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The Status of Private Practice Physicians under Employment Discrimination and Labor Laws

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A cutting-edge issue in employment and health care law is the employment status of physicians in private practice who participate in managed care programs, as opposed to hospital staff physicians or residents. Are these private practice physicians employees or independent contractors? If they are employees, then the next issue is whether these physicians can unionize for the purpose of collective bargaining or other joint negotiations with health maintenance organizations ("HMOs"). If these physicians are not employees, then they cannot unionize, and they may be precluded from bringing certain employment discrimination, harassment, or retaliation claims against a HMO or other managed health care provider.

This chapter discusses and analyzes the following issues: (1) a brief overview of the historical background and the current status of private practice physicians within the managed health care market (2) the applicable statutory and case law under the National Labor Relations Act; (3) the applicable statutory and case law under Title VII and related federal employment discrimination statutes; (4) physicians as whistleblowers and as the targets of investigations; and (5) pending or enacted federal and state legislation relating to physician unionization and whistleblower investigation issues.

1. Historical Background and the Modern Health Care Market.

The days are long gone when physicians were usually solo practitioners or general partners in a partnership, made house calls, and were customarily paid directly by their patients on a fee-for-service basis. In those circumstances, private practice physicians were free to set

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their fees in relation to the prevailing local market rates, and were not supervised by managers or insurance companies. Today, however, the health care market is a highly managed corporate enterprise driven largely by the insurance companies, HMOs, and other managed health care providers. Physicians who ostensibly are partners in a private practice are, in reality, subject to micromanagement of their patient care by the patients' insurance companies and the managed health care providers. Physicians, in order to be reimbursed by the insurance companies, or to accept patients enrolled in HMOs, or to have staff privileges at a hospital, must comply with the rules and regulations of these entities. As discussed below, this transformation has led some private practice physicians to claim that they are now employees entitled to collective bargaining and to protection under federal and state employment discrimination statutes.[2]

2. Physicians and the National Labor Relations Act.

The National Labor Relations Act ("NLRA"), 29 U.S.C. §§ 151-169, provides employees with the statutory right to unionize and engage in other collective activities:

> Employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection . . .

29 U.S.C. § 157. However, the NLRA's statutory definition of "employee" specifically excludes from its coverage individuals who are independent contractors:

> The term "employee" . . . shall not include . . . any individual having the status of an independent contractor . . .

29 U.S.C. § 152(3). There has been a significant body of case law as to whether the status of a given individual or job category is that of an employee or of an independent contractor. The Supreme Court has adopted the common-law agency principles for making this distinction under the NLRA. NLRB v. United Ins. Co. of Am., 390 U.S. 254, 256 (1968) ("Thus there is no doubt that we should apply the common-law agency test here in distinguishing an employee from an independent contractor."); accord NLRB v. Town & Country Elec., Inc., 516 U.S. 85, 94 (1995). Similarly, the Supreme Court has subsequently adopted common-law agency principles for making this determination under other statutes which make similar statutory distinctions. See, e.g., Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 323 (1992) (Employee Retirement

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[2] See also W.S. Brewbaker, "Physician Unions and the Future of Competition in the Health Care Sector," 33 U.C. Davis L. Rev. 545 (2000); J.J. Deis, "The Unionization of Independent Contracting Physicians: A Comedy of Errors," 36 Hous. L. Rev. 951 (1999); J. Lutsky, "Is Your Physician Becoming a Teamster? The Rising Trend of Physicians Joining Labor Unions in the Late 1990s," 2 DePaul J. Health Care L. 55, 57-59 (1997).

Income Security Act of 1974); Community for Creative Non-Violence v. Reid, 490 U.S. 730, 739-40 (1989) (Copyright Act of 1976).

A. Private Practice Physicians and the NLRA.

The National Labor Relations Board ("NLRB"), recently denied review (thereby upholding) an agency decision made by Dorothy L. Moore-Duncan, an NLRB Regional Director that was a decision of first impression. The NLRB affirmed the Regional Director's holding that physicians affiliated with a New Jersey HMO were independent contractors, not employees, and hence were ineligible to join a union for purposes of organizing and collective bargaining with the HMO. AmeriHealth Inc./AmeriHealth HMO, 329 NLRB No. 76, slip op. at 1 (Oct. 18, 1999) (affirming AmeriHealth Inc./AmeriHealth HMO, NLRB Case 4-RC-19260 (NLRB Fourth Region, May 24, 1999)) ("AmeriHealth II"). The NLRB did not issue a separate opinion, but adopted the Regional Director's opinion by summarizing that "We agree with the Regional Director that the consideration of all factors of the common law agency test . . . favor a finding of independent contractor status for the petitioned-for physicians."). AmeriHealth II, 329 NLRB No. 76, slip op. at 1 n.1.

On January 8, 1998, Regional Director Moore-Duncan had initially dismissed the physicians' petition on the grounds that the physicians were independent contractors and hence ineligible for representation under the NLRA. The NLRB commissioners granted the physicians' request for review and remanded the case for a full hearing, including briefs and exhibits. AmeriHealth Inc./AmeriHealth HMO, 326 NLRB 509, 510 (1998) ("AmeriHealth I"). The NLRB commissioners recognized that this issue merited fuller briefing:

> The involvement of the HMOs in the physicians' delivery of health care services and access to patients is a feature of the changing nature of the health care industry which is presented to the Board for the first time in this case. It calls into question the historical understanding of the status of physicians who maintain their own practices.

Id. at 509. After 14 days of hearings, which included 4,500 pages of exhibits, Regional Director Moore-Duncan reiterated her prior holding. AmeriHealth II. The underlying factual background is briefly set forth since it is representative of many private practice physicians who are affiliated with HMOs or other managed care entities. Although the 652 physician-petitioners in two New Jersey counties were all affiliated with AmeriHealth, they were also affiliated with several other HMOs, and accepted patients on Medicare or other non-HMO insurance plans. AmeriHealth and each physician entered into contractual "Physician Managed Care Agreements" setting forth the terms and conditions for providing health care services to the plan members and for being reimbursed. AmeriHealth staff nurses periodically inspected the physicians' offices, but the actual provision of medical care was largely determined by the individual physicians, with only a small number of procedures requiring precertification by AmeriHealth medical staff, which was invariably granted. Id.

Regional Director Moore-Duncan noted, in AmeriHealth II, that the NLRB had itself recently recognized its obligation, under Darden, Reid, and United Insurance, to apply the common law of agency to determine whether an individual was an employee or an independent contractor. Roadway Package System, 326 NLRB 842, 848-50 (1998). The NLRB adopted the criteria as set forth in the Restatement (Second) of Agency to differentiate between "servants" (i.e., employees) and independent contractors:

> (1) A servant is a person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the services is subject to the other's control or right to control.
>
> (2) In determining whether one acting for another is a servant or an independent contractor, the following matters of fact, among others, are considered:
>
> (a) the extent of control which, by the agreement, the master may exercise over the details of the work;
> (b) whether or not the one employed is engaged in a distinct occupation or business;
> (c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision;
> (d) the skill required in the particular occupation;
> (e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;
> (f) the length of time for which the person is employed;
> (g) the method of payment, whether by the time or by the job;
> (h) whether or not the work is a part of the regular business of the employer;
> (i) whether or not the parties believe they are creating the relation of master and servant; and
> (j) whether the principal is or is not in business.

Id. at 849 n.32 (quoting Restatement (Second) of Agency, § 220 (1958)). The NLRB recognized that these factors are not exclusive, and that this test "encompasses a careful examination of all factors and not just those that involve a right of control." Id. at 849; accord Dial-A-Mattress, 326 NLRB 884, 891 (1998).

In AmeriHealth, the factors which supported the holding that the physicians were independent contractors, not employees, were that AmeriHealth: (1) "does not own or directly operate any health care facilities for its members;" (2) "does not pay any of the physicians on either an hourly or a salaried basis, and provides no benefits to the physicians;" (3) "does not withhold taxes from payments to a physician or the physician's practice, and reports those payments on an IRS Form 1099 rather than a W-2;" (4) allows the physicians "to contract with, or even serve as advisors to, competing insurance companies;" (5) "imposes no restrictions on competition between AmeriHealth's network physicians;" (6) "has no direct financial interest in the physicians' practices;" (7) has no control over the structuring of the physician partnerships or

their affiliation with hospitals; (8) does not require the physicians to "account for their hours of work to AmeriHealth;" (9) "has no involvement in determining the number, identity, duties, supervision or compensation of the physicians' staff;" (10) "does not control or monitor the manner in which physicians perform procedures on patients;" (11) allows the physician and the patient to receive services not covered by AmeriHealth, provided that the patient will individually pay for such services; and (12) "pays physicians not 'by the time' but 'by the job.'" AmeriHealth II.

Similarly, the physicians: (1) "maintain their separateness from AmeriHealth;" (2) "advertise and do business in their own names or the names of their practices, and not in AmeriHealth's name;" (3) "compete for patients against other physicians within AmeriHealth's network;" (4) "are highly skilled professionals engaged in a distinct occupation who receive no training from AmeriHealth;" (5) "must abide by standards and ethical rules apart from any requirements that AmeriHealth may impose;" (6) "do not work at AmeriHealth's facilities, but instead supply 'the instrumentalities, tools and the place of work;'" (7) had the ability to negotiate fee arrangements with AmeriHealth; and (8) "are paid fees 'by the job' from which they must cover a wide variety of unreimbursed expenses, including the wages and benefits of their own employees." Id.

Finally, AmeriHealth lacked substantial market power, since within the two counties in the covered region, only 4% and 7% of the insured populations were members of AmeriHealth. Id., slip. op. at 4. On a nationwide basis, only about 35% of all insured patients are members of HMOs. Id., slip op. at 2. Since HMOs generally, and AmeriHealth specifically, currently do not dominate their markets, the potential antitrust concerns are not at the level that would exist if these entities had monopoly power. However, in areas where one HMO has substantial market power, antitrust issues would have to be considered in this analysis under the NLRA.

Regional Director Moore-Duncan therefore dismissed the physicians' petition, since:

> I find that while AmeriHealth controls, or has the right to control, which particular health care services the physicians provide AmeriHealth members that will be covered by AmeriHealth's insurance plans, AmeriHealth lacks substantial control "with respect to the physical conduct in the performance of the services" the physicians provide. . . . Accordingly, I find that the factors of the common law agency test weigh heavily in favor of independent contractor status for the petitioned-for physicians, and conclude that the physicians are not employees of AmeriHealth but are independent contractors within the meaning of the [NLRA].

Id., slip op. at 15.

The AmeriHealth decision, while being only that of a Regional Director, was not reversed by the NLRB commissioners. The decision is of significant import as being of first impression, and is likely to prove influential in other jurisdictions where private practice physicians are engaged in ongoing efforts to unionize or otherwise collectively negotiate with

HMOs and other managed health care provider entities.[3] However, the NLRB commissioners noted in denying review, that they were "not necessarily precluding a finding that physicians under contract to health maintenance organizations may, in other circumstances, be found to be statutory employees." AmeriHealth II, slip. op. at 1 n.1.[4]

B. Hospital Physicians and the NLRA.

In contrast to the unsuccessful attempt by private practice physicians to engage in collective bargaining, hospital physicians and residents have, under some circumstances, been successful in being recognized by the NLRB as a bargaining unit under the NLRA.[5] Indeed, the NLRB itself promulgated regulations in 1989 expressly recognizing that hospital physicians can form a bargaining unit. See 29 C.F.R. § 103.30(a)(2); see also American Hosp. Ass'n v. NLRB, 499 U.S. 606, 620 (1991) (upholding NLRB's rulemaking). However, these regulations only cover physicians at "acute care hospitals" and exclude physicians at "nursing homes, primarily psychiatric homes, or primarily rehabilitation hospitals." See 29 C.F.R. § 103.30(f)(2). Furthermore, physicians who are themselves supervisors are statutorily precluded from collective bargaining. See 29 U.S.C. § 152(3) ("The term 'employee' . . . shall not include . . . any individual employed as a supervisor . . .").

For example, the staff physicians of the Thomas-Davis Medical Centers ("TDMC") in Arizona voted in December of 1996 to be represented by a union, the Federation of Physicians and Dentists, an affiliate of the AFSCME (American Federation of State, County and Municipal Employees).[6] Thomas-Davis Medical Centers, P.C., 324 NLRB 29, 30 (1997), aff'd 157 F.3d 909 (D.C. Cir. 1998). However, the TDMC refused "the Union's request to bargain following the Union's certification . . . as the exclusive bargaining representative of the physicians." Id. at 29. TDMC "admit[ted] their refusal to bargain, but they attack[ed] the validity of the certification on the grounds that the physicians are supervisors or managerial personnel." Id.

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[3] See also "Regional Director Finds HMO Physicians in New Jersey are Independent Contractors," 67 U.S.L.W. 2713-14 (June 1, 1999) (describing this "eagerly awaited decision" which "comes as record numbers of physicians are seeking out unions in reaction to restrictions imposed by managed health care programs").

[4] See also P.D. Stergios & J.D. Williams, "NLRB Redefines 'Employee' in the Medical Field," Nat'l L.J., Feb. 14, 2000, at C2, C5.

[5] See also D. Van Duch, "Employed Physicians Unionizing: Price-Fix Risks," Nat'l L.J., July 21, 1997, at A1 ("Eight physician unions now represent an estimated 20,000 doctors, primarily residents, interns or other physicians employed by hospitals or health maintenance organizations.").

[6] See generally L.A. Flavin, "The Thomas-Davis Cases: The Appropriateness of Physicians as Bargaining Units and the Possible Implications for Insurance Companies Under the National Labor Relations Act," 30 Ariz. St. L.J. 811, 821-23 (1998).

The Regional Director had, during the representation stage, rejected TDMC's assertion that the physicians were supervisors, and the NLRB upheld this decision, finding that TDMC's "refusal constitutes an unlawful refusal to bargain in violation of the [NLRA]." Id. at 30. Therefore, the NRLB ordered TDMC to (1) "Cease and desist from refusing to bargain with the [Union];" (2) bargain with the Union as the exclusive representative of the employees [physicians];" and (3) post a notice in all its worksites, for 60 days, stating that the TDMC had violated the NLRA, and that the TDMC will bargain with the Union. Id. at 31-32. It should be noted that the physicians in the bargaining unit encompassed "all regular full-time and part-time physicians, including department chairs . . . excluding all other employees, physician medical directors, assistant medical directors . . ." thereby carving out some supervisory physicians from the bargaining unit. Id. at 31.

In November 1999, the NLRB ruled that medical residents and interns (also known as "housestaff"), who are medical school graduates engaged in supervised post-graduate training before becoming fully licensed physicians, and are associated with privately operated hospitals that are not within the scope of state public employee statutes were "employees" under the NLRA and therefore could obtain union representation for the purpose of engaging in collective bargaining. Boston Med. Ctr. Corp., 330 NLRB No. 30 (Nov. 26, 1999). The NLRB thereby overruled two of its prior opinions and their progeny that were to the contrary. Id., slip op. at 1 (overruling St. Clare's Hosp. & Health Ctr., 229 NLRB 1000, 1001-02 (1977); Cedars-Sinai Med. Ctr., 223 NLRB 251, 253 (1976)).[7]

The NLRB made extensive factual findings that the residents and interns were analogous to employees, not to medical students. Boston Med. Ctr. Corp., 330 NLRB No. 30, slip op. at 2-5, 9-10. The NLRB recognized that this finding was congruent with those made by a number of courts. Id., slip op. at 12 ("Almost without exception, every other court, agency, and legal analyst to have grappled with this issue has concluded that interns, residents, and fellows are, in large measure, employees.") (collecting cases).[8]

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[7] See also Physicians Nat'l House Staff Ass'n v. Fanning, 642 F.2d 492, 500 (D.C. Cir. 1980) (en banc) (refusing to review NLRB's determination that housestaff are students, not employees). See generally D.L. Gregory, "The Problematic Employment Dynamics of Student Internships," 12 Notre Dame J. L. Ethics & Pub. Pol'y 227, 250-52 (1998) (discussing housestaff unionization attempts at Boston Medical Center Hospital, Howard University Hospital and Maimonides Hospital of Brooklyn); J.P. Furfaro & M.B. Josephson, "New York Medical Residents Organizing at Increasing Rate," N.Y. L.J., Apr. 10, 2001 (noting that in March 2001, medical interns and residents at two New York hospitals "voted to join the Committee of Interns and Residents," a union).

[8] The NRC subsequently extended Boston Medical to hold that graduate students who were teaching or research assistants at private universities had the right to collectively bargain. See New York Univ., 332 NLRB No. 111, slip op. at 4 (Oct. 31, 2000). However, this holding only covers graduate students whose scholarship or stipend is paid directly by the university, and

The courts have previously recognized that medical residents and interns at hospitals operated by a public university or a governmental entity can engage in collective bargaining. See, e.g., Regents of the Univ. of Cal. v. Public Empl. Relations Bd., 715 P.2d 590, 599-600 (Cal. 1986) (collecting cases). For example, the Supreme Court of California recognized that the California public employee statute allowed medical students at the public university medical school hospitals who were in certain categories of employment, including housestaff, to bargain collectively. Id. at 593-600.

3. Private Practice Physicians and Federal Employment Discrimination Laws.

Private practice physicians, who are independent contractors and hence have been excluded from the NLRA, are faced with similar problems under certain federal and state employment discrimination laws, since their status as independent contractors has often been held to preclude them from the protection of these latter statutes. Although the following discussion is based on federal employment discrimination statutes, specifically Title VII, analogous results would obtain under many state and local statutes, which are often modeled on Title VII's statutory scheme.

Section 703 of Title VII of the Civil Rights Act of 1964, as amended, provides in relevant part, that:

> (a) It shall be an unlawful employment practice for an employer — (1) . . . to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex or national origin.

42 U.S.C. § 2000e-2(a)(1) (emphasis added). Title VII also includes a "mixed motive" element whereby the plaintiff can recover when she "demonstrates that race, color, religion, sex, or national origin was a motivating factor for any employment practice, even though other factors also motivated the practice." 42 U.S.C. § 2000e-2(m). Finally, Title VII also protects employees from retaliation for (1) opposing discrimination or harassment, or (2) participating in an inquiry into discrimination or harassment. The "opposition" clause makes it unlawful to discriminate against a person who "has opposed any practice made an unlawful employment practice by this subchapter," and the "participation" clause similarly makes it unlawful to discriminate against a person who "has made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this subchapter." 42 U.S.C. § 2000e-3(a) (emphasis added).

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not those who are supported by external grants, such National Science Foundation (NSF) or National Institutes of Health (NIH) grants. Id. at 4, 10, 15-16. Since graduate assistants at medical schools are more likely to have external grant support, they would not be covered by this recent decision.

The definition of "employee" under Title VII is circular: an employee is defined as "an individual employed by an employer" while an employer is defined as "a person . . . who has fifteen or more employees [for a stated time period]." 42 U.S.C. §§ 2000e(b), 2000e(f). Therefore, the courts have had to determine, as discussed in Section 2, supra, whether physicians in private practice or associated with a hospital are employees under Title VII and other federal employment discrimination statutes. As discussed infra, the courts have usually denied the statutory protections of Title VII to physicians who were found to be independent contractors. The determination of the employment status of physicians largely turns on the underlying facts which have been incorporated into the following discussion.

Physicians can enter into various contractual relationships with a hospital. Some physicians are employed directly by the hospital, instead of having a private practice. Such physicians, sometimes termed house physicians, are considered employees of the hospital, since the terms and conditions of their employment are controlled by the hospital. In contrast, staff physicians are those who have a private practice away from the hospital, and have "staff privileges" with the hospital which allows them to use the hospital to provide medical treatment to their patients. As the Fourth Circuit stated, "Staff privileges at a hospital facilitate a physician's practice. Such privileges enable a physician to admit and treat patients, order medication and procedures, receive various services from hospital staff, and use hospital equipment and office space." Bender v. Suburban Hosp., Inc., 159 F.3d 186, 187 (4th Cir. 1998). Physicians may have staff privileges at multiple hospitals.

A. Independent Contractors under Section 1981.

It must be emphasized that Section 1981, the Civil Rights Act of 1866 statute which prohibits racial discrimination in the making and enforcement of contracts, does not turn on the employment status of the aggrieved individual, but rather is based upon the existence of a contractual relationship between the parties. 42 U.S.C. § 1981; see also Danco, Inc. v. Wal-Mart Stores, Inc., 178 F.3d 8, 14 (1st Cir. 1999) (independent contractors have a cause of action under Section 1981), cert. denied, 528 U.S. 1105 (2000). Therefore, physicians who are independent contractors can bring Section 1981 claims against the discriminating entity with whom they have contracted to provide services, although they have not necessarily been successful in proving the alleged discrimination. See, e.g., Pamintuan v. Nanticoke Mem'l Hosp., Inc., 192 F.3d 378, 385-88 (3d Cir. 1999) (upholding summary judgment to hospital on physician's Section 1981 claim since no discriminatory motive existed); Vakharia v. Swedish Covenant Hosp., 190 F.3d 799, 806-10 (7th Cir. 1999) (same), cert. denied, 530 U.S. 1204 (2000).[9]

[9] See generally E.W. Glover, "Legitimacy of Independent Contractor Suits for Hostile Work Environment under Section 1981," 52 Ala. L. Rev. 1301, 1310 (2001) ("The overwhelming majority of the cases have allowed an independent contractor to sue under Section 1981."). However, two district courts have held that, since the same legal framework should be used for both Title VII and Section 1981 claims, that an independent contractor cannot bring a Section 1981 claim. See Holtzman v. World Book Co., No. 00-3771, 2001 WL 936492 (E.D.

A further complicating factor for Section 1981 claims is that physicians with staff privileges may structure their contractual relationship with the hospital indirectly, through their own professional corporation. In such circumstances, the contractual relationship for the purposes of Section 1981 is not between the physician and the hospital, but is between the physician's professional corporation and the hospital. Where the independent contractor physician lacks a direct contractual relationship with the hospital, then she will not have a Section 1981 claim. See Danco, 178 F.3d at 14 ("It appears, not surprisingly, that the contract in question was between Wal-Mart and Danco. Nothing in Section 1981 provides a personal claim, so far as its language is concerned, to one who is merely affiliated — as an owner or employee — with a contracting party that is discriminated against by the company that made the contract."); accord North Am. Roofing & Sheet Metal Co. v. Building & Constr. Trades Council of Phila. & Vicinity, AFL-CIO, No. Civ. A. 99-2050, 2000 WL 230214, *3 (E.D. Pa. Feb. 29, 2000). Thus, only the corporation would be entitled to a direct award of Section 1981 damages; a physician can only receive those damages through her professional corporation, if she has properly pled her professional corporation as a co-plaintiff.[10]

In what appears to be a case of first impression, the Colorado Court of Appeals recently held that a hospital's medical staff bylaws did not create a Section 1981 contractual relationship between a physician and the hospital, where the physician was employed by a corporation that had a contract to provide emergency room services to the hospital. Lufti v. Brighton Community Hosp. Ass'n, 85 Fair Empl. Prac. Cases (BNA) 1157, 1161-62 (Colo. Ct. App. 2001).

Similarly, some state or local anti-discrimination statutes may also protect independent contractors. See, e.g., Marquis v. City of Spokane, 922 P.2d 43, 53 (Wash. 1996) (independent contractor had a cause of action under the Washington state civil rights statute). At the same time, Section 1981 claims are not available against state government entities thereby precluding such suits by physicians against state university hospitals. See Freeman v. Michigan Dep't of State, 808 F.2d 1174, 1178-80 (6th Cir. 1987) (Section 1981 claims of state employees barred by the Eleventh Amendment) (collecting cases).

B. Title VII Cases Holding Physicians to be Independent Contractors.

In Cilecek, the plaintiff physician alleged that his employment was terminated in retaliation for having testified in a hospital employee's sexual harassment lawsuit. Cilecek v.

Pa. Aug. 13, 2001); Roscoe v. Aetna Cas. & Sur. Co., No. 88-AR-0882-S, 1988 WL 214511 (N.D. Ala. Nov. 8, 1988). These two cases arguably have mistaken the jurisdictional issue (standing) with the burden of proof.

[10] See also Glover, supra note 9, at 1314 ("Secondly, only the independent contracting party may sue. This second limitation means that, in the future, only a proper party to the contract can sue; thus, the First Circuit reasoned that only Danco should have been able to bring the claim, not [Mr.] Giuliani.").

Inova Health Sys. Serv., 115 F.3d 256, 259 (4th Cir. 1997). Dr. Cilecek provided emergency room services at two hospitals owned and operated by defendants, but his letter to the defendants accepting the contract expressly stated that he was an independent contractor, paid on an hourly rate and with a flexible work schedule. Id. at 258. The Fourth Circuit applied the aforementioned common law of agency factors in determining whether a physician was an employee or an independent contractor. Thus, the Cilecek court recognized that both physician and hospital had control over the services provided by the physician: "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." Id. at 260.

The Cilecek court concluded that, in the medical context, the "degree of control" test for determining employee status was best considered with regard to "the control involved in deciding when a doctor performs his services, the number of hours he performs them, and the administrative details incident to his professional services," as opposed to "the control over the discharge of professional services" which is less relevant for physicians than for non-professional service relationships. Id.

Therefore, the Fourth Circuit listed the following ten factors as relevant for determining whether a physician on contract with a hospital was an employee or an independent contractor:

> (1) the control of when the doctor works, how many hours he works, and the administrative details incident to his work; (2) the source of instrumentalities of the doctor's work; (3) the duration of the relationship between the parties; (4) whether the hiring party has the right to assign additional work to the doctor or to preclude the doctor from working at other facilities; (5) the method of payment; (6) the doctor's role in hiring and paying assistants; (7) whether the work is part of the regular business of the hiring party and how it is customarily discharged; (8) the provision of pension benefits and other employee benefits; (9) the tax treatment of the doctor's income; and (10) whether the parties believe they have created an employment relationship or an independent contractor relationship.

Id. at 261. After reviewing the underlying contractual relationship and the nature of Dr. Cilecek's duties, the Fourth Circuit concluded that the plaintiff physician "exercised an independence from [defendants] that enabled him to determine his hours, his income, and who he worked for. These are core incidents to a work relationship that are inconsistent with employee status." Id. Furthermore, "the parties carefully designed their relationship to give Cilecek greater freedom than might otherwise be enjoyed by salaried employees of a hospital, and to that end they mutually agreed that they wanted to establish an independent contractor relationship." Id. at 262. Finally, "the mutual intent to create an independent contractor relationship was confirmed uniformly by the parties in the way they treated benefits and taxes and in the way they represented their relationship to third parties." Id. at 262-63.

Cilecek is important not merely for its underlying factual pattern which is analogous to other physicians who have a contractual relationship with a hospital yet are not regular staff physicians, but also for its straightforward elaboration of the aforementioned ten factors.

In Bender, the plaintiff physician, who had a private practice, had staff privileges with two hospitals in Maryland, and she alleged that the termination of her staff privileges at one hospital was based on gender discrimination and retaliation. Bender v. Suburban Hosp., Inc., 998 F. Supp. 631, 632 (D. Md.) ("Bender I"), aff'd 159 F.3d 186 (4th Cir. 1998) ("Bender II"). The District Court, relying on Cilecek, recognized that Dr. Bender's status as a staff physician placed her beyond independent contractors from the scope of Title VII's protection of employees. Bender I, 998 F. Supp. at 635-36. The District Court applied Cilecek's aforementioned differentiation of physicians who are independent contractors from those "merely with [staff] privileges" by stating that:

> This language must mean that there exists a continuum with "doctors merely with privileges" being even further removed from the employee status than are independent contractors. At the other end of the continuum are physician-employees, doctors employed by a hospital on a full-time basis to treat the hospital's patients. . . . The "mere privilege" category apparently contemplates doctors whose privileges grant them access to hospital facilities to treat their own patients but require no commitment to use the facilities or to treat a hospital's patients.

Id. at 635 (internal citation omitted). As in Cilecek, the terms and conditions of Dr. Bender's relationship with the defendant hospital were "inconsistent with employee status" given the large degree of independence that the plaintiff had in deciding whether and how to use the hospital's facilities. Id. at 636. The District Court concluded that its determination "is consistent with the outcome of numerous cases analyzing physician-hospital relationships. . . . [which] share a common result by holding that physicians are not employees of privilege-granting hospitals." Id. at 637 (collecting cases). The District Court also dismissed Dr. Bender's claim that the defendant hospital had interfered with her employment with third parties, i.e., through reporting the termination of her staff privileges to the National Practitioners Data Bank, as required by federal statute. Id. at 634, 637-38. The Fourth Circuit affirmed the District Court on the latter issue, which was the only one raised on appeal. Bender II, 159 F.3d at 190-92.

In Alexander, the plaintiff physician alleged that his employment was terminated on the basis of his religion (Muslim) and national origin (Egyptian). Alexander v. Rush North Shore Med. Ctr., 101 F.3d 487, 489-90 (7th Cir. 1996). Dr. Alexander, an anesthesiologist, had staff privileges at Rush North Shore which essentially allowed him great flexibility in exercising those privileges, except that he "was required to spend a specified amount of time per week 'on call' to the hospital's emergency room." Id. at 489. After an incident where Dr. Alexander refused to assist with an emergency room patient, "his staff privileges had been revoked for violation of the hospital's on-call policy." Id. The Seventh Circuit affirmed the grant of summary judgment to defendants on the grounds that Dr. Alexander was an independent

contractor, not an employee of the hospital, and hence could not bring suit under Title VII. Id. at 494.

The Alexander court reviewed the common law of agency and concluded that of the analytical factors, the most important was "the employer's right to control" or the "employer's control over the manner of work performance." Id. at 492-93 & n.1 (citations omitted). Here, Dr. Alexander: "[1] listed his employer . . . as his personal wholly-owned professional corporation that was responsible for paying [all his benefits]; [2] was responsible for billing his patients and he collected his fees directly from them; [3] never received any compensation, paid vacation, private office space, or other paid benefits from Rush North Shore; [4] he had the authority to exercise his own independent discretion concerning the care he delivered to his patients based on his professional judgment . . .; [5] he was not required to admit his patients to Rush North Shore; and [6] he was free to associate himself with other hospitals if he wished to do so." Id. at 493 (bracketed numbering added). The Seventh Circuit expressly rejected Dr. Alexander's claim that the on-call requirement made him an employee, since such "constraints do not, however, establish an employer-employee relationship because the details concerning performance of the work remained essentially within the control of the [plaintiff]." Id. (quoting Ost v. West Suburban Travelers Limousine, Inc., 83 F.3d 435, 438 (7th Cir. 1996)). Alexander is analogous to other physicians in private practice who have staff privileges at local hospitals, yet have structured their contractual relationship through their own professional corporations.

In addition to the Fourth and Seventh Circuits, the Fifth and Eleventh Circuits and district courts in the District of Columbia, Second and Third Circuits have similarly concluded that physicians with staff privileges are not employees under Title VII. Diggs v. Harris Hosp.-Methodist, Inc., 847 F.2d 270, 272-73 (5th Cir. 1988); Pardazi v. Cullman Med. Ctr., 838 F.2d 1155, 1156 (11th Cir. 1988); Pamintuan v. Nanticoke Mem'l Hosp., Inc., 78 Fair Empl. Prac. Cases (BNA) 1071, 1077-78 (D. Del. 1997), aff'd on other grounds, 192 F.3d 378 (3d Cir. 1999); Johnson v. Greater Southeast Community Hosp., 903 F. Supp. 140, 154-56 (D.D.C. 1995); Beverley v. Douglas, 591 F. Supp. 1321, 1326-29 (S.D.N.Y. 1984).

Although the provisions and coverage of the federal statutes that prohibit discrimination against the disabled are beyond the scope of this chapter, the Third Circuit, in Menkowitz, held that a physician with staff privileges who alleged that his termination was based on his disability (i.e., attention deficit disorder), could bring a discrimination claim under Title III of the Americans with Disabilities Act, 42 U.S.C. §§ 12181-12189 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Menkowitz v. Pottstown Mem'l Med. Ctr., 154 F.3d 113, 117-25 (3d Cir. 1998). In contrast, the Sixth Circuit, in an unpublished opinion, held that a physician with staff privileges could not bring an ADA claim, since he was an independent contractor. Chadha v. Hardin Mem'l Hosp., No. 99-3166, 2000 WL 32023, at *3, 202 F.3d 267 (6th Cir. Jan. 6, 2000) (per curiam).[11]

[11] See generally M.R. Lowe, "Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees Under Title VII or the ADA Act when Alleging

C. Title VII Cases Holding Physicians to be Employees.

In contrast, relatively few cases have held that physicians with staff privileges or another independent contractor relationship are employees of the defendant hospital. Indeed, the Bender district court expressly disagreed with Pao and Mallare, infra, on the grounds "that they improperly merge the consideration of interference in third party employment relationships with the question of whether the hospital and physician had an employment relationship." Bender I, 998 F. Supp. at 637 n.3. Furthermore, four of the cases discussed herein are all from the 1980s, thereby predating the Supreme Court's Town & Country/Darden/Reid analytical framework for differentiating between employees and independent contractors.

In Mitchell, the Ninth Circuit held that a physician with an oral contract to provide radiology services for a small rural hospital was an employee, not an independent contractor, for the purposes of Title VII. Mitchell v. Frank R. Howard Mem'l Hosp., 853 F.2d 762, 766-67 (9th Cir. 1988). Dr. Mitchell, a Mormon, alleged that the termination of the contract by the defendants violated Title VII on the basis of religious discrimination. Id. at 763. The district court had dismissed the Title VII claim, holding that Dr. Mitchell was an independent contractor and hence lacked an employment relationship with the hospital. Id. at 766. The Ninth Circuit reversed, primarily because (1) Dr. Mitchell's contract "provided that he would treat Hospital patients; he does not allege that he used the Hospital's facilities to treat his own patients;" and (2) Dr. Mitchell "would receive in compensation for his services forty percent of the gross billings of the radiology department during the time the agreement was in effect. . . . [he] was paid by the Hospital rather than by the patients." Id. at 766-67. Therefore, "the Hospital enjoyed considerable control over 'the means and manner' of Dr. Mitchell's performance." Id. at 767. Thus, even though the hospital's contractual relationship with Dr. Mitchell was through his professional corporation, of which he was the sole shareholder and sole employee, the Ninth Circuit found an employment relationship. Mitchell is distinguishable from the cases cited in the previous section, since Dr. Mitchell did not have mere staff privileges, but was more analogous to a regular hospital employee, notwithstanding the existence of his professional corporation. See also Bender I, 998 F. Supp. at 637 n.3 (differentiating Mitchell on the basis of the compensation agreement).

In Vakharia, a district court in Illinois initially denied defendant's motion to dismiss the Title VII and ADEA claims, since the employment status of the plaintiff physician with "staff privileges" was found to be that of an employee, not an independent contractor, primarily because the plaintiff did not have an outside practice and only obtained patients through assignment by the hospital and its staff surgeons. Vakharia v. Swedish Covenant Hosp., 765 F. Supp. 461, 463-69 (N.D. Ill. 1991). However, the district court ultimately granted summary judgment to the defendants on the Title VII claims, since under the Seventh Circuit's intervening Alexander decision, supra, Dr. Vakharia was an independent contractor, not an employee of the defendant hospital. Vakharia v. Swedish Covenant Hosp., 987 F. Supp. 633, 635-36 (N.D. Ill.

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an Employment Discrimination Claim?" 13 Lab. Law. 225 (1997).

1997), aff'd, 190 F.3d 799, 806-10 (7th Cir. 1999), cert. denied, 530 U.S. 1204 (2000). Further, there was no evidence of discriminatory conduct. Vakharia, 987 F. Supp. at 640-43.

In Mallare, a district court in Pennsylvania denied defendant's motion for summary judgment on the Title VII claim, since it was an issue for trial as to whether a physician who had been denied staff privileges by a hospital after having served that hospital as a resident had an employment relationship under Title VII. Mallare v. St. Luke's Hosp. of Bethlehem, 699 F. Supp. 1127, 1133 (E.D. Pa. 1988). Dr. Mallare, an obstetrician/gynecologist, alleged national origin (Filipino) discrimination. Id. at 1131. The court reviewed the nature of control by hospitals over physicians with staff privileges, and recognized "that most doctors would not consider themselves employees of the hospitals at which they maintain staff privileges." Id. at 1130. However, the court then recognized that "ultimate control can be exercised by a hospital in the sense that privileges can be withdrawn if a doctor's performance does not comport with hospital standards." Id. The determinative issue at the summary judgment stage was that "there is only one hospital in the area in which the doctor expects to practice, [therefore] denial of staff privileges there severely limits, if it does not completely foreclose, the opportunity to develop a full practice in obstetrics/gynecology." Id. Thus, Mallare is distinguishable from many physicians in private practice who have a choice of hospitals to obtain staff privileges. After trial, the district court ultimately entered judgment for the defendant hospital on the grounds that while Dr. Mallare, as a resident, had "a legitimate expectation that he would be granted staff privileges if he successfully completed the prescribed residency program," his failure to obtain these privileges was based on "his lack of competence in the field of obstetrics and gynecology," and not his nationality. Mallare v. St. Luke's Hosp. of Bethlehem, C.A. No. 86-7291, 1989 WL 156304, at *1, *9 (E.D. Pa. Dec. 21, 1989), aff'd 914 F.2d 243 (3d Cir. 1990) (table)..

In Amro, a case involving the same defendant hospital as Mallare, the district court found that the plaintiff's residency had an implied promise of staff privileges upon successful completion of the residency. Amro v. St. Luke's Hosp. of Bethlehem, 39 Fair Empl. Prac. Cases (BNA) 1574, 1577 (E.D. Pa. 1986) ("Even though the right to have staff privileges was not a contractual provision in Dr. Amro's contract, it would still be actionable under Title VII as a benefit which cannot be doled out in a discriminatory manner."). However, the court then granted summary judgment to defendants on plaintiff's Title VII national origin claim, since the plaintiff failed to submit sufficient evidence to create a genuine issue of material fact regarding the existence of discrimination. Id. at 1579.

In Pao, a district court in Pennsylvania denied the defendant's motion to dismiss the Title VII claim of a physician who alleged that the repeated denials of his application for staff privileges were discriminatory. Pao v. Holy Redeemer Hosp., 547 F. Supp. 484, 494-95 (E.D. Pa. 1982). Dr. Pao, of Chinese ancestry and race, was an ophthalmologist who already had staff privileges at other hospitals in the area, but desired staff privileges at the defendant hospital since "(a) Holy Redeemer is often the most convenient hospital for his patients; (b) the Hospital contains special ophthalmological equipment which he needs to provide comprehensive treatment to his patients; and (c) he has lost patients due to the lack of staff privileges." Id. at 488. The district court recognized that the availability to a physician of staff privileges at other

hospitals "is not relevant to the principal question whether his Title VII rights have been violated" which instead turns on whether "defendants' discriminatory conduct will have deprived the plaintiff of prospective patients desiring the convenience and resources of Holy Redeemer Hospital's retinal facilities." Id. at 494. Thus, Pao may be distinguishable from the typical physician staff privilege case, since in Pao the defendant hospital had certain medical equipment not available at the other local hospitals where the plaintiff physician had staff privileges, which, in essence, created a monopoly situation.

D. The Employment Status of "Permatemps."

Recent years have seen the increasing growth in the use of outside employment agencies that provide contract employees to work on a temporary basis with companies and other entities.[12] Although the likes of "Kelly Girls" have been around for decades, the new "permatemps" are those workers who are "long-term temporary workers" who may work at one employer for substantial periods of time, running into years, and often longer than regular employees.[13] The Ninth Circuit, in a case of first impression, recently held that these temporary employees of Microsoft were entitled to employee benefits, specifically the employee stock purchase plan, notwithstanding the fact that they were ostensibly employed through employment agencies and not directly by Microsoft itself. Vizcaino v. Microsoft Corp., 173 F.3d 713, 725 (9th Cir. 1999), cert. denied, 528 U.S. 1105 (2000). Microsoft had denied employee benefits to these permatemps, since "Microsoft considered them independent contractors or employees of third-party employment agencies." Id. at 717.

The Ninth Circuit recognized the inherent complexities in the analytical framework:

> We agree that the assessment of the triangular relationship between worker, temporary employment agency and client is not wholly congruent with the two-party relationship involving independent contractors. . . . Even if for some purposes a worker is considered an employee of the agency, that would not preclude his status of common law employee of Microsoft. The two are not mutually exclusive.

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[12] See General Accounting Office, "Contingent Workers: Incomes and Benefits Lag Behind Those of Rest of Workforce," GAO/HEHS-00-76 (June 2000).

[13] See L. Bernabei, "Microsoft: Separate and Unequal Treatment of Its Employees," 2 J. Empl. Disc. L. 205 (2000); see generally P. Barnes, "Revolt of the Worker Bees: 'Permatemps' Sue Employers over Benefits, Stock Options," ABA J., Sept. 1999, at 26-27.

Id. at 723. The Ninth Circuit stated that "the determination of whether temps were Microsoft's common law employees turns not on whether they were also employees of an agency but rather on application of the Darden factors to their relationship with Microsoft." Id. at 724.[14]

On August 25, 2000, the NLRB ruled that temporary workers could be included for representational purposes in a bargaining unit with employees who are solely employed by the employer. M.B. Sturgis, Inc., 331 NLRB No. 173 (Aug. 25, 2000). The NLRB recognized that contingent workers had become an increasingly important component of the modern workforce, and that it would be inequitable to exclude them from the benefits of unionization. Id., slip op. at 10 ("There is but one set of labor laws in this country, and it is our obligation to respond to developing policy issues that come before the Board."). For that reason, the NLRB overruled its prior precedent which excluded contingent workers from union representation. Id., slip op. at 11 ("Here too, unless we are to jettison important statutory rights for a growing segment of the work force, we should alter our policy."). This NLRB decision is expected to have a significant impact for employees,[15] including those at medical facilities. Indeed, the general counsel of the Service Employees International Union has already stated that her union "would be able to boost its organizing in hospitals that often hire temporary nurses on a long-term basis."[16]

In an analogous context, the Supreme Court recognized that an individual could be a statutory employee under the NLRA of two employers at the same time. NLRB v. Town & Country Elec., Inc., 516 U.S. 85, 94-95 (1995); see also AmeriHealth II, slip op. at 16 (citing NLRB commission decisions holding certain "individuals to be employees of an employer, even though the employees may perform the same work for others during the same period").

The Microsoft litigation and the NLRB's recent M.B. Sturgis, Inc. ruling are of direct relevance to private practice physicians who structure their employment relationship with a hospital or HMO through their own professional corporation or through a third party employment agency, as this may allow them to argue that they are employees of both the professional corporation or agency and of the hospital or HMO. Similarly, many hospitals and medical centers are using increasing numbers of permatemps to staff their nursing, technician,

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[14] Microsoft ultimately settled this class action, agreeing to pay $96.9 million to the permatemps. See S. Greenhouse, "Temp Workers at Microsoft Win Lawsuit," N.Y. Times, Dec. 13, 2000, at C1, C7; S. Schafer & A. Joyce, "Microsoft to Settle with Temp Workers," Wash. Post, Dec. 13, 2000, at E1, E2.

[15] See generally N. Schiffer, "Organizing Contingency Workers: Community of Interest v. Consent," 17 Lab. Law. 167 (2001) (discussing consequences of M.B. Sturgis); R.W. Tollen, "When Is a Multiemployer Bargaining Unit a 'Multiemployer Bargaining Unit'?," 17 Lab. Law. 183 (2001) (same).

[16] See F. Swoboda, "Temporary Workers Win Benefits Ruling," Wash. Post, Aug. 31, 2000, at A1, A22-A23; see generally C. Johnson, "Ruling on Temps Reflects a Changing Workplace," Wash. Post, Sept. 10, 2000, at M1, M2.

clerical and other positions. These medical permatemps can also claim that they should be entitled to the same fringe benefits as received by the regular hospital employees, and should be allowed to unionize.

E. Other Remedies for Physicians.

In addition to the federal and state employment discrimination laws, physicians have sought other remedies to recover for alleged wrongful termination by the HMO or hospital for having made medical decisions that were in the best interests of their patient, but were not approved by the HMO for economic reasons.

The California Court of Appeal, the intermediate appellate court, in Wickline, recognized that a health insurance provider could be held liable if it made a decision not to allow a medical treatment and the patient subsequently was injured because of that denial of treatment. Wickline v. State of Calif., 192 Cal. App. 3d 1630, 1645 (Cal. Ct. App. 1986). The Court also recognized that the physician has an obligation to protest such a denial of treatment if her medical judgment indicates that treatment is necessary; the physician "cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour." Id.

In 1993, the California Legislature enacted Section 2056 of the Business and Professions Code, which has the statutory purpose "to provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients pursuant to Wickline ..." Cal. Bus. & Prof. Code § 2056(a). Specifically, "a decision to terminate an employment or other contractual relationship with, or otherwise penalize, a physician or surgeon principally for advocating for medically appropriate health care . . . violates the public policy of this state." Id., § 2056(c). In 1996, the California statute was amended to add the provision that "No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate health care." Id.

There are no published cases under this California statutory provision. In 1998, a state court jury in San Diego awarded $1.75 million in compensatory damages to a pediatrician "who claimed that he was fired by [defendants] for refusing to limit care to HMO patients;" the case settled for $2.4 million before the jury considered punitive damages.[17]

In contrast, the Supreme Court recently held that patients could not sue their HMO under the Employee Retirement Income Security Act ("ERISA") to allege that the HMO wrongfully denied them medical treatment for economic reasons. Pegram v. Herdrich, 530 U.S. 211 (2000).

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[17] See M.C. Fisk, "Old Torts, New Bottles," Nat'l L.J., Sept. 27, 1999, at A1, A9 (discussing Self v. Children's Assoc. Med. Group, No. 655870 (Super. Ct. San Diego Co.)).

The Supreme Court held that eligibility for treatment decisions did not fall within the scope of ERISA's fiduciary duty statute, 29 U.S.C. § 1109(a), since the consequence would be that every state law malpractice claim against a physician would be transformed into a federal law fiduciary claim against the HMO. Id. at 235-37.

F. Hospital Liability for Harassment by Physicians with Staff Privileges.

Hospitals and related medical entities should be aware that even though physicians with staff privileges may not be employees for purposes of Title VII, the hospital itself can still be liable for harassment by those physicians of hospital employees. There is a growing body of case law which recognizes that employers can be liable for harassment of their employees by non-employees -- typically customers, but also independent contractors on the worksite. See, e.g., Berry v. Delta Airlines, Inc., ___ F.3d ___, 2001 WL 910781, *8 (7th Cir. Aug. 14, 2001) (collecting cases); Lockard v. Pizza Hut, Inc., 162 F.3d 1062, 1073-74 (10th Cir. 1998) (same); Graves v. County of Dauphin, 98 F. Supp. 2d 613, 619-20 (M.D. Pa. 2000) (same).[18] The EEOC regulations interpreting Title VII similarly recognize employer liability for actions of non-employees. See 29 C.F.R. § 1604.11(e) (2001).

Thus, several courts have held that hospitals can be liable for sexual harassment of an employee by an independent contractor, where the employee reported the harassment, but the hospital delayed in taking effective action. See Otis v. Wyse, No. 93-2349-KHV, 1994 WL 566943, at *6-7 (D. Kan. Aug. 24, 1994) (independent medical provider); Sparks v. Regional Med. Ctr. Bd., 792 F. Supp. 735, 738, 742-47 (N.D. Ala. 1992) (director of hospital pathology lab); Woods-Pirozzi v. Nabisco Foods, 675 A.2d 684, 694 (N.J. Super. Ct. App. Div. 1996) (health lab physician). Since physicians with staff privileges and other independent contractors are generally not supervisors of the affected employees, the standard of liability is the negligence standard applied to harassment by co-workers, and not the vicarious liability standard for harassment by supervisors. Berry, 2001 WL 910781, at *8; Lockard, 162 F.3d at 1074.

These cases illustrate the need for hospitals and medical centers to ensure that they provide appropriate anti-harassment training to all physicians and other health care providers with staff privileges or who otherwise have access to their facility. In the alternative, hospitals and medical centers should ensure that their contracts with the third-party corporation that provides these independent contractors stipulate that the contracting party provide such training to its own employees who will work at the hospital or medical center.

4. Physicians as Whistleblowers and as the Target of Whistleblowers.

[18] See generally J.M. Kelly & A. Sinclair, "Sexual Harassment of Employees by Customers and Other Third Parties: American and British Views," 31 Tex. Tech L. Rev. 807, 831-33 (2000) (collecting cases).

An area that continues to generate significant controversy among lawyers and physicians is the investigation and resolution of reports made by physicians and others in the health care industry who allege scientific misconduct by medical researchers, particularly in the context of research that is funded by National Institutes of Health ("NIH") grants. On the one hand, the responsible entities need to investigate these allegations and ensure that the whistleblower is not retaliated against for having reported potential misconduct. On the other hand, these same entities also need to ensure that those who are accused of wrongdoing receive the full due process to which they are entitled before being subjected to administrative sanctions. As the following synopsis shows, the government's performance has been deficient on both fronts.

A. The Applicable Statutes and Regulations.

For medical researchers and entities who receive federal research funding from the NIH, there are a series of procedures for reporting and investigating allegations of scientific misconduct.[19] In 1993, Congress established the Office of Research Integrity ("ORI"), an independent entity within the Department of Health and Human Services ("HHS"). See Pub. L. No. 103-43, Title I, §§ 161, 163 (June 10, 1993), codified at 42 U.S.C. § 289b. The ORI was a successor to the Office of Scientific Integrity ("OSI"), located within NIH, and the Office of Scientific Integrity Review ("OSIR"), located within HHS.[20] Congress recognized that it was necessary to protect the rights of both complainants and the accused:

> It is critical to uncover abuses and to protect the rights of complainants, including the prevention of retaliation against those who have made allegations in good faith. It is equally important to protect the privacy rights and rights to due process of researchers and institutions and to minimize the damage that may result from groundless allegations.

S. Rep. No. 103-2, at 30 (Jan. 27, 1993), reprinted in 1993 U.S.C.C.A.N. 196, 226.

Under the current regulatory scheme, the home institution that receives federal research funds from NIH is required to conduct an initial inquiry into all whistleblower allegations. See

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[19] The discussion herein is based on procedures applicable to medical researchers at universities and other entities that receive federal funding. A different set of procedures applies to researchers at NIH. See "NIH Intramural Research Program Policies & Procedures for Investigating Scientific Misconduct" (May 2, 2001); "NIH Intramural Research Program: Processes for Resolution of Conflicts" (Apr. 23, 1997).

[20] See J.A. Goldner, "The Unending Saga of Legal Controls over Scientific Misconduct: A Clash of Cultures Needing Resolution," 24 Am. J.L. & Med. 293, 296 (1998) (explaining history of ORI and its predecessors).

42 C.F.R. § 50.103(d) (2000).[21] Only if the home institution determines on the basis of the inquiry that an investigation is warranted is the ORI to be notified. Id. at § 50.104(a).[22] The home institution then conducts an investigation and must submit its final report of investigation to ORI. Id. at § 50.104(a)(4). The home institution is responsible for "imposing appropriate sanctions on individuals when the allegation of misconduct has been substantiated." Id. at § 50.103(14).

ORI then reviews the home institution's report, and "may then request clarification or additional information and, if necessary, perform its own investigation." Id. at § 50.104(a)(6). If ORI determines that it must conduct its own investigation, and it proposes a finding of misconduct, then the respondent (accused person) can request a hearing and can provide comments on the draft report.[23] If ORI makes a finding that misconduct occurred, then the respondent has the right to appeal to the Research Integrity Adjudications Panel ("RIAP"), which conducts a de novo review of the underlying allegations.[24] Only upon the issuance of a final agency decision can an accused person seek judicial review. Abbs v. Sullivan, 963 F.2d 918, 926-28 (7th Cir. 1992) (dismissing action for declarative and injunctive relief against OSI investigation since there was no final agency decision).

B. The Government's Mixed Track Record in Resolving Whistleblower Allegations.

Although this administrative scheme of investigation by the home institution, ORI and RIAP is governed by procedures that seemingly address every conceivable issue, the reality has been that in contested cases, these entities have performed poorly, have provided inadequate due process, and have taken longer to resolve issues than is fair to the parties.

ORI has proclaimed its high success rate in closing cases and in upholding guilty findings. For example, for the period 1992-1996, ORI announced that it had a 92% success rate in sustaining findings of misconduct, i.e., 68 cases out of 74.[25] However, outside observers of ORI quickly noted that this statistic does not reflect the fact that in order to achieve these 68 successful resolutions, "ORI had to wade through at least 1500 misconduct allegations," and that

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[21] Although the current regulations still refer to the OSI, they continue to be applied to ORI proceedings.

[22] See Goldner, supra note 20, at 299-302, for a detailed explanation of the inquiry and investigation process as conducted by the home institution.

[23] See Goldner, supra note 20, at 302-03, for a detailed explanation of the ORI process.

[24] See Goldner, supra note 20, at 304-05, for a detailed explanation of the RIAP process.

[25] See J. Friedly, "ORI's Self-Assessment: A Batting Average of .920?" Science, Feb. 28, 1997, at 1255.

ORI has lost in every instance but one where it reversed the home institution's not guilty finding, and the respondent had appealed the ORI's adverse decision.[26]

Several high profile contested cases demonstrate the problems arising from ORI investigations. In 1986, Dr. Margaret O'Toole, a post-doctoral fellow in the laboratory of Dr. Thereza Imanishi-Kari (who was then at MIT and subsequently moved to Tufts), alleged that Dr. Imanishi-Kari had fabricated data in a paper that was co-authored with Nobel laureate David Baltimore. It took ten years for the home institution, NIH, ORI, and RIAP to resolve Dr. O'Toole's allegations, which generated extensive coverage in the scientific press and garnered criticism of these agencies by Congress. After 8.5 years, ORI issued its final report which found that scientific misconduct had occurred and recommended that Dr. Imanishi-Kari be barred from receiving federal research support for ten years.[27]

It took another one and one-half years for the RIAP to completely reverse ORI by finding in Dr. Imanishi-Kari's favor.[28] See Thereza Imanishi-Kari, Ph.D., Docket No. A-95-33, Decision No. 1582, 1996 WL 399931 (H.H.S. June 21, 1996).[29] However, the RIAP decision was criticized by some long-time observers of the HHS process for ignoring highly probative and irrefutable evidence, including that obtained by the Secret Service, and that these process reflect a bias in favor of researchers as opposed to getting to the bottom of the underlying controversy.[30] The Imanishi-Kari case was another in a line of high profile defeats for ORI: after

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[26] Id.

[27] See R. Stone & E. Marshall, "Imanishi-Kari Case: ORI Finds Fraud," Science, Dec. 2, 1994, at 1468-69.

[28] See J. Kaiser & E. Marshall, "Imanishi-Kari Ruling Slams ORI," Science, June 28, 1996, at 1864-66 (discussing history of proceedings); Goldner, supra note 20, at 315-22 (same).

[29] The RIAP concluded that much of the ORI's evidentiary record was irrelevant, inconsistent, lacked credibility, or otherwise was insufficient. See 1996 WL 399931. The RIAP also identified problems with allowing the whistleblower to be too closely involved with the investigation, because "such involvement can compromise both the ability of the investigators to maintain objectivity and the ability of the whistleblower to avoid becoming too vested in the outcome." Id. at n.227.

[30] See J.D. Dingell, "The Elusive Truths of the Baltimore Case," Wash. Post, July 18, 1996, at A27; but see J. Friedly, "How Congressional Pressure Shaped the 'Baltimore Case,'" Science, Aug. 16, 1996, at 873-75; G. Kolata, "Inquiry Lacking Due Process," N.Y. Times, June 25, 1996, at C3.

losing two cases on appeal in 1993 and 1994, ORI then hastily abandoned two other highly publicized cases, including one involving the well-known AIDS researcher Robert Gallo.[31]

Another concern arising from ORI investigations is that even when a person is cleared of misconduct, it is difficult to fully restore that person's reputation arising from the stigma of being the target of an ORI investigation.[32] A 1996 survey of those who were the targets of cases that were ultimately closed found that 60% had experienced one or more adverse professional consequence, such as losing their job, being denied a raise or promotion, or being shunned by their colleagues.[33] There are also potentially discriminatory imbalances in the targets of ORI investigations: women are more likely to be found guilty than are men, and those lower in the academic hierarchy are more likely to be found guilty than higher-ranking persons.[34]

C. False Claims Act and Other Litigation by Whistleblowers.

In light of these problems, it is not surprising that some physicians and other medical researchers, instead of reporting allegations of misconduct through their home institution and ORI, have chosen other legal venues in an attempt to punish the alleged wrongdoer and deter others from comparable misconduct. One approach, taken with mixed success, has been for the complainant to file a False Claims Act claim, pursuant 31 U.S.C. §§ 3729-3733, alleging that the wrongdoer defrauded the government through grant applications or other submissions.

Although it is beyond the scope of this article to review the complex body of law surrounding false claims litigation, at least two federal courts have rejected such claims arising from false statements allegedly made to NIH by medical researchers. See United States *ex rel.* Berge v. Board of Trustees of the Univ. of Ala., 104 F.3d 1453, 1462 (4th Cir. 1997) (reversing $1.66 million jury verdict because statements made to NIH, while potentially not giving relator full credit for her work, were not material);[35] United States *ex rel.* Milam v. Regents of Univ. of

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[31] See C. Anderson, "The Aftermath of the Gallo Case," Science, Jan. 7, 1994, at 20-22; see also Goldner, supra note 20, at 307-14.

[32] The identity of allegers and of those who were successfully exonerated of misconduct are to be kept confidential and cannot be disclosed through a FOIA request. McCutchen v. U.S. Dep't of Health & Human Serv., 30 F.3d 183, 187-90 (D.C. Cir. 1994). However, any reputational damage may have already occurred during the course of the investigation.

[33] See J. Kaiser, "Swift Justice Salvages Reputations," Science, Oct. 18, 1996, at 338.

[34] See J. Kaiser, "ORI Report Tracks Gun-Shy Feds," Science, May 7, 1999, at 901.

[35] See also J. Kaiser, "$1.6 Million Fraud Award Overturned," Science, Jan. 31, 1997, at 610 ("University groups believe the court's scathing language will discourage other qui tam suits. . . . The decision is narrower than some had hoped, however. The judges did not address whether the False Claims Act should be used to resolve scientific disputes.").

Calif., 912 F. Supp. 868, 889 (D. Md. 1995) (granting summary judgment to defendants because alleged statements were not false). The district court in Milam cautioned that not all scientific disputes rise to the level of false claims or are suitable for legal resolution:

> At most, the Court is presented with a legitimate scientific dispute, not a fraud case. Disagreements with scientific methodology do not give rise to False Claims Act liability. Furthermore, the legal process is not suited to resolving scientific disputes or identifying scientific misconduct.

Milam, 912 F. Supp. at 886 (internal citations omitted). The court did note that the underlying ORI report and its findings would be admissible had there been a trial, but would not have preclusive effect, primarily because ORI did not conduct a hearing and the parties could not litigate the issues before ORI. Id. at 880.

Physicians who are whistleblowers have chosen statutory whistleblower claims, as well as various common law claims, in an attempt to recover for the damages that they suffered from their reports of alleged scientific misconduct. For example, in 1997, the Michigan Court of Appeals upheld a researcher's fraud and state Whistleblower Protection Act claims against two of her colleagues whom she alleged had misappropriated her research, falsely accused her of misconduct, suspended her employment, and refused to renew her contract. Phinney v. Perlmutter, 564 N.W.2d 534, 222 Mich. App. 513 (Mich. Ct. App. 1997).[36]

Similarly, physicians and other researchers who allege that they were wrongly accused of misconduct have sought legal recourse, typically on breach of contract and due process grounds.[37] For example, Marguerite Kay, a tenured professor at the University of Arizona medical school, was dismissed in 1998 from her endowed chair after the university concluded that she had fabricated or manipulated medical research data. Dr. Kay sued the University of Arizona in federal court, seeking a preliminary injunction and a temporary restraining order; this

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[36] See also Goldner, supra note 20, at 324-25 (discussing history of case). Dr. Phinney announced that she would use her $1.67 million damage award to establish a support group, Whistleblowers for Integrity in Science and Education ("WISE"). See J. Kaiser, "Home for Scientific Whistleblowers," Science, Sept. 12, 1997, at 1611 ("Phinney plans to use some of her settlement money on WISE to offer counseling, form a network of informed lawyers, and provide access to a database on misconduct cases."). However, we could not find any subsequent information about this entity.

[37] See Goldner, supra note 20, at 337 ("Perhaps the greatest concern — both for potential whistleblowers and for others who are asked to participate in the investigatory process either as witnesses or as decision-makers — is the possibility that they or their institutions might be named as defendants in a civil action brought by a scientist accused of misconduct.").

complaint was dismissed without prejudice in April of 1998.[38] Dr. Kay also sued the University of Arizona in state court; the trial judge found in 1999 that the University was arbitrary and capricious, had breached her contractual right to various procedures prior to termination, and had violated her rights under Arizona statutes to be represented by an attorney in the administrative hearing.[39] In response, the President of the University reinstated and dismissed her anew on the same day in February of 2000.[40] Pursuant to university rules, a panel of researchers from the University and other institutions conducted an independent review of the allegations; this panel concluded that there was no wrongdoing and recommended her reinstatement.[41] However, the University refused to allow Dr. Kay to return to campus; she then filed a second lawsuit in state court on December 7, 2000, which was removed to federal court on April 21, 2000; defendants' motion to dismiss was granted and her claims were dismissed with prejudice on March 30, 2001.[42] Dr. Kay then filed a notice of appeal; this case is currently being briefed before the Ninth Circuit.[43] Meanwhile, her first state court lawsuit was appealed to the Arizona Court of Appeals, which held that the trial judge had the authority to order her reinstatement, thereby vacating in part the trial judge's decision; the University of Arizona petitioned the Arizona Supreme Court for review, which was granted on February 16, 2001.[44]

The foregoing discussion demonstrates the mixed record that physicians and medical researchers have had -- whether as whistleblowers or as those accused of scientific misconduct -- in proceeding through the administrative and judicial systems.

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[38] Kay v. Arizona Board of Regents, Civ-98-146-TUC-FRZ (D. Ariz.) (docketed Mar. 27, 1998). The complaint was dismissed on April 27, 1998.

[39] E-mail from D. Awerkamp to A.R. Kabat (Sept. 10, 2001); see also E. Marshall, "The Misconduct Case That Won't Go Away," Science, Nov. 5, 1999, at 1076-77.

[40] See E. Marshall, "Fired Researcher is Rehired and Refired," Science, Feb. 18, 2000, at 1183-84.

[41] See J. MacNeil & D. Malakoff, "In or Out?," Science, Aug. 11, 2000, at 847.

[42] Kay v. Tolbert, Civ-00-290-TUC-JMR (D. Ariz.) (docketed Apr. 21, 2000). The district court's opinion was not published.

[43] Kay v. Tolbert, No. CA-01-15893 (9th Cir.) (docketed Apr. 25, 2001). Dr. Kay filed for bankruptcy in Texas in June 2001, which arose from her litigation expenses (e-mail from D. Awerkamp to A.R. Kabat, Sept. 7, 2001).

[44] Kay v. Arizona, No. 2 CA-CV 00-0036 (Ariz. Ct. App. Div. 2) (docketed Feb. 25, 2000). The Arizona Court of Appeals decision was not published. The Arizona Supreme Court denied the request for oral argument and is considering the matter as submitted on the pleadings (e-mail from D. Awerkamp to A.R. Kabat, Sept. 10, 2001).

5. Recent Legislative Developments.

From 1999 to the present there have been increased efforts to enact federal and state legislation that would allow some degree of collective bargaining or joint negotiations by physicians with HMOs and other managed health care provider entities, and permit them to bypass the proscriptions of antitrust law. These legislative efforts were bolstered by the June 23, 1999 vote by the American Medical Association ("AMA") to form an affiliated national labor organization to allow private practice physicians to engage in contractual negotiations, while asserting that physicians would never go on strike.[45] This position reflects the 1999 AMA Board of Trustees Report, which while recommending continued support of (1) private sector advocacy, (2) the Congressional legislation proposed in 1999, H.R. 1304 (infra) and (3) independent housestaff organizations, also expressly recommended that the AMA "not form or sponsor any 'labor organization' (as defined by the National Labor Relations Act)." AMA, Report 30 of the Board of Trustees (A-99), "Collective Bargaining as an AMA Advocacy Tool," at 19-20 (1999). Therefore, the AMA claims that it is not itself actually forming a "union" in the traditional sense under labor law.

The legislative efforts have proceeded on parallel federal and state fronts.[46] Both have had to address antitrust concerns, by demonstrating that unionization or other collective bargaining by physicians who do not share a common employer will not result in price fixing, group boycotts, or other anticompetitive activities prohibited by the federal and state antitrust statutes. At the state level, the enacted and proposed state statutes have attempted to avoid these concerns through the "state action doctrine," which allows antitrust immunity under the federal Sherman Act for state programs which otherwise restrain trade provided that "the challenged restraint must be one clearly articulated and affirmatively expressed as state policy [and] the policy must be actively supervised by the State itself." California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (internal quotation marks omitted). In 1992, the Supreme Court reiterated this state action doctrine:

> Midcal confirms that while a State may not confer antitrust immunity on private persons by fiat, it may displace competition with active supervision if the displacement is both intended by the State and implemented in its specific details. Actual state involvement, not deference to private pricefixing arrangements under

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[45] See, e.g., A. Goldstein, "AMA Votes to Unionize Doctors," Wash. Post., June 24, 1999, at A1; S. Greenhouse, "AMA's Delegates Decide to Create Union of Doctors," N.Y. Times, June 24, 1999, at A1; R.A. Rosenblatt, "Seeking Clout in HMO Era, AMA Votes for Union," L.A. Times, June 24, 1999, at A1.

[46] It must be emphasized that few bills are enacted. For example, during the 106th Congress (1999-2000), 8,968 bills were introduced, but only 604 bills became law, or 6.74 % of all introduced bills. See "Resume of Congressional Activity, 106th Congress," 147 Cong. Rec. D46-D47 (daily ed. Jan. 30, 2001), <http://thomas.loc.gov/home/resume/106res.html>.

the general auspices of state law, is the precondition for immunity from federal law.

FTC v. Ticor Title Ins. Co., 504 U.S. 621, 633 (1992). The purpose of the supervision requirement "is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." Id. at 634-35.

A. Congressional Legislation.

During the 106th session of Congress (1999-2000), there was extensive legislative activity relating to a bill passed by the House of Representatives, the "Quality Health-Care Coalition Act" (H.R. 1304). This was a controversial bill that intended to allow health care professionals to bargain collectively with health plans regarding the terms and conditions of their contracts.[47] This bill was supported by the AMA[48] but was opposed by the Antitrust Division, Department of Justice,[49] the Federal Trade Commission,[50] the Section of Antitrust Law, American Bar Association[51] and the Health Insurance Association of America.[52] Although this bill was approved by the House on June 30, 2000, the Senate Majority Leader, Senator Trent

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[47] See "Quality Health-Care Coalition Act of 2000," H. Rep. No. 106-625 (2000) (hereinafter "House Report") (legislative history).

[48] "Statement of the American Medical Association to the Committee on the Judiciary U.S. House of Representatives, re: In Support of the Quality Health-Care Coalition Act of 1999 - H.R. 1304," <http://www.ama-assn.org/ama/pub/article/4111-4137.html> (June 22, 1999).

[49] J.I. Klein, "H.R. 1304, The Quality Health-Care Coalition Act of 1999: Statement, Before the House Judiciary Committee," reprinted in House Report, supra note 47, at 41-48 (also online at <http://www.usdoj.gov/atr/public/testimony/2502.htm> (June 22, 1999).

[50] R. Pitofsky, "Prepared Statement of the Federal Trade Commission Before the Committee on the Judiciary," reprinted in House Report, supra note 47, at 29-41 (also online at <http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm> (June 22, 1999); see also Federal Trade Commission, News Release, "FTC Chairman Tells House Judiciary Committee [that] Doctor Collective Bargaining Bill Would be Bad Medicine for Consumers," <http://www.ftc.gov/opa/1999/9906/doctors.htm> (June 22, 1999).

[51] Section of Antitrust Law, American Bar Ass'n, "Report on the Quality Health Care Coalition Act of 1999," <http://www.abanet.org/antitrust/coalitionact.html> (Dec. 17, 1999).

[52] Health Insurance Ass'n of America, "Antitrust Waivers for Physicians: Costs and Consequences," <http://www.hiaa.org/news/news-state/antitrustreportfront.htm> (June 1999).

Lott, announced his strong opposition to the bill,[53] which was referred to the Senate Committee on Health, Education, Labor and Pensions, and was not acted upon before the close of the 106th Congress. As of August 15, 2001, this bill has not been reintroduced in the 107th Congress.

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The "Independent Contractor Determination Act of 2001" (S. 837, introduced on May 7, 2001 and H.R. 1783, introduced on May 9, 2001), would add a new section, Section 3511, to the Internal Revenue Code, to provide that certain individuals are independent contractors, not employees. The terminology used in this legislation is that of "service provider" (= independent contractor; e.g., private practice physician with staff privileges or affiliated with a HMO) and "service recipient" (e.g., hospital).[54] The consequences of this bill is that, since private practice physicians would be treated as independent contractors under the tax code, it would be harder for them to argue that they are employees under Title VII. As of August 15, 2001, both bills were in committee: the Senate Committee on Finance and the House Committee on Ways and Means.

The "Patient Safety and Health Care Whistleblower Protection Act of 2001" (H.R. 2340, introduced on June 27, 2001), would provide a private cause of action to health care workers who allege that they were retaliated or discriminated against for having "in good faith (1) engaged in any disclosure of information relating to the care, services or conditions of a health care entity; (2) advocated on behalf of a patient or group of patients with respect to the care, services, or conditions of a health care entity; or (3) initiated, cooperated, or otherwise participated in any investigation or proceeding of any governmental entity relating to the care, services or conditions of a health care entity." H.R. 2340, § 2(a)(1)-(3). In order for the disclosure under subsection (a)(1) to be protected, the health care worker must reasonably believe that the information is true, and that the information either "evidences a violation of any law, rule, or regulation, or of a generally recognized professional or clinical standard" or "relates to care, services, or conditions which potentially endangers one or more patients or workers or the public." Id. at § 2(e).[55]

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[53] See R. Pear, "After Doctors' Antitrust Triumph, Lott Puts Up Roadblock in Senate," N.Y. Times, July 1, 2000, at A1, A9 ("Mr. Lott's position reduces the chances that the bill will get through the Senate this year."); M. Vita, "House Approves AMA-Backed Bill," Wash. Post, July 1, 2000, at A5 (quoting Senator Lott, "I won't be trying to find a way to pass it").

[54] This legislation is somewhat similar to the "Independent Contractor Clarification Act of 1999," H.R. 1525 (introduced on April 22, 1999 by Rep. Kleczka, D.-Wis.), which did not proceed beyond the House Committee on Ways and Means, despite having 100 cosponsors.

[55] This bill is similar in many respects to federal and state whistleblower protection statutes. See generally L. Bernabei, "Whistleblower Litigation Update," American Bar Association, Section of Labor and Employment Law, 1996 Annual Meeting Program Materials, ch. 40 (Aug. 4-7, 1996); E.S. Callahan & T.M. Dworkin, "The State of Whistleblower Protection," 38 Am. Bus. L.J. 99 (2000); S.M. Kohn, Concepts and Procedures in Whistleblower

This bill would protect not only health care workers who are employed directly by health care entities, but also employees of subcontractors, and independent contractors. Id. at § 6(2). Thus, this bill would cover private practice physicians. This bill provides that a private cause of action may be initiated in either federal or state court, id. at § 4(a)(1), and if the court determines that there has been a violation, then damages shall be awarded.[56] The court may also issue injunctive relief. Id. at § 4(a)(3). There is a two-year statute of limitations for bringing an action. Id. at § 4(a)(4). In addition, the court is authorized to impose civil penalties of up to $10,000 for each violation on "any person", id. at § 4(b), as well as criminal penalties, including up to 1 year imprisonment, for willful and repeated violations of a serious nature. Id. at § 4(c). As of August 15, 2001, this bill was in the House Judiciary Committee and the Energy and Commerce Committee.

The "Bipartisan Patient Protection Act" (S. 1052 and H.R. 2563) is the high-profile health care legislation of the 107th Congress. Section 135 of this legislation is intended to protect health care professionals, including physicians, from retaliation for having engaged in patient advocacy, i.e., the person, in good faith "(A) discloses information relating to the care, service, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issue to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or (B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions." S. 1052, at § 135(b)(1). The bill limits "good faith actions" to those disclosures that are (A) "made on the basis of personal knowledge" and based on professional skill; (B) reasonably believed to be true; (C) "evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury;" and (D) "the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure," with certain exceptions. Id. at § 135(b)(2). However, unlike the "Patient Safety and Health Care Whistleblower Protection Act of 2001" (H.R. 2340), this legislation does not provide for a private cause of action or individual remedies for violations of Section 135. Nor does this legislation specify how Section 135 is to be enforced.

Law (2001); R.G. Vaughn, "State Whistleblower Statutes and the Future of Whistleblower Protection," 51 Admin. L. Rev. 581 (1999).

[56] See H.R. 2340, § 4(a)(2) ("[The] court shall award such damages which result from the unlawful act or acts, including compensatory damages, reinstatement, reimbursement of any wages, salary, employment benefits, or other compensation denied or lost to such employee by reason of the violation, as well as punitive damages, attorneys' fees, and costs (including expert witness fees). The court shall award interest on the amount of damages awarded at the prevailing rate.").

The "Bipartisan Patient Protection Act" would cover physicians who are independent contractors, not just those directly employed by a hospital. Id. at §135(b)(7). This legislation was approved by the Senate on June 29, 2001; and by the House of Representatives on August 2, 2001. Although Section 135 is identical in these two bills, there are other significant differences (particularly regarding the ability of patients to sue their health plans) that have to be reconciled by the conference committee before this legislation can be presented to the President.[57]

B. State Legislation.

The first state statute allowing some level of collective action by physicians was enacted in Vermont. Vt. St. Ann. tit. 18, § 9409. This statute authorizes the creation of "health care provider bargaining groups, consisting of health care providers who choose to participate." Id. at § 9409(a). These groups can then negotiate with designated state officials "in regard to provider regulation, provider reimbursement or quality of health care." Id.; see also Vt. Code R. 21-040-006 (1997) (implementing regulations).

In 1993, Washington state enacted a broader statute, Chapter 43.72, "Health Services Reform - Health Services Commission" (as amended in 1997), which exempts from state antitrust laws and provides immunity from federal antitrust laws, through the state action doctrine, those activities that would accomplish any of six enumerated purposes, of which the first five focus on containing costs and improving the provision of services, while the sixth is "to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents." Wash. Rev. Code § 43.72.300(2). However, the statute then excludes activities that would constitute per se antitrust violations including price fixing and group boycotts. Id., § 43.72.300(3). Any health care person or entity may request that the state Department of Health obtain an informal opinion from the state Attorney General "as to whether particular conduct is authorized" under this statute, id., § 43.72.310(1), and upon a favorable determination, the Department of Health may authorize conduct that could otherwise "tend to lessen competition in the relevant market," id., § 43.72.310(2)(a), and "shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate the terms and conditions of contracts with a health carrier including the ability of providers to meet and communicate for the purposes of these regulations." Id., § 43.72.310(2)(c).

As of April 1997, four immunity applications for integrated health services delivery arrangements had been approved under this Washington state statute.[58]

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[57] See A. Goldstein, "House Passes Patients' Rights," Wash. Post, Aug. 3, 2001, at A1; A. Goldstein, "The Patients' Rights Fight, Round 2," Wash. Post, Aug. 5, 2001, at A5.

[58] Washington Senate Committee on Ways and Means, Senate Bill Report: S.B. 6092, "An Act Relating to Abolishing the State Health Care Policy Board" (Apr. 7, 1997).

Texas followed suit in 1999 with a much broader bill, "An Act Relating to the Regulation of Physician Joint Negotiation" (S.B. No. 1468), codified as Chapter 29 of the Insurance Code. Tex. Ins. Code §§ 29.01-29.14. On June 20, 1999, Governor Bush signed this act, which takes effect on September 1, 1999 and expires on September 1, 2003.[59] The AMA supported this legislation, on the ground that it "would provide physicians with a venue to discuss contract terms and conditions and communicate any concerns to the health plans in a single unified voice."[60] The Bureau of Competition of the Federal Trade Commission expressed concerns with this legislation, while recognizing that it had significant differences from the pending federal legislation.[61] The FTC noted that the Texas legislation required that the Texas Attorney General exercise some degree of oversight of the negotiation process, but provided vague or no standards for the exercise of this authority. Nonetheless, the enacted bill contained substantially the same provisions concerning which the FTC had raised its concerns.

The Texas statute commences with legislative findings that, since health plans may "dominate the market" and "dictate the terms of the contracts they offer physicians," it was essential "to authorize joint negotiations on fee-based and other issues" where such imbalances are present. Tex. Ins. Code § 29.01. The statute then sets forth a virtual laundry list of sixteen contractual terms and conditions for which "competing physicians within the service area of a health benefit plan may meet and communicate for the purpose of jointly negotiating . . . with the health benefit plan." Id., § 29.04. The statute then recognizes limitations on joint negotiation, principally on "fees or prices for services," id., § 29.05, while carving out exceptions to these limitations "where the health benefit plan has substantial market power and those terms and conditions have already affected or threatened to adversely effect the quality and availability of patient care." Id., § 29.06(a). The determination of the presence of "substantial market power" which allows the exception to the limitation is to be made by the state Attorney General. Id. As the Bureau of Competition of the FTC had noted, the statute does not provide any guidance for making that determination.

The joint negotiation process itself is subject to specified criteria governing the process by which the physicians are allowed to communicate with each other and with their designated third party representative regarding the contractual terms and conditions. Id., § 29.07. The third party representative must obtain approval from the Attorney General before acting as a representative of the physicians. Id., § 29.08. The statute also prohibits physicians from "jointly coordinat[ing] any cessation, reduction, or limitation of health care services," thereby precluding

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[59] See also 1 Tex. Admin. Code §§ 58.1 - 58.3 (2001) (implementing regulations).

[60] AMA Press Release, "Texas Bill Could Open Door for Physicians to Collectively Negotiate Health Plans," <http://www.ama-assn.org/ad-com/releases/1999/99mar30.htm> (Mar. 30, 1999).

[61] William J. Baer, Letter to Rep. Rene O. Oliveira, Texas House of Representatives, <http://www.ftc.gov/be/v990009.htm> (May 13, 1999).

striking or refusals to deal with patients or third parties. Id., § 29.10. The Texas Attorney General shall approve joint negotiation requests or proposed contracts:

> if the attorney general determines that the applicants have demonstrated that the likely benefits resulting from the joint negotiation or proposed contract outweigh the disadvantages attributable to a reduction in competition that may result from the joint negotiation or proposed contract. The attorney general shall consider physician distribution by specialty and its effect on competition. The joint negotiation shall represent no more than 10 percent of the physicians in a health benefit plan's defined geographic area except in cases where in conformance with the other provisions of this subsection conditions support the approval of a greater or lesser percentage.

Id., § 29.09(b). The Bureau of Competition of the FTC had raised concerns with this provision, since the "10 percent" rule failed to recognize that physicians might organize by speciality, reflecting different product markets within a geographic market.[62] In other words, the FTC believed that the appropriate level of analysis should be by physician speciality (e.g., all pediatricians or all obstetricians/gynecologists), and not by combining all private practice physicians into a single market.

The District of Columbia Council introduced, on July 6, 1999, the "Physicians Negotiation Act of 1999 (Bill 13-333), which is similar in many respects to the Texas statute.[63] However, this legislation differs from the Texas statute in explicitly providing a statutory definition of substantial market power:

> Substantial market power will be found where the health plan's market share exceeds 15% as measured by the number of covered lives as reported by the insurance commissioner or the actual number of consumers of prepaid comprehensive health services. Substantial market power also exists where a health plan's market share exceeds 15% within a particular market segment, broken down into the following market segments: Medicare, Medicaid, and commercial, managed care and health maintenance organization[s].

Bill 13-333, § 4. Conversely, the District of Columbia legislation places a limitation on physicians' representatives with respect to very small health markets:

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[62] Id. ("the provision . . . provides no significant limitation on the aggregation of bargaining power by many types of physician groups").

[63] See generally A. Goldstein, "D.C. Council Considers Bill to Let Doctors Bargain Collectively," Wash. Post, Aug. 6, 1999, at B7 (noting that this bill is "based on AMA model legislation").

> The physicians' representative shall not represent more than 30% of the market of practicing physicians for the provision of services or a particular physician type or speciality in the service area of a health plan with less than 5% of the market.

Bill 13-333, § 5(f). Since the District of Columbia does not have an attorney general, the approval process is by the Mayor, as guided by the Corporation Counsel. Bill 13-333, § 7. This bill was approved by the D.C. Council on June 6, 2000, signed by the Mayor on June 27, 2000, and sent to the D.C. Control Board for review prior to transmission to Congress for final approval.[64] However, the D.C. Control Board voided the bill on the grounds that it was an unfunded mandate that would allegedly cost the District of Columbia more than $3 million annually by 2004.[65]

Comparable legislation in various other states, including Delaware, New Jersey, New York and Pennsylvania, is pending or has been proposed in recent legislative sessions.[66]

6. Conclusions.

Private practice physicians are finding themselves at the threshold of fundamentally redefining their status with regard to HMOs, hospitals, and other managed health care entities as employees rather than independent contractors. The determination of whether physicians are independent contractors or employees will have significant consequences for their treatment under the labor, employment discrimination, and antitrust statutes. The judicial trend appears to be recognition of their status as independent contractors, while the legislative trend is to allow physicians limited immunity from antitrust statutes despite their judicially determined independent contractor status. Meanwhile, physicians and other medical personnel who are employed as permatemps or contingent workers are obtaining the right to receive fringe benefits and to join unions for the purpose of collective bargaining.

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[64] See "Doctors Allowed Collective Bargaining," Wash. Post, June 7, 2000, at B3; Medical Society of the District of Columbia, "Bill 13-333: A Timeline," <http://www.msdc.org/body_13333.htm>.

[65] See "Bargaining Rights for Doctors Rejected," Wash. Post, Jan. 18, 2001, at B5.

[66] See C. Bowman & K. Fernandez, "More Physician-Bargaining Bills Expected as MDs Seek Strength Through State Action," 68 U.S.L.W. 2461 (Feb. 8, 2000).