

Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians

PETER B. JURGELEIT*

“A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.”¹

“There is no public policy more important or more fundamental than the one favoring the effective protection of the lives . . . of citizens.”²

INTRODUCTION

As soaring medical costs³ have fueled the drive for increasingly competitive managed health care, the concentration of health care providers, services, and facilities in the hands of managed care organizations (“MCOs”)⁴ has had an ever

* J.D. Candidate, 1998, Indiana University School of Law—Bloomington; A.B., 1991, Dartmouth College. Special thanks to Professor Kenneth G. Dau-Schmidt for his suggestions on earlier drafts of this Note. I would also like to thank my parents, my brother, and my sister for their motivational support over the years.

1. PRINCIPLES OF MEDICAL ETHICS Principle I (1997), *reprinted in* COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS at xiv (1997).

2. *Palmateer v. International Harvester Co.*, 421 N.E.2d 876, 879 (Ill. 1981) (extending a retaliatory discharge cause of action to a worker fired for supplying information to a local law enforcement agency regarding a coworker’s theft of a two-dollar screwdriver).

3. National health care spending in 1994 totaled \$949.4 billion, or 13.7% of the nation’s gross domestic product. See Robert Pear, *Health Costs Are Growing More Slowly, Report Says*, N.Y. TIMES, May 28, 1996, at A13. In 1995, national health expenditures reached \$988.5 billion. See Katharine R. Levit et al., *National Health Expenditures, 1995*, HEALTH CARE FIN. REV., Fall 1996, at 175, 175. Assuming current laws remain in force and that the trends in current practices of health care delivery and financing continue, national health expenditures are estimated to grow to \$2.2 trillion, or 17.9% of the gross domestic product, by the year 2005. See Sally T. Burner & Daniel R. Waldo, *National Health Expenditure Projections, 1994-2005*, HEALTH CARE FIN. REV., Summer 1995, at 221, 221-22.

4. As used in this Note, “managed care organization” will refer to any health care provider that attempts “to control [the] standards of practice and referrals to specialists and to hospitals.” MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS’ CONFLICTS OF INTEREST 138 (1993). As one authority on the subject defines it:

The term *managed care* refers to HMOs [health maintenance organizations], PPOs [preferred provider organizations], and increasingly, to most indemnity plans with management structures that control practice standards and referrals [i.e., independent practice associations, (“IPAs”)]. Managed-care providers attempt to organize systematically the use of medical care and the manner in which it is delivered in order to achieve explicit objectives Managing care requires restricting patients’ choice of providers and medical options and physicians’ clinical autonomy. Both the physician and the patient are managed.

Id. at 138-39 (emphasis in original) (footnote omitted). For alternative definitions of “managed care,” see George W. Rimler & Richard D. Morrison, *The Ethical Impacts of Managed Care*, 12 J. BUS. ETHICS 493, 494 (1993).

expanding effect on the way medical treatment is both administered and received in this country. Unlike the patient-physician relationship of yesteryear, when a doctor's discretion over medical decisions concerning a patient's health remained relatively unfettered by any institutional pressures or financial incentives to limit care, the emergence of managed care over the last twenty years has increasingly operated to influence physicians' decisionmaking processes, financially inducing their more limited use of medical treatment, referrals, and facilities. In fact, in many ways HMOs have supplanted physicians and their patients as the decisionmaking authority in health care delivery.

As private employers, insurance companies, and the federal government encourage employees, policyholders, and benefits recipients (e.g., Medicaid and Medicare beneficiaries) to enroll in HMOs, the commercial influence, physical size, and enhanced bargaining power of HMOs continue to expand. Given the increasing pressure to control costs by rationing care, HMOs routinely terminate the contracts of those physicians who either overutilize HMO services, or who tend to appeal HMO denial-of-treatment decisions. This creates a substantial conflict of interest for many physicians, one that pits their ethical duty to provide competent care against their financial interest in protecting their access to a steady flow of patients. With the corporate muscle to restrict a physician's access to the patient supply (and thus remuneration), HMOs can force physicians to defer to the HMOs' judgment over the appropriateness and necessity of a particular medical treatment, even when it is against the physicians' best judgment.

Physicians typically contract with HMOs on an at-will basis.⁵ In other words, if in spite of financial incentives encouraging more limited use of medical treatment, services, and procedures, a doctor nevertheless continues to prescribe treatment the HMO feels is unwarranted, the HMO can terminate the contract.

Combining medical insurance with provision of services, HMOs provide comprehensive medical care to subscribers, using a closed panel of physicians. Members pay a fixed monthly premium and only nominal fees for services rendered (copayments) The crucial factor [of HMO managed care] is that choices traditionally made exclusively within the patient-physician relationship are explicitly controlled by organizational and institutional arrangements.

RODWIN, *supra*, at 138-39.

On the other hand, with PPOs, the other main form of managed care, "[s]ubscribers can receive medical care from a closed panel of physicians . . . [or] from any other physician they choose, as in indemnity insurance, if they make a significant copayment (usually about 20 to 30% of the fee). Insurance kicks in only after the patient has paid a deductible." *Id.* at 138.

Because non-HMO managed care organizations "permit physicians to maintain their independent practices, to serve most of their patients under traditional insurance arrangements, and to be reimbursed on a discounted fee-for-service basis," Douglas R. Wholey et al., *The Effect of Physician and Corporate Interests on the Formation of Health Maintenance Organizations*, 99 AM. J. SOC. 164, 169 (1993), the coercive effects of managed care's financial incentives, and thus any conflict of interest, is not as great in the non-HMO setting as it is in the HMO setting. Except for an occasional reference to managed care generally, this Note will concentrate on termination of HMO-physician contracts.

5. See Alan Somers, *What You and Your Physician Client Need to Know About Managed Care Contracts (Part I)*, PRAC. LAW., Mar. 1996, at 15, 26-27.

The same result can occur when the physician must serve as his patient's advocate, pleading to HMO review boards on his patient's behalf for treatment approval. Moreover, from a negotiating standpoint, not only are HMO-affiliated physicians terminable at-will, they are also independent contractors,⁶ a legal status that complicates and impairs assertion of any wrongful termination claim. Physicians' position as at-will independent contractors enhances HMO bargaining power, enabling HMOs to exercise much greater control over physician behavior than traditional indemnity insurers ever could.

At-will employment has existed for over a century.⁷ Historically, the at-will relationship meant that in the absence of any express contractual provision to the contrary, an employer could dismiss an employee for any reason, for no reason, or even for a bad reason. In recent years, however, courts have carved exceptions into the employment-at-will rule, granting a cause of action for wrongful discharge where the discharge either violated public policy,⁸ or breached an implied-in-law⁹ or implied-in-fact¹⁰ contract. In fact, in some states, if a discharged professional can point to a clear public policy embodied in his profession's code of ethics, establish that his termination was based on his refusal

6. See *id.* at 24-25.

7. An 1877 employment law treatise by Horace G. Wood is generally credited as the first articulation of the employment-at-will doctrine. See Kimberly Kraly Gearity, Note, *At-Will Employment: Time for Good Faith and Fair Dealing Between Employers and Employees*, 28 WILLAMETTE L. REV. 681, 681 (1992). According to Wood:

With us the rule is inflexible, that a general or indefinite hiring is *prima facie* a hiring at will, and if the servant seeks to make it out a yearly hiring, the burden is upon him to establish it by proof. A hiring at so much a day, week, month or year, no time being specified, is an indefinite hiring, and no presumption attaches that it was for a day even, but only at the rate fixed for whatever time the party may serve.

H.G. WOOD, A TREATISE ON THE LAW OF MASTER AND SERVANT 272 (Albany, NY, John D. Parsons, Jr. 1877). *Payne v. Western & Atlantic Railroad* is generally recognized as the first judicial application of the employment-at-will rule. "[A]ll [employers] may dismiss their employe[e]s at will . . . for good cause, for no cause or even for cause morally wrong, without being thereby guilty of legal wrong." *Payne v. Western & Atl. R.R.*, 81 Tenn. 507, 519-20, 13 Lea 401, 411 (1884), *overruled on other grounds*, *Hutton v. Watters*, 179 S.W. 134 (Tenn. 1915).

8. See, e.g., *Petermann v. International Bhd. of Teamsters*, 344 P.2d 25 (Cal. Dist. Ct. App. 1959) (holding that public policy was violated when employee was discharged for refusing to commit perjury).

9. See, e.g., *Fortune v. National Cash Register Co.*, 364 N.E.2d 1251 (Mass. 1977) (holding that implied covenant of good faith and fair dealing was violated when employer discharged employee in order to avoid paying employee commissions to which he was otherwise entitled).

10. See, e.g., *Toussaint v. Blue Cross & Blue Shield*, 292 N.W.2d 880 (Mich. 1980) (holding that implied-in-fact contract was violated when discharged employee had legitimate expectation of employment tenure based on the employer's policy statements and handbooks). Of the three exceptions, the public policy exception is the one most widely recognized. Currently 43 jurisdictions have adopted the "retaliatory discharge" cause of action as a restraint on the employer's historically unlimited right to terminate at will. See Sara A. Corello, Note, *In-House Counsel's Right to Sue for Retaliatory Discharge*, 92 COLUM. L. REV. 389, 394 n.22 (1992).

to comply with his employer's wishes, and prove that compliance with those wishes would have required him to violate a mandatory ethical duty, then he may be able to rely upon that code as a foundation for a retaliatory discharge claim.¹¹ If a physician could establish that, despite the "independent contractor" label, the extent of the HMO's control over his decisionmaking nevertheless warranted granting him de facto employee status, then he should be able to state a cognizable retaliatory discharge claim (assuming the termination violated the public policy embodied in the physician's ethical code). When public policy commands adequate medical care, and a physician feels ethically bound to prescribe a particular treatment, perform a certain procedure, or lobby for treatment approval, termination of an at-will HMO employment contract should entitle a discharged physician to a cause of action.

Part I of this Note will demonstrate how, given the financial and political pressure to embrace managed care as a solution to skyrocketing health care costs, the radically different employment setting in which physicians work today, the increasing number of Americans enrolled in HMO plans, and most importantly, the widening disparity in bargaining power between HMOs and physicians, doctors today face previously unknown conflicts of interest which force them to choose between either compromising their ethical duties or jeopardizing their professional existence. Part II will argue that physicians should be treated as de facto HMO employees for retaliatory discharge purposes. Part III will then trace the development of employment-at-will, articulating the strengths and weaknesses of the available exceptions to the rule. Drawing on case law regarding the use of professional ethics as a source of public policy in which a wrongful discharge cause of action may be rooted, Part IV will then argue in favor of judicial recognition of a wrongfully terminated at-will HMO contract, where the termination contravenes public policy. Finally, Part V will define the elements of

11. See, e.g., *General Dynamics Corp. v. Superior Court*, 876 P.2d 487, 501 (Cal. 1994) (granting retaliatory discharge remedy to terminated corporate counsel where attorney's "mandatory ethical norms . . . collide with illegitimate demands of employer and attorney insists on adhering to . . . clear professional duty"); *Rocky Mountain Hosp. & Med. Serv. v. Mariani*, 916 P.2d 519 (Colo. 1996) (allowing terminated CPA to rely on State Board of Accountancy Rules of Professional Conduct as source of public policy for purposes of wrongful discharge claim); *GTE Prods. Corp. v. Stewart*, 653 N.E.2d 161, 167 (Mass. 1995) (allowing a discharged in-house legal counsel to bring a wrongful discharge cause of action where employer's demands would have required attorney to violate "explicit and unequivocal statutory ethical norms . . . which embody policies of importance to the public at large"); cf. *Wieder v. Skala*, 609 N.E.2d 105 (N.Y. 1992) (granting discharged law firm associate a cause of action for breach of contract where compliance with firm's governing disciplinary rules was an implied term in employment agreement, but rejecting associate's attempt to rely on state's code of professional responsibility in action for abusive discharge). *But see* *Willy v. Coastal Corp.*, 647 F. Supp. 116 (S.D. Tex. 1986) (declining to extend Texas's public policy exception to an at-will attorney where he was discharged for refusing to do what he believed violated the law), *rev'd on other grounds*, 855 F.2d 1160 (5th Cir. 1988), *aff'd*, 503 U.S. 131 (1992); *Balla v. Gambro, Inc.*, 584 N.E.2d 104 (Ill. 1991) (declining to grant dismissed in-house counsel a cause of action for retaliatory discharge, where attorney adhered to ethical code in effort to protect public health).

the proposed cause of action, delineate the tort's boundaries, and articulate why extending the tort to doctors would make good policy.

I. BACKGROUND: THE EVOLUTION AND EXPANSION OF MANAGED CARE

Like the massive corporations whose abuse of private economic power eventually spawned the birth of the labor movement and indirectly triggered the erosion of the employment-at-will rule, HMOs and other forms of MCOs have assumed a bargaining position vis-à-vis health care providers that is every bit as powerful, influential, and coercive as those of any other large corporation. Despite their status as independent contractors, HMO-affiliated physicians today find themselves forced to comply with HMO protocols regarding appropriate medical care. For many doctors, this may mean either compromising patient health or losing coveted HMO affiliation. To understand the ways in which an HMO may take undue advantage of physicians through its power of the purse, one must first understand the evolution of managed care and the impact it has had on physician discretion and autonomy.

A. Traditional Practice of and Payment for Medicine

At the turn of the century, when a person became sick, she went to her family doctor for treatment. For each service the doctor rendered, she owed a fee.¹² Fee-for-service payment encouraged physicians to prescribe treatment: the more the physician treated, regardless of patient need or desire, the more money he made.¹³ Despite this incentive, medicine in the early twentieth century was in many ways nevertheless an eleemosynary profession. Doctors were not particularly wealthy, and in fact many could not even make ends meet.¹⁴ One's ability to pay, a genuinely real and visible factor to consider when every patient paid out-of-pocket, effectively prevented most physicians from taking economic advantage of their patients.¹⁵

More importantly, turn-of-the-century medicine's limited profit-making potential diluted the value of any financial incentive to treat, inhibiting any tendency to compromise a physician's ethical duty to place patient health above all other considerations.¹⁶ However, during the Great Depression, hospitals,

12. See RODWIN, *supra* note 4, at 2. Until 1929, 90% of patients paid for medical care entirely out-of-pocket. See BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 198 (1991).

13. *But see* RODWIN, *supra* note 4, at 13 (noting that when treating the poor, "physicians [often] set lower fees, did not charge, or could not collect").

14. *See id.* at 2-5.

15. See David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1715 (1992) ("To the extent that the market for medical care was primarily private, the ability of people to pay . . . set strict constraints on its consumption.").

16. "[T]he central canon of medical ethics . . . emphasizes that physicians have [a duty] to: (1) be loyal to patients; (2) act in their patients' interests; (3) make their patients' welfare their first consideration, even when their own financial well-being is opposed; and (4) keep patient

private employers, health insurance companies, and physicians developed a voluntary health insurance system that paid physicians for their services through third-party payers.¹⁷ Whether sponsored or subsidized by hospitals, Blue Cross, Blue Shield, commercial insurers, or private employers,¹⁸ the underlying purpose of all third-party payer systems was fundamentally the same: "to reimburse physicians and patients for all appropriate medical care for which patients are insured."¹⁹ With third parties paying the bill, doctors gradually became less concerned with both the cost of their services and the value of the treatment in relation to that cost.²⁰ This arrangement strengthened the physician's financial interest in the cure they prescribed because it insulated them from any budget constraints.²¹ "Physicians . . . developed practice styles based on fee-for-service incentives that encourage[d] high utilization of medical services."²² They soon enjoyed virtually unlimited control over both the medical practice and its workplace.²³ While physicians may have been undercompensated at the start of the twentieth century, by the end of the century, few could argue such a claim.²⁴

information confidential." RODWIN, *supra* note 4, at 8. As one philosopher has construed the ethos:

"In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agent of society, nor of the interest of medical science, the patient's family, the patient's co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care . . . [H]e is bound not to let any other interest interfere with that of the patient in being cured . . . We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God."

Id. (omissions and alterations in original) (quoting Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, 98 DAEDALUS 219, 239 (1969)).

Although fee-for-service payment pitted a physician's personal interest in making money against his professional interest in keeping his medical judgment untainted by considerations of cost to the patient or potential profit to the physician, it usually inured to the patient's physical benefit in any event (albeit perhaps only marginally, and always at the patient's financial detriment). In most cases, as far as the patient was concerned, the physician's interests were aligned with his. In fact, until the late 1960s, this conflict of interest and its ethical implications were seldom even mentioned in professional writing. *See id.* at 2.

17. *See id.* at 13. For a discussion of the historical development of the health insurance industry in the United States, see FURROW ET AL., *supra* note 12, at 198-203.

18. *See* FURROW ET AL., *supra* note 12, at 198-203.

19. RODWIN, *supra* note 4, at 14.

20. *See id.*

21. *See id.* at 5, 14. *But see* Mechanic, *supra* note 15, at 1715-17 (asserting that despite the public's inability to see "an obvious link between the theoretical availability of entitlements and difficulties in obtaining them," insurance companies have been rationing care since before World War II).

22. RODWIN, *supra* note 4, at 139.

23. *See* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445 (1988).

24. Indeed, by 1990, an average physician's annual income after expenses and before taxes had risen to \$155,800, more than seven times the average salary. *See* RODWIN, *supra* note 4, at 5. *But see* George J. Church, *Backlash Against HMOs*, TIME, Apr. 14, 1997, at 32, 34-35 (reporting that "[i]n California, where HMOs are most dominant, the average earnings of a primary care physician dropped from \$172,000 in 1993 to \$146,000 in 1995"); *Study Finds*

*B. Physician Compensation and Decisionmaking Under
Typical HMO Rules*

Understandably, with physician salaries rising, rapid advances in science and technology, an aging population (often with a high prevalence of chronic disease), heightened patient expectations, and an increasing number of health professionals and physicians (who to some degree create demand for their own services), health care costs have soared.²⁵ Concomitantly, pressure to contain costs has increased as well. Stimulated in part by the federal government,²⁶ managed care has emerged in response to evidence that traditional fee-for-service health insurance plans encouraged the delivery of often unnecessary or inappropriate health care services.²⁷

To reduce a physician's self-interest in performing unnecessary treatment, HMOs eliminate many of the financial incentives traditionally associated with fee-for-service payment arrangements.²⁸ Typically, once a physician contracts her services with an HMO, she is subject to a number of different pressures, each one designed to encourage her to prescribe, treat, and refer less. Under an HMO framework, one group of physicians serves as "gatekeepers," regulating patient access to laboratory services, specialists, and in-patient hospital stays.²⁹ In treating patients, each primary care physician must weigh the medical necessity of a particular treatment against the financial "hit" she will take if she prescribes that treatment.³⁰ In essence, participating physicians get paid more to do less. Non-"gatekeepers" are subject to many of the same incentives, and are likewise penalized for excessive laboratory tests, physician referrals, and in-patient hospital visits.

Capitation and salary, the two main alternatives to fee-for-service payment, both result in the physician being paid a fixed level of compensation, regardless of the number of services she provides.³¹ With capitation, "the physician assumes responsibility for the care of a number of patients and is paid a fixed amount of

Dip in Income of Doctors, N.Y. TIMES, Sept. 3, 1996, at D9 (reporting that, due in large part to managed care's efforts to control costs, physicians' annual earnings for 1994 dropped four percent from their 1993 levels, the first such drop since the statistics were compiled).

25. See Mechanic, *supra* note 15, at 1717-18; see also statistics cited *supra* note 3.

26. In 1973, the federal government passed the Health Maintenance Organization Act to stimulate efforts to manage and finance health care. See Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e to e-14a (1994). Between 1973 and 1982, the federal government invested \$340 million in prepaid health plans. See Robert Pear, *Health Care Units Will Lose U.S. Aid*, N.Y. TIMES, Apr. 18, 1982, § 1, at 26.

27. See Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1825 (1995).

28. See David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158 (1996).

29. See McGraw, *supra* note 27, at 1824.

30. See *id.*

31. See Orentlicher, *supra* note 28, at 158.

money for each patient.³² If a physician is paid by salary, she works for an HMO on a full-time basis, receiving a certain amount of remuneration regardless of the number of patients she sees.³³ The one important difference between capitation and salary is that, with capitation “physicians have an incentive to increase the number of patients for whom they have responsibility while, with salary, physicians have an incentive to reduce the number of patients for whom they have responsibility.”³⁴ In either case, for any given patient, the physician has no incentive to provide excessive services.

However, because neither capitation nor salary penalizes a physician for overusing ancillary services (e.g., a laboratory test, a referral to another physician, etc.), HMOs rely on financial incentives (i.e., bonuses, fee withholds, and expanded capitation), to discourage overutilization of such services. In a bonus arrangement, the HMO earmarks a certain percentage of enrollee premium funds to pay for ancillary services. If any unspent monies remain at the end of the year, the HMO splits them between itself and the physicians.³⁵ Similarly, with fee withholds, the HMO “deducts a percentage of physician compensation at each pay period”³⁶ and pools the monies to fund ancillary services. Like bonuses, if any residual funds remain, they are returned to the physicians.³⁷ Finally, under an expanded capitation arrangement, “a physician’s capitation payments are designed to cover not only the physician’s own services [to a patient,] but also some or all of the ancillary services.”³⁸ This means that the cost of referring a patient or ordering a laboratory test comes out of the physician’s pocket.³⁹ “In short, financial incentives to limit care discourage physicians from providing high levels of care by transferring from the health plan to the physician some of the financial risk of costly medical care.”⁴⁰

Regardless of what financial incentives an HMO employs, almost all of them incorporate some form of utilization review into the claims payment process.⁴¹

32. *Id.* Capitation fee contracts have become standard in many parts of the country. See Elisabeth Rosenthal, *Reduced H.M.O. Fees Cause Concern About Patient Care*, N.Y. TIMES, Nov. 25, 1996, at A1 (reporting that in California, such contracts cover more than 60% of HMO payments to physicians).

33. See Orentlicher, *supra* note 28, at 158-59.

34. *Id.* at 159.

35. See *id.* at 160.

36. *Id.* Physicians in managed care programs get paid on a monthly basis “almost universally.” Somers, *supra* note 5, at 27.

37. See Orentlicher, *supra* note 28, at 160.

38. *Id.*

39. See *id.*

40. *Id.* Federal law, however, regulates many incentive payment plans, requiring HMOs to meet minimum procedural and substantive obligations. See 42 C.F.R. § 417.479 (1996) (defining when an incentive plan places a physician at “substantial financial risk,” that is, when a plan places too large a percentage of a physician’s potential maximum salary in the form of withholds or bonuses, and setting forth safeguards to protect HMO enrollees); see also 42 U.S.C. § 1395mm(i)(8)(A)(i) (1994) (prohibiting HMOs from making patient-specific payments directly to physicians as an inducement to reduce or limit that patient’s use of medically necessary services).

41. See Rimler & Morrison, *supra* note 4, at 496.

Utilization review allows HMOs to closely monitor physicians' clinical decisions, ferreting out unnecessary medical services.⁴² No matter which form an HMO uses,⁴³ utilization review diminishes the role and authority of physicians' judgment. By approving or denying particular treatment, setting standards for the length of hospital visits, intervening if prescribed services are judged excessive, and requiring physicians to act as patient advocates in order to deviate from protocols, HMOs exercise enormous control over clinical decisionmaking.

Notwithstanding the systematic evidence that utilization management has no impact on provider costs, that it "adds to the administrative burden of practitioners, . . . and [that it] contributes to resentment about reduced professional autonomy and satisfaction,"⁴⁴ HMOs still rely on utilization review to dictate the delivery of medical care and monitor the productivity and profitability of their physicians. Regardless of any ethical or fiduciary obligations the physician may have to the patient, if an HMO perceives a physician as an overutilizer, or feels that a physician is a "troublemaker" because he has a tendency to advocate too vigorously or too frequently on his patients' behalf, the HMO may invoke its right to terminate the physician's contract at will,⁴⁵ thereby

42. Even before the advent of HMOs, health insurance companies used utilization programs to monitor physician behavior. However, because they did not contract with the physicians whom they were paying, it was much harder for them to control or influence physician behavior. With control over patient access, HMOs can control not only physician payment, but behavior as well. See discussion *supra* note 4.

43. See RODWIN, *supra* note 4, at 112-13. Professor Rodwin describes three different forms of review:

Preauthorization review programs require physicians to receive approval before admitting patients to hospitals for routine or elective surgery. Some programs offer or require patients to obtain a second opinion when their physician recommends a major medical procedure. Others set standard lengths for hospital stays for particular medical conditions. Physicians must receive program approval to deviate from protocols. *Concurrent review* programs monitor patients' medical charts while they are receiving hospital care. They can intervene if excess services are being provided or if alternative therapies are preferable. *Retrospective review* programs analyze hospital records after the patient has been treated. If the program finds that physicians or hospitals provided unnecessary, inappropriate, or overly costly services, they can deny payment.

Id. at 112 (emphasis in original).

44. Rimpler & Morrison, *supra* note 4, at 497. For further criticism of utilization review as a means of controlling health care costs, see RODWIN, *supra* note 4, at 113-15.

45. Under some contracts, when the termination is without cause, the HMO is not even required to provide notice or an opportunity to be heard. Many physicians find this "lack of notice and hearing following an MCO . . . termination [to be] the hallmark of the arbitrariness of the MCO contracting relationship." Stephen E. Ronai, *Physician Deselection*, CONN. L. TRIB., Sept. 23, 1996, Health L. Supp., at 4. Moreover, until *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962 (N.H. 1996), courts had "uniformly refused to read similar notice and fair hearing protections into MCO provider agreements when physicians ha[d] sought relief from allegedly peremptory 'without cause' deselection decisions." Ronai, *supra*, at 4; see discussion of *Harper infra* Part IV.C.

protecting the HMO's profits while cutting off the physician from his patient supply.⁴⁶

But control the delivery and financing of health care, and one controls the cost of health care. The profit-making and cost-cutting success of HMOs is a testament to the validity of this principle. "The imposition of controls, such as utilization review, and the transfer of risk to physicians theoretically enables the HMO to lower its medical care costs relative to costs under traditional insurance, charge lower premiums, and thus attract cost-conscious employers and their employees."⁴⁷ A look at the success and expansion of HMOs in this country will not only reveal that the halcyon days of fee-for-service medicine are likely never to return, but also that physicians today cannot survive without acquiescing to at least some HMO affiliation and control.

C. Big Business

Stimulated by the Reagan Administration in the early 1980s,⁴⁸ private investment in managed health care has become hugely profitable for both management and shareholders.⁴⁹ In 1994, cash and stock bonuses to CEOs of the nation's seven largest for-profit HMOs averaged \$7 million, with the biggest award (\$15.5 million) going to the chief executive of Healthsource, a "medium-sized" HMO.⁵⁰ For shareholders, HMO share prices grew by 100% or more a year

46. See Richard C. Reuben, *In Pursuit of Health*, A.B.A. J., Oct. 1996, at 54, 60 (quoting two health care lawyers).

47. Wholey et al., *supra* note 4, at 168.

48. See Pear, *supra* note 26, § 1, at 26. Between 1973 and 1982, the federal government invested \$340 million in prepaid health care plans (i.e., HMOs). Over that ten-year time period, private investment totaled \$1.1 billion. In an attempt to stimulate further private investment, the Reagan Administration began to withdraw federal subsidies from HMOs in 1981, and mounted an intensive campaign instead to encourage banks, businesses, hospitals, physicians, and insurance companies to invest in HMOs privately. *See id.*

49. Not all HMOs are for-profit. Unlike for-profit HMOs which are beholden to their shareholders when making business decisions, nonprofit HMOs seek primarily to provide health care to communities. Nevertheless, nonprofit HMOs still rely on many of the same financial incentives to discourage physician overutilization of services. *See* RODWIN, *supra* note 4, at 220. However, because nonprofit HMOs emphasize providing health care, rather than satisfying shareholders, there is less pressure to increase physician "productivity." Thus, physicians working for nonprofit HMOs do not face the same degree of economic pressure that confronts for-profit HMO physicians. The difference in strength of financial incentives may explain both why nonprofit HMOs have had difficulty breaking even, and why their financial independence appears uncertain. *See* Milt Freudenheim, *Hospitals Are Tempted but Wary as For-Profit Chains Woo Them*, N.Y. TIMES, Jan. 4, 1995, at A1 (reporting that despite the desire of many of the nation's 4500 nonprofit hospitals to preserve their identity and protect their mission, they may have to merge with for-profit chains in order to survive); Margaret Isa, *Merger Set for Two N.E. HMOs*, BOSTON GLOBE, Aug. 20, 1994, at 11 (reporting possible merger between a for-profit HMO, Healthsource, and a nonprofit HMO, Central Massachusetts Health Care).

50. Milt Freudenheim, *Penny-Pinching H.M.O.'s Showed Their Generosity in Executive Paychecks*, N.Y. TIMES, Apr. 11, 1995, at D1. One executive compensation expert responded that such "monstrously large grants [to HMO chief executives were] . . . among the highest we

in the early 1990s.⁵¹ Because size and breadth in the managed care market are necessary to obtain more favorable prices from doctors and hospitals, to spread fixed costs over a wider base, and to create bargaining leverage with employers, government agencies, and other companies, the incentive for HMOs to consolidate has reached a "fever pitch."⁵² The drive to widen profit margin and expand market share means the pressure to cut costs will only increase in the future.

The purpose of a corporation is to make money for its shareholders.⁵³ Consequently, the goal of most management decisions is to maximize profit. In the world of for-profit managed care, this means terminating the employment of any physician whose utilization of ancillary services cuts too deeply into the profit margin, even if that physician would have violated her ethical obligation to treat, or exposed herself to possible malpractice liability, had she not prescribed such treatment. Such a termination violates the public policy in favor of maintaining a healthy public, and the public policy in favor of protecting the fiduciary nature of the doctor-patient relationship. No matter how gigantic managed care companies grow, or how cutthroat the competition for available patients becomes, sacrificing either of these policies is simply a price too high to pay.

have seen in any industry." *Id.* In fact, according to one survey, "the salaries of HMO chiefs averaged 62% higher than those earned by the heads of other corporations of comparable size." Church, *supra* note 24, at 34.

51. See *Yet More of the Same Medicine?*, *ECONOMIST*, Apr. 6, 1996, at 67, 67. *But see id.* (reporting that increases in share prices have remained flat for almost a year).

52. Milt Freudenheim, *2 Hospital Chains to Join; 2 H.M.O.'s Also Merging*, *N.Y. TIMES*, Jan. 11, 1994, at D4 (quoting Margo Vignola, a Salomon Brothers analyst); *see, e.g., Columbia Healthcare-HCA Merger Is Completed*, *N.Y. TIMES*, Feb. 11, 1994, at D3 (reporting shareholder approval of a \$7.6 billion merger between the nation's two largest for-profit hospital chains); Freudenheim, *supra*, at D4 (announcing the merger of two of the country's largest investor-owned hospital chains); Richard Ringer, *Two California H.M.O.'s in a \$1.1 Billion Merger*, *N.Y. TIMES*, Mar. 5, 1994, §1, at 41 (announcing the completion of the highest-priced acquisition in the HMO industry); *see also Yet More of the Same Medicine?*, *supra* note 51, at 67 (reporting that between October, 1993 and April, 1996, the aggregate value of health care company mergers surpassed \$150 billion). HMOs and insurance companies have also been merging. *Compare id.* (announcing insurance company's plan to acquire an HMO), with Michael Quint, *Humana Agrees to Purchase Emphesys, a Health Insurer*, *N.Y. TIMES*, Aug. 11, 1995, at D3 (announcing an HMO's plan to acquire a health insurance company). According to some analysts in California, the more than 30 managed care insurers competing there today will be concentrated into 7 to 10 by 2005. *See Church, supra* note 24, at 34.

53. *See Dodge v. Ford Motor Co.*, 170 N.W. 668, 684 (Mich. 1919) ("A business corporation is organized and carried on primarily for the profit of the stockholders. The powers of the directors are to be employed for that end. The discretion of directors . . . does not extend . . . to the non-distribution of profits among stockholders in order to devote them to other purposes.").

D. The Business Necessity of HMO-Affiliation

To rein in health care costs, private employers, the government, and insurance companies contract with HMOs as a means of delivering less costly medical care to their employees, beneficiaries, and policyholders. Typically, in order for a patient to take maximum advantage of available health care benefits, she must select a "gatekeeper" from a list of physicians affiliated with her employer's HMO (often called "preferred providers"). As the number of employer, hospital, and insurance company contracts with MCOs increases, more and more Americans will undoubtedly enroll in managed care programs, whether voluntarily or not.

Over the last twenty-five years, the number of Americans enrolled in HMOs has multiplied more than seventeen-fold.⁵⁴ Currently, more than sixty million Americans are enrolled in HMOs, with ninety million more in other forms of managed care.⁵⁵ With Americans enrolling at such an explosive rate,⁵⁶ the patient base available to any non-HMO-affiliated physicians has naturally diminished.⁵⁷ In order to stay in business today, many physicians and other health care providers have found HMO affiliation to be a virtual necessity.⁵⁸ "In 1995, more

54. See Pear, *supra* note 26, §1, at 26. In 1970, 3.5 million Americans were enrolled in HMOs; in 1981, membership had risen to 11 million, and was expected to surpass 30 million by 1990. See *id.* Indeed the prediction held true: by 1990, HMO membership had grown to 36 million. See Alain E. Enthoven & Richard Kronick, *Will Managed Competition Work?: Better Care at Lower Cost*, N.Y. TIMES, Jan. 25, 1992, at 23. By 1996, more than 60 million Americans were enrolled in HMOs. See Robert Pear, *Stakes High as California Debates Ballot Issues to Rein in H.M.O.'s*, N.Y. TIMES, Oct. 3, 1996, at A1. This number represents more than a fifth of America's population. See *Yet More of the Same Medicine?*, *supra* note 51, at 67.

55. See Pear, *supra* note 54, at A1. For a description of other forms of managed care, see discussion *supra* note 4.

56. In California alone, HMO enrollment has grown by more than 500,000 new enrollees a year, an average of 1300 new enrollees a day. See Pear, *supra* note 54, at A1.

57. Of course, the percentage of insured patients enrolled in HMOs also depends, among other things, on the part of the country. For example, only an estimated 12% of the insured population in Maine is enrolled in a managed care plan, see Alex Pham, *Harvard Pilgrim Adds Doctors in Maine*, BOSTON GLOBE, Feb. 9, 1996, at 37, while 75% of the insured population in California is in such a plan, see Church, *supra* note 24, at 35.

58. See Barry F. Rosen & Anastasia Watson Smith, *Careful Contracts*, LEGAL TIMES, Nov. 16, 1992, Supp. at 29. Indeed,

[f]ew professional or institutional health-care providers, be they primary-care physicians, specialists, laboratories, hospitals, or ambulatory services, can survive today without developing a relationship with at least one managed-care company, whether it be a health maintenance organization, a preferred provider organization, an independent practice association, or some hybrid of these traditional managed-care entities.

Id. One's dependence on HMOs also depends on the number of employers, HMOs, and hospitals in a given community. For example, if one employer employs a whole community, and that employer contracts for its employees' health care with one HMO, then any physician wishing to practice in that community must contract with that HMO. Cf. Rosenthal, *supra* note 32, at A1 (reporting that many HMO doctors "have so many patients in . . . managed care plans that they cannot afford to quit").

than eighty-three percent of all physicians had at least one managed care contract⁵⁹ But even when not employed or affiliated with an HMO, hospital, or group practice, physicians are nevertheless increasingly tied to the interests of hospitals and other providers or third-party payers.⁶⁰ An HMO's absorption of the available patient base enhances its bargaining position vis-à-vis its physicians, because once the HMO knows a physician has nowhere else to turn for patients, it can drive a bargain as hard as it likes.

*E. Conflicts of Interest Under Managed Care*⁶¹

While the reality of stratospheric health care costs may leave any argument about the ethical impropriety of financial incentives no longer tenable,⁶² no managed care practice or inducement should be so strong as to pit a physician's continued HMO affiliation against his ethical judgment that additional health care is medically necessary. Currently, federal law regulates how strong HMO financial incentives may be.⁶³ However, neither federal law nor the courts recognize that HMOs are still free to impose the ultimate financial incentive—retention of one's HMO affiliation. To allow HMOs the unregulated power of contract termination circumvents the purpose of federal incentive-strength regulations.

But this is exactly what HMOs do when they rely on utilization review as a means of weeding out unprofitable doctors. Of course, not all of private industry's mechanisms for curbing physicians' tendency to overtreat, for containing health care costs, or for reducing waste are unethical per se.⁶⁴ However, when a procedure is medically necessary, a physician should not be forced to risk his continued affiliation with an HMO (and thus his patient supply)⁶⁵ whenever he lobbies for HMO approval of a particular treatment.

59. *Study Finds Dip in Income of Doctors*, *supra* note 24, at D9.

60. See RODWIN, *supra* note 4, at 17. "[P]hysicians compete for patients, and, since HMOs provide access to clients, any professional demographic changes that make it more difficult for physicians to remain fully occupied in their practices encourage at least some physicians to participate in HMOs." Wholey et al., *supra* note 4, at 174.

61. For a thoughtful analysis of the myriad ways in which current practices often provide doctors with financial incentives to promote various goals that may be at odds with the interests of patients, see RODWIN, *supra* note 4.

While this Note acknowledges that managed care's financial incentives create numerous conflicts of interest, its focus is on the particular deterrent effect utilization review has on the physician's duty to treat and act on the patient's behalf.

62. "Insisting on the fiscal purity of treatment decisions ignores the financial incentives inherent in the fee-for-service method of payment and the astonishing health care inflation those incentives have caused." Hall, *supra* note 23, at 516.

63. See statutes cited *supra* note 40.

64. Cf. Hall, *supra* note 23, at 474 ("In order for health care cost containment to succeed, we must abandon the established orthodoxy that shields the purity of medical decisionmaking from outside influence, yet retain that degree of protection necessary to ensure sound medical judgment.").

65. Of course, if HMO enrollees represent a smaller percentage of a physician's patient base, then loss of HMO affiliation may not be as economically disastrous. The severity of a physician's conflict of interest rises and falls with the percentage of her patients that are HMO

Burdening a physician with the prospect of job loss, when the physician does what he is ethically required to do,⁶⁶ crosses the line between acceptable and unacceptable corporate behavior.

Patients come to physicians at a time when they are sick, needy, and vulnerable. Under such circumstances, they are especially dependent upon the physicians' judgment, placing their health and often their lives in the physicians' hands. Patients trust their physicians to diagnose them, prescribe medicine for them, order laboratory tests for them, refer them to specialists, and above all, act in their best interests. Under managed care, physicians' responsibilities have even expanded to include some of the skills traditionally associated with the legal profession. Particularly where utilization review takes place before or during treatment, a physician may have to go to battle with the HMO's review board in order to convince it that a particular treatment is necessary.⁶⁷

However, HMOs occupy a powerful bargaining position. Because affiliation with an HMO is a necessity, many physicians have no choice but to adhere to the many written and unwritten terms of their HMO agreement. The ability of the HMO to terminate the contract at will encourages doctors to err on the side of not treating the patient, deters them from prescribing treatment, and often discourages them from appealing any denial of treatment they do prescribe. This creates a terrible conflict of interest for doctors, particularly when courts appear willing to hold physicians negligent for failing to appeal a denial-of-treatment order.⁶⁸ Nevertheless, if professional survival is the name of the game, many physicians may find such odds worth the risk.

enrollees. *See supra* note 57 and accompanying text. Similarly, a physician whose patients represent several different HMOs may not suffer that much by the loss of only one HMO contract. Nevertheless, where many of a physician's patients are HMO enrollees, or where there is only one HMO in town, the conflict may be intolerable. Moreover, with billions of dollars' worth of mergers and consolidation taking place in the health care industry every year, the possibility that all of a doctor's patients will eventually come from one HMO, if they do not already, is increasingly likely. *See* Reuben, *supra* note 46, at 60.

66. "The treating physician must remain a patient advocate . . ." CURRENT OPINIONS OF THE COUNCIL ON ETHICAL & JUDICIAL AFFAIRS Opinion 2.03 (1994), *in* COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at 6.

67. Of course, if review takes place after treatment, then the physician absorbs all the loss, because the HMO enrollee is not obligated to pay more than his prepaid premium. Such an arrangement places a stronger incentive on the doctor not to perform the treatment if he thinks he will not be reimbursed.

68. *See, e.g., Wickline v. State*, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (dicta) ("[T]he physician who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour.").

II. THE ARGUMENT FOR GRANTING HMO-AFFILIATED PHYSICIANS DE FACTO EMPLOYEE STATUS

Technically speaking, HMOs do not “employ” physicians; HMOs retain them as independent contractors.⁶⁹ Since the law will not impute to a principal any negligent care attributable to an independent contractor,⁷⁰ HMO contracts typically state that the physician relates to the HMO as an independent contractor.⁷¹ In addition to insulating the HMO from liability, the independent contractor relationship also makes it more difficult, if not impossible, for the physician to assert a retaliatory discharge claim.⁷² But regardless of what one calls it, the physician-HMO relationship nevertheless bears many of the hallmarks of an employee-employer arrangement, and courts should begin to recognize it as such.

In light of HMOs’ increasing control over access to patients, their unilateral power to set virtually all terms and conditions of any physician’s contract, their retention of ultimate clinical decisionmaking authority, and their right to dismiss any physician with or without cause,⁷³ drawing a legal distinction between an HMO physician and any other at-will employee puts form over substance. The

69. See *Raglin v. HMO Ill., Inc.*, 595 N.E.2d 153, 156 (Ill. App. Ct. 1992) (characterizing HMO-affiliated physicians as independent contractors and rejecting the claim that the doctrine of respondeat superior applies to the physician-HMO contractual arrangement).

70. See RESTATEMENT (SECOND) OF AGENCY § 220 cmt. e (1958) (“ordinarily a principal is not liable for the incidental physical acts of negligence in the performance of duties committed by an agent who is not a servant”); see also *id.* § 250 (principal not liable for negligence of nonservant agent if principal neither intended nor authorized the result nor the manner of performance, unless principal was under a duty of care). But see *Martin C. McWilliams, Jr. & Hamilton E. Russell, III, Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C.L. REV. 431, 443 (1996) (reporting that, despite the weight of authority, in some cases courts have concluded “that general operating guidelines imposed on physicians by hospitals constitute sufficient control over an alleged independent contractor physician to support respondeat superior liability”).

71. See *Somers*, *supra* note 5, at 24-25.

72. See, e.g., *Abrahamson v. NME Hosps., Inc.*, 241 Cal. Rptr. 396 (Ct. App. 1987) (holding physician’s status as an independent contractor prevented him from bringing wrongful discharge suit, and that the covenant of good faith and fair dealing was not implied in contract where express provision allowed for termination at will); *Ostrander v. Farm Bureau Mut. Ins. Co.*, 851 P.2d 946 (Idaho 1993) (holding plaintiff’s status as an independent contractor prevented her from bringing wrongful discharge claims); *New Horizons Elecs. Mktg., Inc. v. Clarion Corp. of Am.*, 561 N.E.2d 283 (Ill. App. Ct. 1990) (same); *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962, 965 (N.H. 1996) (deciding HMO physician’s status as a nonemployee precluded him from bringing any wrongful termination-of-employment claim); cf. *Driveaway & Truckaway Serv., Inc. v. Aaron Driveaway & Truckaway Co.*, 781 F. Supp. 548 (N.D. Ill. 1991) (refusing to extend the tort of retaliatory discharge to a principal-agent relationship).

73. “Strong evidence in support of an employment relationship is the right to discharge at will, without cause.” *Tieberg v. Unemployment Ins. Appeals Bd.*, 471 P.2d 975, 979 (Cal. 1970) (quoting *Empire Star Mines Co. v. California Employment Comm’n*, 168 P.2d 686, 692 (Cal. 1946)).

ability of HMOs to redefine medical standards and dictate medical decisionmaking has stripped independent contractor physicians of their "independence." "The categorization of a working relationship depends not on the nominal label adopted by the parties, but rather on its salient features and the specific context in which the rights and duties that inhere in the relationship are ultimately determined."⁷⁴ Consequently, even if a physician's contract states that he is an "independent contractor," courts should nevertheless grant him de facto employee status, if only for use in wrongful discharge cases.

A. The Possibility of a Public Policy-Based Wrongful Termination Cause of Action

Theoretically, just like employees, independent contractors ought to be able to assert public policy as grounds for wrongful termination of contract. After all, it is well-settled, black letter law that if a contract contravenes public policy, it will not be enforced.⁷⁵ However, although courts may discharge a party of a contractual duty where the contract violates public policy, no court has awarded a wrongful termination cause of action for a contractual *breach* which violates public policy. For example, simply because a commercial landlord refuses to renew a lease for reasons which violate public policy does not mean that the tenant is entitled to a cause of action.⁷⁶ According to one court, this so-called "doctrine of retaliatory eviction" "has never . . . been applied in a commercial setting."⁷⁷

Courts simply have not allowed independent contractors to rely on public policy as grounds for asserting that termination of their contracts is wrongful. The Supreme Court of Idaho has even recently held that cases where an independent contractor alleges violation of public policy as the basis for a wrongful discharge claim are "distinguishable [,and thus fail to state a claim,] from cases where we

74. *MacDougall v. Weichert*, 677 A.2d 162, 166 (N.J. 1996) (holding that despite explicit contract language naming plaintiff an "independent contractor," genuine issues of material fact precluded summary judgment on whether a discharged real estate salesman was or was not an employee for purposes of a wrongful discharge claim).

75. If "a court . . . decide[s] that the public interest in freedom of contract is outweighed by some public policy[, it] . . . will refuse to enforce the agreement or some part of it on that ground." E. ALLAN FARNSWORTH, *CONTRACTS* § 5.1, at 345 (2d ed. 1990).

76. *See Mobil Oil Corp. v. Rubenfeld*, 370 N.Y.S.2d 943 (App. Div. 1975) (holding violation of antitrust laws by a landlord is not available to a tenant as a defense to the landlord's action for possession upon expiration of lease); *William C. Cornitius, Inc. v. Wheeler*, 556 P.2d 666, 671 (Or. 1976) ("In the commercial setting, we are unwilling to hold that the landlord's refusal to renew a lease for motives which are, or may be, improper gives the tenant the right to remain on the premises indefinitely."); *Clark Oil & Ref. Corp. v. Leistikow*, 230 N.W.2d 736 (Wis. 1975) (ruling dealer's defenses of antitrust violations, promissory estoppel, and policy of franchise investment law would not defeat oil company's action for possession of service station premises after expiration of lease). Although failure to renew a contract is distinguishable from a breach of contract, the public policy implications are nevertheless the same if the decision to do either violates public policy. *See infra* text accompanying note 188.

77. *Wheeler*, 556 P.2d at 670.

recognized that particular terms of a contract may be unenforceable as against public policy.⁷⁸ Thus, although courts will recognize claims based on an allegation that a specific provision of a contract violates public policy, they will not recognize claims by independent contractors where the reasons for termination are against public policy.⁷⁹ Judicial failure to recognize that the public's interest is no less implicated by a contract termination that violates public policy than it is by a contract *term* that, by itself, violates public policy, has created a glaring inconsistency in the law.⁸⁰ Therefore, in order for independent contractor physicians to state a public policy-based wrongful discharge claim, they will first need to convince the courts that they should be conferred employee status.

B. "Servant" (i.e., "Employee") as Defined in the
Restatement (Second) of Agency

Many of the factors listed in section 220 of the *Restatement (Second) of Agency*⁸¹ as relevant to the independent contractor determination are present in the physician-HMO relationship.⁸² "Of the several criteria to be applied in determining the relationship, the right to control the worker in the performance and manner of doing the work is the most decisive test."⁸³ While HMOs do not supervise *how* physicians conduct their day-to-day business, nor physically

78. *Ostrander v. Farm Bureau Mut. Ins. Co.*, 851 P.2d 946, 949 (Idaho 1993) (denying an independent contractor statutory protection against age and gender discrimination otherwise available to employees); *see also* *Robinson v. Ladd Furniture, Inc.*, 872 F. Supp. 248, 253 (M.D.N.C. 1994) (holding that a claim for wrongful termination in violation of public policy "is only recognized in the employee/employer context and, as such, does not apply to independent contractors"); *Cogan v. Harford Mem'l Hosp.*, 843 F. Supp. 1013, 1022 (D. Md. 1994) ("there are no cases in Maryland that address the issue of extending to independent contractors the right to sue for abusive or wrongful termination of an 'employment' relationship"); *Lumia v. Roper Pump Co.*, 724 F. Supp. 694, 697 (N.D. Cal. 1989) (holding that, because plaintiff was an independent contractor, and because state's statutory protection only applied to employees, plaintiff could not assert any age discrimination claim against his employer).

79. *See Ostrander*, 851 P.2d at 948-49.

80. Rejecting this inconsistency as unsound, one state supreme court justice has rightly asked, "Why should we allow an independent contractor to be terminated for reasons which would be void for public policy if s/he were an employee?" *Id.* at 951 (Bistline, J., dissenting).

81. RESTATEMENT (SECOND) OF AGENCY § 220 (1958).

82. These include, among other things: the extent of the master's control; whether the work is usually done under the direction of the employer or by a specialist; the skill required; whether the employer or the workman supplies the instrumentalities, tools, and the place of work; length of employment period; method of payment; whether or not the parties believe they are creating a master-servant relationship; and whether the principal is or is not a business. *See id.*

83. *Criminal Injuries Compensation Bd. v. Gould*, 331 A.2d 55, 74 (Md. 1975); *see also* *United States v. Webb, Inc.*, 397 U.S. 179, 192 (1970) ("Control is probably the most important factor under maritime law, just as it is under the tests of land-based employment.") (emphasis added) (footnote omitted).

intervene in actual patient examinations, therapies, or surgical procedures,⁸⁴ they do control *what* physicians do. Through utilization review, an HMO may ultimately determine how many in-patient hospital days an illness warrants, whether particular symptoms require expensive diagnostic laboratory tests, and whether referral to a specialist is necessary. In many cases, a second opinion is required before a physician may perform any major medical procedure.⁸⁵ Additionally, in an effort to cut costs, managed care plans routinely replace the doctor-prescribed drugs with similar, but less expensive ones, changing the medicines of thousands of patients every week.⁸⁶ In an attempt to reduce patient demand for potentially expensive services, some HMO contracts limit what information physicians may convey to their patients. These "gag clauses" prohibit doctors from informing patients about treatment options unless they are preapproved by the HMO.⁸⁷ HMO supervision has deprived physicians of much

84. See *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962, 965 (N.H. 1996) (observing that because an HMO "does not control, and has no right to control, the manner of performance of [a physician's] duties," the physician's relationship with the HMO is not an employee-employer relationship).

85. See RODWIN, *supra* note 4, at 112.

86. See Milt Freudenheim, *Not Quite What Doctor Ordered*, N.Y. TIMES, Oct. 8, 1996, at D1. In fact, many of the large managed care companies have computerized their drug prescription procedure, allowing them to change a patient's prescription between the time the doctor transmits it and the time the pharmacy receives it. See *id.* Most patients are not aware of the switch unless their pharmacist tells them, though some patients have experienced adverse reactions in response to the substituted medication. See *id.*

87. See *U.S. Healthcare to End Limits on Doctors' Advice to Patients*, N.Y. TIMES, Feb. 6, 1996, at D2. Reports that such clauses burden open communication in the doctor-patient relationship have led 16 states to adopt laws which nullify any efforts to limit what doctors can tell their patients. See Robert Pear, *Laws Won't Let H.M.O.'s Tell Doctors What to Say*, N.Y. TIMES, Sept. 17, 1996, at A12; cf. Chuck Hutchcraft, *Humana to Modify Doctors' Contracts*, CHI. TRIB., Oct. 30, 1996, at B1 (reporting that Humana, Inc. had made plans to eliminate an alleged "gag clause" from its physician contracts, and that other HMOs might follow suit); *U.S. Healthcare to End Limits on Doctors' Advice to Patients*, *supra*, at D2 (reporting that U.S. Healthcare planned to do the same). In fact, President Clinton recently prohibited HMOs from limiting what doctors may tell Medicaid patients about treatment options. See Robert Pear, *Clinton Prohibits H.M.O. Limit on Advice to Medicaid Patients*, N.Y. TIMES, Feb. 21, 1997, at A22.

Moreover, such clauses may even violate the Employee Retirement Income Security Act of 1974 ("ERISA"). According to the Supreme Court, ERISA fiduciaries must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members. See *Varity Corp. v. Howe*, 116 S. Ct. 1065, 1075 (1996). "To participate knowingly and significantly in deceiving a plan's beneficiaries in order to save the employer money at the beneficiaries' expense, is not to act 'solely in the interest of the participants and beneficiaries.'" *Id.* at 1074-75 (quoting ERISA § 404(a), 29 U.S.C. § 1104(a)(1) (1994)). The Court in *Varity Corp.* did not reach the issue of whether mere failure to disclose information would constitute a breach of any duty of loyalty running between the employer and its beneficiary (in this case, the employee). See *id.* at 1075.

However, in the first circuit ruling of its kind, see *HMO Refused to Refer Patient to a Specialist; Liable Under ERISA?*, LAW. WKLY. USA, Mar. 10, 1997, at 4, 4, the Eighth Circuit recently held that an HMO's failure to tell a now-deceased patient that it penalized doctors for making too many referrals did breach the HMO's fiduciary duty to its beneficiary (in this case,

of the independence and autonomy which they had come to expect from the profession, and has even led some physicians to turn to unionization as a means of enhancing their bargaining leverage.⁸⁸

In other contexts, courts have relied on the character of the principal's control over the agent to decide whether an agent is an employee or an independent contractor. For example, in determining that a pilot hired exclusively to navigate the waters of a port was not an independent contractor, the California Supreme Court held that "the most important factor is the right to control the manner and means by which the work is to be performed."⁸⁹ The court found the facts that the shipowner controlled the pilot's premises and that the shipowner retained the power to countermand the pilot's orders pivotal to its decision.⁹⁰ In *Duke v. Uniroyal, Inc.*,⁹¹ a U.S. district court held that despite explicit contractual language stating that the plaintiff, a real estate consultant, was an independent contractor, the plaintiff was nevertheless an employee because the parties' employment agreement described the manner of performance, because the plaintiff received a salary, because the plaintiff's work required a high degree of skill and knowledge, and because the plaintiff worked for the defendant for five years.⁹² Finally, in *Borello & Sons, Inc. v. Department of Industrial Relations*,⁹³

the patient) under ERISA. See *Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 118 S. Ct. 297 (1997).

From the patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self-serving [sic] financial considerations created by the health insurance provider.

Id. at 628. For more discussion of the effects of ERISA on managed care malpractice claims, see *infra* note 215.

88. See Peter T. Kilborn, *Feeling Devalued by Change, Doctors Seek Union Banner*, N.Y. TIMES, May 30, 1996, at A1 (reporting that, in response to the spread of managed care companies, many doctors are joining labor unions). "Many doctors . . . who contract with managed-care companies to obtain patients, now consider themselves so stripped of their independence that they have become de facto employees of the health care companies." *Id.*; see also Steven Greenhouse, *Podiatrists to Form Nationwide Union; A Reply to H.M.O.'s*, N.Y. TIMES, Oct. 25, 1996, at A1 (reporting that associations representing the nation's podiatrists had announced plans to form the first nationwide labor union for doctors). Roughly 44,000 physicians and dentists are members of unions today, a 120% increase in the last 10 years. See Steven Findlay, *Frustration Pushes Them to New Tactic*, USA TODAY, Apr. 15, 1997, at 3A. According to the podiatrist union's executive director: "What's going on now is H.M.O.'s and preferred provider organizations are moving private doctors closer to the status of being real employees. These groups are really setting the terms and conditions of employment, what procedures doctors can and can't do. It's very similar to an employee situation." Greenhouse, *supra*, at A1.

89. *Societa per Azioni de Navigazione Italia v. City of Los Angeles*, 645 P.2d 102, 108 (Cal. 1982).

90. See *id.* at 109. But see *id.* (noting that the limited degree of control might not be sufficient to establish a master-servant relationship in a land-based occupation).

91. 777 F. Supp. 428 (E.D.N.C. 1991).

92. See *id.* at 432.

93. 769 P.2d 399 (Cal. 1989).

the California Supreme Court found that temporary sharefarmers were employees, not independent contractors, despite the fact that the sharefarmers were self-employed, contracted for a finished job, and controlled their own work.⁹⁴ The issue in these inquiries is not whether the employer *actually* controls the employee, but whether the employer *has the authority* to do so.⁹⁵ “If the employer has the authority to exercise complete control, . . . an employer-employee relationship exists.”⁹⁶

While there are many obvious differences between physicians and maritime pilots, real estate consultants, and sharefarmers, the principles which guided the courts’ decisions in those cases are nevertheless applicable and useful in making similar determinations in the managed care setting. That a physician is a highly skilled worker, that he is frequently only employed for a year at a time, and that both he and the HMO acknowledged at the time of contract formation that he was to relate to the HMO as an independent contractor, all militate in favor of denying the physician *de facto* employee status.⁹⁷ Nevertheless, the countervailing evidence in favor of *de facto* status outweighs these factors. Not only do HMOs select what ends a physician will seek, but in many cases they also select the means to those ends. To whatever extent an HMO retains the right to second-guess (i.e., has the authority to control) a physician’s clinical decisions, the HMO “controls” the physician.⁹⁸ Unlike an independent contractor, a physician subject to HMO veto authority does *not* perform his work “according to his own means and methods, free from the control of his employer in all details connected with the performance of the work, except as to product or result.”⁹⁹

HMOs frequently own hospitals, providing a physician with his place of work (e.g., operating and examination rooms), and many of his instrumentalities (e.g., examination equipment, diagnostic laboratory facilities, nursing and secretarial services, and office space).¹⁰⁰ Significantly, HMO physicians are usually paid monthly by either capitation or salary (methods of payment which are not pegged to the amount of services rendered),¹⁰¹ and are typically affiliated for at least a

94. *See id.* at 407-10.

95. *See* Tieberg v. Unemployment Ins. Appeals Bd., 471 P.2d 975, 979 (Cal. 1970).

96. *Id.* (omission added) (quoting Empire Star Mines Co. v. California Employment Comm’n, 168 P.2d 686, 692 (Cal. 1946)).

97. *But see* MacDougall v. Weichert, 677 A.2d 162, 166 (N.J. 1996) (stating that the determination depends not on the label but on the features and context of the relationship).

98. *Cf. Borello & Sons*, 769 P.2d at 408 (“A business entity may not avoid its statutory obligations [under the California Workers’ Compensation Act] by carving up its production process into minute steps, then asserting that it lacks ‘control’ over the exact means by which one such step is performed by the responsible workers.”).

99. Criminal Injuries Compensation Bd. v. Gould, 331 A.2d 55, 74 (Md. 1975) (defining an independent contractor as one who is free of such control).

100. *See* RESTATEMENT (SECOND) OF AGENCY § 220 cmt. k (1958) (“[I]f the worker is using his employer’s tools or instrumentalities, *especially if they are of substantial value*, it is normally understood that he will follow the directions of the owner in their use, and this indicates that the owner is a master.”) (emphasis added).

101. *See* discussion *supra* Part I.B.

year at a time. Both factors weigh in favor of employee status recognition.¹⁰² Given the substantial sacrifice physicians must make in terms of professional independence and decisionmaking authority in order to gain access to HMO-enrolled patients, refusing to grant them employee status ignores the reality many physicians face in their current employment relationships, and denies them the judicial protection presently extended to other occupations where the master retains ultimate decisionmaking authority.

C. Unequal Bargaining Power

Additionally, as discussed above, an HMO is at a substantial advantage in negotiating a managed care contract with a physician. The larger the percentage of potential patients enrolled in a given HMO, the less freedom the physician has to treat only non-HMO enrollees, and the greater the pressure to affiliate oneself with an HMO. Aside from the security of access to a patient supply, the terms of HMO employment are often of little other financial advantage to the physician. Many managed care contracts are frequently exclusive,¹⁰³ requiring the physician to waive any right to contract with other HMOs.¹⁰⁴ Others are even more onerous, requiring the physician to indemnify the HMO for any costs it incurs as a result of the physician's negligence.¹⁰⁵ Almost all contracts include a clause allowing

102. For a court to grant an alleged independent contractor de facto employee status for the purpose of a wrongful discharge claim, but then deny him that status for the purpose of tort liability is not necessarily an inconsistent position. "An individual may be considered an employee for some purposes but an independent contractor for others." *Weichert*, 677 A.2d at 166.

Despite HMO control, a physician is still responsible for his patient's diagnosis, treatment, and therapy, conduct for which de facto employee status, and thus any potential for vicarious liability, might not attach. *But see* Joe Niedzielski, *Court Rulings Prompt New Liability Plan Development*, NAT'L UNDERWRITER, May 13, 1996, at 13 (reporting that recent court rulings indicate that MCOs can be held vicariously liable for actions of physician contractors); *see also* Hall, *supra* note 23.

If a health care institution run by lay investors, directors, or administrators attempts to impose control through administrative restrictions and treatment protocols, it risks engaging in the unlicensed practice of medicine. If treatment is ordered instead of supervising physicians, or if control is imposed through financial influence rather than command, the concept of tortious interference with the physician/patient relationship, although not yet explicitly recognized, may create liability.

Id. at 451-52 (footnotes omitted).

103. "An exclusive contract is a binding contract in which the parties agree to buy or sell only from each other for their total requirements." Peter E. Borkon, *Exclusive Contracts: Are Constructively Terminated Incumbent Physicians Entitled to a Fair Hearing?*, 17 J. LEGAL MED. 143, 143 (1996).

104. *See* Somers, *supra* note 5, at 22; *cf.* *Olaf v. Christie Clinic Ass'n*, 558 N.E.2d 610 (Ill. App. Ct. 1990) (discussing physician dismissed for violating exclusivity term). "Although exclusive contracts were once limited to hospital-based medical specialties such as radiology, pathology, and nuclear medicine, the practice of entering into such contracts is becoming increasingly widespread." Borkon, *supra* note 103, at 143 (footnote omitted).

105. *See* Rosen & Smith, *supra* note 58, at 29.

the managed care organization to change the payment structure at will, without requiring the physician's consent,¹⁰⁶ a provision which grants the HMO the de facto right to "bait-and-switch." Many physicians, recognizing their complete lack of recourse and bargaining power, do not even read the contracts they sign.¹⁰⁷ Without the bargaining power to negotiate the terms of the working relationship, physicians lose much of their alleged independence. Furthermore, once physicians have signed on with an HMO, their fear of termination and subsequent loss of patient base stifles any desire to renegotiate during the contract period. In such an environment, it is inequitable to shelter HMOs from potential wrongful discharge claims solely on the ground that physicians are labeled "independent" contractors.¹⁰⁸

III. EMPLOYMENT-AT-WILL

For the HMO, the most powerful clause in a managed care contract is the one which grants the parties the right to terminate the contract without cause.¹⁰⁹ Despite the apparent mutuality of contract freedom, the reality is that physicians are far more HMO-dependent than HMOs are physician-dependent. Given the relative immobility of physicians, the power to terminate at-will is a right that inures substantially to the HMO's benefit.¹¹⁰ For the doctor, at-will employment means that in the absence of any express contractual provision to the contrary, the

106. See Rosenthal, *supra* note 32, at A1.

107. See *id.* (quoting Dr. Zoltan Brody, a Staten Island physician). Paralyzed with the fear of being blacklisted by other HMO plans, some doctors even request anonymity when relating their woes to the media. See, e.g., *id.* (discussing doctor who requested anonymity for fear his defiance would cause him to be blacklisted).

108. At least one state supreme court has recognized that bargaining power is relevant to the determination of whether one is a de facto employee. See *Ostrander v. Farm Bureau Mut. Ins. Co.*, 851 P.2d 946, 950 (Idaho 1993) (dictum) ("[D]ue to bargaining position and other circumstances surrounding a working relationship some nominal independent contractors may be de facto employees."); see also *MacDougall v. Weichert*, 677 A.2d 162, 166 (N.J. 1996) ("The critical issue is whether the elements of control and dependence coupled with the absence of any employment protection predominate over factors that favor an independent contractor status."); cf. *Bartels v. Birmingham*, 332 U.S. 126, 130 (1947) ("Obviously control is characteristically associated with the employer-employee relationship, but in the application of social legislation employees are those who as a matter of economic reality are dependent upon the business to which they render service.").

109. In addition to termination without cause, managed care contracts also grant the parties the right to terminate the relationship *for cause*. Typically, "cause" includes: the physician's failure to maintain state licensure, specialty board certification, hospital staff privileges, or proper insurance coverage levels; too many patient complaints regarding the physician's care; the MCO's perception of serious problems in care quality; evidence of fraud; the MCO's failure to maintain state licensure or insurance levels; or either party's discovery that the other party has breached a specific contractual provision. See Somers, *supra* note 5, at 25-26. The scope of this Note is limited to a discussion of at-will termination.

110. See Lawrence E. Blades, *Employment at Will vs. Individual Freedom: On Limiting the Abusive Exercise of Employer Power*, 67 COLUM. L. REV. 1404, 1405-06 (1967) (arguing that the nonunion employee's immobility makes the absolute right of discharge the employer's prime source of power over the employee).

HMO may dismiss him for any reason, no reason, or even a bad reason. Courts have, however, recognized limited exceptions to this rule's historically irrebuttable presumption. Assuming a court first conferred him de facto employee status, a physician could recover against the HMO so long as he could convince the court that his discharge fell within the purview of one of the rule's exceptions. But to assess a terminated physician's potential for redress, one must first understand the at-will doctrine and its exceptions.

A. The Rule

A "unique product of American common law,"¹¹¹ the employment-at-will doctrine gives either party the right to walk away from the employment relationship at any time without liability. If the employee is upset, dissatisfied, or unfulfilled in a particular position, or if the employer is angered or displeased with the employee's performance, each has the right to terminate the relationship. Even beyond that, either party may terminate the relationship for *any* reason, no matter how silly, unsubstantiated, or irrational. "The at will rule conform[s] with a premise of complete social freedom; only if an individual clearly intend[s] to obligate himself [will] the law enforce any restriction on his basic freedom."¹¹² This statement, of course, assumes that both parties can and do negotiate *ex ante* the terms by which they wish to be bound. If an employee neglects to bargain for express contractual protection, the courts will not intervene to imply a term on one or the other party's behalf.¹¹³

B. The Exceptions

Nevertheless, beginning in 1959,¹¹⁴ courts began to carve exceptions into the historically bulletproof doctrine, recognizing that under certain circumstances, sound public policy had to impose limits on employers' right to discharge.¹¹⁵ Eventually, three general exceptions to the at-will rule emerged, each of which would entitle the employee to relief: (1) where upholding the discharge would violate clearly established public policy; (2) where the dismissal breaches the implied-in-law covenant of good faith and fair dealing; or (3) where the dismissal breaches any implied-in-fact contracts.

111. Seymour Moskowitz, *Employment-at-Will & Codes of Ethics: The Professional's Dilemma*, 23 VAL. U. L. REV. 33, 33 (1988). See generally Jay M. Feinman, *The Development of the Employment at Will Rule*, 20 AM. J. LEGAL HIST. 118 (1976) (tracing the history and evolution of the employment-at-will doctrine).

112. Note, *Protecting At Will Employees Against Wrongful Discharge: The Duty to Terminate Only in Good Faith*, 93 HARV. L. REV. 1816, 1825 (1980).

113. See *id.* at 1819.

114. See *Petermann v. International Bhd. of Teamsters*, 344 P.2d 25 (Cal. Dist. Ct. App. 1959).

115. Unionized employees, however, had at least received some protection from an employer's absolute right to discharge since 1937. See *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 45 (1937) (prohibiting employers from "using the right of discharge to intimidate and coerce [their] employees"). On the unequal bargaining power between employers and nonunion at-will employees, see *Blades*, *supra* note 110.

1. Public Policy

Academics often consider *Petermann v. International Brotherhood of Teamsters*¹¹⁶ the seminal, paradigmatic public policy tort case.¹¹⁷ In *Petermann*, the plaintiff, an at-will employee, was subpoenaed to testify before a state legislative committee. Despite the defendant-employer's express instructions to make false statements under oath, the plaintiff testified truthfully at the hearing. On returning to work, the defendant fired the plaintiff.¹¹⁸ The plaintiff then filed suit, alleging that he had been wrongfully discharged.¹¹⁹ The court ruled for the plaintiff, finding it "obnoxious to the interests of the state and contrary to public policy and sound morality to allow an employer to discharge any employee, whether the employment be for a designated or unspecified duration, on the ground that the employee declined to commit perjury, an act specifically enjoined by statute."¹²⁰ The state's criminal sanctions against committing perjury reflected a legislative determination that committing perjury violated public policy, and "public policy . . . would be seriously impaired if it were to be held that one could be discharged by reason of his refusal to commit perjury."¹²¹ Since "it ha[d] universally been held [prior to *Petermann*] that under such a contract an employer [could] discharge his employee for any reason, without subjecting himself to liability,"¹²² *Petermann* represented an innovation in at-will employment law.¹²³ Thus, because the public's interest in discouraging illegal behavior is so strong, if an employer requires an employee to either violate the law or face losing his job, then that employee is entitled to a cause of action if he is discharged for his decision not to violate the law.

Since *Petermann*, courts have extended the public policy tort exception to the historically insurmountable employment-at-will rule to cases which fall into five distinct categories: (1) where the employer has asked the employee to risk losing his job for refusing to commit a criminal act;¹²⁴ (2) where the employer has

116. 344 P.2d 25.

117. Note, however, that the *Petermann* court recognized the cause of action under contract principles; according to the court, the employer's conduct breached a covenant of good faith and fair dealing implied in the at-will employment contract. *See id.* at 28.

118. *See id.* at 26.

119. *See id.*

120. *Id.* at 27.

121. *Id.*

122. *Contracts—Termination of Employment at Will—Public Policy May Modify Employer's Right to Discharge*, 14 RUTGERS L. REV. 624, 624 (1960).

123. *See id.* "In juxtaposition to the employer's interest in running his business as he sees fit are both the interest of the employee in maintaining his employment, and the interest of the public at large . . . in maintaining a morally sound societal structure." *Id.* at 625 (footnotes omitted).

124. *See, e.g., Petermann*, 344 P.2d 25; *see also* *Lucas v. Brown & Root, Inc.*, 736 F.2d 1202 (8th Cir. 1984) (granting a cause of action to plaintiff-employee who was fired for refusing to sleep with her foreman); *Kalman v. Grand Union Co.*, 443 A.2d 728 (N.J. Super. Ct. App. Div. 1982) (granting a cause of action to plaintiff-employee, a pharmacist, who was fired for refusing to honor employer's wishes, where employer had instructed plaintiff not to

discharged the employee for praiseworthy conduct (e.g., "whistleblowing");¹²⁵ (3) where the employer has discharged the employee for exercising a statutorily granted right;¹²⁶ (4) where the employer has discharged the employee for fulfilling a civic duty;¹²⁷ and (5) where the employer has discharged the employee for refusing to participate politically on the employer's behalf.¹²⁸

2. Implied Covenant of Good Faith and Fair Dealing

The implied covenant of good faith and fair dealing offers another possible cause of action for the dismissed at-will employee. The defendant's actions in *Fortune v. National Cash Register Co.*¹²⁹ typify breach of the implied covenant of good faith and fair dealing. In *Fortune*, the plaintiff worked as an at-will salesman for the defendant.¹³⁰ After the plaintiff had landed a \$5 million purchase order for the defendant, but before the defendant had paid all of the commissions owed to the plaintiff, the defendant fired the plaintiff, thereby depriving the plaintiff of his justly deserved commissions.¹³¹ The Massachusetts Supreme

work on a federal holiday, and where plaintiff's compliance would have left in-store pharmacy unattended and open to the public in violation of state law and pharmacist's code of ethics); *Delaney v. Taco Time Int'l, Inc.*, 681 P.2d 114 (Or. 1984) (en banc) (granting a cause of action to plaintiff-employee who was fired for refusing to sign a false and arguably tortious statement); *Ludwick v. This Minute of Carolina, Inc.*, 337 S.E.2d 213 (S.C. 1985) (granting a cause of action to plaintiff-employee who was fired for refusing to defy a subpoena); *Sabine Pilot Serv., Inc. v. Hauck*, 687 S.W.2d 733 (Tex. 1985) (granting a cause of action to plaintiff-employee who was fired for refusing to pump boat bilges illegally). *But see Lampe v. Presbyterian Med. Ctr.*, 590 P.2d 513 (Colo. Ct. App. 1978) (refusing to extend a cause of action to plaintiff-employee, a head nurse, who was fired for refusing to reduce the staffing in her intensive care unit to levels that she felt would endanger public safety).

125. *See, e.g., Sheets v. Teddy's Frosted Foods, Inc.*, 427 A.2d 385 (Conn. 1980) (granting a cause of action to plaintiff-employee, defendant-employer's quality control director and operations manager, who was fired for insisting that his employer comply with requirements of Food, Drug and Cosmetics Act); *see also Palmateer v. International Harvester Co.*, 421 N.E.2d 876 (Ill. 1981) (granting a cause of action to plaintiff-employee who was fired for supplying to local law enforcement agency information indicating that coemployee might be violating criminal code). *But see Geary v. United States Steel Corp.*, 319 A.2d 174 (Pa. 1974) (refusing to extend a cause of action to plaintiff-employee, a former salesman, who was fired for pointing out to superiors unsafe nature of products to be shipped to oil and gas industry).

126. *See, e.g., Kelsay v. Motorola, Inc.*, 384 N.E.2d 353 (Ill. 1978) (granting a cause of action to plaintiff-employee who was fired for filing workmen's compensation claim); *Frampton v. Central Ind. Gas Co.*, 297 N.E.2d 425 (Ind. 1973) (same). *But see Kavanagh v. KLM Royal Dutch Airlines*, 566 F. Supp. 242 (N.D. Ill. 1983) (refusing to extend a cause of action to plaintiff-employee who was fired for retaining an attorney in anticipation of salary dispute).

127. *See, e.g., Nees v. Hocks*, 536 P.2d 512 (Or. 1975) (en banc) (granting a cause of action to plaintiff-employee fired for reporting to jury duty).

128. *See, e.g., Novosel v. Nationwide Mut. Ins. Co.*, 721 F.2d 894 (3d Cir. 1983) (granting a cause of action to plaintiff-employee who was fired for refusing to lobby state legislature on defendant-employer's behalf).

129. 364 N.E.2d 1251 (Mass. 1977).

130. *See id.* at 1253.

131. *See id.* at 1254.

Judicial Court held that the defendant's written contract contained "an implied covenant of good faith and fair dealing, and that a termination not made in good faith constitutes a breach of the contract."¹³²

However, even though "[e]very contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement,"¹³³ Massachusetts is one of only ten states which recognize that the employment contract contains such an implied covenant, breach of which entitles the discharged employee to damages.¹³⁴ Moreover, even in some of those states, courts refuse to recognize such an implied covenant in the independent contractor setting.¹³⁵ Courts' rejection of such a claim places individual, noncorporate independent contractors between a rock and a hard place: they are denied both the advantages of being an employee as well as the advantages of being a full-fledged, corporate, commercial contractor. If courts are going to treat an agent as an independent contractor, then they should at least extend to those contractors the same level of judicial protection that they extend to all contracting parties.¹³⁶

In those states that do recognize the implied covenant of good faith and fair dealing, courts use it primarily to prevent unjust enrichment.¹³⁷ Therefore, its utility as a remedy is far more limited than the public policy tort exception, which can theoretically be used anywhere, so long as the court is convinced that sufficiently clear public policy would be contravened if the employer were allowed to go unpunished. Some courts even require a violation of public policy anyway in order for a plaintiff to state a cognizable breach-of-the-implied-covenant claim.¹³⁸ Thus, if a state does require a public policy violation in order

132. *Id.* at 1255-56.

133. RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981). Regarding the covenant of good faith and fair dealing in the commercial setting, see U.C.C. § 1-203 (1990) ("Every contract or duty within this Act imposes an obligation of good faith in its performance or enforcement.").

134. Those states are: Alabama, Alaska, Arizona, California, Connecticut, Idaho, Massachusetts, Montana, Nevada, and New Hampshire. See Gearity, *supra* note 7, at 687 n.40. For a discussion of the status of the law in each of those ten states, see *id.* at 688-97. For a sound analysis of the reasons against implying the covenant, see *Murphy v. American Home Products Corp.*, 448 N.E.2d 86, 91 (N.Y. 1983) ("[I]t would be incongruous to say that an inference may be drawn that the employer impliedly agreed to a provision which would be destructive of his right of termination.").

135. See *Ostrander v. Farm Bureau Mut. Ins. Co.*, 851 P.2d 946, 949-50 (Idaho 1993) (refusing to find any implied covenant of good faith and fair dealing in independent contractor contracts).

136. As one state supreme court justice has criticized, "[T]here is a bizarre lack of analysis and consistency in holding that there exists a duty of good faith and fair dealing in a contract between arms-length commercial parties, yet none is to be found in an independent contractor's contract." *Id.* at 952 (Bistline, J., dissenting).

137. See JOHN D. CALAMARI & JOSEPH M. PERILLO, CONTRACTS 20 (3d ed. 1987).

138. Although some states may require a violation of public policy in order to recognize a breach of the covenant, others do not. Compare *Crenshaw v. Bozeman Deaconess Hosp.*, 693 P.2d 487, 492-93 (Mont. 1984) (holding violation of public policy is not a necessary element of the doctrine of good faith and fair dealing), with *Brockmeyer v. Dun & Bradstreet*, 335 N.W.2d 834, 840-41 (Wis. 1983) (holding implied covenant of good faith and fair dealing cannot be broken absent a violation of public policy).

to state a claim for breach of the implied covenant, then the practical applicability of the implied covenant exception is at worst a smaller class within the public policy tort exception, and is at best coterminous with it. Although the covenant is a powerful doctrine,¹³⁹ its limited jurisdictional recognition and legal applicability may render it of little use to the discharged employee.

3. Implied-in-Fact Contract

When an employee has received, either through oral or written communications, implied or express promises of permanent employment, courts will occasionally recognize a third exception to the employment-at-will doctrine. The courts in both *Toussaint v. Blue Cross & Blue Shield*¹⁴⁰ and *Weiner v. McGraw-Hill, Inc.*¹⁴¹ found implied promises of tenure in assurances in employee handbooks and personnel manuals that the employee would not be fired unless her job performance was unsatisfactory.¹⁴² However, informal, vague, or indefinite language or promises will often preclude recovery under an implied-in-fact contract theory.¹⁴³

Despite the erosion in the doctrine, employment-at-will has remained substantially unchanged since its inception.¹⁴⁴ One of the main reasons for the at-will doctrine's longevity is that it allows an employer to be flexible in the face of business uncertainty.¹⁴⁵ An employer has every right to run her business as she sees fit, hiring those employees that she feels will be the most efficient and productive, and firing those whom she does not like. An employer need not

139. "Powerful" because it "represents a way to place employment tenure beyond the employer's control." HENRY H. PERRITT, JR., *EMPLOYEE DISMISSAL LAW & PRACTICE* 191 (2d ed. 1987). "[A] termination . . . which is motivated by bad faith or malice or based on retaliation is not the best interest [sic] of the economic system or the public good and constitutes a breach of the employment contract." *Monge v. Beebe Rubber Co.*, 316 A.2d 549, 551 (N.H. 1974); *see, e.g., id.* (granting a cause of action to at-will plaintiff-employee who was discharged for failing to date her foreman on the grounds that her dismissal breached an implied promise of employment tenure). The length of time that someone has worked for a particular employer is also relevant to determining whether an implied promise of tenure was ever made. *Cf. Perry v. Sindermann*, 408 U.S. 593, 602 (1972) ("A teacher . . . who has held his position for a number of years, might be able to show from the circumstances of this service—and from other relevant facts—that he has a legitimate claim of entitlement to job tenure.").

140. 292 N.W.2d 880 (Mich. 1980).

141. 443 N.E.2d 441 (N.Y. 1982).

142. If an employee can only be dismissed for job-related reasons, the employment is not at-will. In such a relationship, the employee may be terminated only *with* cause, that is, "just" or "for" cause. For examples of what constitutes just cause in the HMO employment setting, see discussion *supra* note 109.

143. *See, e.g., Hunt v. IBM Mid Am. Employees Fed. Credit Union*, 384 N.W.2d 853, 857 (Minn. 1986) (finding that the "discipline and termination phraseology in the employment manual was too indefinite to inform the basis of an enforceable contract giving rise to a contract action for its breach").

144. *See Moskowitz, supra* note 111, at 33.

145. *See Dennis M. Hyatt, Employment at Will and the Law of Contracts*, 23 *BUFF. L. REV.* 211, 237 (1973).

produce a "good" nor a "just" cause for dismissing an employee. Nevertheless, "any assessment of the dismissal of an employee must accommodate both the employee's interests and the employer's business interests in maintaining the control, efficiency, and productivity of the business."¹⁴⁶

C. *The Choice of the Public Policy Route to Recovery*

In order to prevail in a wrongful discharge case, a physician must establish that his termination violated public policy, breached the implied covenant of good faith and fair dealing, or breached an implied-in-fact contract. Of these three possible routes to recovery, the public policy exception is the most efficacious.¹⁴⁷ Because only ten states recognize breach of the implied covenant of good faith and fair dealing as an injury that warrants granting the plaintiff a cause of action,¹⁴⁸ an HMO physician practicing in a jurisdiction that does not recognize the covenant would have his complaint quickly dismissed.¹⁴⁹ To win an implied-in-fact claim, a physician would have to establish that the HMO had promised, through some form of communication, never to discharge him except for good cause. Even if a physician could state such a claim, it would not contribute to the current discussion, as such a claim would turn on the HMO's representations as to tenure (not on the physician's conduct), and would exist independently of any possible tort claim. Furthermore, since the primary purpose in recognizing a cause of action in the case of a terminated HMO physician is to protect society's interest in preventing any erosion of the doctor-patient fiduciary relationship, the ultimate beneficiary of such wrongful discharge lawsuits would be the public at large, not the physician. Consequently, the objectionable conduct is best characterized as a violation of public policy, and not as a breach of either the implied covenant of good faith and fair dealing, or any implied-in-fact contracts.

IV. WHY COURTS SHOULD RECOGNIZE A CAUSE OF ACTION FOR THE TERMINATED HMO PHYSICIAN

A physician is a professional, and like members of many other professions, she is bound by a code of ethics to practice her profession in accordance with the directives of that code. While a professional employee would presumably be able to bring any public policy tort claim that a nonprofessional employee is able to

146. J. Peter Shapiro & James F. Tune, Note, *Implied Contract Rights to Job Security*, 26 STAN. L. REV. 335, 336 (1974).

147. In most cases, courts require some violation of public policy to state a claim anyway. "Nearly all jurisdictions link the success of the wrongful discharged [sic] employee's action to proof that the discharge violated public policy." *Pierce v. Ortho Pharm. Corp.*, 417 A.2d 505, 509 (N.J. 1980).

148. See list of states *supra* note 134.

149. This is not to say that a cause of action predicated on the implied covenant of good faith and fair dealing would not work at all in a jurisdiction that did recognize it. However, because more courts would recognize the public policy violation claim and because it is beyond the scope of this Note to discuss the potential success of a breached covenant claim, this Note will concentrate only on the viability of a public policy tort claim.

bring,¹⁵⁰ courts have recently recognized that professional codes of ethics may also serve as sufficiently clear embodiments of public policy that a professional terminated for adhering to them (in contravention of her employer's wishes) may be able to state a wrongful discharge cause of action.¹⁵¹ When an HMO constructively threatens to dismiss a physician for prescribing medically necessary treatment or for advocating on a patient's behalf, conduct ethically required under the *Code of Medical Ethics*,¹⁵² a physician should not be forced to comply with the HMO's wishes in order to save her job. Embodied in the *Code of Medical Ethics*, the public policies in favor of ensuring competent medical treatment and preserving society's faith in the medical profession are every bit as compelling as those which condemn criminal or fraudulent corporate activity.¹⁵³ Therefore, if lawyers¹⁵⁴ and accountants may bring public policy-based wrongful discharge claims predicated on their respective professional codes, then physicians should likewise be able to bring similar actions when rooted in their professional code.

*A. Recent Judicial Treatment of Ethical Codes as a
Source of Public Policy*

The leading case in favor of recognizing professional ethics as a legitimate source of public policy is undoubtedly *General Dynamics Corp. v. Superior Court*.¹⁵⁵ In *General Dynamics*, the plaintiff had worked for the defendant as an at-will, in-house attorney for fourteen years, earning repeated commendations throughout his career.¹⁵⁶ Though the plaintiff was in line to become a division vice-president and general counsel,¹⁵⁷ the defendant allegedly fired him for protesting the company's failure to investigate the bugging of the office of the chief of security (an alleged criminal offense), and for advising his employer that part of its salary policy might be in violation of the Fair Labor Standards Act.¹⁵⁸ While conceding that "no client should be forced to suffer representation by an attorney in whom that confidence and trust lying at the heart of a fiduciary relationship has been lost,"¹⁵⁹ the California Supreme Court nevertheless held that where an in-house attorney is discharged for following mandatory ethical obligations prescribed by professional rule or statute, the attorney states a claim

150. For example, both professional and nonprofessional employees would be able to bring a public policy tort claim if either were discharged for refusing to testify falsely. See *Petermann v. International Bhd. of Teamsters*, 344 P.2d 25 (Cal. Dist. Ct. App. 1959) (granting a cause of action to an employee discharged for such a reason).

151. See cases cited *supra* note 11.

152. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at xxxix-xl.

153. See *id.*

154. See generally *Corello*, *supra* note 10 (arguing in favor of granting in-house attorneys the right to sue for retaliatory discharge when they are dismissed for refusing to violate their professional ethics).

155. 876 P.2d 487 (Cal. 1994).

156. See *id.* at 490.

157. See *id.*

158. See *id.* at 490-91.

159. *Id.* at 493.

for retaliatory discharge, and thereby limits the right of a corporate client to discharge its in-house counsel.¹⁶⁰

The *General Dynamics* court refused to follow the holding and reasoning announced by the Illinois Supreme Court in *Balla v. Gambro, Inc.*¹⁶¹ In *Balla*, the plaintiff was an in-house attorney allegedly discharged for advising the company president that, unless the company rejected a shipment of defective and harmful dialyzers sent from Germany for sale in the U.S., the plaintiff would be ethically bound to do whatever was necessary to stop their sale.¹⁶² Perceiving no conflict of interest between the plaintiff's economic livelihood and his acknowledged duty (under the state's rules of professional conduct)¹⁶³ to report his employer to the FDA,¹⁶⁴ the Illinois Supreme Court held: "However difficult economically and perhaps emotionally it is for in-house counsel to discontinue representing an employer/client, we refuse to allow in-house counsel to sue their employer/client for damages because they obeyed their ethical obligations."¹⁶⁵ Thus, from the

160. *See id.* at 502-03. The court narrowed the holding in two ways, however. If the conduct were merely ethically permissible, or if the wrongful discharge claim could not be established without breaching the attorney-client privilege, the suit would be dismissed. *See id.* at 503-04. Because the plaintiff in *General Dynamics* had not alleged that the conduct that allegedly precipitated his termination was "required or supported by any requirement of [the California] Rules of Professional Responsibility or [other] relevant statute," the California Supreme Court remanded the case to the trial court to allow the plaintiff to amend his complaint accordingly. *Id.* at 505.

161. 584 N.E.2d 104 (Ill. 1991).

162. *See id.* at 105-06.

163. Illinois Rule of Professional Conduct 1.6(b) requires Illinois attorneys to "reveal information about a client to the extent it appears necessary to prevent the client from committing an act that would result in death or serious bodily harm." ILL. R.P.C. 1.6(b).

164. The *Balla* court acknowledged that under this rule, which it had mandated, the plaintiff was compelled to report the sale of the dialyzers. *Balla*, 584 N.E.2d at 109.

In-house counsel do not have a choice of whether to follow their ethical obligations as attorneys licensed to practice law, or follow the illegal and unethical demands of their clients. In-house counsel must abide by the Rules of Professional Conduct. Appellee had no choice but to report [his employer] to the FDA

Id.

165. *Id.* at 110. That the Illinois Supreme Court decided *Balla* in favor of the employer 10 years after deciding *Palmateer* in favor of the employee is truly ironic. *See Palmateer v. International Harvester Co.*, 421 N.E.2d 876 (Ill. 1981) (extending a retaliatory discharge cause of action to a worker fired for supplying information to a local law enforcement agency regarding a coworker's theft of a two-dollar screwdriver). After all, if the Illinois Supreme Court was willing to grant a retaliatory discharge cause of action to an at-will employee fired for reporting the theft of a two-dollar screwdriver, *see id.* at 880-81, one would think the same court would be willing to grant an action to an at-will attorney (client confidentiality notwithstanding) discharged for threatening to report the sale of defective dialyzers, particularly once it had conceded the grave danger the *Balla* defendant's action posed to public health. *See Balla*, 584 N.E.2d at 109. The crime in *Balla* had potentially far more harmful and widespread effects, and carried much broader public policy implications, than the petty larceny in *Palmateer*. The court's counterintuitive approach appears even more acute when one considers the fact that unlike the attorney in *Balla*, the employee in *Palmateer* was not under any ethical obligation to report the violation in the first place, and yet the court granted the

plaintiff's perspective, the only alternative to jeopardizing his continued employment with the defendant was to withdraw representation, a move which would, of course, be tantamount to discharge.

According to the *Balla* court, because "[i]n-house counsel *must* abide by the Rules of Professional Conduct,"¹⁶⁶ the public's interest in "protecting the lives and property of citizens is adequately safeguarded without extending the tort of retaliatory discharge to in-house counsel."¹⁶⁷ Thus, once he knew of the illegal activity, the attorney discharged in *Balla* had a preexisting, superseding duty to report his employer to the FDA, a duty the consequences of which were apparently unavoidable and irremediable. Furthermore, the court felt that if the specter of suits by in-house counsel would chill attorney-client communication, it was not worth granting in-house counsel the cause of action.¹⁶⁸

The *General Dynamics* court found *Balla*'s emphasis on withdrawal as an alternative remedy to be "illusory" because it "fail[ed] to confront seriously the extraordinarily high cost that resignation entails."¹⁶⁹ According to the court, withdrawal was "fraught with the possibility of economic catastrophe and professional banishment,"¹⁷⁰ and therefore was not a viable option. Of pivotal importance to the court in *General Dynamics* was the fact that

[t]he economic fate of in-house attorneys . . . is tied to a single employer, at whose sufferance they serve. . . . Th[e] expansion in the scope and stature of in-house counsel's work, together with an inevitably close professional identification with the fortunes and objectives of the corporate employer, can easily subject the in-house attorney to unusual pressures to conform to organizational goals, pressures that are qualitatively different from those imposed on the outside lawyer.¹⁷¹

As the *General Dynamics* court recognized, denying the discharged in-house career lawyer, who owes his livelihood, career goals, and professional satisfaction to a single organizational employer, a cause of action would degrade in-house counsel's professional stature.

B. Extending General Dynamics to the Medical Profession

By penalizing employers who do not appreciate or respect the value of a professional's ethical code to the existence of fiduciary relationships in our society, *General Dynamics* and similar cases¹⁷² place limits on an employer's ability to manipulate their professional employees. Where a professional employee depends on one party for all or a substantial part of his income, he

Palmateer plaintiff a cause of action while denying the *Balla* plaintiff similar judicial protection.

166. *Balla*, 584 N.E.2d at 109 (emphasis added).

167. *Id.* at 108.

168. *See id.* at 110. The court also felt the employer should not have to bear the economic consequences (i.e., a retaliatory discharge tort judgment) of in-house counsel's compliance with ethical obligations. *See id.*

169. *General Dynamics Corp. v. Superior Court*, 876 P.2d 487, 502 (Cal. 1994).

170. *Id.*

171. *Id.* at 491-92.

172. *See cases cited supra* note 11.

should not be the one who bears the loss of adhering to his ethical code. HMO physicians, relative newcomers to this dilemma,¹⁷³ should be treated no differently. Doctors must be “dedicated to providing competent medical service”¹⁷⁴ and devoted to advocating in their patients’ best interests.¹⁷⁵ Furthermore, since patients have “the right to receive information from physicians[,] . . . to discuss the benefits, risks, and costs of appropriate treatment alternatives[,] and to] . . . receive guidance from their physicians as to the optimal course of action,”¹⁷⁶ doctors should not be punished for fulfilling these obligations.

Smothering physicians’ professional autonomy with a cloud of doubt, uncertainty, and anxiety over job security, HMOs can intimidate physicians, coercing them into compromising their ethical imperatives in order to keep their jobs. Like in-house attorneys pressured to disregard their ethical duties in order to secure their professional existence and protect their economic livelihood, HMO physicians are similarly “no less given to the temptation to either ignore or rationalize away their ethical obligations when complying therewith may render them unable to feed and support their families.”¹⁷⁷ If society’s interest in condemning criminal conduct is so substantial that courts will grant an attorney discharged for preventing its occurrence a cause of action, then society’s interests in protecting the public health and the doctor-patient relationship should be equally, if not more, substantial. After all, if “[t]here is no public policy more important or more fundamental than the one favoring the effective protection of the lives . . . of citizens,”¹⁷⁸ then physicians should be even better positioned than attorneys to have their grievances heard in court.

C. Relevant Case Law Relating to HMO Contract Terminations

Recently, courts have begun to address the issue of whether, and under what circumstances, termination of a physician’s at-will HMO contract contravenes

173. See *Blades*, *supra* note 110, at 1408-09:

Consider . . . the plight of an engineer who is told he will lose his job unless he falsifies his data or conclusions, or unless he approves a product which does not conform to specifications or meet minimum standards. Consider also . . . the predicament of an accountant who is told to falsify his employer’s profit and loss statement in order to enable the employer to obtain credit.

Id.; see also *Rocky Mountain Hosp. & Med. Serv. v. Mariani*, 916 P.2d 519, 525 (Colo. 1996) (“A professional employee [e.g., an accountant] forced to choose between violating his or her ethical obligations or being terminated is placed in an intolerable position.”).

174. PRINCIPLES OF MEDICAL ETHICS Principle 1, *reprinted in* COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at xiv.

175. See CURRENT OPINIONS OF THE COUNCIL ON ETHICAL & JUDICIAL AFFAIRS Opinion 2.03 (1994), *in* COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at 6.

176. FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP (1994), *reprinted in* COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at xxxix.

177. *Balla v. Gambro, Inc.*, 584 N.E.2d 104, 113 (Ill. 1991) (Freeman, J., dissenting).

178. *Palmateer v. International Harvester Co.*, 421 N.E.2d 876, 879 (Ill. 1981).

public policy.¹⁷⁹ However, neither the *Harper* court nor the *Aiken* court explicitly granted a right to a wrongful discharge claim predicated on a refusal to violate professional ethics as a source of public policy.¹⁸⁰ Nevertheless, analysis of these two cases will help one explore the potential of, and likely limitations on, a judicially cognizable cause of action for terminated HMO physicians.

In *Harper v. Healthsource N.H., Inc.*,¹⁸¹ the Supreme Court of New Hampshire held that “the public interest and fundamental fairness demand that a health maintenance organization’s decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy.”¹⁸² The issue in *Harper* was not whether the physician could state a wrongful discharge claim predicated on his ethical duties, but rather whether he was entitled to some requisite level of due process as an at-will party. The defendant had allegedly manipulated the medical records of the plaintiff’s patients to justify its decision not to renew the plaintiff’s contract.¹⁸³ When the plaintiff requested to see the documentation supporting the defendant’s decision, the defendant refused and affirmed the termination without cause.¹⁸⁴ The plaintiff then sued alleging that the “without cause” provision in his employment contract was void as against public policy. The court concluded that “[a] terminated physician [wa]s entitled to review of the termination decision under [the covenant of good faith and fair dealing/public policy] standard, whether the termination was for cause, or without cause.”¹⁸⁵ Since the defendant had refused to produce the evidence upon which its decision was based, the court remanded the case to allow the plaintiff the

179. See *Aiken v. Business & Indus. Health Group, Inc.*, 886 F. Supp. 1565 (D. Kan. 1995), *aff’d sub nom. Aiken v. Employer Health Servs., Inc.*, 81 F.3d 172 (10th Cir. 1996); *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962 (N.H. 1996).

180. See *Aiken*, 886 F. Supp. 1565; *Harper*, 674 A.2d 962.

181. 674 A.2d 962.

182. *Id.* at 966. Since *Monge v. Beebe Rubber Co.*, 316 A.2d 549 (N.H. 1974), the decision which granted a wrongful discharge cause of action based on a breach of the implied covenant of good faith and fair dealing in the employment relationship, the New Hampshire Supreme Court had limited its recognition of implied-covenant-based theories, imposing on plaintiff the additional requirement of proving he was discharged either “because he performed an act that public policy would encourage, or [because he] refused to do that which public policy would condemn.” *Howard v. Dorr Woolen Co.*, 414 A.2d 1273, 1274 (N.H. 1980).

183. See *Harper*, 674 A.2d at 963-64. Although refusal to renew a contract is not technically a termination, the public policy implications are nevertheless the same. “[A] distinction between at-will contracts and definite term contracts [e.g., like *Harper*’s contract] is an illusory one that exalts legal formalities but refuses to address the reality of an employer’s decision, which costs an employee his or her job and seriously harms the community’s interests.” Mark M. Madden, Case Comment, 26 SUFFOLK U.L. REV. 1194, 1200 (1992) (criticizing *Willitts v. Roman Catholic Archbishop*, 581 N.E.2d 475 (Mass. 1991), wherein the court held that a teacher, whose employer refused to renew her contract because she had tried to unionize other teachers, did not state a wrongful discharge cause of action).

184. See *Harper*, 674 A.2d at 964.

185. *Id.* at 966.

opportunity to prove the decision was made in bad faith or violated public policy.¹⁸⁶

The *Harper* court acknowledged that the public had a “substantial interest”¹⁸⁷ in the physician-HMO relationship, though it did not specify in what way the termination implicated that interest.¹⁸⁸ The plaintiff in *Aiken v. Business & Industrial Health Group, Inc.*¹⁸⁹ did, however, identify such a connection. In *Aiken*, the plaintiff, a nine-year employee of the defendant’s, had been cited more than eight times for granting too much “loss time” to patients whose employer had complained to the defendant clinic that too many of its employees were unavailable to work due to plaintiff-imposed work restrictions.¹⁹⁰ After further disagreement with his supervising physician, the plaintiff was eventually terminated.¹⁹¹ The plaintiff sued, alleging he was terminated for “refus[ing] to violate a clear mandate of public policy as recognized by law and professional ethical codes.”¹⁹² Applying Missouri law to defendant’s summary judgment motion, the court held that since the plaintiff had not alleged that his superior’s medical judgment had fallen below the acceptable standard of care for the profession, the state’s public policy exception was unavailable.¹⁹³ Because the plaintiff had not presented any evidence of “incompetence, gross negligence or misconduct” or “obvious injurious consequences,”¹⁹⁴ the court remained unconvinced that a public policy exists that “prohibits an employer from terminating a health care employee over a disagreement or difference of professional judgment where the judgment of each is within the bounds of reasonable care.”¹⁹⁵

Together, *Harper* and *Aiken* stand for the proposition that a wrongful discharge claim predicated on a physician’s ethical code might, if well-pleaded, be viable.

186. *See id.* at 966-67. The *Harper* court, however, specifically rejected the trial court’s characterization of the arrangement between the HMO and the physician as an employer-employee relationship. *See id.* at 965.

187. *Id.* at 966.

188. One commentator has identified the *Harper* physician’s “implied suggestion that the HMO’s ‘skewing’ of [the physician’s] own patients’ records could affect their reliability and thus implicate patient care” as a possible factor which would demonstrate that the termination decision contravened public policy. Ronai, *supra* note 45, at 4.

189. 886 F. Supp. 1565 (D. Kan. 1995), *aff’d sub nom.* *Aiken v. Employer Health Servs., Inc.*, 81 F.3d 172 (10th Cir. 1996).

190. *See id.* at 1568.

191. *See id.* at 1568-69.

192. *Id.* at 1570.

193. *See id.* at 1572. According to the court, although the plaintiff had cited several general state laws, professional ethics, and the Hippocratic Oath, he did not cite any provision indicating that state public policy “demand[ed]” that his judgment prevail over his employer’s. *Id.* at 1571.

194. *Id.* at 1572 (quoting *Kirk v. Mercy Hosp. Tri-County*, 851 S.W.2d 617, 622 (Mo. Ct. App. 1993)).

195. *Id.* at 1573. In an unpublished decision, the Tenth Circuit affirmed the district court, holding that because the plaintiff’s failure to produce such evidence was “fatal” to his claim, it was unnecessary to decide whether any code of professional ethics or the Hippocratic Oath would have established a clear mandate of public policy. *Aiken v. Employer Health Servs., Inc.*, 81 F.3d 172 (10th Cir. 1996), *available in* 1996 WL 134933, at *5-*6.

Both cases also illustrate some of the limits to such a theory. However, given the right factual circumstances, it seems clear that a terminated physician could rest a public policy wrongful termination claim on her obligations to her patients' care.

First, the *Harper* court conceded that the public had a substantial interest in the physician-HMO relationship, noting that the termination of such a relationship affected more than just the HMO and the physician.¹⁹⁶ Although the court made no express opinion on how or what sort of employer conduct would implicate that interest, neither did it confine its holding to the narrow set of circumstances presented in the case before it. Certainly, the court's blanket prohibition on termination decisions which are contrary to public policy lends credence to the argument that a physician may not be terminated for attempting to fulfill her professional obligations. In fact, the court felt the physician-HMO relationship was perhaps "the most important factor" in connecting the physician to the patient.¹⁹⁷ If the physician-HMO relationship is so important to the physician-patient relationship, then the public policies in favor of encouraging physicians to act in their patients' best interests and of fostering patient trust in physicians should place some limits on HMOs' power to terminate a physician at will.

Second, although the *Aiken*¹⁹⁸ court did not allow the plaintiff to survive summary judgment, the court's opinion impliedly conceded that, under the right circumstances, a medical code of ethics could serve as a sufficiently clear mandate of public policy that a physician could rely on it if he were discharged for refusing to violate it.¹⁹⁹ In distinguishing a Missouri court of appeals case which held that a discharged nurse stated a cause of action if she could show that her employer's professional conduct evinced incompetence, gross negligence, or misconduct,²⁰⁰ the *Aiken* court rested its affirmance on the fact that in *Aiken* the plaintiff had not alleged such behavior. Despite this deficiency in pleading, the *Aiken* court nevertheless constructively articulated the standard that would have applied, had plaintiff alleged and shown such evidence of misconduct.²⁰¹ Therefore, under *Aiken*, if a physician-plaintiff can prove she was discharged for performing an act that public policy would encourage, then she may state a claim on a public policy theory.

196. See *Harper v. Hcalthsource N.H., Inc.*, 674 A.2d 962, 966 (N.H. 1996).

197. *Id.*

198. *Aiken v. Business & Indus. Health Group, Inc.*, 886 F. Supp. 1565, 1571-72 (D. Kan. 1995), *aff'd sub nom. Aiken v. Employer Health Servs., Inc.*, 81 F.3d 172 (10th Cir. 1996).

199. *But see Aiken*, 81 F.3d 172, available in 1996 WL 134933, at *5-*6 (refusing to rule on whether professional code might serve as a clear mandate of public policy).

200. See *Kirk v. Mercy Hosp. Tri-County*, 851 S.W.2d 617, 622 (Mo. Ct. App. 1993).

201. See *Aiken*, 886 F. Supp. at 1572 n.5 ("[T]he court finds that plaintiff has not alleged, let alone made a sufficient showing, that the defendant's policies, or [his superior's] judgments, regarding patient care and treatment violated *the applicable standard of care of the profession . . .*") (emphasis added).

V. THE CAUSE OF ACTION

By now it should be clear that some limits to HMO termination rights are necessary to prevent the intimidation of physicians into silence and inaction. “[U]nchecked employer power . . . has been seen to present a distinct threat to the public policy carefully considered and adopted by society as a whole. . . . [A] proper balance must be maintained among [the employer’s, the employee’s, and society’s interests].”²⁰² If cowered into submission, doctors will eventually lose their motivation for and commitment to patient health, the public’s health will deteriorate, and patients will lose confidence in physicians.

A. Articulating the Public Policy

Although courts have struggled with the definition of what “public policy” actually is,²⁰³ virtually every one of them has required that the public policy upon which the plaintiff relies be “clearly” stated.²⁰⁴ But the problem with relying on medical principles of ethics as a source of public policy is that the principles may be subject to one’s own interpretation.²⁰⁵ Unlike the ethical code for lawyers, which contains several provisions tailored to address some of the possible predicaments in which lawyers might find themselves, the *Code of Medical Ethics* (only seven principles) anticipates few such situations for doctors, leaving much of the principles’ interpretation up to physician discretion.

For instance, Principle I states that “[a] physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.”²⁰⁶ Due to the infinite number of patient conditions, the vagaries of clinical diagnosis, the uncertainty—acknowledged profession-wide—of ever knowing which approach to treatment is most appropriate, and the variance of medical opinion and judgment within the profession, it would be hard to say specifically when a decision to terminate an at-will physician violated the public policy embodied in the above-quoted ethical principle. Where a supervisor’s

202. *Palmateer v. International Harvester Co.*, 421 N.E.2d 876, 878 (Ill. 1981).

203. See, e.g., *Noble v. City of Palo Alto*, 264 P. 529, 530 (Cal. Dist. Ct. App. 1928) (“[P]ublic policy’ is . . . that principle of law which holds that no citizen can lawfully do that which has a tendency to be injurious to the public or against the public good”); *Palmateer*, 421 N.E.2d at 878-79 (“[P]ublic policy concerns what is right and just and what affects the citizens of the State collectively [A] matter must strike at the heart of a citizen’s social rights, duties, and responsibilities before the tort will be allowed.”).

204. See, e.g., *Adams v. Budd Co.*, 583 F. Supp. 711, 715 (E.D. Pa. 1984) (“clear mandate of public policy”); *Adler v. American Standard Corp.*, 432 A.2d 464, 471 (Md. 1981) (same); *Suchodolski v. Michigan Consol. Gas Co.*, 316 N.W.2d 710, 712 (Mich. 1982) (per curiam) (same); *Pierce v. Ortho Pharm. Corp.*, 417 A.2d 505, 512 (N.J. 1980) (same); *Brockmeyer v. Dun & Bradstreet*, 335 N.W.2d 834, 840 (Wis. 1983) (“clearly contravenes the public welfare and gravely violates paramount requirements of public interest”).

205. See PRINCIPLES OF MEDICAL ETHICS (1997), reprinted in COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at xiv.

206. *Id.* Principle I, reprinted in COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 1, at xiv.

medical judgment falls within the bounds of reasonable care, public policy does not prohibit an employer from terminating a health care employee over a difference of judgment.²⁰⁷ This is reasonable, for if every terminated HMO physician could cite a mere difference of professional opinion as incompetence and a violation of public policy, then determining malpractice would be impossible, managed care would lose any cost efficiency it had, and discharged physicians would inundate courts with claims. Physicians may not subjectively set the standard for ethically required care.

But by the same token, neither should HMOs be permitted to set such a standard. Accordingly, I propose the following articulation of public policy, proof of violation of which entitles the physician to a cause of action: It shall be against public policy (and therefore unlawful) for an HMO to terminate a physician's at-will contract in retaliation for physician conduct that comports with that physician's ethical duty to provide competent medical service, including in particular that physician's ethical duty to serve as the patient's advocate. Of course, in order for this standard to work, "ethical duty" and "competent medical service" need to be precisely defined.

B. The Tort's Availability and Limitations

In any HMO employing a utilization review program,²⁰⁸ a physician may not be terminated for appealing a review board's decision to deny a patient treatment.²⁰⁹ The concept of utilization review means that someone other than the patient's physician has a role in deciding which treatment is appropriate.²¹⁰ Since there are likely to be (and in fact are) many disputes over the necessary approach to treatment in the managed care environment, the meaning of "competent medical care" must be expanded to include vigorous patient advocacy. A physician should not feel coerced into silence when his patient's health is at issue, particularly when it is he, and not the utilization board, who is the patient's doctor, fiduciary, and confidant. This seems fair, since the physician may well be liable for any undertreatment.²¹¹ Surely, it would be ironic for a court to hold a physician's failure to appeal as medical negligence and yet at the same time deny that it was incompetent or unethical. Accordingly, a physician's "ethical duty" includes any

207. See *Aiken v. Business & Indus. Health Group, Inc.*, 886 F. Supp. 1565, 1573 (D. Kan. 1995), *aff'd sub nom. Aiken v. Employer Health Servs., Inc.*, 81 F.3d 172 (10th Cir. 1996).

208. See discussion *supra* note 43.

209. Cf. John Hale, *Bill on Managed Health Care Dies Early Death*, BANGOR DAILY NEWS, Mar. 21, 1996, at 1, available in 1996 WL 2188467 (reporting that a majority of a Maine state legislative committee favored a managed care bill which would prohibit managed care plans from "terminating . . . [participating] providers . . . when the provider advocates for medically appropriate care").

210. "Private utilization review programs are managed by insurers, employers, and HMOs that pay physicians and have an interest in ferreting out unnecessary medical services to limit their expenditures." RODWIN, *supra* note 4, at 113.

211. See e.g., *Wickline v. State*, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (dicta) ("The patient who requires treatment and who is harmed when care which should have been provided is not provided *should recover for the injuries suffered from all those responsible* for the deprivation of such care . . .") (emphasis added).

lobbying efforts taken on behalf of a patient, and HMOs should be prohibited from resting any termination decision on such grounds.

A physician dismissed for overutilization of HMO services would also be entitled to bring a wrongful discharge action if he could establish that, had he followed the HMO's protocols instead of allegedly overtreating the patient, he would have been forced to breach his primary duty of care, that is, to commit malpractice and violate his ethical duty to provide competent medical care. Regardless of what HMO protocol holds is medically necessary or appropriate, a physician's duty of care is nevertheless that which a reasonable physician in the community would have provided.²¹² Thus, if a physician can prove that following HMO protocol would have been professionally unreasonable in light of community standards, and that the treatment he ultimately prescribed (for which he was allegedly discharged) was professionally reasonable, then he may rely on his ethical duty of care as grounds for a wrongful termination claim. This is, of course, exactly what the plaintiff in *Aiken*²¹³ had failed to prove. However, according to *Aiken*, a discharged physician could state a claim if he could establish that the treatment he was being asked to administer was subpar.²¹⁴

There are, undoubtedly, significant proof problems inherent in such a theory of recovery, because in many cases the difference between what the physician did and what the HMO would have done will boil down to a disagreement over medical opinion, which as *Aiken* held, is not (and should not be) actionable. Only when the board's protocol is professionally unreasonable or manifestly incompetent would plaintiff be entitled to recover. But because utilization review boards are typically composed of physicians hired as consultants, whose judgment would arguably reflect the community standard of reasonable care, clearing this proof hurdle will be plaintiff's most daunting obstacle. Nevertheless, plaintiff should at least be given the opportunity to state a claim on such a basis, even if he might be ultimately unsuccessful on summary judgment or at trial.

C. Good Policy

Granting physicians a cause of action for retaliatory discharge would accomplish several things. First of all, it would maintain the country's standards of public and patient health. To deny the action would discourage physicians from zealously acting in their patients' best interests. Fearing a retaliatory discharge for contesting a denial-of-treatment decision, physicians would be reluctant to appeal. On the other hand, doctors might comply with the HMO's decision, despite knowing such a (lack of) treatment constitutes malpractice. Either way, doctors might decide that, as between an increased risk of malpractice exposure or an increased risk of losing their HMO affiliation, accepting the increased risk

212. See Reuben, *supra* note 46, at 58.

213. *Aiken v. Business & Indus. Health Group, Inc.*, 886 F. Supp. 1565 (D. Kan. 1995), *aff'd sub nom. Aiken v. Employer Health Servs., Inc.*, 81 F.3d 172 (10th Cir. 1996).

214. See *id.* at 1573.

of malpractice would be the lesser of two evils.²¹⁵ The standards of health care would eventually slide. While this might be acceptable to shareholders, it would undoubtedly contravene the public policy in favor of “competent” health care. This would have a detrimental effect not only on the public’s health, but on the public’s perception of managed care.

Second, granting physicians the cause of action would restore patients’ trust in physicians.²¹⁶ In an age when doctors are under increasing pressure to cut costs, and in fact receive financial incentives for doing so, patients’ faith in their physicians’ dedication is gradually deteriorating. Many people are concerned that managed care has undermined the physician-patient relationship too much already.²¹⁷ Except for the very sick, a drop in society’s confidence might in fact discourage some patients from seeking treatment, further jeopardizing the public health. “A fundamental premise of modern labor law is that society cannot allow the employer’s economic power to dominate individual workers when that power produces socially undesirable results.”²¹⁸ Allowing a physician to bring suit would curb the “undesirable result” of managed care’s tendency to undermine the public’s confidence in the physician-patient relationship.

Finally, by enhancing physicians’ overall bargaining position, extending the tort of retaliatory discharge would help restore physician morale. For many

215. If this were the case, then even the court in *Balla v. Gambro, Inc.*, 584 N.E.2d 104 (Ill. 1991), which had denied a discharged in-house attorney a cause of action, see *supra* Part IV.A, would likely agree that “the public policy . . . of protecting the lives . . . of citizens, [would not be] adequately safeguarded without extending the tort of retaliatory discharge.” *Balla*, 584 N.E.2d at 108 (intentionally mischaracterized).

The federal Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. §§ 1001-1461 (1994), preempts any lawsuits—including ones directed against HMOs—that “relate to” any employee benefit. According to § 1144(a), ERISA “supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[, e.g., a health insurance/care plan].” 29 U.S.C. § 1144(a). This means that an injured party cannot directly sue an HMO for any malpractice arising from its clinical decisions. See generally Alan S. Rutkin & Erica B. Garay, *ERISA Pre-empts Many HMO Claims*, NAT’L L.J., Sept. 9, 1996, at B11. Nevertheless, the doctor still remains exposed. Between the shield of ERISA immunity and the sword of contract termination power, HMOs can and do take enormous advantage of physicians, reaping the financial benefits associated with lower service and expenses without having to assume any of the legal risk of undertreatment. See Robert Pear, *HMOs Say Federal Law Shields Them from Charges of Malpractice*, HOUSTON CHRON., Nov. 17, 1996, at 15, available in 1996 WL 11576759. It is beyond the scope of this Note to reach these issues.

216. “In a poll conducted by the nonpartisan National Coalition on Health Care, 80% of respondents said they believed the quality of medical care is often compromised by insurance companies to save money.” Church, *supra* note 24, at 36.

217. Almost all 50 states are considering legislation that would respond to consumer complaints about HMOs. See Richard C. Reuben, *Curing HMO Ills by Ballot*, A.B.A. J., Oct. 1996, at 58. In Connecticut, for example, the state legislature recently passed a law granting the state the power to overturn managed care companies’ decisions on what medical procedures they will pay for. See Jonathan Rabinovitz, *Connecticut Seeks to Appeal Managed Health Care Denials*, N.Y. TIMES, May 22, 1997, at A1. In fact, at the federal level, President Clinton appointed a 34-member advisory committee to draft a patients’ bill of rights and investigate how to enforce those rights legislatively. See Church, *supra* note 24, at 32.

218. Moskowitz, *supra* note 111, at 34.

doctors, the move to managed care has meant relinquishing much of their professional independence. HMOs' close scrutiny of physician utilization "signatures," referral rates, and treatment successes and failures has diminished the profession's self-value.²¹⁹ Although courts may well be reluctant to play a role in massaging doctors' collective ego, they still should not turn a blind eye when that ego is a symptom of a deteriorating commitment to patient health. While diminished physician self-esteem may not be a primary motivating factor, recognizing a claim of wrongful discharge under the circumstances I have enumerated above would nonetheless alleviate the forces that tend to undermine professional morale.

D. The Potential for Statutory Protection

The judiciary, however, should not be the only branch of government concerned with preserving the public's trust in physicians. In addition to any court-granted cause of action, legislatures could also offer physicians protection from wrongful termination of their HMO affiliation.²²⁰ For example, either the state or the federal legislatures could draft legislation prohibiting HMOs from terminating physicians on account of any clinical decision to appeal a denial-of-treatment order, prescribe a medically necessary procedure, or defer to another physician's or specialist's judgment on a matter of patient health. This would help restore the public's confidence in a health care system already wracked with distrust.²²¹ It would also make professional and contractual relationships in the HMO setting more predictable, because physicians would no longer have to shadowbox the HMO regarding clinical decisionmaking. Naturally, such legislative action would also enhance physician job security, a particularly weighty concern in a profession whose independent access to patients is quickly evaporating under the managed care regime.

Of course, a legislatively granted remedy in this area would face the same practical obstacles as a judicially granted one: How should a legislature decide what is "medically necessary" without opening the door to a flood of lawsuits by lawfully discharged, formerly HMO-affiliated physicians? Fortunately, the answer is the same whether the action is judicially or legislatively created: the dimensions of a statutory cause of action are coterminous with those of a common law cause of action.²²² To the extent any termination decision is based on the physician's decision to inform a patient of the merits and success rates of various methods of treatment, surgical procedures, etc., the physician should be allowed to proceed. Additionally, if the termination decision is based on a physician's frequency of appealing denial-of-treatment orders, that physician should likewise be given the opportunity to prove his case. Finally, in a more borderline case where the decision to terminate is based on an allegedly "mere" difference of

219. See Kilborn, *supra* note 88, at A1.

220. Cf. Church, *supra* note 24, at 36 (reporting that in 1996, 35 states passed 56 laws to "regulate or weaken HMOs").

221. See *supra* note 216.

222. See discussion *supra* Part V.A-C.

medical opinion, the physician should be allowed to proceed only where he alleges that following HMO protocol would have been professionally unreasonable in light of community standards.²²³

Despite the tone of this Note, managed care has had one undeniable benefit: it has begun to slow the increasing cost of health care expenditures. Although managed care may mean that physicians will no longer command the salaries they once could,²²⁴ it nevertheless has started to bring the per-patient cost of health care down.²²⁵ However, experts are concerned that public health may suffer due to society's still primitive ability to measure health care quality.²²⁶ The public outcry against many HMO practices²²⁷ confirms this suspicion, and evinces a lack of trust in managed care's commitment to providing competent medical care to the public. To safeguard against the erosion of society's confidence in health care providers and the deterioration of public health, courts and legislatures need to recognize physicians' moral duty to contest HMO protocol whenever it falls below the level of competent care.

CONCLUSION

As the administration and delivery of health care in this country has evolved from fee-for-service arrangements to a managed care system, physicians have found themselves increasingly trapped between their ethical duty to remain dedicated to their patients' health, and their genuine financial need to protect their status as HMO preferred providers. For many doctors, the rise of HMOs has required a variety of different sacrifices—a diminishing salary, a loss of professional autonomy, and an increased financial dependence on institutions. Although soaring health care costs may make the corporate management of medicine inevitable, under no circumstances should it require physicians to compromise their professional and ethical obligations to their patients. However, the contract termination practices of many HMOs today are putting physicians' commitment to that obligation to the test.

223. See discussion *supra* Part V.A-C.

224. See Kilborn, *supra* note 88, at A1 (reporting that doctors' incomes fell for the first time in 1994, from an average of \$189,000 in 1993 to \$182,000 in 1994).

225. See Milt Freudenheim, *Health Costs Paid by Employers Drop for First Time in a Decade*, N.Y. TIMES, Feb. 14, 1995, at A1 (reporting that, for the first time in a decade, the employer's average cost of health benefits for each employee declined from \$3781 in 1993 to \$3741 in 1994); cf. Holcomb B. Noble, *H.M.O. Quality Called Equal, at Less Cost*, N.Y. TIMES, Nov. 8, 1995, at A14 (reporting that in the first comprehensive case-by-case comparison of treatment and cost, researchers found that patients treated by HMOs and those treated by doctors in traditional medical practices had similar results, even though HMOs cost less).

226. See Rosenthal, *supra* note 32 (quoting Marc Rodwin, professor at Indiana University—Bloomington's School of Public and Environmental Affairs and author of *Medicine, Money, and Morals*).

227. According to the National Conference of State Legislators, 400 bills affecting managed care practices were introduced in state legislatures within the first five months of 1995. See Milt Freudenheim, *H.M.O.'s Cope with a Backlash on Cost Cutting*, N.Y. TIMES, May 19, 1996, § 1, at 1.

As at-will independent contractors, physicians today receive little judicial protection against the side effects of corporate medicine's parallel goals of reining in health care costs and maximizing profits. With control over physician access to both patients and money, HMOs can exercise enormous bargaining power over physicians wishing to receive coveted preferred-provider status. To increase profit margins, HMOs coerce physicians into undertreating their patients by threatening to terminate their HMO affiliation. This may happen even when the physician satisfies her ethical duty to provide competent medical service. Discharging physicians under these circumstances contravenes the clear public policies in favor of protecting the public health and restoring the public's faith in the doctor-patient relationship. Denying discharged physicians access to the tort of retaliatory discharge will only stifle efforts to further such policies and exacerbate the problem. It is time for courts to grant physicians and their ethical duties the respect and protection they deserve.