The Fahlen Floodgates: Straight Talk about Two-Track Peer Review

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The California Supreme Court unanimously ruled on February 20, 2014, that a physician claiming that her/his privileges were terminated in retaliation for whistleblowing to safeguard patient care and safety does not have to seek and obtain a writ of mandate before suing the hospital under California Health & Safety Code § 1278.5 (H&S 1278.5).

While the much-anticipated decision in *Fahlen v. Sutter Central Valley Hospitals* is narrow and straightforward, *Fahlen* is still a game changer for both physicians and hospitals in two ways. The decision settles years of debate about whether a physician could sue a hospital before the end of peer review proceedings. On the other hand, it raises myriad new legal questions that no healthcare professional or entity can afford to ignore.

Dueling Proceedings

Fahlen allows a physician to open a second front in her/his battle with a hospital by confirming an exception to the formerly airtight rule that a suing doctor must first exhaust her/his remedies through the peer review process and subsequent court review. Physicians now can and will use a whistleblower claim to pursue a civil action based on H&S 1278.5 and any claims that are "functionally ancillary" to that claim—before the hospital has finished, or even begun, peer review proceedings.

Now that the *Fahlen* floodgates have opened, two concurrent proceedings about essentially the same set of facts at a hospital might very well become common. A hospital may be in the administrative process of disciplining a physician at the same time that the physician is suing the hospital on the basis that the peer review is pretextual and aimed at punishing her/him for speaking out for patients.

Such two-tracked proceedings could force hospitals and medical staffs to navigate peer review issues in a general litigation environment far more frequently than in the past. An aggrieved physician may drag fellow medical staff members and others involved in the peer review process before a jury—where issues of quality of care and physician behavior will be evaluated by lay jurors for whom the interplay between quality of care and retaliatory motives could become even more muddled. In a *Fahlen* anti-retaliation lawsuit, a physician will even have the advantage of a legal presumption that her/his termination was retaliatory if it happened within 120 days of a complaint. Some wonder whether *Fahlen*, over time, could have a chilling effect on medical disciplinary actions if hospitals reduce peer review actions to avoid protracted, costly litigation.

In the *Fahlen* decision, the Supreme Court of California acknowledged the hazards of such dueling proceedings. The Court conceded that so-called "mixed motives" (both quality of care and retaliation) may be in play when a physician faces charges at a hospital, and noted, "We also realize that two things may be true at the same time." Indeed, the peer review hearing and the physician's whistleblower action could conceivably end in different, even mutually inconsistent, outcomes. A disruptive or dangerous physician might also be, or claim to be, a whistleblower with a legitimate point to make. What preclusive effect, if any, should the outcome of a peer review hearing have on a parallel H&S 1278.5 trial? The Court raised the question—and left it unanswered.

While physicians may rush to use *Fahlen* to initiate concurrent litigation, hospitals should consider H&S 1278.5(h), which permits a medical staff to obtain an injunction preventing a putative whistleblower-physician from obtaining discovery that would impede peer review or endanger patients; but that process only delays the whistleblower case. It does not preempt it. The Court discussed subsection (h) in detail in its ruling, and it will likely take on greater importance in future litigation. Notably, discovery in a whistleblower action may cut both ways, affording advantages to medical staffs as well as to physicians.

In addition, physicians who participate in peer review (for example, on medical executive, ad hoc investigative, and judicial review committees) may have cause for concern after *Fahlen*. The ruling confirmed that California law gives physicians a powerful tool to probe the motives behind peer review actions. Even the Health Care Quality Improvement Act (HCQIA), the federal statute granting immunity to reviewing physicians, does not necessarily preclude remedies under the California statute, because a *Fahlen* challenger of a peer review action could claim that the discipline was not based on objective facts. As the *Fahlen* court pointed out, hospitals cannot argue that HCQIA pre-empts the *Fahlen* floodgates: HCQIA says nothing about the procedures individual states may utilize to determine whether peer review decisions are subject to challenge.

Steps That Healthcare Entities Should Consider

Advocates are already criticizing the new rules of the game ushered in by *Fahlen*. But a change in California law to strengthen the rule of exhaustion is unlikely. Nor is there any immediate prospect of federal legislation to pre-empt statutes like H&S 1278.5.

Therefore, healthcare entities should move quickly to plug holes in their system that could be exploited via *Fahlen* by a physician in an attempt to foreclose otherwise warranted disciplinary actions. But, keeping in mind that although the ***fact*** of a whistleblower's complaint may be protected, that does not necessarily mean that the ***method*** of registering the complaint is also insulated. Those issues remain for another day. Hospitals and medical staffs should consider adopting joint policies that encourage effective—but respectful—communication of concerns without fear of retaliation. Such policies should outline the key steps for

receiving and registering a complaint, processing the complaint, and responding to the complaint; and they should require that members of the medical staff comply with the policy when they do wish to register a grievance or complaint.

Any complaint policy should also acknowledge the hospital's and medical staff's obligations and commitments to maintain effective quality assurance and peer review systems. Finally, it should acknowledge the individual medical staff member's obligation to adhere to the appropriate channels of communication so that all participants are also protected.

Key to complying with H&S 1278.5 is assuring there is no retaliation against the medical staff member ***because*** of the member's having complained. Now, more than ever before, it will be important for hospitals and medical staffs dealing with classic disruptive behavior to clearly delineate the difference between appropriate and inappropriate expression of complaints and concerns. And hospitals may need to re-examine a host of other peer review issues in the wake of Fahlen, such as the duration of peer review hearings. Medical staffs may find that lengthy hearings cede a significant advantage to plaintiff physicians.

How Nossaman Can Help

Nossaman attorneys are experienced in medical staff peer review activities, physician conduct guidelines, and hospital grievance policies and procedures. We are available to assist in tailoring policies and procedures for your hospital and medical staff that will draw on this experience and enable you to navigate carefully and effectively through the complex issues associated with H&S 1278.5 and *Fahlen*.

Nossaman's award-winning Healthcare Practice Group combines a long history of excellence with cutting-edge knowledge of the rapidly changing healthcare industry. Chambers and Partners recognized Nossaman's 34-member Healthcare Practice Group as one of the best in California, praising the Group's combination of "hands-on knowledge of the legislative process and medicine with legal expertise to offer practical solutions to its clients." Nossaman healthcare attorneys provide regulatory, transactional, legislative and litigation expertise, and represent a wide variety of healthcare clients, including hospitals, integrated health systems, all varieties of health plans and managed care organizations, research institutions, surgicenters, discount plans as well as medical practice entities and individual professionals.