3 Civil C029159

COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

NOSRAT KHAJAVI, D.O.,

Plaintiff/Appellant,

vs.

FEATHER RIVER ANESTHESIA
MEDICAL GROUP, INC., AND
ROBERT DEL PERO, M.D.

Defendants/Respondents.

_______________________________________/

Appeal from Judgment of the Superior Court
Sutter County
Honorable Perry Parker, Judge
Sutter County Superior Court No. CVCS 96-2778

AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF APPELLANT

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I. INTRODUCTION

Without a doubt, the most important statutory codification of public policy in the health care context is set forth in Business & Professions Code §2056. This provision protects against retaliation by any person activity critical to the public health and welfare—a physician's advocacy for medically appropriate health care. Despite the breadth of this statute, the trial court improperly and unwisely narrowed its application by ruling that Business & Professions Code §2056's protective scope applies to prohibit only third party payors, and not medical groups, independent practice associations or other entities that employ or contract with physicians to deliver health services, from taking revenge against physicians as a result of their efforts to protect their patients. Nothing in the statute, its legislative history, or the public policy underlying Business & Professions Code §2056 supports such a strained and limited interpretation. All entities, not just third party payors, must be held accontable when they exact retribution against a physician for advocating medically appropriate health care.

The California Medical Association ("CMA") is a non-profit, incorporated professional association of more than 30,000 physicians practicing in the State of California. CMA's membership includes California physicians who are engaged in the private practice of medicine, in all specialties. CMA's primary purposes are: "...to promote the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession."

The CMA believes it is critical to the continuation of 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 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).

Retaliation by any person against a physician for patient advocacy 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 give appropriate weight to the importance of the physician-patient relationship, Business & Professions Code §2056 must be interpreted as the legislature intended. Physicians who speak out on matters of importance concerning their patients' medical care must be protected from retaliation by any person, including not only third party payors, but any person or entity who has the

ability to apply and render a decision to terminate or otherwise penalize a physician and surgeon for advocating for medically appropriate health care.[1]

II. CALIFORNIA LAW EXPRESSLY PROHIBITS RETALIATION OF ANY SORT BY ANY PERSON OR ENTITY FOR ADVOCATING FOR MEDICALLY APPROPRIATE HEALTH CARE

A. The Language of Business & Professions Code §2056 Unambiguously Applies to All Entities, Including Medical Groups

Business & Professions Code §2056 is unmistakable on its face that the application and rendering by **any person**, including a medical group or other entity, of a decision that penalizes a physician and surgeon principally for advocating medically appropriate health care violates public policy. The prohibition provides, in pertinent part, as follows:

> a) The purpose of this section is to provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients pursuant to Wickline v. State of California 192 Cal.App.3d 1630.
>
> b) It is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. For purposes of this section, "to advocate for medically appropriate health care" means to appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or **to protest a decision, policy or practice that the**

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[1] CMA takes no position on the facts presented by this case which, given its procedural posture, are the subject of significant dispute. Rather, CMA submits this *amicus curiae* brief to discuss the proper interpretation of Business & Professions Code §2056, and the importance of that interpretation to the integrity of the health care system in California. While CMA agrees with appellant that the argument was not timely raised, should this Court reach the interpretation of Civil Code §43.8, CMA would be pleased to file a supplemental brief discussing peer review, and the complex statutory scheme governing that activity.

> **physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients.**
>
> c) The application and rendering by any person of a decision to terminate an employment or other contractual relationship with, or otherwise penalize, a physician and surgeon principally for advocating for medically appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care violates the public policy of this state. No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate health care.
>
> * * *
>
> h) For the purposes of this section, "person" has the same meaning as set forth in Section 2032.

Business & Professions Code §2056 (Emphasis added).

For purposes of the Medical Practice Act, of which Section 2056 is a part, the legislature broadly defined "person" to encompass every individual and every legal entity. Pursuant to Business & Professions Code §2032, a "person" is defined as "any individual, partnership, corporation, limited liability company, or other organization, or any combination thereof, except that only a natural person shall be licensed under this chapter."

Nowhere does the statute limit its application to third party payors. As subdivision (c) unequivocally demonstrates, it protects against retaliation from "**any person**," which, given the word's statutory definition, includes not only third

party payors, but also medical groups and other entities that have the ability to apply and render a decision to penalize a physician for his or her advocacy. Any decision limiting the scope of that protection would (1) significantly threaten a physician's ability to voice disapproval and/or opposition to policies and practices that could cause substandard health care, (2) contravene the California legislature's clear intent when enacting Business & Professions Code §2056 to prohibit retaliation by "any person," and (3) make no sense in the context of, and insulate from liability major players in, California's health delivery system.

Moreover, the statute is not limited to advocacy against cost-containment strategies. While there is no doubt that concern with the potential adverse ramifications of cost-containment activities was the focus of the court in the Wickline case, the language of Business & Professions Code §2056 is not so limited. To the contrary, the language is particularly expansive, including as it does any and every protest of "a decision, policy or practice that the physician . . . reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients." Business & Professions Code §2056(b).

The reason for the statute's breadth is clear. Retaliation (or the credible threat thereof) against a physician by terminating an employment or other contractual relationship, or inflicting some other penalty, can have profound implications on a patient's health. The public must be assured that the physicians who care for them are being open and honest in their recommendations, and are

not being unduly influenced by fear of retaliation. 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. That statement is only more true today than it was in 1972. Medical technology and pharmaceutical options are becoming increasingly numerous, and medical decision-making concomitantly more complex. At the same time, pressures for cost-containment are now omnipresent. Patients are simply not in a position to navigate in this environment without the help of their physicians acting as strong patient advocates. The consuming public—patients—have an overriding interest in protecting their physician-patient relationship and assuring that their physicians are not retaliated against for advocating for appropriate medical care. CMA urges this court to issue an forceful ruling to protect physicians and their patients against unlawful retaliation for the patient advocacy quality health care demands of physicians.

B. The Legislature Clearly Intended that Business & Professions Code §2056 Apply to All Entities, Including Medical Groups.

Business & Professions Code §2056 was sponsored by the California Medical Association, and enacted by the legislature to clarify existing law and expressly state the public policy in favor of physician advocacy for appropriate health care for their patients and against retaliation against physicians for such

advocacy. A.B. 1676 (Margolin), Chapter 947, Statutes of 1993. Business & Professions Code §2056 recognizes that a physician must be able to speak freely about any and all quality concerns which exist. 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 even more importantly, to the physician's patient's health and well-being.

CMA sponsored A.B. 1676 in light of the numerous complaints it had received from physicians who had been terminated by managed care plans, physician groups, and other physician networks as result of their advocating for appropriate health care for their patients, consistent with their obligations as set forth in the Wickline and Wilson decisions discussed below.[2] Unfortunately, however, physicians who had been terminated for advocating for their patients may have had no recourse against the retaliating party in light of a California Supreme Court decision requiring that any public policy basis for a breach of the covenant of good faith and fair dealing be set forth in statute. *See* Gantt v. Sentry Insurance (1992) 1 Cal.4th 1083.

Neither the Senate, Assembly, nor Governor's office had any doubt about the breadth of Section 2056, including to whom it was to apply. For example, the

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2 *See* California Medical Association Floor Alert, dated August 24, 1993, a true and correct copy of which is attached hereto as Exhibit "1." Pursuant to Evidence Code §§451 and 452, the California Medical Association requests judicial notice of this and the following legislative materials which are attached to this brief.

Senate Committee on Business & Professions' analysis of Assembly Bill 1676 states, among other things:

> This bill is sponsored by the California Medical Association (CMA) to provide an express statutory public policy in favor of physicians' advocacy for appropriate health care of their patients and against employment termination or penalization of physicians for such advocacy. . . . The sponsor states that it has received numerous and increasing numbers of complaints from physicians who have been terminated by managed health care plans, **physician groups, physician networks, and others** allegedly as a consequence of having challenged the utilization review decisions of those organizations on behalf of their patients.
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> * * *
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> CMA argued that the bill's provisions are intended to provide physicians with some viable protection **against employment or other contractual termination or penalties by employers or third party payors** because the physician has protested or challenged their UR/cost containment decisions.

(Emphasis added.)

Nor did A.B. 1676's opponents have any question about the fact that the bill would prohibit retaliation by entities other than health plans, such as medical groups. As the Senate Analysis further stated:

> The bill is opposed by the California Association of Hospitals and Health Systems (CAHHS) and Kaiser Permantente. . . . Kaiser believes a physician could circumvent health plan **or medical group** treatment guidelines simply by challenging he or she is advocating for "appropriate" patient care. (Emphasis added.)[3]

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[3] *See* Senate Committee on Business and Professions Analysis, dated July 12, 1993, entitled "Physicians and Surgeons–Enacting Statutory Public Policy to Support and Protect a Physician's Advocacy for Appropriate Health Care for His or Her Patient," a true and correct copy of which is attached hereto as Exhibit "2."

The Assembly Health Committee similarly understood the scope of Business & Professions Code §2056. As the comments section to the Assembly Health Committee Republican Analysis states:

> It seems reasonable that the legislature clearly states that it is good public policy that doctors should not be terminated or penalized by their employer (managed care plan, physician group) if they advocate for what they believe to be adequate health care for their patients.[4]

Finally, then Governor Wilson similarly recognized that Business & Professions Code §2056 means what it says, a decision by "any person" to penalize a physician for advocating medically appropriate care violates public policy. *See* Governor's press release concerning signed legislation, dated October 10, 1993, a true and correct copy of which is attached hereto as Exhibit "4." (Stating "A.B. 1676...Assembly member Burt Margolin (D-Los Angeles)...encourages doctors to advocate for the most medically appropriate health care for their patients regardless of policies or decisions made by managed care plans, physician groups, or other networks.") Thus, in addition to the plain language of Business & Professions Code §2056, the statute's legislative history unequivocally demonstrates that other entities, in addition to third party payors, are covered by the law.

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4 A true and correct copy of the Assembly Health Committee Republican Analysis, dated May 17, 1993, is attached hereto as Exhibit "3."

1. Given Today's Managed Care Environment, it Would Be Absurd to Limit Business & Professions Code §2056 to Third Party Payors

As is evident by the language of Section 2056, the legislature clearly understood that many entities, in addition to third party payors, could penalize a physician as a result of his or her patient care advocacy. The legislative materials supporting the statute demonstrate that retaliatory actions were undertaken not only by managed care plans, but also physician groups and networks. These phenomena reflect the fact that physicians typically do not contract directly with HMOs or other managed care plans, but rather, participate in organizations such as independent practice associations (IPAs) and medical groups, which in turn contract with the HMO or other managed care plan directly.[5] Immunizing these entities from Business & Professions Code §2056's prohibitions would result in absurd, unjust and unreasonable consequences—a result to be avoided. *See* Santa Clara County Local Transportation Authority v. Guardian (1995) 11 Cal.4th 220, 45 Cal.Rptr.2d 207.

In California, in particular, it is common for HMOs to contract with large medical groups that are paid through capitation and are responsible for managing a full spectrum of medical services. *See* J.C. Robinson and L.P. Casalino, "The Growth of Medical Groups Paid Through Capitation in California," *New England*

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5 An Independent Practice Association (IPA) is an association of individual physicians or physician practice groups organized for the purpose of contracting with one or more managed care plans. In an IPA arrangement, physicians practice in their own offices and the IPA acts as an intermediary between the physician or physician group and an HMO, with respect to managed care contracting.

Journal of Medicine, 333 No. 25 (1995): 1684-1687. In addition, IPAs have become a prominent organizational structure in California, where there is a "three tier" form of managed care. *See* K. Grumbach, J. Coffman, et al., "Independent Practice Association Physician Groups in California," *Health Affairs*, May/June 1998, Vol. 17, No. 3, p. 227-237. As was explained in this recent study:

> Rather than contracting directly with different HMOs, physicians in office-based practice participate in one or more IPAs, and the IPA–rather than the individual physician–relates to HMOs and other managed care plans.

Id. at 227.

According to the study, most HMOs in California use this three tier model and contract with IPAs and other large physician medical groups rather than individual physicians. Citing a 1996 study, the article recognized that approximately three quarters of the primary care physicians in the state of California participate in at least one IPA.

As IPAs and medical groups have assumed financial risk under their contracts with HMOs, they have become more involved in the clinical activities of their physicians and retain increasing authority over utilization and treatment decision-making.[6] Put another way, when these entities accept financial risk, in many respects they act as health plans. For this reason, the legislature has on

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[6] *See* also Report of Managed Health Care Improvement Task Force convened by former Governor Wilson pursuant to Health & Safety Code §1342.1 (Richter, Ch. 815, Stats. 1996) entitled "Health Industry Profile," a true and correct copy of which is attached hereto as Exhibit "5." Pursuant to Evidence Code §§451 and 452, the California Medical Association requests judicial notice of this document.

numerous occasions been careful to ensure that legislation protecting continuity of care and the physician-patient relationship extend not only to health plans, but also to those entities that it contracts with, such as IPAs and medical groups. *See* Health & Safety Code §1371 (obligation of the health plan to make payment "shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services"); *see also* Health & Safety Code §1367.02 (each plan that uses economic profiling shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles of individual providers provide a copy of the individual economic profiling information to the individual providers who are profiled and every health care plan must file with the Department of Corporations a description of any policies and procedures related to economic profiling utilized by the plan and its medical groups and individual practice associations.)

III. CALIFORNIA COURTS HAVE FIRMLY RECOGNIZED THAT PHYSICIANS HAVE AN AFFIRMATIVE OBLIGATION TO PROTEST INAPPROPRIATE MEDICAL PRACTICE.

The legislative decision to enact Business & Professions Code §2056 is hardly surprising given the preexisting body of case law establishing the fundamental societal interest in encouraging health care professionals to voice their disapproval and opposition to substandard health care practices and standards. 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.

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 as early as 1962 by the California Supreme Court in a case striking down a decision to exclude a physician from hospital medical staff membership:

> 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.)

Rosner v. Eden Township Hospital District (1962) 58 Cal.2d 592, 25 Cal.Rptr. 551.

More recently, the Rosner court's recognition that physicians must be free to advocate on their patient's behalf was 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 eight-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 $500,000 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 stated, 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. *Id.* at 1645.

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.*

The effect of the Wickline decision is clear: decisions by third parties, such as hospitals, medical groups or managed care companies, will not 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 "it is essential that cost limitation programs not be permitted to corrupt medical judgment." *Id.* at 1647. See also Wilson v. Blue Cross of Southern California (1990) 222 Cal.App.3d 660, 271 Cal.Rptr. 876. (review denied Oct. 11, 1990.)

It is now absolutely clear that a physician has an obligation to fight, on behalf of his or her patients, the battle for medically necessary care, appropriate utilization review mechanisms, and the like. As the patient's advocate, the physician has a duty to take reasonable steps to attempt to modify any decision,

protocol or practice which the physician reasonably believes would be harmful.[7] By the passage of Business & Professions Code §2056, the legislature has assured that physicians fulfilling that duty are not penalized for their patient advocacy.

IV. A BROAD INTERPRETATION OF BUSINESS & PROFESSIONS CODE §2056 IS NECESSARY TO PROTECT BOTH THE PHYSICIAN-PATIENT RELATIONSHIP AND PATIENT WELFARE

A. Continuous Physician-Patient Relationships Are Essential to Quality Health Care

The delivery of quality health care depends upon a strong physician-patient relationship. As discussed above, patients do and must depend on their physicians to help them understand and make critical decisions related to their health care.

Of all retaliatory acts, retaliatory terminations are particularly problematic. From both a professional and a personal standpoint, physicians are not fungible. Physicians who know their patients can better evaluate the significance of their symptoms when they seek care. With long-standing relationships, patients are more likely to trust their physicians and feel comfortable seeking care. As a result, it has been observed that when patients have established physician-patient relationships, "patients are more likely to consult their physician early in the course of an illness, before the illness becomes difficult to treat."[8] This

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7 Thus, according to Wickline, the physician must utilize reasonable avenues of appeal to modify a harmful decision or protocol. If he or she does not, then the physician may, along with the party imposing the harmful decision or protocol, be held liable for any resultant injuries.

8 Orentlicher, M.D., J.D., David, "Health Care Reform and the Physician-Patient Relationship." *Health Matrix*, Vol. 5:83, p. 141, 143 (1995).

observation was reaffirmed in the Managed Health Care Improvement Task Force's findings and recommendations concerning the physician-patient relationship. As the Governor's Task Force concluded:

> A continuous relationship with a health care practitioner provides familiarity with patient medical histories. As a result, providers can react quickly in emergencies, make knowledgeable decisions, and handle many situations on the telephone. In addition, studies have shown that patients staying with the same physician for long periods of time are less likely to be hospitalized, more likely to have lower costs, and to be more satisfied. *Id.* at 2.

The clinical benefits of continuous care have also been demonstrated in the medical literature. Summarizing the literature, a recent study states that there are several benefits of sustained relationships, such as:

- Greater satisfaction among patients, physicians, and other staff;
- Fewer and/or shortened hospitalizations;
- Fewer broken appointments;
- Decreased use of laboratory tests; and
- Decreased use of emergency rooms for care.

In addition, increased patient disclosure of personal problems and better compliance with physician instructions has been reported. *See* Weiss, PH.D. and Blustein, Jan, MD, Ph.D., "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans." *American Journal of Public Health*, Dec. 1996, Vol. 186, No. 12, p. 1742. *See also* Blumenthal, B., et al., "The Efficacy of Primary Care for Vulnerable and Other Population Groups," *Health Services Research*, 30, 1995, 253–273. To

force a patient to sever a physician-patient relationship for no good reason only results in an adverse impact on the patient's welfare. *See, e.g.,* Sweeney, K.G., Gray, D.P., "Patient Who Do Not Receive Continuity of Care from Their General Practitioner—Are They a Vulnerable Group?" *British Journal of General Practice*, March 1995; 392:133–135 (finding that patients who do not receive continuity of care from their general practitioner suffered some additional morbidity, an increased number of relationship problems, "difficult" consultations, nonattendance at medical appointments, and an increase in the use of open-access clinics).

Transferring medical records to a new physician is not an adequate substitute for a continuous relationship. First, it is not efficient. The new physician will require that the patient repeat his/her medical history and undergo a duplicative evaluation. In addition, the physician may also need to repeat laboratory tests and other diagnostic procedures to evaluate the patient. This process is frustrating and time-consuming for both the patient and the physician.[9]

Second, from a clinical standpoint, medical records cannot replace the knowledge that is gained through continuity of care. As one observer commented:

> Moreover, even well-organized and detailed medical records fail to convey important nuances about patients. Conscientious physicians provide quality medical care by learning about their patients' particular reactions to their diseases, their social support systems, their tolerance for pain and disability,

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[9] *See* Emanuel, Ezekiel, J., MD and Brett, Alan S., MD, "Managed Competition and the Physician-Patient Relationship," *New England Journal of Medicine* (1993) 329:12, 879–882.

> the effect of illness on their work and interests, and their general value and preferences regarding medical care. Physicians obtain this sort of information and understanding gradually by interacting with patients and their families over a long period of time, not by assembling records from a series of health plans. *Id.* at 80.

Thus, not only is the threat of termination a very powerful tool for chilling patient advocacy given the devastating economic harm termination may have on the physician, but the actual termination of a physician may have profound ramifications for that physician's patients. By enacting Business & Professions Code §2056, the legislature sought to eliminate these untoward results.

1. Physicians Who Treat High Risk Patients Must Be Protected

These concerns are particularly acute with respect to patients who need more health care services and the physicians who care for them. More than one fourth of IPAs recently surveyed in this state attributed a physician's "excessively costly practice pattern" as a reason contributing to contract termination. *See* Grumbach, *supra*, "Independent Practice Association Physician Groups in California." These profiles rank physicians by their prescription of medical services for patients. *See* Aynah V. Askanas, "Physician Termination in Managed Care: Why Are They Occurring? How Do We Ensure They Are Just?," 6 *Health Matrix* 167, 170 (Winter, 1996). Terminations based on "failing grades" occur when a physician incurs costs for patient care above an average or predetermined level.

Unfortunately, utilization reviews may not consider important differences between the particular physician's practice and the norm.[10] For instance, a failure to adjust for differences in the relative health of a physician's patient population may result in a negative review. *Id.* at 170-71. Catastrophic cases are more likely to produce negative utilization reports, and some physicians treat more difficult cases than do others. Demographic factors may also impact some physicians adversely. A recent study in the Journal of the American Medical Association concluded that "nonwhite physicians are more likely to care for minority, medically indigent and sicker patients." Ernest Moy and Barbara A. Bartman, "Physician Race and Care of Minority and Medically Indigent Patients," 273 *JAMA* 1515, 1517 (1995). With respect to physician profiling, the authors stated:

> Physician profiling requires adjustment for severity of illness to distinguish poor patient outcomes attributable to more severe illness from poor patient outcomes attributable to poor-quality medical care. Because nonwhite physicians care for sicker patients, they are particularly dependent on accurate adjustment for severity of illness. Failure to adjust adequately could deny nonwhite physicians just reimbursement or erroneously attribute poor patient outcomes to poor care.

Id. at 1518.

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10 *See, e.g.,* Edward Hirshfeld, "The Case for Physician Direction in Health Plans," 2 Annals Health L. 81 (1994). Preferred provider organizations generally recruit a "large percentage of physicians . . . to become part of the approved panel from which beneficiaries can obtain care, reducing concerns over a loss of freedom of choice." *Id.* at 88. Later, physicians are terminated "who use more resources per patient than average, or who use more resources than a predetermined or predicted level," often without determining the underlying reasons for the additional costs. *Id.* (citing "Deselection Predilection," *Med. Staff & Physician Org. Advisor*, Mar. 1994, at 1). Attention is placed on cost, not care. Hirshfeld cites an example of a physician who was named "physician of the month" and then terminated later for exceeding the predicted cost level. *Id.* at 88 n. 42 (citing "Deselection Predilection," *Med. Staff & Physician Org. Advisor*, Mar. 1994, at 1).

Physicians must not be retaliated against by anyone for their medically appropriate advocacy. Business & Professions Code §2056 must apply, as its own words state, to any person to prevent inappropriate retaliation and the concomitant disruption of the physician-patient relationship.

V. CONCLUSION

Neither law nor public policy tolerates retaliation against physicians who advocate for appropriate medical care for their patients or protest policies which undermine quality health care. The physician-patient relationship, and physicians' patient advocacy role are critically important to the provision of quality medical care. No one can be free to retaliate against physicians who exercise their duty to advocate for their patients. If such retaliation occurs, physicians must be given the right to judicial redress. Any contrary conclusion jeopardizes the public health and safety.

DATE: February 12, 1999

Respectfully submitted,

California Medical Association
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By:______________________
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