Independent Contractor vs. Employee: Federal Appeals Court Instructs How to Structure Physician Agreements To Avoid Misclassification

Insights
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While the use of independent contractors in the healthcare industry has been a longstanding practice, it is now front and center as the gig economy continues to expand across several industries and the preference for freelance work grows. This ongoing development in the healthcare industry is also due in large part to a nationwide shortage of qualified providers, including physician – and this trend is only expected to increase in the coming years.

According to a recently published study by the Association of American Medical Colleges (AAMC), the United States is projected to see a shortage of between 54,100 and 139,000 physicians by 2033. The study identifies two main reasons for the projected shortage: (1) an increasing population of individuals over age 65 (which is expected to grow by 45.1% during the 15 years covered by the study); and (2) an increasing number of physicians reaching retirement age.

To add to the crisis, these projections were based on data collected **before** the COVID-19 pandemic struck, which suggests the shortage will be even higher. AAMC President and CEO David J. Skorton, M.D. recently stated: "As our health care system continues to treat patients during the COVID-19 pandemic, the need for a strong and sufficient health care workforce is more apparent than ever. Specialty physician shortages, especially those that are hospital-based, including critical care, emergency medicine, and pulmonary specialists, are particularly urgent."

The Gig Economy Meets The Healthcare Industry

Physician shortages have already led to the creation of services, such as Nomad Health (founded in 2015), an online platform that directly connects freelance physicians to hospitals. Physicians are able to search for available "gigs," negotiate their independent contractor agreements, and are provided malpractice insurance. With physician shortages only increasing in the coming years, we expect companies such as Nomad to dominate the temporary staffing market and the need for such workers to continue.

Of course, as we know, the use of such temporary or gig workers brings with it various legal challenges, including classification issues. Moreover, there are different tests and standards implemented by various entities to determine if independent contractor status for such workers is appropriate, including the IRS, Department of Labor, National Labor Relations Board, federal and

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state courts, and state agencies. Thus, you need to be up-to-date on these standards before implementing independent contractor agreements with physicians.

Workplace Dispute Hinges On Worker Status

A recent case from the 9th Circuit Court of Appeals demonstrates how hospitals should structure their agreements with physicians to ensure appropriate classification as an independent contractor. In *Henry v. Adventist Health Castle Medical Center*, the court found that a general and bariatric surgeon was unable to sue Adventist Health for Title VII discrimination and retaliation claims because he was not its employee.

Dr. Henry joined the staff of Adventist Health in 2015 with clinical privileges and performed surgeries at its hospital in Kailua, Hawaii. He entered into two agreements with Adventist: (1) the Physician Recruitment Agreement; and (2) the Emergency Department Call Coverage and Uninsured Patient Services Agreement. The first agreement stated Dr. Henry would manage a full-time private practice. The second agreement required Dr. Henry to be available for five days of on-call service in the hospital's emergency department each month. Both agreements specified that Dr. Henry "shall at all times be an independent contractor."

While on call, Dr. Henry did not need to remain on the hospital's campus unless an emergency intervention was needed. Further, if he arranged backup coverage, he could use his on-call time to perform elective surgeries. Dr. Henry additionally leased space from Adventist Health for elective surgeries on non-hospital patients. There was also no obligation for Dr. Henry to refer his general surgery patients to the hospital. In addition to the bariatric surgeries he performed for Adventist Health, he also performed non-bariatric surgeries at a competing hospital, where he also had clinical privileges.

Adventist Health did levy some control over his actions. It determined which surgical assistants would work with Dr. Henry, supervised their performance and pay, and specified which medical record system would be utilized for patient care provided at the hospital. It further instructed Dr. Henry to comply with its Code of Conduct, Corporate Compliance Program, and other regulations/bylaws.

Adventist Health did not pay Dr. Henry a salary. Rather, it paid him $100/on-call shift if there were no emergency services rendered. If emergency intervention was needed, it paid him $500/emergency. It only ever issued Dr. Henry a Form 1099 and never issued a W-2. Dr. Henry reported his income from Adventist Health on a Form 1040, which is used by self-employed individuals. His earnings from the hospital only accounted for 10% of his 2016 income, and he was not provided any employee benefits, such as health insurance.

As stated above, Dr. Henry filed suit alleging violations of Title VII for racial discrimination and retaliation. The hospital asked the court to rule in its favor, arguing that Dr. Henry was not an employee and, thus, was not protected under Title VII. The lower court granted the hospital's motion, citing how the doctor was paid, his lack of typical employee benefits, and his tax treatment, in

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citing how the doctor was paid, his lack of typical employee benefits, and his tax treatment, in addition to how both contracts characterized his status an independent contractor and allowed him to work at competing hospitals. While some factors may have swayed in Dr. Henry's favor, the majority of the evidence demonstrated he was an independent contractor. Dr. Henry appealed the ruling, but the 9th Circuit Court of Appeals agreed with the lower court that he was correctly classified as a contractor.

Guidance From Appeals Court

The 9th Circuit Court of Appeals stated that, when evaluating whether an individual is an employee under Title VII, it must review "the hiring party's right to control the manner and means by which the product is accomplished." It referred to a non-exhaustive list of factors to consider (which is very similar to the economic realities test):

1. The skills required;
2. The source of the instrumentalities and tools;
3. The location of the work;
4. The duration of the relationship between the parties;
5. Whether the hiring party has the right to assign additional projects to the hired party;
6. The extent of the hired party's discretion over when and how long to work;
7. The method of payment;
8. The hired party's role in hiring and paying assistants;
9. Whether the work is part of the regular business of the hiring party;
10. Whether the hiring party is in business;
11. The provision of employee benefits; and
12. The tax treatment of the hired party.

The appeals court concluded many of the factors weighed in favor of Dr. Henry's status as an independent contractor. First, the way he was paid was characteristic of an independent contractor relationship, since his hours varied and he did not receive a set salary. Further, he did not receive any employee benefits, and both parties reported his earnings to the IRS as if he were an independent contractor.

Next, the 9th Circuit found his duties for the hospital were limited, which gave him the opportunity to operate his own private practice. Dr. Henry was not obligated to be present at the hospital during his on-call shifts and could perform elective surgeries with backup coverage. Finally, the appeals court cited to the agreements between Adventist Health and Dr. Henry, which both identified him as an independent contractor.

The appeals court rejected Dr. Henry's argument that he was an employee due to the high skill level required for his responsibilities, the hospital's providing of staff and medical equipment, and the

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required for his responsibilities, the hospital's providing of staff and medical equipment, and the hospital's mandatory professional standards. It noted that these factors may be convincing in other lines of work, but as other circuits have pointed out, in the physician-hospital context, "the level of skill required, location of the work, and source of equipment and staff are not indicative of employee status because all hospital medical staff are skilled and must work inside the hospital using its equipment."

It also was not persuasive that Adventist Health required Dr. Henry to follow its rules and regulations, as hospitals are responsible for upholding the standard of care and ensuring the safety of its patients. Consequently, "rather than evidencing a right to control the manner of Henry's practice, the regulations reflect a shared professional responsibility to cooperate with the hospitals to maintain standards of patient care, to keep appropriate records, and to follow established procedures … and are therefore consistent with an independent contractor relationship."

Conclusion

This opinion is a great result for hospital employers, as it recognizes the nuances in the hospital-physician relationship and demonstrates that courts will support the independent contractor status of these workers. By following these steps, you will put your organization in the best position to avoid a costly misclassification claim. Of course, each state examines this issue differently, so make sure to check with counsel to ensure your business model is in compliance with local standards.

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