies, or contradictions in the employer’s proffered legitimate reasons for its action that a reasonable factfinder could find them unworthy of credence.” *Combs v. Plantation Patterns*, 106 F.3d 1519, 1538 (11th Cir. 1997).

In order to create an issue of material fact for trial and to position their case for success at trial, plaintiffs in employment discrimination cases often seek (and obtain) broad discovery as to how their putative employer treated others who were similarly situated to him or herself. See e.g., *Nathan v. The Ohio State Univ.*, Civ. A. No. 2:10-cv-872, 2012 U.S. Dist. LEXIS 154693 (S.D. Ohio Oct. 29, 2012) (granting plaintiff’s (a cardiac anesthesiologist) motion to compel documents and information related to similarly situated physicians, including peer review documents). In order to support a claim of discrimination by citing to similarly situated individuals (who are referred to as comparators), plaintiffs often attempt to cite to the more favorable treatment of others outside of their protected class. For example, in *Brintley v. St. Mary Mercy Hospital*, No. 12-2616, 2013 U.S. App. LEXIS 23144, at *8 (6th Cir. 2013), the plaintiff cited to less restrictive proctorships imposed by the hospital on two Caucasian doctors, thereby asking the court to infer that her less favorable treatment was due to her race. The Sixth Circuit rejected plaintiff’s position, finding that the other two Caucasian doctors did not have “the history of serious complications that Brintley did.” *Id.*; see also *Bhan v. Battle Creek Health Sys.*, Case No. 1:10-CV-202, 2013 U.S. Dist. LEXIS 58407, at *10-11 (W.D. Mich. Apr. 24, 2013) (“In this case, Bhan has not offered any evidence that someone similarly situated was treated differently.”).



III. Why Independent Staff Physicians Have Generally Not Been Treated As Employees

Although hospitals and physicians occupy the same physical space and work closely together to provide medical care to patients in the inpatient setting, they have, historically, maintained a separate and distinct status, both economically and legally. Hospitals have been regarded as suppliers of bricks and mortar, equipment, supplies, clinical and operational assistance which supports physicians in their delivery of inpatient healthcare services. Physicians have been the ones responsible for treating patients, by diagnosing them (applying their independent medical judgment), directing their clinical care, ordering and providing treatment, and performing surgical procedures.

Hospitals and physicians have, until now, remained largely independent of each other economically. One of the primary reasons for this, historically, has been the strongly rooted “corporate practice of medicine” doctrine that exists in many states, designed to promote the exercise of independent medical judgment by physicians and avoid the commercialization of medicine, by prohibiting the employment of physicians by corporations and other business entities.²⁴ At one time, virtually every state prohibited the corporate practice of medicine. Pennsylvania has a corporate medicine doctrine with deep historic roots. See *Neill v. Gimbel Brothers*, 330 Pa. 213 (1938) (discussing the “evils of divided loyalty and impaired confidence” arising from “lay control” over the medical profession).²⁵ However, its impact was substantially mitigated by the amendment of the Healthcare Facilities Act in 2003 to permit employment of physicians by healthcare facilities, so long as the physicians’ independent medical judgment is not impaired.²⁶

As a direct consequence of this doctrine, physicians have traditionally practiced either singly or in group practices, through which they provide professional services directly to their own patients, bill those patients (or their insurers) for the services provided, and collect professional revenues from those patients and insurers. This independent professional practice structure was described in *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487, 493 (7th Cir. 1996), wherein the court found that the plaintiff, Dr. Alexander:

... listed his employer on income tax returns as Central Anesthesiologists, Ltd., his personal whollyowned [sic] professional corporation that was responsible for paying malpractice insurance premiums, employment benefits, and income and social security taxes; he was responsible for billing his patients and he collected his fees directly from them; he never received any compensation, paid vacation, private office space, or any other paid benefits from Rush North Shore. ... he was not required to admit his patients to Rush North Shore; and he was free to associate himself with other hospitals if he wished to do so.

Economic independence is a factor that has weighed strongly against finding physicians to be “employees” of hospitals under various employment discrimination laws, including Title VII, the

ADEA and state law, among others. *E.g.*, *Shah v. Deaconess Hosp.*, 355 F.3d 496, 500 (6th Cir. 2004) (“Deaconess does not pay Shah for his services or provide him with a W-2 form, and Shah performs about forty-five percent of his surgeries at other hospitals”); *Alexander*, 101 F.3d at 493 (stating that Dr.



Alexander “was responsible for billing his patients and he collected fees directly from them; he never received any compensation, paid vacation, private office space, or any other paid benefits from Rush North Shore”); *Diggs v. Harris Hosp.-Methodist, Inc.*, 847 F.2d 270, 273 (5th Cir. 1988) (“Diggs is under no duty to admit any of her patients to Harris Hospital, and Harris Hospital does not pay her for her services ... the hospital does not provide salary or wages to physicians with staff privileges, nor does it pay their licensing fees, professional dues, insurance, taxes or retirement benefits.”); *Brintley v. St. Mary Mercy Hosp.*, 904 F. Supp. 2d 699, 719 (E.D. Mich. Nov. 16, 2012).

Economic independence, however, is not the only significant factor that courts have looked at in finding physicians not to be “employees” for Title VII purposes. The other critical factor is that, as highly skilled professionals, physicians exercise independent medical judgment in the diagnosis and treatment of their patients – which is contrary to the notion that the hospital has the “right to control” the physician. As the Seventh Circuit pointed out in...

²⁴ See, e.g., Andrew Fichter, “Owning a Piece of the Doc: State Law Restraints on Lay Ownership of Healthcare Enterprises,” *American Health Lawyers Association Journal of Health Law*, Vol. 39, No. 1 (Winter, 2006).

²⁵ See Attorney General’s Opinion No. 243 (1961).

²⁶ See Healthcare Facilities Act, 35 Pa. C. S. § 448.817a.

..., in describing Dr. Alexander:

he had the authority to exercise his own independent discretion concerning the care he delivered to his patients based on his professional judgment as to what was in their best interest.

Alexander, 101 F.3d at 493.

Recent cases have affirmed the importance of independent physician decision-making. In *Shah*, the Sixth Circuit pointed out that “nothing in the record suggests that Deaconess has the right to interfere with Shah’s medical discretion or otherwise control the manner and means of his performance as a surgeon.” *Shah*, 355 F.3d at 500 (rejecting plaintiff-physician’s claim that he qualified as an employee under the ADEA, Title VII and state law). The court explained that “although the hospital requires all physicians having surgical privileges to abide by the applicable standards of care, this requirement applies regardless of employment status and is enforced only after-the-fact through the peer review process.

Nothing in the record suggests that Deaconess has the right to interfere with Shah’s medical discretion or otherwise control the manner and means of his performance as a surgeon.”

(emphasis added). Likewise, “Dr. Diggs treated her patients in Harris Hospital without direct supervision.” *Diggs*, 847 F.2d at 273. In *Brintley*, 904 F. Supp. 2d at 719–20, aff’d No. 12-2616, 2013 U.S. App. LEXIS 23144 (6th Cir. 2013), the court said that “the fact that Brintley was subjected to corrective action, including proctoring, pursuant to the Medical Staff Bylaws does not alter the Court’s conclusion that Brintley was not an employee of SMMH.” In affirming that decision, the Sixth Circuit noted that “[t]he factors here point uniformly towards an independent-contractor relationship” such that, “until the botched appendectomy in January 2008, Brintley controlled all aspects of her surgeries.” *Brintley*, 2013 U.S. App. LEXIS 23144, at *5.

The independence of physicians has been formally recognized in Pennsylvania’s hospital regulations, which explicitly require that physician services provided in the hospital setting be under the oversight, not of the hospital’s executive leadership, but of the “organized medical staff.”²⁷ Specifically, a hospital in Pennsylvania must have “an organized medical staff which is accountable to the governing body and which has responsibility for the quality of all medical care provided to patients and for the ethical conduct and professional practice of its members.”²⁸ The “organized medical staff” has its own set of medical staff bylaws, rules and regulations,²⁹ officers (usually elected by the medical staff),³⁰ an executive committee responsible “for the effectiveness of all medical activities of the staff,”³¹ a chairman for each clinical department responsible for “maintain continuing surveillance of the professional performance of all members of the medical staff with privileges in his department,”³² and a host of additional committees responsible for, e.g., credentialing, tissue review, medical care evaluation, radiation safety, pharmacy-therapeutics, and medical records.³³

In order to be admitted to the “organized medical staff,” a physician must undergo a credentialing process, during which his professional background, training and experience are thoroughly vetted (first by the medical staff, then by the hospital’s governing board) to ensure that he or she meets the hospital’s

minimum standards of quality and professionalism. In order to be “privileged” to practice at the hospital, the physician’s training

and expertise for the particular services he wishes to provide are examined to ensure that he has the appropriate level of skill as to those services.³⁴ Significantly, however, the medical staff’s credentialing and privileging decisions are not subject to direct review by the hospital’s executive team, but rather, by its governing body.³⁵ This independence in medical oversight is reflected at the federal level through the Centers for Medicare and Medicaid Services’ Conditions of Participation (CMS COPs).³⁶

After admission to the medical staff and the granting of clinical privileges, physicians are subject to the ongoing quality oversight of the medical leadership (and ultimately, the hospital governing body) through: (i) the requirement that they adhere at all times to the provisions of various hospital mandates that appear in medical staff bylaws, rules and regulations, clinical protocols and policies; (ii) the ongoing process of peer and quality review by which they are continually reviewed by the hospital’s medical leadership to ensure such adherence; (iii) the requirement that they participate in the hospital’s on-call system for evening and weekend emergency coverage; and (iv) the formal corrective action, hearing and appeal procedures that exist in the event that they engage in conduct that may lead to the loss (or curtailment) of their clinical privileges and membership on the medical staff.

Largely because of the independence of physicians in exercising professional judgment, and the lack of direct control by the hospital’s executive team, the organized medical staff’s quality oversight of physicians has not typically created the level of hospital “control” that is sufficient to create an employment relationship for purposes of federal and state employment discrimination laws. The mere issuance of clinical privileges does not, in itself, give the hospital the “right to control” its independent staff physicians. *Shah*, 355 F.3d at 500; *Diggs*, 847 F.2d at 273 (“while it imposes standards upon those permitted to hold staff privileges, the hospital does not direct the manner or means by which Diggs renders medical care”). Nor does the fact that staff physicians are required to participate in a hospital’s system of on-call rotation morph independent staff physicians into “employees” under employment discrimination laws. *Alexander*, 101 F.3d at 493; see also *McPherson v. HCA-HealthOne, LLC*, 202 F. Supp. 2d 1156, 1166 (D. Colo. 2002). The setting of hours for physicians also does not create employment-level “control.” *Cilecek v. Inova Health Sys. Servs.*, 115 F.3d 256, 261 (4th Cir. 1997). Nor does the use of hospital-supplied instruments. *Id.*; *Diggs*, 847 F.2d at 273. Moreover, requiring privileged physicians to perform administrative functions, such as serving on medical staff committees, does not convert them from independent contractors to employees. *Savas v. William Beaumont Hosp.*, 216 F. Supp. 2d 660, 668 (E.D. Mich. 2002); *Bender v. Suburban Hosp.*, 998 F. Supp. 631, 636 (D. Md. 1998).

In short, under the above analysis, the independence of staff physicians, from an economic and medical decision-making perspective, has proven to be the decisive factor, leading courts to conclude that physicians are not “employees” notwithstanding other significant indicia of hospital control over their staff physicians.

medical care provided by the patients.” The governing body must consider the “recommendations of the medical staff” in determining whether to “grant, deny, continue, revise, discontinue, limit or revoke specific privileges, including medical staff membership.” 42 C.F.R. § 482.12(a)(2) (interpretive guidelines).

33 28 Pa. Code § 107.26.

34 28 Pa. Code § 107.3.

35 *Id.*

36 42 C.F.R. §§ 482.12(a), 482.22. The CMS COPs require a “well organized” medical staff, operating pursuant to medical staff bylaws, and “accountable to the governing body for the quality of

IV. Expanding Liability for Physicians as Employers

A. Contracted Service Providers

There have been certain categories of physicians who, even under traditional analysis, have qualified as “employees” in certain cases. The first are the contracted service providers for hospital-based services, such as emergency services, radiology, anesthesiology and laboratory medicine. The hospital-based services are the essential services that *support* the provision of care by other providers – such as surgeons, obstetricians, gastroenterologists and internists. For decades, many hospitals have contracted with external physician groups to provide these services on an exclusive basis, for the specific purpose of gaining greater assurance and control over the quality and efficiency of the services provided. *E.g., Adler v. Montefiore Med. Center of Western Pennsylvania*, 453 Pa. 60 (Pa. 1973) (citing the benefits of exclusive contracting for hospitals).³⁷

However, that increased level of control can increase the potential for “employer” liability *vis a vis* the contracted physicians. In *Cilecek*, the Fourth Circuit addressed this question in the context of hospital’s exclusive contract with an emergency services provider. Plaintiff, Dr. Cilecek was a physician who had entered into an independent contractor arrangement with an independent group, Emergency Physicians, which, in turn, had an exclusive emergency services contract with Inova Health System’s Fairfax Hospital. The issue that the court had to decide was whether Dr. Cilecek was an employee of Emergency Physicians and, by extension, Inova/Fairfax.³⁸

The Fourth Circuit closely examined the relationship between Dr. Cilecek and Emergency Physicians, and ultimately concluded that Dr. Cilecek was not an “employee” but rather an “independent contractor.” The court cited the following factors in support of its decision:

1. The parties expressly set out from the beginning to create an independent contractor relationship, in contrast to the employment relationship that Emergency Physicians had with other doctors;
2. Cilecek proposed the number of hours he would work during any given month along with the allocation of those hours to various shifts, and the number of hours he worked fluctuated;
3. Cilecek had freedom to do other work, not only for himself but also for other health care facilities unrelated to the hospital or Emergency Physicians;
4. Cilecek was paid only for work actually performed and was not paid not a salary;
5. Except for professional liability insurance, Cilecek funded his own pension and other “employment benefits;” and

6. Both Cilecek and Emergency Physicians treated his taxes as if Cilecek were an independent contractor, in that Emergency Physicians did not withhold any taxes that were incident to an employment relationship.

Cilecek, 115 F.3d at 261.

Dr. Cilecek’s independence from Emergency Physicians, both economic and otherwise, insulated Emergency Physicians and the hospital from suit under Title VII. *Id.* at 262-63 (“It is important to our conclusion in this case that the parties carefully designed their relationship to give Cilecek greater freedom than might otherwise be enjoyed by salaried employees of a hospital”).

What is particularly interesting, however, is the way in which the Fourth Circuit grappled with the evidence of significant control by the hospital, which went beyond the mere control of hours worked and supplying of instruments. The evidence showed that the hospital had issued comprehensive rules and regulations governing the manner in which Dr. Cilecek provided medical care:

The rules and regulations governed every aspect of patient care, including: taking medical histories; conducting physical exams, tests and other procedures; patient progress notes; the manner of issuing patient medical orders; prerequisites and post-requisites to surgical procedures; ordering and administration of medications and medical devices; obtaining consultations and referrals; and making entries in medical records.

Cilecek, 115 F.3d at 261-62.

Dr. Cilecek argued that these comprehensive regulations evidenced the hospital’s “right to control” the manner in which he delivered his professional services.

The Fourth Circuit rejected Dr. Cilecek’s argument, concluding that the hospital’s rules were not evidence of hospital control, but of shared control between the hospital and its physicians in pursuit of their shared interest in promoting quality:

All of these regulations, however, relate to the professional standard for providing health care to patients for which both Emergency Physicians and the Inova hospitals had professional responsibility to their patients. While Cilecek certainly retained a professional independence in performing professional services, he also shared a professional responsibility to cooperate with the hospitals to maintain standards of patient care, to keep appropriate records, and to follow established procedures. This shared control ...

³⁷ In *Adler*, the hospital advanced the following justifications for awarding an exclusive contract to a single cardiologist for the administrative and clinical operation of the hospital’s cardiac catheterization laboratory: (1) as the procedures are essentially team functions, the members are able to develop a routine as well as a familiarity with the equipment and its utilization by a particular physician; (2) full-time presence at the hospital by the operator permits optimal patient care because complications can be treated by the physician who performed the procedure; (3) physician competence can be maintained only by the performance of at least three cardiac catheterizations per week, and in a low volume laboratory such as Montefiore’s this could only be assured by restricting performance to the full-time director; (4) a full-time physician-director has the extra time necessary to teach effectively the many medical students, interns and residents who utilize the laboratory as a basic learning tool; (5) scheduling problems are reduced when it is not necessary to attempt to accommodate practitioners on the staff who have outside commitments; (6) procedures should be scheduled when possible in the morning so that the performing physician can be available in the afternoon should complications arise; (7) a full-time

director insures that the non-professional, but essential administrative details of operating a laboratory will be performed by a physician; were the director’s volume of procedures reduced by allowing others to perform them, it would be extremely difficult to obtain a qualified cardiologist willing to assume the administrative functions; (8) equipment breakdowns and lack of reliability are minimized by limiting equipment utilization to a single physician; and (9) the hospital has a substantial and legitimate interest in insuring the optimal performance of its employees and use of equipment because it is liable for negligently caused injuries. *Adler*, 453 Pa. at 67-68.

³⁸ Interestingly, the Fourth Circuit’s opinion does not distinguish between Emergency Physicians and Inova/Fairfax Hospital with regard to the “employer” analysis, but rather, seems to treat them as one and the same. This suggests the possibility that the court, had it determined that Dr. Cilecek was an “employee” of Emergency Physicians, would also, by virtue of the same analysis, have found him to be an “employee” of Inova’s Fairfax Hospital. However, the Cilecek opinion does not squarely address that issue.

... exists both for employee doctors and for doctors merely enjoying practice privileges at a facility. If the hospitals did not insist on such details in the performance in the professional services by doctors at their facilities, they would be exposing themselves to recognized professional liability.

Cilecek, 115 F.3d at 262.

In a particularly telling comment, the Fourth Circuit went on to suggest that its decision was at least in part policy-driven: “because of the overarching demands of the medical profession, the tension in professional control between doctors and hospitals for medical services rendered at hospitals is not, we believe, a reliable indicator of whether the doctor is an employee or an independent contractor at the hospital.” *Id.*; see also *Wojewski v. Rapid City Reg. Hosp., Inc.*, 450 F.3d 338, 343-44 (8th Cir. 2006) (affirming district court’s grant of summary judgment to hospital as to plaintiff’s Title I ADA disability discrimination claim, stating that the letter-agreement which placed restrictions on physician-plaintiff following diagnosis of bipolar disorder was “akin to the normal tensions discussed in *Cilecek*.”).

The *Cilecek* decision generated a strongly worded dissent. Circuit Judge Murnaghan, departing from the majority’s *shared control* analysis, pointed out a number of factors that he regarded as evidence of *hospital control* of Dr. Cilecek’s provision of professional services: (i) Dr. Cilecek worked under the “direction and supervision” of the Department Director; (ii) comprehensive hospital rules controlled the way in which he practiced; (iii) Dr. Cilecek’s hours were established according to a schedule dictated by the hospital; and (iv) the hospital provided the workplace and equipment. Judge Murnaghan concluded that the jury should have been permitted to decide whether these *indicia* of hospital control were sufficient to establish employment notwithstanding the plaintiff’s acknowledged economic independence. *Cilecek*, 115 F.3d at 264.

The *Cilecek* case, with its majority and dissenting opinions, reveal the complexities of applying the “right to control” test in the context of hospital-physician relationships.³⁹

B. Section 1981 Claims of Race Discrimination

In addition, physicians can bring race discrimination claims under 42 U.S.C. § 1981 (“Section 1981”), not based on “employment” but bottomed on the “contractual relationship” created between the independent staff physician and the hospital through medical staff bylaws.

Section 1981 prohibits discrimination on the basis of race in “mak[ing] and enforc[ing] contracts,” and further defines “make and enforce contracts” to include “the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.” 42 U.S.C. §§ 1981(a), (b).

Several courts have held that Section 1981 claims, unlike Title VII and other typical employment discrimination claims, can be asserted by “independent contractor” physicians against hospitals in relation to adverse privileging decisions. See e.g., *Pamintuan v. Nanticoke Mem’l Hosp.*, 192 F.3d 378 (3d Cir. 1999); *Vakharia v. Swedith Covenant Hosp.*, 190 F.3d 799, 806 (7th Cir. 1999); see also *Vesom v. Atchison Hosp. Ass’n*, 279 F. App’x 624, 635-36 (10th Cir. 2008) (assuming without deciding that the hospital’s by-laws created a contract sufficient to support a Section 1981 claim). In *Vesom*, plaintiff also asserted a claim of race discrimination under Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, which provides that, “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

In *Guinn v. Mt. Carmel Health*, Case No. 2:09-cv-226, 2013 U.S. Dist. LEXIS 123983, at *26-27 (S.D. Ohio Aug. 29, 2013), an Ohio district court denied the hospital’s motion for summary judgment as to plaintiff-physician’s race discrimination claim under 42 U.S.C. § 1981 and Ohio state law on the basis that a contractual relationship was formed between the physician and the hospital through the hospital’s Medical Staff Bylaws. In its decision, the court pointed out the many ways that the hospital controlled the independent physician’s practice of medicine:

[Plaintiff] submits evidence that Defendants continuously monitored the procedures he performed, instructed him on areas of opportunity, controlled the types of medication that he could prescribe to patients, provided the nursing/technical staff, provided all instruments he used, controlled all of the scheduling of Dr. Guinn’s patients’ procedures, issued ‘report cards’ on his performance, instructed him on hospital preferred procedures and devices, created mentoring and proctoring plans to change the manner in which Dr. Guinn completed his work at the hospital, regulated the way he spoke to nursing staff, regulated the way he was allowed to behave in the hospital, owned the medical records of all Dr. Guinn’s patients, and educated Dr. Guinn on times that he should do rounds. *Id.* at *24-25.

“Section 1981 prohibits discrimination on the basis of race in “mak[ing] and enforc[ing] contracts,” and further defines “make and enforce contracts” to include “the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.”

³⁹ The majority and dissenting opinions in *Cilecek* also disagreed on the degree to which the manner that the parties themselves expressed their intent to create an “independent contractor” relationship should factor into the analysis. The majority cited favorably to this factor, while Judge Murnaghan reasoned that “[t]he choice of the term ‘independent contractor’ by *Cilecek* to describe himself, . . . was by no means controlling.” *Id.* at 263-64 (citing *Darden*, 503 U.S. 318); see also *Prothro v. Prime Healthcare Servs.-Remo, LLC*, No. 3:13-CV-108-RJ-WGC, 2013 U.S. Dist. LEXIS 148853, at *19-21 (D. Nev. Oct. 16, 2013) (finding that plaintiff-physician was not an employee under the ADA, reasoning that “Defendant provides evidence that Plaintiff signed Applications for Reappointment to the SMRMC medical staff that explicitly stated that the documents were ‘Not for Use for Employment Purposes’ and that the Applications were not for employment and that acceptance of the Applications did not result in employment by SMRMC.”). In a case decided after *Cilecek*, the

Supreme Court has made clear that in analyzing whether a physician qualified as an employee of a medical practice (as opposed to a partner), “[t]he mere fact that a person has a particular title . . . should not necessarily be used to determine whether he or she is an employee or a proprietor.” *Clackamas Gastroenterology Assoc., P.C. v. Wells*, 538 U.S. 440, 450-51 (2003); see also *Guinn v. Mt. Carmel Health*, Case No. 2:09-cv-226, 2013 U.S. Dist. LEXIS 123983, at *24 (S.D. Ohio Aug. 29, 2013) (“the labels that parties assign to themselves are not dispositive as to whether a legal employee-employer relationship exists”) (citation omitted).

Not all courts agree with this approach. In *Brintley v. St. Mary Mercy Hosp.*, No. 12-2616, 2013 U.S. App. LEXIS 23144, at *6-7 (6th Cir. 2013), the Sixth Circuit rejected the physician-plaintiff's argument that the medical staff bylaws created a contractual relationship between plaintiff and the hospital, citing to plaintiff's failure to cite to a specific provision of the bylaws in support of her position. Nevertheless, the type of "control" analysis applied in *Guinn* to support Section 1981 liability is easily transferable to the employment-based statutes, as will be discussed more fully below. practice privileges at a facility. If the hospitals did not insist on such details in the performance in the professional services by doctors at their facilities, they would be exposing themselves to recognized professional liability.

C. EMTALA: The *Zawislak* & *Muzaffar* Decisions

In two recent cases arising under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), federal district courts have held that independent staff physicians can qualify as "employees" for purposes of EMTALA's anti-retaliation "whistleblower" protection provisions. In 2011, a Texas federal district court held that Dr. Zawislak, an independent staff physician who worked in the emergency department of Hermann Memorial Hospital, was an "employee" of the hospital for purposes of EMTALA. *Zawislak v. Hermann Mem'l Hosp.*, Civ. A. No. H-11-1335, 2011 U.S. Dist. LEXIS 123598 (S.D. Tex. Oct. 26, 2011). On November 27, 2013, a district court in Wisconsin came to the same conclusion with regard to Dr. Kamal Muzaffar, an independent staff physician who had reported alleged EMTALA violations that he observed while fulfilling his "on-call" obligations in the emergency department of the Aurora Lakeland Hospital in Wisconsin. *Muzaffar v. Aurora Health Care Southern Lakes, Inc.*, Civ. A. No. 13-CV-744, 2013 U.S. Dist. LEXIS 168813 (E.D. Wis. Nov. 27, 2013).

Dr. Zawislak alleged that his privileges had been suspended after he made internal reports of inappropriate patient transfers that he observed while on duty in the emergency room. *Zawislak*, 2011 U.S. Dist. LEXIS 123598, at *1-2. Dr. Muzaffar alleged that he was retaliated against for reporting EMTALA violations that he observed while serving as an on-call physician. *Muzaffar*, 2013 U.S. Dist. LEXIS 168813, at *1. EMTALA's "whistleblower" provision states that a hospital may not "penalize or take adverse action against . . . any hospital employee because the employee reports [an EMTALA violation]."⁴⁰ In *Zawislak*, the court, noting that the issue was one of first impression, issued a policy-based decision, as follows:

The legislative purpose of the statute is best served by construing it to prohibit participating hospitals from penalizing physicians with medical privileges. EMTALA was enacted to prevent 'patient dumping,' which is the practice of refusing to treat patients who are unable to pay. A physician with medical privileges in a hospital's emergency room is in an advantageous position to observe whether a hospital is encouraging and instructing physicians to dump

patients. 'In rare cases where application of the literal terms of the statute will produce a result that is demonstrably at odds with the intentions of its drafters, those intentions must be controlling.' Accordingly, the whistleblower provision must be construed to include physicians with medical privileges within the definition of 'hospital employee.'

Zawislak, 2011 U.S. Dist. LEXIS 123598, at *12-13 (citations omitted).

In *Muzaffar*, drawing on Title VII precedent, the defendants argued strenuously that the plaintiff-physician should not be treated as an "employee:"

Aurora submits that Dr. Muzaffar is not an employee. His on-call services are a condition of privileging rather than a condition of employment. . . . Aurora does not compensate Dr. Muzaffar in any way; it does not provide him with employment benefits, does not pay his malpractice premiums, does not provide him with office space, does not bill his patients, does not pay his income or social security taxes, and does not provide him with paid vacation.

Muzaffar, 2012 U.S. Dist. LEXIS 168813, at *4-5 (citations omitted).

The hospital also pointed out that it required its employed physicians to enter into Employment Agreements, and Dr. Muzaffar had no such agreement. Dr. Muzaffar's office was not located at the hospital. He was not required to admit his patients to the hospital, but rather, was "free to associate himself with other hospitals." *Id.* Based on this evidence, the court concluded that, under established Seventh Circuit Title VII precedent, Dr. Muzaffar would have been regarded as an independent contractor, not an employee. *Id.* at *8-9 (citing *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir. 1996)).

The Wisconsin district court, however, declined to apply the Title VII test, noting that Title VII's purpose is to "prohibit workplace discrimination" whereas EMTALA's legislative purpose "is to prevent patient dumping and the whistleblower provision enforces that purpose." *Id.* at *9. The court, instead, adopted the *Zawislak* policy rationale, and ruled that Dr. Muzaffar could qualify as an "employee" for EMTALA purposes. *Id.* at *11. The court was careful to limit the effect of its ruling to EMTALA cases:

Using the plain meaning of employee--one who works for and is paid by another person, business or firm--would result in Dr. Muzaffar not being considered an employee for purposes of the EMTALA whistleblower provision. To repeat, EMTALA was passed in order to avoid the practice of "patient dumping." The federal government cannot be in all emergency hospitals at all times. Enforcement of the statute must therefore depend on those working in hospitals who are in the best position to observe and report EMTALA violations. To find that physicians with staff privileges are not employees for purposes of EMTALA's whistleblower provisions would leave unprotected a group of people in an 'advantageous position' to observe and...

40 42 U.S.C. § 1395dd(f).

... report potential violations. This would be 'demonstrably at odds' with the purpose of the statute as well as the intentions of the drafters, which were to provide protection to those reporting violations.

Id. at *12-13 (citation omitted).

Despite the express attempt to limit its ruling to EMTALA cases, the district courts' willingness to expand the definition of "employee" to meet the policy mandates of EMTALA may presage further expansion of the definition of "employee" in other circumstances, such as the employment discrimination laws.

D. Title VII: The Second Circuit's *Salamon* Decision

In 2008, the Second Circuit Court of Appeals determined that material issues of fact precluded summary judgment for the hospital on the question of whether Dr. Barbara Salamon, an independent gastroenterologist with hospital staff privileges at Our Lady of Victory Hospital ("OLV"), qualified as an employee of the hospital under Title VII and the New York Human Rights Law ("NYHRL"), N.Y. Exec. Law § 290 *et seq.* *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217 (2d Cir. 2008).⁴¹ In reversing the district court's grant of summary judgment, the Second Circuit not only took issue with the application of the multi-factored *Reid* test to Salamon's fact-specific relationship with OLV, it rejected the analysis itself as "logically flawed" because:

The district court assumed that if a certain *Reid* factor holds true **for most doctor-hospital relationships**, that factor is 'irrelevant' to the employment status inquiry. **But the ubiquity of a factor in industry employment relationships does not make that factor 'irrelevant' or 'indeterminate.' On the contrary, it may suggest that putative independent contractors in this industry more closely resemble 'employees' than in other industries.**

Id. at 228 n.11 (emphasis added).

The *Salamon* court's detailed analysis of the relationship between OLV and Salamon is instructive as hospitals grapple with the challenges created by their management of their independent medical staff.

Salamon brought suit against OLV as well as four individual defendants (physicians/administrators of OLV), asserting various claims including claims of sexual harassment and a discriminatory/retaliatory peer review process that ultimately resulted in a "reeducation" and mentoring requirement. Salamon alleged that Dr. Michael Moore, Chief of the GI division, made sexual advances toward her. After she rejected his advances, Salamon contends that she was subject to increased administrative scrutiny regarding her medical practice. In August 1996, Salamon met with the President and CEO of OLV and OLV's Chief of Staff and complained about her treatment. Less than a week after that meeting, the President and CEO of OLV and OLV's Chief of Staff along with three others met and decided to examine Salamon's practice, including

during periods that already previously had been reviewed by OLV. *Id.* at 223-24. According to the Second Circuit, Salamon's work was subjected to several additional levels of review, some of which found that her patient treatment was satisfactory. Significantly, this level of scrutiny, according to the Second Circuit, "contravened [OLV's] usual protocols." *Id.* at 224. According to Salamon, around that time, she stopped receiving patient referrals from other physicians at OLV.

In applying the *Reid* test, the *Salamon* court focused on the manner and means by which Salamon performed her duties, finding that the "significant contested facts" in the record made summary judgment inappropriate. *Id.* at 228. Rejecting the district court's emphasis on Salamon's professional judgment as a physician as "[i]n effect . . . carv[ing] out all physicians, as a category from the protections of the antidiscrimination statutes," the Second Circuit instead focused on the level of control exercised by OLV. *Id.* at 228-29 ("There is nothing intrinsic to the exercise of discretion and professional judgment that prevents a person from being an employee, although it may complicate the analysis. The issue is the balance between the employee's judgment and the employer's control"). The Second Circuit found that taking Salamon's allegations as true, OLV "exercised substantial control . . . over the details and methods of her work by":

- application of its quality assurance standards, which went beyond 'measure[ing] the quality of her patient treatment outcomes,' to include: (a) mandating the performance of certain procedures; (b) mandating the timing of other procedures; and (c) impacting choices of medication to prescribe, 'not in the interest of medical judgment, but to maximize hospital profit.'
- OLV's quality assurance review program, which resulted in recommendation of a 'detailed reeducation program,' which was 'designed expressly to change the methods by which she arrived at diagnoses and treatment,' including: '(a) indications and treatment for EGDs [esophagogastroduodenoscopies]; (b) appropriate treatment for AV [arteriovenous] malformations and removal of polyps found on colonoscopy; (c) use of ph monitoring with esophageal manometry[;] and (d) length of colonoscopy procedures and level of sedation during colonoscopy.'

"In applying the Reid test, the Salamon court focused on the manner and means by which Salamon performed her duties, finding that the "significant contested facts" in the record made summary judgment inappropriate."

⁴¹ The three-judge panel included now-Justice Sotomayor, who joined in the unanimous decision written by District Court Judge Nancy Gertner of the United States District Court for the District of Massachusetts, who was sitting by designation.

- exercising control on a 'continuous' rather than an 'intermittent' basis and by not limiting the control exercised solely to negative medical outcomes, but for 'variations from the recommended procedures.'

Id. at 229-31.

Significantly, the Second Circuit rejected the argument made by OLV that the detailed re-education and other quality assurance standards merely, "reflect[ed] professional and governmental regulatory standards," finding that the statutes cited by OLV "do not dictate the detailed treatment requirements OLV instituted." *Id.* at 230 (citing *Cilecek*, 115 F.3d at 262). Rather, the Second Circuit found that the types of requirements set forth above are "exactly the kind of 'manner and means' of practice over which employers exert control."⁴² *Id.*

The Second Circuit made mention of the decisions of the other circuits in *Shah*, *Cilecek*, *Alexander*, and *Diggs* among others, which affirmed the grant of summary judgment involving discrimination claims brought by independent staff physicians, and sought to distinguish them on their facts. *Id.* at 231. The *Salamon* court reasoned that taking Salamon's allegations as true, "a reasonable fact-finder could conclude that OLV's quality assurance program exceeded the control exerted in [*Shah*, *Cilecek*, *Alexander*, and *Diggs*], particularly as evidenced by what occurred after the alleged instances of harassment. *Id.* Ultimately, the Second Circuit concluded that it was a material issue of fact as to whether the requirements that OLV placed on Salamon "merely reflected professional standards" or "demonstrate a greater degree of control sufficient to establish an employer-employee relationship." *Id.* at 231.

Following the Second Circuit's reversal, defendants again moved for summary judgment before the district court. The district court denied summary judgment and allowed the case to proceed to trial. *Salamon v. Our Lady of Victory Hosp.*, No. 99-CV-048S, 2012 U.S. Dist. LEXIS 47176 (W.D.N.Y. Apr. 3, 2012). Citing heavily to the Second Circuit's reasoning, the district court found that material issues of fact as to whether Salamon was an employee under Title VII precluded summary judgment. In addition to the facts cited by the Second Circuit, the district court relied upon the following in holding that issues of fact remained for trial:

- As to the issue of control over the manner and means of performance of her duties, the district court cited to Salamon's affidavit which stated that she was "repeatedly instructed to discharge [her] patients before their treatment could be completed and to perform endoscopic procedures on an outpatient basis to economically benefit the Hospital." 2012 U.S. Dist. LEXIS 47176, at *20.
- As to the fact that Salamon had privileges to practice medicine at other hospitals, the district court cited to the fact that Salamon was not permitted to refuse patients referred to her directly from OLV, was required to treat

patients admitted to OLV and was required to treat many of her patients at OLV. 2012 U.S. Dist. LEXIS 47176, at *23-24.

- As to the discretion over work hours, the district court found a dispute as to whether Salamon could provide her own schedule, citing to the limited hours she could use the endoscopy equipment, the ability of OLV to unilaterally modify her schedule, and the need to have OLV staff available in order to monitor her work. 2012 U.S. Dist. LEXIS 47176, at *28-29.
- As to the hiring and paying of assistants, the district court found that OLV maintained control over the staff at the hospital. It also characterized Salamon's case as "unique" because "the Hospital directed the GI lab nurses to supervise Plaintiff's work and report to the OLV administration any perceived deviations from standard practice and policy as part of the QA program that Plaintiff was subject to." 2012 U.S. Dist. LEXIS 47176, at *31-32.

After reversal by the Second Circuit and denial of summary judgment by the district court, defendants sought reconsideration of the district court's denial of summary judgment. *Salamon v. Our Lady of Victory Hosp.*, 867 F. Supp. 2d 344 (W.D.N.Y. 2012). In denying reconsideration, the district court provided further insight into its reasons for denying summary judgment. Specifically, the court discussed the issue of pretext and noted that following Salamon's formal complaint to the OLV administration, the alleged harasser Moore "continued to participate to some extent and discussed Plaintiff's case with the physician appointed to review her practice." *Id.* at 361.

The *Salamon* decision already has expanded the scope of hospital liability in the Second Circuit, at least. See *Kunajukr v. Lawrence & Mem'l Hosp., Inc.*, 2009 U.S. Dist. LEXIS 129545, at *82 (D. Conn. Jan. 12, 2009) (assuming, without deciding, that Dr. Kunajukr was an "employee" for purposes of Title VII liability arising out of the loss of his medical staff membership at the defendant hospital). However, to date, no other jurisdictions have followed its lead. See, e.g., *Brintley*, 904 F. Supp. 2d at 716 (courts have "uniformly rejected" the argument that a hospital's "right to control" a physician's work "establishes an employer-employee relationship with the hospital").



⁴² While the Second Circuit "express[ed] no opinion" as to the extent that motive is relevant in the "manner and means" analysis, it went on to state that Salamon had adduced evidence that some of the practices required by the hospital "were not motivated by concern over compliance with external statutes, but aimed at maximizing OLV's revenue and punishing her for complaining about Moore's alleged harassment." *Id.*

E. Legal Implications

Given the ACA-based quality reforms and increasing government scrutiny and accountability for quality of care, it is likely that hospitals will continue to exert more, not less, control over physician decision-making and treatment methods, all of which seems likely to increase the risk of Salomon-like exposure under federal and state discrimination laws. If other federal circuits opt to follow the Second Circuit's lead in analyzing the increase in clinical protocols, metrics-based accountability, and the systems-based care model that increasingly dictate physician conduct in the hospital environment as a basis for imposing liability under federal and state discrimination laws, then hospitals may be facing potentially expansive legal exposure for negative privileging actions taken against independent staff practitioners. Not only could the Salomon decision and its ilk substantially increase the volume and range of potential legal actions that may be filed against hospitals from physicians on their medical staffs, but it also could substantially reduce efficacy of the federal immunity protection that was established by the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, (HCQIA) specifically to encourage hospitals to take action against incompetent and unprofessional physicians.

Hospitals typically grant privileges to many more physicians than they employ in the traditional sense (if indeed they employ any physicians at all). Thus, the increase in volume of cases alone could represent a significant cost to the hospital industry, regardless of whether those cases have legal merit or not.

A significant concern for hospitals is the potential loss of HCQIA immunity. HCQIA was enacted in 1986 to address a national need for more proactive peer review and greater transparency that would "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physicians' previous damaging or incompetent performance."⁴³ HCQIA provides "incentive and protection for physicians engaging in effective professional peer review," by providing immunity from damages actions, (including treble damages under the federal antitrust laws), provided that certain statutory standards are met.⁴⁴ The immunity from damages is an extremely valuable protection. When physicians lose their hospital privileges, they often allege not only federal antitrust violations, but claims for defamation, breach of contract, tortious interference with present and future contractual relations, and seek damages for injury to their incomes and professional reputations in the millions of dollars. Moreover, HCQIA protects not only hospitals, but also their physician leaders from potentially astronomical legal exposures.

Poliner v. Texas Health Systems is a case in point. Dr. Poliner was a cardiologist whose clinical privileges to perform cardiac catheterizations were restricted for a period of about six months while a series of serious patient incidents were investigated. After his privileges were restored, he filed suit against the hospital and several of its physician leaders. The antitrust causes of action were

dismissed from the case, but the jury awarded the plaintiff \$366 million in compensatory and punitive damages for defamation, breach of contract, business disparagement, interference with contractual relations, and intentional infliction of emotional distress. The jury verdict was remitted to \$33 million by the trial court, and then overturned on appeal based on the HCQIA immunity protections.⁴⁵ If not for HCQIA, Texas Health Systems would have sustained crushing financial harm from this one case.

There are standards that hospitals must follow in order to qualify for HCQIA immunity. The challenged privileging actions must have been taken: (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts and after meeting the requirements of paragraph (3).⁴⁶ In order to ensure compliance with these standards, hospitals have extensive internal processes for investigating and evaluating quality concerns before any recommendation for adverse action is made, and then provide extensive "due process" hearings and appeals to adversely impacted physicians, before a matter gets to the hospital's governing board for final decision. Such internal processes can take months, or even years, to complete, but once completed, provide the foundation for crucial HCQIA protections.⁴⁷

The HCQIA jurisprudence that has developed over the past two decades is protective of hospitals and physicians sued for adverse privileging actions. HCQIA includes a statutory presumption that hospital privileging action was taken in compliance with the four prongs of the HCQIA test.⁴⁸ It is therefore the plaintiff's burden to overcome that presumption by a preponderance of the evidence.⁴⁹ Physician plaintiffs cannot overcome this presumption through evidence of subjective intent – i.e., that the hospital's administrative or medical leadership was biased or prejudiced. Rather, under HCQIA case law, physicians are required to prove that the action taken was *objectively unreasonable*.⁵⁰ The inquiry...

"Hospitals typically grant privileges to many more physicians than they employ in the traditional sense (if indeed they employ any physicians at all). Thus, the increase in volume of cases alone could represent a significant cost to the hospital industry, regardless of whether those cases have legal merit or not."

43 U.S.C. § 11101(2) (Findings).

44 U.S.C. §§ 11101(4) and (5), 11111, and 11112.

45 *Poliner v. Texas Health Systems*, 537 F.3d 368 (5th Cir. 2008).

46 U.S.C. § 11112(a).

47 See, e.g., *Freilich v. Upper Chesapeake Health Sys., Inc.*, 423 Md. 690 (Md. App. 2011) (noting that hospital had begun investigating Dr. Freilich in 1998, and ultimately, on April 11, 2000, after extensive internal hospital proceedings, decided by final vote of the board of directors not to reappoint her to the medical staff).

48 U.S.C. § 11112(a).

49 *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1333 (11th Cir. 1994).

50 *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996) (collecting cases). The Third Circuit noted that the legislative history supports use of the objectively reasonable standard as a way of promoting resolution of HCQIA privileging cases on summary judgment: "Imposition of an objective standard allows a court to make a determination that the defendant has or has not met the standards specified in section [11112(a)] . . . even though other issues in the case remain to be resolved." H.R. Rep. No. 903, 99th Cong., 2d Sess. 2 (1986), reprinted in 1986 U.S.C.C.A.N. at 6394." *Id.*

V. Measures for Hospitals to Mitigate Legal Risks

Hospitals faced with the prospect of increased exposure under federal and state discrimination laws for independent staff physicians could react in one of two ways: (A) not move forward with reforms designed to achieve quality metrics-driven, systems-based approaches to care so as to reduce the possibility that their staff physicians will be judicially determined to be “employees” for Title VII (or other employment discrimination) purposes, or (B) move forward with the systems-based approaches to care while taking proactive measures to reduce the potential risk exposure under employment discrimination laws. Although the first option likely appeals to the more litigation-savvy in-house counsel, the changing business and external legal imperatives may well dictate that hospitals follow the second path, prudently, but proactively.

A. Reigning in Systems-based Reforms to Curb Litigation Exposures

In response to the new risk exposures under federal and state discrimination laws, some hospitals may opt to reign in the high degree of control that could lead the courts to treat independent medical staff members as “employees.” Drawing on the *Salamon* analysis, some specific measures that could help reduce risk include:

- Reducing or eliminating the use of mandatory clinical protocols;
- Making clinical protocols less prescriptive (i.e., allowing more latitude in individual physician decision-making);
- Confining peer review activities to retrospective analysis, as opposed to proctoring, monitoring, re-education, skills training, or other forms of dynamic or concurrent intervention;
- Eliminating mandatory minimum patient encounter criteria designed to ensure a sufficient volume of clinical activity to adequately review and evaluate practitioner competence;
- Eliminating mandatory on-call service requirements; and
- Eliminating mandatory consultation requirements for medical staff members.

However, for a variety of reasons, such measures are for the most part unrealistic or unachievable. For instance:

- On-call requirements are subject to federal EMTALA mandates and operational pressures that preclude most hospitals from making on-call services completely voluntary;
- Consultation requirements are likewise driven by the need for comprehensive specialist coverage in order to ensure that patients’ medical needs will be met; and
- Requirements for proactive peer review, such as through Focused Professional Practice Evaluation, are mandated by current Joint Commission accreditation standards, and TJC-accredited hospitals therefore could not, even if they desired, eliminate those methods of peer review.

Moreover, activities such as on-call and consultation requirements,

Reducing Potential Risk with Systems Based Approach

- **Reigning in Systems-based Reforms to Curb Litigation Exposures**
- **Minimizing Risks of Systems-based Reforms**
 1. **Adopting and enforcing standards of conduct**
 2. **Consistent application of medical staff bylaws**
 3. **Cultivating a culture of compliance**
 4. **Proactively addressing and resolving concerns**
 5. **Attention to medical staff comparators**

and proactive peer review, have existed for many years and did not, at least prior to *Salamon*, provide the basis for a finding that independent staff physicians are “employees.”

What the *Salamon* decision reflects is the “modern” extensive use of metrics-driven clinical protocols that dictate in specific detail the manner in which physician services are rendered. Hospitals generally have more latitude to choose whether or and to what extent to implement clinical protocols, than they do, for instance, in deciding whether to require on-call coverage or proactive peer review. However, the industry pressures moving hospitals towards systems-based care may be hard to resist. As the new reimbursement environment increasingly rewards and drives quality and efficiency, hospitals are under enormous external pressure to “control” the manner and means of service delivery through protocol-driven care. Thus, for many hospitals, clinical protocols already have become integrated into the system of care.

B. Minimizing Risks of Systems-based Reforms

Although reducing mandates on physicians is one way of avoiding the possibility that privileged physicians might qualify as employees under employment discrimination laws, given the changing health care landscape, hospitals also should anticipate the possibility of *Salamon*-type exposure, and position their organizations to defend against lawsuits brought by independent medical staff members claiming the protections of employment discrimination laws.

1. Adopting and enforcing standards of conduct

To the extent they have not already done so, it would be wise for hospitals to implement robust anti-discrimination, anti-harassment and anti-retaliation standards of conduct that apply to the independent medical staff as well as to the hospital’s employees. Regulatory and accreditation mandates dictate that, when it comes to the independent medical staff, the enforcement of such codes of conduct must be handled, in its initial stages, through the medical leadership framework, as opposed to hospital management. Hospitals nevertheless should, to the extent possible, strive for consistency in the policies and procedures applied to the independent medical staff and to the hospitals’ employees. Hospitals also should create several mechanisms for...employees, contractors and privileged physicians to voice complaints of discrimination, harassment and/or ...

...retaliation of any kind. In addition to addressing (and mitigating against) the risk of employment discrimination lawsuits by independent staff physicians, the creation and implementation of standards of conduct for the independent medical staff community also would mitigate against the risk of potential discrimination, harassment and/or retaliation claims by hospital employees related to the conduct of independent staff physicians. Interestingly, in *Salamon*, the physician who allegedly harassed and retaliated against Salamon was himself an independent staff physician rather than an employee of OLV. Despite this fact, the district court allowed the case against OLV to proceed because there was a disputed issue of fact as to whether OLV “accepted or condoned Moore’s alleged conduct.” *Salamon*, 867 F. Supp. 2d at 365.

2. Consistent application of medical staff bylaws

One undercurrent from the Second Circuit’s decision in *Salamon* was its discomfort with the hospital’s failure to follow its own internal processes, including peer review of Salamon’s patient care that already previously had been reviewed, as well as the initiation of examination of Salamon’s practice on the heels of her complaint of sexual harassment. Sometimes courts are results-oriented when they perceive deviations from clearly defined protocols. Following well-established processes from the medical staff bylaws will do much to undercut arguments from physicians that they were discriminated against based on a protected characteristic, rather than due to their clinical competence.

3. Cultivating a culture of compliance

Hospitals should consider requiring all of the medical leadership (President/Vice President of the Medical Staff, MEC, Department Chairs, Division Chiefs, Key Committee Chairs) to undergo compliance training, including training in employment discrimination, harassment and retaliation as a condition of service in their leadership positions.

They also should consider requiring the medical leadership to mandate compliance training for all staff physicians – *i.e.*, prohibitions against discrimination, harassment and retaliation. Attendance at such trainings could be made a condition of continued staff membership/privileges. Other sanctions, such as medical staff fines, automatic suspension and/or other consequences also could be considered as a means of promoting full participation in such compliance training.

For all contracted groups, the hospital could, through its services contract, make the Group accountable for maintaining full compliance among the physicians in the Groups. One means of implementing this requirement, while simultaneously not exercising direct “control” over independent staff physicians, is to require that all training be conducted by a third-party vendor and that certification be provided by the vendor to the hospital.

4. Proactively addressing and resolving concerns

If an allegation of discrimination/harassment/retaliation is made, the hospital should be prepared to work with the medical leadership and through the medical staff bylaws and policies that have been put into place to have the alleged bad actor removed

from any role related to any adverse or materially adverse action against the complainant. For example, as it relates to peer review, an alleged perpetrator should have no communications with reviewers related to complainant’s performance. If the alleged perpetrator serves in a medical leadership position, such as department chair, there should be mechanism in place through the bylaws or policies to have that perpetrator removed from service and/or not permitted to be involved in any decisionmaking process related to the individual who made the complaint.

5. Attention to medical staff concerns

Failure to treat similarly situated individuals in a similar manner can create an inference of discrimination or retaliation. If there is a belief that an individual should be treated differently than others in the past, the creation of contemporaneous documentation articulating the reasons why the situation merits differential treatment (whether more or less severe) is essential. Hospitals should be cognizant that in making decisions related to independent medical staff, they are constantly creating comparators.

Quality Metrics, Contractors and the “Right to Control”: *Extending “Employee” Rights to the Independent Medical Staff*

The era of the fully “independent medical staff” has passed. As hospitals increasingly seek to control all aspects of the care delivery system within their walls, including the physician component, this increased control will bring with it increased employment discrimination liability exposure. Hospitals need to anticipate and mitigate the potential risks arising under the employment discrimination laws which previously have not applied to independent staff practitioners.

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