No. F 10197

IN THE COURT OF APPEAL OF CALIFORNIA

FIFTH APPELLATE DISTRICT

Deane Hillsman, M.D.,

Plaintiffs and Appellant,

v.

Sutter Community Hospitals of Sacramento, et al.,

Defendants and Respondents.

AMICUS CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF APPELLANT DEANE HILLSMAN, M.D.

CATHERINE I. HANSON
ASTRID G. MEGHRIGIAN
221 Main Street
P.O. Box 7690
San Francisco, California 94120-7690
Telephone (415) 541-0900

Attorneys for Amicus Curiae
CALIFORNIA MEDICAL ASSOCIATION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

ATTORNEY GENERAL OPINIONS

FEDERAL STATUTES AND REGULATIONS

STATUTES

REGULATIONS

STATE STATUTES AND REGULATIONS

STATUTES

REGULATIONS

MISCELLANEOUS

Blum, Economic Credentialing: A New Twist in Hospital Physician Appraisal Processes, _____ J. Legal Medicine _____ (1991) 28

Joint Commission, Accreditation Manual for Hospitals, (1991) 15, 16

Levine, Judicial Backpedaling: Putting the Brakes on California's

I. INTRODUCTION

A. Interest of the Amicus Curiae

Amicus Curiae California Medical Association (CMA) is a non-profit, incorporated professional association of approximately 32,000 physicians practicing in the State of California. CMA's membership includes most of the California physicians who are engaged in the private practice of medicine. The association's primary purposes are: ". . . to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession . . . ."

The case involves serious allegations that a physician was retaliated against by a hospital as a result of his protestations over substandard medical care being provided at that facility. Because this case directly impacts the ability of physicians to speak freely when attempting to improve the quality of care and protect patients from harm, this case will directly affect the interests of the entire CMA membership and their patients.

The CMA believes it is critical to the continuation of high quality health care that physicians and other health care professionals be permitted and in fact encouraged to raise objections if they reasonably believe treatment practices or facilities are substandard, without fear of or actual retaliation. The quality of health care provided to patients today depends upon vigorous and informed physician advocacy. Unlike others involved in the health care arena, physicians

are both legally and ethically obligated to ensure that they keep abreast of relevant medical technology and resources and that their patients receive competent medical care not delayed, jeopardized or thwarted by third persons. *See* Wickline v. State of California (1986) 192 Cal.App.3d 1630, 239 Cal.Rptr. 810 (recognizing that physicians have a legal duty to act as a buffer between the patient and third party payors and to challenge cost containment decisions which jeopardize the patient's health).

Both legal and ethical standards demand that physicians not sit back and watch conditions that could potentially be harmful to their patients. Quality of care depends upon physicians asserting their views and advocating quality health care. Indeed, as was recognized by the California Supreme Court in Rosner v. Eden Township Hospital District (1962) 58 Cal.2d 592, 25 Cal.Rptr. 551:

> The goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital practices are being followed. Considerations of harmony in the hospital must give way where the welfare of patients is involved, and the physician by making his objections known, whether or not tactfully done, should not be required to risk his right to practice medicine. (Emphasis added.)

Firing or otherwise disciplining a physician for advocating compliance with appropriate medical standards is a matter of grave importance to the public health, welfare and safety and must not be condoned by this court. Especially in the current economic environment which may not fully respect the promotion of patient health and welfare first and foremost, the law must protect physicians who, acting as patient advocates, express their concerns over the quality of care.

Because there is no justification for retaliating against physicians who choose not to condone or acquiesce in treating patients under substandard conditions or who actively advocate changes to improve patient care, CMA urges that this court protect patient welfare by ruling that public policy is defeated whenever physicians and other health professionals who exercise their lawful right and responsibility to protest unsafe conditions face retaliatory measures.

B. Statement of the Case and the Facts

If the jury believes Dr. Hillsman, he lost his job because:

1) He had a duty to establish medically appropriate standards for the Respiratory Therapy Department at Sutter General and Sutter Memorial Hospitals. Appendix 379 at lines 14-22, 384 at lines 19-28, 385 at lines 1-28, 386 at lines 1-16 and 396-397;

2) He reasonably believed that respiratory therapy requires an average time of at least 25 minutes per patient to be medically adequate. Appendix 628 at lines 11-24, 629 at lines 10-28, and 630 at lines 1-2;

3) As he expanded the respiratory therapy program there was not a sufficient increase in staffing to enable the respiratory therapists to devote an average of 25 minutes to each case. Appendix 169 at lines 11-28 , 170 at lines 1-18, and 181 at lines 9-16;

4) Rather than provide more staffing, the hospital transferred the medical direction of the Respiratory Therapy Department to a nonphysician and stopped providing Dr. Hillsman the raw data he needed to determine

how much time the therapists were averaging per case and how their services were affecting the quality of patient care, Appendix 386 at lines 16-28, 628 at line 28, 629 at lines 1-9, and the hospital took these actions despite the fact Dr. Hillsman's contract specifically required that he be in charge of the medical direction of the Department and that he receive the raw data necessary for him to make these computations. Appendix 396-397; and

5) When the hospital realized that new accreditation standards were about to be implemented requiring that a physician be in charge of the respiratory therapy program, it knew it would either have to comply with Dr. Hillsman's requests or fire Dr. Hillsman and attempt to find a more compliant physician to head the Department. Appendix 389, lines 19-28.

If the jury believes the hospital, Dr. Hillsman lost his job because he is a "chronically wrong complainer." R.B. at 16, lines 2-5.

The sole issue in this appeal is whether Dr. Hillsman is entitled to his day in court. The trial court said no. Amicus respectfully urges this court to hold that the correct answer is yes and reverse.

C. Question Presented

Whether Dr. Hillsman has established facts sufficient to permit to go to the jury a cause of action for breach of an implied-in-fact employment contract on the

basis of a wrongful discharge under the public policy exception to the terminable at-will doctrine.

II. LEGAL ARGUMENT

A. The Public Policy Exception to the Terminable At-Will Doctrine

1. General Application.

An employment relationship having no specified term may generally be terminated at the will of either employer or employee on notice to the other. Labor Code § 2922. However, there are several well-recognized exceptions to the terminable at-will doctrine embodied in § 2922. The exception applicable to this case is the public policy exception as set forth in Tameny v. Atlantic Richfield Co. (1980) 27 Cal.3d 167, 164 Cal.Rptr. 839. In that case, the California Supreme Court ruled that an action for wrongful termination based upon public policy sounds in tort[1]. Courts are extremely solicitous of this exception, which limits the employer's right to dismiss an at-will employee if the termination violates a public policy, and routinely affirm its principles where necessary to safeguard the public interest. Tameny, *supra* (at-will employee allegedly fired because he refused to violate antitrust laws could maintain action for wrongful discharge against

---

[1] *See* Levine, Judicial Backpedaling: Putting the Brakes on California's Law of Wrongful Termination, 20 Pac.L.J. 993 (1989). The California Supreme Court first adopted the public policy exception to the at-will doctrine in Tameny from the 1959 Court of Appeals decision of Petermann v. Teamsters 174 Cal.App.2d 184, 344 P.2d 25. Id. at 999-1000, which defined public policy as "that principle of law which holds that no citizen can lawfully do that which has a tendency to be injurious to the public or against the public good. . . ." Id. at 188 (quoting Safeway Stores v. Retail Clerks (1953) 41 Cal.2d 567, 575.).

employer); Petermann v. International Brotherhood of Teamsters (1959) 174 Cal.App.2d 184, 344 P.2d 25 (employee alleging he had been dismissed because he refused to commit perjury, a criminal violation, supported claim that discharge was against public policy); Foley v. Interactive Data Corp. (1988) 47 Cal.3d 654, 254 Cal.Rptr. 211 (reaffirming viability of wrongful discharge action where discharge contravenes fundamental public policy); Jenkins v. Family Health Program (1989) 214 Cal.App.3d 440, 262 Cal.Rptr. 798 (upholding a nurse's ability to maintain an action for retaliatory discharge for protesting unsafe and unhealthy working conditions) and Rojo v. Kliger (1990) 52 Cal.3d 65, 276 Cal.Rptr. 130 (sex discrimination in employment may support claim of tortious discharge in contravention of public policy).

In Foley v. Interactive Data Corp. (1988) 47 Cal.3d 654, 254 Cal.Rptr. 11, the California Supreme Court upheld the principal that employment termination or discipline of an individual which violates public policy gives rise to tort liability. In doing so, the court determined that, even where the plaintiff alleges a statutory basis for the action, the proper focus is on whether there is such a "substantial," "fundamental," and "basic" public policy being implicated that a court is justified in imposing tort damages upon the employer. Id. at 669. The asserted interests also must be "public" in nature. Id. Thus, a court must also determine whether the policy "inures to the benefit of the public at large rather than to a particular employer or employee." Id.

Daniel Foley, an at-will employee, was terminated after nearly seven years of service to his employer. The event that led to Foley's discharge was a conversation in which he told a vice-president of Interactive about a current F.B.I investigation of Foley's immediate supervisor. Foley believed that the corporation had a legitimate interest in knowing about a high executive's alleged prior criminal conduct. Within two weeks of the conversation Foley was given the option to resign or be fired. Mr. Foley alleged that the defendant discharged him in "sharp derogation" of a substantial public policy that imposes a legal duty on employees to report relevant business information to management. Id. at 669.

The court found that whether or not there was a statutory duty requiring an employee to report information relevant to his employer's interest, there was no substantial public policy prohibiting an employer from discharging an employee for performing that duty. Id. at 670. The underpinning of the court's holding was that the "public" prong of the public policy exception was not met. That is, Foley's disclosure was only of interest to the private employer, not the public at large. "When the duty of an employee to disclose information to his employer serves only the private interest of the employer, the rationale underlying the Tameny cause of action in not implicated." Id. at 670-671.

The Foley court's rationale for its refusal to extend the public policy exception to matters which concern the private interests of the employer is critical to an understanding of when the public policy exception is implicated. In a footnote, the court explained that if an employer and an employee could agree that

the employee had no duty to do or refrain from doing something (such as not inform the employer about another employer's adverse background), then "nothing in the state's public policy would render such an agreement void" and that it could not be "said that an employer, in discharging an employee on this basis, violates a fundamental duty imposed on all employers for the protection of the public interest." Fn. 12 at 670. In such cases, according to the Court, there is an absence of a "distinctly `public' interest". Conversely, the court recognized that where parties may not lawfully contract to circumvent the public interest at stake, the public policy exception is implicated. Thus, fundamental to the question of whether the discharge violates public policy is whether the discharge resulted from the exercise or non exercise of a lawful "duty" to protect the public interest. Any attempts to retaliate against individuals for exercising such a duty necessarily is against public policy and therefore falls within the exception to the at-will doctrine.

The public policy exception was further expanded by the Supreme Court in Rojo v. Kliger (1990) 52 Cal.3d 65, 276 Cal.Rptr. 130. In that case, the female plaintiffs alleged that their refusal to accept demands for sexual favors and tolerate sexual harassment resulted in their wrongful discharge. In support of their argument, they claimed that this discharge violated California's fundamental public policy against sex discrimination in the workplace as reflected in Article I,

Section 8 of the California Constitution.[2] The Court agreed, holding whether or not the constitutional provision applied to private parties, it "unquestionably reflects a fundamental public policy against discrimination in employment - public or private - on account of sex" and therefore held that the employees stated a claim for tortious discharge in violation of public policy. Id. (Emphasis supplied by the court.) As is evident by the holding of the Rojo case, neither the discharge itself nor the activity in question need affect the public; rather, even where only one or two parties are concerned, discharges implicating the public interest will be remedied. Consequently, courts can and should protect under the public policy exception individual rights, such as the individual right to be free from sexual harassment or the right to petition for safer conditions, so long as some public policy is at stake.[3]

Finally, the Rojo court refused to limit the public policy exception to situations in which the employer coerces the employee to commit an act that violates public policy or restrains the individual from exercising a fundamental right, privilege or obligation. Id. at 46. Rather, the court emphasized that a wrongful discharge exists where "the basis for the discharge contravenes a

---

[2] That provides: "A person may not be disqualified from entering or pursuing a business, profession, vocation, or employment because of sex, race, creed, color, or national or ethic origin."

[3] Thus public policy exception to the at-will doctrine is far different than the "private attorney general" doctrine as codified in Code of Civil Procedure Section 1021.5 which authorizes the recovery of attorney fees to successful parties who vindicate "important rights." Under the statutory fee provision, the litigation must confer a "significant benefit" "on the general public or a large class of person." As the Rojo case illustrates, on the other hand, the public policy exception vindicates individual rights where public interests are implicated.

fundamental public policy." Id. *See also* Semore v. Pool (1990) 217 Cal.App.3d 1087, 266 Cal.Rptr. 280 (private employer terminated as a result of a refusal to take random drug test may properly rely on public policy exception to assert violation of constitutional right to privacy).

2. The Public Policy at Stake May be Based on Constitutional, Statutory and Non-Statutory Sources.

In sum, therefore, the public policy exception to the terminable at-will doctrine applies where:

(1) an employer forces an employee to violate the law or otherwise restrains an employee from exercising a fundamental right, privilege or obligation (Tameny and Petermann);

(2) an employee is disciplined for the exercise of a lawful duty to protect the public interest (or the public interest at stake cannot lawfully be circumvented by an agreement between the parties) (Foley); or

(3) an employee is disciplined as a result of a policy which inures to the benefit of the public at large, even though individual interests are at stake (Rojo).

This application is consistent with the logic behind the public policy exception, described by the California Supreme Court in the Foley case as follows: the "[e]mployer's right to discharge an `at-will' employee is still subject to limits imposed by public policy, since otherwise the threat of discharge could be used to coerce employees into committing crimes, concealing wrongdoing, or taking other

action harmful to the public weal. 47 Cal.3d at 665. Consequently, the exception does not arise out of a contractual obligation; rather, it arises from the duty of every employer in this state to conduct its affairs in a manner consistent with public policy. The exception recognizes violations or "disparagements" of public policies, such as retaliating against individuals for exercising a fundamental right, must be remedied in order to achieve the state's goals in promoting the public interest.

Given the purpose of the public policy exception, there is no justification for restricting its application to policies expressed in the Constitution or statutes. The judiciary clearly has the power to declare principles of public policy where a fundamental public issue is concerned, even if that policy is not reflected in an independent statutory or constitutional source. The Tameny court firmly recognized that the exception to the at-will doctrine exists where a discharge has "clearly violated an express statutory objective or undermined a firmly established principle of public policy." Tameny at 172. (Emphasis added.) As more recently stated in Koehrer v. Superior Court (1986) 181 Cal.App.3d 1155, 1165, 226 Cal.Rptr. 820:

> [t]he "public policy" limitation and the "violation of statute" limitation pointed out in Patterson [Patterson v. Philco Corp. (1967) 252 Cal.App.2d 63, 60 Cal.Rptr. 110] are in effect two aspects of a single doctrine: fundamental public policy may be expressed either by the Legislature in a statute or by the courts in decisional law. Insofar as affording remedies to an employee discharged in contravention of a fundamental public policy is concerned, it is immaterial whether the public policy is proclaimed by statute or delineated in a judicial decision. Id. (Emphasis added.)

Dabbs v. Cardiopulmonary Management Services (1987) 188 Cal.App.3d 1437, 234 Cal.Rptr. 129 compels the conclusion that physicians and other health care workers have judicial redress under the public policy exception against third parties that retaliate against them for advocating and promoting quality of care, regardless of whether a statutory source of public policy exists. In Dabbs, a certified respiratory therapist was terminated from her position when she walked off the job because she felt there was insufficient staff to provide quality patient care. In overruling the lower court's granting of the defendant's motion for summary judgment, the Court of Appeal held that the employee's allegations were sufficient to state a cause of action based upon general societal concerns for qualified patient care and statutory provisions governing the health professions. A violation of a specific statute was not required.

Expressly acknowledging California's policy favoring qualified medical care, the Dabbs court recognized that retaliatory measures must not be imposed upon practitioners who point out deficiencies or who refuse to condone substandard care. Citing numerous provisions in the Business and Professions Code regulating the practices of the various categories of health professionals, the court observed that the "legislation recognizes each particular practice affects the public health, safety, and welfare and as such require regulation and control." The court then explained that the "Respiratory Care Practice Act" (Business and Professions Code § 3700 et seq.) (a provision which is relevant also to the instant case) specifically addressed "the need to regulate and control those who deal in

respiratory care." Nonetheless, even apart from that Act, the court found support for its decision "in general societal concerns for qualified patient care" as follows:

> We find support for our position in general societal concerns for qualified patient care. This policy militates against allowing employers to discriminate against or discharge an employee for voicing dissatisfaction with procedures he or she reasonably believes might endanger the health, safety and welfare of the patients to which the employee is responsible.

Id. at 1444 (emphasis added).

Foley does not reject the view that public policy may be pronounced by courts. While technically the court left the issue open, the court's primary concern was whether public policy has been violated, not whether the policy had a statutory or constitutional origin. As the court stated, "Regardless of whether the existence of a statutory or constitutional link is required under Tameny, disparagement of a basic public policy must be alleged . . . " Id. at 669. (Emphasis supplied by the court.)

The emphasis on the nature of public policy itself, as opposed to whether it is embodied in a statute or constitutional provision was reiterated by the Supreme Court more recently in Rojo v. Kliger (1990) 52 Cal.3d 65, 276 Cal.Rptr. 130. Although the public policy at issue in that case - the policy against sex discrimination in the workplace - was reflected in the California Constitution, the court declared "irrelevant" the question of whether the provision applied "exclusively to state (as opposed to private) action". Therefore whether the provision was enforceable by the plaintiffs was immaterial to the court's

conclusion that the public policy exception applied to a wrongful discharge case involving sexual harassment.

B. Substantial Public Policies, as Reflected in Both Statutory and Common Law, Were Violated by Dr. Hillsman's Discharge.

If the jury believes his side of the story, Dr. Hillsman's discharge was in violation of a substantial public policy. By advocating quality medical care Dr. Hillsman sought to protect the public from substandard medical care. Specifically, Dr. Hillsman was attempting to ensure that patients received an adequate amount of respiratory therapy.

As Medical Director of the Respiratory Therapy Department, it was Dr. Hillsman's duty to ensure his patients received adequate therapy. As is discussed below, this duty stemmed from both statute and common law. Although the health care profession is heavily regulated, the complexity of medical care and the inability of patients to either identify problems or do anything about them prevents the regulations from being effective without continued vigilance by health professionals. Health care professionals who disclose illegal, unethical, or unsafe practices must be protected from retaliatory termination or discipline if California's public policy of quality medical care is to be enforced.

1. California Statutory and Regulatory Law Firmly Establish the Public Policy That Physicians Advocate Compliance With Medical Standards, Free From Lay Interference.

The public policy in favor of health care professionals actively encouraging qualified health care has been widely accepted and firmly established by the California Legislature.

a. *Health Licensure Statutes.*

First, California's statutory scheme licensing and regulating health professionals independently establishes a statutory source sufficient to invoke the public policy exception. As the Dabbs court recognized, "[t]here is no question California has a public policy favoring qualified care for its ill and infirm." Dabbs, supra at 1444. According to the court, this policy was reflected by, among other things, the "lengthy" list of sections in the Business and Professions Code dealing with safeguards for the health of patients and recognizing each health care practice impacts the public health and therefore requires regulation and control. (*See* Business and Professions Code §§ 2000 et seq., Physicians and Surgeons; 1200 et seq., Clinical Laboratory Technology; 1600 et seq., Dentistry; 2700 et seq., Nursing, etc.) Accordingly, the court held that statutes governing health professions (in addition to general societal concerns) are sufficient to sustain an action for wrongful discharge.

Of particular relevance to this case as in the Dabbs case, is the "Respiratory Care Practice Act" (Business and Professions Code § 3700 et seq.).[4] Section 3701

---

[4] The fact that the Respiratory Care Practice Act was enacted in 1983, nearly ten years after Dr. Hillsman's termination, does not undercut the force of the public policy being expressed by the Legislature. That policy was not new, indeed the Legislature expressly stated that one purpose of the Act was to "provide clear legal authority for functions and procedures which have common acceptance and usage." Section 3701.

of the Act provides: "The Legislature finds and declares that the practice of respiratory care in California affects the public health, safety, and welfare and is to be subject to regulation and control in the public interest to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons certified to practice respiratory care. . . ." Business and Professions Code § 3701 (emphasis added). Because of the strong public policy to protect the people from harmful practices by respiratory care therapists, the legislature enacted additional provisions designed to promote patient welfare. For example, Business and Professions Code Section 3702 expressly requires that the practice of respiratory care be performed "under the supervision of a medical director in accordance with a prescription of a physician and surgeon or pursuant to a respiratory care protocol (defined as policies and protocols developed through collaboration with, among others, physicians, nurses, physical therapists, respiratory care practitioners, and other licensed health care practitioners)" as specified in Section 3702. Consequently, by statute, physicians are responsible for the performance of respiratory care and have the legal obligation to protest any instances where the performance of that care falls below accepted standards. See also 22 California Code of Regulations § 70619 (requiring that a physician have overall responsibility for the respiratory care service).

b. *Statutes Mandating Medical Staff Control Over the Provision of Health Care.*

The responsibility of physicians with respect to respiratory care is not surprising given California's statutory scheme governing the performance of all health care, including the performance of professional work within California's hospitals. In order to promote quality patient care, medical staffs and their physicians members are required to perform both direct patient care activities and the ongoing review, evaluation, and monitoring functions of the care rendered. Thus, members of a hospital's staff are responsible for possessing, securing, and implementing the professional expertise necessary to assure the delivery of quality care.

First, each physician member of the medical staff is responsible for overseeing the general medical condition of every patient that the physician admits to the hospital. *See e.g.* 22 California Code of Regulations § 70703(a) (physician responsible for adequacy and quality of medical care rendered to patients in hospital). Indeed, the standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),[5] the private association which accredits hospitals nationwide, require that physicians perform a "comprehensive physical examination" on all hospitalized patients and that physicians be responsible for "each patient's general medical condition." Joint

---

[5] This organization was previously known as the Joint Commission on Accreditation of Hospitals (JCAH).

Commission, Accreditation Manual for Hospitals, p. 112, Medical Staff Standard MS4.3.5 (1991).[6]

Aside from the responsibility of medical staff members to patients, both the medical staff and its members are responsible for credentialing, that is, assuring the initial and ongoing competence of every physician, dentist, podiatrist, and some in cases clinical psychologist who practices in the hospital. See generally Unterthiner v. Desert Hospital District (1983) 33 Cal.3d 285, 188 Cal.Rptr. 590. In light of the medical staff's expertise in the credentialing area, DHS specifically requires that the medical staff, and not the hospital, establish peer review in credentialing procedures. 22 C.C.R. § 70701(a)(7). Thus, it is the medical staff which enforces those procedures and makes recommendations as appropriate. 22 C.C.R. § 70703.

To properly perform these vital quality of care functions, California law requires that medical staffs retain their separate identity and be self-governing. *See* Business and Professions Code § 2282, Health & Safety Code § 1250(a) and 22 C.C.R. §§ 70701 and 70703. Thus, California law prohibits the practice of medicine by physicians and the licensure of hospitals unless the medical staff is

---

[6] Of course, this Court may properly take judicial notice of the JCAHO Standards pursuant to Evidence Code Section 452(h). *See* Anton v. San Antonio Community Hospital (1977) 19 Cal.3d 802, 819, 140 Cal.Rptr. 442. Moreover, it should be noted that institutions accredited as hospitals by the JCAHO are generally deemed to meet all of the Medicare conditions of participation. *See* 42 U.S.C. § 1395bb(a)(1); 42 C.F.R. § 488.5. *See also* Health & Safety Code § 1282 (authorizing quality of care inspections of hospitals by the JCAHO). Finally, there is no doubt that hospitals must, as a practical matter, obtain accreditation. *See, e.g.* Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment (1989) 137 U.Pa.L.Rev. 431, n. 366. The importance of JCAHO as a hospital accreditation organization was recognized in Medi-Cal regulations effective in 1970,, Title 22, section 51207 (Register 70, No. 40-9-30-72). The provision is set out verbatim in Appellant's Opening Brief, p. 34.

"self-governing with respect to the professional work performed." Id.[7] This carefully crafted scheme ensures that medical staffs and their members independently exercise their professional expertise and advocate quality patient standards with respect to the professional work performed in the hospital. This law plainly does not countenance unlawful intrusions, such as retaliatory efforts against physicians, into matters which are exclusively within the medical staff's (and its physician members') proper domain.[8]

c. *Statutes Prohibiting Lay Control Over the Practice of Medicine.*

The mandate that medical staffs be self-governing and therefore independent with respect to the professional work performed in a hospital derives its genesis from California law generally prohibiting lay persons from exercising control or otherwise interfering with the professional judgment of physicians and other health care professionals. This prohibition, known as the "Corporate Practice of Medicine Bar" is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine.

This general prohibition is codified in Business and Professions Code Section 2400 (initially enacted in 1937 as Business and Professions Code Section 2008), a provision which denies corporations and other artificial legal entities professional

---

[7] Joint Commission Standards mirror California law as they clearly mandate that organized medical staffs be responsible for the control and provision of professional services provided at the hospital. *See* Medical Staff Standards 1, 2 and 3.

[8] Given the medical staff's quality assurance responsibilities, it is not surprising that as a matter of law, the respiratory care service is responsible and accountable to the medical staff. 22 C.C.R. § 70617.

rights, privileges or powers pursuant to California's Medical Practice Act. (Business and Professions Code § 2000 et seq.) The proscription provides a fundamental protection against the potential that the provision of medical care and treatment will be subject to commercial exploitation. The bar ensures that those who make decisions which affect, generally or indirectly, the provision of medical services (1) understand the quality of care implications of those decisions; (2) have a professional ethical obligation to place the patient's interests foremost; and (3) are subject to the full panoply of the enforcement powers of the Medical Board of California, the state agency which charged with the administration of the Medical Practice Act.[9]

Concerns which gave rise to the longstanding proscription against the corporate practice of medicine apply with even greater urgency at the present time. As is discussed below, there have been profound changes in the financing of both

---

[9] The strength of California law against permitting lay persons to practice medicine or exercise any form of control over mec practice cannot be questioned. *See e.g.* Business and Professions Code §§ 2052, 2400, 2408, 2409; Corporations Code §§ 13400 et seq. Parker v. Board of Dental Examiners (1932) 216 Cal. 285, rehearing denied, Sept. 28, 1932 (lay persons may not serve as director professional corporations); Pacific Employers Ins. Co. v. Carpenter (1935) 10 Cal. App. 2d 592, 594-596 (holding that for-profit corpora may not engage in business of providing medical services and stating that "professions are not open to commercial exploitation as it is sai be against public policy to permit a 'middle-man' to intervene for a profit in establishing a professional relationship between members of professions and the members of the public"); Benjamin Franklin Life Assurance Co. v. Mitchell (1936) 14 Cal. App. 2d 645, 657 (sai People v. Pacific Health Corp. (1938) 12 Cal. App. 2d 156, 158-159 (same); Complete Service Bureau v. San Diego Medical Society (1954 Cal. 2d 201, 211 (non-profit corporations may secure low cost medical services for their members only if they do not interfere with the mec practice of the associated physician); California Physician Service v. Garrison (1946) 28 Cal. 2d 790 (same); Blank v. Palo Alto-Stan Hospital Center (1965) 234 Cal. App. 2d 377, 390 (non-profit hospital may employ radiologist only if the hospital does not interfere with radiologists' practice of medicine); Letsch v. Northern San Diego County Hospital District (1966) 246 Cal. App. 2d 673, 677 (district hos may contract with radiologists under restriction imposed in Blank above); California Association of Dispensing Opticians v. Pearle Vi Center, Inc. (1983) 143 Cal. App. 3d 419, 427 (Pearle Vision Center Inc.'s franchise program violates California's prohibition against corporate practice of medicine); Marik v. Superior Court (1987) 191 Cal.App.3d 1136, 236 Cal.Rptr. 751 (a provisional director of a mec corporation must be either a physician or other qualified licensed person); 65 Cal. Op. Atty. Gen. (1982) (general business corporation may lawfully engage licensed physicians to treat employees even though physicians act as independent contractors and not as employees); 63 Op. Atty. Gen. 729, 732 (1980) (for-profit corporation may not engage in the practice of medicine directly nor may it hire physician perform professional services); 57 Cal. Op. Atty. Gen. 213, 234 (1974) (only professional corporations are authorized to practice medicine); Cal. Op. Atty. Gen. 103 (1972) (hospital may not control the practice of medicine).

governmental and private health care delivery systems in the last few years. Increasing competition, as well as cost consciousness on the part of both public and private payors, have created an environment rife with potential for jeopardy to quality patient care. Under these circumstances, courts should be especially solicitous of patient welfare and especially leery of retaliatory actions against physicians based upon the latter's lawful right and duty to control a patient's medical treatment.[10]

2. Statutory Protections Further Demonstrate the Importance of Speaking Out Against Substandard Conditions.

In addition, there are a number of statutory protections which limit a physician's liability for "whistleblowing", that is reporting instances of substandard medical care. These statutes reflect California's public policy to promote the quality of health care afforded in this state by encouraging physicians and other individuals to report candidly and without fear of retaliation, what they perceive to be instances of substandard care. For example, Civil Code Section

---

[10] Although we do not have access to all of the facts, it appears that the portion of Dr. Hillsman's contract with Sutter relating to the actual practice of medicine, as opposed to administrative services, may violate the Corporate Practice Bar. However, the analysis should be the same even if Dr. Hillsman had been an independent contractor. Abrahamson v. NME (1987) 195 Cal.App.3d 1325, 241 Cal.Rptr. 396 is distinguishable, and it was wrongly decided in any event. There, the court recognized that an employee may state a claim for wrongful discharge based on the fact that the discharge was for a reason contravening fundamental principles of public policy - the failure to acquiesce in the hospital's failure to provide appropriate patient care. The court did, however, refuse to extend its analysis to actions brought by independent contractors. First, unlike Dr. Abrahamson, Dr. Hillsman alleges that he was an employee of the hospital. Second, no principle of law or public policy supports the conclusion that an independent contractor may be terminated in violation of fundamental public policy or law. Given the Supreme Court's emphasis on public policy and lack of concern as to whether that policy is based in statute, it is highly questionable whether Abrahamson, which makes an arbitrary distinction between employees and independent contractors for the purposes of the public policy exception, survives Foley or Rojo.

47(b) provides an absolute privilege for communications made "in the initiation or course of any other proceeding authorized by law and reviewable pursuant to Chapter 2 . . . of the Code of Civil Procedure." This provision applies broadly to protect communications to medical staffs and regulatory bodies in connection with the initiation of conduct of credentialing and disciplinary proceedings. In Long v. Pinto (1981) 126 Cal.App.3d 946, 179 Cal.Rptr. 182, for example, the Court held that a letter sent by a surgeon appointed by a hospital's medical review committee to look at the professional qualifications of a medical staff applicant to the Medical Board of California and to another hospital concerning unnecessary operations allegedly performed by an applicant was absolutely privileged and hence could not form the basis of a defamation action. Similarly, in Dorn v. Mendelzon (1987) 196 Cal.App.3d 933, 242 Cal.Rptr. 259, the court held that a hospital administrator's letter to the MBC reporting the imposition of restriction son a physician's medical staff privileges was a privileged communication for defamation purposes, even though the administrator's believe that he had a mandatory duty to file the report pursuant to Business and Professions Code Section 805 was erroneous.[11] The courts in these cases recognized that as a matter of public policy, "the importance of providing to citizens free and open access to

---

[11] In a nutshell, Business and Professions Code Section 805 requires peer review bodies, as defined, to file reports with MBC whenever adverse action has been taken against a physician for a medical disciplinary cause of reason. Subdivision (d) of that statute states, "No person shall incur any civil or criminal liability as the result of making any report required by this section." According to the Dorn court, this provision "underscores the Legislature's patent intent that hospital and medical personnel who file MBC disciplinary reports be free from the prospect of having to defend themselves in court as the result of any statement contained therein."

governmental agencies for the reporting of suspected illegal activity outweighs the occasional harm that might befall a defamed individual." Long, *supra*, at 950; Dorn, *supra*, at 941-43.[12]

C. California Courts Have Firmly Recognized that Physicians Have an Affirmative Obligation to Protest Inappropriate Medical Standards.

California courts have established that there is a fundamental societal interest in encouraging its health care professionals to voice their disapproval and opposition to substandard health care. The Dabbs Court correctly recognized "[t]his policy [of general societal concerns for qualified patient care] militates against allowing an employer to discriminate against or discharge an employee for voicing dissatisfaction with procedures he or she reasonably believes might endanger the health, safety, and welfare of the patients for which the employee is responsible." Dabbs, supra at 1445. Obviously, the consequences of substandard health care are serious - the repercussions are increased morbidity and mortality. Due to the specialization of health care, no one is more qualified to determine whether health care procedures and facilities are sufficient than the physicians themselves. This policy of societal concern is founded in part upon the physician-patient relationship whose essential component is trust. The patient

---

[12] There are a number of statutory immunities available to individuals who communicate information about the provision of health care, all of which will not be repeated here. At least one more is worth noting, however. Effective January 1, 1991, Civil Code Section 43.8 provides an absolute immunity for those who communicate to a medical staff or other peer review committees information "intended to aid in the evaluation of the qualification, character, or insurability of a practitioner of the healing arts . . . ."

must not only trust that the physician's primary goal is to enhance the patient's well-being, but also that the physician is competent to make clinical decisions and to evaluate correctly the adequacy of the facility in which treatment is to be administered. As the California Supreme Court recognized in Cobbs v. Grant (1972) 8 Cal.3d 229, 104 Cal.Rptr. 505, "the patient, being unlearned in the medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician which transcends arms-length transactions." Id. at 242. Consequently, patients depend on their physicians to help them understand and make critical decisions such as what care and treatment they receive, where they receive treatment, what diagnostic tests are essential, and what therapy is appropriate.

In order to promote quality care and recognizing the unique and fiduciary nature of the physician-patient relationship, the courts and the Legislature have imposed numerous duties on physicians to protect patients from harm. For example, absent a determination of a physician-patient relationship, a physician's relationship with his or her patient is a continuing one that imposes ongoing obligations. *See* Tresemer v. Barke (1988) 86 Cal.App.3d 656, 150 Cal.Rptr. 384 (holding that patient stated a cause of action against a physician who had inserted an intrauterine device on the grounds that the physician, who had seen the patient only once, failed to warn her of its dangerous side effects of which he learned after its insertion). Moreover, the California Supreme Court has recognized that at the

heart of the physician-patient relationship lies the physician's right and responsibility to advocate standards pertaining to quality medical care. *See* Rosner v. Eden Township Hospital District (1962) 58 Cal.2d 592, 598, 25 Cal.Rptr. 551 (stating, among other things, "the goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital practices are being followed."

More recently, the Rosner court's recognition that physicians must be free to advocate on their patient's behalf has been extended by the courts to encompass an affirmative legal duty, on the part of physicians, to speak up and challenge cost containment decisions which jeopardize a patient's health. In the landmark case of Wickline v. State of California (1986) 192 Cal.App.3d 1630, 239 Cal.Rptr. 810, the court strongly suggested that an injured patient is entitled to recover compensation from all persons responsible for the deprivation of care, including physicians and third party payors, when medically inappropriate decisions result from defects in the design or implementation of cost containment programs.

In the Wickline case, a Medi-Cal patient sued the state of California for negligence. The patient alleged that Medi-Cal's utilization procedures led to her premature dismissal from the hospital, which in turn subjected her to medical complications that necessitated the amputation of her leg. The patient was hospitalized for an arterial transplant and authorized for a ten-day stay under Medi-Cal's utilization review program. As a result of complications, the attending

physician sought an 8-day extension. However, only four days were authorized at the end of which the plaintiff was discharged despite her protest. Nine days later the plaintiff was readmitted with severe complications which resulted in the amputation of her leg. The jury awarded $500,00 in damages to the plaintiff.

The appellate court reversed, finding that Medi-Cal was not liable as a matter of law for Mrs. Wickline's injuries based on the facts presented. The court concluded, however, that the treating physician who complies without protest with the limitations imposed by a third-party payor when medical judgment dictates otherwise cannot avoid ultimate responsibility for the patient's care. 239 Cal.Rptr. at 819.

Thus, notwithstanding the fact that the Court expanded the possible realm of tortfeasors in medical malpractice cases to include third party payors, the Court emphasized that its ruling did not relieve physicians of their obligations to ensure that their patients receive proper medical care by protesting decisions made by lay persons. According to the Court, if it was medically appropriate, Mrs. Wickline's physician could have and indeed "should have" made some effort to protest the denial of extra hospital days by Medi-Cal. The court recognized that although her physician may have been intimidated by the Medi-Cal program, he was neither "paralyzed" nor "powerless to act". Thus, "when the consequences of his own determinative decisions go sour", a physician "cannot point to the health care payor as the liability scapegoat." Id. at 819.

The effect of the Wickline decision is clear: it reveals judicial hostility to the argument that decisions from third parties, such as hospitals or insurance companies, should get a physician off the hook for a patient injury. Indeed, while the Court expressly recognized that "cost consciousness has become a permanent feature of the health care system," it stressed that "cost limitation programs not be permitted to corrupt medical judgment." Id. at 820.

It is now absolutely clear that a physician has an obligation to fight, on behalf of his patients, the battle for safe conditions at treatment facilities, appropriate utilization review mechanisms, adequate training of staff and the like. As the patient's advocate, the physician has a duty to attempt to modify any protocol which the physician feels would be potentially harmful.[13] This is particularly true given the fact that, with respect to their hospitalized patients, physicians are dependent on hospitals for a host of facilities and services, including but not limited to diagnostic machinery, computer-assisted tests, drugs, and medical devices. If physicians do not speak up, lay people will have unbridled and potentially uninformed discretion to decide what equipment, drugs and devices will be bought and what controls are to be imposed. Indeed, the Corporate Practice Bar has been interpreted broadly, consistent with its protective purposes to encompass "business" and "administrative" decisions which have medical implications. In Marik v. Superior Court (1987) 191 Cal.App.3d 1136, 236

---

[13] Thus, according to Wickline, the physician must utilize all available avenues of appeal to modify a harmful protocol. If he or she does not, then the physician will be held liable for any resultant injuries.

Cal.Rptr. 751, for example, the court recognized that it is difficult if not impossible in the health care area to isolate "purely business" decisions from those affecting the quality of care. Notably, in holding that a provisional director of a medical corporation was required either to be a physician or other qualified licensed person, the Marik court recognized the interrelated nature of these concerns and correctly observed:

> For example, the prospective purchase of a piece of radiological equipment could be implicated by business considerations (cost, gross billings to be generated, space and employee needs), medical considerations (type of equipment needed, scope of practice, skill levels required by operators of the equipment, medical ethics) or an amalgam of factors emanating from both business and medical areas. The interfacing of these variables may also require medical training, experience, and judgment. Id. at 1140, n. 4.

In order to conform with existing law, a physician must be able to speak freely about any and all potentially unsafe conditions which exist that are under a hospital's ownership or possession. If not, the risk of harm runs not only to the physician in terms of his or her legal liability and potential professional censure, but also to the patient's physical well-being. Certainly the law does not countenance such a result.

D. The Policy of Promoting Patient Welfare is Plainly "Public" for the Purposes of Foley.

There can be no doubt that California's policy requiring that physicians advocate quality of care for their patients is sufficiently public for the purposes of the public policy exception to the at-will doctrine. Indeed, it is for the public that the California Legislature has so carefully crafted a system which ensures that

physicians exercise their professional judgment without improper lay interference. The duty of physicians to exercise that judgment, which includes protesting substandard conditions, is not a duty which involves the private interests of an employer, but rather, it precisely the type of duty which both Foley and Rojo have recognized to be "public": the very essence of the duty involves the protection of the public interest. Indeed, as Foley recognized, this type of issue is a "distinctly `public' interest" since it would be against public policy and a court would declare void a contract between a physician and a lay party agreeing that the physician should remain silent in the face of inappropriate and potentially harmful health care practices.

Dr. Hillsman sought to serve the public by improving Sutter Hospitals' respiratory therapy program, not merely the hospitals' private interest. Promoting the public welfare, an interest which is of paramount importance to the state, plainly is sufficiently "public" for the purposes of the public policy exception.

E. "Cost Containment" Programs Render the Policy Particularly Substantial

The importance of the policy has increased with the advent of cost containment. That is, with hospitals constantly looking for ways to save a dollar, there is heightened risk that the push for cost containment may threaten patient welfare and it is imperative that health care professionals advocate high-quality medical care. In response to soaring costs and unprecedented competition, health

care facilities have been forced to enter into cost containment programs.[14] Cost containment changes have had a significant impact on health care delivery in the United States. For example, hospital reimbursement under Medicare has shifted from cost-based retrospective reimbursement to a prospective reimbursement system based on specific categories of medical conditions known as diagnosis-related groups (DRG's).[15] Private insurers have also developed prospective payment initiatives. Hence, many health care expenditures are now based on a predetermined rate which purports to define what each illness is worth in financial terms, regardless of the services actually rendered or the actual length of hospitalization. Costs incurred over the designated rate must be absorbed by the hospital.[16] Therefore, hospitals stand to gain financially to the extent that they keep their costs below the DRG or other contracted rate. Accordingly, hospitals now have strong incentives to reduce their costs by, for example, shortening a patient's stay, ordering fewer tests and limiting ancillary services.[17]

---

[14] For example, in 1960 approximately 5.3% of the GNP was spent on health care expenditures. That figure increased to approximately 11.4% by the end of 1987. See Ginzburg, A Hard Look at Cost Containment, 316 New Eng.J.Med. 1151 (1987).

[15] See generally, Rethinking Medical Malpractice Law in Light of Medicare Cost Cutting, 98 Harvard L.Rev. 1004 (1985).

[16] Id.

[17] Id. See also, Shortell and Hughes, The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients, 318 New Eng.J.Med. 1100. "Under the Medicare prospective payment system, for instance, hospitals have incentives to discourage the admission of beneficiaries with high costs, to reduce the diagnostic and therapeutic resources used for these beneficiaries, and to discharge them sooner." Id. at 1101.

Moreover, studies suggest that in light of increasing economic pressures, hospital boards may take retaliatory actions against physicians. Because physicians control approximately 60 to 70 percent of health care expenditures, their participation is essential to the success of cost-containment programs.[18] Accordingly, techniques are being implemented by hospitals and health care payors to pressure physicians to cuts costs by, for example, performing more procedures on an outpatient basis and discharging patients earlier.[19] With the increasing development and utilization of computerized information systems, hospitals can now identify physicians who engage in "costly and inefficient" behavior and subject them to "education, peer pressure, or conceivably, even restrictions of privileges, if their costly behavior persists."[20]

With the proliferation of cost-containment programs, physician advocacy is critical. The need for physician advocacy in the context of hospital conditions is acute, particularly in light of the fact that the increasing emphasis on cost-containment in the delivery of health care could seriously jeopardize the quality of care. In fact, a recent study strongly suggests that cost saving programs dramatically affect the quality of care.[21] The study indicates that there are higher

---

[18] *See* Spivey, The Relationship Between Hospital Management and Medical Staff Under Prospective Payment System 310 New Eng.J.Med. 984 (1984).

[19] *See* Morriem, Cost Containment and the Standard of Care, 70 Cal.L.Rev. 1719, 1724 (1987).

[20] Spivey, *supra*, at 985. *See also* Blum, Economic Credentialing: A New Twist in Hospital Physician Appraisal Processes, _____ J. Legal Medicine _____ (1991).

[21] Shortell and Hughes, The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients, 318 New Eng.J.Med. 1100 (1987).

mortality rates among patients who are admitted to hospitals in relatively competitive markets.[22] Further findings "underscore the need for improved monitoring of the issue of the quality of care and patients' outcome as regulatory and competitive approaches to hospital cost containment continue to become more stringent.[23] Health care professionals are in the best position to monitor the quality of care. Therefore, physicians must be able to freely and vigorously advocate compliance with appropriate medical standards.

Thus, California has an important and compelling public policy favoring health care professionals protesting substandard patient care. As cost containment programs and various cost-saving measures become ever more prevalent, it is increasingly imperative that a health care professional's duty to advocate qualified health care be protected.

F. The Public Policy Exception in Other Jurisdictions Recognizes That Physicians May Not be Retaliated Against for Advocating High Patient Standards.

Many states have permitted a cause of action for wrongful discharge in violation of public policy in the health care arena. For example, the Supreme Court of New Jersey held that an employee has a cause of action for wrongful discharge when the discharge is contrary to a clear mandate of public policy.

---

22 Id. at 1100.

23 Id. at 1106.

Pierce v. Ortho Pharmaceutical Corp. (N.J 1980) 417 A.2d 505, 512. The New Jersey court found that the sources of public policy include legislation; administrative rules, regulations or decisions; and judicial decisions. Id. at 512. The court also noted that employees who are professionals owe a special duty to abide not only by federal and state law, but also by the recognized codes of ethics of their professions. Id. However, the court in Pierce issued a caveat: unless an employee at will identifies a specific expression of public policy, he may be discharged with or without cause. Id. On the facts of the case, the Pierce court did not find a violation of public policy where a physician employed in research by a pharmaceutical company opposed continued research on a drug that was controversial. Id. Although if continuing work with the drug was dangerous a violation might have been found, the FDA had not approved any testing on humans and no danger was imminent. Id. at 513-514.

The Supreme Court of Washington recently recognized a public policy in qualified health care which would support an action for wrongful termination. Farnam v. Crista Ministries, 807 P.2d 830 (Wash. 1991). The court found that the policy was not violated in this case when a nursing home fired a nurse in retaliation for her report to the state ombudsman of the removal of a nasogastric feeding tube, because the employer had a legal right under state law to remove the feeding tubes. Id. at 835-836. Furthermore, unlike Dr. Hillsman, the plaintiff's motive was not to further the public good but merely to encourage her employer to adopt her religous views.

> To state a cause of action, Farnam must have been seeking to `further the public good, and not merely private or proprietary interests'. (Citing Dicomes v. State, 113 Wash.2d 612, 620, 782 P.2d 1002.) Conduct that may be praiseworthy from a subjective standpoint or may remotely benefit the public will not support a claim for wrongful discharge. Dicomes at 624. While the sincerity of Farnam's belief is not questioned, her concern appears to be directed at urging Christian health care providers to adopt her view rather than furthering the public good.

Id. at 836.

Dr. Hillsman's actions, on the other hand, were not made merely to further his private interests. Dr. Hillsman's contentions were designed to protect patients, were accepted in his field and were ultimately adopted by the Joint Commission on the Accreditation of Hospitals (JCAH).

Several other states have recognized the important public policy in promoting patient care and have protected physicians and others in the health care industry from retaliatory discharges. For example, in Watassek v. Michigan Department of Mental Health (Mich. 1985) 372 N.W.2d 617, a former employee filed suit against the Department of Mental Health alleging that he was terminated from his nursing position at a mental health facility in retaliation for his reporting incidents of patient abuse to his superior. The court held that the former employee stated a cause of action upon which relief could be granted. Id. at 621.

In addition, the Kansas Supreme Court held in Palmer v. Brown (Kan. 1988) 752 P.2d 685, that the termination of a medical technician in retaliation for good faith reporting of infractions of rules, regulations, or laws pertaining to public health, safety and general welfare by the employer to either company management or law enforcement officials is an actionable tort. Id. at 689-690. The Court declared that it was the public policy of Kansas to encourage citizens to report an infraction of law pertaining to public health. Id. at 685. The court also noted that the "whistle-blowing" must have been done out of a good faith concern for the wrongful activity reported rather than from a corrupt motive such as malice, spite, or personal gain. Id. at 686. See also Boyle v. Vista Eyewear, Inc. (Mo. 1985) 700 S.W.2d 859 (holding that an employee of an optical manufacturing company who complained to superiors, OSHA, and FDA concerning inferior manufacturing practices which could result in eye injuries properly stated a cause of action for wrongful discharge based on public policy in light of the fact that the jury could find that her discharge was "in retaliation for her resistance to the defendant's illegal practices and directives for filing complaints with OSHA and the FDA".)

Federal law similarly ensures that physicians and other health care workers are provided redress to address their grievances concerning retaliatory efforts made by employers and/or health facilities as a result of legitimate protests. It is well settled that speech concerning the quality of care provided to patients is a matter of public concern and should be afforded heightened First Amendment protection. For example, the Ninth Circuit held in Roth v. Veterans

Administration of the Government of the United States (9th Cir. 1988) 856 F.2d 1401 that physicians who work for the government may not be retaliated against as a result of their exercising their First Amendment rights as "whistle-blowers" by reporting problems affecting the delivery of health care. Moreover, federal courts routinely permit Bivens actions by physicians charging that they were victims of retaliatory acts for speaking out against what is perceived to be the patient abuse and other improper medical treatment. McAnaw v. Custis (1982 U.S.D.C. D. Kan.) 28 Fair Emp.Prac.Cas. 218; 29 Emp.Prac.D.C. (CCH) paragraph 32778 (granting physician's motion for a Temporary Restraining Order enjoining her transfer to another hospital, in retaliation for speaking out about improper medical treatment). *See also* Cohen v. County of Cook (N.D.Ill. 1988) 677 F.Supp. 547 (physician charging that he was injured in retaliation for his participation in protest against certain hospital policies granted preliminary injunction pursuant to 42 U.S.C. 1983 requiring hospital to process the physician's application to become the attending physician in the Division of Pulmonary Medicine).

III. CONCLUSION

In sum, neither the law nor public policy tolerates retaliation against physicians and other individuals who advocate appropriate compliance with medical standards and protest deviations from those standards. Given the importance of the physician-patient relationship to the provision of quality health care, and indeed the safety and well-being of the public at large, no third party

should be able to dictate directly or indirectly through retaliatory efforts, that substandard medical care be provided. If such efforts are made, physicians must be guaranteed the right to obtain judicial redress for any and all damages proximately caused thereby. Any other conclusion jeopardizes patient welfare and safety.

For all the foregoing reasons, we urge this court to reverse the judgment and remand this case for trial.

Dated: July __, 1991

Respectfully submitted,

By:_____

Catherine I. Hanson

Attorney for Amicus Curiae
CALIFORNIA MEDICAL ASSOCIATION

D:\PLD\AC\HILLSMAN.BRF