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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF VENTURA

MEDICAL STAFF OF COMMUNITY MEMORIAL HOSPITAL OF SAN BUENA VENTURA, An Unincorporated Association Suing On Its Own Behalf, And In Its Representative Capacity For Its Members And Their Patients,

Plaintiffs,

v.

COMMUNITY MEMORIAL HOSPITAL OF SAN BUENA VENTURA; MICHAEL D. BAKST, PhD; SANDY MASIEL; RALPH R. BENNETT; RALPH B. BUSCH, M.D.; PHILIP C. DRESCHER, ESQ.; JOHN J. HAMMER; WILLIAM L. HART, M.D.; FRITZ R. HUNTSINGER.; HARRY L. MAYNARD; F. "TED" MUEGENBURG, JR, ESQ.; LEONARD ORTIZ; JANICE P. WILLIS; MICHAEL D. BRADBURY, ESQ.; PETER GAAL, M.D.; GREG SMITH; JIM WOODBURN, III, M.D.; CADUCEUS MEDICAL MANAGEMENT, INC,; and DOES 1-100, inclusive,

Defendants.

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Case No. CIV219107

BRIEF OF AMICI CURIAE OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFF'S OPPOSITION TO DEMURRERS

Hearing Date: July 30, 2003
Time: 8:30 a.m.
Dept.: 34

Judge: Hon. Henry J. Walsh

Action Filed: April 24, 2003
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Trial Date: Not Set

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I. INTRODUCTION

This case alleges a series of unprecedented actions by a hospital board of trustees which entirely subvert the legally mandated role of the hospital medical staff, including by not limited to:

1. Usurpation of the medical staff's credentialing, standard setting, disciplinary and quality assurance functions.

2. Refusal to recognize duly elected medical staff leadership, and purported unilateral designation of replacement officers.

3. Unilateral amendment of the medical staff bylaws, and improper interference with the medical staff's efforts to review and update its bylaws.

4. Seizure of the medical staff treasury.

These actions, which given the procedural posture of this case must be presumed to have occurred, cannot be reconciled with the medical staff's legal responsibility to be self-governing with respect to the professional work performed in the hospital, including but not limited to its obligation to set standards of patient care, establish and enforce standards for medical staff membership, and protect patients' interests in obtaining quality care through continuous review and evaluation of the medical care rendered in the hospital.

The California Medical Association appreciates the important role a hospital board plays in the running of a successful hospital. We are long past the point where hospitals may be viewed as merely the "doctors' workshop." However, the pendulum has not swung so far as the defendants would like this court to believe. Under California law, hospital boards most certainly do not have unchecked power over hospital medical staffs. To the contrary, California's statutory and regulatory scheme vests medical staffs and hospital boards with mutual duties of surveillance, designed to ensure that they serve as a check and balance on each other in order to assure an appropriate symmetry between corporate and patient care interests. It recognizes that each hospital's medical staff is the only body with the necessary medical expertise and experience to properly conduct credentialing and patient care review functions,

and to assess the impact of "business" and "administrative" decisions on the delivery of quality care in the hospital.

Under these circumstances, there is no question that, under California law, a hospital medical staff has standing to enforce its legal rights. See *Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, 809, 140 Cal.Rptr. 442 (defining a medical staff as "an unincorporated association organized under the auspices of the hospital's board of directors"); *Hongsathavij v. Queen of Angels* (1998) 62 Cal.App.4th 1123, 1131 n.2, 73 Cal.Rptr.2d 695 ("A hospital's medical staff is a separate legal entity, an unincorporated association, which is required to be self-governing and independently responsible from the hospital for its own duties and for policing its member physicians").[1] Both the Legislature and the Department of Health Services have assigned responsibilities to hospital medical staffs, responsibilities essential to the provision of quality patient care in California's hospitals. The medical staff of Ventura Community Memorial Hospital clearly constitutes "(1) a group whose members share a common purpose, and (2) [which] functions under a common name under circumstances where fairness requires the group be recognized as a legal entity." (*Barr v. United Methodist Church* (1979) 90 Cal.App.3d 259, 153 Cal.Rptr. 322; Corporations Code §§2400, 20001, 21000.) It is thus entitled to bring this action pursuant to Code of Civil Procedure §369.5(a) ("A partnership or other unincorporated association, whether organized for profit or not, may sue and be sued in the name it has assumed or by which it is known").

Nor is there any merit to the suggestion that this case is barred by the exhaustion doctrine. Even assuming there were any administrative procedures to exhaust relevant to these allegations set forth in the medical staff bylaws, the core of the medical staff's complaint is that the hospital board has entirely repudiated the binding nature of those bylaws and has further refused to acknowledge the parties who would exercise those remedies, the medical staff's duly elected representatives. The law does not demand a futile act.

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[1] Defendants' extensive reliance on out of state cases is misplaced given the controlling California precedent.

Given the critical role a hospital medical staff plays in the delivery of health care, the potential ramifications of this case are profound. If hospital boards are allowed to run roughshod over hospital medical staffs, without regard for the laws designed to ensure that does not happen, the ability of hospital medical staffs to provide quality care in hospitals will be jeopardized throughout the state. We urge this Court to recognize a hospital medical staff's legal right and ability to perform functions essential to the provision of quality patient care. Hospital boards must not be allowed, with impunity, to vitiate laws designed to ensure the people of California that their interests in receiving quality care will be placed first and foremost.

II. ORGANIZED MEDICAL STAFFS PERFORM THE ONGOING PROFESSIONAL FUNCTIONS NECESSARY TO QUALITY PATIENT CARE

To appreciate what is at issue in this case, the role of the medical staff in a hospital must be understood. In order to ensure quality patient care, professional services in the hospital must be regularly monitored and evaluated. A comprehensive quality assurance process is critical to the resolution of problems as well as the identification of opportunities to improve patient care. Protocols and procedures must be continuously analyzed and revised to reflect new information and technologies. The clinical performance of physicians and other health care professionals must be repeatedly assessed so that substandard performance and impaired or incompetent individuals may be identified **before** patients are seriously injured.

To be effective, this monitoring function must be performed by individuals who have both the expertise necessary to conduct these quality assurance activities and the ability to implement any indicated changes. An effective medical staff peer review system provides the optimal solution. Medical staffs, comprised of physicians and certain other health professionals, have both the necessary expertise and familiarity with the health care facility and the physicians and other health care providers involved to conduct effective peer review. **These quality assurance activities depend on effective medical staff organization and leadership.**

The importance of medical staff activity cannot be overstated. Indeed, recognizing the fundamental importance of medical staff activity to quality patient care in hospitals throughout California, the Legislature and the Department of Health Services have established a comprehensive scheme requiring medical staffs and their physician members to perform direct patient care activities and to perform the ongoing review, evaluation and monitoring functions of the care rendered.

A. The Law Vests Within The Medical Staff's Realm Of Responsibility Activities Which Are Critical To The Provision Of Quality Care.

1. Patient Care Services

First and foremost, each physician member of the medical staff is responsible for overseeing the general medical condition of every patient that physician admits to the hospital. This is not only a moral and ethical obligation, it is required by legal standards. See e.g. 22 California Code of Regulations Section 70703(a) (physician responsible for adequacy and quality of medical care rendered to patients in hospital). Indeed, the standards established by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO), the private association which accredits hospitals nationwide, require that physicians perform an "appropriate physical examination" on all hospitalized patients and that physicians be responsible for "the management of each patient's care." Joint Commission, *Accreditation Manual for Hospitals*, 2003 Medical Staff Standards MS.6.2 and 6.5.[2]

By the same token, physicians are legally responsible for the care and treatment provided to their patients and must take steps to reduce the risk that their patients are subject to known or reasonably suspected unsafe conditions at the hospital. In caring for their patients,

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[2] Of course, this court may properly take judicial notice of the JCAHO's standards pursuant to Evidence Code §452 (h). See *Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, 819; 140 Cal.Rptr. 442. Moreover, it should be noted that institutions accredited as hospitals by the JCAHO are generally deemed to meet all of the Medicare conditions of participation. See 42 U.S.C. §1395bb(a)(1); 42 C.F.R. §488.5. See also Health & Safety Code §1282 (authorizing quality of care inspections of hospitals by the JCAHO).

physicians' conduct must conform to the appropriate standards at all times. Although the standard of care in California for physicians and surgeons does not call for them to use the highest skill known to medical science, *Sinz v. Owens* (1949) 33 Cal.2d 749, it does require that they exercise that degree of skill, knowledge and care ordinarily possessed and exercised by other members of the profession under similar conditions and circumstances. See *Landeros v. Flood* (1976) 17 Cal.3d 399, 408, 131 Cal.Rptr. 69. Physicians are required to possess and exercise that same standard of care in both diagnosis and treatment. (*Id.* at 408.)

Additionally, because medicine is a continually evolving science, physicians must be continually aware of, employ, and strive to improve the developing medical procedures and technology. Patients expect, and the law requires, such ongoing activity. See *Cobbs v. Grant* (1972) 8 Cal.3d 229, 104 Cal.Rptr. 505. See also the American Medical Association Principles of Medical Ethics V (which provides: "A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.")

Of course, a physician's "professional work" is not limited to the diagnosis and treatment of patients. Physicians have a number of unique and important responsibilities towards their patients which exist separate and apart from their duty to conform to the standard of care involving clinical determinations. For example, absent termination of a physician-patient relationship, a physician's relationship with his or her patient is a continuing one that imposes ongoing obligations, such as warning patients of subsequently discovered dangers from prior treatments. See *Tresemer v. Barke* (1988) 86 Cal.App.3d 656, 150 Cal.Rptr. 384 (holding that patient stated a cause of action against a physician who had inserted an intrauterine device on the grounds that the physician, who had seen the patient only once, failed to warn her of its dangerous side effects of which he learned only after its insertion). And if physicians know, or should know, that a patient needs more specialized care, they have a duty to make appropriate referrals. (BAJI 6.04.) In making the referral, the physician has a duty to inform the patient of

the risks of not seeing a specialist. (*Moore v. Preventative Medicine Medical Group, Inc.* (1986) 17 Cal.App.3d 728.)

Moreover, the California Supreme Court has recognized that at the heart of the physician-patient relationship lies the physician's right and responsibility to advocate standards pertaining to quality medical care. See *Rosner v. Eden Township Hospital District* (1962) 58 Cal.2d 592, 598, 25 Cal.Rptr. 551 (stating, among other things, "the goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital practices are being followed. Considerations of harmony in the hospital must give way where the welfare of patients is involved, and the physician by making his objections know, whether or not tactfully done, should not be required to risk his right to practice medicine.")

More recently, the *Rosner* court's recognition that physicians must be free to advocate on their patient's behalf has been extended by the courts to encompass an affirmative legal duty, on the part of physicians, to speak up and challenge decisions which jeopardize a patient's health. In the landmark case of *Wickline v. State of California* (1986) 192 Cal.App.3d 1630, 239 Cal.Rptr. 810, the court strongly suggested that an injured patient is entitled to recover compensation from all persons responsible for the deprivation of medically necessary care, including physicians and third party payors, when medically inappropriate decisions result from defects in the design or implementation of cost containment programs.

Most recently, the California Legislature has codified the protections acknowledged by the Supreme Court in *Rosner* to be necessary to assure appropriate patient advocacy by enactment of Business & Professions Code §2056. Section 2056 broadly protects physicians from retaliation for advocating medically appropriate health care, that is, any protest of a decision, policy or practice that reasonably impairs his or her ability to provide medically appropriate health care. See generally, *Khajavi v. Feather River Anesthesia Medical Group* (2000) 84 Cal.App.4th 32, 100 Cal.Rptr.2d 621 (physician states a claim for wrongful discharge in violation of public policy expressed in section 2056). In sum, as part of their professional work, physicians on the medical staff have a number of direct patient care responsibilities which

are designed to ensure that patients receive quality care. Neither hospitals nor their trustees have parallel duties.[3]

2. Credentialing

Aside from the responsibility of medical staff members for the provision of medical care to patients, the medical staff is responsible for credentialing, that is, assuring the initial and ongoing competence of every physician, dentist, podiatrist, and in some cases clinical psychologist who practices in the hospital. See, generally, *Unterthiner v. Desert Hospital District* (1983) 33 Cal.3d 285, 188 Cal.Rptr. 590.

The Department of Health Services has emphasized the importance of the medical staff's expertise in the credentialing area. DHS specifically requires hospital boards to have the medical staff establish peer review and credentialing procedures. (22 C.C.R. §70701(a)(7).) It is the medical staff which must develop, adopt and enforce "formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeal mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate." (22 C.C.R. §70703(b).) Moreover, these procedures must be:

> [D]esigned to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. 22 C.C.R. §70701(a)(7).

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[3] Notably, the courts refuse to extend duties to hospitals or third party payers where the duty could jeopardize the physician-patient relationship. For example, in *Derrick v. Ontario Community Hospital* (1975) 47 Cal.App.3d 145, 120 Cal.Rptr. 566, a patient with an infectious disease was not advised about the nature of her condition, resulting in another person contracting the infection. There, the court held that the hospital where she was admitted had no legal duty to advise as to her condition. The court found that the duty was solely the responsibility of the treating physician. Otherwise, the court added, imposing such a legal duty on the hospital "might substantially interfere with the relationship between the patient and her attending physician." (*Id.* at 174.)

3. Patient Care Review

Finally, the medical staff is also primarily responsible for assuring the ongoing quality of patient care throughout the hospital. Indeed, hospital licensing regulations specifically require that the medical staff maintain one or more committees formally organized to monitor the care and treatment rendered to hospital patients. (22 C.C.R. §§70203 and 70703(d).) For example, pursuant to the law, the medical staff is obligated to perform the following patient care review functions on a regular basis:

1. **Medical records review**: the evaluation of medical records for their timely completion and adequate reflection of the patient's condition and treatment which is necessary to ensure that others will be able to assume the patient's care if required. (22 C.C.R. §§70703(d), 70749 and 70751.)

2. **Surgery review**: the evaluation of surgeries performed to determine whether the surgery was both indicated and properly executed. (22 C.C.R. §§70703(d) and 70223 subdivisions (b) and (h).)

3. **Utilization review**: the evaluation of the allocation of the hospital's health care resources to monitor and address overutilization, underutilization and inefficient scheduling. (22 C.C.R. §70703(d).)

4. **Infection control and antibiotic usage review**: the evaluation of the clinical use of antibiotics and the ongoing prevention, surveillance, and control of infections from whatever source, throughout the hospital. (22 C.C.R. §70703(d) and 70739.)

5. **Pharmacy and therapeutics review**: the evaluation of pharmacy and therapeutics practice and the development of a drug formulary and policy relating to the safe handling, distribution, and administration of drugs. (22 C.C.R. §70703(d) and 70263.)

6. **Interdisciplinary practice committee**: the development of written "standardized procedures" and supervision requirements which permit nurses and physicians' assistants to perform extended functions in the hospital. Business & Professions Code §2725. (22 C.C.R. §§70706 *et seq.*)

7. **Clinical laboratories/radiology/anesthesiology review**: the evaluation of, and the development of procedures governing clinical laboratory, radiology and anesthesiology practice. (22 C.C.R. §§70233, 70243, and 70253.)

8. **Disaster planning**: the development of a written disaster and mass casualty program. (22 C.C.R. §70741.)

9. **Hospital safety planning**: the development of a written program to deal with internal disasters such as fires. (22 C.C.R. §§70743, 70745 and 70746.)

10. **Continuing education**: the development of and participation in a mandatory, ongoing program of continuing education addressing the problems discovered during the foregoing patient care review activities. (22 C.C.R. §70703(g).)

B. The Importance Of Medical Staff Functions Is Further Evidenced By The Various Statutory Protections For This Activity.

The California Legislature has enacted a number of statutes specifically protecting members of the medical staff engaged in quality assurance activity. These statutes include:

(1) Civil Code §43.7 which provides a conditional immunity for actions taken by members of medical staff committees engaged in quality assurance activities;

(2) Civil Code §43.8 which provides a conditional immunity for those who communicate information to medical staff committees "intended to aid in the evaluation of the qualifications, fitness, character or insurability of the practitioner of the healing arts";

(3) Civil Code §47 subdivision 2 (4) which provides an **absolute** privilege for any "publication or broadcast" made "in the initiation or course of . . . proceedings authorized by law and reviewable" by way of administrative mandamus. This section applies to medical staff disciplinary hearings such as those conducted as a result of credentialing disputes. (*Long v. Pinto* (1981) 126 Cal.App.3d 946, 179 Cal.Rptr. 182.)

(4) Evidence Code §1157 which provides a broad protection for the confidentiality of the proceedings in records of medical staff committees by generally insulating them from discovery.

The existence of these protections clearly demonstrates the Legislature's recognition of the importance of medical staff quality assurance activity, and the Legislature's intention to take those steps necessary to ensure that medical staffs continue to perform these functions, without interference from third parties, including the courts. Indeed, the courts have recognized the important policy underlying the protection of medical staff activities. As the court stated in

Matchett v. Superior Court (1974) 40 Cal.App.2d 623, 628-629, 115 Cal.Rptr. 317, an opinion upholding the protection from discovery afforded by Evidence Code §1157:

> When medical staff committees bear delegated responsibility for the competence of staff practitioners, the quality of in-house medical care depends heavily upon the committees members' frankness in evaluating their associates' medical skills and their objectivity in regulating staff privileges. Although composed of volunteer professionals, these committees are affected with a strong element of public interest.

Nor is this legislative recognition limited to the protection of individual medical staff members. The Legislature has also recognized the importance of the medical staff as an entity, and required that appropriate deference be given to its determinations in cases involving disciplinary actions against medical staff members. Thus, a hospital board has the authority to direct the medical staff to initiate an investigation or disciplinary action, but only where a medical staff's failure to do so is contrary to the weight of the evidence, and even then, only after consultation with the medical staff. In addition the law provides "no such action shall be taken in an unreasonable manner." (Business & Professions Code §809.05(b).)

Where the medical staff fails to abide by the hospital board's direction to act as set forth above, the hospital board may itself undertake an investigation or institute disciplinary action. If it does so, it must first notify the medical staff in writing, and follow the statutorily prescribed fair hearing requirements. (Business & Professions Code §809.05(c).)

The law further provides that both hospital boards and medical staffs must "act exclusively in the interest of maintaining and enhancing quality patient care," (Business & Professions Code §809.05(d)), and further requires hospital boards, in all peer review matters, to give "great weight" to medical staff actions, and in no event act in arbitrary or capricious manner. (Business & Professions Code §809.05(a).)

The law also sets out a special rule applicable to summary suspension. Specifically, the law allows a hospital board or its designee to summarily suspend a medical staff member's clinical privileges, but only where:

1. the failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual;

2. the hospital board has first made reasonable attempts to contract the medical staffs; and

3. such a suspension terminates automatically if it is not ratified by the medical staff within two (2) working days.

(Business & Professions Code §809.5(b).)[4]

Finally, hospitals are entitled to a conditional immunity from damages (except specific economic damages) for any disciplinary action taken which must be reported to the Medical Board of California pursuant to Business & Professions Code §805, **only when the hospital takes action upon the recommendation of the medical staff**. The law expects the hospital board to rely upon the independent judgment of the medical staff in professional matters.

Plainly, these statutes evince a legislative judgment that medical staff activities are critical to the ongoing performance of quality care in hospitals throughout California.

III. TO PROPERLY PERFORM THEIR VITAL FUNCTIONS, MEDICAL STAFFS MUST RETAIN THEIR SEPARATE IDENTITY AND BE SELF-GOVERNING

Recognizing the fundamental importance of medical staff activity to quality patient care in hospitals throughout California, and recognizing that only medical staff members can make the requisite determinations concerning the provision of quality care, the Legislature and the Department of Health Services have established a comprehensive scheme requiring medical staff performance of ongoing review, evaluation and monitoring of the quality of patient care and treatment rendered in hospitals. See Business & Professions Code §2282, Health & Safety Code §1250(a), 22 C.C.R. §§70701 and 70703. See discussion above. Recognizing that these conditions are necessary to assure that medical staffs properly carry out their functions, the law demands that medical staffs be (a) separate and (b) self-governing.

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[4] Note also that "it is the intent of the Legislature that written provisions implementing Sections 809 to 809.8, inclusive in the acute care hospital setting shall be included in medical staff bylaws which shall be adopted by a vote of the members of the organized medical staff and which shall be subject to governing body approval, which approval shall not be withheld unreasonably." (Business & Professions Code §809(a)(8).)

A. A Medical Staff Is A Separate Entity Whose Legal Existence Is Independent Of A Hospital's Governing Body.

"A hospital's medical staff is a separate legal entity, an unincorporated association, which is required to be self-governing and independently responsible from the hospital for its own duties and for policing its member physicians." (*Hongsathavij v. Queen of Angels* (1998) 62 Cal.App.4th 1123, 1131 n.2, 73 Cal.Rptr.2d 695.) Indeed, the California Supreme Court has expressly recognized the legal status of the medical staff. (*Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, 809, 140 Cal.Rptr. 442 (defining a medical staff as "an unincorporated association organized under the auspices of the hospital's board of directors").) As an unincorporated association, the medical staff is an entity which has enforceable legal rights. See California Code of Civil Procedure §369.5.[5]

The fact that a medical staff may be under the auspices of the hospital's board of directors does not deprive it of its status as a separately recognizable entity. Organizations of all types are subject to varying degrees of control, ranging from requirements imposed by federal and state law to operational limitations imposed by parent corporations or associations. Nevertheless, both California and federal courts have recognized the separate legal status of unincorporated associations subject to at least the measure of control exercised by a hospital's governing body over the medical staff. See, e.g., *Killeen v. Hotel and Restaurant Employees etc. League* (1948) 84 Cal.App.2d 87 (recognizing independent legal existence of local union even though it was bound by bylaws and constitution of parent association); *California Dental Association v. American Dental Association* (1979) 23 Cal.3d 346 (same); *Associated Students of University of California Riverside v. Kleindist* (C.D.Cal. 1973) 60 F.R.D. 65 (student organization is not a mere sub-unit of the Regents of the University of California). Under California law, all that is required for a determination of separate legal status is "(1) a group

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[5] The enforceability of medical staff bylaws was recently affirmed in *O'Byrne v. Santa Monica Hospital Medical Center* (2001) 94 Cal.App.4th 797, 881, 114 Cal.Rptr.2d 575 (although the bylaws do not constitute a contract, they remain enforceable; a physician can enjoin a hospital from contravening the terms and provisions of the bylaws).

whose members share a common purpose, and (2) who function under a common name under circumstances where fairness requires the group be recognized as a legal entity." (*Barr v. Union Methodist Church* (1979) 90 Cal.App.3d 259, 153 Cal.Rptr. 322; Corporations Code §§2400; 20001; 21000.)

A medical staff's independence from the hospital corporate structure is further demonstrated by the fact that both California and federal laws specifically require that hospitals have "organized" medical staffs. See Health & Safety Code §32128; Health & Safety Code §1250(a); Business & Professions Code §2282, 22 C.C.R. §§70701 and 70703; 42 C.F.R. §482.22. JCAHO standards similarly require that the medical staff be "organized." See, Joint Commission *Accreditation Manual for Hospitals* (2003) MS. 1.

There is no room for doubt about the meaning of the term "organized." Accordingly, the term must be given its plain meaning. (*Shippen v. Department of Motor Vehicles* (1984) 161 Cal.App.3d 1119, 208 Cal.Rptr. 13.) The term "organized" is defined as "having a formal organization to coordinate and carry out activities." (Webster's Ninth New Collegiate Dictionary (1988).) Similarly, the term "organize" means "to cause to develop an organic structure," "to organize or form into a coherent unity or functioning whole." (*Id.*) Given the plain meaning of the statutes governing the existence of a medical staff, it is abundantly clear that the medical staff is a separate legal entity which exists independent of the hospital governing body.

B. California Law Prohibits The Practice Of Medicine By Physicians In Hospitals And Licensure Of Hospitals Unless The Medical Staff Is "Self-Governing With Respect To The Professional Work Performed"

As will be discussed in greater detail below, California law generally prohibits lay persons from exercising control or otherwise interfering with the professional judgment of physicians and other health care professionals. The reason for this prohibition is simple: lay individuals, including hospital trustees, have neither the expertise nor experience to render, implement, or exercise control over decisions made by physicians and medical staffs.

Recognizing these practical realities, both the Legislature and the Department of Health Services have specifically concluded that the public welfare depends on medical staff control and regulation of the professional work performed in hospitals. Accordingly, California statutes mandate the establishment of organized, self-governing medical staffs to control the performance of that work. In fact, physicians are prohibited by law from practicing medicine in hospitals without such medical staffs. Business & Professions Code §2282 provides, among other things, that it shall be unprofessional conduct for a physician to practice medicine in a hospital which does not have the rules providing for at least the following:

1. **[T]he organization of physicians and surgeons** licensed to practice in this state who are permitted to practice in the hospital **into a formal medical staff with appropriate officers and bylaws** . . .

2. **[T]hat membership on the medical staff shall be restricted to physicians and surgeons and other licensed practitioners** competent in their respective fields . . . and

3. [T]hat the medical staff shall be **self-governing with respect to the professional work performed in the hospital** . . . . (Emphasis added)

Parallel provisions regarding self-governing medical staffs apply to hospitals. Health & Safety Code §1250(a) defines "general acute care hospitals" as health facilities having "an organized medical staff." Department of Health Services regulations governing acute care hospitals expand on this definition. 22 C.C.R. §70701 provides, in relevant part:

(a) The governing body shall:

(1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:

* * *

(D) **Formal organization of the medical staff with appropriate officers and bylaws.**

* * *

(F) **Self-government by the medical staff with respect to the professional work performed** in the hospital, periodic meetings of the medical staff to review and analyze at regular intervals their clinical experience and requirement that the medical records of the patient shall be the basis for such review and analysis.

* * *

(7) **Require that the medical staff establish controls** that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. [Emphasis added].

Hospital licensing regulations further define the role and responsibilities of an "organized medical staff." Relevant subdivisions of 22 C.C.R. §70703 include:

(d) The medical staff bylaws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff's members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly.

(e) The medical staff shall provide in its bylaws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospitals. . . . "

JCAHO standards mirror California law. These standards clearly mandate that organized medical staffs be responsible for the control and provision of professional services provided at the hospital. The relevant JCAHO Medical Staff Standards provide:

MS.1 One or more organized, self-governing medical staffs[6] have overall responsibility for the quality of professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body.

MS.1.1.3 All medical staff members and all others with delineated clinical privileges are subject to medical staff and departmental bylaws, rules and regulations, and policies and are subject to review as part of the organization's performance-improvement activities.

MS.2 Each medical staff develops and adopts bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing body.

MS.2.1 Medical staff bylaws and rules and regulations are adopted by the medical staff and approved by the governing body before becoming effective. Neither body may unilaterally amend the medical staff bylaws or rules and regulations.

MS.2.2 Medical staff bylaws and rules and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.

MS.2.3 Medical staff bylaws include provisions for at least the following: an executive committee of the medical staff (MS.2.3.1); fair-hearing and appellate review mechanisms for medical staff members and other individuals holding clinical privileges (MS.2.3.2); mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership or clinical privileges (MS.2.3.3); and a description of the medical staff's organization, including categories of medical staff membership, when such exist, and appropriate officer positions, with the stipulation that each officer is a medical staff member (MS.2.3.4).

MS.2.3.4.1 The bylaws define: the method of selecting officers (MS.2.3.4.1.1); the qualifications, responsibilities, and tenures of officers (MS.2.3.4.1.2); and the

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[6]California law requires that hospitals with consolidated licenses have a single medical staff for all the facilities maintained and operated by the licensee, with a single set of bylaws, rules and regulations which prescribe a single committee structure. (Health & Safety Code §1250.8(b)(3).)

conditions and mechanisms for removing officers from their positions (MS.2.3.4.1.3); if there are multiple levels of governance, there is an established mechanism for the medical staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the hospital (MS.2.3.6.1); a mechanism for adopting and amending medical staff bylaws, rules and regulations, and policies (MS.2.3.7); and medical staff representation and participation in any hospital deliberation affecting the discharge of medical staff responsibilities (MS.2.3.8).

MS.3 The medical staff is organized to accomplish its functions.

Medicare similarly requires that hospitals have an organized self-governing medical staff responsible for the quality of medical care provided to patients by the hospital. (42 C.F.R. §482.12.)

This carefully crafted scheme ensures that medical staffs and their members independently exercise their professional expertise with respect to the professional work performed in the hospital. Neither the law nor public policy countenance unlawful or otherwise unwarranted intrusions into matters which are exclusively within the medical staff's (and its physician members') proper domain. Indeed, without an "organized," "self-governing" medical staff which controls the "professional work performed in the hospital," California laws designed to maintain quality care in hospitals become meaningless.

1. Self-Governance Requires Control Over One's Own Affairs

Like the term "organized," the meaning of the term "self-governance" is not subject to dispute. "Self-government" is defined in Webster's Ninth New Collegiate Dictionary (1988) to mean "1: SELF-COMMAND, SELF-CONTROL. 2: government under the control and direction of the inhabitants of a political unit rather than by an outside authority; broadly: control of one's own affairs." Given the breadth of this term, it could not be more clear that medical staffs and their physician members must exercise their lawful right and responsibility to assure quality care, without improper interference or control by a hospital's board of trustees.

The conclusion that hospital boards may not interfere in setting patient care standards or medical staff bylaws development, refuse to recognize duly elected medical staff officers, seize medical staff funds or otherwise improperly undermine the hospital medical staff is compelled

by a consideration of other cases discussing "self-governing" entities in other contexts. For example, the United States Supreme Court has declared that "a collective bargaining agreement is an effort to erect a system of industrial self-government." (*United States Steel Workers v Warrior & G. Nav. Co.* (1960) 363 U.S. 574, 580, 4 L.Ed.2d 1409.) With respect to collective bargaining agreements, therefore, self-government means complete control over internal grievances without resort to external powers. (*Id.*) Similarly, Indian tribes, as "distinct political communities," operate under a system of "self-government." (*Estate of Johnson* (1981) 125 Cal.App.3d 1044, 178 Cal.Rptr. 123.) Therefore, the state may not lawfully impose estate taxes on self-governing Indian tribes. The Regents of the University of California enjoy a similar status as a "self-governing" entity. (*Regents of Univ. of Cal. City of Santa Monica* (1978) 77 Cal.App.3d 130, 143 Cal.Rptr. 276.) Accordingly, when constructing improvements for educational purposes, the Regents are exempt from local building codes and zoning regulations. (*Id.*) The California State Bar has also been described as "an organization of members of the legal profession of the state with a large measure of self-government performing such functions as examining applicants for admission, formulating rules of professional conduct, disciplining members for misconduct, preventing the unlawful practice of law, and engaging in the study and recommendation of changes in procedural law and improvement of the administration of justice." See *Saleeby v. State Bar* (1985) 39 Cal.3d 547, 557, 216 Cal.Rptr. 367. See also *Rapid Transit Advocates, Inc. v. Southern California Rapid Transit District* (1986) 185 Cal.App.3d 996, 230 Cal.Rptr. 225 (holding that transit district, a governmental body with "virtual autonomy and self-governance" was not subject to regulations propounded by city or county).

At the very least, therefore, the term "self-governance" in the context of medical staffs, means a substantial degree of independence and discretion, particularly in regard to its own inner workings.

2. "Professional Work Performed In The Hospital" Encompasses Not Only Clinical And Other Determinations Necessary To The Practice Of Medicine, But Also All Decisions Regarding The Medical Staff's Right And Responsibility To Conduct Quality Of Care And Patient Review Activities.

The Legislature mandated the broad grant of authority to medical staffs to be self-governing in the "professional work performed in the hospitals," recognizing that medical staffs and their members are not only responsible for providing quality medical care to their patients, but also for the performance of quality assurance functions (thereby assuring the quality of care) in hospitals. Only through this broad authority granted to medical staffs can the letter and spirit of California's strong protections prohibiting the commercial exploitation of the practice of medicine and protecting the integrity of the physician/patient relationship be maintained.

The breadth of the "professional work" performed by the medical staff and its members has been addressed above. Indeed, as the court in *Marik v. Superior Court* (1987) 191 Cal.App.3d 1136, 236 Cal.Rptr. 751, correctly observed, the practice of medicine includes a host of considerations ranging from the type of equipment needed, skill levels required by operators of the equipment, scope of practice, and medical ethics, to business considerations which encompass factors that have medical ramifications. (See *Marik, supra.* fn. 4 at 1140. "For example, the prospective purchase of a piece of radiological equipment could be implicated by business considerations (cost, gross billings to be generated, space and employee needs), medical considerations (type of equipment needed, scope of practice, skilled levels required by operators of the equipment, medical ethics) or an amalgam of factors emanating from both business and medical areas. The interfacing of these variables may also require medical training, experience, and judgment."

The phrase "professional work performed in the hospital," therefore, encompasses an extensive range of matters concerning patient care, credentialing and quality assurance activities, as well as administrative concerns in furtherance of those activities. Accordingly, in light of the mandate that medical staffs be "self-governing," California law clearly grants the organized medical staff the right and responsibility to maintain the integrity of the physician-

patient relationship (and the unique constellation of rights and responsibilities which are attendant thereto) to initiate, develop and establish criteria and standards governing its "professional work" and to enforce those standards to ensure that appropriate practices are observed in all medical staff departments and committees. Thus, the medical staff's right to self-governance includes, but is not limited to, the medical staff's ability to:[7]

(a) initiate, develop and adopt its own bylaws;

(b) select and remove its own officers;

(c) set the standards of patient care;

(d) establish and enforce criteria and standards for medical staff membership;

(e) approve or disapprove amendments to medical staff bylaws, rules and regulations;

(f) take corrective action, and when necessary disciplinary action, against its own members,

(g) protect patients' interests in obtaining quality care;

(h) maintain the confidentiality of patient information; and

(i) manage its own financial and legal affairs.

C. Recognizing That Hospital Board Of Trustees Are Not Qualified To Make Medical Judgments, The Board's Authority Over Functions Vested In The Medical Staff Is Limited.

In sharp contrast to the comprehensive scheme vesting the medical staff with broad authority over the performance of professional work in the hospital, the board of trustees' role is clearly circumscribed and does not extend to the exercise of unilateral control of the medical

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[7] See also the analogous rights of unions, also "self-governing" entities as set forth at Labor Code §923 which provides, in relevant part, ". . . [I]t is necessary that the individual workman have full freedom of association, self-organization, and designation of representatives of his own choosing, to negotiate the terms and conditions of his employment, and that he shall be free from the interference, restraint, or coercion of employers of labor, or their agents, in the designation of such representatives or in self-organization or in other concerted activities for the purpose of collective bargaining or other mutual aid or protection."

staff's professional judgment. Thus, while the board of trustees must assume the "overall administrative responsibility" for the hospital, Health & Safety Code §1250(a) and adopt bylaws governing the hospital's general conduct, 22 C.C.R. §70701, the board is also required to provide for an "organized medical staff which provides 24-hour inpatient care," Health & Safety Code §1250(a), including "formal organization of the medical staff with appropriate officers and bylaws," and "self-government by the medical staff with respect to the professional work performed in the hospital." (22 C.C.R. §70701(a)(1)(D)(F).) Moreover, hospital boards are specifically mandated to require that the medical staff establish and perform the credentialing function of the hospital. (22 C.C.R. §70701(a)(7).) Similarly, hospital boards must approve all reasonable medical staff bylaws, 22 C.C.R. §70701(a)(8), and may not impose unreasonable restrictions on staff membership. Cf. *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826. Finally, as described above, hospital boards are statutorily required to give "great weight" to all medical staff peer review actions, may initiate a disciplinary action only under limited circumstances, and are flatly prohibited from imposing a summary suspension of a medical staff member's privileges for more than two (2) working days without the medical staff's ratification. (Business & Professions Code §809.05 and 809.5.)

Any remaining doubt as to the limits of the hospital board's role in matters concerning the medical staff's affairs which involve the exercise of informed professional judgment is removed by a consideration of those areas in which hospital board has been expressly authorized to act by the Legislature. For example, the Legislature has delegated to the board the authority to determine whether to impose a professional liability insurance requirement as a condition of staff privileges—a decision which, while clearly affecting medical staff members, does not involve the exercise of the medical staff's informed professional judgment. (Health & Safety Code §1319.) In fact, following the reasoning of the court in *Wilkinson v. Madera Community Hospital* (1983) 144 Cal.App.3d 436, 192 Cal.Rptr. 593 (upholding §1319 against a challenge that the statute unconstitutionally delegated legislative power to a private entity), it is unclear whether the court would uphold a statute delegating unchecked legislative power to hospital boards to control the professional work in the hospital. As the *Wilkinson* court stated:

> "An unconstitutional delegation of legislative power occurs when the legislature confers with . . . unrestricted authority to make fundamental policy decisions. [Citations] In order to avoid an unlawful delegation of its authority, the legislature must first resolve the "truly fundamental issues" and **must then 'establish an effective mechanism to assure the proper implementation of its policy decisions.'** [Citation]
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> Thus, **a delegation of authority must be accompanied by safeguards that ensure that the delegatee does not act arbitrarily**. *Id.* at 442. [Emphasis added]."

Accordingly, California law governing the provision of "professional work" performed in hospitals provides safeguards against improper action by mandating medical staff participation and self-governance over matters involving patient welfare which may be outside of the board of trustees' area of expertise, contrary to the hospital's financial interest, or both. These safeguards severely restrict the board's authority to act, particularly where matters properly within the realm of the medical staff's control are involved.

This limitation on the board's role and authority is further emphasized by the omission of any protection in Evidence Code §1157 for records other than those of medical staff committees. As the court stated in *Matchett v. Superior Court* (1974) 40 Cal.App.2d 623, 115 Cal.Rptr. 317, "§1157 does not embrace the files of the hospital administration (as distinguished from the staff). The trial court should have inquired into the existence of a hospital administration file concerning the doctor and, if such file existed, should have permitted its inspection excluding any portions which reflected the proceeding of staff committees conforming to the specifications of the immunity statute." (*Id.* at 628.)

We acknowledge that *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156 imposes tort liability of hospitals for negligently screening the competency of its medical staff. However, just as *Elam* imposes a duty upon governing boards to oversee the medical staff's credentialing activities, the principles of the *Wickline* case would appear to

impose on medical staffs a parallel duty to oversee actions of the board. Neither entity has unchecked power over the other.[8]

In sum, the relationship between the hospital board and the hospital medical staff is one of mutual accountability, interdependence and responsibility for the proper performance of respective obligations. While hospital boards have the right and obligation to make certain decisions, they must make those decisions with the guidance of the hospital medical staff's expertise.[9] "Ultimate" authority does not mean "unilateral" authority. Medical staffs have the right and duty to ensure that their authority is not usurped, including the right to seek judicial redress.

IV. HOSPITAL BYLAWS OR OTHER POLICIES PURPORTING TO ABRIDGE THE MEDICAL STAFF'S RIGHT TO SELF-GOVERNANCE ARE VOID

Defendants argue that their actions are all authorized by the hospital bylaws. This argument ignores the fact that a bylaw cannot, consistent with California law, grant such unchecked power to the hospital's governing body.

Any doubt about this conclusion is removed by a consideration of cases invalidating bylaws which dilute the power of separate entities, such as medical staffs, or vests too much discretion within hospital boards. In *Health Maintenance Network of Southern California v. Blue Cross of Southern California* (1988) 202 Cal.App.3d 1043, 249 Cal.Rptr. 220, for example, a health maintenance organization brought an action seeking declaratory and injunctive relief prohibiting a non-profit health insurer (Blue Cross) from interfering in the HMO's corporate operations. In a nutshell, Blue Cross formed the HMO in 1977 in order to

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[8] It should be noted that the original *Elam* decision imposed a duty of supervision. In its final modified opinion, the court removed the duty of supervision when formulating the statement of the hospital's duty. Thus, in medical malpractice actions, hospitals may be held liable either on a "negligent oversight" of the medical staff's credentialing process theory or on the theory of "ostensible agency" when the facts support that theory. See *Elam, supra.*

[9] In this regard, it is worthy of note that hospital governing boards are specifically insulated from liability if they reasonably rely on the medical staff's professional judgment. See Corporations Code §309.

obtain a marketing advantage from a federal law requiring employers to offer employees a qualified HMO program if requested. Pursuant to federal law, HMOs must maintain an independent, legal existence in order to obtain certification. (42 U.S.C. §300e.) However, the HMO's bylaws contained a provision permitting Blue Cross to appoint HMO corporate members.[10] In 1980, the California Corporations Code was amended to allow non-profit corporations to eliminate members. In 1983, the HMO's board amended the bylaws by providing there would be no members at all. Once Blue Cross discovered the significance of the bylaw amendment, it undertook a number of actions designed to reinstate its control of the HMO such as appointing new members who purported to replace the existing HMO board with new directors. Those actions forced Health Net to seek judicial intervention. The Superior Court granted preliminary and permanent injunctive relief and an appeal was taken. On appeal, the court held, among other things, that the HMOs' bylaw provision permitting Blue Cross to appoint the HMOs corporate members was inconsistent with federal and state law requiring that the HMO maintain an independent legal existence, and so that the bylaw could be properly eliminated. See also *In the Matter of Osteopathic Hospital Association of Delaware* (1963) 191 A.2d 333, aff'd 195 A.2d 759 (holding bylaw amendment which was duly adopted by board of trustees of non-profit Osteopathic Association but which would substantially change structure of organization and would dilute power of physician members to control the board through elections was unreasonable in operation and void).

Moreover, bylaws which are so vague and ambiguous as to permit arbitrary or capricious decision-making have been repeatedly struck down by the courts where medical staffs' members' rights are concerned. For example, in *Wyatt v. Tahoe Forest Hospital Dist.* (1959) 174 Cal.App.2d 709, a court invalidated a bylaw which read, in pertinent part, "membership to the medical staff shall be limited to those physicians and surgeons licensed to practice in the

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[10] The court explained the role of corporate members as "the functional equivalent of stockholders in for-profit corporations." (*Health Maintenance Network, supra* at fn.3, 1048.) Such members usually have the right to elect the board of directors and to vote on changes to the corporate articles of incorporation or bylaws. (*Id.*)

state of California, whose background, experience and training ensures, **in the judgment of the Board of Directors**, that any patient admitted to or treated in the Tahoe Forest Hospital will be given the best possible care and professional skill." (Emphasis added.) (*Id.* at 712, 713.) The court held that under that standard, admission to medical staff membership can depend on the "whim and caprice of the directors" and, after noting that no statute authorized a bylaw of that type, held that the rule was too vague and uncertain to be valid. (*Id.* at 715.)

Similarly, in *Rosner v. Eden Township Hospital Dist.* (1962) 58 Cal.2d 592, the board of directors of the hospital excluded a physician from membership on the grounds, among others, he was not "temperamentally suitable for hospital staff practice." The court invalidated this action and held that a public hospital district was not statutorily authorized to adopt such a standard for staff admission. Additionally, as the court observed:

> . . . a hospital district should not be permitted to adopt standards for the exclusion of doctors from the use of its hospital which are so vague and ambiguous as to provide a substantial danger of arbitrary discrimination in their application. In asserting their views as to proper treatment and hospital practices, many physicians will become involved in a certain amount of dispute and friction, and the determination that such common occurrences have more than their usual significance and show temperamental unsuitability for hospital practice of one of the doctors is of necessity highly conjectural. In these circumstances there is the danger that the requirement of temperamental suitability will be applied as a subterfuge where considerations having no relevance to fitness are present. (*Id.* at 598.)

This concern was reemphasized by the California Supreme Court in *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826. In *Miller*, the Court prohibited exclusion of a physician from the medical staff based solely on his failure to adequately demonstrate, as required by a medical staff bylaw provision, his "ability to work with others." The Court viewed this bylaw requirement, standing alone, as posing a danger of "arbitrary and irrational application and the concomitant danger that such a bylaw may be used as a subterfuge where considerations having no relevance to fitness are present." (*Miller, supra*, 27 Cal.3d at 629.) Specifically, the *Miller* Court stated:

> "We are not prepared to say that an applicant's ability to work with other medical personnel in the hospital setting may not have a clear effect on the level of patient care provided. [Citation omitted.] What we do say, however, is that in order to avoid the danger of *arbitrary and irrational application and the concomitant danger that such a bylaw may be used 'as a subterfuge where considerations having no relevance to fitness are present'* [Citing *Rosner v. Eden Township Hospital District* (1962) 58 Cal.2d 592, 598, 25 Cal.Rptr. 551] it must be read to demand a showing, in cases of rejection on this ground, that an applicant's inability to 'work with others' in the hospital setting is such as to present a real and substantial danger that patients treated by him might receive other than a 'high quality of medical care' at the facility if he were admitted to membership." (*Miller*, supra, 27 Cal.3d at 629, emphasis added.)

Thus, the Court in *Miller* interpreted a medical staff bylaw requiring the ability to "work with others" as inherently arbitrary and discriminatory unless it were interpreted to also require the hospital to prove a "real and substantial" nexus with patient care. The Court clearly understood that without that "nexus" requirement, a requirement that a physician be able to "work [well] with others" could permit exclusion based on "subterfuge where considerations having no relevance to fitness are present." The Court further stated:

> "[A] rule governing the admission of qualified physicians to staff membership in any hospital whether public or private, cannot stand if it establishes a standard for admission which is substantively irrational or otherwise unreasonably susceptible of arbitrary or discriminatory application." (*Miller* at p. 627.)

The dangers recognized by the *Wyatt, Rosner* and *Miller* courts are equally present here. Just as in *Rosner*, there is no statutory authorization for (and indeed, the statutes mandating self-governance prohibit) a unilateral and arbitrary decision by a hospital's board to bar a duly-elected physician from serving as a medical staff leader, or to terminate a qualified physician's right to practice medicine based on a unilaterally imposed and enforced "Code of Conduct" or "Conflict of Interest Policy." Moreover, as in *Wyatt* and *Miller*, implementation of several of these standards depends on the "whim and caprice" of the board of trustees. Accordingly, these bylaw provisions and policies are void. See also *Westlake Community Hospital v. Superior Court* (1976) 17 Cal.3d 465, 131 Cal.Rptr. 90 (invalidating exculpatory clause in bylaw as void against public policy).

V. MEDICAL STAFF SELF-GOVERNANCE DERIVES ITS GENESIS FROM CALIFORNIA'S LONG STANDING POLICY OF DEFERENCE TO A PHYSICIAN'S PROFESSIONAL JUDGMENT AND REFUSAL TO PERMIT LAY INTERFERENCE WITH THAT JUDGMENT

As the foregoing discussion illustrates, the laws governing the delivery of health care in hospitals mandate that the hospital board play a carefully circumscribed role in the oversight of the medical staff's functions. This scheme reflects the practical fact that lay members of the board of trustees do not have the experience to second-guess the medical staff's professional judgment. Indeed, California law has long recognized that the complexities of the practice of medicine and the fiduciary nature of the physician/patient relationship requires that third parties be prohibited from interfering with that relationship. The mandate for medical staff self-governance stems from this recognition. Accordingly, the right of a medical staff to select its own leaders becomes even clearer upon consideration of the relationship between physicians and their patients.

A. Quality Patient Care Depends On Deference To A Physician's Judgment

A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights. The American Medical Association Principles of Medical Ethics, Principle No. I.

This principle of medical ethics is a standard of conduct which defines an essential element of both legal and ethical behavior for physicians. This principle reflects a physician's special obligations to both his or her patients and society to continually strive to provide high quality care notwithstanding forces in society that threaten medical professionalism and jeopardize the provision of quality medial practice in providing medical services to individual patients.

As the discussion above demonstrates, the quality of health care provided to patients today requires that the judgment of the physician be respected. Only physicians have the requisite skill, education, experience and loyalties to make the relevant assessments concerning the provision of health care.

B. The Corporate Practice Bar Serves To Insure That The Physician-Patient Relationship, Which Places Unique Obligations Upon Physicians Regardless Of The Policies Instituted Or Maintained By Third Parties, Including Hospitals, Is Not Disrupted

Integrally related to the public policy and laws requiring medical staff self-governance, and encouraging physicians to speak freely and exercise their independent judgment in the best interest of their patients is California's strict limitations on the employment or other control of physicians by non-physicians, as set forth in Business & Professions Code §2400, also known as the "corporate practice of medicine bar." This prohibition generally prohibits lay entities from hiring or employing physicians or other health care practitioners, or from otherwise interfering with the physician or other health care practitioner's practice of medicine. California's corporate practice of medicine bar is designed to ensure that a physician's judgment in the provision of medical care will not be compromised by a lay entity, either directly or indirectly. See Business & Professions Code §§2052 and 2400. The Bar protects against:

(1) a division of the physician's loyalty between a lay entity and the patient;

(2) the dangers of commercial exploitation of the medical profession; and

(3) lay control over the physician's professional judgment.[11]

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[11] The strength of California's policy against permitting lay persons to practice medicine or to exercise control, directly or indirectly, over medical practice cannot be questioned. (See, for example, Business & Professions Code §§2052, 2400, 2408, 2409, 2410; Corporations Code §§13400 et seq.; *Parker v. Board of Dental Examiners* (1932) 216 Cal. 285, rehg. den. September 28, 1932 (lay persons may not serve as directors of professional corporations); *Pacific Employers Ins. Co. v. Carpenter* (1935) 10 Cal.App.2d 592, 594-596 (holding that for-profit corporation may not engage in business of providing medical services and stating that "professions are not open to commercial exploitation as it is said to be against public policy to permit a 'middle-man' to intervene for a profit in establishing a professional relationship between members of said professions and the members of the public"); *Benjamin Franklin Life Assurance Co. v. Mitchell* (1936) 14 Cal.App.2d 654, 657 (same); *People v. Pacific Health Corp.* (1938) 12 Cal.2d 156, 158-159 (same); *Complete Service Bureau v. San Diego Medical Society* (1954) 43 Cal.2d 201, 211 (non-profit corporations may secure low-cost medical services for their members only if they do not interfere with the medical practice of the associated physician); *California Physicians Service v. Garrison* (1946) 28 Cal.2d 790 (same); *Blank v. Palo Alto-Stanford Hospital Center* (1965) 234 Cal.App.2d 377, 390, 44 Cal.Rptr. 572 (non-profit hospital may employ radiologist only if the hospital does not interfere with the

All of these threats to a physician's professional autonomy undermine the profound public policy that physicians, who deal with the most intimate bodily functions, the most personal mental processes, and most profound life and death issues, will devote their entire professional judgment and training to the furtherance of their patients' best interests. For this reason, the law provides a structural safeguard which prohibits lay economic and clinical control over a physician, to ensure that a physician's medical decisions are not based on commercial interests, but rather on professional medical judgment. These concerns apply to hospitals, and indeed, in addition to mandating medical staff self-governance over the professional work performed in the hospital, California law prohibits hospitals from employing physicians. See e.g., *Conrad v. Medical Board of California* (1996) 48 Cal.App.4th 1038, 55 Cal.Rptr. 901.[12]

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radiologists' practice of medicine); *Letsch v. Northern San Diego County Hospital District* (1966) 246 Cal.App.2d 673, 677, 55 Cal.Rptr. 118 (district hospital may contract with radiologists under restriction imposed in Blank above); *California Association of Dispensing Opticians v. Pearle Vision Center, Inc.* (1983) 143 Cal.App.3d 419, 427, 191 Cal.Rptr. 762, 767 (Pearle Vision Center, Inc.'s franchise program violates California's prohibition against the corporate practice of medicine); *Conrad v. Medical Board of California* (1996) 48 Cal.App.4th 1038, 55 Cal.Rptr. 901 (Hospital District may not employ physicians); *Steinsmith v. Medical Board* (2000) 85 Cal.App.4th 458, 102 Cal.Rptr.2d 115 (physician who worked for clinic not owned by licensed physicians as an independent contractor aided the unlicensed practice of medicine). 55 Ops.Cal.Atty.Gen. 103 (1972) (hospital may not control the practice of medicine); 57 Ops.Cal.Atty.Gen. 231, 234 (1974) (only professional corporations are authorized to practice medicine); 63 Ops.Cal.Atty.Gen. 729, 732 (1980) (for-profit corporation may not engage in the practice of medicine directly nor may it hire physicians to perform professional services); 65 Ops.Cal.Atty.Gen. 223 (1982) (general business corporation may not lawfully engage licensed physicians to treat employees even though physicians act as independent contractors and not as employees); 83 Ops.Cal.Atty.Gen. 170 (2000) (management services organization may not select, schedule, secure, or pay for radiology diagnostic services).)

[12] The corporate practice bar mandates not only medical staff self-governance in the hospital, but also physician control over the various services. Consequently, because physicians bear the ultimate responsibility for ensuring that patients receive proper care, and because lay individuals have neither the expertise nor experience to render decisions regarding the provision of medical care, the Department of Health Services has set up an elaborate system designed to ensure that physicians on the medical staff are responsible for the variety of patient care "services" provided in the hospital. For example, the law demands that only a physician can be responsible for the "medical service", which consists of "those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff."

Concerns which gave rise to the longstanding proscription against the corporate practice of medicine apply with even greater urgency at the present time. There have been profound changes in the financing of both governmental and private health care delivery systems in the last few years. Increasing competition, as well as cost consciousness on the part of both public and private payors, have created an environment rife with potential for jeopardy to quality patient care.

With managed care, physicians no longer exercise unfettered discretion in his or her decisionmaking. For example, a large number of utilization review firms "employ practices that undermine professional autonomy in seemingly inappropriate ways." (Schlesinger, et al., *Medical Professionalism Under Managed Care: The Pros and Cons of Utilization Review* (1997) Health Affairs Vol. 1601.)

Managed care has also had a profound effect on hospitals, with hospitals merging, closing or decreasing in size in response to financial pressures. Health care that was performed in hospitals over the past few decades is now being performed increasingly in outpatient settings. (Robinson, *Decline in Hospital Utilization and Cost Inflation Under Managed Care in California* (1996) 276 JAMA p. 1060.) Further, the financial pressures that are changing the role of hospitals are also creating pressures on physicians and their traditional role as advocates for patient care. (Kassirer, *Managed Care and the Morality of the Marketplace* (1995) 333 N. Engl. J. Med. p. 50.)

(22 C.C.R. §§70201, 70205.) Similarly, physicians are responsible for other "services" provided by the hospital. See 22 C.C.R. §§70225 (surgical service), 70235 (anesthesia service), 70245 (clinical laboratory service), 70255 (radiological service), 70405 (acute respiratory care service), 70415 (basic emergency medical service), 70425 (burn service), 70435 (cardiovascular surgery service), 70445 (chronic dialysis service), 70455 (comprehensive emergency medical service), 70465 (coronary care service), 70485 (intensive care newborn nursery service), 70495 (intensive care service), 70509 (nuclear medicine service), 70539 (pediatric service), 70549 (perinatal unit service), 70589 (radiation therapy service), 70599 (rehabilitation center service), 70609 (renal transplant center), 70619 (respiratory care service).

VI. MEDICAL STAFFS DO NOT HAVE TO EXHAUST MEDICAL STAFF BYLAWS REMEDIES WHERE THE HOSPITAL BOARD HAS ARROGATED TO ITSELF THE RIGHT TO UNILATERALLY AMEND THOSE BYLAWS AND REFUSED TO RECOGNIZE THE DULY-ELECTED MEDICAL STAFF LEADERS WHO WOULD EXERCISE THOSE REMEDIES

Defendants argue that internal administrative remedies are available to the medical staff, and therefore the medical staff is required to exhaust them. Defendants point to the medical staff bylaws as requiring such exhaustion "before resorting to formal legal action." (Demurrer to Medical Staff Complaint at 14.) However, defendants have failed to indicate what those administrative remedies are. Further, taking the allegations in the complaint as true, it would be ironic that the very medical staff bylaws which the defendants have so consistently denigrated, violated, and unilaterally amended, could be used by them as a shield against this lawsuit. Moreover, the parties who would be required to exhaust those remedies, the duly elected members of the Medical Executive Committee, are not recognized by the hospital. Can there be any doubt as to the result if the hospital board's hand-selected medical staff "representatives" meet with the hospital board to purportedly enforce the medical staff's rights to self-governance? Obviously, this affords a remedy that can only be viewed as "futile."

VII. CONCLUSION

It is critical that this court prohibit lay intrusions into the medical staff's legitimate and proper realm of decision-making. The regulation of professional work performed in the hospital and the establishment of patient care standards is an inherent professional right which can only be initiated and implemented by duly licensed physicians. Assuming the truth of the allegations, defendants have severely abridged that right and have unjustifiably intruded into the

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medical staff's decision-making process and quality assurance activities essential to providing quality patient care. We urge this court to allow the Medical Staff of Ventura Community Memorial Hospital to redress that wrong.

DATE: July 18, 2003

Respectfully submitted,

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