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## The EEOC'S New Treatment of Healthcare Workers Under the Americans with Disabilities Act

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### I. Introduction

On February 26, 2007, the Equal Employment Opportunity Commission (EEOC) issued "Questions and Answers about Healthcare Workers and the Americans with Disabilities Act." The EEOC's healthcare "Q&A" takes an aggressive stance interpreting the ADA and its reasonable accommodation requirement for healthcare employers. The new Q&A forecasts turbulent waters for healthcare employers faced with disability related claims.

So, why is the EEOC focused currently, and aggressively, on the healthcare industry in particular? Labor market statistics tell part of the story. Healthcare is the largest industry in the American economy, employing more than 13 million individuals.<sup>1</sup> Despite the non-hazardous nature of the vast majority of healthcare positions—as opposed to, for example, heavy manufacturing or construction jobs—healthcare workers are nearly twice as likely to be injured in the workplace, and therefore potentially protected under

the ADA, than workers in any other industry.<sup>2</sup>

According to the EEOC's recently released Q&A, "the rules under Title I of the ADA and Section 501 of the Rehabilitation Act are the same for all industries and work settings."<sup>3</sup> At least one of its regional attorneys has taken a slightly different view, commenting in announcing the settlement of a disability claim against a healthcare employer that healthcare employers have special knowledge about disabilities that puts them in leadership roles among employers, and they should be especially sensitive to this role. This tension between the EEOC's official position and the belief that healthcare employers should be taking a leadership role in ADA matters is manifest throughout the Q&A. Regardless, courts will likely give deference to the EEOC's most recent Q&A.<sup>4</sup>

### II. The Q&A

Following an introduction, the Q&A provides general information on basic ADA concepts, such as what makes an impaired employee a "qualified individual with a disability," an employer's duty of reasonable accommodation, and the defenses of undue hardship and direct threat to safety. The Q&A also addresses medical inquires and testing. Woven throughout the EEOC's general explanation of these ADA concepts are 33 "examples," ostensibly created to

demonstrate how these concepts apply to real-life employment situations in the healthcare industry.

Some of the examples in the Q&A are taken from actual legal opinions. For other examples, however, the EEOC does not rely upon or provide citation to any legal opinions, but instead refers to magazine articles and guidance from other government agencies. For several of those examples, there *are* judicial opinions applying the ADA in analogous situations. The EEOC does not provide citation to those opinions, all of which take a more conservative approach than that suggested in the Q&A.

Upon close review, the examples the EEOC provides in this Q&A are not the majority view of courts currently applying the ADA in disputes between healthcare employees and employers. Rather, these examples demonstrate the EEOC's position that healthcare employers should shoulder greater responsibility in accommodating employees well beyond current judicial interpretation of the ADA's requirements. Moreover, the examples do not take into account the realities faced by healthcare employers who are treating individuals who are often at their most vulnerable stage in life and the real threat of malpractice liability and other risk management issues.

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Leading Health Law to Excellence through Education, Information, and Dialogue

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—from a declaration of the American Bar Association

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*A. The EEOC's Focus on Equipment to Accommodate Healthcare Employees: Mobility Devices*

One theme evident in the Q&A is the EEOC's focus on the use of newly developed equipment to accommodate disabled healthcare workers. The EEOC accepts the use of such equipment as a reasonable accommodation with far less reservation than those courts that have addressed the same issue, and several of the examples in the Q&A explore the use of devices as a way to accommodate the restrictions of healthcare employees.

In a section of the Q&A differentiating between "essential" and "marginal" job functions, the Q&A includes an example hypothesizing that, in a pharmacy technician position that requires the delivery of medication for one hour each shift, the delivery function is "essential" due to the size of the hospital and limited staff to perform delivery functions.<sup>5</sup> Following this example, the EEOC states, "if the hospital cannot eliminate the delivery function but another reasonable accommodation exists that would not result in an undue hardship, such as a mobility device with carrying baskets for the technician to use within the hospital, the hospital must provide the alternative accommodation."<sup>6</sup>

This example—providing a "mobility device" to an employee responsible for delivering medication—is fairly unremarkable standing alone. Setting aside the requisite fact-specific analysis of whether the employee actually can perform all of

his or her essential job functions with a mobility device and whether providing the mobility device poses an undue hardship, providing a motorized cart to an employee making deliveries throughout a large facility may very well be a reasonable accommodation (but certainly not, as the Q&A might lead one to believe, the *only* reasonable accommodation).

The Q&A, however, follows up with another "mobility device" example. In example 10, a "hospital patient access technician" has paraplegia and uses a wheelchair. One of this employee's essential job functions appears to be "moving patients who may be in wheelchairs to their next location."<sup>7</sup> This example concludes: "The applicant will be considered qualified for the position if she has the requisite education, experience, and skills, and has the ability to push others in wheelchairs satisfactorily and safely even though she uses a wheelchair herself."<sup>8</sup> The EEOC notes that this example is based upon a lawsuit filed by the EEOC and voluntarily settled.<sup>9</sup> The EEOC also cites an Eighth Circuit case and notes a "disagreement between the majority and dissenting opinions regarding whether pushing wheelchairs was an essential function of a nursing home nurse position, and if so whether the nurse could have performed this function if provided a motorized cart as an accommodation."<sup>10</sup> In noting the "disagreement," the EEOC omits from its discussion the important fact that the Eighth Circuit's majority held that the nurse in question could *not* perform the essential functions of her position.<sup>11</sup> Most importantly, on the issue of mov-

ing residents in wheelchairs, the Eighth Circuit stated that the proof at trial tended to show that the nurse could not move such residents while using a motorized mobility device, thus undercutting the validity of example 10 altogether.

*B. Equipment as an Accommodation, Part II: Patient Lifting Devices*

The use of newly developed equipment as an accommodation appears also again in the section addressing "undue hardship." Section 7 addresses the circumstances under which a healthcare employer may deny a requested accommodation because it is too difficult, disruptive, or expensive to provide.<sup>12</sup> As the Q&A correctly notes, "an employer does not have to provide a reasonable accommodation that would result in an undue hardship on the operation of the employer's business. . . ." Among the factors to be considered in determining whether an accommodation is an undue hardship are the cost of the accommodation, the employer's size and financial resources, and the nature and structure of its operation.<sup>13</sup> The first example provided in this section ostensibly is meant to provide a scenario where a particular accommodation would not pose an undue hardship:

A nursing assistant at a large hospital injures her back and as a result has a permanent ten-pound lifting restriction. She informs her supervisor that she can nevertheless perform all of her duties except for lifting patients, which is an essential function of her position. She requests that the hospital purchase a

portable mechanical patient lifting device as an accommodation that would permit her to perform this function. The hospital administrator learns that the hospital can acquire the device for approximately \$1500. The administrator also consults with the hospital occupational health and safety officer who informs the administrator that the device can be used safely and appropriately to perform this employee's duties, and that training in using the device properly will be necessary. Purchase of the device and the cost of the associated training would not pose an undue hardship.

As noted above, the purpose of this example is to illustrate an accommodation that would not pose an undue hardship. Interestingly, the example does not directly address many of the factors the EEOC listed as considerations for the undue hardship analysis. All the example mentions is that the hospital is "large" and the device costs \$1,500.

Most telling in this example, however, is not the EEOC's undue hardship analysis, but the underlying premise that a "portable mechanical patient lifting device" is a reasonable accommodation in the first place. For this example, the EEOC does not rely upon any judicial opinion holding, much less evaluating, lifting devices as a reasonable accommodation, but rather an Occupational Safety and Health Administration article about a nursing home that began using "resident-lifting devices."<sup>14</sup> Perhaps it does not because there is no such legal authority.

Indeed, contrary to the EEOC's position, the First Circuit has upheld a lower court's determination that a lifting device was *not* a reasonable accommodation for an Institutional Assistant because, among other reasons, "physically or mentally incapacitated patients are not always able to position themselves on a lift, and . . . that a lift would not assist [the Institutional Assistant] in certain essential activities, such as walking and exercising patients."<sup>15</sup> The Tenth Circuit has noted with approval a lower court's determination that there was no evidence a mechanical lift would permit a Staff Nurse to perform "all" of her essential job functions in a safe manner.<sup>16</sup> An Illinois federal district court evaluated a Registered Nurse's claim that she could use a lifting device to accommodate her lifting restrictions and concluded that a lifting device could assist in planned patient transfers, but no evidence was offered demonstrating "how a mechanical lifting device would assist [an RN] in helping a patient from an unplanned fall, or in other emergency situations."<sup>17</sup> Those decisions focus on the realistic issues faced by healthcare employers in this context.

In short, all of the published cases that have analyzed whether lifting devices are a reasonable accommodation for healthcare workers with lifting restrictions have concluded that the requested accommodation was not reasonable. Those courts have based their analysis, respectively and generally, upon the inability of the healthcare worker to respond appropriately to unexpected or emergency situations where lifting is required, even if the lifting devices could assist with rou-

tine lifting tasks. These courts recognize that for which the Q&A fails to account: the need to lift a patient is not always a matter of assisting in a scheduled move from one room to another. Unfortunately, but realistically, patients fall or an emergency arises and the patient's well being requires immediate action. Responding to these "unplanned" incidents is an essential function of the jobs many healthcare employees perform. Fortunately, courts appear to have deferred to healthcare providers' assessment of the requirements for patient safety.

### *C. What About the Cost of an Accommodation? When is the Expense an Undue Hardship?*

The Q&A notes that in some instances, an employer is not legally required to accommodate a healthcare employee's disability because the only available reasonable accommodations would pose an undue hardship on the employer. The Q&A seems to suggest that the \$1,500 cost of a mechanical lifting device, plus the cost of training, would not pose an undue hardship on a large hospital. This is the only dollar figure provided in the Q&A, so the EEOC does not offer a comparison example of what expense *would* pose an undue financial hardship on a healthcare employer.

The Q&A provides some other examples of accommodations in the healthcare context, but because these examples are provided only to illustrate possible accommodations, no analysis is provided as to whether the accommodation would pose an undue hardship on the employer.

Example 16 relates a scenario in which a physician develops a hearing impairment as an adult and does not use sign language. The example goes on to state that the accommodations provided by his employer are a qualified oral interpreter, a stethoscope with an amplifier, a vibrating pager, and accessible telephone equipment.<sup>18</sup> This example is based on the accommodations made for a Michigan resident (employed) physician. The article the EEOC cites notes that these accommodations cost the hospital approximately \$115,000 per year.<sup>19</sup> The EEOC does not reference this expense in the Q&A, and thus does not indicate whether *this* expense, obviously considerably greater than the \$1,500 mechanical lifting device, would or would not pose an undue financial hardship on a healthcare employer. By using this example, the EEOC presumably takes the position that an accommodation that costs \$115,000 annually is *not* an undue burden.

While the Q&A offers many ideas for potential accommodations, it offers less guidance as to where the line is for what is actually legally required of healthcare employers, and specifically, which costs are legally reasonable and which are not.

### *D. Direct Threat to Safety in the Healthcare Context*

The Q&A provides only two examples that address direct threat to safety. One presents a direct threat and the other a situation where, according to the EEOC, no direct threat exists.

The EEOC's example of no direct threat to safety hypothe-

sizes that a phlebotomist and a certified nurse's aide in a nursing home are both HIV-positive; however, based on the "best available medical evidence at the time of the employer's decision that HIV-positive healthcare workers in these types of positions do not pose a direct threat to the safety of patients if they adhere to universal precautions, neither the phlebotomist nor the nurse's aide poses a direct threat," and their employers would not be justified in "reassigning these employees to different positions or terminating them."<sup>20</sup> For this example, the EEOC cites to a 1991 Centers for Disease Control and Prevention report addressing HIV-positive healthcare workers.<sup>21</sup> This may be the proper analysis, especially in light of the Supreme Court's decision in *Bragdon v. Abbott*.<sup>22</sup> The EEOC, however, does not rely upon or provide citation to any judicial opinions holding that HIV-positive nurse's aides or phlebotomists do not pose a direct threat to safety.

Courts have analyzed direct threats to safety posed by HIV-positive dental hygienists and surgical technicians, concluding that, in those positions, a HIV-positive employee *does* pose a direct threat as a matter of law.<sup>23</sup> These cases rely on guidance from the CDC in determining the risk of infection based on the specific job functions a particular healthcare employee performs. In the case of the dental hygienist and the surgical technician, the critical factor was the risk posed by the employee's hands being in close proximity to sharp instruments either in a patient's mouth or open wound.

*Continued on page 4*

*Continued from page 3*

There is no judicial guidance on whether an HIV-positive phlebotomist poses a direct threat to safety.<sup>24</sup> While the EEOC's general conclusion on this example may be correct, the Q&A does not provide much guidance to a healthcare employer making a direct threat assessment. The Q&A offers only two examples to illustrate a direct threat analysis, neither of which addresses the wide variety of job functions healthcare employees perform. For some functions, such as moving patients, a disease such as HIV probably does not pose a direct threat as long as the employee is following universal precautions. For other functions, such as directly assisting during surgery, the risk of transmission is greater, and the ADA recognizes this increased threat. Along this continuum, there are myriad other job functions with varying degrees of risk. Most helpful in this example is an implicit point in the Q&A: Healthcare employers need to consider guidance provided by public health organizations as well as make case-by-case and fact specific determinations, rather than relying upon stereotypes, when evaluating whether an employee's impairment may pose a direct threat.

*E. Other Examples Where Considerations of Patient Safety are Strangely Lacking*

Example 25, ostensibly demonstrating a direct threat, unremarkably states that a physician whose responsibilities in addition to patient care include supervising 150 physicians and others as "Chief of the Department of Internal Medicine," who had

previously suffered both alcohol and barbiturate addictions, and who is now showing up for work visibly intoxicated, would pose a direct threat to safety.<sup>25</sup> This example was taken from a New York case that concluded the physician was indeed a direct threat. Most notable about this example is how extreme it is. The Q&A offers this as the *only* example of a direct threat in the healthcare context, and it certainly is not a close call. What about situations that might be closer to the line, such as a nurse with less responsibility who may be easier to monitor? The extreme facts of the single example the EEOC provides do not offer much guidance to healthcare employers faced with real-life, though less extraordinary, situations.

After this single example of a direct threat to safety, the Q&A is silent about patient safety concerns. This is remarkable because patient safety is a consideration in virtually all decisions healthcare providers make, including employment decisions.

As noted above, while the Q&A suggests that "patient lifting devices" might allow a nursing assistant to perform the essential job function of "patient lifting," the same example fails to even mention a patient safety concern recognized by every court that has addressed the issue: patients in hospitals and residents in nursing homes sometimes fall unexpectedly and need immediate assistance.<sup>26</sup> It is remarkable that the Q&A does not even mention these concerns, given the fact that patient safety in such unexpected situations has factored so prominently in the judicial analysis of lifting accommodations.

*F. Other Examples of the EEOC's Efforts to Expand the ADA's Protections for Healthcare Employees*

Although the Q&A neglects to cite many judicial opinions that would seem to be directly applicable to the examples presented, the EEOC does not seem to miss many opportunities to cite those judicial decisions that push the envelope in favor of greater protections under the ADA. For instance, one of the introductory sections in the Q&A preceding the specific examples notes that many healthcare employers are state or local governments, covered by Title II of the ADA, or "public accommodations," covered by Title III of the ADA. At the end of this paragraph, the EEOC drops a footnote to *Menkowitz v. Pottstown Memorial Medical Center*, noting at least one court has held that a physician with hospital privileges was protected by Title III of the ADA even though he was not an employee of the hospital under Title I.<sup>27</sup> The EEOC does not reference any of the subsequent, well reasoned opinions that cast doubt on this decision.<sup>28</sup>

**III. Conclusion**

The healthcare community's understanding of and ability to accommodate physical and mental impairments continues to progress, and few would dispute that many impairments now can be accommodated much less expensively than in the past. In addition, medical understanding of conditions, such as HIV, has developed significantly in the last decade. These developments have implications for how courts will apply the mandates of the ADA.

The EEOC's Q&A, however, does not merely catalogue the current judicial approach to these issues. Rather, the Q&A appears to push the envelope of employer responsibility for accommodating disabled healthcare employees. And while the Q&A notes developments offering the potential for greater accommodation, it gives short shrift to the real-life, practical concerns—such as patient safety—that healthcare employers must factor into their decisions.

In so limiting its analysis, the EEOC fails to provide the guidance needed by healthcare employers when confronted with the most common issues involving disabled employees. Likewise, the EEOC unfairly places additional ADA burdens on healthcare employers. The Q&A is no miracle drug for healthcare employers and, if not reviewed carefully, may very well be a poison pill.

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## Endnotes

<sup>1</sup> "Questions and Answers about Health Care Workers and the Americans with Disabilities Act." (Feb. 26, 2007), available at [www.eeoc.gov/facts/health\\_care\\_workers.html](http://www.eeoc.gov/facts/health_care_workers.html).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Q&A* at Example 9.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.* at Example 10.

<sup>8</sup> *Id.*

<sup>9</sup> *See id.* at n. 24, citing *EEOC v. New Hanover Med. Ctr.*, C.A. No. 7:05-cv-180-D(2).

<sup>10</sup> *Id.*

<sup>11</sup> *Stafne v. Unicare Homes*, 266 F.3d 771, 774-75 (8th Cir. 2001) (finding that "pushing wheelchair-bound residents to their proper seating locations" was an essential function of the nurse's job, then noting that "all of the evidence at trial tended to show that [the nurse] would not have been able to push wheelchairs or assist the residents in their dining even if [the facility] had allowed her to use an Amigo, the accommodation that she requested and was denied").

<sup>12</sup> *Q&A* at Examples 22 and 23.

<sup>13</sup> *Id.*

<sup>14</sup> "Caring for Caregivers at Braxton." Joint Safety & Health Quarterly, available at [www.osha.gov/Publications/JSHQ/spring2003/caregivers.htm](http://www.osha.gov/Publications/JSHQ/spring2003/caregivers.htm).

<sup>15</sup> *Feliciano v. Rhode Island*, 160 F.3d 780, 785 (1st Cir. 1998).

<sup>16</sup> *Ingerson v. HealthSouth Corp.*, 139 F.3d 912 (10th Cir. 1998).

<sup>17</sup> *Squibb v. Memorial Med. Ctr.*, No. 04-3097, 2006 WL 988458, \*19 (C.D. Ill. Apr. 13, 2006).

<sup>18</sup> *Q&A* at Example 16.

<sup>19</sup> Wahlberg, David, "The Doctor is Deaf But He Listens Well" (Ann Arbor News Nov. 26, 2000), available at [www.amphl.org/articles/wahlberg2000.html](http://www.amphl.org/articles/wahlberg2000.html).

<sup>20</sup> *Q&A* at Example 24.

<sup>21</sup> Centers for Disease Control and Prevention (CDC) "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures" (1991), available at [www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm).

<sup>22</sup> *See Bradgon v. Abbott*, 524 U.S. 624, 650 (1998) (stating that the "views of public health authorities are of special weight and authority").

<sup>23</sup> *Waddell v. Valley Forge Dental Assocs., Inc.*, 276 F.3d 1275 (11th Cir. 2001) (holding that a HIV-positive dental hygienist posed a direct threat to safety, and therefore was not a qualified individual with a disability); *Mauro v. Borgess Med. Ctr.*, 137 F.3d 398 (6th Cir. 1998) (holding that a HIV-positive surgical technician posed a direct threat to safety, based primarily on job functions requiring him to place his fingers inside of a patient's wound during surgery in close proximity to sharp instruments).

<sup>24</sup> There is only one published case that addresses an ADA claim brought by a HIV-positive phlebotomist. *Couture v. Belle Bonfils Mem'l Blood Ctr.*, No. 04-1397, 151 Fed. Appx. 685 (10th Cir. Oct. 25, 2005). The plaintiff was not allowed to finish training to become a phlebotomist based on his HIV-positive status, but was offered a different position with similar pay and benefits, although the alternative position involved less patient contact. The Tenth Circuit held that the plaintiff failed to establish a claim for disability discrimination because he had not been subjected to an adverse employment action.

<sup>25</sup> *Id.* at Example 25.

<sup>26</sup> *See supra*, notes 15-17.

<sup>27</sup> *Id.*, citing *Menkowitz v. Pottstown Mem'l Med. Ctr.*, 154 F.3d 113 (3d Cir. 1998).

<sup>28</sup> *See, e.g., Bauer v. Muscular Dystrophy Assoc., Inc.*, 268 F. Supp. 2d 1281 (D. Kan. 2003).

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## Potential RICO Liability for Hiring Undocumented, Illegal Workers in the Healthcare Industry

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In several recent cases, employees have sued their employers under the Racketeer Influenced and Corrupt Organizations Act (RICO), alleging the seemingly novel theory that by hiring undocumented, illegal aliens through recruiters and independent contractor employment services, the employer depressed the wages of the employees legally entitled to work in the United States. RICO was not originally intended to apply to such actions. Indeed, various healthcare-related RICO claims have been summarily dismissed in the past due to the employee's failure to sufficiently plead a RICO violation. Nevertheless, the Supreme Court and various circuit courts recently have recognized this theory as a viable one, enabling such RICO actions to proceed, thereby subjecting employers to potentially crippling damage awards or settlements. Employers in the healthcare industry should be mindful of these potential RICO claims and take action to reduce the chances of becoming a target of a similar RICO class action lawsuit.

A recent decision by the United States Supreme Court to deny *certiorari* in *Williams v. Mohawk Industries, Inc.*, 465 F.3d 1277 (11th Cir. 2006), *cert. denied*, 2007 U.S. LEXIS 2798 (Feb. 26, 2007), is illustrative of the manner in which employees have now found a way to properly plead RICO claims against their employers. There, the circuit court held that the employees' class-action complaint alleging that their employer had "conspired with recruiting agencies to hire and harbor illegal workers in an effort to keep labor costs as low as possible" was sufficient to state a RICO violation.

In an earlier decision, the *Mohawk Industries* circuit court stated that the employees had satisfied the pleading requirement of a pattern of racketeering activity by alleging that their employer had committed multiple and ongoing violations of the Immigration and Nationality Act (IRCA). *See* 411 F.3d 1252 (11th Cir. 2005), *vacated and remanded by* 126 S. Ct. 2016 (2006). Specifically, the plaintiffs alleged that the defendant knowingly hired undocumented aliens and accepted fraudulent documentation for employment, and then transported the undocumented aliens from the Texas-Mexico border to the employer's facility in North Georgia. The court held that the employees had sufficiently alleged that their business interest—consisting of a legal entitlement to employment relations free from RICO violations—had been directly injured by the employer's alleged unlawful conduct because the employees' wages had allegedly been depressed by the employment of illegal workers. The Supreme Court vacated and remanded the first *Mohawk Industries* decision in June 2006 on the grounds that the plaintiffs failed to show their damages were proximately caused by the defendant's allegedly illegal racketeering conduct.

In light of the Supreme Court's remand, the Eleventh Circuit re-examined the plaintiffs' claim that the defendant's alleged violations of IRCA proximately caused their depressed labor wages. Ultimately, the court held that the plaintiffs did allege sufficient proximate cause to preclude dismissal because, according to the plaintiffs' complaint, the defendant's scheme of knowingly hiring and harboring illegal workers directly resulted in depressing the wages paid to the plaintiffs. The court noted that wholesale illegal hiring depressed wages for the legal workers in Georgia where the defendant's business was located.<sup>1</sup> On February 26, 2007, the Supreme Court let the Eleventh Circuit's latest decision stand, allowing the plaintiffs to proceed with their RICO lawsuit. *Mohawk Indus. Inc., v. Williams*, U.S. No. 06-873, 167 L.Ed. 2d 174 (Feb. 26, 2007).

Interestingly, on the same day the Supreme Court enabled the *Mohawk Industries* case to proceed, the Fifth Circuit reversed a lower court's dismissal of a similar RICO claim in which 167 Indian workers alleged their employer committed visa fraud, immigration violations, extortion, and other illegal acts in efforts to depress employee wages. *See Abraham v. Singh*, 480 F.3d 351 (5th Cir., Feb. 26, 2007). The appeals court held that the plaintiffs adequately pled a pattern of racketeering activity because the complaint alleged that the defendants "engaged in at least a two year scheme involving repeated international travel to convince up to 200 or more Indian citizens to borrow thousands of dollars to travel to the United States only to find upon their arrival that things were not as they had been promised."

Before the *Mohawk Industries* decision, cases involving RICO allegations against employers in the healthcare industry had not survived dispositive motions on the grounds that the plaintiffs failed to allege that the defendants' conduct proximately caused their alleged damages. For example, in *Barnes v. St. Joseph's Hospital*, 187 F.3d 640, (8th Cir. 1999), the plaintiff, a practicing otolaryngologist, alleged that the defendant health clinics stopped referring patients to him after one clinic hired another doctor (an alleged illegal immigrant) by filing false statements with the Immigration and Naturalization Service in violation of the Immigration and Naturalization Act of 1990. The plaintiff claimed that defendants' RICO violations resulted in the loss of his medical practice and other employment opportunities. However, the district court dismissed the complaint, concluding that the plaintiff had not shown his alleged damages were proximately caused by the alleged RICO violations. If the case had been filed after the *Mohawk Industries* decision, it certainly is possible that the court would have found that the plaintiffs properly alleged that their damages were proximately caused by the defendant's RICO violations.

These recent cases demonstrate the potential for RICO claims similar to the *Mohawk Industries* case in the healthcare industry. Most often, these types of RICO cases are brought against employers in labor-intensive industries where large numbers of unskilled or semi-skilled workers are employed and employers must rely heavily on immigrant workers. Certainly some parts of the healthcare industry fit that model. Furthermore, the plaintiffs typically allege collusion between an employer and recruiting agency to hire undocumented illegal aliens to fill these types of positions. It is well known that large healthcare employers often rely upon recruiting or temporary agencies for these positions. In the collective mind of the plaintiff's bar, healthcare employers already fit the mold for potential defendants in these RICO class action lawsuits. With the Supreme Court's recent ruling in the *Mohawk Industries* case and the significant number of non-citizen healthcare workers throughout the United States, we can expect to see a heightened emphasis on these types of claims. Already, the healthcare industry is no stranger to conspiracy-type claims arising from the employment relationship. Last summer, nurses in four cities—Albany, Memphis, San Antonio, and Chicago—filed class action lawsuits against hospitals, alleging that the hospitals had committed antitrust violations by colluding to depress the wages of registered nurses. It does not take much imagination to see an expansion to incorporate RICO conspiracy allegations similar to those in *Mohawk Industries*.

Assuming an employer is found liable for violating RICO, the damages can be severe. Under section 1964(c) of RICO, a civil plaintiff shall recover “threefold the damages he sustains” and reasonable attorneys’ fees. In the context of a RICO immigration action brought by employees, the damages presumably would be the difference in the wages the employees actually earned from the wages they would have earned had the employer defendant not depressed their wages through alleged racketeering activities. These damages would then be multiplied by three. In class action lawsuits, where the class members might number in the dozens, these damages could quickly reach hundreds of thousands of dollars or greater, and an award of attorneys’ fees.

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#### Endnotes

<sup>1</sup> The Sixth and Ninth Circuit have also concluded that employees, similarly situated to the ones in *Mohawk Industries*, have alleged sufficient proximate cause to proceed with their RICO claims. See *Trollinger v. Tyson Foods*, 370 F.3d 602 (6th Cir. 2004); *Mendoza v. Zirkle Fruit Co.*, 301 F.3d 1163 (9th Cir. 2002).

### Message From the Chair

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As the Annual Meeting fast approaches, I look forward to seeing you in Chicago and thank you for your support of our Practice Group (PG) this year. The Labor and Employment PG Mid-Year Luncheon at the Long Term Care and the Law conference, featuring Scott Cairns of McGuireWoods discussing “Wage and Hour Law: Recent Developments and Issues Facing Health Care Employers,” was well received. Maya Bordeaux, Executive Director of Human Resources, University of Chicago Medical Center, will be our speaker at the Labor and Employment PG Annual Luncheon at the Annual Meeting, scheduled for Monday, June 25. Her topic is “REAL TALK: An Interactive Discussion About Day-to-Day Labor Relations in a Unionized Hospital.” Rob Niccolini, Vice Chair, arranged for both of these outstanding speakers.

Our newsletter, under the editorship of Rob Niccolini and Scotty Shively, continues to be published on a quarterly basis, and we are always looking for new authors. If you have an idea for a topic, or a prepared article, submit it to Rob or Scotty for review. (See page 11 for contact information.)

Vice Chair Jim Bailinson has been very helpful with respect to our website and listserv, as well as in organizing teleconferences. Our newest Vice Chair, Scott Hardy, is taking over our membership efforts and also serving as moderator for an upcoming teleconference focusing on advice for non-union employers from the traditional labor law world. Watch for an announcement of date and time for this teleconference.

I have enjoyed serving as Chair of this PG and value the many friendships I have made through membership in the AHLA. Again, I look forward to seeing you in Chicago. I will, of course, shamelessly use my name to receive the best restaurant reservations!

Michael J. Jordan  
*Chair, Labor and Employment Practice Group*

## Having Your Cake and Eating It, Too—The (Un)Enforceability of Releases on Pre-Filing Qui Tam Claims

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Sitting at her desk and putting the final touches on a settlement agreement and release of all claims, in-house counsel Lisa Loophole could not resist enjoying a moment of satisfaction. Hostile Hospitals was about to close a troubling chapter with Derrick Disgruntled, the hospital's Chief Compliance Officer. For the past six weeks, Loophole had been negotiating skillfully with Disgruntled's attorney to avoid what would have been a messy age discrimination lawsuit. During negotiations with Disgruntled's counsel, Loophole had discovered that Disgruntled was a pro—he had won a \$350,000 verdict against his prior employer for similar claims. In hindsight, it was clear that Disgruntled had spent the past six months setting up his next severance package. The Hospital's CEO had given Loophole her marching orders—cut Disgruntled out of the system and send him packing with a severance agreement containing an iron-clad release. Disgruntled was now walking away with less than the hospital was willing to give to avoid litigation. After weeks of painstaking negotiations, a deal had been reached. Or so Loophole thought.

Then, her email icon began to blink. Loophole's anxiety rose as she saw that the message was from Disgruntled. The re: line warned, "unresolved concerns."

She opened the email and read, "I want to remind you that I still have concerns about several compliance issues that I brought to the hospital's attention over the last several months. I hope the future Chief Compliance Officer will have better luck than I did getting the hospital to take these concerns seriously." Loophole shrank back into her chair. What concerns? What was he talking about? Headlines from recent articles flashed before her eyes, each one announcing an even larger whistleblower award against competing hospital chains. Hostile Hospitals had been careful to avoid these traps, until now. Would Hostile Hospitals be the next victim? Then, she returned to the release language in Disgruntled's settlement agreement. Only moments ago, the document was a symbol of a crisis-averted. Now, it looked weak and flimsy on her desk. Would the release cover this claim? Will Hostile Hospitals ever be rid of Disgruntled? Or was Hostile Hospital's generous twelve month settlement package simply funding his next lawsuit? "We've been set up," whispered Loophole as she realized her foot was stuck firmly in Disgruntled's trap.

### I. The False Claims Act Dilemma

The "*qui tam*" provision of the False Claims Act (FCA) encourages private citizens to bring a civil action on behalf of the United States against persons who defraud the government. 31 U.S.C. § 3729, 3730(b). The term "*qui tam*" is an abbreviation for a Latin phrase which means, "he who sues on behalf of the King as well as for him-

self." The whistleblowing employee, called a "relator" in a *qui tam* action, must first file his or her complaint under seal, allowing the government time to decide if it wishes to intercede in the action before the complaint is served on the defendant. *Id.* at § 3730(b). During this initial period of review by the government, the *qui tam* action may only be settled and dismissed with written consent by both the court and the Attorney General. *Id.* To encourage insiders to come forward, the successful whistleblower may recover attorneys' fees and costs, as well as a share of the recovery, usually up to 30% of the award. *Id.* at § 3730(d). If the government decides not to intervene following this initial review period, the whistleblower has the right to settle the claim. *Id.*

The FCA is silent, however, regarding the whistleblower's right to settle a potential *qui tam* claim prior to filing the claim in court. Doing so arguably prevents the government from ever becoming aware of the fraud and results in all of the settlement proceeds going to the whistleblower, not to the government. After all, the government is the party that was harmed by the fraud. The whistleblower just happened to be in the "wrong spot, at the right time" to take advantage of the claim. On the other hand, employers have an interest in finality when negotiating potential liability with their current and former employees, and the payout to the employee would certainly act as a deterrent to future misconduct. While relatively few jurisdictions have addressed this issue, most courts having done so have found that

releases for yet-to-be-filed *qui tam* claims are void as against public policy.

### II. The Current State of the Law

The prevailing case arises from the Ninth Circuit. *U.S. ex rel. Green v. Northrop Corp.*, 59 F.3d 953 (9th Cir. 1995)(*Green*). The whistleblower in that case, Michael Green, had previously been employed as an investigator by Northrop's Advanced Systems Division. After being terminated, Green filed a wrongful discharge claim in state court alleging he had been fired for raising issues about Northrop's billing practices. To settle the discharge claim, Northrop paid Green \$190,000 in exchange for Green's release of "any and all claims . . . under the law." Nine months later, Green filed a *qui tam* action against Northrop in federal court under the FCA, raising the same billing issues he had asserted in the settled state-law suit. After the United States declined to intervene, the district court granted summary judgment, finding Green's settlement agreement in the prior suit barred his right to recovery.

The Ninth Circuit reversed, finding that releases of *qui tam* claims prior to filing suit would undermine the central purpose of the FCA's *qui tam* provisions—incentivizing insiders to blow the whistle on fraud against the government. The Ninth Circuit was concerned that employers would settle with whistleblowers for an amount less than they would have to pay as a result of a successful *qui tam* claim. Under the FCA, whistleblowers only keep up to 30% of the recovery. The court reasoned that if pre-filing releases were

allowed, a rational employee would be willing to accept a settlement for less than the total liability because the whistleblower would not have to share the settlement with the government. Moreover, the government, who was the wronged party in the first place, would recover nothing.

This result, makes final settlement with an outgoing employee virtually impossible. Even if the employee agrees to release any and every possible claim, that employee could literally deposit the settlement proceeds at the bank on their way to the courthouse to file a *qui tam* claim. Even if the government declined to proceed with the case, the employee, under the rationale of the *Green* decision, would be free to proceed with the FCA claim, including the potential for an additional 30% recovery plus reimbursement of attorney's fees and costs. Most courts addressing this issue have adopted the Ninth Circuit's reasoning. *See, e.g., U.S. ex rel. Pogue v. American Healthcorp, Inc.*, 1995 WL 626514 (M.D. Tenn. Sep. 14, 1995), *vacated on other grounds*, 914 F. Supp. 1507 (M.D. Tenn. 1996); *U.S. ex rel. DeCarlo v. Kiewit/AFC Enters., Inc.*, 937 F. Supp. 1039 (S.D. N.Y. 1996); *U.S. ex rel. Bahrani v. ConAgra, Inc.*, 1983 F. Supp. 2d 1272 (D. Colo. 2002).

### III. A Glimmer of Hope?

An October 2005 decision by the Southern District of Georgia created some hope that pre-filing releases of FCA *qui tam* claims might be enforceable. *U.S. ex rel. Whitten v. Triad Hosps., Inc.*, 2005 WL 3741538 (S.D. Ga. Oct. 27, 2005). Unfortunately, the Eleventh

Circuit recently reversed and remanded that decision, but left open the question of whether such a release would be enforceable. *U.S. ex rel. Whitten v. Triad Hosps., Inc.*, 2006 WL 3626992 (11th Cir. Dec. 13, 2006). The whistleblower, Ted Whitten, had served as the compliance officer for Quorum Health Resources, a hospital management company that supplied the Glen Brunswick Memorial Hospital Authority (Authority) with management services, including a CEO and CFO to manage the Authority's day-to-day operation of its two hospitals. In September 2000, the Authority terminated its relationship with Quorum, and a few months later, Whitten's employment with the Authority ended. In January 2001, Whitten entered into a severance agreement with the Authority containing a general release of all claims. Despite signing the severance and release agreement, Whitten subsequently filed a *qui tam* action against Triad Hospitals, the successor to Quorum.

The district court dismissed the action, finding that the release barred the claim. Significantly, the Southern District of Georgia held that the agreement *was enforceable and did not violate public policy*. The Eleventh Circuit, however, reversed and remanded the claim, finding that under Georgia contract law, the language of the severance agreement only released the Authority, not Quorum. By ruling on this narrow contract issue, the Eleventh Circuit avoided addressing whether a pre-filing release of *qui tam* claims would be enforceable as a matter of public policy.

Only the Eighth Circuit has found a pre-filing release to be

enforceable to bar a future *qui tam* claim. *U.S. ex rel. Gebert v. Transport Admin. Servs.*, 260 F.3d 909 (8th Cir. 2001). The Eighth Circuit, however, cautioned that its decision was extremely limited. The husband and wife relations in *Gebert* were terminated after their employer discovered the Geberts may have misappropriated over \$500,000 in company assets. The Geberts subsequently filed for bankruptcy. When their former employer filed claims against them for misappropriation, the Geberts countered with a claim for \$1.2 million. The bankruptcy trustee, the Geberts, and the former employer then entered into a settlement in which the trustee and the Geberts released the former employer for all claims. At no point, however, did the Geberts list among their schedule of assets a potential FCA claim.

The Geberts subsequently filed a *qui tam* lawsuit against their former employer. The Eighth Circuit, however, ruled the Geberts were barred from bringing the *qui tam* claim because of the release entered into during the bankruptcy proceedings. Moreover, the court found the Geberts to be judicially estopped from bringing the claim because the Geberts had failed to list their FCA claim in the schedule of assets before the bankruptcy court. The Eighth Circuit distinguished the Ninth Circuit's decision in *Green*, finding that the interest in enforcing the parties' release outweighed other policy concerns because the release was entered in the context of a bankruptcy proceeding rather than a general, independent release of a claim for money. Essentially, the court found that

the public policy concerns addressed by *Green* were not present because the claim belonged to the bankruptcy estate, not to the former employees, and the proceeds of the release would flow to the estate instead of to the employee. The court noted, "the unique context of this case will have an exceedingly narrow application and, accordingly, will void nearly all of the public-interest harms discussed in [*Green*]."

### IV. Strategies for Uncertain Times

Unfortunately, healthcare entities must assume that pre-filing releases of *qui tam* claims will be unenforceable. While counsel may not be able to provide an "iron-clad guarantee" that a final release is indeed final, they can undercut the ability of former employees to pursue a *qui tam* claim. For instance, the release agreement could contain a representation and warranty section requiring that the employee affirmatively disclose any and all compliance issues with specificity, describe how the employee has first hand knowledge of the issue, identify to whom and when the issue was reported, and indicate why they feel these claims have not been cured. Doing so forces the employee to disclose all known concerns, and helps narrow the universe of possible claims. Although a release may not be effective, counsel will at least know what possible claims may exist, placing settlement negotiations on a more level field. Also, if the former employee later asserts a *qui tam* claim on an undisclosed issue, counsel has ammunition to attack the

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credibility of the relator. Thus, while Lisa Loophole may not be able to keep Mr. Disgruntled out of the courtroom, she may be able to make him think twice before filing suit.

\* Todd P. Photopulos, Esquire, is a member of Butler Snow O'Mara Stevens & Cannada PLLC, where he regularly represents healthcare clients in labor, employment, and business immigration issues.

### Join Us in Chicago!

The Labor and Employment Practice Group (PG) will hold an informal meeting at the continental breakfast on Tuesday, June 26, 2007 at the AHLA Annual Meeting in Chicago, IL. This will be a great opportunity to meet other Labor and Employment PG members, share ideas, and learn more about becoming involved in the PG's future activities! We will be easy to spot; just look for our PG sign.

For information about the Annual Meeting, please visit: [www.healthlawyers.org/annual](http://www.healthlawyers.org/annual)

## UPCOMING TELECONFERENCES

### DMEPOS Competitive Bidding Final Rule: An Overview and Analysis

Wednesday, May 16, 2007

1:00-2:30 pm Eastern

*Sponsored by the Regulation, Accreditation, and Payment Practice Group*

### 2 Part Series: Joint Ventures—When Reimbursement and Fraud and Abuse Collide

*Cosponsored by the Fraud and Abuse, Self-Referrals, and False Claims; Hospitals and Health Systems; Physician Organizations; and Regulation, Accreditation, and Payment Practice Groups*

#### Part I: The Nuts and Bolts of Reimbursement and Fraud and Abuse

(a.k.a. *Who Came Up with These Rules Anyway?*)

Thursday, May 17, 2007

1:00-2:30 pm Eastern

#### Part II: From Theory to Practice

(a.k.a. *Will Somebody Please Just Tell Me The Answer?*)

Thursday, May 24, 2007

1:00-2:30 pm Eastern

### Physician Vendor Relationship Issues

Wednesday, June 13, 2007

1:00-2:30 pm Eastern

*Cosponsored by the Corporate Governance Task Force, a joint endeavor of the HMOs and Health Plans, Hospitals and Health Systems, In-House Counsel, Tax and Finance, and Teaching Hospitals and Academic Medical Centers Practice Groups, and the Physician Organizations and Life Sciences Practice Groups*

### Managed Care Litigation Developments: Legal and Practical Considerations for Health Plans and Providers (Intermediate)

Tuesday, July 24, 2007

1:00-2:30 pm Eastern

*Cosponsored by HMOs and Health Plans and In-House Counsel Practice Groups*

For complete listing, more information, and to register visit:  
[www.healthlawyers.org/teleconferences](http://www.healthlawyers.org/teleconferences)

## New AHLA Publication

### The Fundamentals of Life Sciences Law: Drugs, Devices, and Biotech (with CD-ROM)

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Register Now!

## Labor and Employment Practice Group Annual Luncheon

at the  
2007 Annual Meeting  
Chicago, Illinois

**Monday, June 25, 2007**

12:30-1:45 pm Eastern

**Title:**

REAL TALK: An Interactive Discussion about Day-to-Day Labor Relations in a Unionized Hospital

**Description:**

The agenda for the discussion will be as follows:

1. Best practices for managers to avoid litigation and liability.
2. Union and corporate campaigns and how they can affect patient care.
3. Real life stories of complex (or just downright funny) cases.
4. Q&A

**Presenter:**

Maya A. Bordeaux, Esquire  
Executive Director, Human Resources  
University of Chicago Medical Center  
Chicago, IL

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For information about the program and to register, please visit:  
[www.healthlawyers.org/annual](http://www.healthlawyers.org/annual)

## Labor & Employment

*Practice Group Leadership  
2006-2007*

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**NETWORKING OPPORTUNITY!**

## **Labor and Employment Practice Group Annual Luncheon**

*Monday, June 25, 2007*

*at the*

**2007 Annual Meeting**  
*Sheraton Chicago Hotel, Chicago, IL*

*More Information on page 11*

**Labor &  
Employment**

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