

As Hospitals Trend Toward Employee Physicians, What Are the Employment Law Consequences?

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The recent increase in hospital-employed physicians is expected to continue. This trend is motivated by a quest for unified quality of care, referrals and market share, uncertainty about the overhaul of the healthcare system and reimbursement changes, and physician desire for a better work-life balance. Regardless of the reasons, transitioning from an independent contractor relationship with a physician to an employee physician

has many consequences in the employment law arena.

The advent of this new norm - employee physicians - presents a change in the hospital's obligations to the physician beyond simply a motivating compensation model. The hospital now takes on many obligations to the physician. It must provide employee benefits, unemployment compensation, workers' compensation, in-

surance and often retirement. The physician will receive the protection of employment laws such as the Americans with Disabilities Act (ADA) and the Family and Medical Leave Act (FMLA). Additionally, the discrimination and harassment provisions of Title VII, the Age Discrimination in Employment Act (ADEA) and similar state laws impact the relationship in a new way. Also, the hospital may choose to bind the physician to a reasonable and enforceable noncompetition agreement.

In addition, the hospital-employed physician with medical staff privileges presents an intersection in the laws affecting peer review and human resources. This is especially true when there are complaints involving a physician's performance. Navigating the investigation of complaints or the termination of the physician's employment and denial of privileges can impact the peer review privilege as well as immunity provided by state law and the Health Care Quality Improvement Act (HCQIA).

In negotiating compensation, hos-

pitals should remember that there are many costs of having the employee that the employer did not have with the independent contractor. These include: professional liability insurance, employment taxes (such as the employer's share of social security), unemployment and workers' compensation taxes and all employee benefits (e.g. vacation, sick leave, life, health, and disability insurance and retirement plans). Additionally, an employee physician may have access to confidential proprietary information about the hospital and/or its employees that would not be available to a contract physician.

The hospital and prospective employee physician will want to negotiate an employment agreement that should consider duration of employment, circumstances under which the employee can be terminated and, in addition to compensation, concomitant issues of hospital privilege, tail insurance, confidentiality, non-compete and non-solicitation of employees, patients, and referral sources, terms of payment, bonuses, benefits, practice control obligations to patients, moonlighting, practice development, arbitration and other ADR provisions. In considering compensation models, hospitals should keep in mind ethical obligations and patient safety, which are sometimes thought to conflict in alternative compensation models, such as volume-based.

Another area involves discrimination law coverage. While there is always an issue regarding whether discrimination laws apply to independent contractor physicians, there is no question that they apply to employee physicians. This

means that employment decisions are easily challenged. Also, a plaintiff alleging discriminatory or harassing actions by an employee physician is in a better position to impose vicarious liability on the hospital than those making a claim against an independent contractor, where the standard is higher. Hospitals should consider providing harassment and discrimination awareness training specific to physicians, taking into account the unique circumstances among personnel in a hospital setting. Hospitals should also consider updating their discrimination and harassment policies to clarify to whom an employee should report inappropriate conduct.

There is also protection for employee physician whistleblowers, as well as all other employees, under the Patient Protection and Affordable Care Act. This includes coverage for employees who report, or are about to report, violations of the Act to the employer or the government and employees who object to or refuse to participate in any activity that they reasonably believe violates the Act, among other things.

Beyond the prohibitions against discrimination and harassment, the hospital has affirmative obligations to the physician under the ADA and FMLA. The ADA requires that an employer provide a reasonable accommodation to a "qualified individual with a disability." A disability is defined as a physical or mental impairment that substantially limits one or more major life activities, or a record of, or being regarded as having, such impairment. The 2008 amendments to the ADA broadened the

scope of the definition of disability by expanding what qualifies as a major life activity to include most physical and mental functions.

To the extent that an employee physician has a disability, the hospital must use the interactive process to seek a reasonable accommodation that will allow the physician to effectively do his or her job. In doing so, the hospital is in a unique position to take into account patient safety and quality of care concerns. Only if the hospital can identify a direct threat to patients, the disabled employee or coworkers, or if no accommodation is reasonable, can it decline to accommodate the employee.

The hospital must also consider the impact of complying with FMLA obligations to the employee physician. The employee physician may be entitled to take up to twelve weeks of leave each year for the birth or adoption of a child, his or her own serious health condition or to care for a family member with a serious health condition. There may also be ADA obligations to provide additional leave as part of a reasonable accommodation or additional pregnancy disability leave. Hospitals must consider the impact of the employee physician's eligibility for significant leave on its staffing models and be prepared to seamlessly provide healthcare through *locum tenens* or other arrangements while protecting the employee physician's leave and reinstatement rights.

Perhaps the most complicated area is when the investigation and decision-making functions of peer review committees and human resources departments collide.

When it comes to an employee physician, the hospital's highly protected peer review information may well become fair game in litigation.

Allegations of employment discrimination under federal civil rights statutes, parallel state laws, claims of retaliation or wrongful termination most often rest upon indirect evidence, in which inferences of illegal actions may be drawn from witness testimony and related documents about the decision and the events leading up to it. For a hospital employee physician with staff privileges, the investigation and decision-making process is often conducted under the umbrella of highly confidential peer review. To prove the case, the physician will likely seek to compel the hospital to produce all documents related to the adverse decision and take the deposition of key decision makers. To protect its peer review material, the hospital will object adamantly (even if the information could help the hospital win its case). Whether the peer review privilege is fair game in the lawsuit depends in large part on whether the case is in federal or

state court and what public policy issues are at play.

While most states have enacted statutory privileges restricting the release of medical peer review information, there is no corresponding federal privilege. Those state law privileges do not apply in federal court when a case is based on a federal anti-discrimination statute. Instead, federal courts will typically order the production of peer review records if there is any possibility that the documents may lead to information relevant to the claim. The number of employment-related claims where peer review information is sought through discovery is on the rise, often resulting in successful motions to compel. Courts will need to be educated on the health law ramifications of the production of peer review information, in order to limit production whenever possible.

It is vital to pay close attention during the investigation and decision-making process to the documents produced and the individuals involved. If a health care provider intends to claim the peer review

privilege, it must be sure that all meetings involve only appropriate individuals, all relevant documents are marked as confidential peer review and the information is held confidential. For documenting in the personnel file, the employer should consider simply including a general summary of the decision and note that the investigation was a confidential quality assurance/peer review matter.

The employee physician model has many advantages, and hospitals are wading through the employment law complications it presents. Paying close attention to these issues every step of the way can help avoid complications. Be sure to contact a trusted legal advisor for assistance.

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