Reassessing the Physician-Hospital Relationship

Victoria Hamscho
NYU School of Law

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REASSESSING THE PHYSICIAN-HOSPITAL RELATIONSHIP

Victoria Hamscho *

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* Victoria Hamscho is a J.D. Candidate at NYU School of Law. Victoria hopes to pursue a career at
the intersection of public policy and law with a focus on health care. At NYU, Victoria served as a
Hermann Biggs Health Policy Fellow, Articles Editor of the NYU Journal of Legislation and Public
Policy, and Co-President of the NYU Latinx Law Student Association. Victoria also participated
and achieved second place at the University of Maryland School of Law's Health Law Regulatoy
& Compliance Competition and the L. Edward Bryant, Jr. National Health Law Transactional
Competition. Victoria has an M.P.H. in Health Policy and Management from Columbia University
and a B.A. in Philosophy from the University of California, Davis.
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I. INTRODUCTION
Physicians with admitting privileges at hospitals are traditionally considered independent contractors and not hospital employees. The classification of admitting physicians as independent contractors is important because the benefits and protections afforded by most labor and employment laws apply only to employees. Yet these laws tend to provide little guidance as to who qualifies as an employee. Moreover, the courts have failed to articulate a consistent test for distinguishing between employees and independent contractors. This mixed body of law has resulted in courts frequently dismissing challenges brought by admitting physicians against hospitals under labor and employment laws because the physicians were not deemed employees.

In *Salamon v. Our Lady of Victory Hospital*, the U.S. Court of Appeals for the Second Circuit (Second Circuit) challenged the long-held assumption that admitting physicians are independent contractors for purposes of Title VII of the Civil Rights Act of 1964 (Title VII), which prohibits employment discrimination based on sex, race, color, national origin, and religion. Relying on the common-law agency test for distinguishing between employees and independent contractors, the Second Circuit found that a question of fact existed as to whether the admitting physician was an employee of the hospital due to the level of control that the hospital exercised on the physician’s medical practice through hospital standards, supervision, and corrective action.

*Salamon* is the most recent case to analyze the worker classification of admitting physicians for purposes of Title VII. In *Salamon*, the Second Circuit addressed the difficulties of applying the common-law agency test in the medical context and provided an innovative framework for analyzing the physician-hospital relationship that focuses on the level of control the hospital exercises on the physician’s practice. This Article argues that the Second Circuit’s framework is superior to the approach that other circuits have endorsed for determining the worker classification of physicians and is consistent with the development of the physician-hospital relationship.

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2. See Patricia Davidson, Comment, *The Definition of Employee Under Title VII: Distinguishing Between Employees and Independent Contractors*, 53 U. CIN. L. REV. 203, 204-19 (1984) (describing how courts employ three different tests for distinguishing between employees and independent contractors: (1) the common-law agency test, (2) the economic realities test, and (3) a hybrid test that combines elements of both the common-law agency test and the economic realities test).

3. See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 228-29 (2d Cir. 2008).
II. THE DEVELOPMENT OF THE PHYSICIAN-HOSPITAL RELATIONSHIP

A. Hospitals as Workshops for Independent Physicians

a. The Reconceptualization of the Hospital in the Early 1900s

Physicians have traditionally been independent of hospitals.⁴ For most of the nineteenth century, hospitals were primarily religious and charitable institutions for tending the sick, rather than medical institutions intended to cure.⁵ Hospitals evolved from almshouses and other unspecialized institutions that served welfare functions for the elderly and mentally ill.⁶ Even as hospitals began treating the sick, they limited their services to low-income patients.⁷ As a result, physicians performed most services for middle and upper class patients outside of hospitals.⁸

Between 1900 and 1910, hospitals moved to the center of medical practice due to advances in science and technology. Control over infections and improvements in diagnostic tools allowed surgeons to operate earlier.⁹ As surgery became safer and more common, physicians became dependent on the diagnostic and therapeutic facilities hospitals could provide.¹⁰ Hospitals began to charge for their care and permitted physicians practicing in their facilities to charge for their services.¹¹ As the demand for hospital services increased, the number of hospitals increased from 178 in 1873 to 4,349 in 1909.¹² With these changes, the concept of the hospital evolved from “refuges for the homeless poor . . . into doctors’ workshops for all types and classes of patients.”¹³

b. Physician Dominance Over the Medical Practice and Its Workplace

The conceptualization of the hospital as a workshop that makes its facilities and equipment available to independent physicians brought important changes to its internal

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⁴ See Robert A. Berenson et al., Hospital-Physician Relations: Cooperation, Competition, or Separation? 26 HEALTH AFFAIRS w31, w31 (2007) (“Physicians traditionally have been relatively independent of hospitals and have used them as ‘workshops’ in which to carry out their services.”).
⁵ See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 145 (1949).
⁶ Id. at 149.
⁷ Id. at 150.
⁸ See id. at 157; see also Morris J. Vogel, The Transformation of the American Hospital, 1850-1920, in HEALTH CARE IN AMERICA: ESSAYS IN SOCIAL HISTORY 105, 105-06 (1979) (noting that during the nineteenth century “even the most difficult surgical procedures were performed in the home”).
⁹ See Starr, supra note 5, at 156.
¹⁰ Id.
¹¹ See id. at 163 (noting that while “no American hospital permitted fees” in 1880, “the widely resented rule forbidding physicians to take fees from private patients . . . began to die out at the turn of the century.”).
¹³ See Starr, supra note 5, at 146 (stating that with medical advances, “the conscientious physician became increasingly dependent on the diagnostic and therapeutic facilities which only a hospital could provide.”).
organization and authority distribution. Early hospitals were largely operated by hospital-based staff.\(^{14}\) Since hospitals relied on charity, trustees decided which physicians were granted privileges, which services were provided, and which patients were admitted.\(^{15}\) As hospitals came to rely on payments from the patients of physicians, independent physicians replaced the trustees as the chief source of income for hospitals and gained authority over the services available and the patients admitted.\(^{16}\)

Between 1900 and 1917, physicians enjoyed unfettered control over the medical practice and its workplace.\(^{17}\) Hospitals exercised no control over the work of physicians and were largely insulated from associated liability.\(^{18}\) As charitable institutions, hospitals were protected from liability for the tortious conduct of physicians by the doctrine of charitable immunity.\(^{19}\) In 1914, Judge Benjamin Cardozo, writing for the New York Court of Appeals, held in Schloendorff v. Society of N.Y. Hospital that a hospital was not liable for the tortious conduct of independent physicians.\(^{20}\) Schloendorff concerned an action against a charitable hospital for an unauthorized surgery.\(^{21}\) Judge Cardozo concluded that the wrong was that of the physicians who were pursuing an independent calling and not the hospital.\(^{22}\) Judge Cardozo reasoned that the hospital did not intend to act through physicians, but rather for the physicians to act on their own responsibility.\(^{23}\)

**B. Quality of Care and Medical Staff Oversight of Physicians**

*a. The Development of Minimum Standards for Hospitals*

As a growing number of physicians gained admitting privileges at hospitals, questions emerged regarding the quality of patient care.\(^{24}\) Surgeons generally believed that hospitals and physicians should meet minimum requirements to ensure quality of care.\(^{25}\)

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\(^{14}\) Id. at 149.

\(^{15}\) Id.

\(^{16}\) See id. at 162 ("When hospitals relied on donations, the trustees were vital. But as hospitals came to rely on receipts from patients, the doctors who brought in the patients became more important.").


\(^{18}\) See Milton Roemer & Jay Friedman, *Doctors in Hospitals: Medical Staff Organization and Hospital Performance* 34 (1971) ("There was no systematic policy in voluntary hospitals toward exercise of controls over the work of private physicians.").

\(^{19}\) See McDonald v. Massachusetts General Hospital, 120 Mass. 432, 436 (1876); see also Sara Rosenbaum et al., *Law and the American Health Care System* 789, 790 (2012) (explaining that "[t]he remarkable thing about the charitable immunity doctrine was not that it existed in 1876, but that it continued to exist into the 1950s and 1960s, long after hospitals had transformed themselves into large economic entities serving paying and low-income patients.").

\(^{20}\) See Schloendorff v. Soc’y of N.Y. Hospital, 211 N.Y. 125, 130 (1914).

\(^{21}\) Id.

\(^{22}\) See id. at 131 (noting that "the wrong was not that of the hospital; it was that of physicians, who were not the [hospital’s] servants, but were pursuing an independent calling.").

\(^{23}\) Id.


\(^{25}\) See id. (explaining that surgeons pushed for the standardization of hospitals in part because a "wide-open hospital practice threatened the economic interests and professional status of surgeons.").
In 1917, the American College of Surgeons (ACS) developed minimum standards for hospitals and a Hospital Standardization Program (HSP) to monitor compliance. These standards were meant to organize hospital facilities and clarify the roles of hospitals and physicians in maintaining quality of care. The HSP was the predecessor of the Joint Commission on Accreditation of Hospitals (JCAH).

Adherence to the ACS standards was voluntary and compliance was widely resisted. However, compliance with these standards became a requirement for participation in private and public licensing, certification, and financing programs. States modeled their licensure statutes after the ACS standards and backed them with enforcement authority. The Medicare program relied on the ACS standards to certify hospitals for participation in the program. In addition, some health plans required compliance with the standards as a condition of participation.

b. Medical Staff Oversight of Physicians

The ACS standards solidified the modern organizational structure of a hospital consisting of the governing body, administrative staff, and medical staff. The standards provided for the self-regulation of physicians through an organized medical staff charged with adopting, with the consent of the hospital's governing body, medical staff bylaws. The bylaws set the organization of the medical staff, defined its relationship with the hospital, and delineated the procedures by which staff privileges would be granted and corrective actions taken against physicians.

The legal status of the medical staff quickly became subject to debate. Following the characterization of the medical staff as a self-governing body consisting of independent physicians, some courts recognized the medical staff as a legal entity separate from...
the hospital. However, most courts have declined to recognize the medical staff as a distinct entity, noting that “[the medical staff] has no legal life of its own and is merely one component of the hospital.” Courts have reasoned that the governing body must delegate certain authority for the medical staff to exercise self-determination due to state laws barring the corporate practice of medicine.

c. The Decline of the Traditional Physician-Hospital Relationship

Hospital regulation and medical staff oversight of physicians during this period challenged the initial conceptualization of the hospital as a workshop of independent physicians. The medical staff was a membership in a self-governing organization that afforded physicians rights and responsibilities. Hospitals provided equipment and staff that enabled physicians to provide medical services that they could not provide elsewhere. In exchange, physicians served on quality and utilization review committees and undertook Emergency Department on-call responsibilities.

However, as a new vision of the hospital emerged as a provider of medical care, the idea of the hospital as a “passive charity removed from operational responsibility” faded away. This shift coincided with court rulings abandoning the doctrines that once protected hospitals from tort liability. In 1957, Judge William Fuld overruled the doctrine of charitable immunity as applied to hospitals, as well as Judge Cardozo’s ruling in Schloendorff.

In Schloendorff, which involved an action against a hospital for injuries caused by some of its nurses, Judge Fuld held that “[t]he conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact.” Judge Fuld noted that hospitals currently provide more than facilities for treatment, which is demonstrated in how hospitals operate.

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40 See Berenson, supra note 4, at w31.

41 Id.

42 See Rosenbaum, supra note 24, at 794.


44 Id. at 8.

45 Id.
This shift was consistent with a growing recognition by the courts that hospitals have direct duties to patients regarding quality of care. In *Darling v. Charleston Community Memorial Hospital*, where injuries resulted from a hospital’s failure to supervise the care provided at its facilities, the Illinois Supreme Court held that hospitals have direct corporate responsibility for the supervision of care. Following *Darling*, courts have recognized a duty to screen out incompetent physicians and other providers at the time of initial appointment or reappointment to the medical staff. In *Johnson v. Misericordia Community Hospital*, which involved a medical procedure that was not performed in accord with standard medical practice, the court held a hospital liable for failing to check with previous hospitals where the physician’s privileges had been revoked. Hospitals have also been held liable for failing to monitor the performance of physicians and terminate physicians with a record of mistakes involving patient care.

C. Managed Care and Institutional Control Over Physicians

a. The Need to Control Health Care Costs

As hospitals gained greater responsibility over quality of care, greater pressure to contain health care costs ensued. Throughout most of the twentieth century, hospitals and physicians were paid a fee for each service they provided. Patients paid out-of-pocket for the services they received. However, a new system of third-party payment emerged with the rise of health insurance coverage and the creation of Medicare. Health insurers and Medicare paid hospitals and physicians based on the cost of each service provided and the prevailing fee in their geographic area. These payment mechanisms insulated hospitals and physicians from the cost of medical care and created incentives to maximize the volume of services to receive higher payments.
The 1970s opened with a crisis in health care. By 1980, health care expenditures had reached $230 billion, up from $69 billion in 1970. As pressure to contain health care expenditures increased, third-party payers began to experiment with payment methods that moved away from the traditional fee-for-service system. In 1983, Medicare adopted the diagnosis-related group (DRG) payment system for hospitals, under which hospitals received a fixed amount per patient based on the patient’s diagnosis rather than an amount based on the actual treatment costs incurred. Other payers, including states and self-insured employers, began to steer patients into Health Maintenance Organizations (HMOs), which functioned as an alternative to health insurance plans. Like the DRG system, HMOs provided patient care for a fixed per capita fee.

b. Institutional Control Over Physicians

Up to eighty percent of health care costs are within the control of physicians. Even though prospective payment systems did not target physicians directly, the ability of hospitals and HMOs to control health care costs depended on the ability to exert institutional control over physicians, whose practices had been largely unregulated. In designing the DRG payment system, the U.S. Department of Health and Human Services recognized that “prospective payment . . . provides a number of . . . desired incentives by inducing hospitals to control physician services which have associated hospital costs.” Similarly, the purpose of HMOs was to manage costs by working with physicians to provide only medically necessary and cost effective medical services.

Accordingly, hospitals and HMOs adopted different strategies to influence physician behavior and reduce medical expenditures. Hospitals and HMOs adopted preauthorization review protocols for ordering certain medications and performing certain procedures. In an effort to control costs, hospitals adopted rigid standardized treatment protocols aimed at decreasing length of stay or the number of medical

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55 Id. at 381.
56 Id. at 380.
58 See Donna Horoshack et al., State Regulation of Managed Care, in ESSENTIALS OF MANAGED HEALTH CARE 765, 767 (Peter R. Kongstvedt ed., 2007).
59 See Peter D. Fox et al., The Origins of Managed Health Care, in ESSENTIALS OF MANAGED HEALTH CARE 3, 6 (Peter R. Kongstvedt ed., 2007).
60 See John M. Eisenberg, Physician Utilization, 23 MED. CARE 461 (1985); see also John M. Eisenberg & Sankey V. Williams, Cost Containment and Changing Physicians’ Practice Behavior, 246 JAMA 2195 (1981) (noting that between 50 and 80 percent of health care costs are controlled by physicians).
62 See Peter R. Kongstvedt, ESSENTIALS OF MANAGED HEALTH CARE 6 (2007) (explaining that the cost containment and quality assessment policies by health maintenance organizations are intended to control the inappropriate use of medical services).
63 See John M. Eisenberg, DOCTORS’ DECISIONS AND THE COST OF MEDICAL CARE 130 (1986); see also Eisenberg & Williams, supra note 60, at 2198 (describing preauthorization review by hospitals).
procedures and diagnostic tests prescribed. Enforcement of these directives varied from barring physicians from using facilities to refusing to pay for unapproved treatment. Physician education and feedback from peer review were used to influence physician behavior and control expenditures.

Hospitals and HMOs relied on institutional inducements in the form of sanctions for excessive treatment and rewards for conservative treatment. The Independent Practice Associations, which compensated physicians on a discounted fee-for-service basis, provided bonuses for efficient performance or reduced payment for inefficiency. Some hospitals paid their medical staff a percentage of profits earned from Medicare patients. Other hospitals rewarded profitable physicians with in-kind or fringe benefits, such as office space, secretarial services, and malpractice insurance. These strategies raised concerns regarding federal and state prohibitions on financial dealings between physicians and the hospitals to which they refer patients.

c. The Beginning of New Physician-Hospital Relationships

Managed care drastically changed the nature of the relationship between physicians and hospitals by bringing changes in both reimbursement and contracting for hospital services. Throughout most of the twentieth century, the economic incentives of physicians and hospitals were aligned and higher reimbursements were associated with providing more services. Prospective payment mechanisms altered this relationship. Because hospitals were paid a fixed sum per patient, administrators were no longer indifferent to resources physicians expended in treatment. Physicians were incentivized to provide more services to receive higher payment.

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64 See Hall, supra note 17, at 449-50 (describing treatment protocols); see also William A. Chittenden III, Malpractice Liability and Managed Care: History and Prognosis, 26 Tort & Ins. L.J. 451, 456 n.28 (1991) (describing standardized diagnosis and treatment protocols by HMOs).
65 See Hall, supra note 17, at 463-64 (describing enforcement mechanisms with standardized protocols).
66 Id. at 484.
67 See id. at 486 (noting, by way of example, that the Paracelsus chain of hospitals in California paid each member of the medical staff a percentage of the profits the hospital earned from that physician’s Medicare patients).
68 See COMM. ON IMPLICATIONS OF FOR-PROFIT ENTERPRISE IN HEALTH CARE, INST. OF MED., FOR-PROFIT ENTERPRISE IN HEALTH CARE 166 n.7 (1986) (describing different in-kind and fringe physician benefits).
69 See Hall, supra note 17, at 487–88 (providing an overview of federal and state fee splitting prohibitions).
70 See Alison E. Cuellar & Paul J. Gertler, Strategic Integration of Hospitals and Physicians, 25 J. HEALTH Econ. 1, 3 (2006) (reasoning that “[m]anaged care brought about a change in hospital contracting and reimbursement”).
71 See Starr, supra note 5, at 385 (“Since under fee-for-service, doctors and hospitals make more money the more services they provide, they have an incentive to maximize the volume of services.”).
72 See Eisenberg & Williams, supra note 60, at 2198 (describing hospital cost-containment strategies).
73 Id.
At the same time, managed care brought changes in contracting for hospital services. Because HMOs provided care on a capitated basis, HMOs selectively contracted with hospitals to negotiate lower prices and shift payment risk to hospitals. Hospitals faced pressure to lower costs and gain bargaining power to improve their competitive position for managed care contracts. In response, hospitals sought more strategic relationships with physicians by acquiring physician practices, including primary care physicians, and employing the physicians. By 1998, more than 66 percent of hospitals were integrated with a physician practice, up from 33 percent in 1993.

Physician integration with employed physicians was intended to help hospitals lower costs and gain bargaining power. The expectation was that employed physicians would be more cooperative with hospital administration to manage costs and secure more hospital admissions. Moreover, employing physicians allowed hospitals to negotiate jointly with HMOs. Due to the risk that failure to reach an agreement would result in the loss of both the hospitals and physicians, employing physicians helped hospitals gain bargaining power. For physicians, hospital employment provided a “shelter from an increasingly complex and unstable market.”

D. Increasing Competition, Quality Expectations, and Physician Employment

a. Physician-Hospital Competition Over Services

Hospitals were under economic pressure to affiliate with physicians, and an adversarial climate with physician-owned facilities ensued. Technological advances enabled more affordable equipment and hospital services to be performed in ambulatory settings. Physicians began to acquire equipment and ambulatory surgical centers, which made physicians direct competitors with hospitals. By owning these facilities, physicians

74 See Cuellar & Gertler, supra note 70, at 3.
75 Id.
77 See Cuellar & Gertler, supra note 70, at 2 (noting that “hospitals in high-managed care areas, i.e., areas with high managed care penetration rates, are more likely to have vertical relationships with physicians than hospitals in low-managed care areas; only 29 percent of hospitals in low-managed care areas had vertical relationships in 1998, compared to 70 percent of hospitals in high-managed care areas.”).
78 See id. at 3-4 (arguing that physician integration increases efficiency and quality by allowing physicians and hospitals to achieve economies of scale); see also Lawrence Casalino & James C. Robinson, Alternative Models of Hospital-Physician Affiliation as the United States Moves Away from Tight Managed Care, 81 The Milbank Q. 331, 338 (2003) (noting that hospitals that employ physicians are more likely to compel cooperation through managerial authority and secure admissions than those with staff physicians).
79 See Cuellar & Gertler, supra note 70, at 5-6 (observing different theories by which hospital-physician integration may be used to increase hospital market power and bargaining power with health plans).
80 See Lawrence P. Casalino et al., Hospital-Physician Relations: Two-Tracks and the Decline of the Voluntary Medical Staff Model, 27 Health Affairs 1305, 1309 (2008) (exploring physician motivations for integrating with hospitals).
81 See Berenson, supra note 4, at w35-w36.
were able to capture the facility fee associated with these services that would otherwise
go to the hospital, increase consumer expectation of a “one-stop shop” for medical
services, and control their work hours and environment.82

b. Patient Safety and Quality of Care Expectations

Hospitals also experienced increasing pressure to improve patient safety and quality of
care. In 1999, the Institute of Medicine issued its landmark report, “To Err Is Human,”
which estimated that as many as 98,000 patients die annually in U.S. hospitals due to
preventable medical errors.83 The report put health care quality in the sight of public
and private payers, leading to a number of initiatives aimed at improving patient safety
and quality of care. One of these initiatives was the publication of comparative quality
information. In 2001, the Medicare program launched the Hospital Quality Initiative.84
Although participation was voluntary, hospitals participated to receive a payment
update.85 In 2002, JCAH began requiring hospital quality performance reporting.86

“Pay-for-performance” programs, an influential initiative, generally imposed financial
penalties on health care providers that failed to meet quality or performance measures.87
These measures included process measures that focused on specific activities that
contribute to positive health outcomes, the effect of care on patients, and patient
satisfaction with the care they received at the hospital.88 The Hospital Value-Based
Purchasing Program was another initiative where hospitals were paid on the basis of
quality measures and performance improvements.89

c. The Rise of Physician Employment and its Impact on Admitting Physicians

In response to the increasingly adversarial environment with physician-owned facilities
and new pressure to improve patient safety and quality of care, hospitals explored

82 See Casalino, supra note 78, at 1310 (explaining that ownership of these facilities enables
physicians to focus on a more narrow range of procedures, which facilitates efficient scheduling
and allows for profitability); see also Berenson, supra note 4, at w34 (noting that motivating factors
included “seeking additional sources of income, increasing consumers’ expectations of ‘one-stop
shopping’ for physician services, and growing physician demand for control over their own work
environment”).
ap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system.
84 See CTRS. FOR MEDICARE AND MEDICAID SERVS., HOSPITAL QUALITY INITIATIVE OVERVIEW 1 (2005),
85 Id. at 2.
86 See Jt. Comm. on Accreditation of Health Care Organizations, Ongoing Activities: 2000 to
2004 Standardization of Metrics, https://www.jointcommission.org/assets/1/18/SIWG_Vision_
paper_ongoing_activities.pdf.
healthaffairs.org/do/10.1377/hpb20121011.90233/full/.
88 Id. at 2.
89 See id. at 3; see also CTRS. FOR MEDICARE AND MEDICAID SERVS., HOSPITAL VALUE-BASED
PURCHASING 1, 3 (2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-
Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.
new relationships with physicians through two main strategies: joint venturing and physician employment.90

Hospitals that enter into joint-venture arrangements generally expect to retain some of the revenue the hospital would have otherwise lost to a competing physician-owned entity.91 For physicians, entering into a joint venture with hospitals allows them to benefit from hospital capital and the hospital’s management.92 However, since many joint ventures occur between not-for-profit hospitals and for-profit physician entities, such arrangements raise concern regarding Internal Revenue Service rules on tax-exempt status.93 Due to the possibility of service referrals, these joint venture arrangements also raise concern regarding the federal Anti-Kickback Statute, which generally prohibits payment for referral of Medicaid or Medicare business.94

Given the regulatory obstacles to establishing joint ventures, hospitals moved to a physician employment model that was focused on employing specialists. Building on earlier trends of employing primary care physicians, the employment of specialists allowed hospitals to preempt competition from physician-owned facilities and increase negotiating leverage with health plans.95 Hospitals also employed physicians to staff Emergency Departments.96 For years, hospitals reported the unwillingness of medical staff to cover the Emergency Department, which forced hospitals to pay generous per diems for physicians to assume on-call responsibilities.97

The employment of specialists threatened hospital relationships with their medical staff. Hospitals have isolated admitting physicians who are members of their medical staff by emphasizing service lines that feature employed specialists.98 Although certain hospitals have branded their service lines with participation of employed specialists and medical staff, many have excluded the medical staff to have greater control over how services are provided and marketed.99

With the rise in physician employment and its impact on medical staff physicians, the definition of the hospital-physician relationship is underscored.100 Pressure from third-party payers to control health care costs and improve patient safety urges hospitals to

90 See Casalino, supra note 77, at 1309 (exploring physician-hospital joint ventures and physician employment).
91 See Berenson, supra note 4, at w38 (exploring hospital motivations for entering into joint ventures).
92 See Timothy Lake et al., Something Old, Something New: Recent Developments in Hospital-Physician Relationships, 38 HEALTH SERVS. RES. 471, 479 (2003) (exploring physician motivations for entering into joint ventures, such as the ability to purchase costly facilities and technologies).
93 See Berenson, supra note 4, at w39 (noting regulatory challenges to establishing joint ventures).
94 Id.
95 See Casalino, supra note 77, at 1308 (exploring hospital motivations for employing physicians).
96 Id.
97 Id.
98 See Berenson, supra note 4, at w40 (assessing the impact of specialist employment on the medical staff).
99 Id.
100 Id.
reassess their relationship with employed physicians and admitting physicians, such as the level of control the hospital wishes to exercise over physician behavior.\textsuperscript{101} Although hospitals may exercise control over the practice of employed physicians, exercising too much control over members of the medical staff can place the hospital at risk of liability.\textsuperscript{102} Thus, the general law behind classifying admitting physicians as independent contractors under federal labor and employment law is instructive.

### III. GENERAL LAW ON CLASSIFYING PHYSICIANS AS INDEPENDENT CONTRACTORS

#### A. Worker Classification Under Title VII

Title VII makes it unlawful for employers “to fail or refuse to hire or to discharge any individual, or otherwise 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.”\textsuperscript{103} The statute defines “employee” as “an individual employed by an employer”\textsuperscript{104} but does not clearly define “employer.”\textsuperscript{105} Given the circularity of this definition, the legislative history of Title VII is instructive to the worker classification of admitting physicians.

#### B. Legislative History of Worker Classification Under Title VII

The legislative history of Title VII suggests Congress permitted the classification of some physicians as employees.\textsuperscript{106} As part of the 1972 amendments to Title VII, Congress considered, but did not include, a proposal to exclude physicians employed by public or private hospitals from Title VII.\textsuperscript{107} During Senate debate, Senator Harrison Williams (D-NJ) warned that “[this amendment] would take from a doctor the protection that the Constitution gives him and would protect through [Title VII].”\textsuperscript{108} Moreover, Senator Jacob Javits (R-NY) explained:

> [T]his amendment would go back beyond decades of struggle and of injustice and reinstate the possibility of discrimination on grounds of ethnic origin, color, sex, religion—just confined to physicians or surgeons, one of the highest rungs

\textsuperscript{101} See Starr, supra note 5, at 385 (describing the pressure to control health care costs); see also INST. OF MED., To ERR Is HUMAN: BUILDING A SAFER HEALTH SYSTEM 31 (2000), https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system (describing how improving patient safety is imperative).

\textsuperscript{102} See Cmty. for Creative Non-Violence v. Reid, 490 U.S. 730, 751 (1989) (describing the control factor in the common-law agency test for distinguishing between employees and independent contractors).


\textsuperscript{105} 42 U.S.C. § 2000e(h) (defining a person engaged in an industry affecting commerce who has fifteen or more employees) (2018).


\textsuperscript{107} See Rinella & Rinella, 401 F. Supp. at 179-80 (citing 118 Cong. Rec. 1647 (1972)).

\textsuperscript{108} See id.
of the ladder that any member of a minority could attain—and thus lock in and fortify the idea that being a doctor or surgeon is just too good for members of a minority, and that they have to be subject to discrimination in respect of it, and the Federal law will not protect them.\footnote{109}

The proposed exclusion of physicians from the protections of Title VII was ultimately defeated, allowing for the classification of some physicians as employees for purposes of Title VII.\footnote{110}

C. Case Law on Worker Classification for Purposes of Title VII

The uncertainty surrounding worker classification under Title VII charges the courts with making this determination. Courts have employed three different tests for distinguishing between employees and independent contractors: (1) the common-law agency test, (2) the economic realities test, and (3) a hybrid test that combines elements of both the common-law agency test and the economic realities test.\footnote{111} In the medical context, most courts have found that admitting physicians are independent contractors who are not covered by Title VII, but some courts have concluded that physicians may be employees by relying on the common-law agency test.

a. Legal Tests for Distinguishing Employees from Independent Contractors

Prior to 1947, courts distinguished an employee from an independent contractor using the common-law agency test.\footnote{112} This test focused on the degree of control the employer exercised over the individual’s work performance.\footnote{113} If the employer controlled not only “what work should be done, but also how it should be done,” the worker was deemed an employee.\footnote{114} In Community for Creative Non-Violence v. Reid, which involved the worker classification of an artist, the Supreme Court noted that an important factor is the employer’s right to control the “manner and means” of the worker’s performance.\footnote{115} Other factors include the skill required, the source of the instrumentalities and tools, the location of the work, the duration of the parties’ relationship, the employer’s provision of employee benefits, the tax treatment of the worker, among others.\footnote{116}

In 1947, the Supreme Court held that the common-law agency test was too narrow for determining worker classification for purposes of social legislation.\footnote{117} The Court

\footnote{109} Id.
\footnote{110} Id.
\footnote{112} See United States v. Silk, 331 U.S. 704, 713 (1947).
\footnote{113} Id.
\footnote{116} See id.; see also Restatement of the Law, Agency, § 220 (listing factors to be considered in determining whether an individual is an employee or an independent contractor when performing services for another person or entity).
\footnote{117} See Bartels v. Birmingham, 332 U.S. 126, 130 (1947) (noting that “[c]ontrol is characteristically associated with the employer-employee relationship, but in the application of social legislation
then proposed the “economic realities” test, which focuses on whether the individual is, as a matter of economic reality, dependent upon the business to which she renders her service. 118 In applying this test, courts examine the degree of control exercised by the employer, the extent of the relative investments of the worker and the employer, the degree to which the worker’s opportunity for profit or loss is determined by the employer, the skill and initiative required in performing the job, and the permanency of the relationship. 119

Notably, the courts have refrained from using the economic realities test for purposes of Title VII. Instead, courts traditionally use the economic realities test only for determining worker status under the Fair Labor Standards Act (FLSA). 120 Unlike Title VII, the legislative history of the FLSA suggests that the term “employee” be given “the broadest definition that has ever been included in any one act.” 121 Some courts have applied a hybrid of the common-law agency test and the economic realities test to determine worker status under Title VII, through which the worker’s economic dependence on the employer is considered under the common-law principles of agency. 122 Applying the economic realities test, courts have noted that the extent of the employer’s right to control the worker’s performance is determinative. 123 In Spirides v. Reinhardt, in which the worker classification of a foreign language broadcaster was considered, the court held that necessary factors that apply to the consideration of worker status under the hybrid test include whether the work performed is under the direction of a supervisor, the skill required for the job, whether the employer furnishes the equipment used and the place of work, and the length of time during which the individual has worked. 124

b. Case Law on the Worker Classification of Physicians for Purposes of Title VII

Until the mid-1990s, courts applied the hybrid test, concluding that admitting physicians at hospitals were independent contractors for purposes of Title VII. In Beverly v. Douglas, where an action against a hospital for denying a physician admitting privileges transpired, the court applied the hybrid test and found that the physician was an independent contractor since the hospital did not exercise control over the manner and means of the physician’s performance. 125 The court noted that

employees are those who as a matter of economic reality are dependent upon the business to which they render service”).

118 See id. (adopting that “in the application of social legislation employees are those who as a matter of economic reality are dependent upon the business to which they render service.”).
119 See Hopkins v. Cornerstone Am., 545 F.3d 338, 343 (5th Cir. 2008).
120 See Cobb v. Sun Papers, Inc., 673 F.2d 337, 340 (11th Cir. 1982).
121 See id. (noting that “there is no statement in the [Civil Rights] Act or legislative history of Title VII comparable to one made by Senator Hugo Black (later Justice Black), during the debates on the Fair Labor Standards Act, that the term ‘employee’ in the FLSA was given ‘the broadest definition that has ever been included in any one act.’”).
122 Id.
124 See id. at 832.
125 See Beverly v. Douglas, 591 F. Supp. 1321, 1330 (S.D.N.Y. 1984) (accepting the hybrid test and finding the physician to be an independent contractor because the hospital did not exercise control
the physician had a practice outside the hospital, was not paid a salary, received no benefits, and had no office space. Later cases emphasized that, in addition to these factors, the hospital did not supervise the physician’s work and did not control the details of the physician’s practice.

The few cases during this time where the court found that physicians were employees for purposes of Title VII identified the ways that the hospital exerted control over the physician. For example, in *Mitchell v. Frank Memorial Hospital*, where an action was brought against a hospital for wrongful termination, the court found that the physician could bring a Title VII action because the hospital controlled the physician’s practice. Moreover, in *Ross v. William Beaumont Hospital*, where a physician brought a sex discrimination action against a hospital, the court found that the physician was an employee because she underwent extensive progressive discipline, including probation and leaves of absence. Finally, in *Mallare v. St. Luke’s Hospital*, where an action against a hospital was brought for denying a physician admitting privileges, the court noted that the hospital exercised control over the physician’s practice by retaining the right to withdraw medical staff privileges if his performance did not comport with hospital standards.

Since the mid-1990s, the courts have relied on the common-law agency test and generally classified physicians as independent contractors for purposes of Title VII. The initial switch was guided by the Supreme Court’s use of this test in the context of the Copyright Act and Employee Retirement Income Security Act (ERISA). The use of this test was

126 See id. (noting that the physician is an independent contractor in part because staff physicians have practices outside the hospital and staff physicians are not paid a salary).

127 See Diggs v. Harris Hosp. Methodist, Inc., 847 F.2d 270, 273 (5th Cir. 1988) (applying the hybrid test and finding the physician to be an independent contractor because the hospital did not direct the manner or means by which the physician rendered medical care and the hospital did not pay salary or licensing fees nor provided benefits); see also Amro v. St Luke’s Hospital, 39 F.E.P 1574, 1576 (E.D. Pa. 1986) (maintaining the hybrid test and finding the physician to be an independent contractor because the hospital did not supervise the physician’s work).

128 See Mitchell v. Frank H. Mem’l Hosp., 853 F.2d 762, 766 (9th Cir. 1988) (reiterating the hybrid test and finding the physician to be an employee in part because the hospital controlled the means and manner of his performance).

129 See Ross v. William Beaumont Hosp., 678 F. Supp. 655, 675 (E.D. Mich. 1988) (assessing the economic realities test and finding physician to be an employee in part because the physician underwent extensive progressive discipline, such as probation and leaves of absence and the physician “based her whole livelihood” on the hospital).

130 See Mallare v. St. Luke’s Hosp., 699 F. Supp. 1127, 1130 (E.D. Pa. 1988) (applying hybrid test and finding that material issues of fact existed as to whether a hospital was the employer of a physician because “the ultimate question was control of the means and manner of job performance,” noting that the hospital exercised control in the sense that staff privileges could be withdrawn if a doctor’s performance did not comport with hospital’s standards and denial of staff privileges would severely limit his opportunity to develop a full practice).

131 See Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 322-23 (1992) (following Reid and adopting the common-law agency test for determining who is an employee for purposes of ERISA); see also Cmty. for Creative Non-Violence v. Reid, 490 U.S. 730, 739-40 (1989) (holding that when Congress uses the term “employee” without defining it in the context of the Copyright Act,
solidified when the Supreme Court adopted this test for purposes of anti-discrimination laws.\textsuperscript{132} In determining whether the hospital exercised control over the physician’s performance, the courts highlighted the physician’s ability to provide services according to her medical judgement and determine her working hours, who to work for, and which patients to treat.\textsuperscript{133} These cases rejected the idea that hospitals exercised control by imposing on-call requirements and hospital standards on physicians.\textsuperscript{134}

In 2008, the Second Circuit challenged the traditional classification of admitting physicians as independent contractors for purposes of Title VII.\textsuperscript{135} In \textit{Salamon}, the court examined what it means for a hospital to exercise control over the “manner and means” of a physician’s performance in light of the nature of the physician-hospital relationship.\textsuperscript{136} The court focused on the means explored in \textit{Mitchell}, \textit{Ross}, and \textit{Mallare}; namely, the scope of hospital standards and policies, active supervision, and corrective action.\textsuperscript{137} These means had been rejected by sister circuits.\textsuperscript{138}

Congress intended to describe the conventional “master-servant” relationship as understood by the common-law agency doctrine.

\textsuperscript{132} See Clackamas Gastroenterology Assocs., P.C. v. Wells, 538 U.S. 440, 442-44 (2003) (delineating \textit{Reid/Darden} and adopting the common-law agency test for determining who is an employee for purposes of anti-discrimination laws, stressing that “the common-law element of control is the principal guidepost that should be followed.”).

\textsuperscript{133} See \textit{Shah v. Deaconess Hosp.}, 355 F.3d 496, 500 (6th Cir. 2004) (concluding that the physician was an independent contractor since the hospital could not interfere with the physician’s medical discretion or control the manner and means of his performance as a surgeon); see also Vakharia v. Swedish Covenant Hospital, 190 F.3d 799, 805 (7th Cir. 1999) (applying the common law agency test and concluding the physician was an independent contractor since the physician provided services according to her professional judgement); see also Cilecek v. Inova Health Sys. Serv., 115 F.3d 256, 259 (4th Cir. 1997) (interpreting the common-law agency test and finding that the physician was an independent contractor since the physician exercised independence in determining his hours, income, and who he worked for); see also Alexander v. Rush North Shore Med., 101 F.3d 487, 493 (7th Cir. 1996) (invoking the common-law agency test and concluding that the physician was an independent contractor because the physician had authority to exercise his independent discretion over his patients care).

\textsuperscript{134} See Pamintuan v. Nanticoke Mem’l Hosp., 192 F.3d 378, 385-86 (3d Cir. 1999) (referring to the common-law agency test and finding the physician to be an independent contractor, while rejecting the idea that being subject to hospital rules and standards made the physician an employee); see also Alexander, 101 F.3d at 490 (rejecting the argument that the on-call requirement made the physician an employee because “the details concerning performance remained within his control”).

\textsuperscript{135} See \textit{Salamon} v. Our Lady of Victory Hosp., 514 F.3d 217, 220-21 (2d Cir. 2008).

\textsuperscript{136} See id. at 228.


\textsuperscript{138} See Shah v. Deaconess Hosp., 355 F.3d 496, 500 (6th Cir. 2004) (disagreeing with the idea that being subject to hospital rules and standards made the physician an employee); see also Vakharia v. Swedish Covenant Hospital, 190 F.3d 799, 805 (7th Cir. 1999) (rebuffing the idea that suspension of staff privileges is indicative of hospital control); see also Pamintuan v. Nanticoke Mem’l Hosp., 192 F.3d 378, 385-86 (3d Cir. 1999) (objecting to the idea that subjecting physicians to hospital
IV. SALAMON AND HOSPITAL CONTROL OVER THE PRACTICES OF ADMITTING PHYSICIANS

Dr. Barbara Salamon practiced at Our Lady of Victory Hospital (OLV) as a member of its medical staff. Dr. Salamon filed a lawsuit against OLV claiming violations of Title VII. She alleged that Dr. Michael Moore, Chief of the Gastroenterology Division, sexually harassed her by making inappropriate comments and sexual advances toward her on multiple occasions. Dr. Salamon claimed that Dr. Moore retaliated by using his administrative authority to give her negative performance reviews and subject her practice to excessive scrutiny when she complained about his behavior. The district court granted summary judgment in favor of OLV, finding that Dr. Salamon was not an employee under Title VII. The Second Circuit reversed and held that a question of fact existed as to whether Dr. Salamon was an employee. The parties reached a settlement before Dr. Salamon’s worker classification could be decided on trial.

A. Salamon’s Relationship with OLV

As a member of OLV’s medical staff, Dr. Salamon received clinical privileges and was subject to the same duty as staff physicians. Her clinical privileges included the use of hospital facilities and access to OLV’s nursing and support staff. Dr. Salamon set her own hours and determined which patients to see and whether to admit them to OLV or a different hospital. However, OLV did not provide Dr. Salamon’s salary, benefits, or any other compensation. As a member of OLV’s medical staff, Dr. Salamon was required to adhere to medical staff rules and by-laws, participate in staff meetings, and cover the Emergency Department. OLV also required Dr. Salamon’s participation in the hospital’s Quality Assurance Program (QAP), which required practitioners to examine the procedures that the hospital used during the quarter.

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139 See Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 221 (2d Cir. 2008).

140 Id. at 220

141 Id.

142 See id. at 233 (discussing that there was a factual issue regarding Dr. Salamon’s status as an employee due to the level of control that the hospital exercised over her medical practice and the methods of her work through hospital standards and policies, active supervision, and corrective action procedures).

143 See Stipulation and Order of Dismissal, Salamon v. Our Lady of Victory Hosp., 514 F.3d 217 (2d Cir. 2008), (No. 1:99-cv-00048).

144 See Salamon, 514 F.3d at 222.

145 See Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 222 (2d Cir. 2008).

146 Id.

147 Id.

148 See id. at 222-23 (explaining that cases flagged as problematic were discussed at OLV’s mandatory GI division meetings, and the attending physician would be subject to a peer review process if necessary).
B. The Alleged Harassment, Retaliation, and Increased Scrutiny

Dr. Salamon alleged that when she complained about Dr. Moore’s conduct to hospital administrators, they told her that her complaints were unfounded.149 The administrators informed Dr. Salamon that several of her cases would be reviewed for quality concerns.150 Dr. Salamon claimed that her practice was subjected to additional levels of review, and that increased scrutiny resulted in Dr. Salamon participating in a reeducation and mentoring program.151

C. The Hospital’s Control of the Manner and Means of the Physician’s Performance

Judge Nancy Gertner, sitting by designation and writing for the Second Circuit, relied on Reid’s framework in analyzing the law governing the worker classification of Dr. Salamon.152 The district court found that the first Reid factor, which focuses on the level of control over the manner and means of a worker’s performance, weighed against Dr. Salamon since she exercised her professional judgment with regard to patient diagnosis and treatment.153 Judge Gertner found sufficient evidence to raise an issue about whether the hospital controlled the manner and means by which Dr. Salamon delivered her services.154 Unlike the district court, Judge Gertner focused not only on Dr. Salamon’s judgment regarding diagnosis and treatment, but also on the level of control the hospital exercised through quality standards, supervision, and corrective action.155

a. Scope of Quality Control Procedures and Policies

Judge Gertner found that OLV exercised significant control over Dr. Salamon’s practice through the application of its quality management standards, which mandated certain procedures, indicated the timing of other procedures, and dictated which medications to prescribe.156 Judge Gertner reasoned that the policies were not quality assurance standards required by health and safety concerns or for ensuring Dr. Salamon’s qualifications, but rather designed to dictate details of Dr. Salamon’s practice.157 Furthermore, Judge Gertner noted that the purpose of these requirements was to maximize OLV’s revenue.158

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149 Id. at 224.
150 Id.
151 See Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 224-25 (2d Cir. 2008) (noting that the additional review included a review by a five-physician ad-hoc committee and a review by an outside expert).
152 Id. at 226.
153 Id. at 227.
154 Id. at 228-29.
155 Id.
156 Id. at 229.
158 Id.
b. Supervision of Physicians with Admitting Privileges
Judge Gertner found that OLV exercised significant control over Dr. Salamon’s practice through active supervision. According to Dr. Salamon, excessive scrutiny began when she declined Dr. Moore’s advances. Judge Gertner found that OLV’s supervision was not merely the result of negative medical outcomes but for variations from recommended procedures. Dr. Salamon contended that OLV’s strict standards resulted in nearly every one of her cases being scrutinized.

c. Methods for Addressing Admitting Physician Performance
Finally, Judge Gertner found that OLV exercised significant control over Dr. Salamon’s practice by subjecting her to a reeducation and mentoring program. Rather than terminate Dr. Salamon’s contract, the hospital required her to attend a reeducation program, which was designed to change the method by which Dr. Salamon carried out her practice. Judge Gertner emphasized that OLV exerted control over the manner and means of Dr. Salamon’s practice by dictating the appropriate treatment for certain conditions and the length of some medical procedures.

V. REASSESSING THE ADMITTING PHYSICIAN-HOSPITAL RELATIONSHIP AFTER SALAMON

A. The Difficulty in Applying the Common-Law Agency Test in the Medical Context

a. Recognizing the Types of Control Inherent in the Physician-Hospital Relationship
The difficulty of applying the common-law agency test in the medical context rests on the nature of the physician-hospital relationship. As the U.S. Court of Appeals for the Fourth Circuit (Fourth Circuit) recognized, “the ultimate control of doctors performing work at hospitals results from a competition for control that is inherent in the duty of each to discharge properly its professional responsibility.” Although a physician must have direct control to make decisions regarding medical care, the hospital must exert conflicting control over the physician’s work to discharge its professional responsibility to patients regarding patient safety and quality of care.

159 Id. at 223.
160 Id. at 231.
161 See id. (restating that Dr. Salamon claimed that nearly all of her cases from 1996 to 2003 were heavily scrutinized).
162 Id.
163 Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 231 (2d Cir. 2008) (“OLV was to dictate (a) indications and treatment of esophagogastroduodenoscopies; (b) appropriate treatment of arteriovenous malformations and removal of polyps found on colonoscopy; (c) use of ph monitoring with esophageal manometry; and (d) length of colonoscopy procedures and level of sedation during colonoscopy”).
b. Failure to Consider the Control Hospitals Can Exert Over Admitting Physicians

The tension in professional control between physicians and hospitals over the discharge of medical services has deterred courts from considering control factors indicative of whether the admitting physician is an employee or an independent contractor. Notably, some courts have concluded that admitting physicians are independent contractors largely due to the assumption that hospitals cannot control a physician’s practice.\textsuperscript{165} Courts have concluded that hospitals are prohibited from interfering with a physician’s obligation to exercise her professional judgment in treating patients.\textsuperscript{166}

In several cases, courts found the control factor in the common-law agency test to weigh in favor of hospital defendants by emphasizing that the physician provided medical services according to her professional judgment. In \textit{Shah v. Deaconess Hospital}, which involved the revocation of a physician’s surgical privileges, the U.S. Court of Appeals for the Sixth Circuit (Sixth Circuit) found that the physician was an independent contractor since the hospital did not have the right to interfere with the physician’s medical discretion.\textsuperscript{167} Similarly, in \textit{Vakharia v. Swedish Covenant Hospital}, where a physician brought an action for wrongful termination, the U.S. Court of Appeals for the Seventh Circuit (Seventh Circuit) applied the common-law agency test and found that the physician was an independent contractor because the physician followed her professional judgment.\textsuperscript{168} By overemphasizing the role of a physician’s professional judgment, the courts did not consider the possibility that the hospital could be exerting control over the physicians’ practices even if the physicians had discretion in treating their patients.

Additionally, the courts have dismissed physicians’ allegations regarding the extent to which hospitals exercise control over their practices by emphasizing the role of the physicians’ professional judgment in treating patients. For example, in \textit{Alexander v. North Shore Medical}, which involved the revocation of hospital privileges, the Seventh Circuit rejected the argument that the hospital exerted control over the physician through its on-call requirement because “the details concerning performance of the work remained essentially within [the physician’s] control.”\textsuperscript{169} Furthermore, in \textit{Diggs v. Harris Methodist Hospital}, which also concerned the revocation of hospital privileges, the U.S. Court of Appeals for the Fifth Circuit (Fifth Circuit) rejected the argument that the hospital exercised control through active supervision during surgical procedures since

\textsuperscript{165} See Salamon, 514 F.3d at 228 (noting that some courts have found admitting physicians to be independent contractors because “a physician’s professional obligation cannot allow the hospital in which she works to dictate the diagnoses or the manner in which diagnoses are reached”).

\textsuperscript{166} See id.

\textsuperscript{167} See Shah v. Deaconess Hosp., 355 F.3d 496, 500 (6th Cir. 2004) (finding the physician to be an independent contractor because there was no evidence that suggested that Deaconess “had the right to interfere with the physician’s medical discretion or control the manner and means of his performance as a surgeon”).


\textsuperscript{169} See Alexander v. Rush North Shore Med., 101 F.3d 487, 493 (7th Cir. 1996) (examining the common-law agency test and finding physician to be an independent contractor because he had authority to exercise his own independent discretion).
the hospital did not control the manner and means by which the physician performed the surgical procedure.\textsuperscript{170} Although not addressed by the courts, hospitals may exert control over physicians’ practices even if the physicians exercised professional discretion.

Physicians have a responsibility to submit themselves to hospital standards and policies in order for the hospitals to exercise its professional responsibility to maintain standards of care. In \textit{Wojewski v. Rapid City Regional Hospital}, which involved the revocation of hospital privileges due to a physician’s manic episode, the U.S. Court of Appeals for the Eight Circuit (Eight Circuit) noted that “[the hospital] could take reasonable steps to ensure patient safety and avoid professional liability while not attempting to control the manner in which [the doctor] performed operations.”\textsuperscript{171} Accordingly, in \textit{Cilecek v. Inova Health System Services}, where a physician brought an action against a hospital for wrongful termination, the Fourth Circuit noted that the physician was responsible for cooperating with the hospital in maintaining standards of patient care.\textsuperscript{172} In both instances, the court found that the physicians were independent contractors without any inquiry as to the level of control the hospitals exercised through such hospital standards.

\textbf{B. Approaches to the Common-Law Agency Test in the Medical Context}

Given the difficulty in applying the common-law agency test in the medical context, courts have adopted different approaches for analyzing the extent to which a hospital exercises control over the manner and means of a physician’s performance. In \textit{Cilecek}, the Fourth Circuit proposed instead of focusing on the level of control that hospitals exercise over the discharge of professional services, courts should focus on the level of control the hospital exercises over administrative details incident to the services.\textsuperscript{173} Despite the endorsement of the Fourth Circuit’s approach by the Sixth and Eighth Circuit, the Second Circuit rejected the approach in \textit{Salamon}. In doing so, the court emphasized that the issue of control over a physician’s performance should focus on the hospital’s control over the “details and methods” of the work, which may be influenced by hospital standards and policies, supervision, and corrective action.

\textit{a. Fourth Circuit’s Emphasis on Administrative Details Incident to Professional Services}

In \textit{Cilecek}, the admitting physician argued that the hospital where he practiced exercised control over the manner and means of his practice through its medical staff bylaws, which provided a mechanism for peer review and corrective action for physicians whose practices did not meet hospital rules and regulations.\textsuperscript{174} The Fourth Circuit recognized that the physician was required to abide by hospital rules and regulations for the

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\textsuperscript{170} See \textit{Diggs v. Harris Hosp.-Methodist, Inc.}, 847 F.2d 270, 273 (5th Cir. 1988) (noting that, although the physician had to have supervision during surgical procedures, “the purpose was to have someone attest to her essential qualifications, not to direct the details of the exercise of her skill”).
\textsuperscript{171} See \textit{Wojewski v. Rapid City Reg’l Hosp., Inc.}, 450 F. 3d 338, 344 (8th Cir. 2006).
\textsuperscript{172} See \textit{Cilecek v. Inova Health Sys. Serv.}, 115 F.3d 256, 262 (4th Cir. 1997) (indicating that the physician retained professional independence).
\textsuperscript{173} See \textit{id.} at 260-61.
\textsuperscript{174} See \textit{id.} at 264.
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treatment of patients, which regulated his work in substantial detail.\textsuperscript{175} These rules and regulations governed “every aspect of patient care,” including medical histories, physical exams, tests and procedures, pre-requisites and post-requisites to surgical procedures, administration of medications, among others.\textsuperscript{176} Nevertheless, the Fourth Circuit found that the hospital did not exert control through these rules and regulations since they relate to the standards of care that the hospital and physician must maintain.\textsuperscript{177}

Due to this dual responsibility, the Fourth Circuit found that focusing on the level of control exercised over the discharge of professional services is less useful in the medical context as it may be in other employer-worker relationships.\textsuperscript{178} The court emphasized that the type of control exerted should be viewed in the context of the work itself and the applicable industry.\textsuperscript{179} In the medical context, the Fourth Circuit focused on whether the hospital controlled the physician when he performed his services and the number of hours the physician performed services, as well as administrative details incident to the services.\textsuperscript{180} The court found the physician was an independent contractor since he determined his hours, income, and which hospital he worked for.\textsuperscript{181} Applying these principles, both the Sixth and Eighth Circuit have found admitting physicians to be independent contractors under Title VII.\textsuperscript{182}

\textbf{b. Second Circuit’s Emphasis on the Details and Methods of a Physician’s Performance}

To date, the Second Circuit has been the only Court of Appeals to challenge the Fourth Circuit’s approach in \textit{Cilecek}. In \textit{Salamon}, the Second Circuit acknowledged the dual responsibility that admitting physicians and hospitals have over the discharge of medical services.\textsuperscript{183} However, the court warned that by overemphasizing the role of professional judgment and minimizing the control factor as the Fourth Circuit did in \textit{Cilecek}, all physicians would be carved out from the protections of the anti-discrimination statutes.\textsuperscript{184} Instead, the courts should focus on the control the hospital exercises over the details and methods of a physician’s work.\textsuperscript{185}

In this case, the Second Circuit focused on the level of control that the hospital exerted on admitting physicians through hospital standards and policies, supervision, and corrective action. While the court acknowledged that hospital standards and policies adopted pursuant to professional and governmental standards generally do not create an

\textsuperscript{175} See id. at 261.
\textsuperscript{176} See id. at 261-262.
\textsuperscript{177} See id. at 262.
\textsuperscript{178} See \textit{Cilecek v. Inova Health Sys. Servs.}, 115 F.3d 256, 260 (4th Cir. 1997).
\textsuperscript{179} Id.
\textsuperscript{180} Id.
\textsuperscript{181} See id. at 261.
\textsuperscript{182} See \textit{Wojewski v. Rapid City Reg’l Hosp., Inc.}, 450 F. 3d 338, 345 (8th Cir. 2006); see \textit{also Shah v. Deaconess Hosp.}, 355 F.3d 496, 500 (6th Cir. 2004).
\textsuperscript{183} See \textit{Salamon v. Our Lady of Victory Hosp.}, 514 F.3d 217, 231 (2d Cir. 2008).
\textsuperscript{184} See id. at 228-29.
\textsuperscript{185} See id. at 229.
employment relationship, the court noted that professional and governmental regulatory standards do not dictate the detailed treatment and peer review requirements that the hospital had implemented in this case.\textsuperscript{186} These standards tend to concern health care administration, record keeping, financing, liability, patients’ rights, and delegation of responsibilities.\textsuperscript{187} Moreover, the court noted that there was evidence in this case that some of the hospital’s actions were aimed at maximizing the hospital’s revenue.\textsuperscript{188}

c. The Benefits of Endorsing the Second Circuit’s Approach in Salamon

The Fourth Circuit’s approach to the common-law agency test focuses on the hospital’s control over administrative details incident to the physician’s practice.\textsuperscript{189} This approach would effectively carve out all admitting physicians from the protections of Title VII and other anti-discrimination laws.\textsuperscript{190} By overemphasizing the level of control hospitals exercise over a physician’s services, the number of hours worked, and the administrative details incident to the services, courts may find that admitting physicians are independent contractors.\textsuperscript{191} Carving physicians out of these protections disregards congressional purpose to allow admitting physicians to be classified as hospital employees for purposes of Title VII.\textsuperscript{192}

Focusing only on the administrative details incident to a physician’s services, the Fourth Circuit’s approach disregards the level of control that a hospital can exercise over the outcome of those services through non-administrative means.\textsuperscript{193} As the Supreme Court noted in \textit{Reid}, the proper focus of the control factor in the common-law agency test is on the level of control the employer exercises over the result accomplished and the manner and means by which the worker brings about that result.\textsuperscript{194} There is nothing intrinsic to the physician-hospital relationship that prevents a court from assessing the

\begin{itemize}
\item \textsuperscript{186} See id. at 230.
\item \textsuperscript{187} See id.
\item \textsuperscript{188} See id.
\item \textsuperscript{189} See Cilecek v. Inova Health Sys. Serv., 115 F.3d 256, 261 (4th Cir. 1997) (finding that the control inquiry should focus on factors, such as the number of hours the physician worked at the hospital and whether the hospital controlled the physician when rendering services).
\item \textsuperscript{190} See Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 228 (2d Cir. 2008) (noting that overemphasizing the role of professional judgment “would carve out all physicians, as a category, from the protections of the antidiscrimination statutes”).
\item \textsuperscript{191} See supra Part III.C (providing an overview of the case law finding that physicians are independent contractors).
\item \textsuperscript{192} See supra Part III.B (explaining that the legislative history of Title VII permits the classification of some physicians as employees).
\item \textsuperscript{193} \textit{Salamon}, 514 F.3d at 231 (“In Cilecek, the court minimized the control factor because of the very nature of the medical profession, in which the doctor and hospital necessarily share control over a doctor’s work.”).
\item \textsuperscript{194} See Cmty. for Creative Non-Violence v. Reid, 490 U.S. 730, 751 (1989) (explaining that “whether a hired party is an employee under the general common law of agency, we consider the hiring party’s right to control the manner and means by which the product is accomplished.”).
\end{itemize}
level of control that a hospital exercises over the details of a physician’s practice and the outcomes of her services through non-administrative means.\textsuperscript{195}

By disregarding the level of control that a hospital can exercise over the treatment outcomes of a physician’s services, the Fourth Circuit’s approach ignores the way in which the physician-hospital relationship has evolved.\textsuperscript{196} The Fourth Circuit’s approach disregards the level of institutional control that hospitals have exerted on physicians through non-administrative means like mandated procedures, supervision, or corrective action.\textsuperscript{197} Moreover, this approach is likely to prove increasingly unworkable. As hospitals continue to face pressure to influence physician behavior and experiment with physician employment, it is essential that hospitals define and differentiate the relationships maintained with employed physicians and admitting physicians.\textsuperscript{198}

By contrast, the Second Circuit’s approach considers both the level of control that the hospital exercises over the administrative details related to a physician’s services, as well as the level of control over the discharge of such services.\textsuperscript{199} Consistent with \textit{Reid}, this approach focuses on the level of control the hospital exercises over both the treatment outcomes of a physician’s practice and the details of her work.\textsuperscript{200} In doing so, the Second Circuit’s approach allows some physicians to be classified as employees for purposes of Title VII, as intended by the statute.\textsuperscript{201} This approach recognizes the level of institutional control that hospitals have increasingly exerted over physicians over time.\textsuperscript{202} As long as health care costs are primarily within the control of physicians, hospitals are incentivized to influence physician’s actions to control health care costs.\textsuperscript{203}

\textsuperscript{195} See \textit{supra} Part V.A (describing the difficulty in applying the common-law agency test in the medical context).

\textsuperscript{196} See \textit{supra} Part II (providing an overview of the development of the physician-hospital relationship).

\textsuperscript{197} See \textit{supra} Part II.C (describing the level of institutional control that hospitals have exercised over physicians through mandated procedures, supervision, and corrective action since the beginning of managed care).

\textsuperscript{198} See \textit{supra} Part II.D (discussing the pressure hospitals face to control costs and the rise of physician employment).

\textsuperscript{199} See \textit{Salamon v. Our Lady of Victory Hosp.}, 514 F.3d 217, 228-29 (2d Cir. 2008) (finding that the control inquiry in the common-law agency test should consider not only on the physician’s judgment regarding her practice, but also the level of control the hospital exercises through quality standards, supervision, and corrective action).

\textsuperscript{200} See \textit{id}.

\textsuperscript{201} See \textit{supra} Part III.B (explaining that the legislative history of Title VII permits the classification of some physicians as employees).

\textsuperscript{202} See \textit{supra} Part II.C (describing the level of institutional control that hospitals have exercised over physicians through mandated procedures, supervision, and corrective action since the beginning of managed care).

\textsuperscript{203} See \textit{supra} Part II.C (describing that the ability of a hospital to control costs depends on physician behavior).
VI. CONCLUSION

Salamon is the most recent case to analyze the worker classification of admitting physicians for purposes of Title VII. The Second Circuit's decision in Salamon has elevated the fact-specific nature of the common-law agency test as applied in the medical context and redefined how courts assess the physician-hospital relationship. As hospitals continue to face pressure from third-party payers to control costs, it is incumbent on hospitals to define and differentiate the relationships maintained with employed physicians and admitting physicians. To minimize risk of liability, hospitals must ensure that the standards and policies, peer review programs, and corrective action procedures they impose on admitting physicians are aligned with government standards and not aimed at influencing physician behavior or maximizing revenue.