No. S205568

IN THE

Supreme Court

OF THE STATE OF CALIFORNIA

MARK T. FAHLEN, M.D.,

Plaintiff and Respondent,

vs.

SUTTER CENTRAL VALLEY HOSPITALS, et al.,

Defendants and Respondents.

After a Decision by the Court of Appeal
Fifth Appellate District
Case No. F063023

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF; *AMICUS CURIAE* BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFF AND RESPONDENT MARK T. FAHLEN, M.D.

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Certificate of Interested Entities or Persons

Pursuant to California Rules of Court, rule 8.208, the undersigned, counsel for the California Medical Association and the American Medical Association, certifies that there are no disclosures to be made.

DATED: July 15, 2013.

By: _____
LONG X. DO

Attorney for the California Medical Association and the American Medical Association

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APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

Pursuant to rule 8.520(f) of the California Rules of Court, the California Medical Association ("CMA") and the American Medical Association ("AMA") hereby request leave to file the attached *amicus curiae* brief in support of the plaintiff and respondent, Mark T. Fahlen, M.D. ("Fahlen").

There are no persons or entities to be identified under rule 8.520(f)(4) of the California Rules of Court.

INTERESTS OF THE *AMICUS CURIAE* APPLICANTS

CMA is a non-profit, incorporated professional association of approximately 37,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private

practice of medicine in all specialties and settings. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting safe, high quality and cost-effective health care for the people of California.

The AMA is a private, voluntary, nonprofit organization of physicians and medical students. It is the largest such organization in the United States. Additionally, through state and specialty medical societies and other groups seated in its House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health. Today, its members practice in all fields of medical specialization and in all states. The AMA submits this application and the accompanying *amicus curiae* brief as a member of the Litigation Center of the American Medical Association and the State Medical Societies ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. Fifty state medical societies and the Medical Society of the District of Columbia join the AMA as members of the Litigation Center.

Both CMA and the AMA have specialty sections comprised of organized medical staffs throughout California and the United States, respectively. With their organized medical staff sections, the *amicus curiae* applicants are committed to safeguarding the ability of physicians to treat their patients effectively and safely in hospitals, free of arbitrary disruptions, including retaliation. To this end, they advocate for strong protections for physician whistleblowers in hospitals, including statutory and practical safeguards against sham peer review and other forms of retaliation against physicians who advocate for, or raise concerns about, patient care and safety.

HOW THE PROPOSED *AMICUS CURIAE* BRIEF CAN HELP

The *amicus curiae* applicants believe their brief can assist the Court by bringing the expertise and experience of state-level and national organized medicine to bear on the important issues that are raised in this case. Specifically, the brief provides historical background and a practical perspective on California's hospital whistleblower statute, Health and Safety Code section 1278.5. This broader context is critical to understanding the Legislature's intent in expanding whistleblower protection to physicians and other members of a hospital's medical staff pursuant to A.B. 632, a bill that CMA sponsored in 2007 to ensure that physicians are afforded the same level of protection as any other hospital health care worker or employee under section 1278.5. In this light, CMA

and the AMA contend that imposing an exhaustion requirement on physician whistleblowers before they can pursue a claim under section 1278.5 would thwart not only the Legislative intent to protect physicians but also the operation of section 1278.5.

For the foregoing reasons, CMA and the AMA respectfully request that the Court accept and file their attached *amicus curiae* brief.

DATED: July 15, 2013.

Respectfully,

CENTER FOR LEGAL AFFAIRS
CALIFORNIA MEDICAL ASS'N

By: _____
LONG X. DO

Attorneys for the California Medical Association and the American Medical Association

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AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFF AND RESPONDENT MARK T. FAHLEN, M.D.

I. INTRODUCTION

Physicians on a hospital's medical staff are in the best position by far to raise and to address concerns about patient care and safety at the hospital. They possess the professional experience, training, judgment and authority not only to provide medical care to hospital patients but also to understand when issues arise that can jeopardize or undermine such care. Yet, according to Defendants and Appellants Sutter Central Valley Hospitals and Steve Mitchell (collectively, "Sutter" or the "Hospital"),

physicians are entitled to less whistleblower protection than anyone else at the hospital.

To put it another way, imagine the following scenario. A hospital in California fails to properly maintain its autoclave equipment[1] to sterilize surgery or lab instruments, jeopardizing the safety of surgical and other hospital patients. A surgeon at the hospital becomes aware of the deficiencies and discusses his concerns with a colleague in a hospital corridor, where they are overheard by a lab technician, a records clerk, a nurse and a janitor. The surgeon and each of the hospital employees alert the hospital of the problem. The surgeon's privileges are then terminated and the employees lose their hospital jobs. Under this imagined scenario, the hospital employees would be able immediately to sue in court for damages and reinstatement under Health and Safety Code section 1278.5, California's hospital whistleblower statute. Moreover, if the hospital terminated any one of the employees within 120 days of his or her complaint, a rebuttable presumption arises that the hospital's action was retaliatory.

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[1]Steam sterilization, as accomplished in an autoclave, involves exposing each item to direct steam contact at a specific temperature and pressure for a specific length of time. The effectiveness of a steam cycle is monitored by sensitive mechanical, chemical, and biological indicators. *See generally* Centers for Disease Control, *Guideline for Disinfection and Sterlization in Healthcare Facilities* (2008), *available online at* http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf.

As to the surgeon, however, the Hospital argues that the surgeon cannot access the same legal remedies and presumption of retaliation as given to the lab technician, the records clerk, the nurse, the janitor or any other whistleblower at the hospital. Instead, the Hospital would have this Court require the surgeon to go through the protracted writ process for challenging adverse peer review decisions where it is highly unlikely the surgeon could even raise retaliation as an issue and the surgeon would face a presumption, not that the hospital's action was retaliatory, but that such action was proper.

By this *amicus curiae* brief, the California Medical Association ("CMA") and the American Medical Association ("AMA") (collectively, "*Amici*") explain why the California Legislature could not have intended such an implausible result when in 2007 it extended the whistleblower protections of section 1278.5[2] to all physicians in hospitals. The Legislature intended that physicians have the *same* whistleblower protection as afforded to all other hospital employees. It took such action knowing full well the reality that retaliation against physician whistleblowers often can take the form of sham peer review actions. Thus, the Legislature took care to broadly tailor the whistleblower protection of the statute to the forms of retaliation physicians are likely to face and to

[2]Unless otherwise noted all statutory references are to the California Health and Safety Code.

provide remedies specifically designed to address those forms of retaliation, including reinstatement of privileges.

The Legislature also took measures to protect a peer review hearing from undue interference when a physician files a whistleblower claim under section 1278.5. *See* Health & Safety Code §1278.5(h) and (i). None of these measures, however, included a requirement that, before a physician can file a claim under section 1278.5, the physician must exhaust judicial and administrative remedies to overturn the adverse peer review decision through a writ proceeding under Code of Civil Procedure 1094.5. Although the hospital industry expressly implored the Legislature to require such exhaustion of remedies, the legislative history of section 1278.5 and the operation of the statute evince an undeniable Legislative intent that physician access to whistleblower protection under section 1278.5 cannot be hampered by an exhaustion requirement.

Reported adverse events in hospitals are on the rise, making section 1278.5's purpose of encouraging physicians to come forward with concerns about patient care at hospitals becomes ever more vital. The court of appeal was correct to conclude that section 1278.5 does not require exhaustion. *Amici* CMA and the AMA accordingly urge the Court to affirm the judgment of the court of appeal.

II. INTERESTS OF *AMICI CURIAE*

CMA is a non-profit, incorporated professional association of approximately 37,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine in all specialties and settings. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting safe, high quality and cost-effective health care for the people of California.

The AMA is a private, voluntary, nonprofit organization of physicians and medical students. It is the largest such organization in the United States. Additionally, through state and specialty medical societies and other groups seated in its House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health. Today, its members practice in all fields of medical specialization and in all states. The AMA files this *amicus curiae* brief as a member of the Litigation Center of the American Medical Association and the State Medical Societies ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical

societies to represent the views of organized medicine in the courts. Fifty state medical societies and the Medical Society of the District of Columbia join the AMA as members of the Litigation Center.

Both CMA and the AMA have specialty sections comprised of organized medical staffs throughout California and the United States, respectively. *Amici* and their organized medical staff sections are committed to safeguarding the ability of physicians to treat their patients effectively and safely in hospitals, free of arbitrary disruptions, including whistleblower retaliation. Serving the interests of medical staffs and physicians in California, in 2007 CMA successfully sponsored the California legislation, A.B. 632, that extended the whistleblower protections of section 1278.5 to physicians. The AMA has similarly worked for physician whistleblower protection at the national level before legislative and regulatory bodies. *Amici* regularly get involved in cases in California and throughout the nation involving medical staff rights and/or peer review, including the last two cases before this Court involving physician rights in peer review, *El-Attar v. Hollywood Presbyterian Medical Center* (June 6, 2013) 157 Cal.Rptr.3d 533, and *Mileikowsky v. West Hills Hospital and Medical Center* (2009) 45 Cal.4th 1259.

On behalf of state-level and federal organized medicine, the CMA and the AMA bring their expertise and experience to bear on the important questions raised here.

III. BACKGROUND

EVOLUTION OF THE CALIFORNIA HOSPITAL WHISTLEBLOWER STATUTE

As shown below, the legislative history of section 1278.5 demonstrates a number of important points. *First*, there is a clear and well-established public policy to protect patients by encouraging health care workers to come forward with concerns about patient care and safety. *Second*, to carry out this public policy, the Legislature has repeatedly extended whistleblower protection in full and without limitation to different health care sectors and to different health care workers. *Third*, when extending section 1278.5 to hospital physicians in 2007, the Legislature was fully aware of the potential consequences on peer review and took steps to prevent undue interference with medical staff peer review functions. *Fourth*, notably, the Legislature did not require exhaustion of judicial or administrative remedies as a precondition for physicians to assert their rights to whistleblower protection under section 1278.5. Ultimately, the purpose of section 1278.5 is to provide the same level of protection to all possible whistleblowers in hospitals and other health care facilities.

A. ORIGINAL ENACTMENT IN 1999

Section 1278.5 has been California's hospital whistleblower statute since its enactment in 1999. *See* S.B. 97, 1999 Stats. ch. 155 (1999-2000 reg. sess.) ("S.B. 97"). As originally enacted the law prohibited hospitals

and other health care facilities from discriminating or retaliating against "any patient or employee" for raising a grievance or complaint regarding the care, services or conditions of the facility. *See* S.B. 97, §1 (codified as section 1278.5(a)). It also created a rebuttable presumption that adverse action is retaliatory if it arose within 120 days of an employee's complaint or within 180 days of a patient's complaint. *See id.* (codified as section 1278.5(c) and (d)). Aggrieved employees were entitled to "reinstatement, reimbursement for lost wages and work benefits caused by the acts of the employer, and the legal costs associated with pursuing the case." *Id.* (codified as section 1278.5 (g)).

The concept of whistleblower protection for health care workers was not new at the time section 1278.5 was enacted. The law then prohibited long-term health care facilities from discriminating or retaliating against their patients and employees for filing grievances or complaints relating to the care, services or conditions at that facility. *See* Health & Safety Code §1432(a). According to the Department of Health Services ("DHS"), however, "a number of retaliation complaints against health facilities, other than long-term care facilities [are received], but without statutory authority DHS cannot follow-up on these types of complaints." Assem. Comm. on Health, Comm. Analysis of S.B. 97 at 3 (June 14, 1999) ("6/14/99 Comm. Analysis of S.B. 97"). S.B. 97's author and sponsor thus explained that the bill "would extend the *same protections in place* for retaliatory actions by

long-term health care facilities to the employees and patients of acute care facilities." *Id.* at 2-3 (emphasis added). Indeed, the key provisions of section 1278.5 as enacted by S.B. 97 are nearly identical to section 1432. *Compare* Health & Safety Code §1432(a), (b) and (c) *with* Health & Safety Code §1278.5(a), (c) and (d).

The hospital industry opposed S.B. 97 from the onset. It argued that a whistleblower statute for hospitals was unnecessary and that the bill "will significantly increase the number of legal actions against" hospitals. *See* 6/14/99 Comm. Analysis of S.B. 97 at 3, 4. The hospital industry also argued that allowing for a rebuttable presumption of retaliation would "encourage incompetent employees to file frivolous complaints." *Id.* at 4. These arguments did not sway the Legislature. The Legislature instead was more convinced by the proponents of S.B. 97, who explained that "[r]etaliatory actions against patients, nurses and other health care workers are on the increase" and that section 1278.5 "would help protect nurses and patients who complain about possible unsafe patient care in hospitals." S. Health & Human Servs. Comm., Comm. Analysis of S.B. 97 at 3 (Mar. 10, 1999). Indeed, through passage of S.B. 97, the Legislature expressly declared that it is the public policy of the State to *encourage* patients and nurses to report unsafe patient care and conditions at hospitals and that "[t]he Legislature encourages this reporting in order to protect patients and in order to assist those government entities charged with ensuring that

health care is safe." S.B. 97, §1 (codified at section 1278.5(a)).

B. 2007 AMENDMENT TO EXTEND WHISTLEBLOWER PROTECTION TO MEMBERS OF THE MEDICAL STAFF

Section 1278.5 has been amended only once, through CMA-sponsored legislation in 2007. *See* A.B. 632, 2007 Stats. ch. 683 (2007-08 reg. sess.) ("A.B. 632"). Similar to the original enactment of section 1278.5, the purpose of the amendment was simply to extend existing whistleblower protection. This time the Legislature wanted whistleblower protection for patients and employees of hospitals to also cover physicians and other members of the medical staff at those hospitals. The need to extend whistleblower protection in A.B. 632 was explained as follows:

> According to the author, existing whistleblower protections in the Health and Safety Code grant protections from retaliation after a grievance is filed by hospital employees and patients but not physicians. By extending the protections to physicians and surgeons this bill would clarify an ambiguity in existing law. This bill also tailors the prohibited type of discrimination or discipline relevant to physicians and surgeons into this code section.
>
> * * * *
>
> According to CMA, this bill clarifies existing law by extending hospital whistleblower protections to physicians and surgeons. Currently the law provides protections to employees and patients and "any other person" who makes complaints about a health facility. CMA states that some attorneys have used this same section to deny protections to a physician who raised concerns by claiming that the physician was not an employee or patient. CMA believes this bill will prevent the argument from happening again, since most physicians are not employees of a hospital.

Assem. Comm. on Health, Comm. Analysis of A.B. 632 at 4, 6 (Apr. 9,

2007) ("4/9/07 Comm. Analysis of A.B. 632").

True to the Legislature's intent, A.B. 632 added language to section 1278.5 to prohibit retaliation against a member of the medical staff in the same way that it prohibits retaliation against hospital patients and employees. The bill did not alter the proscriptive language of section 1278.5 but rather only added "members of the medical staff" as an additional class of protected persons:

> [A.B. 632] extends the protection from discrimination or retaliation by a health care facility against persons who present grievances or complaints, or who initiate an investigation regarding the facility's quality of care, services, or conditions, to members of the medical staff and other health care workers of the facility. This bill also extends the rebuttable presumption that a retaliatory action has occurred, if discriminatory treatment occurs within 120 days of the filing of the grievance or complaint, to members of the medical staff and other health care workers.

S. Health Comm., Comm. Analysis of A.B. 632 at 3 (June 12, 2007) ("6/12/07 Comm. Analysis of A.B. 632").

The Legislature was aware "that physicians are generally not employees of a hospital. Instead, they enjoy privileges at the hospital and have a relationship with the hospital that is governed by Medical Staff By-Laws, a peer review process, the protections of Business and Professions Code 809, and other protective measures." *Id.* at 7. The Legislature also was made aware that, in light of the unique relationship between a hospital and its medical staff members, retaliation can be "expressed in a variety of methods, including termination of a physician or surgeon's hospital

privileges." Assem. Floor Analysis, Concurrence in S. Amends. at 4 (Sept. 12, 2007) ("9/12/07 Comm. Analysis of A.B. 632"). Thus, A.B. 632 not only extends section 1278.5 whistleblower protections to physicians and other medical staff members, but it also tailors the statute in light of peer review and hospital privileges. An Assembly analysis of A.B. 632 states that the bill:

> Requires "discriminatory treatment of a physician or surgeon" to include discharge, demotion, suspension, any other unfavorable changes in the terms or conditions of the privileges of the physician and surgeon at the health facility or its affiliate, or the threat of any of these actions.
>
> Entitles a physician and surgeon who has been discriminated against pursuant to this bill to reinstatement, reimbursement for lost income resulting from any change in the terms or conditions of his or her privileges caused by the acts of the facility or its affiliate, and the legal costs associated with pursuing the case.

4/9/07 Comm. Analysis of A.B. 632 at 1.

While the Legislature sought to protect physician whistleblowers against retaliation on their hospital privileges, it also took steps to prevent undue interference with a medical staff's peer review functions. A.B. 632 thus included a provision for medical staffs to obtain a court injunction that would "protect a peer review committee from being required to comply with evidentiary demands on a pending peer review hearing from the member of the medical staff who has filed an action pursuant to [section 1278.5], if the evidentiary demands from the complainant would impede the peer review process or endanger the health and safety of patients of the

health facility during the peer review process." Health & Safety Code §1278.5(h).

IV. DISCUSSION

A. THERE IS A GREAT NEED FOR WHISTLEBLOWER PROTECTION OF HOSPITAL HEALTH CARE WORKERS.

The public policy behind section 1278.5 and the need to protect hospital physician whistleblowers remains as relevant today as it was in 1999 when the statute was first enacted or in 2007 when the Legislature extended whistleblower protection to physicians.

DHS reported in 2006 that more than 30,000 complaints were made about the quality of care, services or conditions of California health care facilities. *See* 6/12/07 Comm. Analysis of A.B. 632 at 5. The vast majority of these complaints came from health care workers or administrators within the facility. *See id.* It was not until 2007, however, that state law mandated hospitals to report adverse events to give a picture of patient safety in hospitals. *See* Health and Safety Code §1279.1. Since then, the number of adverse events that are reported has continued to steadily rise. *See* Cal. Health Care Almanac, *California Hospitals: Buildings, Beds, and Business*, CAL. HEALTHCARE FOUND. at 38 (Jan. 2013), *available online at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniaHospitals2013.pdf.

More than half a century ago, this Court recognized that "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." *Rosner v. Eden Township Hosp. Dist.*, 58 Cal. 2d 592, 598 (1962). However, the Court also recognized, "[i]n asserting their views as to proper treatment and hospital practices, many physicians will become involved in a certain amount of dispute and friction." *Id.* Because such disputes are "common occurrences," the Court cautioned against the use of peer review to oust physicians who are competent but who may not fit an overbroad or amorphous standard for medical staff membership. *Id.* (observing there "is a danger that the requirement of temperamental suitability will be applied as a subterfuge where considerations having no relevance to fitness are present"). An amorphous medical staff membership requirement requiring an "ability to work with others" poses a "danger of arbitrary and irrational application" and "the concomitant danger that such a bylaw may be used 'as a subterfuge where considerations having no relevance to fitness are present.'" *Miller v. Eisenhower Med. Ctr.*, 27 Cal. 3d 614, 629 (1980) (quoting *Rosner*, 58 Cal. 2d at 598).

In *Mileikowsky v. West Hills Hosp. & Med. Ctr.* (2009) 45 Cal.4th 1259, 1272, the Court again recognized, "[i]t is not inconceivable a governing body would wish to remove a physician from a hospital staff for

reasons having no bearing on quality of care." More specifically, as one legal commentator notes, "[r]ather than using peer review committees for analyzing and attempting to correct adverse events or to discipline health care providers who deserve to be disciplined, a current trend among hospitals is to use the committees as a way to weed out competition." Leigh Ann Lauth, "The Patient Safety and Quality Improvement Act of 2005: An Invitation for Sham Peer Review in the Health Care Setting," 4 IND. HEALTH L. REV. 151, 167 (2007).[3] Finally, this Court recently reiterated *Mileikowsky* in observing that "[t]here is certainly the potential for a hospital's governing body to abuse the power of appointment in a way that would deprive a physician of a fair hearing. A hospital's governing body could undoubtedly seek to select hearing officers and panel members biased against the physician. It might even do so because it wishes 'to remove a physician from a hospital staff for reasons having no bearing on quality of care.'" *El-Attar v. Hollywood Presbyterian Medical Center* (Cal. S. Ct., June 6, 2013) __ Cal.4th __, 157 Cal.Rptr.3d 533, 545.

According to a study commissioned by the Medical Board of California, "disruptive physician behavior" is one of the most common reasons for a peer review referral to a medical staff executive committee.

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[3]This Court's observations belie the Hospital's claim that "peer review does not give rise to the concerns of easy manipulation." Reply Brief on the Merits at 8.

See Jeann Ann Seago, *et al.*, "Comprehensive Study of Peer Review in California: Final Report," Lumetra Report for the Medical Board of California at 65 (Jul. 31, 2008), *online at http://www.mbc.ca.gov/publications/peer_review.pdf.* Undoubtedly, certain instances of disruptive behavior can compromise a physician's ability to deliver safe care, and there are cases where a physician's privileges should be limited or terminated due to disruptive behavior. Nevertheless, the standards for designating someone a disruptive physician sometimes can be ambiguous or overbroad, and sham peer review proceedings, when they do arise, are commonly based on allegations that a physician is engaged in disruptive behavior.

The facts of this case illustrate the continuing great need to have whistleblower protections for medical staff physicians who face adverse peer review decisions.[4] Respondent Dr. Fahlen was an established medical staff member whose privileges were terminated through peer review using a broad "disruptive behavior" standard. Tbe underlying peer review hearing yielded no evidence of a nexus between Dr. Fahlen's behavior towards nursing staff and his inability to practice medicine safely. Not surprisingly, the physician peers sitting on the judicial review committee determined that

[4]Dr. Fahlen has provided a fuller account of the facts leading to his termination from the medical staff at Memorial Medical Center. *See* Answering Brief of Plaintiff and Respondent at 2-10 ("Answering Brief").

Dr. Fahlen should remain on the medical staff. The medical executive committee, which had originally initiated the peer review proceeding, accepted that finding. The Hospital also conceded that Dr. Fahlen's conduct had not led to any specific act or omission that compromised patient safety at the hospital. Nevertheless, it terminated Dr. Fahlen's privileges despite the joint review committee's findings and conclusions.[5] All of this – initiation of peer review and termination of Dr. Fahlen's privileges – was done because Dr. Fahlen had raised complaints about nursing competence at the hospital. In other words, the facts strongly suggest Dr. Fahlen's privileges were terminated after he raised concerns about patient care.

B. REQUIRING EXHAUSTION OF JUDICIAL AND ADMINISTRATIVE REMEDIES WOULD CONTRADICT THE LEGISLATIVE INTENT IN EXTENDING SECTION 1278.5 WHISTLEBLOWER PROTECTION TO PHYSICIANS AND THWART THE OPERATION OF THE STATUTE.

The Hospital is wrong in arguing, "[n]othing that the Legislature said or did in amending Section 1278.5 clearly and unequivocally disclosed

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[5]The Hospital's own actions toward Dr. Fahlen belie its argument that:

> [P]eer review is driven by the medical staff, *not* the facility. Medical staff leaders regularly identify concerns that trigger peer review, investigate the concerns and recommend corrective action, while other medical staff members sitting as a judicial review committee ("JRC") determine the reasonableness of any actions.

Reply Brief on the Merits at 7.

an intent to scuttle the [exhaustion] rule or thwart this foundation element of quasi-judicial medical peer review." Reply Brief on the Merits at 2. On the contrary, the Legislature did clearly and unequivocally intend for physicians to have unfettered access to all of the remedies of section 1278.5, which would be impossible to realize if section 1278.5 is made subject to an exhaustion requirement.

1. The Legislature Rejected an Exhaustion Requirement for Section 1278.5 Claims.

The hospital industry opposed A.B. 632 from beginning to end (in the same manner that the hospital industry opposed S.B. 97 that first enacted section 1278.5). Raising very similar arguments to the arguments that had been lodged against S.B. 97, the industry argued that extending whistleblower protection to physicians could have a chilling effect on peer review or would encourage incompetent physicians to use whistleblower protection to thwart legitimate peer review or to dissuade other physicians from participating in peer review. *See* S. Jud. Comm., Comm. Analysis of A.B. 632 at 9-10 (July 12, 2007) ("7/12/07 Comm. Analysis of A.B. 632"). It also argued that "there is no evidence that physicians have been subject to retaliation" and that "there are already sufficient whistleblower protections...for physicians and surgeons." S. Health Comm., Comm. Analysis of A.B. 632 at 6-7 (June 12, 2007) ("6/12/07 Comm. Analysis of A.B. 632").

However, unlike their opposition to whistleblower protection for hospital nurses and patients, the hospital industry focused its opposition to A.B. 632 on the relationship between hospitals and medical staff members and the potential impact on peer review. In an early version of A.B. 632, the California Hospital Association ("CHA") expressed concern that the bill "needs further clarification to ensure that hospitals retain the right to take disciplinary action with regard to disruptive behavior by employees, patients and physicians, regardless of their protected activity." *Id.* at 7.

The potential impact on peer review of extending section 1278.5 to medical staff members soon became a central focus for the Legislature as well as the proponents and opponents of A.B. 632. On the one hand, the proponents argued the bill was needed "for clarifying existing law to protect physicians from retaliation or discrimination, which they argue is expressed in a variety of methods, *including termination of a physician or surgeon's hospital privileges*." 9/12/07 Comm. Analysis of A.B. 632 at 4 (emphasis added). More broadly speaking, CMA argued that "[o]ften physicians are faced with having to decide if they should report allegations of poor patient care or conditions knowing their practice and livelihood may be harmed." 7/12/07 Comm. Analysis of A.B. 632 at 9. On the other hand, CHA and other hospital interests argued that extending section 1278.5 to medical staff members would have a "chilling effect" on peer review; "the bill could stop a peer review process in its tracks by the simple

filing of a 1278.5 action, or it could compel a peer review committee to not initiate a peer review process for fear that it could be considered a retaliatory action and subject the committee to the misdemeanor penalties of 1278.5." *Id.* at 9.

The clear underlying presumption of this debate is that retaliation against a physician's privileges arises through peer review. Indeed, in a committee report, the Legislature was reminded that "[t]he peer review process is given great deference as a means of ensuring safe health care in the state" and that various peer review protections have been established "to encourage participation by physicians in the peer review process and to ensure their freedom from fear of retribution for participating." 7/12/07 Comm. Analysis of A.B. 632 at 9.

Given the hospital industry's concerns that whistleblower claims challenging adverse peer review decisions may impede legitimate peer review functions, CHA repeatedly sought an amendment to A.B. 632 that would require a physician to exhaust administrative and judicial remedies to reverse an adverse peer review decision *before* being able to pursue remedies under section 1278.5. Specifically, CHA sought an amendment that would provide:

> [S]ection 1278.5 does not apply to a proposed or taken investigation, corrective or disciplinary action by a medical staff or a hospital governing board against a member of the medical staff or an applicant unless and until there has been a determination that the member or applicant has been determined to have substantially

prevailed in such action as specified in current law.

CHA S. Fl. Alert at 2 (Aug. 21, 2007) (Ex. 6 to Sutter's Req. for Jud. Notice); CHA Assem. Fl. Alert at 2 (Sept. 10, 2007) (Ex. 9 to Sutter's Req. for Jud. Notice).

The Hospital tries to make much of CMA's illustrative list of retaliatory actions provided to the Legislature. It claims that "[c]onspicuously absent was any suggestion that hospitals use quasi – judicial peer review to suppress reporting or that the amendment would meaningfully impact peer review." Opening Brief on the Merits at 30. As shown however, CMA did make the Legislature aware that sham peer review is a method of retaliation against physicians; and in any event, regardless of anything CMA said or did not say, the debate over A.B. 632 was indeed centered on peer review and the impact of extending whistleblower protection to physicians can have on peer review proceedings.

Ultimately, the issue before this Court, whether a section 1278.5 claim should be subject to the exhaustion requirement, was squarely presented to the Legislature through CHA's proposed amendments to A.B. 632. Although the Legislature was aware of the potential impact section 1278.5 claims might have on peer review, it did not grant CHA's repeated requests. Instead, the Legislature focused on protecting a medical staff's pending peer review proceeding from interference due to the filing of a

section 1278.5 claim. The end result of the Legislature's balancing of the need for whistleblower protection for physicians against potential interference with peer review proceedings is adoption of the language that currently exists in subdivision (h) of section 1278.5. *See* S. Rules Comm., Comm. Analysis of A.B. 632 at 1-2 (Sept. 6, 2007) (subdivision (h) was meant to "deal with the effect of a whistleblower complaint in the context of peer review proceedings"); 9/12/07 Comm. Analysis of A.B. 632 at 4 (explaining the language of subdivision (h) "were taken to deal with some objections made by the hospitals regarding the impact of the bill on the peer review").

Notably, nothing in the Legislature's response to the hospital industry's criticism of A.B. 632 involved requiring physician whistleblowers to exhaust judicial and administrative remedies, even though such a possibility was squarely posed to the Legislature not only by CHA but also by legislative staff. *See* 7/12/07 Comm. Analysis of A.B. 632 at 2 (after discussing hospital opposition based potential impact to medical staff peer review, posing the question "SHOULD A 1278.5 ACTION BE HELD IN ABEYANCE UNTIL A PEER REVIEW PROCESS, IF INITIATED, HAS BEEN COMPLETED?").

In these circumstances, this Court should not now construe section 1278.5 to require such exhaustion. *See Joyce G. v. Superior Court* (1995) 38 Cal.App.4th 1501, 1509-10 (holding a court should not adopt a meaning

of a statute considered and rejected by the Legislature, in the absence of constitutional infirmity); *see also Central Delta Water Agency v. State Water Resources Control Bd.* (1993) 17 Cal.App.4th 621, 634 ("The fact that the Legislature chose to omit a provision from the final version of a statute which was included in an earlier version constitutes strong evidence that the act as adopted should not be construed to incorporate the original provision"); *Wilson v. City of Laguna Beach* (1992) 6 Cal.App.4th 543, 555 ("The rejection [by the Legislature] of a specific provision contained in an act as originally introduced is 'most persuasive' that the act should not be interpreted to include what was left out").

2. A.B. 632's Express Purpose Leaves No Room for an Exhaustion Requirement.

As the hypothetical scenario posed in the Introduction illustrates, an exhaustion requirement would introduce unwarranted disparity in the level of whistleblower protection afforded to physicians versus hospital employees. An exhaustion requirement would mean that a physician who raises the same grievance about patient safety would be entitled to less whistleblower protection than a lab technician, a records clerk, a nurse, a janitor or any other whistleblower at the hospital who raises the exact same grievance. Such an incongruous construction of section 1278.5 would be incompatible with the Legislature's purpose in enacting A.B. 632. That purpose was to ensure that the provisions of section 1278.5 "provide

equivalent whistleblower protection to a doctor that is currently available to an employee or patient of a hospital facility and to other health care workers." 9/12/07 Comm. Analysis of A.B. 632 at 4 (emphasis added). Of course, A.B. 632 accomplished that very equivalency, but accepting Sutter's arguments in this case would effectively undo all that was intended by the Legislature and restore an older and disfavored version of section 1278.5.

3. Section 1278.5 Could Not Operate as the Legislature Intended If There Is an Exhaustion Requirement.

As the court of appeal recognized, several key provisions of section 1278.5 would effectively be nullified if an exhaustion requirement were imposed. The court noted "it would be virtually impossible to implement that [evidentiary presumption of section 1278.5(d)(1)] in a civil action under section 1278.5 after judicial ratification of a hospital's administrative action under the narrow standard of review in writ proceedings, during which the presumption would not have been operable."[6] *Fahlen v. Sutter*

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[6]This rebuttable presumption was always a part of the expansion of whistleblower protection for health care workers. In S.B. 97, it was imported virtually verbatim from section 1432 when the Legislature first enacted whistleblower protection for hospital nurses and patients. And, in A.B. 632, it was again imported verbatim when the Legislature determined that physicians deserved the same level of whistleblower protection. Dr. Fahlen's case demonstrates that imposing an exhaustion requirement would effectively nullify the rebuttable presumption. As he explained, a writ of mandate proceeding gives hospitals a great advantage that is not available if a sham peer review is challenged under section 1278.5. *See* Answering Brief at 24-25. Thus, whereas under a section 1278.5 claim, Dr. Fahlen

Central Valley Hosps. (Aug. 14, 2012, case no. F063023) (Slip Op.) at 27. The court also observed that "[i]t is evident from this [A.B. 632] legislative history that the Legislature was not only cognizant of the possibility of parallel peer review administrative proceedings, but that it expressly contemplated that such proceedings could, with certain limitations, occur simultaneously with a civil action under section 1278.5." *Id.* at 25 (referring to section 1278.5(h)). "In such circumstances," continued the court, "'to hold an adverse administrative finding preclusive in the expressly authorized damages action would be contrary to the evident legislative intent.'" *Id.* (citation omitted). Finally, the court stated, "the range of remedies authorized by section 1278.5, subdivision (g), is incompatible with a requirement for successful judicial review of a peer review decision." *Id.* at 27. Specifically, according to the court of appeal, "[i]f a doctor were required to successfully set aside an administrative order terminating his or her privileges as a precondition to a section 1278.5 action . . ., there would never be a circumstance in which reinstatement of a

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would be entitled to a rebuttable presumption that the Hospital's termination of his privileges was retaliatory, no such presumption arises in a writ proceeding to reverse the termination of his privileges. Just the opposite – in such a writ proceeding there is a presumption that the Hospital's termination of Dr. Fahlen's privileges was proper. *See Hongsathavij v. Queen of Angels Medical Center* (1998) 62 Cal.App.4th 1123, 1137 ("[A]n appellate court must uphold administrative findings unless the findings are so lacking in evidentiary support as to render them unreasonable") (citations omitted).

doctor's staff privileges would still be required in the civil action. This is true even though reinstatement is a remedy specified by the Legislature in section 1278.5, subdivision (g)." *Id.*

Sutter's response to these compelling observations is not to deny the logic or applicability of the court of appeal's reasoning but instead to come up with rare, if not nonexistent, situations that the court may not have considered. Sutter observes that the injunction provision of section 1278.5's subdivision (h) may be used to protect an "ongoing peer review hearing . . . involv[ing] a different physician and the [evidentiary demand in a section 1278.5 claim] may be directed at establishing disparate treatment." Opening Brief on the Merits at 42. While such a scenario may conceivably arise, it certainly was not the heart of the criticism of A.B. 632 to which the Legislature was responding in adopting subdivision (h). *See* 7/12/07 Comm. Analysis of A.B. 632 at 10 ("The critical question, according to the principal opponents of A.B. 632, is what would happen to a pending peer review action, or to the evidentiary protections and immunity from liability that attend peer review actions, once the member of the medical staff files a 1278.5 action? The hospital, CHA states, could very well be required to produce evidence in the 1278.5 action even before that evidence has been fully developed and presented in a Medical Staff fair hearing under Bus. & Prof. C. 809 et seq."). When the Legislature adopted subdivision (h) of section 1278.5, it was focused on the exact situation

described by the court of appeal where a physician who files a section 1278.5 claim is the subject of a contemporaneous parallel peer review hearing.

The same can be said of Sutter's list of rare situations when a hospital may terminate a physician's privileges in a manner that does not trigger the peer review protections. *See* Opening Brief on the Merits at 43 and n.3. Sutter propounds these examples only to suggest that there may be cases of retaliation when the peer review procedures may not be triggered, and thus there would be no conflict between a section 1278.5 claim and the exhaustion requirement. However, the Legislature was not directed to non-peer review terminations of privileges in the debate over A.B. 632. The crux of the hospital industry's opposition to whistleblower protection for physicians is the impact of a section 1278.5 claim on peer review. That is why CHA proposed an amendment to require exhaustion of remedies prior to the filing of a section 1278.5 action challenging an adverse peer review decision.

Sutter's position fails to acknowledge that the use of peer review is the most common way that a physician's hospital privileges are terminated. That is because the peer review statutes provide protections not only to the physicians whose privileges are at stake, but also to peer review participants, including the hospital. Furthermore, the standard for application of the peer review statute is very broad – whenever a

physician's privileges are terminated for a medical disciplinary cause or reason, defined as "that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care." Bus. & Prof. Code §805(a)(6).

In any event, regardless whether the Legislature contemplated the most common scenarios of retaliation or the rare situations raised by Sutter, the crucial consideration is that the Legislature intended for all physicians to have equal access to the full panoply of whistleblower protection under section 1278.5 that had been afforded to hospital patients and employees. That broad intent is clear in the legislative history of A.B. 632, and it should be given full effect in constructing section 1278.5 here. *See Khajavi v. Feather River Anesthesia Medical Group* (2000) 84 Cal.App.4th 32, 51 ("The specific impetus for a bill does not limit its scope when its text speaks to its subject more broadly. . . . Indeed, when the Legislature has made a deliberate choice by selecting broad and unambiguous statutory language, 'it is unimportant that the particular application may not have been contemplated'") (citation omitted).

C. PEER REVIEW IS NOT DESIGNED TO RESOLVE CLAIMS OF WHISTLEBLOWER RETALIATION.

The Hospital's argument to impose an exhaustion requirement into section 1278.5 presumes that there is an alternative forum whereby physicians can raise retaliation claims. In reality, as well as in Dr. Fahlen's

own case, peer review proceedings are not designed to handle retaliation claims.

By its very nature, a peer review hearing evaluates a physician's ability to provide medical care for patients. *See* Bus. & Prof. Code §809(a)(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"); *see* Bus. & Prof. Code §§805(a)(6), 809.1(a) and 809.2(a) (peer review notices and hearing procedures required whenever privileges are terminated for a medical disciplinary cause or reason). In all peer review proceedings, the medical staff or other body charged with peer review (typically the medical executive committee ("MEC") of the medical staff) has the obligation to provide the physician with written notice of the proposed adverse action and the reasons for seeking such proposed adverse action. Bus. & Prof. Code §809.1(b). The MEC also bears the burden of proof that recommended adverse action against a physician's privileges is reasonable and warranted. Bus. & Prof. Code §809.3(b)(3).

There is little, if any, opportunity in a peer review proceeding for a physician to raise a section 1278.5 retaliation claim, much less to present evidence on the matter. The MEC's written notice of charges determines the scope of the issues in the peer review hearing. There is no provision in

the peer review statutes for the physician to raise affirmative defenses, nor is there any requirement that the peer review hearing body must consider affirmative defenses that do not directly relate to a physician's ability to practice medicine. It is entirely possible, if not likely, that a peer review body or a hearing officer will prevent a physician from raising a claim or presenting evidence on retaliation on the grounds that such a claim or evidence is not relevant to the charges.[7]

Sutter may argue that, notwithstanding the limitations of the peer review statutes to permit for retaliation claims to be heard, it may be possible for particular hospitals through their individual medical staff bylaws to provide peer review procedures going beyond the requirements of the peer review statutes. *See* Bus. & Prof. Code §809.6. That would mean that the extent of a physician's ability to raise a retaliation claim (and necessarily the extent of whistleblower protection afforded to that physician) depends on where the physician has privileges. Whistleblower protection should not vary by geography or happenstance.

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[7]That is exactly what happened in Dr. Fahlen's case. *See* Answering Brief at 32-33 (explaining that "Dr. Fahlen's retaliation claim was never considered or decided in any fashion before he filed his civil action for reinstatement and damages pursuant to Section 1278.5"). After successfully arguing in Dr. Fahlen's peer review hearing that he should not have an opportunity to litigate his retaliation claims in that hearing, the Hospital's claim now that "nothing prevents a physician from developing a record on pretext retaliatory animus" in a peer review hearing is demonstrably erroneous. *See* Reply Brief on the Merits at 17.

Even assuming physicians can raise retaliation claims in a peer review hearing at a particular hospital, there still would be more daunting obstacles. The members of the peer review panel, always other physicians, may not have sufficient evidence to resolve the claim of retaliation fairly, given that the subject physician does not have an opportunity to obtain any discovery other than the production of documents that the hospital deems relevant to its charges. *See* Bus. & Prof. Code §809.2. Additionally, they may feel pressure to reject the retaliation claim, which can open the door to damages and other forms of liability against the hospital at which they practice. Regardless how the peer review hearing panel rules, ultimately the hospital governing body would make the final decision in the peer review hearing. *See El-Attar*, 157 Cal.Rptr.3d at 543. However, the hospital governing body has an inherent actual conflict of interest in deciding the retaliation matter – it essentially would be voting whether to subject itself to legal liability. The Legislature's intent to afford physicians with the same whistleblower protection as any other hospital employee certainly cannot be realized when the defendant in a retaliation claim gets to make the ultimate decision on that claim.

D. SECTION 1278.5 DOES NOT CONFLICT WITH FEDERAL IMMUNITY FOR PEER REVIEW.

In an eleventh hour argument, the Hospital argues that "[c]onstruing Section 1278.5 to abrogate the exhaustion requirement would put California

at odds with the federal Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 *et seq.* However, the availability of a section 1278.5 claim in no way would affect federal peer review immunity, which can always be raised as an affirmative defense.

HCQIA peer review immunity is a qualified immunity that only applies against claims for damages, not claims for reinstatement or other injunctive or declaratory relief. 42 U.S.C. §11111(a); *see also Austin v. McNamara* (9th Cir. 1992) 979 F.2d 728, 733. Specifically, the qualified immunity arises only if the peer review action was taken (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of (3). 42 U.S.C.A. §11112(a)(1).

Qualified immunity is an affirmative defense, and "the burden of pleading it rests with the defendant." *Gomez v. Toledo* (1980) 446 U.S. 635, 639-641. In a section 1278.5 action challenging a peer review decision, assuming the physician seeks damages, the hospital is not automatically entitled to HCQIA immunity but rather must plead the foundational elements to be entitled to the qualified immunity. That

remains true even if the physician was not required to go through a writ process before bringing the section 1278.5 action.

The Hospital's claim that there is some "constitutional doubt" about section 1278.5 in relation to HCQIA is specious. The somewhat confusing argument seems to suggest that the rebuttable presumption of section 1278.5, subdivision (d)(1), conflicts with the qualified immunity of HCQIA. However, as the Hospital has already pointed out, the presumption of section 1278.5 does not affect the burden of proof but only affects the burden of producing evidence as provided in Evidence Code section 603. *See* Opening Brief at 45. Application of the rebuttable presumption (which only arises if adverse action is taken against a physician within 120 days of the physician's complaint or grievance) would in no way deprive a hospital of the qualified immunity of HCQIA. There is no "constitutional doubt" over section 1278.5, and the Hospital has not cited any cases or authority to suggest so.

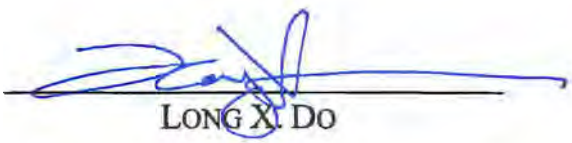
V. CONCLUSION

For the foregoing reasons, *Amici* CMA and the AMA respectfully request that the Court affirm the judgment of the court of appeal in favor of Dr. Fahlen.

DATED: July 15, 2013.

Respectfully,

CENTER FOR LEGAL AFFAIRS
CALIFORNIA MEDICAL ASS'N

By: 
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CERTIFICATION OF WORD COUNT

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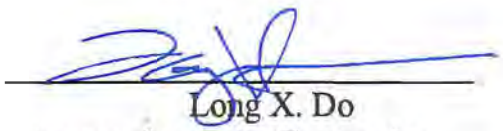

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PROOF OF SERVICE

Fahlen v. Sutter Central Valley Hospitals, et al., no. S205568

I, Lisa Matsubara, hereby declare:

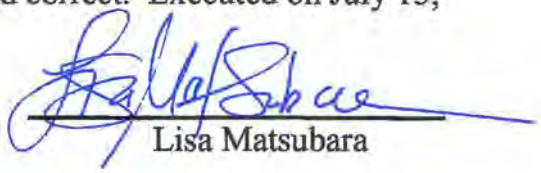
I am employed in Sacramento, California. I am over the age of eighteen years and am not a party to the above-entitled action. My business address is 1201 J Street, Suite 200, Sacramento, California 95814.

On July 15, 2013, I caused the document(s) to be served as indicated below:

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF; *AMICUS CURIAE* BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFF AND RESPONDENT MARK T. FAHLEN, M.D.

U.S. Mail: By mailing a true copy thereof via first-class postage through the United States Postal Service, as set forth in the attached Service List.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on July 15, 2013, at Sacramento, California.



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