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Stop Gagging Physicians!

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NOTES

STOP GAGGING PHYSICIANS!

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INTRODUCTION

NINE-YEAR-OLD CARLEY CHRISTIE was diagnosed with Wilms Tumor, a rare and malignant kidney cancer.[1] The Christie's Health Maintenance Organization (HMO) did not inform the family that National Cancer Institute Guidelines (NCIG) forbid surgeons without previous Wilms Tumor experi-

1. *See* Edmund Sanders, *HMO Hit with Big Fine for Denying Care*, SAN JOSE MERCURY NEWS, Nov. 18, 1994, at 3B (discussing the first time California fined a health care plan for failing to provide quality care to a member); Harry W. Christie, HMOs-What We Don't Know! 1 (Nov. 1, 1994) (describing one family's battle to get coverage for Wilms Tumor surgery) (unpublished manuscript on file with author).

ence from performing surgery to remove these particular malignant tumors. Rather, their HMO recommended a plan-affiliated general surgeon with no Wilms Tumor experience nor any pediatric experience generally.[2] The Christies were neither informed of their daughter's medical options nor told about the NCIG mandate.[3] As over fifty-five million people in the United States receive their health care from HMOs,[4] Carley Christie could be your neighbor, a passenger in your car-pool, or even a member of your own family.[5]

There has recently been an influx of media attention on the existence of "gag provisions" in contracts between physicians and for-profit HMOs. Under the threat of deselection or perhaps more subtle reprisal, gag provisions prohibit physicians from communicating information to patients about treatment options, payment policies, specialist referral, or other plan policies. For the purposes of this Note, that is the definition of a "gag provision."

Coupled with having their tongues tied regarding essential communications to patients, many physician-HMO contracts are terminable at-will.[6] In other words, an HMO can terminate

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2. *See* Sanders, *supra* note 1, at 3B; Christie, *supra* note 1, at 1.

3. Carley Christie was not advised to seek the medically necessary care that she needed from plan-affiliated physicians because they were "gagged" from disclosing any information that would undermine her confidence in her HMO. Fortunately, she has parents who had the initiative and wherewithal to seek treatment alternatives not covered by her HMO. Carley Christie received the surgery and treatment that was medically necessary from non-plan affiliated surgeons and is presently in recovery. However, due to the enormous amount of trust that patients generally bestow upon the advice of their physicians, many patients in the Christie's position, would not have sought care outside their HMO. Thus, the "happy ending" of Carley Christie's story is probably not the norm. The Christie family spent over one year lobbying state regulators to act against TakeCare Inc., their HMO, for neither advising them of the care that was medically necessary for their daughter, nor paying for their daughter's treatment when they went outside the HMO for a Wilms Tumor specialist. The family won an arbitration case requiring TakeCare Inc. to pay all medical costs. Subsequently, the Department of Corporations, (DOC) which regulates California HMOs fined TakeCare Inc., $500,000 for failing to provide quality care to Carley Christie. It is believed to be the first time DOC has fined a health plan for failing to provide quality care. *See* Sanders, *supra* note 1, at 3B; Christie, *supra* note 1, at 3-4.

4. *See* American Medical Association, Background Information About "Gag" Clauses 1 [hereinafter Background Information About "Gag" Clauses] (unpublished information provided by the AMA on file with author). *See also* Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Care Industry*, 47 BAYLOR L. REV. 285, 288 (1995) (discussing the growth of HMO enrollment by 1988 from modest beginnings).

5. One possible explanation for why few cases have been brought to public attention regarding the inadequate quality of care due to gag provisions is because many patient-HMO contracts require the patient to forgo the right to a jury trial in favor of binding arbitration. *See, e.g.*, Sanders, *supra* note 1, at 3B; Christie, *supra* note 1, at 2.

6. An "employee at-will" can be discharged at any time, for any reason, or for no reason

any participating physician on short notice for any reason, and at the same time, not reveal to the physician or his patients the reason for termination. The existence of gag provisions and terminable at-will employment places physicians in an odious position: if they offer services prohibited by gag clauses which they believe should be provided, they run the risk of termination without recourse.

For purposes of this Note, a physician "blows the whistle" on the existence of a gag provision when she either complains to the managed care entity directly or when she discloses to a patient that the HMO cannot provide the patient with the care that he needs. For physicians who are terminable at-will, both forms of disclosure are lethal because either may lead to retaliation by their employer. Therefore, whistle-blowing by either form of disclosure must be protected. Critical analysis will illustrate, however, that present common law and statutory whistle-blower protections are not sufficient.

Despite the abundance of criticism of these gag clauses, there is no in-depth analysis of the legal ramifications of gag provisions on the doctor-patient relationship or the effect of these gag clauses when coupled with employment that is terminable at-will. Furthermore, there are few proposals which will adequately address this problem. This Note will focus on these concerns.

Part I provides the foundation of my analysis by explaining the managed care backdrop in which gag provisions have arisen. This atmosphere makes it increasingly difficult for physicians to practice medicine independently from managed care entities. Next, this Part discusses, from the perspectives of both physicians and HMOs, what exactly gag provisions are, who they affect, and what they encompass.

Part II investigates the two primary ways that the enforcement of gag provisions breaches physicians' fiduciary duty to patients. First, gag provisions cause an unlawful conflict of interest for physicians. Second, gag clauses prevent physicians

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at all. *See, e.g.*, Payne v. Western & Atlantic R.R., 81 Tenn. 507, 519-20 (1884) (Tenn. 1915). Accordingly, if an at-will employment relationship exists, employment can be terminated "for good cause, for no cause or even for cause morally wrong, without being thereby guilty of legal wrong." *Id.*

from adequately obtaining informed consent from their patients. This analysis results in the conclusion that gag provisions are unlawful; however, as a pragmatic matter, legal analysis cannot stop there.

Part III examines potential common law and statutory protections for physicians who refuse to abide by gag provisions and are subsequently subject to reprisals. First, I examine the common law employment-at-will doctrine and its public policy exception which should provide physicians with some legal recourse should their termination result from their refusal to abide by gag clause restraints. Next, I examine state statute whistle-blower provisions which arguably may also afford physicians relief if they are discharged due to their refusal to obey gag provisions. Lastly, I critically examine legislation that is either pending or has recently been passed, which purports to deal with the existence of gag provisions. Finally, Part III concludes that neither statutory nor common law remedies afford physicians the protection that they need to adequately provide necessary care without jeopardizing their employment status.

Finally, in Part IV, I propose several recommendations which I strongly encourage legislatures to implement in upcoming bills. Without including these protections in state legislation, physicians will not receive the protection that they need to provide the medical and ethical care that they deem necessary.

I. GAG PROVISIONS: BACKGROUND

A. The Managed Care Backdrop: Physicians' Increased Dependence on HMOs for Patient Enrollment

The U.S. health care system has been moving steadily away from delivery of health care through independent, fee-for-service[7] practitioners and towards more integrated ap-

7. The fee-for-service method of payment "refers to the typical relationship between a physician and a patient in which the patient pays a separate fee for each service rendered by the independent physician." Michael Kanute, Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841, 841 n.1 (1989) *citing* Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1376-77

proaches. Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care where a primary emphasis is on controlling costs to patients and third-party payers.[8] For more than fifty-five million people in the United States, health care is provided by HMOs.[9] HMOs offer basic and supplemental health care in exchange for a periodic, prepaid, per-capita premium.[10] HMOs reimburse health care providers through a negotiated, capitated payment made on behalf of each person or family unit enrolled in the plan.[11] In addition, HMOs shift the risk, particularly the cost of office facilities and medical malpractice liability, onto doctors.[12]

Although it is recognized that no system of reimbursement is devoid of financial self-interest,[13] the movement from fee-for-service payment for care to capitated coverage has been problematic.[14] Just as fee-for-service gave physicians the incentive to over-prescribe treatment, under new fee arrangements, physicians can profit if they cut back services to patients.[15] In addition, most HMOs have financial incentives and bonuses available for physicians if they limit the treatments that they provide and recommend.[16] Though encouraging phy-

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(1975).

8. *See generally* John K. Inglehart, *Physicians and the Growth of Managed Care*, 331 HEALTH POL'Y REP. 1167, 1167 (1994) (defining the concept of managed care and its primary goals).

9. *See* Background Information About "Gag" Clauses, *supra* note 4, at 1; *News: Doctors Agree on Discussing HMO Coverage With Patients*, (CNN television broadcast, Dec. 28, 1995) (available on Westlaw).

10. *See* Bearden & Maedgen, *supra* note 4, at 289. There are several basic structures of HMOs. Typically, HMOs organize their physician relationships in one of three ways: staff, group, or independent practice associations. For further discussion, refer to *id.* at 292-94.

11. *See id.* at 289.

12. *See* Steffie Woolhandler & David U. Himmelstein, *Extreme Risk-The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706, 1706 (1995).

13. *See* Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?* 273 JAMA 338, 338 (1995) (discussing the growth of managed care entities and ramifications on health care).

14. *See id.*

15. *See id.* at 339. *See also* Woolhandler & Himmelstein, *supra* note 12, at 1706. *But see Nightline* (ABC television broadcast, Dec. 26, 1995) (transcript available on Westlaw) (transcribing the comments of Dr. Sam Ho regarding the differences between fee-for-service and HMO incentives and the consequences of those incentives on quality control). "The November 8th issue of the Journal of the American Medical Association compared fee-for-service patients and HMO patients with diabetes and hypertension and found no significant changes, no significant difference in their health outcomes, so basically, what we're saying is that HMOs and fee-for-service medicine both practice the same level of care." *Id.*

16. *See* Paul Gray, *Gagging the Doctors*, TIME, Jan. 8, 1996, at 50 (illustrating HMO

sicians to be more cost-effective by using bonuses, fee withholds, and other financial incentives to withhold care is not inherently unethical, it certainly can be depending on the design and intensity of the incentive.[17] Finally, many physicians practice medicine under the threat of deselection from their managed care entity if they do not make enough money for that entity.[18] This may occur despite a physician's stellar success rate, impeccable quality of care, unquestionable competence, and complete patient satisfaction.[19]

Why have so many physicians joined managed care entities if their treatment options are increasingly based on economics rather than on their own medical judgment? Have all medical doctors turned into Mr. Hydes? Have physicians abandoned their sense of humanity, professionalism, and ethical responsibilities? The reality of today's delivery of health care has forced physicians to join managed care entities or lose substantial numbers of patients.[20] Just as patients are forced into managed care by their employers and insurers, likewise, physicians are pressured to sign up with HMOs or surrender patients.[21]

It takes little imagination to conceptualize the effect that this shift to economic values has had on the what one traditionally views as foundations in the practice of medicine: "doctors putting patients' interests first above all others, including the physicians' pecuniary interests; doctors being true to medi-

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financial incentives to physicians for limiting hospital stays). For example, in David Himmelstein's U.S. Healthcare contract he was promised bonuses based on a formula for keeping his patients out of hospitals. However, if the total number of days patients spent hospitalized exceeded a fixed number, he would receive no money at all. *Id.* *See also* Council on Ethical & Judicial Affairs, AMA, *Ethical Issues in Managed Care*, 273 JAMA 330, 330-31 (1995) [hereinafter AMA Ethics] (describing financial incentives used to encourage physician to make cost-conscious treatment decisions).

17. *See* AMA Ethics, *supra* note 16, at 333.

18. This process is commonly referred to as economic credentialing. Economic credentialing "has nothing to do with professional quality and competence," but rather is solely based on economic criteria. Howard L. Lang, *Curb Economic Credentialing*, MOD. HEALTHCARE, Apr. 29, 1991, at 28. Economic credentialing should be distinguished from the peer review credentialing process which evaluates physicians based on quality and competence factors in order to promote high care quality. *See* Brad Dallet, *Economic Credentialing: Your Money or Your Life!* 4 HEALTH MATRIX 325, 338-39 (1994).

19. *See* Dallet, *supra* note 18, at 325-26.

20. *See* Gray, *supra* note 16, at 50.

21. *Cf.* Joan Beck, *The Scary New World of Health Care*, CHI. TRIB., Dec. 21, 1995, at 3 (discussing the economic power of HMOs over those who provide care).

cal-ethical values before economic values; . . . and doctors putting love of the profession and its knowledge above concern for self."[22] The existence of gag provisions in provider contracts epitomizes this shift to economic values and completely strangles a physician's ability to place quality of care before cost containment.

B. What are Gag Provisions and Whom Do They Affect?[23]

Gag provisions are located in physicians' contracts[24] and prevent physicians, either explicitly or implicitly, from giving patients information about treatment options that are not covered by their health plans, even if the treatment options are necessary, safe, and effective.[25] Gag clauses may also prevent physicians from disclosing to patients the form of payment system they are on, which as discussed previously, can affect the amount and possibly the quality of care provided by the physician.[26] Finally, gag provisions may prevent physicians from referring sick patients to specialists outside the patients' health plans, even if those specialists have rare expertise in the

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22. Eric J. Cassell, *The Legal Implications of Health Care Cost Containment: A Symposium:* Commentary, 36 CASE W. RES. L. REV. 771, 776 (1986). "When money is the major value of medical practice, the dominant force is greed." *Id.* at 771.

23. It is interesting to note, that to date, only one lawsuit has been filed which specifically criticizes the unlawful existence of gag provisions in physicians contracts. *See In re* League of Physicians & Surgeons, Inc. v. Debuono, (N.Y. Sup. Ct. filed Sept. 21, 1995) (unpublished petition on file with author).

24. This Note will only discuss gag provisions that are located in physician-HMO contracts. However, the AMA states that in addition to the gag provisions located in provider contracts, some patient-HMO contracts may contain gag clauses as well. These "patient gag clauses" prohibit patients from criticizing HMO practices and policies and prohibit patients from seeking care outside the plan. For example, HIP of New Jersey refused to authorize surgery for a fourteen-year-old boy with a brain tumor. His parents sought opinions from five outside pediatric neurosurgeons, and all of them agreed surgery should take place immediately. When the parents sued HIP for coverage, HIP invoked a gag provision in the contract. HIP stated that they would not pay the claim because the parents violated their contract by receiving counsel from physicians not affiliated with the Plan. HIP finally paid pursuant to a settlement agreement. *See* Background Information about "Gag" Clauses, *supra* note 4, at 1; Diane Curcio, *Boy Gains Brain Surgery*, STAR LEDGER, Mar. 16, 1990, at 12.

25. *See* News Release from American Medical Association, AMA Calls Managed Care Providers to Cancel Gag Clauses and Submit Contracts for Ethical Review (Jan. 23, 1996) [hereinafter AMA Calls to Cancel Gag Clauses] (discussing the harmful effects of gag clauses on patient care) (on file with author).

26. *See H.M.O. Gag Rules*, N.Y. TIMES, Jan. 6, 1996, at 18 (declaring that if health maintenance organizations impose "gag" rules on doctors unfavorable results for patients may result).

type of care needed.[27] Not all HMO-physician contracts contain gag provisions; however, the American Medical Association (AMA) estimates that gag clauses affect tens of millions of Americans.[28]

1. From Physicians' and Patients' Perspectives

Physicians argue that gag provisions restrict their ability to advocate on behalf of their patients.[29] It is certainly true that gag provisions are extremely broad in what they prohibit physicians from disclosing. For example, the following gag clause is quoted from an actual physician-HMO contract:

> Physicians shall take *no action* nor make *any* communication *which undermines* or could undermine the *confidence of Enrollees*, potential Enrollees, their employers, Plan Sponsors, or the public in this organization or in the quality of care which this organization's Enrollees receive.[30]

This clause forbids physicians from telling patients anything that might undermine patients' trust in their HMO.[31] For example, physicians with this clause in their contract could not advise patients that the HMO is not staffed with a physician who has the expertise to most properly treat their medical condition.[32] Further, by forbidding physicians from making *any* communication that *might* undermine patients' confidence, physicians are precluded from recommending services not

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27. *See generally* AMA Calls to Cancel Gag Clauses, *supra* note 25.

28. Background Information About "Gag" Clauses, *supra* note 4, at 1. The AMA states that U.S. Healthcare, ChoiceCare, HIP of New Jersey, Aetna, and Cigna, which are some of the largest health insurance companies in the country, have gag-type policies and protocols. *Id.* Gag rules also appear in physician contracts written by Foundation Health Corp., FHP/TakeCare, Health Net, and CaliforniaCare according to *The HMO Gag Rule*, SACRAMENTO BEE FINAL, Apr. 20, 1995, at B8 (decrying the existence of gag provision's and the detrimental impact gag provisions have on physicians' abilities to make honest recommendations about professional services). *See also* Rachel Kreier, *N.Y. Suit Fights Increasingly Common HMO "Gag Rules,"* AM. MED. NEWS, Dec. 11, 1995, at 5 (discussing the frequent use of confidentiality clauses in HMO contracts); Tim Bonfield, *ChoiceCare to Docs: Hush!* CINCINNATI ENQUIRER, Dec. 8, 1992, at A1 (focusing on the controversy involving the gag clause in ChoiceCare's, Cincinnati's largest HMO, contracts with physicians); Tim Bonfield, *Physicians Have Criticized Latest Contract with ChoiceCare*, CINCINNATI ENQUIRER, Dec. 13, 1992, at F1 (citing that 85% of the doctors practicing in the Cincinnati area signed the ChoiceCare's 1993 contract thereby agreeing to abide by a gag rule).

29. *See* Kreier, *supra* note 28, at 5.

30. Background Information About "Gag" Clauses, *supra* note 4, at 2 (emphasis added).

31. *See id.*

32. *See id.*

offered by the HMO even if such services would be safer, more effective, or less costly.[33]

Another actual gag provision states:

> During the term of the Agreement and each renewal thereof, physicians shall discuss any concerns relating to compensation and other matters hereunder *exclusively with IPA* and not with Enrollees. Physicians shall not, directly or indirectly, counsel or *advise any Enrollee to disenroll* from any Contracting Payor program or product or to access such program or product through any person or entity other than the IPA.[34]

This clause forbids physicians from disclosing what form of payment system they are on (i.e., fee-for-service or capitation which as discussed previously may affect both quantity and quality of care). Further, this gag clause prevents physicians from advising patients which plan might best suit their particular medical needs. Finally, this clause forbids physicians from telling a patient that his present plan will not adequately provide for his medical needs.

A third actual gag clause states:

> In no event shall Physician market or offer to Enrollees services *beyond those which are medically necessary* or which are prescribed by the referring participating physician.[35]

This gag provision prohibits physicians from telling patients about expensive treatments and referring patients to the best specialists or facilities for treatment if such centers of excellence do not participate in the plan.[36]

Finally, a fourth gag provision states:

> Provider expressly *waives* Provider's rights to contact [Plan] Members in any way *about the termination of this Agreement*, including those Members who are patients of the Provider, and expressly agrees *not to communicate* in any form or manner with such Members concerning the termination; *the options such Members may have* to join other health care service plans . . . or to switch to other providers as a result of the termination; or the fact that the provider will no longer be the Member's health care provider.[37]

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33. *See id.*
34. *Id.* (emphasis added).
35. *Id.* at 3 (emphasis added).
36. *See id.*
37. AMA, *Examples of Contract Clauses that Prohibit Physician-Patient Communications*

This gag provision prohibits physicians from discussing with a patient other plans that might provide more complete coverage for the patient's illness. Further, if a patient tells a physician during his open-enrollment period that he wants to continue to receive care from the physician and would change HMOs to remain under the physician's care, the physician cannot disclose to the patient whether or not her (meaning the physician's contract) has been renewed. This clause robs patients of the opportunity to switch plans if they wish to remain with a particular physician, yet enables HMOs to change their enrollees' physicians without notice. Quite clearly, from both patients' and physicians' perspectives, gag clauses create medical and ethical problems.

2. From the HMO's Perspective

Representatives of HMOs describe the clauses in physicians' contracts not as "gag" provisions which unlawfully restrict physicians from disclosing information to their patients, but rather as "confidentiality clauses" which protect proprietary information from competitors.[38] HMO representatives also argue that the restrictions are intended to protect trade secrets from competing HMOs.[39] Defenders of the clauses further maintain that "almost all, if not all, managed care firms have confidentiality clauses."[40]

Moreover, HMO representatives assert that these clauses are essential to help health plans build "a physician network of cooperative team players."[41] For example, they declare that confidentiality clauses urge physicians to take any criticisms

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(1996) (on file with author) (emphasis added).

38. *See* Kreier, *supra* note 28, at 5.

39. *See* Robert Pear, *Doctors Say H.M.O.'s Limit What They Can Tell Patients*, N.Y. TIMES, Dec. 21, 1995, at A1. "The trick is to expose the incentives that payment schemes provide doctors without revealing precise dollar amounts. If disclosure goes too far, and precise contracts are made public, then plans will lose the power to bargain for discounted fees with individual physicians." *H.M.O. Gag Rules*, *supra* note 26, at 18.

40. Kreier, *supra* note 28, at 5. "It's something the attorneys put in, no matter if it's health care or a maker of widgets." *Id.* (Both these statements were made by John Kaegi, a spokesperson for ChoiceCare of Long Island, a 163,000-member HMO). It seems ironic that one of the HMOs major arguments for the existence of these clauses is as weak as stating everyone does it, so therefore, it must be fine.

41. *Id.*

that they have about their HMO through proper administrative channels. In other words, advocates believe that these clauses encourage physicians to take their complaints to management rather than to their patients.[42] Thus, advocates insist that these clauses prevent patients from being placed in the middle of economic disputes between doctors and managed care organizations. Furthermore, advocates stress that confidentiality clauses do not prevent physicians from filing complaints with regulatory agencies if the HMO's administration is not receptive.[43] In short, HMO representatives assert that these clauses merely provide a structured and insulated framework for grievances.

Supporters further state that few doctors are so dissatisfied with confidentiality clauses that they refuse to sign their contracts.[44] In addition, supporters assert that "doctors are misrepresenting what the state of the world is" and that "[doctors] have to decide whether [they want] to put their wallets ahead of their patients."[45] Finally, advocates maintain that, "[p]hysicians are not used to being a part of a broader organization" and "[t]hat's one of the challenges the medical community is going to have to face."[46]

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42. *See id.* Cincinnati ChoiceCare President Daniel Gregorie, M.D., analogizes confidentiality clauses in physician contracts to contracts between non-medical companies and their employees: "Proctor and Gamble or G.E. would not look too kindly on someone who was a consultant for the company or working for the company if they publicly badmouthed the company." *Id.*

I disagree, as will be discussed *infra* due to the sensitivity of the fiduciary relationship between a physician and a patient. *See also* Maurice Bernstein, M.D., e-mail letter (Feb. 3, 1996) <http://www-hsc.usc.edu/~mbernste>, (printed copy on file with author). Physicians have the responsibility, "without 'gag' rules, to avoid telling the patient unsubstantiated information about their plan as facts or exaggerate the real facts with inflammatory rhetoric. We should be as straightforeword [sic] and accurate in talking with patients about their medical plans as we would want to be in discussing their medical illness." *Id.*

43. *See ChoiceCare to Docs: Hush!*, *supra* note 28, at A1.

44. *See id.* Again, this statement is extremely weak as it does not take into consideration the realities of the health care market discussed *supra*, where physicians are increasingly dependent on managed care organizations for the majority of their patients. *See* Gray, *supra* note 16, at 50. Dr. David Himmelstein states that he found a gag provision in his U.S. Healthcare contract "so obnoxious I crossed it out." *Id. See also Physicians Have Criticized Latest Contract With ChoiceCare*, *supra* note 28, at F1. "Others noticed [the gag clause], but signed the contract anyway because they felt they could not afford to lose their ChoiceCare patients." *Id.*

45. Alison Bass, *Therapists Say Insurer Gag Order Hurts Patients: Health Professionals Tell of a Blacklist*, BOSTON GLOBE, Dec. 20, 1995, at Metro 1. This statement seems to undermine the very argument HMOs are purporting to make: this advocate is acknowledging the conflict of interest that physicians face when they have to decide whether their own financial interests should prevail over quality of care to patients.

46. *ChoiceCare to Docs: Hush!*, *supra* note 28, at A1.

The immense outrage caused by the publicizing of gag clauses suggests that advocates of "confidentiality clauses" may be fighting a losing battle.[47] Physicians should not have to compromise their medical practices to participate in a managed care system, but rather, managed care entities will have to refocus their perception of delivering care in a cost-effective system.

II. GAG PROVISIONS: VIOLATIONS OF THE PHYSICIAN-PATIENT FIDUCIARY RELATIONSHIP

The practice of medicine is described as a moral-technical profession.[48] While medicine is strongly rooted in science and technology, the moral basis of medicine arises from the following characteristics: first, medicine is directed at the welfare of patients;[49] second, its primary tenets are to "do good and avoid harm;"[50] third, medical care rests on the relationship between doctor and patient.[51] These characteristics encompass the contractual and fiduciary foundations of the doctor-patient relationship. The enforcement of gag provisions undermines these firmly rooted foundations of ethics and law.

A. Background: The Doctor-Patient Relationship

1. Foundations in Contract Law

A physician's duty to a patient arises from the mutual assent of both parties.[52] A physician, therefore, has no duty to aid a person in peril, unless the physician has a previously established relationship with that individual.[53] The doctor-pa-

47. *See, e.g.*, Robert Kazel & Michael Schachner, *HMOs Under Attack for 'Gag' Clauses: Plans Contend the Problem is Overblown*, BUS. INS., Feb. 12, 1996, at 1. "Now HMOs are coming under fire from state legislatures and local and national doctors' organizations, which maintain that any attempt by an HMO to map out what a doctor can say to patients represents a threat to health care quality and the privileged doctor/patient relationship." *Id.*

48. *See* Cassell, *supra* note 22, at 771.

49. *See id.* (defining "welfare" as the conception of "the good and the right").

50. *Id.*

51. *See id.*

52. *See, e.g.*, Lyons v. Grether, 239 S.E.2d 103, 105 (Va. 1977). The doctor-patient relationship "springs from a consensual transaction, a contract, express or implied, general or special . . . ." *Id.*

53. *See, e.g.*, Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901) (finding no duty to

tient relationship constitutes a contract, whether express or implied, and the rights and duties of the parties are governed by contract law.[54] However, due to the essential inequality of the parties with respect to the subject matter of the contract, the physician's duty to a patient extends beyond that which parties in commercial contracts owe each other.[55] Common law rejects a purely contractual description of the physician-patient relationship. Therefore, to further protect the patient, non-negotiable tort and fiduciary duties are imposed on the physician.[56]

2. Foundations in Tort Law

Once established, the relationship between a physician and a patient is governed by the ethics of the medical profession[57] and by the rules of statutory and common law. The duty of care a physician owes a patient is governed by tort principles. A physician risks medical malpractice liability if she fails to provide the care to a patient that a reasonable physician under the same circumstances would provide, even if the physician is prevented from providing reasonable care by limited resources.[58] Moreover, once the physician-patient relationship is es-

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provide care even if refusing to do so will cause death).

54. *See* Halle Fine Terrion, Note, *Informed Choice: Physicians' Duty to Disclose Nonreadily Available Alternatives*, 43 CASE W. RES. L. REV. 491, 509 (1993) (examining duty of physicians to disclose nonreadily available alternatives to patients under fiduciary and informed consent doctrines).

55. *See* Terrion, *supra* note 54, at 509; Austin W. Scott, *The Fiduciary Principle*, 37 CAL. L. REV. 539, 541 (1949) (discussing the principles behind fiduciary relationships).

56. *See* Scott, *supra* note 55, at 540.

57. *See* Ralph Crawshaw et al., *Patient-Physician Covenant*, 273 JAMA 1553, 1553 (1995). "Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obligated to act as advocates for the sick . . . ." *Id. See also* Ludwig Edelstein, *The Hippocratic Oath, Text, Translation, and Interpretation*, 1 BULL. HIST. MED. 1, 3 (1943); AMA Ethics, *supra* note 16, at 333 (reiterating the physician's commitment to patient welfare first).

58. *See* Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 352 (1993) (discussing the extent to which physicians are required to furnish access to health care regardless of resource constraints); Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1302 (1994) [hereinafter *Medical Malpractice Law*]. *See also* Wickline v. California, 228 Cal. Rptr. 661, 671 (Ct. App. 1986) (stating that a physician who complies without protest to limitations imposed by a third-party payor cannot avoid ultimate responsibility for patient's care if the care provided is unreasonable); Wilson v. Blue Cross, 222 Cal. App. 3d 660, 663-666 (Ct. App. 1990) (affirming the *Wickline*

tablished, the skill and care required of a physician cannot be proportional to his expectation of pecuniary recompense.[59] Efforts in managed care to contain health care costs by forcing physicians to take into account economic concerns undercuts the notion that physicians have sole authority to define appropriate health care outcomes for society and, therefore, should be ultimately liable.[60] Thus, case law is emerging that extends liability to the managed care entity which governs physicians' actions. These cases have been brought under theories of vicarious liability,[61] direct corporate liability for negligent selection[62] and utilization management,[63] breach of warranty,[64] misrepresentation,[65] and bad faith.[66]

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holding in a situation where patient committed suicide after an early discharge from hospital).

59. Becker v. Janinski, 15 N.Y.S.2d 675, 677 (1891). "Whether a patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care." *Id.* *See also* RESTATEMENT (SECOND) OF TORTS § 324 Cmt. (d) (1965) (stating that fiduciary may have to risk a loss of compensation to fulfill his duty to his patient); Mehlman, *supra* note 58, at 371 (stating that if a patient can show that the care was denied solely to increase the physician's income, the physician will be liable for breach of his fiduciary duty to the patient). *But see* Madsen v. Park Nicollet Med. Ctr., 419 N.W.2d 511, 515 (Minn. Ct. App. 1988) (stating it was proper to exclude that profit motivation may have caused an HMO physician to fail to hospitalize a patient with pregnancy complications, observing that, "this evidence was only marginally relevant [to malpractice] and potentially very prejudicial."), *rev'd en banc* 431 N.W.2d 855 (Minn. 1988).

60. *See Medical Malpractice Law*, *supra* note 58, at 1302.

61. *See, e.g.*, Dunn v. Praiss, 606 A.2d 862, 868-69 (N.J. Super. Ct. App. Div. 1992) (stating that an HMO can be held liable under the doctrine of respondeat superior), *cert. denied*, 611 A.2d 657 (N.J. 1992); Schleier v. Kaiser Found. Health Plan, 876 F.2d 174, 178 (D.C. Cir. 1989) (holding an HMO vicariously liable for the negligence of a physician who was brought in as an outside consultant by the HMO's physician, even though the consulting physician was not an HMO participant); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (reversing summary judgment for an HMO to allow consideration of the theory of ostensible agency which would allow the HMO to be held vicariously liable for physician's actions); Sloan v. Metro. Health, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987) (holding a staff model HMO in Indiana liable under the doctrine of respondeat superior for the negligent acts of a participating physician). *But see, e.g.*, Raglin v. HMO, 595 N.E.2d 153, 156 (Ill. App. Ct. 1992) (holding that the physicians who worked for the medical group that contracted with the HMO were independent contractors and therefore, the doctrine of respondeat superior did not apply).

62. *See, e.g.*, McClellan v. H.M.O., 604 A.2d 1053, 1058 (Pa. Super. Ct. 1992) (determining that the theory of corporate negligence could be extended to determine whether such HMOs have a non-delegable duty to select and retain only competent primary care physicians).

63. *See, e.g.*, *Wickline*, 228 Cal. Rptr. at 670 (recognizing that in certain instances the third-party payor can be held liable in the utilization review process where there is a wrongful withholding of payment); *Wilson*, 271 Cal. Rptr. at 883 (explaining that the test for joint tort liability applied).

64. *See, e.g.*, Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392, 393 (Cal. Ct. App. 1979) (holding that a breach of warranty claim was unsuccessful in the instant case because the HMO did not clearly and unequivocally warrant that a course of treatment recommended would produce a certain result).

65. *See, e.g.*, *McClellan*, 604 A.2d at 1060-61 (stating that an HMO may be liable for false

3. Foundations in Fiduciary Law

As well as encompassing contract and tort law principles, the physician-patient relationship also has foundations in fiduciary law. Most courts recognize the fiduciary nature of the physician-patient relationship.[67] A fiduciary is defined as "[a] person having a duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking."[68] Fiduciary duties are implied in the doctor-patient relationship due to the high degree of trust and loyalty mandated by the relationship.[69] Furthermore, this element is implied because a physician traditionally possesses superior knowledge of medical diagnoses and services.[70] Finally, once

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representation because it knew the public would rely on advertising to its detriment).

66. *See, e.g.*, Williams v. HealthAmerica, 535 N.E.2d 717, 720 (Ohio Ct. App. 1987) (analogizing a bad faith action against an HMO with bad faith claims against insurers).

67. *See, e.g.*, Petrillo v. Syntex Lab., Inc., 499 N.E.2d 952, 961 (Ill. App. Ct. 1986) (stating that society has an established and beneficial interest in the fiduciary quality of the patient-physician relationship); Mull v. String, 448 So. 2d 952, 953 (Ala. 1984) (recognizing the concept of physician's fiduciary duty); Salis v. United States, 522 F. Supp. 989, 997 n.10 (M.D. Pa. 1981) (stating that the fiduciary relationship is one of trust and confidence); Woolley v. Henderson, 418 A.2d 1123, 1128 n.3 (Me. 1980) (stating that the historical underpinnings of the doctrine of informed consent are frequently attributed to the fiduciary quality of the physician-patient relationship); Demers v. Gerety, 515 P.2d 645, 653-654 (N.M. Ct. App. 1973) (stating that a physician is required to exercise the utmost good faith towards a patient), *rev'd. on other grounds*, 520 P.2d 869 (N.M. 1974); Cobbs v. Grant, 502 P.2d 1, 2 (Cal. 1972) (defining fully informed consent as "raising an obligation in the physician that transcends arms-length transactions"); Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972) (stating that the patient's trust in the physician creates obligations); Hammonds v. Aetna Cas. & Sur. Co., 237 F. Supp. 96, 102, (N.D. Ohio 1965) (stating that it is axiomatic that the physician-patient relationship is a fiduciary one); Nixdorf v. Hicken, 612 P.2d 348, 354 (Utah 1980) (finding of fiduciary qualities in physician-patient relationship).

68. BLACK'S LAW DICTIONARY 625 (6th ed. 1990).

69. *See* David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 148 (1995). "The willingness of patients to turn to physicians for care, to speak openly about intimate and potentially embarrassing information, and to rely on their physicians' recommendations depends in large part on the ability of patients to trust that physicians are acting primarily to advance the interests of their patients." *Id. See also* Anne T. Corrigan, Note, *A Paper Tiger: Lawsuits Against Doctors for Non-Disclosure of Economic Interests in Patients' Cells, Tissues and Organs*, 42 CASE W. RES. L. REV. 565, 572 (1992) (discussing the high degree of trust required in fiduciary relationships).

Some commentators have noted that the trust between patients and physicians has deteriorated. *But see* Orentlicher, *supra* at 148 n.16 citing Leslie McAneny, *Honesty and Ethics Poll: Pharmacists Retain Wide Lead as Most Honorable Profession*, L.A. TIMES SYNDICATE, July 29, 1993, *available in* Gallup Poll News Service (stating that surveys by the Gallup Poll taken over the last fifteen years have consistently found that the public has greater trust in physicians than most other professionals).

70. *See Canterbury*, 464 F.2d at 780 n.14. "Patients ordinarily are persons unlearned in the

patients are disabled by an illness, in addition to lacking medical knowledge, they may be unable to educate themselves about their medical conditions and options.[71] Thus, the duties imposed on physicians by their fiduciary status helps to minimize the extreme differences in their bargaining power with that of patients.

B. Enforcement of Gag Provisions Creates an Unlawful Conflict of Interest for Physicians

Conflicts of interest for fiduciaries are not new to the medical arena.[72] The law acknowledges the likelihood of these conflicts, and therefore, attempts to fashion preventive rules for fiduciaries. Though the existence and enforcement of gag provisions creates a conflict for physicians that the law has not specifically dealt with before, general conflict-of-interest principles, for the most part, can be applied.

Gag provisions force physicians to place their employment status in jeopardy in order to provide necessary services or information to their patients. Furthermore, because most physician-HMO contracts are terminable at-will, physicians are not entitled to any explanation for their discharge. Thus, physicians must either compromise the quality of care they offer to patients or lose their jobs and patients for not doing so. This conflict of interest creates a dilemma in the delivery of health care and one that must be eliminated.

Gag provisions create a conflict of interest that is unlawful; however, it sometimes may be difficult to determine whether a physician is acting out of self-interest or for the good of a particular patient.[73] Though physicians have wide

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medical sciences ... [and] it is only in the unusual case that a court could safely assume that the patient's insights were on a parity with those of the treating physician." *Id.*

71. *See* Orentlicher, *supra* note 69, at 147.

72. *See* discussion *supra* about incentives created by fee-for-service payment systems as compared with capitated systems.

73. *See* Cassell, *supra* note 22, at 772. "One cannot know directly whether or not the patient's interest and fidelity are dominating the medical enterprise at any given moment." *Id.* at 772. *See also* Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 807-09 (1983) [hereinafter *Fiduciary Law*]. "[I]t is difficult or impossible to eliminate the fiduciary's ability to use the power

latitudes about treatment options, the authorization of tests, and the recommendation of procedures, gag provisions accentuate the conflict between patients' needs and the personal financial interests of physicians by mandating that physicians act a certain way. Gag clauses prohibit a physician from recommending treatments that are not offered by the patient's particular HMO. Thus, gag clauses often force physicians to view procedures that they once considered necessary, as elective;[74] compel physicians to delay or completely omit tests and procedures;[75] and finally, mandate that general practitioners assume responsibility for care that should be referred to specialists.[76]

Careful observers of medical practice agree that the quality of medical performance is often "context-dependent."[77] In environments where a physician is rewarded for proper and moral medical behavior, physicians will make the "right" medical decisions even when that conflicts with their personal needs.[78] Likewise, in an atmosphere where high medical standards either are not rewarded, or are actively discouraged, physicians are more inclined to make "incorrect" medical decisions.[79] The enforcement of gag provisions has created an environment which fosters the financial interest of HMOs' at the expense of patient care. Thus, if gag clauses or protocols are permitted to continue, either explicitly in physician contracts or

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for another purpose to the detriment of the entrustor." *Id.* at 809.

74. *See, e.g.*, Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44, 47. David Robinson, a primary-care physician, states that "[h]e would request what he believed were necessary tests and referrals, only to have them countermanded by utilization review managers. He recalls requesting a CAT scan for a boy who had experienced seizures and occasional losses of consciousness, possible warnings of a brain tumor, only to have his request denied." Robinson grew so dissatisfied that he left the practice resolving only to see fee-for-service patients. *Id.*

75. Dr. Jones, of Colorado, is convinced that "women who once would have come to him for a transplant aren't coming because their doctors, operating under tight managed-care cost guidelines, aren't telling them that transplants are a medical option." *Id.* at 48.

76. *See, e.g.*, Carley Christie story discussed *supra* at notes 1-3 and accompanying text. For a general discussion of incentives for physicians to limit care refer to Alan A. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 86 (1989). Keep in mind, however, that incentives are very different from gag provisions which are absolute mandates.

77. Cassell, *supra* note 22, at 774 n.3 and accompanying text, *citing Quantity, Quality, and Cost of Medical and Hospital Care Secured by a Sample of Teamster Family Members in New York City* (1962) and *A Study of the Quality of Hospital Care Secured by a Sample of Teamster Family Members in New York City* (1964) (both studies published by Columbia University School of Public Health and Administrative Medicine).

78. *Id.*

79. *See id.*

implicitly in practice, they will destroy the delivery of quality medical care by forcing physicians to make "incorrect" medical decisions.[80]

Commentators contend that a conflict of interest between a physician and a patient need not terminate a fiduciary relationship if there is full disclosure of the conflict to the principal.[81] However, this legal premise cannot hold true with gag provisions because the exact substance of gag clauses prevents full disclosure to patients. Thus, as gag provisions not only prevent physicians from disclosing medically necessary information to their patients, but also prevent physicians from disclosing that they are being "gagged," traditional conflict-of-interest principles cannot ensure or protect the relationship.

Finally, protective mechanisms in the fiduciary relationship that should prevent physicians from compromising quality of medical care due to a conflict of interest (with or without the existence of gag provisions) cannot stand up to an HMO's threat of termination without cause.[82] If physicians are not

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80. The Court in *Wickline*, 228 Cal. Rptr. at 672, seemed to foreshadow the existence of gag provisions by stating "it is essential that cost limitation programs not be permitted to corrupt medical judgment."

81. *See* RESTATEMENT (SECOND) OF AGENCY § 390 (1957) (asserting that disclosure is required in a principal-agent relationship to prevent the violation of an agent's duty to the principal); Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 759 (1994). "While undisclosed or extremely corrupting conflicts may be prohibited outright, properly informed insurance subscribers may rationally agree to strategically crafted incentives which better induce doctors to act as both medical treatment and economic purchasing agents for their patients." *Id. But see* Hall, *supra* n. 38, *citing with disapproval* MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 156-62 (1993) (arguing that the protective mechanisms inherent in fiduciary relationship are not present in the physician-patient relationship and, therefore, even full disclosure of a conflict of interest is not enough). *See also* Marc A. Rodwin, *Physicians' Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. 1405, 1407 (1989) (discussing strict prohibitions against conflict of interest that apply to government officials).

82. First, courts prohibit, supervise, or limit self-dealing. Furthermore, if an agent self-deals with the principal's consent, the law imposes a duty on him to act fairly and to disclose to the principal all material information. *See* RESTATEMENT (SECOND) OF AGENCY § 390 (1957). Second, the law prohibits the fiduciary from using his superior power to take advantage of the principal. *See generally* Joseph M. Healey, Jr. & Kara L. Dowling, *Controlling Conflicts of Interest in the Doctor-Patient Relationship: Lessons from Moore v. Regents of the University of California*, 42 MERCER L. REV. 989 (1991). Third, courts may remove a disloyal fiduciary when the structure of the relation is not compatible with his removal by the entrustor. *See generally Fiduciary Law*, *supra* note 73, at 805-06. Finally, because courts impose such a high standard on fiduciaries, it seems likely that punitive damages may be imposed on the fiduciary for breach of the relationship. *Cf. id.* at 830 (stating that courts impose a high standard on fiduciary and even incorporate morality into fiduciary law).

entitled to have their voices heard after termination and an HMO does not have to premise termination on a valid, legal explanation, then nothing from preventing malpractice liability to upholding their Hippocratic Oath will provide physicians with a valid defense to their termination. Part IV, discussed infra, will propose possible solutions to this impasse.

C. Gag Provisions Prevent Physicians from Providing their Patients with Informed Consent

The doctrine of informed consent is based on the perceived right of a patient to exercise control over his own body by deciding whether to submit to a particular treatment,[83] on the fiduciary nature of the doctor-patient relationship,[84] and on the principles of medical ethics.[85] For patients, the doctrine of informed consent is the guardian of individualism:

> [I]t protects the patient's right to determine his own destiny in medical matters; . . . it guards against overreaching on the part of the physician; it protects his physical and psychic integrity and thus his privacy; and it compensates him both for affronts to his dignity and for the untoward consequences of medical care.[86]

The doctrine of informed consent has its origins in the common law battery action which establishes civil liability for

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83. Judge Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ." Schloendlorff v. Soc'y N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

84. *See, e.g.*, Carter v. Hoblit, 755 P.2d 1084, 1086 (Alaska 1988) (stating that "fraud can be established by silence or nondisclosure when a fiduciary relationship exists between the parties . . . . The fiduciary has a duty to fully disclose information which might affect the other person's rights and influence his action"); Miller v. Kennedy, 522 P.2d 852, 862 (Wash. Ct. App. 1974) (finding that the fiduciary duty of the physician requires disclosure), *aff'd* 530 P.2d 334 (Wash. 1975); Emmett v. Eastern Dispensary & Cas. Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967) (stating "in the fiducial qualities of [the doctor-patient] relationship the physician's duty [is] to reveal to the patient that which in his best interests it is important that he should know").

85. It is essential to note that although the AMA is extremely influential in the medical arena, its statements on medical ethics are not legally binding. *See generally In re* AMA, 114 F.T.C. 575 (1991).

86. Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 414-12 (1979).

unauthorized treatment.[87] Over time, the doctrine of informed consent has greatly expanded in scope.[88]

Informed consent[89] requires a physician to explain the proposed procedure to a patient and to warn him of any material risks inherent in the treatment so that the patient can make an intelligent decision to undergo the procedure.[90] The duty requires disclosure of the nature of the medical problem and the proposed treatment,[91] including the proposed treatment's risks and benefits, its probability of success,[92] and alternative methods of treatment.[93] However, a physician does not have a duty to provide informed consent when a "patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment"[94] or when communication of the information would be a threat to the patient's well-being.[95] Finally, the law recognizes the doctrine of informed consent as a vehicle by which patients can determine whether a physician's medical recommendation is clouded by personal motive.[96] Due

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87. *See, e.g.*, Pratt v. Davis, 79 N.E. 562, 563 (Ill. 1906) (holding that liability was based on "trespass to the person"); Mohr v. Williams, 104 N.W. 12, 16 (Minn. 1905) (holding that a physician's unauthorized examination and surgery of patient's ear was a "technical assault and battery").

88. Informed consent cases are primarily viewed as negligence actions rather than intentional torts; therefore, courts require patients to show actual harm rather than just the dignitary harm of non-consented touching. *See Canterbury*, 464 F.2d at 772.

89. The issue of patients' rights to actually comprehend medical information beyond their right of informed consent is outside the scope of this Note. However, it is interesting to note that *Canterbury* dismisses patient comprehension by stating, "the focus . . . is more properly upon the nature and content of the physician's divulgence than the patient's understanding or consent." *Canterbury*, 464 F.2d at 780 n.15. For discussion of this issue refer to Ladonna L. Griffith, Comment, *Informed Consent: Patient's Right to Comprehend*, 27 HOW. L.J. 975, 989 nn.83-89 and accompanying text (1984).

90. *See Canterbury*, 464 F.2d at 773 (defining informed consent).

91. *See, e.g.*, Harwell v. Pittman, 428 So. 2d 1049, 1051 (La. Ct. App. 1983) (stating that patient's consent was invalid because the physician underwent gallbladder surgery without any discussion of test results or the proposed surgery).

92. *See, e.g.*, Nishi v. Hartwell, 473 P.2d 116, 119 (Haw. 1970) (identifying rule requiring physicians to inform patients of risks, benefits, outcomes, and alternatives for treatments).

93. *See, e.g.*, Sard v. Hardy, 379 A.2d 1014, 1020 (Md. 1977) (stating that advising patients of alternative methods of treatment is a component of informed consent).

94. *See, e.g.*, Eis v. Chesnut, 627 P.2d 1244, 1247 (N.M. 1981) (precluding summary judgment where a physician obtained the consent of the patient's daughter, but not the patient, before performing a second leg operation).

95. *See Canterbury*, 464 F.2d at 789 (recognizing that patients occasionally become so ill or emotionally distraught as to prohibit the making of a rational decision).

96. *See, e.g.*, Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 485 n.9 (Cal. 1990) (stating that a physician's duty to disclose a personal interest may depend on the materiality of

to the inherent imbalance in the degree of knowledge and understanding of patients and physicians,[97] it is unlikely that a patient would be able to waive his right to receive informed consent.[98]

The AMA recognizes the importance of the doctrine of informed consent in medical practice and has enumerated several of its components in a report entitled "Ethical Issues in Managed Care."[99] Additionally, the AMA specifically addresses the impact of gag clauses on informed consent and mandates that physicians disclose all treatment alternatives to patients, including those not offered by the patients' managed care plans.[100] Likewise, the AMA mandates that physicians or plan administrators fully disclose to patients any incentives physicians are given to limit care.[101] Moreover, the AMA specif-

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that interest to the physician's recommendation of a particular medical procedure); Magan Med. Clinic v. Cal. Bd. Med. Exam'rs, 57 Cal. Rptr. 256, 262 (Ct. App. 1967) (stating that "a sick patient deserves to be free of any reasonable suspicion that his doctor's judgment is influenced by a profit motive").

97. *See Canterbury*, 464 F.2d at 780 (stating "[t]he average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision").

98. *See* Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 414-15 (1990) (discussing the ramifications of a patient's decision to waive her right to receive information regarding the risks and benefits of proposed treatment). *But see* Meisel, *supra* note 86, at 453-60 (discussing the waiver exception to informed consent). In addition, courts have, virtually without exception, rejected the position that patients and physicians should be permitted to bargain over the terms of their relationship. *See, e.g.*, Tunkel v. Regents Univ. of Cal., 383 P.2d 441, 441 (Cal. 1963) (rejecting an agreement between a patient and a hospital which released hospital from liability).

99. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMA, ETHICAL ISSUES IN MANAGED CARE (1994) (on file with author). Guideline 2(f) states:

> Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives . . . is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all their treatment options, even those that may not be covered under the terms of the managed care plan.

100. *See id.* at 4-5. This statement has support in common law. Physicians are obligated to inform patients about the possibility of obtaining care from another provider when the original physician lacks sufficient skill to render reasonable care. *See, e.g.*, Haley v. United States, 739 F.2d 1502, 1503 (10th Cir. 1984) (holding that a physician is liable for not suggesting referral to gastroenterologist); Moore v. Preventive Med. Inc., 178 Cal. App. 3d 728, 734 (Cal. Ct. App. 1986) (stating that an internist is liable if he fails to disclose information necessary to allow patient to decide whether to go to a specialist).

101. ETHICAL ISSUES IN MANAGED CARE, *supra* note 99, at Guideline 3 states the following:

> When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients . . . . Any

ically addresses the role of physicians employed by managed care entities and states that the requirement of informed consent remains with the physician.[102] Finally, the AMA stresses that the doctrine of informed consent has a dual function: while physicians have a duty to present the medical facts accurately to patients, in turn, patients have the duty to educate themselves so that they can exercise their right to make their own determinations about medical treatment.[103]

Specifically addressing the existence of gag provisions in provider contracts, then-AMA President Lonnie R. Bristow, M.D., declared: "AMA physicians cannot abide by gag clauses."[104] Further, in January 1996, the AMA Council on Ethical and Judicial Affairs released the following statement on gag clauses:

> Patients cannot be subject to making decisions with inadequate information. That would be an *absolute violation* of the *informed consent requirements*. If these [gag] clauses are carried out and the physicians are subject to sanction, a *reduction in the quality of patient care* will result.[105]

This statement summarizes the ramifications of the issue at hand, but does not offer any pragmatic recommendations or solutions.

Furthermore, although the AMA's statement that gag clauses violate informed consent requirements is inherently valid, it does not clearly enumerate how courts should determine whether the duty has been breached. The relevant legal inquiry regarding whether there has been a violation of a patient's right to informed consent is a two-step analysis: first, would the patient have consented to treatment had the physician adequately disclosed the material risks, benefits, and alter-

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incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter.

102. *Id.* at Guideline 2f. Guideline 2(e) states: "Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan." *Id.*

103. *Id.* (stating in Guideline 2(f) that physician's have an obligation to inform patients of all treatment options and patients may decide if they want to seek care outside the plan for treatment not covered).

104. AMA Calls to Cancel Gag Clauses, *supra* note 25.

105. Background Information About "Gag" Clauses, *supra* note 4, at 3 (emphasis added).

natives[106] and second, if the duty has been breached, was nondisclosure the proximate cause of the patient's injury?[107] Thus, whether a particular gag provision in a physician's contract has forced a physician to violate her duty of informed consent must be determined on a case-by-case basis. However, because gag clauses often prevent physicians from disclosing medically necessary treatment options and from disclosing what payment system they are on, it is likely that by not disclosing this information, patients are making decisions that they would not have made had they been fully informed. Gag provisions must, therefore, be eliminated from physician-HMO contracts in order to eliminate the possibility that a physician may be prohibited from fully informing her patients.

III. STATUTORY AND COMMON LAW PROTECTIONS FOR PHYSICIANS WHO REFUSE TO ABIDE BY GAG PROVISIONS AND ARE SUBSEQUENTLY SUBJECT TO REPRISALS

Although gag clauses clearly create an unlawful conflict of interest for physicians as well as prohibit physicians from fulfilling their duty to fully inform patients, when combined with the existence of termination-without-cause provisions, physicians are placed in an odious position. If an HMO has the power to terminate physicians for any reason, what HMO really needs an explicit gag clause? Thus, some HMOs may have gag-like protocols and policies that are inherent in their utilization review systems, but are not explicitly apparent. Therefore, the most important issue that must be addressed is whether physicians have any legal recourse if their employment is at-will and they refuse to abide by gag provisions or gag-like protocols. The remainder of this Note will focus on this concern and will conclude that present protections are not adequate.

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106. *See* Terrion, *supra* note 54, at 500-01. This first step may be resolved by applying one of three different standards for disclosure: the professional standard, the reasonable patient standard, or the subjective standard. For a more in-depth analysis of these three standards refer to *id.* at 502-06. *See also* Griffith, *supra* note 89, at 977-83.

107. *See* Terrion, *supra* note 54, at 500-01.

However, before analyzing existing common law and statutory protections for whistle-blowers, it must be noted that measuring the cost of retaliation discharge is an extremely difficult process. The few physicians who have spoken out against gag clauses and their subsequent discharge due to the presence of these clauses may not adequately represent the broad scope of this problem. In fact:

> [T]he full cost of [the] uneven and half-hearted enforcement of . . . freedom of speech cannot be measured since the content of the lost speech is unknown. This much, however, is clear: this cost should not be estimated by looking only at the personalities and the message of the handful of employees who initiate lawsuits challenging their discipline on free speech grounds.[108]

This statement is particularly relevant when discussing physicians who are gagged in the managed care context. As discussed previously, physicians are increasingly dependent on HMOs for patients. Thus, the threat of deselection may be great enough to prevent physicians from blowing the whistle, especially when the decision not to provide care is in the gray area of a medical opinion rather than a clear-cut case of medical malpractice.[109]

A. Common Law Employment At-Will and its Public Policy Exception

As recently as two decades ago, the law in almost every state, regarding an employee's termination, was the same:[110]

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108. Toni M. Massaro, *Significant Silences: Freedom of Speech in the Public Sector Workplace*, 61 S. CAL. L. REV. 3, 67 (1987). *See also* Cynthia L. Estlund, *Free Speech and Due Process in the Workplace*, 71 IND. L.J. 101, 103 (1995). Estlund states the following:

> Evidence for my contentions would be found not in the cases adjudicating claims of retaliation, but in the silence that surrounds them — the silence of the typical employee who is neither uncommonly brave nor litigious, whose job is crucially important to her and her family, and who is guided in her actions by expectations about the consequences of those actions.

Id.

109. This will be discussed in more detail *infra* footnotes 124-36 and accompanying text.

110. *See* Elletta Sangrey Callahan & John W. Collins, *Employee Attitudes Toward Whistleblowing: Management and Public Policy Implications*, 11 J. BUS. ETHICS 939, 939-40 (1992) (reporting the results from a Syracuse University survey on trends in employee termination). For a discussion of factors that contributed to an increase in wrongful termination litigation in the 1980's refer to Susan R. Mendelsohn, *Wrongful Termination Litigation in the*

unless an employee had an employment contract that stated otherwise, an employee was an employee at-will, and could be discharged at any time, for any reason, or for no reason at all.[111] Today, some states refuse to deviate from the employment at-will doctrine; and therefore, in those states, a discharged whistle-blower has no common law remedy.[112]

However, since the early 1980s the employment at-will doctrine has been tremendously eroded by exception.[113] For example, the public policy exception has greatly expanded the scope of recourse for whistle-blowers. Furthermore, a majority of states have adopted it as a viable exception.[114] In a state

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United States and Its Effect on the Employment Relationship, 3 LAB. MKT. & SOC. POL'Y OCCASIONAL PAPERS 1, 3-4 (1990).

111. *See Payne*, 81 Tenn. at 519-20 (stating that employee can be terminated "... for good cause, for no cause or even for cause morally wrong, without being thereby guilty of legal wrong").

112. The following is a list of cases in alphabetical order by jurisdiction, where courts have refused to recognize a public policy exception to the employment at-will doctrine: *See, e.g.*, Jones v. Ethridge, 497 So. 2d 1107, 1107 (Ala. 1986) (upholding the right of an employer to discharge an employee because the employee refused to commit a crime); Ivy v. Army Times Publ'g Co., 428 A.2d 831 (D.C. 1981) (denying a rehearing *en banc* where employer discharged employee for truthful testimony adverse to employer); Evans v. Bibb Co., 342 S.E.2d 484, 484 (Ga. Ct. App. 1986) (reaffirming that Georgia has refused to adopt a public policy exception in case involving a long-term disability claim); Kelly v. Miss. Valley Gas Co., 397 So.2d 874, 875 (Miss. 1981) (discharging employee for filing workers' compensation claim upheld); Leibowitz v. Bank Leumi Trust Co., 548 N.Y.S.2d 513, 516 (App. Div. 1989) (refusing to recognize a public policy exception for employee who reported illegal activities because the employee did not allege any violations of law that presented substantial and specific danger to public health or safety).

113. The themes justifying the exceptions to the employment at-will doctrine fall into three categories: (1) implied consent, (2) public policy, and (3) duty of good faith and fair dealing. However, the scope of this Note will only encompass the public policy exception. For an in-depth discussion of the other exceptions, refer to Todd M. Smith, Note, *Wrongful Discharge Reexamined: The Crisis Matures, Ohio Responds*, 41 CASE W. RES. L. REV. 1209, 1215 (1991) (focusing on the employment at-will doctrine in Ohio, but this analysis is applicable elsewhere as well).

114. Many states recognize a public policy exception to the employment at-will doctrine and have indicated that the exception should be extended to whistle-blowers. The following is a list of cases, in alphabetical order by jurisdiction, that demonstrate this extension: *See, e.g.*, Vermillion v. AAA Pro Moving & Storage, 704 P.2d 1360, 1361 (Ariz. Ct. App. 1985) (recognizing a claim for an employee allegedly dismissed for refusing to participate in theft); Sterling Drug, Inc. v. Oxford, 743 S.W.2d 380, 381-82 (Ark. 1988) (recognizing a public policy exception for employee who blew the whistle on employer who was overcharging the government); Tameny v. Atl. Richfield Co., 610 P.2d 1330, 1330 (Cal. 1980) (recognizing a public policy claim for an employee who refused to engage in antitrust violations); Cronk v. Intermountain Rural Elec. Ass'n., 765 P.2d 619, 622 (Colo. Ct. App. 1988) (recognizing a claim for a public utility employee who refused to testify untruthfully before regulatory commission); Sheets v. Teddy's Frosted Foods, Inc., 427 A.2d 385, 388-89 (Conn. 1980) (recognizing a claim for an employee who complained about food packaging violations); Parnar v. Americana Hotels, Inc., 652 P.2d 625, 626 (Haw. 1982) (recognizing a claim for an employee who was discharged because of his participation in an antitrust investigation); Palmateer v. Int'l Harvester Co., 421 N.E.2d 876, 879

where the public policy exception has been adopted, an employee cannot be terminated for exposing an employer's wrongdoing if it is a violation of public policy. Nevertheless, because the public policy exception is often narrowly defined, it does not seem to adequately protect employees from discharge. Therefore, it is equally unlikely that physicians who attempt to justify their whistle-blowing on public policy grounds will be successful.

1. Background

It is difficult to precisely define what the public policy exception encompasses because it varies tremendously from state to state.[115] Some states base the exception on what the state's legislature enumerates as public policy,[116] while others base the definition on the state's constitution,[117] administrative regulations,[118] and in certain circumstances, professional codes of ethics.[119] Furthermore, some states adopt a broad meaning to the exception,[120] whereas others hold that the protection is very narrow.[121] However, it is apparent that courts have little difficulty defining the elusive term "public policy" to encompass the reporting of criminal law violations and, by extension, specifically enumerated civil law violations.[122] In

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(Ill. 1981) (recognizing a claim for discharge due to aiding in the criminal investigation of a coworker); Frampton v. Cent. Ind. Gas Co., 297 N.E.2d 425, 428 (Ind. 1973) (recognizing a claim for an employee who was discharged for filing a workers' compensation claim).

115. *See* BLACK'S LAW DICTIONARY 1231 (6th ed. 1990) (defining public policy as "[c]ommunity common sense and common conscience, extended and applied throughout the state to matter of public morals, health, safety, welfare, and the like... having due regard to all circumstances of each particular relation and situation").

116. *See, e.g., Frampton*, 297 N.E.2d at 425.

117. *See, e.g.*, Novosel v. Nationwide Ins. Co., 721 F.2d 894, 898-9 (3rd Cir. 1983).

118. *See, e.g.*, Nye v. Dept. of Livestock, 639 P.2d 498, 500 (Mont. 1982).

119. *See generally* Pierce v. Ortho Pharm. Corp., 417 A.2d 505, 512 (N.J. 1980) (discussing professional ethics involving physician's refusal to continue controversial drug tests).

120. *See, e.g.*, Hinson v. Cameron, 742 P.2d 549, 552-53 (Okla. 1987) (holding that nurse assistant's refusal to perform the order to give a patient an enema did not violate any of the public policy grounds enumerated as follows: 1) refusing to participate in an illegal activity; 2) performing an important public obligation; 3) exercising a legal right or interest; 4) exposing some wrongdoing by an employer; and, 5) performing an act that public policy would encourage).

121. *See* Firestone Textile Co. Div. v. Meadows, 666 S.W.2d 730, 732 (Ky. 1983) (stating that an employee has a cause of action for wrongful discharge when his employment is terminated in violation of a legislature's express or implied expression of public policy).

122. *See* DANIEL P. WESTMAN, WHISTLEBLOWING: THE LAW OF RETALIATORY DISCHARGE 87 (1991) (detailing state legislature's enactment of private sector whistle-blower protection stat-

contrast, courts have difficulty including professional codes within the public policy exception because a violation of these codes may not be an indication of criminal wrongdoing.[123] Despite these inconsistencies, punitive damages may be awarded for termination due to reporting of a public policy exception. Thus, whistle-blowers who have suffered retaliation may have a financial incentive to bring their claims using this common law exception.[124]

2. The Gray Area of Medical Opinion: Protected by the Public Policy Exception or Not?

The case of *Pierce v. Ortho Pharmaceutical Corporation*[125] is analogous to many of the issues that gag provisions and terminable at-will employment have created. Just as many physicians have at-will HMO contracts, in *Pierce*, a physician was employed pursuant to an at-will relationship.[126] Furthermore, the physician in *Pierce* was the only medical person on a research team assigned with the responsibility of testing drugs for pre-market approval.[127] This is analogous to the situation where a physician, employed by an HMO, works with nurse practitioners, but is the only individual with a medical degree treating a particular patient. Finally, the physician in *Pierce* was pressured by decision-makers, who did not have medical degrees, to make a decision that was financially beneficial for the group, but that was contrary to her medical judgment. Likewise, a physician employed by an HMO must often get pre-approval from a utilization review committee that is composed of non-physicians before she can treat or refer patients. These non-physician decision-makers may pressure physicians to act in accordance with the HMO's financial interests as opposed to a patient's medical well-being.

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utes).

123. As discussed previously, The Code of Ethics, promulgated by the AMA is not legally binding. *See In re* AMA, 114 F.T.C. 575, 575 (1991).

124. *See* MARCIA P. MICELI & JANET P. NEAR, BLOWING THE WHISTLE: THE ORGANIZATIONAL AND LEGAL IMPLICATIONS FOR COMPANIES AND EMPLOYEES 240 (1992) (discussing whistle-blowing by employees and the results of such employee action).

125. *See generally Pierce*, 417 A.2d 505 (N.J. 1980).

126. *Id.* at 506.

127. *Id.* at 506-07.

The physician in *Pierce* refused to submit a drug containing a high level of saccharin for clinical testing because she feared the drug's potential carcinogenic attributes.[128] Dr. Pierce based her decision in part on the fact that although the drug was consistent with concentration standards in Europe, it was unsuitable for use in the United States.[129] Therefore, Dr. Pierce stated that to seek the Federal Food and Drug Administration's permission for the high concentration of saccharin would be a violation of the Hippocratic Oath.[130] Since Dr. Pierce's approval was necessary for the project and she would not approve clinical testing of the drug, she was terminated from the project.[131] Dr. Pierce alleged that it was against public policy to terminate her solely because she would not approve testing of a potentially controversial drug.

Though the court in *Pierce* recognized that professionals owe a special duty to abide by federal and state law as well as the recognized code of ethics of their profession,[132] the court did not allow the physician's public policy claim to prevail. The court stated that the controversy involved a *difference of medical opinions* and that discharging an employee on that basis was not a violation of clearly expressed public policy.[133] Furthermore, the court stated that because the plaintiff did not allege that the drug testing was "dangerous" and only alleged it was "controversial," her argument that the tests were a violation of the Hippocratic Oath was unfounded.[134] Thus, Dr. Pierce's termination did not fit into the public policy exception, and therefore, it was lawful.

The result in *Pierce* is troubling. Much of the practice of medicine is based on medical opinions;[135] therefore, to allow a physician to be terminated based on a difference of medical

128. *Id.* at 507.
129. *Id.*
130. *Id.* The physician cited the part of the Oath that read: "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." *Id.* at 513.
131. *Id.* at 507-08.
132. *Id.* at 512.
133. *Id.* at 514.
134. *Id.* at 514.
135. It is commonplace to get several medical opinions before deciding what course of treatment to pursue with a medical problem.

opinion provides HMOs with a large loophole. Though the *Pierce* court acknowledged that a physician's termination due to refusal to abide by practices which would result in medical malpractice would be encompassed by the public policy exception,[136] much of medical practice involves less clear medical determinations. Using the *Pierce* court's rationale, it appears that physicians with a contract that contains gag provisions or gag-like protocols could be terminated for recommending treatments or referrals that violate the explicit or unspoken gag language. Just as Dr. Pierce was terminated without recourse for voicing a medical opinion that was contrary to the financial goals of Ortho Pharmaceutical Corporation, likewise, a physician in an HMO could be terminated for voicing a medical opinion that is contrary to an explicit or implied gag provision. After all, the *Pierce* court implies that differences of opinions are viable reasons for termination.

Using the *Pierce* court's rational and applying it to an at-will HMO-physician contract that is coupled with the existence of a gag provision, HMOs have an extremely strong argument for lawful deselection. To prevail, an HMO would merely have to illustrate the following: 1) that the physician's contract is terminable at-will; 2) that the physician was deselected because the parties differed in opinions of necessary care for a patient; and, 3) that the physician refused to abide by the HMO's service restrictions and therefore, violated a gag clause by revealing alternative services to the patient.[137] Thus, using the *Pierce* court's rationale, it appears that the public policy exception does not provide physicians with adequate protection if they recommend services that are based on medical opinion and contrary to gag protocols.

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136. *Pierce*, 417 A.2d at 511-12.

137. In fact, this is precisely the argument that U.S. Healthcare used when it deselected Dr. Himmelstein from the HMO because he criticized the HMO's gag clauses. U.S. Healthcare stated, "Given the fact that he has expressed a lack of comfort with us, we assumed that he no longer wanted to participate and that he would have welcomed the notice that we provided to him." Gray, *supra* note 16, at 50.

B. Statutory Protections for At-Will Employees Who Blow the Whistle on Unlawful Practices

Many states have whistle-blower protections that are intended to protect employees from retaliation for refusing to engage in unlawful activities.[138] Some states protect both private and public employees,[139] some merely protect public employees,[140] and some states do not have any protection enumerated by statute.[141] Additionally, statutes vary in their definitions of employer wrongdoing,[142] the procedure a whistle-blower must follow to gain recourse, the damages awarded to whistle-blowers, and the penalties imposed on wrongdoers. Finally, if a state provides a statutory remedy for a whistle-blower claim, some courts require that an employee invoke the statutory remedy instead of the public policy common law remedy.[143] As will be discussed infra, due to the narrow definition state statutes usually apply to the term "wrongdoing,"

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138. An at-length discussion of federal whistle-blower protections is beyond the scope of this Note. For a general list of federal statutes that protect employees against reprisals, refer to Estlund, *supra* note 108, at 117 nn.62-63.

139. *See, e.g.*, CONN. GEN. STAT. § 31-51m(a)(2)-(3) (1994); FLA. STAT. ch. 448.101(2)-(3) (1995); HAW. REV. STAT. ANN. § 378-61 (Michie 1995); LA. REV. STAT. ANN. § 30.2027(A) (West 1995); ME. REV. STAT. ANN. tit. 26, § 832(1)-(2) (West 1995); MICH. COMP. LAWS ANN. § 17.428(2) (West 1996); MINN. STAT. § 181.931(1)(a) (1995); N.H. REV. STAT. ANN. § 275-E:1(I)-(II) (1995); N.J. STAT. ANN. § 34:19-2(a)&(b) (West 1995); N.Y. LAB. LAW § 740(1)(a)-(b) (Consol. 1996); OHIO REV. CODE ANN. § 4113.51(A)-(B) (Anderson 1996).

140. *See, e.g.*, ARIZ. REV. STAT. § 38-531(1) (1996); DEL. CODE ANN. tit. 29, § 5115(a)(1) (1995); GA. CODE ANN. § 45-1-4(d) (1996); IOWA CODE § 70A.28(1)-(2) (1995); KAN. STAT. ANN. § 75-2973 (1995); KY. REV. STAT. ANN. § 61.102 (Michie 1995); MO. REV. STAT. § 105.055 (1995); 43 PA. CONS. STAT. § 1422 (1996); S.C. CODE ANN. § 8-27-10(2) (Law. Co-op. 1993); UTAH CODE ANN. § 67-21-2(3)-(4)(a) (1996); W. VA. CODE § 6C-1-2(b)-(c) (1996); WIS. STAT. ANN. § 230.80(3)-(4) (1994).

141. As summarized in 12 TERMINATION OF EMPLOYMENT ¶20,031 (1996) the following states do not have statutory enumerated whistle-blower protections: Arkansas, the District of Columbia, Nevada, New Mexico, Puerto Rico, South Dakota, Vermont, Virginia, and Wyoming.

142. "While illegal acts are most clear cut, employees also may act because they consider the misdeed to be immoral, unethical, or simply beyond the purview of what an organization legitimately can expect an employee to do." Terry Morehead Dworkin & Janet P. Near, *Whistleblowing Statutes: Are They Working?* 25 AM. BUS. L. J. 241, 244 (1987).

143. This may significantly decrease the damages that an employee is entitled to because few statutes offer punitive damages and under the public policy exception, punitive damages are often awarded. *See, e.g.*, Dudewicz v. Norris-Schmid, Inc., 503 N.W.2d 645, 650 (Mich. 1993) (stating that punitive damages for wrongful discharge which is in violation of public policy are only sustainable when there is no applicable statutory prohibition against retaliatory discharge for the conduct at issue). *But see, e.g.*, Greenwald v. N. Miami Beach, 587 F.2d 779, 781 (5th Cir. 1979) (stating that the federal remedies for whistle-blowers under the Safe Drinking Water Act were entirely independent of any state or local remedies).

the stringent statutory procedural requirements whistle-blowers must follow, and the inadequate damages provided, statutory whistle-blower protections are, for the most part, extremely inadequate. Thus, it seems unlikely that state statutes will provide physicians with the protection they need to prevent unjust retaliation for their refusal to obey gag provisions.

1. Background

In general, the scope of coverage for whistle-blowers under state statutes is narrower than that which is protected under common law theories.[144] "Legislatures do not want to leave much to the whistle-blower's discretion,"[145] and thus, often limit reportable wrongdoing to those activities which violate state, federal, or municipal law.[146] Moreover, no state statute that protects private employees has gone so far as to protect whistle-blowers who complain about alleged violations of ethical codes.[147] Many states also require that the violation be "imminent"[148] or "substantial and specific."[149] Finally, most states require that the employee report the violation in good faith and make an effort to reasonably investigate the veracity of the allegation.[150]

A similar lack of consensus exists between states regarding procedural requirements for whistle-blowers. Some states require that employees first report alleged violations internally,[151] while others require reports to be made externally.[152]

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144. *See* MICELI & NEAR, *supra* note 124, at 241 (stating that state statutes are no broader and often are narrower than common law).

145. *Id.*

146. *See, e.g.*, CONN. GEN. STAT. § 31-51m (1994); LA. REV. STAT. ANN. § 30.2027(A)(1) (West 1996).

147. *See* WESTMAN, *supra* note 122, at 71. *But see, e.g.*, 43 PA. CONS. STAT. § 1422 (1996) which states that a public employee cannot discharge an employee who refused to participate in a violation of federal, state, or local law, regulation, ordinance, code of conduct, or code of ethics.

148. *See, e.g.*, OHIO REV. CODE ANN. § 4113.52(A)(1)(a) (Anderson 1996).

149. *See, e.g.*, N.Y. LAB. LAW § 740(2)(a) (Consol. 1996).

150. *See, e.g.*, CONN. GEN. STAT. § 31-51m (1994) (noting that employees who make false reports of violations are subject to disciplinary action); LA. REV. STAT. ANN. § 30.2027(A) (West 1996).

151. *See, e.g.*, ME. REV. STAT. ANN. tit. 26, § 833(2) (West 1995); N.H. REV. STAT. ANN. § 275-E:2(II) (1995). These statutes give employers the opportunity to correct the problem before it becomes public knowledge.

152. *See, e.g.*, CONN. GEN. STAT. § 31-51m(b) (1994) (stating that state employees may give to a public body any information they have about violations of state law).

Furthermore, some states will only recognize a claim if the report of the alleged violation has first been made in writing.[153] Lastly, most state statutes have very short statute of limitations within which claims must be made.[154] The stringent procedural requirements that state statutes impose on whistle-blowers makes it difficult for whistle-blowers, even those with valid claims, to receive recourse.[155]

Finally, the remedies and penalties provided by state statutes may not make whistle-blowing worth an employee's expense, time, or energy. The most commonly provided remedies are reinstatement, back pay, lost benefits, and injunctive relief.[156] Only a few states allow discharged employees to bring suit for damages.[157] To make matters worse, sanctions against wrongdoers are minimal, usually not more than $500.[158] This low monetary penalty provides no disincentive for wrongdoers, and therefore, they continue to retaliate against whistle-blowers.

2. Criticisms of Whistle-Blower Statutes

State legislatures passed existing whistle-blower protection statutes with the hope that state-mandated protections would encourage whistle-blowing.[159] However, when compared to states without statutory protection, enactment of whistle-blowing statutes has not resulted in the increase of whistle-blower claims.[160] Thus, it appears that state statutes are neither being

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153. *See, e.g.*, N.J. STAT. ANN. § 34:19-4 (West 1995) (requiring an employee to submit written notice of a violation to give the employer a reasonable opportunity to correct the violation).

154. Statutes of limitations range from ninety days, *see, e.g.*, CONN. GEN. STAT. § 31-51m(c) (1994), to within two years, *see, e.g.*, FLA. STAT. ch. 448.103(1)(a) (1995).

155. *See, e.g.*, Contreras v. Ferro Corp., 652 N.E.2d 940, 945 (Ohio 1995) (stating that employee must strictly comply with the dictates of the Ohio Revised Code to be afforded protection as a whistle-blower).

156. *See, e.g.*, CONN. GEN. STAT. § 31-107(c) (1994); HAW. REV. STAT. ANN. § 368-17(a) (Michie 1995); MINN. STAT. § 181.935(a) (1995).

157. *See, e.g.*, LA. REV. STAT. ANN. § 30.2027(B)(1) (West 1996) (allowing suit for treble damages).

158. *But see, e.g.*, MINN. STAT. § 181.935(b) (1995) (allowing an employer to be fined up to $750 per employee who is injured due to the employer's failure to inform the employee of a violation).

159. *See* Dworkin & Near, *supra* note 142, at 253 & 258-59 (discussing several whistle-blowing statutes).

160. *Id.* at 254. However, studies also show that there has been an increase in whistle-

interpreted in a way that offers maximum protection to whistle-blowers, nor are drafted to best protect whistle-blowers and encourage the reporting of malfeasance.

There are several explanations for why state whistle-blowing statutes have not increased the incidence of whistle-blowing. First, widespread ignorance of the law combined with what is typically a very short statute of limitations precludes many claims before they are even recognized.[161] Second, the risks of whistle-blowing and the motivations behind it outweigh statutory protection and compensation.[162] For example, the remedies presently offered, particularly back pay and reinstatement, do not compensate an employee for the emotional and physical upheaval associated with unemployment, the branding as a traitor by co-workers, and the expense associated with pursuing a lawsuit.[163] However, if statutes would routinely award compensatory damages for emotional distress or punitive damages to sanction wrongdoers, the incentive for whistle-blowing would increase.[164] A final possible explanation for why more whistle-blower suits have not been brought following the enactment of state statutes is that companies are no longer retaliating against whistle-blowers.[165] However, this explanation does not seem likely in light of two recent studies on retaliatory actions.[166]

One must address the following two questions to determine whether statutory enactments adequately protect employ-

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blower claims generally. *See id.* at footnotes 166-79 and accompanying text.

161. *See* MICELI & NEAR, *supra* note 124, at 235. "[I]t is only the extremely knowledgeable or aggressive employees who will realize that they have a claim and [will] be motivated to act within that time frame." *Id.*

162. *See* Dworkin & Near, *supra* note 142, at 260.

163. *See id.* at 262.

164. *See id.*

165. *See id.* at 263.

166. A survey of 276 people was performed in Syracuse, New York. (55.2% of those given questionnaires, participated in the survey). This survey found the following: (1) recognition by employees of a hierarchy of proper whistle-blower outlets: internal first, law enforcement agencies second, and news media last; (2) less employee support for legal protection for whistle-blowers who report unethical activities than for those who report illegal conduct; (3) very strong overall support for legal protection of whistle-blowers, even among managerial and supervisory employees; (4) a belief among employees that a fear of being fired deters whistle-blowers. *See* Callahan & Collins, *supra* note 110, at 940-41; U.S. MERIT SYSTEMS PROTECTION BOARD, WHISTLEBLOWING IN THE FEDERAL GOVERNMENT: AN UPDATE (1992) [hereinafter 1992 UPDATE] (comparing a survey from 1992 with a 1983 survey of whistle-blowing in the federal government and making recommendations for improvement).

ees from reprisal: First, how prevalent is employer retaliation against protected speech? Second, to what extent do employees feel free of the threat of employer retaliation? The most detailed answers to these questions are provided by the federal government[167] whose employees are protected by both the First Amendment and the 1989 Whistle-Blowing Protection Act.[168] Thus, as federal employees are often referred to as having greater job security than just about any other group of employees,[169] this study raises serious concerns about freedom of expression in the private sector workplace where job security may not be as great.

The government surveyed over thirteen-thousand employees[170] and then compared the data with a similar study it had performed in 1983.[171] On a positive note, the study revealed that progress has been made towards encouraging employees to blow the whistle.[172] Furthermore, the study revealed that employees are most likely to report illegal activities when the continuance of the wrongdoing endangers lives.[173] Applying this statistic to physicians who are gagged from disclosing treatments that are medically necessary, it is encouraging to note that despite the existence of a gag clause, many physicians would likely blow the whistle on the lack of adequate care provided by HMOs.

However, the study also revealed that the number of employees who were victims of subtle reprisal, as contrasted with outright employment termination, significantly increased.[174]

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167. *See generally* 1992 UPDATE, *supra* note 166.

168. Whistleblower Protection Act of 1989, Pub. L. No. 101-12, 103 STAT. 16-35 (codified as amended 5 U.S.C. § 1201 (1989)) (guaranteeing rights and protection to federal employees who disclose information regarding government illegality, waste, and corruption). However, one critic of the Act stated, "protection under the Whistleblower [Protection] Act is a myth. I would not encourage anyone to 'blow the whistle' on waste, fraud or abuse." 1992 UPDATE, *supra* note 166, at 14.

169. *See* Estlund, *supra* note 108, at 120.

170. *See* 1992 UPDATE, *supra* note 166, at i.

171. *See id.*

172. *See id.* at 9-17. The study revealed that in 1983, 30% said they reported illegal or wasteful activities whereas in 1992, 50% reported those activities. *Id.*

173. *Id.* at 9-11. The survey revealed that 96% of respondents said that this would be a very important factor in encouraging them to report. *Id.* Of least importance was eligibility to receive cash awards for reporting such activities. *Id.*

174. *Id.* at ii & 19-26. The study revealed that in 1983, 24% of those who reported illegal or wasteful activity experienced actual or threatened retaliation, whereas in 1992 that figure had risen

The most prevalent threat of reprisal that reporting employees received was the threat of poor performance appraisal.[175] Therefore, this would prevent their advancement at work. Additionally, the most commonly experienced reprisals reported by employees were shunning by co-workers[176] and verbal harassment.[177] It is disturbing that there was an increase in subtle reprisals in 1992 because that rise represents a more insidious strategy for retaliating against whistle-blowers and one that present statutes do not provide protection from: present statutes only accommodate individuals who have been *terminated* from employment for their whistle-blowing activity. Of those individuals who took actions against the subtle reprisals that they experienced,[178] forty-five percent said that it got them in more trouble, and forty-four percent stated that it made no difference.[179]

All of these explanations suggest that "it is not the rarity of employer reprisals, but rather weaknesses in the system of enforcement — some combination of employee ignorance about these provisions, inadequate agency resources, lack of political will, and vagaries of proof — that have rendered many statutory anti-retaliation provisions virtually dormant."[180] Applying the federal government's statistics to physicians who are gagged by HMOs, it is likely that an increased number of physicians will experience some sort of retaliation. As present statutory and common law remedies are not adequate to offer physicians protection, recommendations must be

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to 37%. *Id.* at 21-22.

175. *See id.* at 19. The study revealed that 12% of those who reported reprisal stated that poor performance reviews were the greatest threat. One individual who actually received a poor performance review stated, "My manager was very careful not to do anything drastic. She was being watched." *Id.* at 21.

176. *See id.* at 19 (revealing that 49% of employees were shunned by co-workers). One individual stated, "I was a whistle-blower [years ago] and was banished to another work area because of it. Management did not want to hear it then and does not want to hear it now. They can (and do) punish you in a more subtle manner now than in years past." *Id.* at 22.

177. The study also revealed that 47% of employees who reported wasteful or illegal activities were subject to verbal harassment. *Id.* at 19.

178. The study revealed that 68% complained to higher level agency management or some other office within the agency. *Id.* at ii & 19.

179. *See id.* at 25.

180. Estlund, *supra* note 108, at 132.

made to guide legislatures to make improvements. This is precisely what I will attempt to do infra in Part IV.

C. Critique of Recently Passed and Pending Legislation Designed to Specifically Deal With Gag Provisions and Managed Care Organizations' Retaliation Against Physicians

Several states have attempted to deal with the existence of gag provisions in physician-HMO contracts. Though the proposals and implemented bills have placed the unethical and unlawful practices of HMOs in the limelight, no proposal provides complete protection for physicians. A closer look at several of these bills will shed light on their strengths and deficiencies and will provide insight for my recommendations.

However, before turning to proposed state solutions to the existence of gag provisions, a comment must be made about the pending federal "Patient Right to Know Act."[181] This bill would prohibit restrictions on information physicians can provide to their patients.[182] Furthermore, health plans would be prohibited from taking retaliatory action against physicians and other health care providers for their discussions with patients.[183] Finally, health care plans that violate the terms of the Act would face fines of $25,000.[184]

Though this federal act addresses many of the issues that gag clauses coupled with at-will employment creates, I do not believe that federal legislation will be passed quickly enough to prevent short-term tragic results. Furthermore, gag clauses and practices often have unique characteristics which vary from HMO to HMO. Therefore, state legislatures are in a better

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181. *See* Diane M. Gianelli, *Federal Managed Care Bill Would Lift Gag*, AM. MED. NEWS, Mar. 11, 1996, at 3.

182. *See* Gerry Clark, *Gag Clauses' Restrict Options*, AM. ACAD. PEDIATRIC NEWS, Apr. 1996, at 1.

183. *See id.* "Examples of retaliatory action include: refusal to contract, termination of contracts, refusal to refer patients, refusal to renew contracts, and refusal to compensate." *Id.*

184. *See id.* Repeat offenders could be fined $100,000. *Id.*

position to investigate the particular gag policies and protocols found in HMOs located in their jurisdiction and are in a better position to immediately remedy the problem. Thus, though a federal bill may be very effective in the long term, to meet the short-term problems created by gag clauses, state legislatures must take immediate action.

1. California

The California Medical Association first called attention to the problem of gag clauses in 1995 summer legislative hearings.[185] Subsequently, a draft amendment to Business and Professions Code, section 2056.1 was promulgated to "prohibit gag clauses" and to "provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients."[186] Specifically, the amendment to section 2056.1 includes the following statement:

> No health care service plan . . . *shall prohibit or restrict* any medical provider *from disclosing* to any subscriber, . . . *any information* that such medical provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation, or test, the decision of any plan to authorize or deny services, or the process the plan or any person contracting with the plan uses, or proposes to use, to authorize or deny health care services or benefits. *Any such prohibition or restriction contained in a contract with a medical provider shall be void and unenforceable.*[187]

This amendment sufficiently touches upon many of the unlawful restrictions that gag provisions place on physicians, but then merely states that such prohibitions are "void and unenforceable." Of course such restrictions are "void and unenforceable" because, as discussed previously, they create an unlawful conflict of interest and violate a patient's right of informed consent. Thus, the legislature does nothing more than

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185. Memorandum from Kelly Kenny, Director, AMA Division of State Legislation, & Carol O'Brien, Senior Attorney, AMA Health Law Division, to Executive Directors & State Legislation Contacts of State Medical Societies and National Medical Specialty Societies (Jan. 22, 1996) (on file with author) (advising recipients of AMA press release about gag clauses in managed care contracts).

186. Draft Amendment to California Business and Professions Code § 2056 to Prohibit "Gag Clauses" (provided by the California Medical Association, on file with author).

187. *Id.* (emphasis added)

reiterate a legal conclusion. It does not get to the heart of the matter by imposing sanctions on HMOs caught with these practices and it does nothing to ensure that physicians will not be terminated for refusing to abide by such unlawful prohibitions. In short, the amendment does not do what it purports to do, i.e., "provide protections against retaliation." Thus, as a pragmatic matter, this amendment will do nothing more than remind physicians of the predicament they are in.

However, on January 12, 1996, Bill 2067 was proposed as an addendum to section 1374.4 of the Health and Safety Code.[188] This proposal takes a step in the correct direction regarding protection of at-will physicians from retaliatory discharge. This proposed bill states that to terminate or penalize a health care practitioner "for advocating for appropriate health care" is a violation of public policy.[189] If this bill is passed, it will provide physicians with a public policy exception that is explicitly defined and mandated by legislature. This proposal, in essence, forbids discharge due to a difference in medical opinions and gives physicians a strong foundation for a wrongful discharge claim. Though providing a clear expression of public policy gives physicians a foundation for a wrongful discharge claim and that is certainly better than not addressing the at-will issue at all, perhaps a better solution would be to mandate due process by prohibiting at-will provider-HMO contracts.[190]

In addition to providing a valid basis for the public policy exception to at-will employment, this bill specifically prohibits gag provisions. The bill states:

> No . . . plan shall discharge, discipline, demote, terminate a contract with, or otherwise sanction, a physician and surgeon or health care practitioner *for advocating on behalf of a patient*, including, but not limited to, *criticizing plan policies that deny, limit, or restrict* medical services.[191]

Therefore, if this bill becomes law, it will prohibit physicians from being terminated for expressing their medical opinions.

188. A.B. 2067, 1995-96 Reg. Sess. (Cal. 1996).
189. *Id.*
190. This will be more fully developed *infra* in Part IV with my recommendations.
191. A.B. 2067, 1995-96 Reg. Sess. (Cal. 1996) (emphasis added).

This will hold true even if the opinions differ from that which is offered by a patient's plan or if opinions are prohibited by a gag clause.

2. Massachusetts

On January 19, 1996, Guenter L. Spanknebel, M.D., President of the Massachusetts Medical Society stated: "Massachusetts physicians will no longer need to fear retaliation from commercial insurers and managed care plans for fulfilling their duty as patient advocates."[192] Dr. Spanknebel released that statement because earlier that day Governor William Weld signed into law House Bill 5347, the "Patient Confidentiality Bill."[193] Dr. Spanknebel was excited about the following portion of the bill:

> A health maintenance organization *shall not refuse* to contract with or compensate for covered services an otherwise eligible provider *solely because such provider has in good faith communicated* with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients.[194]

The purpose of this bill is to encourage physicians to talk openly to their patients about insurance coverage and treatment options.[195] However, as I read this enactment, it is much too vague to adequately protect physicians from anything, much less unlawful discharge. No mention is made of sanctions that will be imposed on HMOs that retaliate against physicians nor mechanisms to ensure that physicians achieve redress. In short, due to its vagueness, I do not think that this bill will achieve the results anticipated by the Massachusetts Medical Society.

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192. Massachusetts Medical Society, *Massachusetts Medical Society Wins Victory to Protect Patient Communications: Physician "Gag Clauses" Now Prohibited*, (Jan. 19, 1996) (news release on file with author) [hereinafter Massachusetts Medical Society].

193. *Id.*

194. MASS. GEN. LAWS ch. 176G, § 6 (1996) (emphasis added).

195. *See* Massachusetts Medical Society, *supra* note 192 (acknowledging that physicians should be encouraged to openly discuss medical care with patients).

3. Washington

On February 15, 1995, months before the media focused its attention on the existence of gag provisions in provider-HMO contracts, Washington legislatures foreshadowed the existence of these clauses, and when coupled with at-will employment, the problems they would cause physicians.[196] Unfortunately, House Bill 1945 was referred to the Committee on Health Care over one year ago and nothing appears to have happened since.

House Bill 1945, section 10(4)(e) is the only proposal that I have seen which strikes at the heart of the gag clause problem by prohibiting the termination of physicians' contracts "without cause."[197] The bill not only prohibits at-will contracts, but also states that plans must provide lawful reasons for the denial or termination of a physician's contract, and mandates a due process appeal from all adverse decisions.[198] As I will discuss infra, the only way to ensure that physicians can practice medicine as they see medically and ethically fit, regardless of whether contracts have gag clauses, is to prohibit at-will employment.

House Bill 1945, section 3(2) also attempts to prohibit managed care organizations from more subtly retaliating against physicians. This portion of the bill states:

> *No entity supervising physicians may impose* on a physician *adverse consequences* of *any kind* because of referring patients for care to facilities or practitioners other than those approved by the supervising entity where the physician in good faith believes that there is a *substantial patient care justification* for doing so and that the care was otherwise unavailable.[199]

At first glance this portion of the bill appears to provide protection from subtle reprisals even if physicians recommend care that is prohibited by gag clauses. However, what worries me about this section is that physicians need "substantial" justification to prescribe services that are not approved by the supervis-

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196. *See* H.B. 1945, 54th Leg., Reg. Sess. (Wash. 1995) (protecting physicians from termination "without cause" as well as common gag provisions in managed care contracts).

197. *See id.* § 10(4)(e).

198. *See id.* § 10(4)(f).

199. *Id.* § 3(2) (emphasis added).

ing entity. Does this mean that a physician is not protected from retaliation if he only has a "reasonable" or "appropriate" justification to recommend the treatment? Might this high degree of justification preclude physicians from recommending tests or referrals merely to rule out the possibility that an individual has a particular illness? Furthermore, what happens to a physician who acts without substantial justification? If her employment is terminated and she cannot get hired elsewhere due to the termination, what recourse does she have if a court subsequently decides that she acted "in good faith" and had "substantial justification?" Finally, this bill does not state what procedures a physician must go through to be afforded protection from retaliation, nor does it impose sanctions on supervising entities should they unlawfully retaliate. In conclusion, though this portion of the bill has potential, it leaves too many unanswered questions to be truly effective.

The Washington Senate was also busy foreshadowing problems physicians would face and on February 15, 1995 recommended a bill that provides whistle-blower protection for any individual who complains about the quality of care provided by a health plan.[200] This bill preserves the confidentiality of the whistle-blower as long as the complaint is made in good faith. The good faith requirement may pose problems for physicians because managed care entities can use that subjective test to discredit a physician's complaint.

The bill further states that a whistle-blower who experiences reprisal or retaliatory action[201] is entitled to the remedies provided under the Washington Revised Code, chapter 49.60.225.[202] The remedies provided by this Chapter include compensatory damages, actual damages, equitable relief, and a civil penalty of $3000 imposed upon the retaliator.[203] On a

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200. *See* S.B. 5935, 54th Leg., Reg. Sess. (Wash. 1995).

201. Reprisal or retaliatory action means, but is not limited to:

> Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion; suspension; dismissal; denial of employment; and a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower.

Id. at 5(2)(b).

202. *See id.* at 5(1).

203. *See id.* However, this Chapter does not appear to provide for punitive damages. *See,*

positive note, this bill allows a whistle-blower to sue for damages which may make their whistle-blowing more financially worthwhile. Additionally, a civil penalty of $3000 is imposed on the wrong-doer which may have a deterrent effect on future malfeasance. However, though I commend the Senate for explicitly encompassing health care providers in their whistle-blower statute, as discussed previously, studies have shown that whistle-blower statutes may not increase the number of claims brought nor offer protection from subtle reprisals.

4. Illinois

On February 6, 1996, the Illinois House introduced House Bill 2876, "The Managed Care Patient Rights Act."[204] This bill addresses the economic tensions that managed care has created for physicians[205] and creates protective mechanisms to ensure the quality of patient care.[206] Overall, this bill seems to effectively ensure the delivery of quality care to patients as well as adequately protect physicians from retaliation. Many of the questions and issues left unanswered by previously discussed bills, are sufficiently dealt with by the Illinois bill.

Section 5-10 enumerates "[m]edically appropriate health care protection."[207] This section states that the public policy of Illinois mandates that physicians advocate[208] for medically

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e.g., McGinnis v. Kentucky Fried Chicken, 51 F.3d 805, 806 (9th Cir. 1994) (stating that punitive damages are not available under Washington law due to the plain adoption of federal remedies).

204. H.B. 2876, 89th Gen. Assembly (Ill. 1996) (addressing the rights that patients have when dealing with managed care entities).

205. *See id.* § 1-5(b). "Managed care entities have the ability to discontinue physicians and other health care providers from their networks effectively precluding patients from being able to choose these physicians . . . and preventing health care providers from treating patients who wish to use their services. Finally, cost considerations can be used by these entities to prevent expenditures for high cost medically necessary care, often with little or no appeal." *Id.*

206. *See id.* "Managed care entities . . . are responsible for making coverage decisions which have a direct effect on the health of patients. Some of these entities make decisions concerning the medical necessity, appropriateness of alternative treatments and length of hospital stays, sometimes with little or no medical input, which can jeopardize the health and welfare of patients . . . . Strong provider-patient relationships, particularly for patients with acute or chronic medical conditions, may enhance the curative process." *Id.*

207. *Id.*

208. *See id.* To advocate for medically appropriate health care means to "appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a managed care plan . . . or to protest a decision, policy, or practice that the physician . . . reasonably believes impairs the physician's . . . ability to provide appropriate health care to his or her patients." *Id.* § 5-10.

appropriate health care for patients. Furthermore, a managed care plan is prohibited from retaliating against a physician who advocates "appropriate health care."[209] Unlike in Washington, discussed previously, where a physician needed "substantial justification" to prevent unjust retaliation, in Illinois, the standard is much lower. This standard gives physicians much more control in the decision-making process of prescribing and recommending care which, as discussed earlier, managed care entities have gradually taken from them.

Second, the Illinois bill states that a managed care entity that terminates or penalizes physicians "for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by physicians . . . practicing in the same or a similar locality and under similar circumstances violates the public policy of this State."[210] Likewise, this violation constitutes a business offense subject to a $10,000 fine.[211] This bill clearly sets out the standard that will be used to determine "appropriate health," outlines a clear expression of public policy, and most importantly, imposes a substantial sanction on managed care entities that unlawfully retaliate. It is likely that the imposition of a $10,000 fine will serve as a powerful incentive for managed care entities not to retaliate against their providers.

Third, the Illinois bill discusses the unlawful restraints gag provisions place on physicians[212] and states that any managed care entities that impose these restraints will be subject to a $10,000 fine[213] and/or the managed care entity may be enjoined from operating.[214] The threat of shutting a managed care organization's doors provides a powerful disincentive to gagging physicians.

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209. *Id.* § 5-10(a).

210. *Id.* § 5-10(c).

211. *See id.* § 5-10(c) & § 20-15(a).

212. *See id.* § 5-25. "No managed care plan may prohibit or discourage health care providers from discussing any alternative health care services and providers, utilization review and quality assurance policies, terms and conditions of plans, and plan policy with enrollees, prospective enrollees, providers, plans, or the public." *Id.*

213. *See id.* § 5-25 & § 20-15(a) (imposing fines if managed care plans restrain physicians' communications).

214. *See id.* § 5-25 & § 20-55 (giving the Director of Public Health the authority to bring an action to enjoin an entity that violates prohibitions against restraining physician's communication).

Finally, the Illinois bill states that if a managed care plan terminates a physician's contract, it must provide a detailed written statement to the physician enumerating the reasons for termination.[215] Though at first glance this statement appears to eliminate termination "without cause," this section also states that a provider's contract can be terminated for "any reason."[216] It is therefore unclear whether the Illinois legislature intends to eliminate at-will employment.[217] Furthermore, the Illinois bill allows a physician's employment to be terminated due to "substantially economic factors." This creates a tremendous loophole in the effectiveness of this bill because in essence it creates an implicit gag clause on physicians. Though Illinois managed care plans may not explicitly prevent physicians from recommending services not covered by the plan, if a physician spends too much of the plan's money advocating for his patients, he can be deselected for that very reason.[218] Thus, though the Illinois bill deals with many issues more effectively than other states, allowing deselection due to economic factors leaves a large loophole for potential abuse.

IV. RECOMMENDATIONS AND CONCLUSION

As the previous analysis has shown, neither present statutory and common law protections, nor pending legislation specifically designed to protect physicians from gag provisions and subsequent retaliation, enables physicians to practice medicine as they see medically and ethically fit. I therefore propose the following recommendations in the hope that state legisla-

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215. *See id.* § 5-35(a)(3).

216. *See id.*

217. *See id.* § 10-5(b)(G)(vii) which states that a physician's employment can be terminated, with 15 days notice "based substantially on economic factors." *Id.* In my opinion, this creates a tremendous loophole in the effectiveness of this Bill because one of the primary purposes of gag provisions is to control the amount of money a managed care organization has to spend on its patients. Thus, allowing deselection due to economic factors, creates an implicit gag provision on physicians.

218. Fear of financial penalty is commonplace for HMO affiliated physicians. *See, e.g.*, Ellyn E. Spragins, *Beware Your HMO: Some Can be Counted on in a Pinch, But Many Delay or Deny Crucial Care if You Require Expensive Tests or Procedures. Here's How to Protect Yourself*, NEWSWEEK, Oct. 23 1995, at 54, 55. Peter Moore, a 46-year-old professor at the University of Illinois College of Medicine, was awarded $6.4 million in his suit against Rush Anchor HMO. *Id.* Describing the predicament, Moore's attorney stated, "I believe doctors are given a message about expenses they incur when they come up for salary review." *Id.*

tures will take them into consideration when voting on upcoming bills.

[1]: First, state legislatures must make it an affirmative duty for physicians to tell patients what services are necessary for their health, despite whether the services are offered by the patients' plan. In addition, to ensure that patients receive proper care, states must also mandate that HMOs have a similar duty to treat.

To understand why a similar affirmative duty must be imposed on HMOs, one must evaluate what a patient's options are when he is told that he is sick and needs to seek care that is not covered by his plan.

Patients, just like physicians, are often locked into "no-win" situations. For example, a patient may not be able to change HMOs because his employer does not offer any alternative programs. Thus, even if a patient is told that his HMO does not provide the needed service, financially he may not be able to afford to go elsewhere. Furthermore, even if a patient could financially afford to receive treatment elsewhere, if a patient is sick, other HMOs will be reluctant to provide him with coverage.[219] Thus, even if a patient has been told that he should seek care elsewhere, in actuality, that patient may have no place to go to receive that care. To alleviate this problem, in addition to mandating that physicians disclose to patients necessary services, even if not offered by their plan, HMOs must also have an affirmative duty to provide that care if the patient seeks the care elsewhere and is denied. Thus, both the physician and the HMO must have affirmative duties to provide necessary treatment.

Physicians and HMOs will continue to argue over whether services are "necessary" or merely "beneficial." I do not purport to have a complete solution to this debate; however, if state legislatures clearly enumerate that both physicians and HMOs have affirmative duties to patients, there certainly will be less room for debate.

Critics may also argue that the affirmative duties imposed upon HMOs and physicians will prevent cost saving which is

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219. Likewise, HMOs would have the same affirmative duty to provide care if a patient could not financially afford to go elsewhere.

the primary impetus for managed care. This criticism is undermined by the observation that no money is saved when necessary care is denied and tragedy occurs.

[2]: As stated previously, a large percentage of physicians rely on their enrollment in managed care plans for the *majority* of their patients. If physicians "blow the whistle" by telling patients about gag clauses or by retaliating against the clauses in another manner, physicians risk being deselected.

Physicians fear deselection for two primary reasons. First and foremost, the physician loses patients if she is deselected from a particular HMO. Secondly, when a physician is deselected from an HMO, that is considered an "adverse action" and must be reported to the National Practitioner Data Bank.[220] To make matters worse, the information stored at the National Practitioners Data Bank *must* be checked by a hospital when a physician applies for hospital privileges and subsequently every two years.[221] In addition, health care entities which have, or may be entering into an employment or affiliation relationship with a physician, have access to these records.[222] As a result, a health care entity may choose not to hire a physician based on the information stated therein. Thus, adverse actions taken by managed care entities, *whether well-founded or not*, are lethal to a physician's future ability to practice medicine.

In short, in order to ensure that unfounded deselection does not harm competent physicians, modifications must be made regarding the communication of adverse actions to the National Practitioner Data Bank. Minimally, there must be the opportunity for both HMOs and physicians to attach comments to the report, which state the individual party's account of the adverse action.[223] Finally, if a physician is deselected but wins a wrongful discharge claim, procedures must be imple-

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220. The Health Care Quality Improvement Act (HCQIA) of 1986, 42 U.S.C. §§ 11101-11152, establishes a National Practitioner Data Bank for adverse information on physicians and other health care practitioners. The HCQIA Regulations are codified in 45 C.F.R. § 60.10-60.14 (1995).

221. *See id.* § 60.10(a)(1)-(2).

222. *See id.* § 60.11(a)(4).

223. Though an HMO may be apprehensive about hiring a "potential troublemaker," at least a physician is given to opportunity to "defend" himself.

mented to ensure that the Data Bank removes the adverse report from the physician's file.[224]

[3]: One way to prevent managed care entities from unjustly terminating physicians is for legislatures to ban at-will employment for physicians.[225] Permitting the existence of at-will employment for physicians gives them freedom of speech and then, in essence, takes away their right to due process. One author describes at-will employment the following way:

> Imagine a society whose citizens had free speech rights but no due process rights. The government could imprison citizens or banish them for any reason, without notice or a hearing or proof of the charges; but it could not punish citizens based on their criticism of the government or other protected speech. The citizen who believed she had in fact been punished for speaking against the government could go to court, and, if she could prove it, secure relief. How free would speech be in such a system? Would citizens feel free to challenge the regime without fear of retaliation?[226]

Mandating that termination of physicians' contracts be "for cause" would force employers to legally justify a physician's termination. Furthermore, for-cause employment is more likely to provide physicians with an appeal process and a forum, other than the courts, within which to work out differences of opinions.[227] The elimination of at-will contracts no doubt pre-

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224. The adverse report should not be removed until a physician successfully defends his retaliatory discharge claim. Though, as stated throughout this Note, it is extremely difficult to prevail with a retaliatory discharge claim, if a physician is permitted to remove the adverse report any time *prior* to his successful claim, the health and welfare of patients could be seriously jeopardized. For example, if a physician could remove the adverse action report while a claim was pending, a physician who is deselected due to incompetence or malpractice could file a bogus suit just so that she could continue to practice medicine during that time.

225. There may in fact be a light at the end of the tunnel regarding physicians' at-will employment status. On April 9, 1996, the Supreme Court of New Hampshire 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 for a reason that is contrary to public policy." Harper v. HealthSource, 674 A.2d 962, 966 (N.H. 1996). The Court went on to clarify its decision by stating that a terminated physician is entitled to review of the termination decision, whether the termination was for cause, or without cause. *Id.* Although the Court specifically stated that it was not eliminating an HMO's contractual right to terminate its relationship with a physician without cause, the court took a step in the right direction by enumerating for the physician a course of action.

226. Estlund, *supra* note 108, at 101-02.

227. Underscoring the ongoing tensions between physicians and HMOs, groups of anesthesiologists at three Long Island, New York hospitals have sued Aetna Health Plans of New

cludes physicians from terminating their relationship with managed care entities "without cause." However, it will also give them greater job security in an increasingly insecure health care market and will increase their willingness to speak out against unjust and unlawful practices.[228] Therefore, I believe that physicians would welcome the tradeoff.

In addition to eliminating employment at-will, deselection due to economic factors should not automatically be a valid "cause" for termination. As mentioned previously, allowing physicians to have their employment terminated due to the amount of revenue that they raise, creates a tremendous loophole within which managed care entities can implement unspoken/unwritten gag policies. To protect physicians from unjust termination while at the same time permitting HMOs to survive tough financial times, legislatures should mandate specific procedural steps for HMOs to take when they terminate a physician due to financial restructuring.[229]

If HMOs financially need to reorganize the services that they provide to enrollees, then they should be also required to make reasonable efforts to find placement for physicians who are terminated. Furthermore, it should be made clear that the physician was not terminated due to her performance quality, but rather, because the HMO was restructuring or reducing its physician network. Finally, should termination occur due to restructuring, physicians should not be required to report their termination to the National Practitioner Data Bank. Thus, because HMOs will have an affirmative duty to mitigate damages

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York Inc. *See* Scott Falk, *New York Anesthesiologists Sue Aetna Alleging Coercive Contracting Practices*, 1 BNA'S MANAGED CARE REP., Aug. 30, 1995, at 221. According to the complaint, the anesthesiologists sought changes to their contract, including a stipulation that physicians would have the right to appeal adverse decisions made by Aetna, and Aetna refused to modify its standard agreement. *Id.*

228. Foundation Health Corporation's 1992 termination of Sacramento OB-GYN William Miller after he publicly made derogatory comments about the health plan, represented "the first time in [Sacramento] a physician has been let go for reasons other than quality of care." Kreier, *supra* note 28, at 5. Not quite three years later, Medical Society Executive Director William Sandberg reported that both "mass terminations and contracts prohibiting patients [sic; should state physicians] from contacting patients' to tell them what [has] happened have become commonplace." *Id.*

229. Even with my suggestions, physicians are not completely protected from retaliation. However, by mandating economic discharge procedures at least HMOs will have a duty to mitigate damages to physicians.

to physicians, a termination of this type will have fewer adverse effects on future employment possibilities.

[4]: As an alternative to prohibiting at-will employment for physicians, state legislatures must take steps to enable physicians to recover under the public policy exception to the at-will doctrine. State legislatures must express clear statements of public policy which will provide physicians with a foundation for a common law suit for retaliatory discharge. In enumerating the state's public policy, legislatures must prohibit as a lawful reason for discharge the difference of medical opinion between a physician and a non-physician decision maker. This will prevent situations that are analogous to *Pierce v. Ortho Pharmaceutical Corporation*, as discussed previously, from occurring.[230] Furthermore, by doing so, physicians will regain much of the medical decision-making control they have lost to non-physician decision makers.[231]

[5]: In addition, state legislatures must also take steps to enable physicians to recover under existing whistle-blower statutes. State legislatures must extend the length of the statute of limitations for bringing actions under state whistle-blower statutes. Few individuals who are discharged from employment have the wherewithal or knowledge to file a claim within a couple of weeks (which is commonly the statute of limitations). Regardless of whether the statute of limitations is extended, legislatures should educate physicians of the time frames within which claims must be brought. Moreover, they should make it clear that if claims are not brought within the enumerated deadlines, statutory whistle-blower claims will be precluded.

[6]: State legislatures also must take steps to further educate physicians on the mandatory procedural requirements to filing a claim under state whistle-blower statutes. Often, whistle-blowers with valid claims are precluded from recourse because they do not follow the proper procedural channels.

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230. *See supra* footnotes 125-37 and accompanying text.

231. It should be noted that in California several HMOs have been formed by physicians that solely employ physicians on the utilization review boards. This enables medical decisions to remain with the medical profession and precludes many of the issues discussed in this Note from occurring.

Thus, the legislature must ensure that physicians are educated so that they are not precluded from recovery on the basis of a statutory procedural technicality.

[7]: Presently, few state whistle-blower statutes award punitive damages to whistle-blowers or impose harsh sanctions on wrongdoers. Thus, there is little incentive for those aware of a problem to blow the whistle; and likewise, there is no disincentive for wrongdoers to retaliate against whistle-blowers.

Present state whistle-blower statutes traditionally award whistle-blowers reinstatement and backpay. This does not adequately reward a whistle-blower physician, who not only fears losing his job, but also fears being blacklisted from employment with all other HMOs. Additionally, reinstatement may not be the ideal solution for a physician who risks subtle reprisals from HMO management and co-workers once she returns to work. The availability of punitive damages will award a physician for her heroic disclosure and will hopefully punish HMOs enough so that it will not be cost-effective for them to implement gag provisions (whether in writing or in practice).

Legislatures must also impose harsh sanctions on managed care entities that promote gag protocols or that unlawfully retaliate against their physicians. The Illinois bill did this very well. In Illinois, violation of the proposed "Managed Care Patient's Right Act" results in a $10,000 civil fine and/or being enjoined by the State Department of Health. These strict sanctions coupled with punitive damages would force managed care entities to think twice before unlawfully imposing gag provisions or retaliating against physicians.

[8]: Unfortunately for whistle-blowers, neither common law protections nor statutory protections prevent wrongdoers from more subtle forms of retaliation than termination. For example, what can protect a whistle-blower from poor performance reviews, shunning from co-workers, banishment to a smaller office, restrictions on the use of facilities, verbal harassment, or denial of promotional opportunity? To help eliminate these subtle reprisals I have a few recommendations.

First, the identity of whistle-blowers must, at all costs, remain confidential. Therefore, it should be at the whistle-blower's discretion whether confidentiality would best be protected by an internal or external complaint system. Whistle-

blowers best know the nature of their individual HMOs and are better able (than state legislatures) to determine whether an internal complaint will be an effective means for having the HMO remedy the problem.[232] If complaints are made externally, because the whistle-blower fears subtle retaliation if the complaint is made internally, the State Department of Health and Safety could be a possible complaint receiver.[233] Though external reporting denies the parties the opportunity to remedy a solution privately, it will prevent HMO management from blacklisting a physician whistle-blower.[234]

Secondly, legislatures must mandate that managed care entities keep records of, and provide reasons for, all promotions, demotions, relocations, and terminations. By forcing managed care entities to document more of their administrative decisions, and by keeping the identity of whistle-blowers confidential, it will be much more difficult for managed care organizations to subtly retaliate against whistle-blowers.

[9]: Physicians have to weigh the threat of medical malpractice if they do not provide a necessary service to a patient against the threat of discharge and/or subtle reprisals if they do recommend the service (which is contrary to the gag). If the threat of malpractice is greater than the threat of retaliation, then a physician may blow the whistle. However, do consumers really want to go to a physician who is forced to weigh these terrible alternatives? All enacted legislation and proposals to date are much too vague in what they prohibit managed care entities from doing. It is not enough to simply state "gag provisions are void and unenforceable." Instead legislation must

232. HMOs would most likely prefer this type of complaint system because it gives them a chance to remedy the problem privately. However, an internal complaint system cannot be effective if the HMO will terminate the whistle-blower instead of remedying the problem. Thus, whether a physician complains internally or externally must be left up to her discretion.

233. I recognize that there may be delay problems if adverse actions must be reported to external organizations first; however, due to the tremendous threat of subtle reprisals, internal complaints, in some HMOs will not be effective.

234. Critics may argue that the complaining physician's identity will become known during the course of the investigation since presumably the physician is complaining about an incident that she was involved in. However, this should not be the case because generally gag-like policies effects all participating physicians of an HMO and not a single doctor. Though not all physicians of a particular plan will be effected equally, generally, all physicians will be effected in one way or another.

be enacted that makes it mandatory for provider-HMO contracts to include the following clauses:

[a]: [HMO] will not in any way prevent a physician from providing a patient with full and informed consent even if that means disclosing to a patient the existence of a service, a treatment, or a provider that is not covered by the patient's plan.

[b]: [HMO] will not in any way prevent a physician from fulfilling her fiduciary obligations to a patient. Therefore, each physician must disclose to her patients the following: 1) the payment system that she is on; 2) any bonuses or incentives she receives or could receive; 3) the requirements the physician must meet to receive those bonuses or incentives; 4) any other information the physician believes affects her medical judgment or potentially causes a conflict of interest.

[c]: [HMO] may not in any way restrict communications between a physician and a patient. This includes, but is not limited to, allowing physicians to speak with candor about the quality and/or quantity of services provided by the patient's plan, as well as recommending other plans, services, or providers that might better serve the patient's medical needs.

Conclusion: It is my hope that the above stated legal analysis and recommendations will decrease the number of Carley Christies that you come in contact with during your lifetime.