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Physician Staffing Issues and Employment-Related Lawsuits: A Litigation Epidemic in the Making?

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There is no doubt that the direct employment of physicians by hospitals and healthcare institutions has increased at an astonishing rate over the past two years. Both the recessionary economy and declining reimbursements have prompted many physicians to seek closer relations with hospitals, and have motivated hospitals to search for ways to maximize their patient care options. However, like any new relationship, this one should not be entered into lightly, without a careful look at the ramifications of adding highly compensated individuals to a group entitled to the many rights and privileges allocated to “employees” under federal and state laws.

The historical relationship between hospitals and physicians typically has been ruled by contract law, and viewed as an independent contractor arrangement in which doctors are in control of their own work and outcomes, within certain parameters established by law and by mutual agreement between doctors and hospitals. More recently, and for the reasons mentioned above, it has become mutually beneficial for physicians to enter into actual employment arrangements with hospitals or healthcare systems, where more of the manner and means of the physician’s work is under the direct control of the employer-healthcare entity.

As this new model has developed, it is becoming clear that most healthcare institutions operate under two mistaken assumptions: first, that “staff” physicians – those with staff privileges to use certain hospital resources and facilities – are independent contractors and cannot sue under existing employment laws; and second, that “employed” physicians will change the landscape of hospital administration only for the better.

However, over the past few years, there has been an obvious shift in the ways in which courts have addressed employment-related claims brought by medical staff members. With increasing frequency, peer review and medical credentialing information previously viewed as confidential or otherwise protected is subject to production during litigation in which staff physicians are deemed to be “employed” for purposes of certain federal laws. Further, there has been an obvious increase in the number of employment-related lawsuits involving healthcare institutions, including discrimination

claims, wrongful discharge lawsuits, and allegations involving the violation of state laws, which increasingly larger amounts of monetary damages being awarded. Let's take a look at the truth behind these two assumptions, and find the important lessons in each of them.

STAFF PHYSICIANS CAN BE VIEWED AS EMPLOYEES BY THE COURTS.

The traditional image of doctors in this country centers around an engagement between an independent medical professional and a patient. Part of the rationale for that "staff physician" model is the assumption that unless a physician is actually an "employee," he or she is ineligible to exercise the rights allocated to employees under the federal and state employment laws. This is not always the case. In fact, there is one important circumstance under which a staff physician could be viewed by the courts as an "employee" for purposes of both federal and state-based employment statutes. It is when the hospital's own peer review process creates the "control" necessary to create an employment relationship, allowing the staff physician to bring a claim of discrimination under an employment-related statute. Hospitals that decide to stay with the traditional staff physician model, rather than join the herd toward the employed physician trend, should fully understand this concept.

Hospital's Peer Review Process May Create Unintended Employment Relationship

The provisions of basic federal anti-discrimination law[i] apply only to employees. The determination of whether an individual is an "employee" for purposes of that law depends largely on whether a putative employer exercises control over the manner and means by which the individual performs a job. While a number of courts specifically have held that hospital peer review procedures do not constitute such control, at least one federal appeals court determined that a hospital's "quality assurance program" that led a physician into its peer review process may actually have created an employment relationship. This determination allowed the physician to move forward with sexual harassment and gender discrimination claims under Title VII.[ii]

In that case, Dr. Barbara Salamon, a staff physician at a New York State hospital, sued the hospital and four other physicians, claiming that she had been discriminated against on the basis of her gender. Salamon alleged that after complaining about sexual harassment by a male physician, she received undeservedly negative performance reviews, and that the hospital's peer review process to punish her for reporting the harassment.

The hospital viewed Salamon as an independent contractor/staff physician, because she billed her patients directly, and therefore was not compensated by the hospital. However, Salamon was required to submit to the hospital's "Staff Rules and Regulations," including a "quality assurance" process under which physicians' medical procedures were reviewed at the hospital. Doctors whose

cases were flagged as “problematic” would be subject to a peer review and, if appropriate, reported to the National Practitioners Data Bank (NPDB). After complaining of sexual harassment, Salamon experienced a significant increase in the number of her cases that were subject to review, and was ordered to undergo a three-month “re-education” and mentoring program. She then was warned that her failure to complete the program would lead to a report to the NPDB.

Salamon filed claims in federal court, including employment discrimination claims under Title VII and related state laws. The district court dismissed those claims on the basis that Salamon’s relationship with the hospital did not meet the common law criteria for an employer/employee relationship. On appeal, the 2d U.S. Circuit Court of Appeals specifically found that the hospital exercised “substantial control” over the treatment outcomes of Dr. Salamon’s practice and over the details and methods of her work, making her an “employee” for purposes of Title VII. While hospital policies that merely reflect professional and governmental regulatory standards may not create the level of control that establishes an employment relationship for purposes of Title VII, there was evidence that the policies imposed upon Dr. Salamon may have been motivated by the hospital’s goal of maximizing revenue, and/or in reaction to Salamon’s complaints of harassment. Because a reasonable fact finder could conclude that the hospital’s quality assurance standards extended beyond health and safety concerns and/or beyond Salamon’s specific medical qualifications, and because Salamon was subject to possible negative peer review for violation of those standards, Salamon was able to demonstrate a genuine factual conflict regarding the extent of control exercised by the hospital over her performance. On that basis, a federal appeals court allowed Salamon’s employment-based claims to go forward to a jury.

Hospitals should be aware of this decision, and should recognize that the degree of control exercised over individuals, if not established for reasons related to the quality of health care, may re-categorize a staff physician into an employee, creating potential exposure to Title VII liability. Therefore, hospitals that decide to stay with the traditional staff physician model on the basis that such a relationship will avoid employment-based litigation should assure that their peer review processes and procedures are carefully reviewed to avoid the result that occurred in the *Salamon* case.

JURY VERDICTS IN EMPLOYED-PHYSICIAN CASES ARE OFTEN SUBSTANTIAL

Healthcare entities who espouse the “employed physician” model, assuming that the control over the manner and means of a physician’s work and productivity is a cost benefit to the hospital should be sure to take into account the possibility of increased litigation when doing a risk analysis of that model.

It is generally understood that employees can bring claims for hostile environment, wrongful termination, or even “constructive discharge” – where an employee claims that an employer made working conditions so intolerable that a reasonable employee would feel compelled to resign. What is

less clearly understood is the extent of the economic damages for which a hospital or health care system may be liable in an employment-related lawsuit. Because a successful litigant in an employment case often is entitled to compensatory damages, lost wages and, in some instances, front pay, a lawsuit by a physician-employee can create the potential for large monetary damage awards.

One example of this is a 2008 unpublished decision by the 3d U.S. Circuit Court of Appeals, upholding judgment in favor of the Chief of Surgery at a Veterans Affairs Health Care System hospital.[iii] In that case, an employed physician claimed to have been wrongfully discharged on the basis of his age. After a bench trial in that case, a judge found that the physician was "the victim of age discrimination and retaliation," and awarded lost pay in the amount of $1,020,031.25, an amount equivalent to the physician's salary until the time of his planned retirement.

A more recent example is a case in which a Texas jury awarded more than $3.6 Million to an Egyptian-born employed physician who claimed that he was forced to resign after race-based comments from another employed physician.[iv] Naiel Nassar, a U.S. citizen since 1990, was born in Egypt and attended medical school there. He did a medical residency and a fellowship in infectious diseases at the University of California, Davis and, in 2001, was hired by the University of Texas Southwestern Medical Center (UTSW) as an Assistant Professor of infectious disease medicine. Part of Nassar's duties required that he provide patient care at the Amelia Court clinic, an outpatient HIV/AIDS clinic affiliated with UTSW.

In 2004, UTSW hired Dr. Beth Levine as the chief of its infectious disease program. In that role, Levine directed that Nassar begin billing for the services he provided to the HIV clinic. Nassar objected to the directive, arguing that his salary for clinical services was fully funded by a federal grant, and stating that billing the patients therefore would be "double dipping." Nassar claimed that Levine also began to "harass" him, making derogatory statement about his race and his Muslim religion, including one comment that "middle easterners were lazy." His allegations were supported by a clinical supervisor, whose affidavit described a "disconnect between Dr. Levine's statements and the reality of Dr. Nassar's work." In 2006, based on his concerns about Levine, Nassar ultimately applied for employment at Parkland Health & Hospital System. Parkland made preparations to hire Nassar, even drafting an offer letter, but never formally hired Nassar. Nassar contended that UTSW retaliated against him by raising the possibility of a violation of an affiliation agreement between UTSW and Parkland, which effectively blocked the offer from Parkland. Nassar ultimately filed an lawsuit in federal court alleging employment discrimination and retaliation. Levine strongly disputed Nassar's allegations, as did UTSW.

At trial, the jury was presented with only two questions: (1) Whether Nassar was constructively discharged from employment because of his race, national origin, or religious preference; and (2) Whether UTSW retaliated against Nassar by blocking or objecting to his employment by Parkland after Nassar complained about his treatment at UTSW. After just one hour of deliberation, the jury answered "Yes" to both questions. Two days after the May 24, 2010 verdict, the jury awarded $3.2

Million in compensatory damages and $438,000 in lost back pay to Nassar. The court will determine whether Nassar's claim for lost front pay – which could range from $200,000 to $4 Million – should be paid as part of the award. In addition, Nassar has made a claim for attorney fees, which also will be heard by the court. UTSW has already stated that it will be appealing the verdict and the resulting judgment.

Hospital and healthcare entities that are contemplating direct hiring of physicians should take the time to read the jury instructions and verdict sheet on which the decision in the jury's decision was based. (Find a copy at www.employmentlawmatters.net.) Most notable is the court's instruction in which it defines "constructive discharge" as a resignation from working conditions "so intolerable that a reasonable employee would feel compelled to resign." The court goes on to point out that, in order to prove constructive discharge, Nassar "need not show that his race, national origin, or religions preference was the sole or even the primary motivation for [UTSW's] conduct." He simply had to prove that his protected characteristics "played a motivating part in [UTSW's] conduct, even though other factors may also have motivated [UTSW].

Prior to deciding that the employed physician model is a cost benefit, as well as a patient benefit, the potential employer should recognize the importance of litigation avoidance and should ensure that supervisors and managers are trained to recognize and remedy discriminatory conduct, to make sure that such conduct does not become viewed as an element of any adverse employment action taken by the employer.

PRODUCTION OF PEER REVIEW DOCUMENTS IN EMPLOYMENT CASES

In addition to the issue of over-sized damage awards in employment cases, hospitals and health systems also should be concerned about a possible unanticipated use of peer review information as evidence in a discrimination case. Allegations of employment discrimination based upon a protected characteristic - most oftenage, race, gender, religion, and disability – typically are raised under federal civil rights statutes or under parallel state laws.

Such claims may be based upon direct evidence, such as the utterance of racial slurs or sexually inappropriate language. Most cases of discrimination, however, rest upon indirect evidence, in which inferences of illegal actions must be drawn from witness testimony and related documents.

The Supreme Court specifically has noted that in a claim of discrimination, a plaintiff must be given a full and fair opportunity to demonstrate by "competent evidence" that the reason given for the adverse action against him was simply a cover-up for an unlawful/discriminatory decision.[v] With increasing frequency, courts have held that the need for such probative evidence in discrimination

cases outweighs a hospital/employer's asserted interest in promoting candor in medical peer review proceedings.[vi]

Effect of the Federal Rules on Production of Peer Review Information

When a discrimination case is brought in federal court, as most are, the Federal Rules of Civil Procedure govern the actions. While most states have enacted statutory privileges restricting the release of peer review information, those state-law privileges generally do not apply in federal court when a case is based upon a federal anti-discrimination statute.[vii] Instead, the courts rely on the wording of Federal Rule of Civil Procedure 26(b)(1) which includes the broad statement that: "Parties may obtain discovery regarding any non-privileged matter that is relevant to any party's claim or defense. . . ." Therefore, courts typically will order the production of peer review records if there is "any possibility" that the documents sought may lead to information that is relevant to any claim or defense in a federal discrimination case.

Using a variety of approaches, federal courts have allowed increasing access to information which hospital and other healthcare provider entities historically have asserted as subject to peer review privilege. Consider these examples:

- In a race discrimination case ultimately decided in 2006, the Fourth Circuit resolved an earlier discovery dispute by ordering a hospital to provide "documents pertaining to competency reviews of [similarly situated doctors] from 1982 through 1997" in response to a broad request from the plaintiff-doctor for all peer review decisions made by the hospital over a 20 year period;[viii]

- One federal district court ordered production of e-mails and computerized memoranda created or maintained by the hospital and "relating to the plaintiff's credentialing as a member of the medical staff," while allowing the hospital to redact certain identifying information;[ix]

- A federal district court in Connecticut found that a composite document summarizing performance review outcomes over the relevant period was not an adequate substitute for the actual peer review material sought by a physician claiming race and nationality discrimination, and ordered production of all such documents, subject to a protective order.[x]

In these cases - and others - courts have found an increasing number of ways to circumvent the application of the state law based privileges typically applied to peer review and credentialing information, including production from a restricted time frame, production with some redactions, and production subject to a protective order. The number of employment-related claims in which peer review and/or credentialing information is the subject of discovery requests and motions to compel continues to rise, and the willingness of courts to make decisions without full consideration of the health law ramifications of the production of such information continues to expand.

CONCLUSION:

The number of employed physicians is increasing, and with it, there has been a corresponding increase in federal employment discrimination cases against healthcare entities. The issues of which knowledgeable healthcare entities should be aware are: (1) situations in which a contract or staff physician might be deemed to be an employee, based upon the hospital's control of the manner and means of employment; (2) all variables necessary to do an effective evaluation of the risk of employment litigation, including the types and amounts of damages that can be awarded in employment cases; and (3) the possibility of the use and/or exposure of peer review information as evidence in an employment lawsuit. Attorneys for both healthcare institutions and healthcare providers should recognize the legal basis for discrimination cases, and become familiar with the rationales used by the courts to accept medical credentialing processes, hospital bylaws, and independent contracts as the basis for such claims, as well as the increasingly accepted employed physician model.

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[i] Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C.S. §§2000e et seq.

[ii] *Salamon v. Our Lady of Victory Hospital, et al.,* 514 F.3d 217 (2d Cir. 2008).

[iii] *Stemple v. Nicholson*, No. 06-3807 (3d. Cir. Aug. 27, 2008).

[iv] *Nassar v. Univ. of Texas Southwestern Medical Center at Dallas, N.D. Tex., No. 08-1337, jury verdict, 5/26/10.*

[v] *McDonnell Douglas v. Green*, 411 U.S. 792 (1973).

[vi] *See, e.g., Mattice v. Memorial Hosp. of S. Bend*, 201 F.R.D. 381(N.D. Ind. 2001)(peer review materials would aid physician in proving he was qualified for position of anesthesiologist, and would support discrimination claim); *Somino v. Univ. of Kansas Hospital Authority*, 220 F.R.D. 633 (D. Kan., 2004)(peer review privilege not a bar to disclosure of documents in female physicians disparate treatment claims); *Virmani v. Novant Health Corporation*, 259 F.3d 284 (4th Cir. 2006)(OB/GYN claiming race and national origin discrimination entitled to peer review records related to "competency reviews of OB-GYNs from 1982 through 1997").

[vii] Federal, rather than state, privilege law applies to a federal action in federal court. *Fed. Rule Civil Pro. 501*. Every federal court to consider the issue has declined to recognize a federal peer review privilege. *See, e.g., Ray v. Pinnacle Health Hospitals, Inc., et al.*, No. 1:07-CV-0715 (M.D. Pa. May 22, 2008).

[viii] *Virmani v. Novant Health Incorporated, et al.*, 259 F.3d 284 (4th Cir. 2001).

[ix] *Kunajahr, et al. v. Lawrence & Memorial Hospital, Inc., et al.*, No. 3:05CV01813 (D. Conn. Feb. 14, 2008).

[x] *Ray v. Pinnacle Health Hospitals, Inc.*, cited above.

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