2 CIV. B100170

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

LOUIS E. POTVIN, M.D.,

Plaintiff and Appellant,

vs.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant and Respondent,

_______________________________________/

Appeal from Judgment of the Superior Court
County of Los Angeles
Case No. BC108588
Honorable Reginald Dunn, Judge

AMICI CURIAE BRIEF OF THE

CALIFORNIA MEDICAL ASSOCIATION AND THE

AMERICAN MEDICAL ASSOCIATION

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I. INTRODUCTION

The issues in this case can be reduced to one fundamental question—should an entity that provides or contracts for the delivery of health care services be able to terminate a physician's participation with that entity pursuant to a "without cause" termination contractual provision when the termination was in reality for a medical disciplinary cause or reason? The unequivocal answer is no.

The California Medical Association ("CMA") is a nonprofit, incorporated professional association of approximately 30,000 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, 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 American Medical Association ("AMA"), founded nearly 150 years ago, is a private, nonprofit organization of physicians. With 290,000 members who practice in all 50 states and in all fields of medicine, the AMA is the primary national organization of physicians in America. The AMA is dedicated to promoting the art and science of medicine and the betterment of public health, and serves physicians and patients by, among other things, establishing and promoting ethical, educational, and clinical standards for the medical profession. These associations have a compelling interest in the proper resolution of the questions at issue in this case.

As is discussed below, contractual language cannot serve as a basis to escape the vital peer review, reporting, and fair hearing obligations imposed upon peer review bodies in California pursuant to Business & Professions Code §805 et seq. The reporting of incompetent physicians to the Medical Board of California is an important component of an effective physician disciplinary system. "Peer review bodies" as defined by California law, have the practical and clinical qualifications, as well as the duties to the public at large, which often make them the most likely candidates to detect quality problems. To encourage full reporting of errant physicians, the Legislature has provided members of peer review bodies with broad immunities from lawsuits. These reports provide an important source of information to the Medical Board, increasing the likelihood it will identify potentially incompetent physicians, prevent those who are found to be harmful from practicing medicine, and protect the public. Unfortunately, despite the statutory mandates and immunities provided to peer review bodies, the reporting of incompetent physicians is on the decline. Thus, it is even more important that this Court enforce the protective mandates of Section 805.

The California Legislature clearly intended that all managed care organizations, including those licensed as insurers, which conduct peer review (including the credentialing functions at issue in this case), be considered "peer review bodies" for the purposes of the reporting obligations of Business & Professions Code §805.[1] Intentionally, the Legislature set forth a broad definition of the phrase to

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[1] The relevant provision of Section 805 with respect to insurers is subdivision (a)(1)(D), which defines a peer review body as including a "committee organized by any entity consisting of or employing more than 25 licentiates of the same class which functions for the purpose of reviewing the quality of

ensure that all entities which delivery or contract for the delivery of care have a duty to report a physician terminated from participating in its network/panel for a medical disciplinary cause or reason. As is discussed below, this language was to close loopholes in the reporting process and thus reduce the number of incompetent physicians. Given the language of Business & Professions Code §805 itself, its legislative history and its salutary purpose, it is absurd to suggest that health facilities, such as general acute care hospitals and licensed clinics, health care service plans, including HMOs, and professional medical societies be required to engage in reporting obligations on the one hand, but that insurers with peer review credentialing responsibilities for managed care organizations do not. Public policy and the law demand that insurers which undertake peer review functions be included within California's peer review system.

As a necessary corollary, the Legislature and the courts have insisted that physicians who are the subject of an adverse decision reportable under Section 805 be afforded their right to fair procedure prior to the final action proposed to be taken. These fair hearing rights reflect the recognition that the ramifications of restricting or terminating a physician's ability to practice in a facility or managed care organization far transcend that physician's ability to treat patients in or on behalf of that particular entity. As a result of the operation of both federal and California law, such adverse actions impose a stigma on a physician's reputation and honor which could require a physician to defend him or herself on a number

professional care provided by members or employees of that entity." As a practical matter, most, if not all, insurers will have more than 25 physicians as members on their panels. *See* discussion below.

of fronts including: other managed care organizations, hospitals, state and federal fraud units, etc. The net result is that a mistaken report causes an unnecessary and generally devastating disruption to the physician-patient relationship and damage to a physician's economic interests. Fair hearings provide a fundamental protection against wrongful restrictions which result in these harms.

Managed care organizations and other entities that provide or contract to provide medical care have the health and lives of the people of California in their hands. They have responsibilities to the public to correctly scrutinize the qualifications of physicians who care for their patients. They have a responsibility to the public to report errant physicians. They have a responsibility to protect their patients against inappropriate disruptions of their relationships with their physicians. They have a responsibility to be fair. Allowing these entities to avoid these fundamental obligations through "without cause" contractual provisions unreasonably jeopardizes quality care and the physician discipline system. Neither the law nor public policy will countenance such a result.

II. LEGAL ARGUMENT

A. Insurers Which Make Adverse Credentialing Determinations Are "Peer Review Bodies" for the Purposes of Business & Professions Code §805.

The trial court inappropriately and overly narrowly construed Business & Professions Code §805's definition of peer review body. This construction not only defies the letter and spirit of Section 805 and California's peer review system,

but will provide all peer review bodies with a subterfuge to avoid the legal duty to report incompetent physicians. This Court must not condone this result.

1. Credentialing is a vital aspect of peer review.

Quality patient care is a matter of vital concern to the public interest. To ensure quality patient care, health care services must be regularly monitored and evaluated. A comprehensive quality assurance process is critical to the identification and resolution of potential or ongoing problems, as well as to the identification of opportunities to improve patient care. Current assessment of the clinical performance of physicians and other health care providers is crucial in order to provide appropriate education and training where warranted, and to identify unqualified or incompetent physicians before patients are seriously injured. Peer review bodies have the expertise to evaluate performance standards and to conduct effective quality and peer review.

Credentialing is the process through which the training and experience of applicants/reapplicants for clinical privileges and/or participation in an organization which delivers or contracts for the delivery of health services are scrutinized in order to assure the initial and ongoing competence of physicians and others. *See, generally,* Unterthiner v. Desert Hospital District (1983) 33 Cal.3d 285, 188 Cal. Rptr. 590. Credentialing entails the gathering and processing of information such as licensure status, malpractice history, and references, which are necessary prerequisites to the provision of the privilege to practice medicine in or

on behalf of a particular entity. In the context of health facilities, credentialing is performed by medical staff committees which:

> Perform investigations of physicians applying for staff privileges, establish standards and procedures for patient care, audit each surgery performed, and investigate discrepancies between preoperative and postoperative diagnoses. The committees compile records and evaluations and engage in frank discussions about the performance and competence of their peers. Should the committee find a peer to be incompetent, a report and recommendation is made to administrators, who may then take action to revoke, limit, or deny medical staff privileges. (California Institute v. Sup. Ct. (1989) 215 Cal.App.3d 1447, quoting Comment, 24 *Santa Clara L. Rev.*, 661, 670.)

Credentialing for most entities is mandated by law. There are a number of state and federal requirements governing the credentialing of providers. For example, California regulations governing hospitals provide that "all members of the medical staff [are] required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee ... at the time of application for appointment to the staff, and at least every two (2) years thereafter." 22 C.C.R. §70707. The Medicare conditions of participation for hospitals provide that "[t]he medical staff must examine credentials of candidates for medical staff membership...□ 42 C.F.R. §482.22(a)(2). Similarly, health care service plans, including health maintenance organizations in California, are required to undertake credentialing activities. 10 C.C.R. §1300.69. Likewise,

when enacting the selective contracting legislation for insurance companies, the Legislature expressly required that insurers that limit patient choice in their managed care networks have "programs for the continuous review of the quality of care, performance of medical or psychological personnel included in the plan, utilization of services and facilities, and costs" by appropriately qualified professionals. Insurance Code §10133.1. In fact, with respect to the instant case, it appears that Metropolitan Life Insurance Company was mandated to undertake credentialing activities as physicians participating in the managed care network, such as Dr. Potvin, were contractually required to refer patients only to other participating physicians in the network. *See* Exhibit 3 to Complaint.

Credentialing must be undertaken by managed care organizations to receive accreditation from the National Committee for Quality Assurance ("NCQA")—an independent nonprofit organization that assesses the quality of managed care plans. Among the NCQA's missions is to promote improvements in the quality of patient care provided through managed health plans, develop and apply oversights, processes, and measures of performance for health plans, and provide information on quality to the public, consumers, purchasers, health plans and other relevant parties.

As part of its accreditation standards, the NCQA mandates that initial and ongoing credentialing take place. At a minimum, the initial credentialing standard requires that the managed care organization obtain and review verification of

(1) a current valid license to practice;

(2) clinical privileges in good standing;

(3) valid Drug Enforcement Agency authorization;

(4) graduation from medical school and completion of a residency, or a board certification as applicable;

(5) work history;

(6) current adequate malpractice insurance; and

(7) history of professional liability claims which resulted in settlements or judgments paid or on behalf of the practitioner.

NCQA Standard CR.5.0

To receive accreditation, the managed care organization must also have a process for recredentialing. This process must be implemented at least every two years, and, in addition to verifying the sources identified above, there must be evidence that the managed care organization requested information from a recognized monitoring organization (such as the National Practitioner Data Bank) and the organization must review member complaints, results of quality reviews, utilization management, and membership satisfaction survey. The recredentialing process also includes an on-site visit to provider offices. NCQA Standards, CR11-13.

Finally, tort law long has resulted in vigorous credentialing by health care delivery systems. It is well established that health facilities and other organizations that are responsible for the delivery of care have a duty to ensure that their physicians are appropriately credentialed. The failure to do so may be negligence. *See* Elam v. College Park Hospital (1982) 132 Cal.App. 3d 332, 183 Cal.Rptr. 156. The theory

of corporate liability for negligent credentialing has steadily expanded to apply to managed care organizations. *See* McClellan v. Health Maintenance Organization of Pennsylvania (1992) 604 A.2nd 1053 and Harrell v. Total Health Care (1989) 781 S.W. 2nd 58.

2. The 805 reporting system safeguards the public and cannot be avoided by "without cause" termination provisions.

"Without cause" terminations must not be used as a subterfuge to avoid the legal duty to report incompetent physicians. This Court should send a strong message that terminations undertaken as a result of a medical disciplinary cause or reason must be undertaken within the framework of California's 805 reporting system.

Pursuant to California law, whenever a physician's application is rejected or membership is terminated by a peer review body for a "medical disciplinary cause or reason," this rejection or termination must be reported to the Medical Board of California, the California agency responsible for licensing physicians. Subdivision (a)(6) of Section 805 defines a "medical disciplinary cause or reason" as "that aspect of a licentiate's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care." Termination of membership due to a physician's malpractice history falls within this definition.

The Legislature defined "peer review body" broadly to ensure that those entities that are in the business of providing or contracting to provide medical care—that

is, those in the best position to know the professional competence of a physician—report errant physicians to the Medical Board. A peer review body includes:

(a) a medical or professional staff of a hospital, licensed health facility or ambulatory surgical center certified by Medicare;

(b) a health care service plan or nonprofit hospital service plan;

(c) a nonprofit, tax-exempt medical, psychological, dental or podiatric society having as members at least 25% of the eligible licentiates in the area in which it functions (which must include at least one county); or

(d) a committee organized by any entity consisting of or employing more than 25 licentiates of the same class which functions for the purpose of reviewing the quality of professional care provided by members or employees of the entity.

Thus, insurers, IPAs and medical groups meeting the statute's definition must also file 805 reports.

The 805 report must include a statement describing the action, its date, all the reasons for, and circumstances surrounding the action and any other relevant information deemed appropriate by the reporter. In addition to the report itself, section 805.1 of the Business & Professions Code provides that the Medical Board of California "shall be entitled to inspect and copy the following documents in the record of any disciplinary proceeding resulting in action which is required to be reported pursuant to Section 805:

(1) Any statement of charges;

(2) Any document, medical chart, or exhibits in evidence;

(3) Any opinion, findings, or conclusions."

The Medical Board is mandated by law to take action once it receives an 805 report. For example, the Medical Board is required to investigate the circumstances underlying any 805 report within 30 days to determine if an interim suspension order or temporary restraining order should be issued. Business & Professions Code §2220. The Board must otherwise provide timely disposition of the reports received pursuant to Section 805. *Id.*

Further, when a physician seeks to obtain or renew his or her staff privileges at any hospital in California, the law requires that that hospital contact the Medical Board of California to determine whether an "805 report" has been filed by any other hospital. *See* Business & Professions Code §805.5. Thus, the filing of 805 reports is not only important to the Medical Board of California but also to other hospitals in California as it ensures that physicians with quality problems do not move from hospital to hospital undetected.

In light of the importance of 805 reports to the protection of the public health, the Legislature has also afforded broad immunities to those involved in the reporting process. For example, Business & Professions Code §805(f) provides, "no person shall incur any civil or criminal liability as the result of making any report required by this section." In order to protect the peer review process generally, the

Legislature has enacted a number of additional statutes, including Evidence Code §1157 (protection against discovery for records of proceedings of committees which conduct peer review), Civil Code §43.7 (conditional immunity for actions taken by members of medical staff committees engaged in quality assurance activities); Civil Code §43.8 (absolute immunity for those who communicate information to, among others, the Medical Board of California "intended to aid in the evaluation of the qualifications, fitness, character or insurability of a practitioner of the healing arts"); Civil Code §47(b) (absolute privilege for any "publication or broadcast" made "in the initiation or course of ... proceedings authorized by law and reviewable" by way of administrative mandamus); and Civil Code §43.97 (conditional immunity from damages, except economic damages, for all persons and hospitals for any disciplinary action which must be and is properly reported to the Medical Board pursuant to Business & Professions Code §805). The existence of these protections clearly demonstrates the Legislature's recognition of the importance of the peer review process and the Legislature's intention to take those steps necessary to ensure that peer review bodies and their members continue to perform these functions robustly, with candor, and free of the fear of frivolous lawsuits.

As the above discussion reveals, the reporting obligations imposed by Business & Professions Code §805 are a mandate. This is not voluntary activity on behalf of "peer review bodies." Indeed, because of the importance of these reports to the quality of care, the Legislature has expressly declared that the intentional failure to file a required 805 report is a crime—a public offense punishable by a fine not

exceeding $10,000. Business & Professions Code §805(g). A failure to file by the administrator of any peer review body or the chief executive officer or administrator of a health care facility who is designated to transmit a report, whether or not the failure is intentional, is punishable by a civil penalty not exceeding $5,000. Moreover, failure to file a report results in the loss of an additional immunity for those involved in the peer review process. Specifically, the failure to make an 805 report results in the loss of the immunity provided by Civil Code §43.97 which generally limits damages to the disciplined physician's economic loss (i.e., no damage for "pain and suffering," etc.).

Despite the fact that the Legislature mandated 805 reporting, despite the fact that the Legislature provided broad protections against lawsuits as a result of 805 reporting, and despite the fact that the Legislature provided penalties for those who failed to make a required report, peer review bodies in California are reporting fewer and fewer instances of physician discipline. For example, as these reports reveal, for the fiscal years 1992–1996, while there has been an increase in the number of licensed physicians with California addresses, there has been a decrease of approximately 38% in physicians reported to the Medical Board.

Fiscal Year	Number of MDs with California Addresses	Number of MDs Reported
1992-1993	76,367	175
1993-1994	76,411	124
1994-1995	77,311	114
1995-1996	78,169	112

True and correct copies of these reports are attached hereto as Exhibit A.[2] The situation is so bad that the Medical Board of California views the decline in reporting to be a "near crisis." *See* "Accurate and Complete 805 Reporting: Cooperation Between Hospitals and MBC in Near Crisis," by Karen McElliott, former president, Division of Medical Quality, Medical Board of California, Jan. 1995 *Action Report*—Medical Board of California, a true and correct copy of which is attached as Exhibit B. Peer review bodies cannot be allowed to hide behind "without cause" termination provisions and avoid their responsibilities to report. The public welfare depends upon reporting. Allowing peer review bodies to rely on these contractual provisions will only provide them with incentives to avoid reporting requirements—a potentially disastrous result.

3. Consistent with Section 805's express language, legislative history, and salutary purpose, its definition of peer review body must be construed to include all managed care organizations, including insurers, which conduct peer review functions.

At issue in this lawsuit is Business & Professions Code §805(a)(1)(D), which includes within the definition of a "peer review body":

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[2] Pursuant to Evidence Code §§451 and 452, *amici curiae* respectfully request judicial notice of this and all further-referenced reports. Pursuant to Evidence Code §452, we request the Court take judicial notice of reports by government agencies and other reports which are "sources of reasonably undisputable accuracy." Evidence Code §452(h).

> A committee organized by any entity consisting of or employing more than 25 licentiates of the same class which functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

This subsection was added following legislative passage of Senate Bill 1620, Chapter 1044, statutes of 1987. Then-Senator Gary K. Hart, the author of the Bill, when urging then-Governor Deukmejian to sign this bill, explained its purpose as follows:

> Under existing law, some doctors who should be reported for medical disciplinary reasons are able to slip through loopholes in the reporting process. By closing these loopholes and clarifying ambiguities in current law, SB 1620 will help to reduce the number of incompetent doctors slipping undetected through the medical malpractice reporting process. (Emphasis added.)

A true and correct copy of then-Senator Hart's September 11, 1987 letter is attached hereto as Exhibit C.

In fact, the bill did a number of things to close then-existing "loopholes." For example:

> (1) With, among other things, the addition of subdivision (D), the bill clarified and expanded on entities required to report;

(2) The bill broadened the definition of staff privileges to include circumstances which might be viewed as "temporary" and therefore not reportable, such as locum tenens and contractual relationships;

(3) The bill defined "medical disciplinary cause or reason" to clarify when reports should be made;

(4) The bill toughened the law regarding reporting of voluntary resignations of licentiates; and

(5) The bill ensured that reports are made within 30 days of a summary suspension.

The Legislature made these enactments to ensure that persons who should be reported for medical disciplinary reasons do not escape such reporting due to loopholes in the law regarding the circumstances, acts, and entities involved in the reporting process. Recognizing the interplay between the private peer review system and the public disciplinary process, the court declared that it was the "intent of the Legislature to further integrate private and public systems of peer review in the provision of health services."

Based on the legislative intent underlying SB 1620 and the words of subdivision (D) itself, it is clear that the Legislature wanted to create an additional entity which would be considered a "peer review body" that was sufficiently broad to encompass virtually all health care delivery systems that consist of or employ more than 25 licentiates of the same class, and which engage in peer review

functions. For example, unlike subdivisions (A) through (C), which are specific in terms of who is intended, i.e., licensed health care facilities, licensed clinics, health care service plans, and professional societies, subdivision (D) utilizes a term with tremendous breadth—"entity"—which *Webster's New Twentieth Century Dictionary* defines as "a thing that has real and individual existence, in reality or in the mind; anything real in itself." Thus, the term on its face applies to anything, and in the context of Section 805, any organization which is engaged in the delivery of health care services.

Nor did the Legislature restrict the business relationship between the "entity" and physicians. As can be seen by subdivision (d), the entity need only "consist of or employ" physicians. Thus, entities which have independent contractor relationships with physicians, as is the case with most managed care organizations, are covered by subdivision (D).

The lower court concluded that Dr. Potvin was not an "employee" or "member" of Metropolitan Life Insurance Company, and therefore there was no legal duty to report him pursuant to Business & Professions Code §805. This interpretation of the law is strained, incorrect, and injurious to the public welfare. Plainly, the physicians who provide the services to patients insured by or otherwise covered by a managed care network are indispensable to that network. They are "constituent parts" thereof and thus "members" within the general meaning given that term in §805(a)(1)(D). Like the term "entity," the Legislature specifically chose a broad term to remove loopholes that reduced the effectiveness of the peer review reporting system. "Member," as defined by *Webster's*, *Id.,* means "a person

belonging to some association, society, community, party, etc." Physician participants in a managed care network, who agree to the terms and conditions of a contract with that network, such as cooperating with and complying with utilization review, peer review and/or audit procedures, "belong" to some "entity."

Lastly, the trial court stated that the credential review was not performed by a "committee," but rather a single medical director. Apart from the fact that there are serious factual questions raised concerning this statement, the legal conclusion reached by the court is incorrect. First, as is stated above, Insurance Code §10133.1 mandates that insurers utilize peer review committees to the extent their contracts with policyholders limit payments to services secured by certain institutional and professional providers. Surely, insurance companies like Metropolitan Life cannot avoid this obligation by delegating the responsibility to a medical director; or, to state it differently, assuming this responsibility is delegated to a single medical director, that medical director must be deemed a "committee" as a matter of law.

Second, courts, when construing statutes concerning the peer review process, do not and should not undertake a technical, narrow reading of the language. Rather, in order to fulfill the statute's overriding protective goals, courts give meaning to the statute that will not result in an absurdity or unreasonable results. *See* Santa Clara County Local Transp. Auth. v. Guardino (1995) 11 Cal.4th 220, 45 Cal.Rptr. 2d 207. Thus, for example, in Roseville Comm. Hosp. v. Superior Court of Placer County (1977) 70 Cal.App.3d 809, 139 Cal.Rptr. 170, a case was brought by a group of pathologists who had held an exclusive contract with the hospital. Their

contract was terminated on the basis that the medical staff had "no confidence" in the group. The group challenged the termination, alleging breach of contract, and sought discovery of the records of the regular and special meetings of the executive committee of the professional standards committee for a specified period of time, insofar as those documents related to the plaintiff group. The trial court ordered discovery of these documents and the hospital appealed. On appeal, the appellate court upheld the trial court's order, finding that the members of the medical group fell within the special exception provided in Evidence Code §1157, generally protecting from discovery the records of peer review "committees" for "any person requesting staff privileges." In so holding, the court noted that, although some of the pathologists involved might not be "staff members" in a technical sense, the legislative intent behind the exception demanded that physicians who were excluded from practicing at the hospital because of the termination of their exclusive contract had the benefit of the exception pertinent to a person seeking staff privileges.

More recently, in County of Los Angeles v. Superior Court (1990) 224 Cal.App.3d 1446, 274 Cal.Rptr. 712, a malpractice plaintiff sought to compel physicians to answer questions relating to the content of discussions at departmental meetings about the plaintiff's labor and delivery. The defendants in that case argued that the department's conferences reviewing the medical chart were privileged pursuant to Evidence Code §1157. In response, the plaintiffs argued that the privilege did not apply because the meeting was of the entire department and no minutes were kept, and therefore there was no "organized" committee. This

contention was easily rejected by the court. The court explained that the records reflected that the department conducted meetings where the physicians on its staff attended, the purpose of which were to reduce morbidity and mortality—i.e., improve patient care. In its ruling, the court reasoned that while technically, there was no "organized committee," the privilege should still apply. As the court explained:

> While it might have been neater for the department to have required minutes and other formal organizational indicia, the statute does not require such procedures. The record reflects that the department "conferences" were meetings of a professional body organized specifically to monitor and improve health care in the obstetrics department. There is no evidence to the contrary. *Id.* at 1453.

Accordingly, courts will look to the substance, not the form, of an activity to determine whether the statute should apply, and therefore public policy be served. Credentialing determinations involve the formation and application of a host of credentialing standards vis-à-vis a physician's membership in an "entity." As such, the activity sufficiently of necessity involves some form of "committee" for the purposes of Business & Professions Code §805.

Finally, concluding that insurance companies that conduct credentialing activities do not fall within section 805(a)(1)(D) would lead to an absurd result—something that must be avoided according to well settled principles of statutory construction. Santa Clara County, *supra.* Just like health care service plans, insurance

companies conducting credentialing activities arrange for the delivery of health services. Just like health care service plans, insurers operating managed care networks have panels of physicians who provide care to patients. Just like health care service plans, insurance companies that limit patient choice are required to conduct strenuous quality assurance programs, including credentialing and utilization review. Just like health care service plans, these insurers must provide accessible medical care consistent with standards of good health care. *See* Insurance Code §10133.5. There simply is no reason, in the law or in public policy, to exempt these organizations from the protective provisions of Business & Professions Code §805. To do so would result in an unreasonable result.

B. Physicians Who are Terminated Must Be Afforded Rights to a Fair Hearing When Their Ability to Practice Medicine and See Their Patients is Restricted.

Both the courts and the Legislature have recognized the need for fair hearings for physicians before final adverse action is taken against them. The harm resulting from these actions is real; it is substantial, and it affects both physicians and their patients. For that reason, California's Legislature and courts have mandated that physicians be afforded their rights to fair procedure prior to an adverse determination pursuant to Business & Professions Code §§809 *et seq.* and the California common law. Significantly, in many respects, the devastating impact

created by a "without cause termination"[3] and an 805 report unfairly generated are the same.

Both contract termination and unfair peer review undermine the physician-patient relationship. The physician-patient relationship is personal to the patient and is marked by trust and confidence. For the vast majority of patients, their choice of a health plan is controlled by their employers, and such choices can be extremely limited. For many, as a practical matter, there will be only one choice that works for them. Conversely, the patient's physician who participates on the provider panel for that one plan, may not be a member of any other plan from which the patient may choose. Under those circumstances, if the physician is expelled from the patient's plan's panel or is the subject of an unfair peer review determination, the patient will have no choice but to seek another physician, assuming a suitable alternative exists. Expulsion of a physician can significantly impair the ability of a patient to obtain access and continuity of care. Notably, in the peer review context, the Legislature recognized that, if not fairly conducted, it "results in harm both to patients and healing arts practitioners by limiting access to care." Business & Professions Code §809(a)(4).

To force a patient to sever this relationship for no good reason may have an adverse impact on the patient's welfare. *See, e.g.,* K.G. Sweeney & D.P. Gray, "Patients Who Do Not Receive Continuity of Care From Their General Practitioner—Are They a Vulnerable Group?," *British Journal of General*

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[3] In reality, "no cause" terminations do not exist. There always is a reason.

Practice, March 1995; 45(392):133-35 (finding that patients who did not receive continuity of care from the general practitioner with whom they were personally registered 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). In this situation, the patient must find another physician and begin the relationship all over again. Continuous quality care cannot be provided and the public can no longer tolerate it.

In fact, the California Public Employees Retirement System (CalPERS), the negotiator for health coverage for California State and many local employees, realizes the deleterious impact termination "without cause" provisions have on quality care and patient satisfaction and is taking steps to remove them. According to an article entitled "CalPERS tells plans, providers: Get Along" in *Modern Health Law,* December 2, 1996 (a true and correct copy of which is attached as Exhibit D), contract terminations are affecting patient care. CalPERS has requested that plans place patients first and is "considering levying severe financial penalties against a health plan that terminates contracts prior to its open enrollment period or imposing a 'patient-care protection guarantee' that would lock plans and providers in for a fixed period of time."

To allow "without cause" terminations would also harm patients by providing managed care plans the opportunity to terminate physicians who are perceived as "troublemakers." Such perceived "troublemakers" include physicians who have vigorously protested utilization determinations of plans seeking to limit care to a patient whom the physician believes must have additional care for proper medical

treatment for the patient's condition. Any doubt that terminations for this reason are improper was dispelled last year when the Legislature enacted Business & Professions Code §2056, which gives physicians a right to recover damages if a health plan (or medical group, IPA, PPO, foundation, hospital medical staff and governing body or payor) terminates an employment or other contractual relationship or otherwise penalizes a physician in retaliation against the physician's efforts to challenge decisions, policies or practices which impair the physician's ability to provide medically appropriate health care to his or her patients.

In addition to the detrimental effect on patients, unfair terminations can be disastrous for physicians. For example, under California law, a physician who seeks to join a medical staff understands that an 805 report will be investigated by the Medical Board of California, and by any other hospital where he or she presently enjoys membership or seeks to enjoy membership or privileges. Business & Professions Code §805.5. Further, because, as discussed above, both hospitals and health plans have a duty to ensure that physicians on their staff/panels are appropriately credentialed, they may exclude a physician who has received an adverse 805 report. These entities understandably are reluctant to allow such physicians membership or privileges, as the Elam obligation may well pose an affirmative duty upon them to investigate carefully all 805 reports filed by other hospitals. Finally, although we do not believe this activity to be appropriate, other managed care organizations may refuse to grant membership to physicians terminated without cause from other organizations.

The simple realities of the medical profession today place great reliance upon the granting and retention of unrestricted medical staff privileges and the ability to participate in managed care networks. Among other things, restrictions or terminations may hamper a physician's attempt to maintain professional liability insurance. Additionally, physicians whose privileges have been restricted or terminated may find their opportunities to provide care to patients who receive health benefits from HMOs, PPOs and other delivery systems, or who receive care from ambulatory care centers, severely curtailed, if not entirely foreclosed. Just as access to hospital facilities has been deemed essential for the practice of medicine in the past (*see, for example* Anton v. Board of Directors of San Antonio Comm. Hosp. (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442), today, continued managed care panel participation is essential if physicians are to be able to continue to practice their professions fully.

In California HMO penetration among patients is high. According to a survey of practice characteristics undertaken by the American Medical Association, California was the state with the greatest number of HMO contracts, covering 25.8% of its population. A true and correct copy of the AMA report entitled "Medical Groups in the U.S.—A Survey of Practice Characteristics" is attached as Exhibit E. In some areas in California, the percentage is even higher. For example, as can be seen from attached charts prepared by InterStudy, a well-reputed source of information to the managed care community, the penetration in the Los Angeles-Long Beach area is as high as 37.8%; in Oakland, 36.0%; in San Francisco, 46.3%, and in Sacramento, 51.2%. A true and correct copy of the

InterStudy *Competitive Edge* Report is attached as Exhibit F. Being terminated from a single managed care organization can result in a physician losing as much as one-third to one-half or more of his or her patient base.

Furthermore, the effects of an adverse 805 determination are not limited to the physician's ability to practice medicine in California. To the contrary, pursuant to the Health Care Quality Improvement Act (HCQIA) 42 U.S.C. §§11101-11152, state boards of medical examiners must report adverse action taken by them against a physician to the National Practitioner Data Bank, a massive data bank designed to track errant physicians, which is operated under the United States Department of Health and Human Services (DHHS). 42 U.S.C. §§11132, 11134(b). Similarly, hospitals and other health care entities that take action based on a physician's competence or professional conduct that adversely affects a physician's membership or clinical privileges must report these actions to the state board of medical examiners which in turn must report them to the Data Bank. 42 U.S.C. §§11133, 11133(b), 11134(b). Additionally, hospitals have a duty, pursuant to HCQIA, to request information about a physician from the Data Bank before they initially grant the physician privileges (and every two years thereafter). Prudent hospitals must investigate any adverse information obtained. Such information remains a permanent part of the Data Bank record on the physician. 42 U.S.C. §11135. Moreover, once information concerning an adverse privilege determination is reported to the Data Bank, DHHS is empowered, through the Medicare and Medicaid Patient and Program Protection Act and the Peer Review Improvement Act, 42 U.S.C. §§1320a-7 *et seq.*, and 42 U.S.C. §§1320c *et seq.*, to

initiate investigations of physicians and exclude them from the Medicare and/or Medicaid programs.

In recognition of the devastating impact 805 reports and terminations without cause have on both patients and their physicians, California law requires that physicians be afforded fair hearing rights prior to the imposition of an adverse 805 report and prior to being terminated from any organization that controls significant economic and professional interests.

1. Business & Professions Code §809 et seq.

Business & Professions Code §809 et seq. sets forth the legislative scheme concerning fair hearings for physicians who are the subject of an adverse 805 report. In enacting the statute, the Legislature declared the following:

> (3) Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.
>
> (4) Peer review which is not conducted fairly results in harm both to patients and to healing arts practitioners by limiting access to care.
>
> (5) Peer review, fairly conducted, will aid the appropriate state licensing boards in their responsibility to regulate and discipline errant healing arts practitioners.
>
> (6) To protect the health and welfare of the people of California, it is the policy of the State of California to exclude, through the peer review

mechanism as provided for by California law, those healing arts practitioners who provide substandard care or who engage in professional misconduct, regardless of the effect of that exclusion on competition.

(7) It is the intent of the Legislature that peer review of professional health care services be done efficiently, on an ongoing basis, with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions.

The hearing mechanism in California law is thereafter set forth in sections 809.1–809.6, which ensure fair procedures to the subject physician including, among other things, the right to notice of any charges against him/her (including the specific acts/omissions with which the physician is charged), the right to receive copies of all relevant documentation in the medical staff's possession, the right to a full and fair hearing on the matter before an unbiased panel or arbitrator, the right to be represented by an attorney or other representative of choice, the right to present evidence and call witnesses, the right to cross-examine adverse witnesses, the right to a presumption of innocence unless the medical staff proves its charges by a preponderance of the evidence, and the right to receive a written decision by the hearing panel, including findings of fact and a conclusion articulating the connection between the evidence produced at a fair hearing and the decision reached.

These fair hearing requirements cannot be escaped when physicians who are terminated for a suspected "medical disciplinary cause or reason" are done so

through "without cause" terminations. The law mandates reports to the Medical Board of adverse disciplinary actions rendered following a fair hearing. The failure to follow California's statutory scheme needlessly jeopardizes patient welfare, interrupts the physician-patient relationship, and deprives the physician of his or her right to practice medicine.

2. California's common law.

In California, the physician's right to fair procedure when being terminated for any reason from any organization that controls significant economic interests is well established. In over three decades of cases regarding fairness in membership determinations by institutions which control significant economic interests, California's common law has evolved to protect physicians and other health care professionals from arbitrary expulsions. *See e.g.,* Wyatt v. Forest Hospital District et al (1959) 174 Cal.App.2d 709; Willis v. Santa Ana Community Hosp Assn (1962) 58 Cal.2d 806, 26 Cal.Rptr. 640; Rossner v. Eden Township Hosp. Dist. (1962) 58 Cal.2d 592; Pinsker v. Pacific Coast Society of Orthodontists ("Pinsker I") (1969) 1 Cal.3d 160, 81 Cal.Rptr. 623; Pinsker v. Pacific Coast Society of Orthodontists ("Pinsker II") (1974) 12 Cal.3d 541, 116 Cal.Rptr. 245; Ascherman v. St. Frances Mem. Hosp. (1975) 45 Cal.App.3d 507, 119 Cal.Rptr. 507; Anton v. Board of Directors of San Antonio Comm. Hosp. (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442; Miller v. Eisenhower Medical Center (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826; Volpicelli v. Jared Sydney Torrance Memorial Hosp. (1980) 109 Cal.App.3d 242, 167 Cal.Rptr. 610; Applebaum v. Board of Directors of Barton Mem. Hosp. (1980) 104 Cal.App.3d 648, 163 Cal.Rptr. 831; Unterthiner v. Desert

Hosp. Dist. of Palm Springs (1983) 33 Cal.3d 285, 188 Cal.Rptr. 590; Bergeron v. Desert Hosp. Corp. (1990) 221 Cal.App.3d 146, 270 Cal.Rptr. 397; Rosenblit v. Sup. Ct. (Fountain Valley Regional Hospital) (1991) 231 Cal.App.3d 1434, 282 Cal.Rptr. 819.

Recent case law has extended these common-law rights to the managed care arena.[4] For example, in Delta Dental Plan of California v. Banasky (1994) 27 Cal.App.4th 1598, 33 Cal.Rptr.2d 381, a California Court of Appeal addressed a dispute regarding whether a disagreement concerning a contract fee schedule, between a managed dental care plan and individual dentists who were part of the plan's provider panel, should be submitted to arbitration. Although the court found that, under the terms of the applicable agreement, the fee dispute was not subject to arbitration, it also found that the dentists had a common law right to fair procedure over the issue, including an internal notice and hearing, followed by judicial review if requested. In so holding, the court recognized that:

> "'California courts have long recognized a common law right to fair procedure protecting individuals from arbitrary exclusion or expulsion from private organizations which control important economic interests [citations]...□ Applebaum v. Board of Directors (1980) [citation]. Fair procedure comes into play where private organizations are 'tinged with public stature or purpose' or attain a 'quasi-public significance,' as contrasted with purely private associations which have no larger ''purpose

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[4] Indeed, it appears that this extension occurred after Dr. Potvin filed his original complaint.

or stature' than pleasant, friendly and congenial social relationships' [citation]' [citations]. Further, the right to fair procedure with respect to membership actions is not limited to matters of exclusion or expulsion [citations omitted]." *Id.* at 385, emphasis added.

Finding that the dental plan controlled an important economic interest, the court concluded that the plan's modification of a participating dentist's list of usual, customary, and reasonable fees gave rise to the right to fair procedure. Thus, the California Court of Appeal in Delta Dental properly recognized that managed care organizations, like the dental plan at issue, control important economic interests of their participating providers and are thus imbued with the same public purpose attributes as hospitals in the delivery of health care. This fact mandates application of the common law protection from arbitrary exclusion or expulsion which has been long applied in the hospital context to the managed care context for physicians.

The Delta Dental case's recognition of extension to the managed care arena of the common-law principles requiring a reasonable basis for termination and fair procedures was expressly recognized in Ambrosino v. Metropolitan Life Insurance Co. 899 F. Supp. 4th 438, ND Cal., 1995. In Ambrosino, the court found that a health insurer's termination of a physician provider was arbitrary, capricious, and in violation of public policy when it was based upon a policy of excluding any and all physicians who had formerly had any type of chemical dependency. Following Delta Dental, the Ambrosino court found that:

> The common-law right to fair procedure has recently been held to extend to health care providers' membership in provider networks such as that operated by Defendant, because such managed care providers control substantial economic interests (citing Delta Dental). (Footnote omitted.) In the instant case, it is undisputed that Defendant controls substantial economic interest affecting Plaintiff, since prior to Plaintiff's termination approximately 15% of Plaintiff's patients were insured by Defendant. (Citations omitted.) Accordingly, Plaintiff had a common-law right to fair procedures, including the right not to be expelled from membership for reasons which are arbitrary, capricious and/or contrary to public policy. (*Id.* at 445.)

In the New Hampshire case of Paul J. Harper, M.D. v. Healthsource New Hampshire, Inc. (1996) NH Sup. Ct., No. 95-535, the plaintiff, Paul J. Harper, M.D., sued the Healthsource HMO after Healthsource terminated his physician provider contract after almost 10 years.

Dr. Harper was a participating physician with Healthsource, as a surgeon and as a primary care physician. Dr. Harper had a patient base with Healthsource of between 3,000 and 4,000 enrollees--approximately thirty to forty percent of his patients. He alleges that in 1994 he "realized that [Healthsource] was ... manipulating and skewing" the records of treatment provided to several patients and that the resultant inaccuracies adversely affected subsequent reports. After Dr. Harper notified Healthsource of such concerns, Healthsource informed him that, although the credentialing committee found no evidence of a quality-of-care

problem, it still recommended termination of his contract because he had not satisfied the company's recredentialing criteria.

Dr. Harper appealed the recommendation of the credentialing committee to the clinical quality assurance committee and requested copies of whatever documentation formed the basis for the credentialing committee's recommendation. The company refused to provide the requested material but advised Harper that he could present evidence to counter the company's evidence. Harper did not participate in the hearing because of the company's refusal to provide him with documentation. The committee affirmed the credentialing committee's recommendation to terminate Dr. Harper for cause "but also decided to terminate him without cause, which the credentialing committee had not done." (Slip Opin., p.2.)

Harper then appealed this recommendation to the company's executive management committee. This group held another hearing which Dr. Harper attended. The company presented no evidence nor did it grant Harper's renewed request for access to evidence supporting the company's recommendation. The executive management committee upheld the clinical quality assurance committee's decision to terminate his contract without cause, but did not terminate him for cause.

After Dr. Harper exhausted all appeal remedies within the company, he sued Healthsource alleging, among other things, that his termination was void as

against public policy. The superior court granted Healthsource's motion to dismiss Dr. Harper's lawsuit.

The New Hampshire Supreme Court overturned relevant portions of that ruling. The Court held that Dr. Harper was entitled to proceed with his claim that Healthsource's decision to terminate him was made in bad faith and violated public policy, because his efforts to correct changes made to his patient records played a role in Healthsource's termination decision. The court stated that public policy should condemn "an insurance company which, upon receipt of a letter from a medical provider asking for assistance in correcting ... records of patient treatments, terminates the doctor's services."

The Court found that plan terminations of physicians affect important public interests because the physician/HMO relationship

> "... is perhaps the most important factor in linking a particular physician with a particular patient. As Harper correctly notes, the termination of his relationship with Healthsource affects more than just his own interest."
>
> Several relationships in our society stand on a different footing from the rest. The most visible are those between wife and husband, lawyer and client, pastor and penitent, and physician and patient. In these relationships, society values truthfulness in communication above other competing interests, ...

The Court also noted that "every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." Under New Hampshire law, preferred provider agreements must be "fair and in the public interest." (Similarly, under California law, physician contracts with HMOs must be "fair and reasonable." Health & Safety Code §1367.) The Court therefore concluded that

> the public interest and fundamental fairness demand that a health maintenance organization's decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy. (Slip Opin., p.6.)

The Court stated that a terminated physician is entitled to review of the termination decision for public policy and fairness considerations, whether the termination was for cause, or without cause. (*Id.*) The court went on to note that this rule does not eliminate a plan's contractual right to terminate its relationship with a physician without cause. However, if a physician's contract is terminated without cause, and the physician believes that such decision was made in bad faith or contrary to public policy, then the physician is entitled to review of that decision by a court of law. (*Id.,* pp. 6–7.)

Apart from these well settled judicial principles, public policy considerations support fair hearing rights for physicians terminated "without cause" from managed care organizations. As has been discussed previously, "without cause"

terminations may be used as a subterfuge to avoid the legal duty to report incompetent physicians. Recognition of fair hearing rights for "without cause" terminations would remove the incentive to use such terminations as a means to avoid reporting requirements.

Particularly given the decline in 805 reporting, this Court must issue a clear statement that managed care organizations and other entities cannot escape their legal and moral obligations to the public to ensure that physicians are appropriately credentialed, and to report any adverse disciplinary action taken after fair hearing procedures confirm a medical disciplinary cause or reason exists. Because of the impact of these determinations on the physician-patient relationship

and the physician's ability to practice medicine, basis fairness must be assured before decisions are made that adversely affect their participation status in managed care organizations. Without this fairness, both physicians and their patients suffer.

DATE: February 20, 1997 Respectfully submitted,

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