A Publication of the American Health Lawyers Association
Labor & Employment Practice Group

Volume 7 • Issue 2 • May 2008

LABOR & Employment

Physician as Employee or Independent Contractor: Has the Second Circuit Changed the Diagnosis?

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Introduction

For years, hospitals have operated under the assumption that the physicians with staff privileges at their facilities were independent contractors and not employees. As professionals, they had to be, right? Wrong, according to the recent Second Circuit decision, *Salamon v. Our Lady of Victory Hospital*.[1] *Salamon* reveals the limits, and the consequences, of relying on what may be an outdated assumption.

Whether a physician is an employee or an independent contractor is a distinction with real consequences because the protection provided by almost all federal labor and employment laws extends only to "employees."[2] Conversely, independent contractors are excluded from coverage.[3] This begs the question: When is one an employee, and when is one an independent contractor? In *Salamon*, the court addressed this issue and held that a question of fact existed as to whether the physician-plaintiff was an employee or an independent contractor because of the extent to which the hospital's quality assurance program controlled how the physician-plaintiff carried out her professional duties at the hospital.

Employee vs. Independent Contractor in Federal Anti-Discrimination Statutes

The actual text of federal labor and employment statutes offer little, if any, guidance in defining "employee,"[4] forcing federal courts to struggle with a useful definition. In *Nationwide Mutual Insurance Co. v. Darden*,[5] the Supreme Court provided some guidance when it used the common law agency test in a case brought under the Employee Retirement Income Security Act (ERISA). Since then, most federal courts have adopted the *Darden* test (or some variant) to determine whether an individual is an employee or independent contractor. In *Darden*, the Supreme Court set forth thirteen factors to consider in deter-

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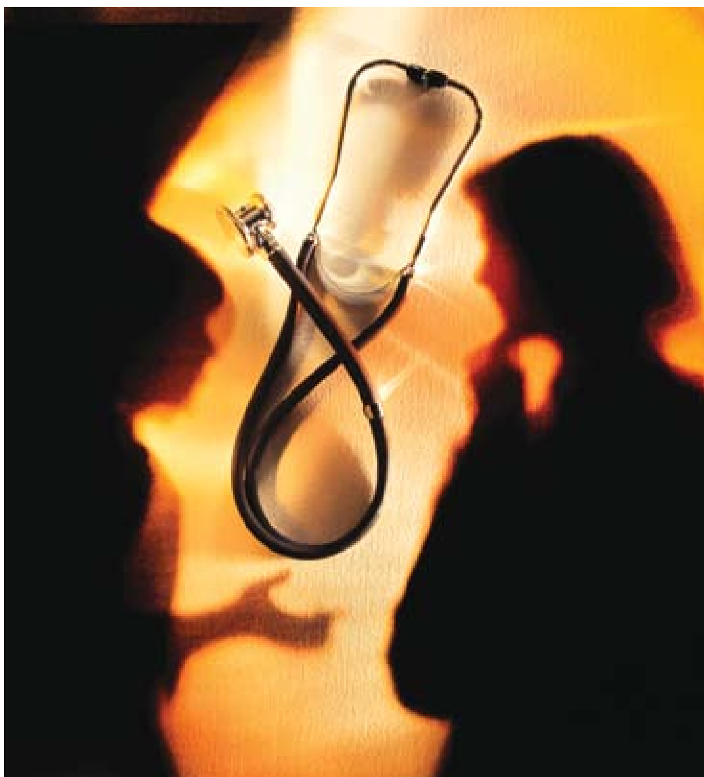
—from a declaration of the American Bar Association



mining whether a plaintiff is an "employee:" (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.

For the court in *Salamon*, not all the *Darden* factors are equal, which gave considerable weight to the first factor: the manner and means by which the hiring party controls the work of the hired party.[6]

What Does "Manner and Means" Really Mean in the Physician-Hospital Context?

The plaintiff in *Salamon*, Dr. Barbara Salamon, was a board-certified gastroenterologist at Our Lady of Victory Hospital (OLV) in Rochester, NY, for almost nine years as an active staff member. In many ways, Dr. Salamon's relationship with OLV appears to have been fairly typical. Dr. Salamon's clinical privileges gave her use of the hospital's facilities, including its endoscopy equipment in the GI lab, as well as the hospital's nursing and support staff. Furthermore, Dr. Salamon was free to set her own hours and workload, subject to the availability of the endoscopy equipment. She also determined which patients to see and treat, and whether to admit them to OLV (or another hospital). Though Dr. Salamon maintained staff privileges at other hospitals, the vast majority of her time was spent at OLV. Finally, Dr. Salamon billed patients (or their insurers) directly for her services, while OLV billed them separately for use of the hospital's facilities.

OLV required that Dr. Salamon adhere to the hospital's staff rules and regulations, participate in staff meetings every three months, and spend a certain amount of time "on call." In addition, OLV required that Dr. Salamon participate in the hospital's "quality assurance program" (QAP). Under the QAP, different hospital practitioners, on a rotating basis, would examine various procedures used at the hospital during the quarter. Cases that were flagged as problematic would be discussed at mandatory GI division meetings. OLV then subjected those physicians whose procedures had been flagged to a peer review process.

In her lawsuit, Dr. Salamon claimed that Dr. Michael C. Moore sexually harassed her on numerous occasions by repeatedly making inappropriate comments and unwanted advances. Dr. Salamon alleged that when she complained about Dr. Moore's conduct, he retaliated against her by using his authority as the hospital administrator to give her undeserved negative performance evaluations. She also alleged that other members of the hospital administration were complicit in this retaliation by using the QAP to punish her. For example:

- Her cases began to be reviewed and criticized at every staff meeting as failing to meet quality standards;
- She was regularly faulted for her refusal to perform esophageal dilatations that she considered medically unnecessary; and
- Dr. Moore focused almost exclusively on her cases, while ignoring complications in cases of other physicians at the hospital.

Dr. Salamon then met with Albert Condino, the President and CEO of OLV, along with John Davanzo (Condino's predecessor), and Franklin Zeplowitz, M.D., the chief of staff for OLV, to complain about Dr. Moore's conduct. After speaking to Dr. Moore, Dr. Zeplowitz and Condino told Dr. Salamon that she had simply misperceived Dr. Moore's actions. Dr. Salamon later wrote a letter to Dr. Moore charging him with wrongfully faulting her for her refusal to perform what she thought were medically unnecessary procedures.

Prior to her complaints about Dr. Moore's behavior, Dr. Salamon had never received a negative performance evaluation. After her complaints, however, her performance was subjected to additional review and oversight, such as a three-physician internal review; review by a five-physician, ad-hoc committee; and review by an outside expert. Eventually, OLV disciplined Dr. Salamon, requiring that she undergo a three-month "re-education" and mentoring program. In order to pass this program, she would have to perform certain practices in a satisfactory manner as indicated by her mentor.[7]

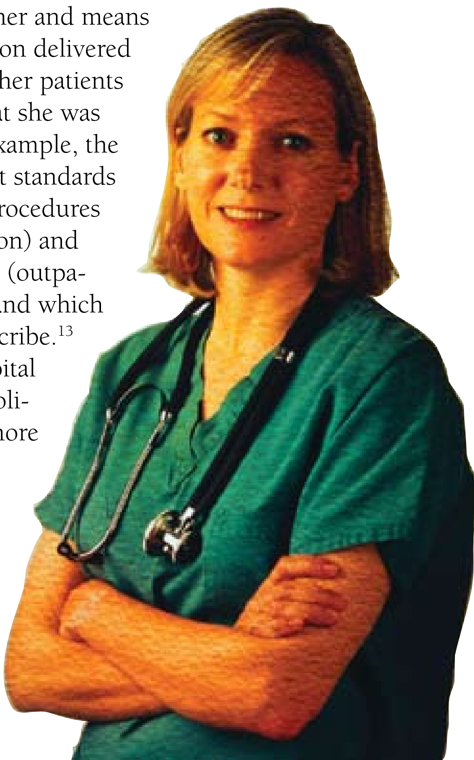
Dr. Salamon subsequently filed a lawsuit in federal district court claiming antitrust violations, tortious interference with business relations, violations of Titles VI and VII of the Civil Rights Act of 1964, and violations of the New York Human Rights Law (NYHRL). The district court dismissed Dr. Salamon's Title VI

and antitrust claims and granted summary judgment as to her Title VII and NYHRL claims because it found that she was not an employee for purposes of Title VII. Dr. Salamon appealed. The Second Circuit reversed and vacated the district's order.

In its analysis, the appeals court relied on the Supreme Court's decision in *Darden*.[8] The court placed special emphasis, however, on the "manner and means" by which the worker completes his or her assigned tasks. As shown below, the impact of the QAP on the "manner and means" by which Dr. Salamon performed her duties as a physician at OLV was crucial in finding that a triable issue of fact existed.

The Second Circuit first faulted the district court for giving little weight to the first *Darden* factor—the putative employer's right to manage the "manner and means" by which the work is accomplished—when it determined that Dr. Salamon "maintained professional independence with respect to diagnosing and treating her patients" (i.e., GI diagnoses, services, and treatment plans).[9] The district court's mistake, as the Second Circuit saw it, was that framing the issue in terms of control over a physician's professional judgment would, in effect, "carve out all physicians, as a category, from the protection of the anti-discrimination statutes."[10] Thus, "[w]hile a physician, like any professional, must be given latitude in which to choose a course of action, especially considering the exigencies of medical practice, the mere existence *vel non* of that latitude is not dispositive of the manner-and-means test."[11] As the court pointed out, there is a difference between a physician who remains free to make diagnoses and recommend treatment and a hospital that directs *how* the physician will carry out the treatment.[12]

In Dr. Salamon's case, there was sufficient evidence to raise an issue as to whether the hospital controlled the manner and means by which Dr. Salamon delivered medical services to her patients to such a degree that she was an employee. For example, the quality management standards mandated certain procedures (esophageal dilatation) and the timing of others (outpatient endoscopies) and which medications to prescribe.[13] The defendant hospital argued that these policies were nothing more than professional guidelines. The court disagreed. It saw the policies at issue not as quality assurance standards required by health and safety concerns or for ensuring the plaintiff's qualifications, but as policies designed to dictate particular details of the plaintiff's medical practice.[14] Furthermore, the purpose of these requirements was to maximize the hospital's profit and, according to Dr. Salamon, was not related to medical outcomes.



The court also found it significant that the control exerted by Dr. Salamon's supervisor was not intermittent but continuous and not merely for negative medical outcomes but for deviations from the recommended practices. Indeed, Dr. Salamon claimed that nearly every one of her cases from 1996 to 2003 were scrutinized in every GI staff meeting.[15] Also, the court found it relevant that rather than terminate Dr. Salamon's contract, as one would expect with an independent contractor, the hospital required Dr. Salamon to attend a "re-education" program, which was designed to change the very method by which Dr. Salamon monitored her patients and carried out her diagnoses and treatment.[16]

Conclusion

The *Salamon* decision is the most recent case to analyze thoroughly the employee/independent contractor status issue in the physician-hospital context. While the court nonetheless applied the generally accepted common-law agency test, the decision represents a shift in favor of physician-plaintiffs because it rejected what, in practical terms, had become something of presumption among the federal courts[17] that physicians *qua* physicians simply had to be independent contractors.[18]

Therefore, in light of the *Salamon* decision, hospitals should examine the scope of their quality control procedures and policies to ensure that they are not interfering with their physicians' decisions as to the manner in which they deliver healthcare. This concern is arguably more acute with physicians who "rely" on the hospital for their patients, like hospitalists, anesthesiologists, and emergency room physicians, as well as physicians with limited staff appointments.[19] In addition, hospitals should examine how they supervise their physicians. Does the hospital use physicians who act like quasi-supervisors who "look over the shoulder" of more "junior" physicians? This was one factor that the *Salamon* court found to indicate an employer-employee relationship. Similarly, hospitals should examine the manner in which they address physician performance. Finally, does the hospital "terminate" the contract with the physician by revoking his or her staff privileges, or does it place the physician on some kind of remedial improvement plan, such as the "re-education" program in *Salamon*?

It remains to be seen what effect the *Salamon* decision will ultimately have. It could turn out to be an aberration, signal a split in the circuits to be resolved by the U.S. Supreme Court, or indicate a new trend. In any case, the *Salamon* decision should not be ignored because as hospitals increasingly seek to gain control over the physicians who deliver inpatient healthcare, they run the risk that they are employers for purposes of federal employment laws.

1 514 F.3d 217 (2d Cir. 2008).

2 Interestingly, the primary source of employee protection under federal law, Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e-2, et seq.), does

not use the term "employee." Section 703(a) of Title VII prohibits discrimination by employers against an "individual." Despite this language, courts have held that an employee-employer relationship must exist between the plaintiff and defendant, respectively, in order for the plaintiff to have a viable claim under the Title VII. *See Elerby v. Illinois, 15th Judicial Cir. Court*, 46 Fair Empl. Prac. Cas. (BNA) 524, 525-527 (N.D. Ill. 1988) (stating that courts in general have required an "employer/employee" relationship between defendant and plaintiff, respectively in Title VII cases). The manner in which the employer-independent contractor issue is addressed under the various state anti-discrimination statutes is clearly beyond the scope (and page limit) of this article.

3 *See Lerohl v. Friends of Minn. Sinfonia*, 322 F.3d 486, 488 (8th Cir. 2003) (holding that Title VII protects employees, but not independent contractors). Independent contractors may, however, bring race discrimination claims under 42 U.S.C. § 1981. *See Danco v. Wal-Mart Stores, Inc.*, 178 F.3d 8, 13-14 (1st Cir. 1999) (holding that nothing in language of § 1981 prevents independent contractor from bringing discrimination claim); *see generally*, Danielle Tarantolo, *From Employment to Contract: Section 1981 and Antidiscrimination Law for the Independent Contractor Workforce*, 116 Yale L.J. 170 (October 2006).

4 In fact, the definitions are maddeningly circular. *See, e.g.*, 42 U.S.C. § 2000e(2) (Title VII) ("the term 'employee' means an individual employed by an employer"); 42 U.S.C. § 12111(4) (ADA) (same); 29 U.S.C. § 630(f) (same) (ADEA).

5 503 U.S. 318 (1992). This test should not be confused with the one promulgated by the Supreme Court in *Clackamas Gastroenterology Assocs. PC v. Wells*, 538 U.S. 440 (2003), in which the court set forth six factors to determine whether a shareholder/member/partner in a business entity is an employee. The factors are: (1) whether the organization can hire or fire the individual or set the rules and regulations of the individual's work; (2) whether and, if so, to what extent the organization supervises the individual's work; (3) whether the individual reports to someone higher in the organization; (4) whether and, if so, to what extent the individual is able to influence the organization; (5) whether the parties intended that the individual be an employee, as expressed in written agreements or contracts; and (6) whether the individual shares in the profits, losses, and liabilities of the organization.

6 514 F.3d at 227 ("In the context of anti-discrimination cases, courts should 'place special weight on the extent to which the hiring party controls the "manner and means" by which the worker completes her assigned tasks.'") quoting *Eisenberg v. Advance Relocation & Storage, Inc.*, 237 F.3d 111, 117 (2d Cir. 2000).

7 Dr. Salamaon never participated in the "re-education" program due to a merger between OLV and another hospital.

8 503 U.S. 318 (1992). As the Court in *Salamon* pointed out, even though *Darden* was an ERISA case, courts have adopted its reasoning to apply the common-law agency test to Title VII and other employment discrimination statutes.

9 514 F.3d at 227.

10 *Id.* at 227-228.

11 *Id.; see also id.* at 229 ("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.").

12 The Fourth Circuit in *Cilecek v. Inova Health Sys. Servs.*, 115 F.3d 256 (4th Cir. 1997) disagreed. It found that an examination of who controls the discharge of services in the medical context is less productive because a hospital will always have the duty to exert some degree of control over a physician, whether he or she is an employee or independent contractor. "A doctor must have direct control to make decisions for providing medical care, but the hospital must assert a degree of conflicting control over every doctor's work—whether an employee, an independent contractor, or a doctor merely with privileges—to discharge its own professional responsibility to patients." *Cilecek*, 115 F.3d at 260.

13 *Salamon*, 514 F.3d at 229.

14 *Id.* at 230.

15 *Id.* at 231.

16 For example, OLV dictated (a) indications and treatment for EGDs (esophagogastroduodenoscopies); (b) appropriate treatment of 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. *Salamon*, 514 F.3d at 230. As the court noted, "[a]ppropriate treatment," "removal," "monitoring," "length of . . . procedures," and "level of sedation" are exactly the kinds of "manner and means" of practice over which employers exert control." *Id.*

17 Most other federal circuit courts that have addressed this issue have held physicians to be independent contractors. *See Shah v. Deaconess Hosp.*, 355 F.3d 496 (6th Cir. 2004) (holding that physician plaintiff was not employee of hospital under Age Discrimination in Employment Act and Title VII because hospital had no right to control manner and means of plaintiff's performance, in that hospital did not interfere with plaintiff's medical decisions or control his performance as surgeon); *Cilecek v. Inova Health Sys. Servs.*, 115 F.3d 256, 263 (4th Cir. 1997) (holding that physician was independent contractor). *Alexander v. Rush North Shore Med. Ctr.*, 101 F.3d 487 (7th Cir. 1996) (holding that anesthesiologist suing the defendant hospital for national origin discrimination was not employee because, even though the hospital assigned him his patients, ultimate control over details concerning performance remained within the control of the physician); *Diggs v. Harris Hosp.-Methodist, Inc.*, 847 F.2d 270, 273 (5th Cir. 1988) (holding that physician was not employee because hospital did not control manner and means by which plaintiff renders medical care).

18 *See Salamon*, 514 F.3d at 232 ("While summary judgment may be appropriate in some cases concerning staff physicians suing hospitals, it is not appropriate in all.").

19 May hospitals create associate staff appointments, which are probationary in nature and subject to greater supervision than full appointment positions.

Letter from the Chair

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Please Join Us in San Francisco

The AHLA Annual Meeting in San Francisco is now right around the corner, and we hope that you will be able to join us for the annual Labor and Employment Practice Group Annual Luncheon on June 30th. We will be co-sponsoring a presentation with the Medical Staff, Credentialing, and Peer Review Practice Group entitled: "Breaking Down the Wall: Erosion of Peer Review Confidentiality in Civil Rights Litigation." We are very lucky to have as our speaker Maria Abrahamsen of Dykema Gossett's Detroit, MI, office. Ms. Abrahamsen's talk will focus upon a survey of recent federal opinions delineating when plaintiffs in litigation can gain access to otherwise confidential peer review records, and strategies for limiting liability in this ever-evolving area of the law. After an extremely busy year for the Practice Group, Ms. Abrahamsen's presentation should be a wonderful way to cap off the accomplishments of so many Practice Group members. We sincerely hope that you will be able to make it to the Annual Meeting, and the other Vice Chairs and I look forward to seeing you at the Practice Group luncheon (*see* page 11 for more information).

Supreme Court Lets Stand Decision Allowing Access to Peer Review in Discrimination Cases

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When the petition for certiorari was filed in *Adkins v. Christie*,[1] many hoped for a decision to the question of whether peer review documents are discoverable in federal discrimination cases. However, on January 7, 2008, the U.S. Supreme Court declined to hear the case, letting stand the Eleventh Circuit's ruling that the medical peer review privilege does not apply in federal employment discrimination cases.[2]

The Eleventh Circuit's Decision

The issue before the Eleventh Circuit was one of first impression in that circuit—whether to recognize the medical peer review privilege in federal civil rights cases. All fifty states and the District of Columbia recognize some form of peer review privilege—a privilege protecting from discovery and/or disclosure records containing performance reviews and assessments of physicians by their peers, primarily in connection with physician practices at hospitals.[3] The states recognize the importance of promoting vigorous oversight of physician performance.

Considerations of privilege in federal cases are governed by Rule 501 of the Federal Rules of Evidence. Under that Rule, state law privileges apply only in cases where substantive state law controls, such as in diversity cases. If federal substantive law controls a civil case, federal common law would govern the question of privilege. In a federal question case where the court is also hearing supplemental state law claims, federal privilege law controls. In reaching its decision, the Eleventh Circuit took into account the Supreme Court's guidance in *Jaffe v. Redmond* to determine whether an evidentiary privilege should be created under Rule 501.[4] In *Jaffe*,[5] the Supreme Court identified some relevant factors to consider, including: (1) the needs of the public good; (2) whether the privilege is rooted in the imperative need for confidence and trust; (3) the evidentiary benefit of the denial of the privilege; and (4) consensus among the states.

In the healthcare context, protection for peer review activity is covered by the Healthcare Quality Improvement Act of 1986 (HCQIA).[6] Under the HCQIA, participants in peer review actions are provided immunity from damages as long as certain conditions are met. However, in civil rights cases, immunity is not available under the HCQIA. Nor does the HCQIA provide an evidentiary privilege against disclosure of peer review materials.

The plaintiff in *Adkins v. Christie*, Dr. Russell Adkins, was an African-American staff physician[7] with privileges at the Houston Medical Center in Warner Robins, GA. Dr Adkins was suspended and subsequently terminated after an external peer review panel determined that his availability and level of care were inadequate. He filed a federal civil rights action pursuant to 42 U.S.C. §§ 1983, 1981, and 1985, alleging racial discrimination against the hospital as well as several physicians who participated in the hospitals' peer review and physician disciplinary process.[8]

Adkins requested discovery of peer review documents for all physicians at the hospital for the seven years he was a member of the hospital staff. The hospital sought a protective order, arguing that the peer review privilege applied under Georgia law.[9] The district court agreed that the privilege applied but ordered limited discovery anyway. The hospital was ordered to provide descriptions of all incidents giving rise to peer review, without having to disclose the documents themselves. The court limited production to five years worth of peer review documents of physicians in the Department of Surgery, which the court deemed to be similarly situated to Dr. Adkins, rather than for all physicians in the hospital over seven years as Dr. Adkins requested. The court reviewed the peer review documents in-camera. The court also reviewed a list identifying the race of forty-seven physicians who had been suspended in the prior five years. Following its review, the court granted summary judgment to the defendants.[10] Dr. Adkins appealed, contending the court improperly recognized the peer review privilege and improperly limited his discovery request.

On appeal, the Eleventh Circuit weighed the interests served by the privilege against the discovery of evidence it deemed essential to determining whether there had been discrimination in employment. The circuit court determined the "compelling governmental interest" of exposing "invidious discrimination"[11]

outweighed the privilege. While overriding the privilege, the court pointed to other measures that were available to protect the hospital's interest in maintaining confidentiality of peer reviews, such as protective orders, confidentiality agreements, and in-camera review prior to disclosure.[12]

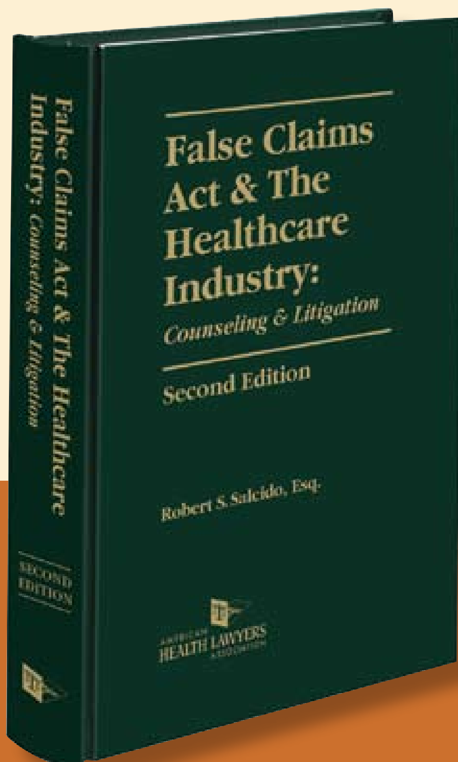
The Eleventh Circuit is not alone in reaching this conclusion. The Fourth and Seventh Circuits also have allowed the peer review privilege to be breached in federal cases. In *Viramani v. Novant Health, Inc.*,[13] the Fourth Circuit court found, in a federal discrimination claim similar to Adkins', that "[t]he interest in facilitating the eradication of discrimination by providing perhaps the only evidence that can establish its occurrence outweighs the interest in promoting candor in the medical peer review process."[14] The plaintiff in *Viramani* sought twenty years of peer review records for all physicians at the hospital. The Fourth Circuit found the documents crucial to his attempt to establish disparate treatment and prove his allegations, and it failed to recognize the North Carolina state law privilege.

In *Memorial Hospital v. Shadur*,[15] a federal antitrust action, the focus of the plaintiff's claim was the peer review process itself. In that case, the plaintiff sought peer review documents to show that the process was conducted in a discriminatory manner and was used by other physicians to conspire against him, destroy his practice, and limit competition.[16] In *Shadur*, the Seventh Circuit weighed the public policy favoring antitrust actions against the Illinois state law privilege. The court decided the privilege should not be recognized where it would effectively bar the plaintiff's claim.[17] District courts that have addressed the issue in discrimination cases have all rejected a medical peer review privilege.[18]

What Does This Mean for Healthcare Employers?

In an *amicus* brief filed with the Supreme Court in support of the hospital's petition for certiorari, the American, Georgia, Alabama, and Florida Hospital Associations warned that allowing the Eleventh Circuit's decision to stand would establish disastrous healthcare policy that undercuts hospitals' efforts to assure the highest quality of patient care and disrupt quality review in hospitals because physicians would be fearful of being honest in reviews.[19] The *amici* also predicted that allowing access to peer-review-privileged materials through federal court filings would increase litigation costs, create incentives for forum shopping between state and federal courts, and encourage misuse of the discovery process.[20]

While the exact effects of this decision have yet to be seen, healthcare employers should not let fear of discrimination cases intrude upon the peer review process. A better course would be to focus on maintaining a peer review process that is free from discrimination, or the appearance of discrimination, against physicians on the basis of race, gender, national origin, and other protected classifications. The best way to do this is to maintain best employment law practices, such as training on anti-discrimination policies, maintaining consistency in the peer review process, thoroughly documenting performance concerns including collecting data on outcomes and other objective performance measures, and seeking the advice of counsel when necessary. Hospitals should also consider whether the diversity of their hearing panels reflects the diversity of their physician staffs.



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One way to curb the dissemination of peer review materials in discrimination cases would be to use alternative dispute resolution measures. Private mediation enables parties to engage in limited disclosure and early negotiation, and production of peer review documents may be avoided if a claim is settled before being filed in court. Arbitration of discrimination claims also provides an opportunity to limit discovery and restrict access to peer review materials. Counsel should consider adding mandatory pre-dispute mediation and arbitration provisions to physician contracts and medical staff bylaws.

Should an employer be faced with potential disclosure of peer review materials in a lawsuit, counsel should seek protective measures. Filing for a protective order, requesting confidentiality agreements, redacting extraneous or confidential information, asking the court for in-camera review of sensitive documents prior to or in lieu of disclosure, and the return or destruction of documents at the conclusion of litigation may help limit access and preserve some semblance of the privilege.

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1 488 F.3d 1324 (11th Cir. 2007).

2 *Christie v. Adkins*, No. 07-538, *cert. denied* (U.S. Jan. 7, 2008).

3 *Adkins*, 488 F.3d at 1326.

4 *Id.*

5 *Jaffee v. Redmond*, 518 U.S. 1 (1996).

6 42 U.S.C. §§ 11101-11152 (HCQIA).

7 In many hospitals, physicians are engaged as non-staff independent contractors and are ordinarily not covered by anti-discrimination laws because they are not employees. However, in light of recent case law in the Second Circuit, it is conceivable that some non-staff physicians could be deemed employees for the purposes of federal discrimination laws. *See Salmon v. Our Lady of Victory Hosp.*, No. 06-1707-cv (2d Cir. Jan. 29, 2008) (physician with staff privileges at hospital might be an employee for purposes of suing the hospital under Title VII of the Civil Rights Act, depending upon the extent of direction and control exercised by the hospital). This case is discussed in detail in this newsletter.

8 *Id.*

9 Georgia law requires that "[t]he proceedings and records of medical review committees shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such committee." GA. CODE ANN. § 31-7-143. The Georgia Supreme Court has interpreted this statutory mandate as placing "an absolute embargo upon the discovery and use of all proceedings, records, findings, and recommendations of peer review groups and medical review committees in civil litigation." *Adkins* at 1327 quoting *Emory Clinic v. Houston*, 369 S.E. 2d 913 (Ga. 1988) (per curium).

10 *Id.* at 1327.

11 *Id.* at 1329.

12 *Id.*

13 259 F.3d 284 (4th Cir. 2001).

14 *Id.* at 289.

15 664 F.2d 1058 (7th Cir. 1981) (per curiam).

16 *Id.* at 1063.

17 *Id.* at 1062-63.

18 *Id.* at note 12, citing *Holland v. Muscatine Gen. Hosp.*, 971 F. Supp. 385, 389 (S.D. Iowa 1997); *Robertson v. Neuromedical Ctr.*, 169 F.R.D. 550, 561 (S.D.N.Y. 1996): *Robertson v. Neuromedical Ctr.*, 169 F.R.D. 80, 83-84 (M.D. La. 1996); *LeMasters v. Christ Hosp.*, 791 F. Supp. 188, 191 (S.D. Ohio 1991). *See also Krolikowski v. University of Mass.*, 150 F. Supp. 2d 246 (D. Mass. 2001).

19 Brief of American Hospital Association, et al., as *Amicus Curiae* in Support of Petitioner's Petition for Writ of Certiorari, at ii.

20 *Id.*

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The Family and Medical Leave Act: Highlights, Updates, and Changes

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The Family and Medical Leave Act (FMLA), as originally passed in 1993, entitles eligible employees to up to twelve weeks of unpaid leave during a twelve-month period for certain medical reasons, for the birth or adoption of a child, or for the care of a spouse, child, or parent who has a serious medical condition.[1]

To the extent that the FMLA allows flexibility to individuals who deal with their own or family-members' serious health conditions, it has been viewed as a boon by employees. However, because of the numerous regulations, notice requirements, and conflicting court decisions associated with the FMLA, it has created an administrative nightmare for many businesses, firms, and associations with the required fifty or more employees, often resulting in employees' claims of interference with FMLA.

Liability for Interference with FMLA Rights Can Lead to Legal Liability

Susan Chanco, a registered nurse for the North Hawaii Community Hospital, asked for FMLA leave to care for her son, who was experiencing kidney failure at the time.[2] After her return from that leave, Chanco administered an improper dose of morphine to a patient. The incident led to "increased monitoring," but no formal discipline against Chanco, but was noted in her early 2005 performance evaluation.

In the following months, Chanco was involved in additional incidents including another narcotic error and a patient burn, and on March 15, 2005, Chanco met with her supervisor to discuss those incidents. The discussion subsequently was determined to be a "Verbal Reminder," the second level of disciplinary action. However, the hospital failed to document that discipline until May 27, 2005, at which time Chanco was again on FMLA leave related to her son. On July 21, 2005, the day on which she returned from that second FMLA leave, Chanco's employment was terminated.

Chanco filed a lawsuit alleging that the hospital violated the FMLA by terminating her from employment instead of reinstating her as required by the Act. The hospital filed a motion for summary judgment, which was denied by the district court on February 25, 2008. Because the FMLA requires reinstatement of an employee upon return from leave, and because at the time of her second FMLA leave, Chanco had not yet received notice of the more serious discipline taken against her, the court determined that there was a genuine question of fact as to whether Chanco's FMLA leave was a factor in her termination.

This case highlights a common mistake—failure to timely document discipline. In addition, the FMLA's requirement of reinstatement-after-leave is a key component in any analysis of an FMLA claim. Therefore, the hospital's delay in imposing discipline until the day Chanco returned from FMLA leave was weighted heavily against the hospital, in spite of the fact that a patient-safety factor formed the actual basis of that discipline. Healthcare employers with strong patient care concerns must timely address such issues in order to adequately defend against employment claims.

Recent Revisions

In January of this year, the FMLA was amended by the National Defense Authorization Act,[3] which allows eligible employees to take up to twenty-six weeks of unpaid leave during a twelve-month period to care for a family member in the Armed Services who is wounded in the line of duty. In addition, employers must grant twelve weeks exigency leave in situations where a family member is on active duty or is notified of a call to active duty. Although exigency leave is not effective (and has not been significantly defined) until the Department of Labor (DOL) issues regulations, the DOL encourages employers to offer the leave immediately. This additional leave is entirely new to the FMLA, and employers should immediately begin to make themselves knowledgeable of their obligations under these provisions.

In addition to becoming familiar with the new military leave provisions, employers also should be aware that in February of this year, the Department of Labor issued a Notice of Proposed Rule Making (NPRM),[4] which is meant to clarify certain issues raised in various courts' interpretations of the FMLA, and which ostensibly will assist employers in implementing a law that has been viewed by some as an administrative nightmare.

Proposed New Regulations

The NPRM addresses five areas of the FMLA: eligibility; intermittent leave; factors affecting leave benefits; notice requirements; and medical certifications.

Clarification of Eligibility Requirements

Under the FMLA, an "eligible" employee is one who has worked for at least 1250 hours during the twelve-month period immediately

prior to the leave request. Further, the employee must have been employed for at least twelve months with the employer from whom the leave has been requested.[5]

One issue not addressed in the NPRM, but frequently dealt with by employers, is what constitutes "hours of service" for purposes of the 1250 hours required. The Sixth Circuit recently determined that a nurse working a "Weekender Program"—in which she worked forty-eight hours each month, but was paid for sixty-eight hours—could not count the additional (unworked) twenty hours in her 1250 "hours of service" calculation for FMLA eligibility.[6] The court noted that the additional hours "flow to participants as an incentive, and not as compensation for hours actually worked."[7]

Another federal court allowed an employee claim for FMLA eligibility, even though the employee's twelve months of service to his employer included a five-year hiatus from work.[8] To clarify the regulations' ambiguity on that issue, the NPRM includes a specific provision addressing how to combine non-consecutive periods of employment. The new regulation would allow non-consecutive time if the break in service was less than five years, but would not allow combined time after a break of more than five years.[9]

The proposed regulations also address the term "chronic condition" as used in the FMLA.[10] The current definition of "chronic condition" requires periodic visits to a healthcare provider, but does not define the term "periodic." The proposed rule specifically includes physicians' assistants[11] as healthcare providers for purposes of FMLA eligibility, and defines "periodic" visits as twice or more per year.[12]

Instruction Regarding Intermittent Leave

When a medical provider can mitigate the frequency of an employee's need for continuous medical leave, FMLA leave can be taken in non-consecutive days or weeks. Intermittent leave under the FMLA had led to administrative headaches, based partly on the lack of specific direction to employers. For example, questions have arisen regarding the proper handling of holidays within an intermittent leave. The NPRM states that if an employee needs less than a full week of intermittent leave, any holiday on which that the employee would not have been required to work is not counted against FMLA leave time.[13] If the employee needs the full week of leave that includes a holiday, that day counts against the employee's FMLA allotment.[14]

Additionally, under the proposed regulations, overtime missed during intermittent FMLA leave must be counted against an employee's FMLA leave if that person would otherwise have been required to report for duty but for the taking of FMLA leave.[15]

Continuation of Benefits During FMLA Leave

The NPRM addresses a number of benefits-related issues that actually may further complicate administration of the FMLA. One of these is the "light duty" issue.

The FMLA includes a provision that requires an employer to reinstate individuals to the same or an equivalent position or pay rate after the expiration of FMLA leave.[16] However, reinstatement to a prior position is required only if the employee is physically able to perform the functions and duties of the position.[17] Based on these provisions, courts typically have held that an employee can be assigned to light duty (pre-supposing an inability to perform his or her original duties) at a reduced salary, rather than being returned to an equivalent job and pay rate.[18]

The NPRM specifically includes the directive that any employee voluntarily performing a light duty assignment will retain rights to FMLA leave, and to ultimate job restoration.[19] However, the NPRM does not specifically address the issue of reduced salary, except to say that an employee retains the right to refuse light duty and remain on FMLA leave, rather than return to work at the reduced wage.[20] On this issue, the new rule may not be as helpful as was hoped by employers.

Definition of Adequate Notice

Under the current regulations, the steps leading to FMLA leave include "adequate notice" from an employee to an employer of a serious health condition. If such notice is not given, an employer may deny the leave request.[21]

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Under the proposed regulations, "adequate notice" from an employee must contain sufficient information that the employee is seeking leave under the FMLA. It is not enough simply to claim to be "sick"—instead, the notice must include an inability to perform job duties, anticipated duration of the absence, and an indication of healthcare or treatment expected.[22]

Placing the responsibility on the employee to provide sufficient notice to raise the possible applicability of FMLA allays employers' concerns on that issue. Those concerns were heightened a few years ago when a federal appellate court held that an employee's requirement of "adequate notice" may be excused if the employee is unable, because of his or her medical condition, to provide that notice.[23]

Further, the proposed regulations retain the requirement that the employee provide thirty days advance notice for foreseeable leave (for scheduled surgery, pre-scheduled treatment, etc.).[24]

Certification of Medical Conditions

The proposed regulations require an employer to request medical certification with five business days after an employee's notice of the need for leave (or for unforeseen leave, within five business days after the leave has begun). The proposed regulations reiterates the existing regulation's provision that employees have fifteen days to submit appropriate medical certification after a request from an employer.[25] This time frame has been upheld in a case in which an employee with a history of repeated absences and non-cooperation with deadlines was terminated after his failure to provide certification within an arbitrary six-day deadline set by his employer.[26] There, the Eleventh Circuit upheld a jury verdict of over $300,000 in favor of the employee for the employer's violation of the individual's rights under the FMLA.

In an important revision, the proposed regulation allows an employer to make contact with an employee's healthcare provider without the employee's permission in order to verify that a submitted medical certification is authentic. However, the employer must comply with the Health Insurance Portability and Accountability Act (HIPAA) if seeking clarification of any substantive information. Under the new rule, if the employee does not provide HIPAA consent after the employer asserts a genuine need for clarification, FMLA leave may be denied.[27]

Certification of Ability to Return to Work

The existing FMLA regulations allow an employer to request medical certification before returning an employee to work, and may allow an employer to refuse reinstatement without sufficient certification.[28] Recently, a medical clinic's termination of a phlebotomist was upheld by a federal district court when that employee failed to provide any medical certification to support her return to work from FMLA leave.[29]

Timing of Final Regulations

The proposed revisions included in the Department of Labor's NPRM appeared in the *Federal Register* on February 11, 2008. The Department of Labor has stated that it is attempting to ensure that FMLA regulations will conform to court decisions that have been critical of or have struck down existing regulations, and that the new rules should help to "streamline" the medical certification process. The public comment period related to these proposed regulation ended April 11, 2008. Typically, a regulatory agency will review those comments within sixty to ninety days, make necessary revisions, and then publish the final rules. After publication, the final rule usually takes effect within thirty days. Based on that schedule, it is anticipated that the new regulations will become effective in the Fall of 2008. However, because most of the proposed changes concern regulations on which courts already have issued opinions, employers should familiarize themselves with the basic substance of the proposed rules and begin to incorporate them into decisions related to FMLA administration.

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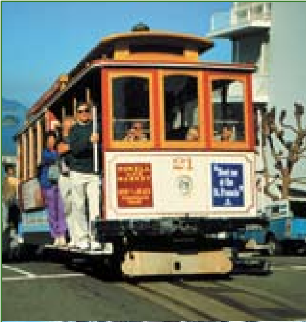
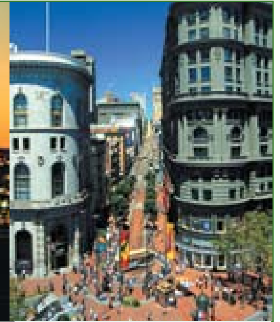
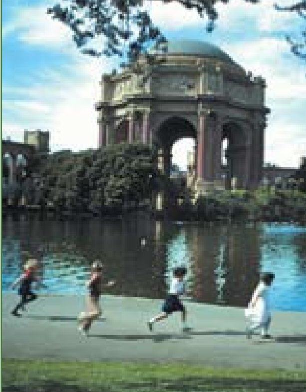
1 29 C.F.R. Part 825.
2 *Chance v. North Haw. Cmty. Hosp., Inc.*, 208 U.S. Dist. LEXIS 13782, D. Hawaii (Feb. 25, 2008).
3 Public Law 110-181 (2008).
4 The Family and Medical Leave Act of 1993, 73 Fed. Reg. 7876 (proposed Feb. 11, 2008); www.dol.gov/esa/whd/fmla/FedRegNPRM.pdf.
5 29 C.F.R. § 825.110.
6 *Mutchler v. Dunlap Mem'l Hosp.*, 485 F.3d 854 (6th Cir. 2007).
7 485 F.3d at 858.
8 *Rucker v. Lee Holding Co.*, 471 F.3d 6 (1st Cir. 2006).
9 73 Fed. Reg at 7882.
10 73 Fed. Reg. at 7888.
11 73 Fed. Reg. at 7891.
12 73 Fed. Reg. at 7888.
13 73 Fed. Reg. at 7892.
14 While this issue has been addressed infrequently by federal appellate courts, interpretation has been consistent with this new rule. *See, e.g., Mellen v. Trustees of Boston Univ.*, 504 F.3d 21 (1st Cir. 2007).
15 73 Fed. Reg. at 7894.
16 29 C.F.R. § 825.214.
17 29 C.F.R. § 825-214(b).
18 *Hendricks v. Compass Group, USA, Inc.*, 496 F.3d 803 (7th Cir. 2007).
19 73 Fed. Reg. at 7900-01.
20 73 Fed. Reg. at 7901.
21 29 C.F.R. § 825.302.
22 73 Fed. Reg. at 7907-11.
23 *Byrne v. Avon Prods., Inc.*, 328 F.3d 379 (7th Cir. 2003).
24 73 Fed. Reg. at 7907-11.
25 73 Fed. Reg. at 7911-16.
26 *Cooper v. Fulton County, Ga.*, 458 F.3d 1282 (11th Cir. 2006).
27 73 Fed. Reg. at 7911-16.
28 29 C.F.R. § 825.310.
29 *Dreiling v. Mowery Clinic*, 19 Am. Disabilities Case (BNA) 1458 (D.Kan. 2007).



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