

# On Your Behalf ...

## Legislative and Practice Affairs Division

### You Can't Say That!

#### One Physician Wins, Another Loses in Free Speech Lawsuits

By David E. Willett, Esq., CSA Legal Counsel

A California Court of Appeal decision in June and a California Supreme Court decision in July applied California's "anti-SLAPP" statute to suits involving physicians. The anti-SLAPP law permits dismissal of law suits which are "strategic law suits against public participation." Enacted in 1992, the law is intended to provide a quick route to dismissal of suits brought against those who have exercised rights of free speech or otherwise spoken out in matters of public importance. The Legislature concluded that such suits are an abuse of process, intended only to intimidate and to punish the exercise of protected rights. In both suits, CMA and AMA appeared as a "friend of the court" in amicus curiae briefs supporting the physicians involved. One used this law to his advantage. The other was the target of an anti-SLAPP motion. A suit will be dismissed if the court concludes that it attacks the exercise of the right of free speech or statements made in connection with official proceedings authorized by law, or in other circumstances of public significance. To avoid dismissal, the plaintiff who brought the suit must show the probability of prevailing.



*Integrated Health Holdings Inc. v. Fitzgibbons* was a suit brought by the purchaser of Western Medical Center-Santa Ana against the hospital's immediate past chief of staff. IHHI claimed that an e-mail sent by Dr. Fitzgibbons to other members of the medical staff, particularly MEC members, constituted defamation and other wrongful acts. The e-mail stated,

By the way, the hospital appears to be underwater and I don't think IHHI can get an investor to pony up the \$20 million for the 60 to 70 million shares of stock that they are selling. Admissions are down 20 percent. They got a reduction of costs by dumping Tenet by 13 percent, and increased insurance payment of 7 percent (but that is neutralized by the factoring). Then their nursing salaries went up 8 percent; so they're in the red. No way to get out. That is ominous. What would the buyer get buying IHHI stock? Control of IHHI but not the land? Sounds like its going BK. Get ready.

The e-mail continues by discussion of what would have happened "if the doctors had been in the deal."

## Legislative & Practice Affairs (cont'd)

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The hospital's suit charged Dr. Fitzgibbons with defamation, intentional or negligent interference with a contractual relationship, and other misdeeds. The "interference with a contractual relationship" allegations addressed stalled negotiations with Blue Cross, attributed to the forwarding of the e-mail to Blue Cross by an unknown party.

The Court of Appeal easily concluded that the e-mail dealt with a matter of "public interest" or importance, noting that IHHI's acquisition of four Orange County hospitals, including WMC-Santa Ana, had been the subject of public hearings by the California Senate and the Board of Supervisors, having also been discussed in articles in numerous newspapers and periodicals, focusing on IHHI's financial ability to operate the hospitals and the impact on the public if it failed. The court concluded that the definition of "public interest" within the meaning of anti-SLAPP protections has been broadly construed to include not only governmental matters, but also private conduct that impacts a broad segment of society and/or that affects a community in a manner similar to a governmental entity. IHHI's ownership of hospitals in Orange County made it large and powerful enough to fit this definition in the context of the e-mail.

Dr. Fitzgibbons thus was able to invoke the protection of the SLAPP statute and could make a motion to dismiss the hospital's suit. To defeat this motion, the hospital had to present evidence supporting the probability of winning. For example, falsehoods or deliberate distortions could be cause for liability. However, in this case the hospital failed to present evidence that what Dr. Fitzgibbons said was false or otherwise wrongful. Accordingly, the Court of Appeal ruled that the Superior Court should have granted Dr. Fitzgibbons' motion to dismiss.

This decision will be an important precedent when physicians must challenge hospital actions that can impact significantly the quality or provision of care in the community. The facts in the case serve as a reminder that no e-mail is confidential, and the contents of an e-mail in the cold light of day could be subject to varying interpretation. However, the appellate court's willingness to consider all of the facts, in the context of larger issues of public importance, is heartening, particularly when the trial court had refused relief.

The physician in the case decided by the California Supreme Court learned that the anti-SLAPP statute is a sword as well as a shield. In *Kibler v. Northern Inyo County Local Hospital District et al.*, Dr. Kibler sued the hospital for defamation and interference with his medical practice. He had been summarily suspended based on his "continuing and recently escalating unprofessional conduct of extremely hostile and threatening verbal assaults, threats of physical violence, including assault with a gun, and related erratic actions of a hostile nature

toward nursing and administrative personnel.” The hospital also sought an injunction against Dr. Kibler under a statute allowing for injunctions against workplace violence. That action was resolved by Dr. Kibler’s agreement to refrain from hostile, violent, intimidating or demeaning conduct toward hospital personnel, and that he not keep or carry a firearm on the premises. The court also entered an injunction requiring Dr. Kibler to attend anger management classes and barring him from bringing any firearm to the hospital. Subsequently, Dr. Kibler brought his defamation suit against the hospital, certain physicians and nurses, seeking damages. The hospital moved to dismiss. Both the trial court and the Court of Appeal agreed that Dr. Kibler’s suit was a lawsuit brought solely to harass the defendants, subject to dismissal under the anti-SLAPP statute.

The Supreme Court granted review in order to decide whether a hospital peer review proceeding is an “official proceeding authorized by law,” so as to fall within the ambit of the anti-SLAPP statute. A 1979 four-to-three Supreme Court decision (*Hackethal v. Weissbein*) had concluded that peer review proceedings were not “official proceedings.” This time, in a unanimous decision, the court reached the opposite conclusion. The court justified its holding on subsequent changes in governing statutes, as well as persuasive evidence that the legislature intended all along that protections extended in official proceedings should apply also in peer review proceedings, as the *Hackethal* dissent had argued. The court reasoned:

As we mentioned earlier, the Legislature has granted to individual hospitals, acting on the recommendations of their peer review committees, the primary responsibility for monitoring the professional conduct of physicians licensed in California. In that respect, these peer review committees oversee “matters of public significance,” as described in the anti-SLAPP statute. As noted in the joint amicus curiae brief of Catholic Healthcare West and The Regents of the University of California filed on behalf of defendant hospital, membership on a hospital’s peer review committee is voluntary and unpaid, and many physicians are reluctant to join peer review committees so as to avoid sitting in judgment of their peers. To hold, as plaintiff Kibler would have us do, that hospital peer review proceedings are *not* “official proceedings authorized by law” with the meaning of [the anti-SLAPP statute] would further discourage participation in peer review by allowing disciplined physicians to file harassing lawsuits against hospitals and their peer review committee members rather than seeking judicial review of the committee’s decision by the available means of a petition for administrative mandate.

In the IHHI case, no “official proceedings” were involved, but the anti-SLAPP statute was applied because of the public interest and resulting significance of the discussion in which communication occurred. In the Kibler case, the court had only to find that peer review proceedings qualified as “official proceedings,” in which these protections apply without the need to evaluate public interest in the specific issues. It is sufficient to note the public’s interest in peer review proceedings and processes generally. In both cases, free speech prevailed.

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### Anesthesia Group Leverage in Contract Negotiation

By Phillip Goldberg, Esq., CSA Legal Counsel

Frequently I am asked questions about technical aspects of the negotiation of contracts between anesthesia groups and hospitals. Often there will be a lengthy discussion about the point of contention between the anesthesia group and the hospital, followed by the question: “Can they do that?” Most of the time, the answer to this question is



“Yes.” For the most part, negotiations between anesthesia groups and hospitals are not constrained by hard and fast rules. There are rather arcane laws applicable to anesthesia contracts, but those laws rarely impact what the parties say or do in contract negotiations. Anesthesiologists should not despair over this circumstance because they often have significant *leverage* in their negotiations with hospitals and are rarely in a position where they must take whatever they are offered. The practical effect of this *leverage* is significant, and anesthesiologists are well served to keep it in mind. I want to review certain aspects of the typical anesthesia group’s negotiation *leverage*.

### Seller’s Market

Although I do not believe the nationwide shortage of qualified anesthesiologists is as acute as it was a few years ago, qualified anesthesiologists remain in relatively short supply. Hospital administrators should be extremely reluctant to reject the last best offer from an anesthesia group in view of the relative scarcity. In this regard, the larger the anesthesia group, the more difficult it is for the hospital to replace it.

### The Devil You Know

Beyond the difficulty of finding replacements for an entire anesthesia department, hospital administrators need to be concerned about the quality of the replacements and the cost of their hire when and if they decide to break off negotiations with the current anesthesia group. Often, *locums* services are used on at least an interim basis when the hospital finds itself acutely short-staffed in its anesthesia department. *Locums* services are always very expensive for hospitals. In the typical *locums* arrangement, the hospital pays the *locums* service to provide the anesthesiologists—the hospital then bills and collects from patients and third-party payers for the *locums*' services. In my experience, hospitals are particularly unsuited to billing and collecting for anesthesia services. As such, *locums* are often a pure expense without any offsetting revenue generated from the hospital's perspective. Additionally, hospitals should be sensitive to the fact that their arrangements with *locums* may violate California's prohibition on the corporate practice of medicine.

### Your Friends on the Medical Staff

Just as hospital administrators should be reluctant to engage either *locums* or even more permanent anesthesiologists to replace an existing group, other members of the medical staff may be reluctant to have to get used to new anesthesiologists. Whenever negotiations between a hospital administrator and an anesthesia group become contentious, anesthesiologists are well served by fostering support for their position among the other members of the medical staff. In particular, they should seek the support of the surgeons who are big admitters to the hospital. You want the surgeons to be your allies—not your enemies. You should take steps to ensure that you have an ongoing proper relationship with your friends on the medical staff.

In conclusion, it may appear to anesthesiologists that hospital administrators hold all the cards when it comes to contract negotiations, but this is clearly not the case. It is easy to understand the anxiety an anesthesiologist feels when he or she is faced with the prospect of losing a position on the medical staff that he or she has held for many years. Comfort can be taken in knowing that the hospital almost always has as much (or more) to lose in those contract negotiations. It is important that anesthesia groups recognize their strengths, not just their weaknesses, in these negotiations.

### Legislative Update

*By William E. Barnaby, III, Esq., CSA  
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The big ticket, controversial bills that make it all the way through the legislative process and get signed into law, dominate legislative headlines, and rightly so. A confluence of events during the 2006 California legislative session unexpectedly produced some major policy developments including an unprecedented \$37 billion infrastructure rebuilding plan, landmark controls on greenhouse gas emissions, a boost in the minimum wage and a prescription drug discount plan for low income and uninsured Californians. Remarkably, these policy breakthroughs resulted from election year “deals” between Republican Governor Arnold Schwarzenegger and the Democratic legislative leadership.

Yet, sometimes overlooked and almost as important are bills that don't make it into law. The veto of a high profile bill draws a brief moment in the public spotlight, but other defeated or stalled measures sometimes return in different forms or fade away entirely.

SB 840 by Senator Sheila Kuehl (D-Santa Monica) was promoted by its supporters as a universal single payer healthcare system that could be readily implemented in short order. The Governor wasted no time in vowing to veto the bill even before it reached his desk. He did not even need to emphasize that the measure could not take effect before a financial plan is enacted, while several other missing ingredients depended upon successful completion of future legislative and executive actions. His quick veto pledge was highly publicized and rendered moot further need to expose the emptiness of the bill.

SB 840 was a much more ambitious proposal when first introduced. But as it worked its way through various committees, it was repeatedly amended to remove its most controversial and opposed provisions. In the wake of the intended veto, Senator Kuehl promised to reintroduce a similar bill next year while other supporters of a state-run health plan look toward a 2008 ballot initiative.

AB 1321 by soon to be Senator Leland Yee (D-San Francisco) would have prohibited “balance billing” by hospital-based physicians for non-contracted services rendered to managed care patients. The bill died early in 2006 but the

## Legislative & Practice Affairs (cont'd)

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issues surrounding health plan payment for out-of-network services returned with a vengeance in regulations proposed by the Department of Managed Health Care. AB 1321 was strongly opposed by the California Medical Association, CSA and other medical specialties. The regulation package initiated in August is facing the same lineup of opponents.

SB 1508 by Senator Debra Bowen (D-Marina del Rey) sought to assure that patients undergoing health plan covered colonoscopies would also have coverage for the type of anesthesia deemed appropriate by the treating physician. This bill was poorly drafted from the start and was subjected to a series of confusing amendments, but made it through the Senate. When it finally was further amended into a form CSA and other physician organizations could accept, the bill had become so tarnished that it died due to uncertainties over where it really was headed. Known by many interested parties around the Capitol as the “Blue Cross bill,” it was designed to counter obstacles to using a professional trained in anesthesia to administer propofol when the treating physician determined this drug was indicated for Blue Cross enrollees.

After SB 1508 met its fate, CSA and the Southern California Society of Gastroenterology joined in directing a strong protest to Wellpoint, Inc., parent of Blue Cross, for its “attempt to prevent physicians’ medical judgments on appropriate use of anesthesia care during colonoscopy.” Blue Cross and Wellpoint continue to ring up huge profits while imposing a barrier to one of the most effective lifesaving screening procedures for the early detection of cancer.

As mentioned, bills that fail one year frequently are repackaged and brought back for renewed attempts. Persistence can pay off. Many programs and state laws are the product of multi-year efforts. Term limits also encourage such repeated attempts. Next year, for example, 35 of the Assembly’s 80 seats will be occupied by new members. Thus, the largest ever freshman class will be unburdened by past debates.

For those of us who have been working the Capitol circuit for awhile, we know better than to throw out all our old bill files. Like neckties, old ones often come back as the hot new fashion.

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