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## Articles

\*301 PHYSICIANS POLICING PHYSICIANS: THE DEVELOPMENT OF MEDICAL  
STAFF PEER  
REVIEW LAW AT CALIFORNIA HOSPITALS

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THE LAW GOVERNING medical staff peer review at California hospitals has changed dramatically over the last thirty years. The days when a hospital could make arbitrary credentialing decisions without affording physicians any recourse are long gone. Primarily as a result of appellate court decisions and legislation, there has been a steady movement toward the formalization of peer review. This article examines the development of peer review law at California hospitals. [FN1] It also identifies a number of shortcomings in the current system and suggests solutions to these problems.

California hospitals help ensure that patients receive high quality medical care by establishing the qualifications for physicians on their medical staffs. State statutes and regulations require all hospitals to have a medical staff. [FN2] The medical staff is an unincorporated association comprised of doctors who have privileges to practice medicine at \*302 a hospital. [FN3] The medical staff must promulgate bylaws that, among other things, provide for the evaluation of qualifications of new applicants and establish mechanisms for

disciplining existing members. [FN4] It also must establish procedures for granting and withdrawing clinical privileges. [FN5] The medical staff evaluates physicians and confers membership and privileges, subject to the hospital governing board's approval. [FN6] For these reasons, the medical staff is a very powerful authority at any hospital. It is a self-governing body [FN7] responsible for making many important decisions affecting patient care.

It is almost impossible for a physician to practice medicine today unless she is a medical staff member at one or more hospitals. This is because a doctor cannot regularly admit or treat patients unless she is a member of the medical staff. Privileges are especially important for specialists, like surgeons, who perform the majority of their services in a hospital setting. For this reason, a hospital's decision to deny membership or clinical privileges, or to discipline a physician, can have an \*303 immediate and devastating effect on a practitioner's career. She may be barred from practicing medicine at the hospital or may have her privileges restricted.

Additionally, as a result of state and federal law, the decision can have long-term effects on the physician. California law requires hospitals to report certain credentialing decisions [FN8] to the Medical Board of California by filing a document known as a Section 805 report. [FN9] The Section 805 report may trigger a Medical Board investigation. The Medical Board has authority to institute proceedings to revoke, suspend, or limit the license of any physician who poses a danger to the public. [FN10] The hospital's decision can also implicate federal law. Responding to complaints about substandard medical care on a national level, Congress enacted the Health Care Quality Improvement Act [FN11] ("HCQIA") in 1986. This consumer protection legislation, which was enacted to promote medical peer review, [FN12] requires health care entities to report to the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners ("NPDB"), so that the activities of incompetent doctors can be tracked more easily. [FN13] The law requires these entities to report professional review activities that adversely affect clinical privileges. [FN14] "Clinical privileges" include privileges, medical staff membership, and other circumstances pertaining to the furnishing of medical care. [FN15]

\*304 Hospitals monitor the information collected in the NPDB. When a physician applies, or reapplies, for membership or privileges at a hospital, or for liability insurance, the applications routinely ask about her status at all hospitals. A negative decision at an institution can have a snowball effect. If one hospital has identified quality concerns, it is very likely that this will lead to investigations at other hospitals. The physician may also face higher liability insurance premiums or even cancellation of

coverage. The decision can also result in the diminishment of professional reputation, loss of patients and referrals, and personal humiliation.

For decades, California courts have recognized the importance of medical staff membership to a physician's career. They treat the right to practice medicine at a hospital as a property interest that directly relates to the pursuit of the physician's livelihood. [FN16] The interest is a fundamental right. [FN17] A hospital, whether public or private, cannot deny medical staff membership or clinical privileges, or discipline an existing member, without following certain procedures. These rules are known as common law fair procedure rights. [FN18] Common law fair procedure requires that a private association's membership qualifications be substantively fair and rational, and that affected parties be given an opportunity to challenge adverse decisions. If a hospital decides to deny an application or to discipline a medical staff member, the individual may contest the decision by means of a hearing before a panel of her peer physicians.

Peer review is intended to protect the interests of three groups: patients, hospitals, and physicians. [FN19] Its primary purpose is to weed out incompetent doctors who endanger patient health. After the state licensing body, hospitals essentially act as secondary gatekeepers for the medical profession. Through the credentialing process, institutions can limit the practice of physicians who have a record of problems that involve quality care-giving.

Some believe peer review has not been an effective tool for improving the quality of patient care. Critics claim that entrusting physicians with the responsibility of policing incompetent colleagues has not worked. [FN20] A system whereby doctors are expected to investigate \*305 their colleagues and report them to the authorities is fraught with conflicts of interest.

Statistics show that state licensing agencies seldom take formal action against doctors. In 2002, the Medical Board of California took "prejudicial action" [FN21] against 452 physicians out of a total number of 88,149 licensed physicians practicing in the state. [FN22] This means that that there were 5.13 prejudicial actions per 1,000 practicing physicians. [FN23] A "Composite Action Index" prepared by the Federation of State Medical Boards of the United States shows that Medical Board actions against physicians in California have fluctuated over the last ten years from a low of 3.02 per 1,000 to a high of 6.10. [FN24] The consumer advocacy group, Public Citizen, ranked California in the middle of states regarding the number of serious disciplinary actions taken against its physicians in 2002. [FN25]

Some hospitals may be protecting doctors by not filing peer review decisions

resulting in discipline as required by law. Nationwide, the number of hospital reports to the NPDB is small. [FN26] The Medical \*306 Board of California compiles statistics on Section 805 reports received from health facilities, which include hospitals. For fiscal year 2000-2001, the total was 135; for 2001-2002, the total was 155. [FN27] The fact that hospitals in many states face relatively mild sanctions for noncompliance may account for the underreporting. [FN28]

In 2001, the California legislature addressed this problem by substantially increasing the amount of fines that may be assessed for failure to file a Section 805 report. For a willful failure, the person required to file the report is subject to a maximum penalty of \$100,000. [FN29] If the report is not made for any other reason, the maximum fine is \$50,000. [FN30] Whether these new penalties will encourage more widespread reporting remains to be seen.

Peer review is also intended to benefit hospitals by allowing them to set and apply their own standards. Institutions are not required to grant medical staff privileges to any physician possessing a medical license. A hospital may enhance its reputation in the medical community by being selective and admitting only highly qualified doctors to its staff.

Peer review also helps hospitals limit their liability for negligence. California recognizes a negligence cause of action when a hospital carelessly allows an incompetent doctor to treat patients. [FN31] The courts have held that a hospital's failure to ensure the competence of its medical staff through careful selection and review creates an unreasonable risk of harm to patients. [FN32] Under the doctrine of corporate negligence, a hospital may be held liable for injuries caused by doctors with medical staff privileges. A hospital can reduce the risk of liability for corporate negligence claims by rejecting applicants with questionable backgrounds and disciplining existing staff members whose performance is substandard.

\*307 The final interest that peer review is intended to protect--the one that is the primary focus of this article--is the physician's. An effective peer review system should ensure that qualified doctors are shielded from arbitrary hospital decisions and the negative consequences accompanying them. Although peer review is criticized as being physician-friendly, many doctors who are targets of investigation believe it is arbitrary and unjust because the hospital controls the process. The argument is that peer review gives too much power to hospital decision makers who may have ulterior motives for rejecting an applicant or disciplining a colleague. The motive can be economic, so as to limit competition for business. It can be based on bias against racial or ethnic minorities or women. Graduates of foreign medical

schools may be targets. Peer review can also be used as a forum to act out personal rivalries and dislikes. [FN33] At a time when many hospitals are concerned about profitability, peer review may be a way to exclude doctors who fail to generate sufficient income for a particular institution. [FN34] The upshot is that a system placing so much power in the hands of hospital authorities invites abuse.

The courts and legislature have tried to guard against possible abuses in the credentialing process by formalizing peer review. As a result of judicial decisions and legislative mandates, physicians now have the right to contest many adverse hospital decisions. The law has also standardized many procedures governing peer review. At the same time, judges and legislators have been reluctant to second-guess the judgment of medical professionals on substantive medical issues, so the law accords great deference to the judgment of health care professionals in matters involving medical expertise.

This article is divided into four parts. Part I reveals that the first legal requirements of peer review were imposed by the courts when they extended the rules of common law fair procedure to the activity of hospitals. The appellate courts held that hospital decisions, both in admission and disciplinary settings, must be substantially rational and procedurally fair. At the same time, the courts were sensitive to the argument that hospital authorities must be free to administer their institutions. So long as hospitals followed rudimentary fair procedure \*308 requirements, the courts generally deferred to the judgment of health care professionals.

Part II shows how federal and state legislation in the late 1980s dramatically changed peer review law by giving physicians rights far beyond common law fair procedure requirements. As a result, peer review is a much more formalized process than it was under the judicial precedents. In 1986, Congress enacted legislation requiring hospitals to provide minimum due process in peer review, but it authorized states to opt out of the congressional plan. California exercised this option in 1989, when the legislature crafted a series of laws governing peer review for most California hospitals. The legislative plan established minimum mandatory procedures that hospitals must follow when conducting peer review. This section discusses these requirements.

Part III considers the important role that a hospital's medical staff bylaws play in peer review today. California law requires a medical staff to have bylaws that articulate the process whereby physicians may dispute credentialing decisions. The California Medical Association ("CMA"), an organization claiming a membership of over 30,000 physicians, has promulgated Annotated Model Medical Staff Bylaws to assist medical staffs in drafting

bylaws. The CMA Model Bylaws incorporate the requirements of state and federal law, as well as the standards of the Joint Commission on the Accreditation of Healthcare Organizations, a group responsible for accrediting hospitals around the country. [FN35] The CMA Model Bylaws give applicants and medical staff members greater procedural rights than those required by statute and judicial precedent. This section uses the CMA Model Bylaws as an illustrative example of how bylaws can affect peer review.

The final section, Part IV, identifies some problems with the current peer review system and suggests changes to make it fairer. The first problem presented is that statutes, cases, and the CMA Model Bylaws give hospital authorities extensive power to control the peer review process, thereby creating the danger that those authorities may improperly affect outcomes. A system vesting so much unchecked authority in the medical staff invites abuse. A danger exists in that peer review committees may merely be a rubber stamp for the decisions of hospital authorities. The second problem is that the current system presents little opportunity for meaningful judicial review of peer review decisions. If a physician wishes to contest a peer review decision \*309 in the courts, she must seek a writ of administrative mandamus. [FN36] However, an amendment to California's administrative mandamus statute severely limits the power of the courts to review most hospital decisions. The article concludes by identifying a problem that may result from the formalization of peer review. There is the danger that the process has become so time-consuming and expensive that hospitals will be reluctant to take action against incompetent doctors. The medical profession and the agencies that oversee the health care system must carefully monitor the peer review process and guard against this risk.

#### I. Common Law Fair Procedure Rights in the Hospital Setting

The physician's right to procedural safeguards in the credentialing process at California hospitals is of judicial creation. During the second half of the twentieth century, California's appellate courts held that a medical staff may not deny, revoke, or suspend membership or clinical privileges without according the physician "fair procedure." Fair procedure is a common law concept that originated in the nineteenth century. [FN37] It first applied to expulsions from private associations such as unions [FN38] and fraternal societies. [FN39] Later, fair procedure was extended to apply where a person was denied membership in a private association. [FN40]

Fair procedure prohibits groups from expelling a member or rejecting an applicant when the reason underlying the action is irrational or when the organization has proceeded in an unfair manner. [FN41] "Taken together, these decisions establish the common law principle that whenever a private association is legally required to refrain from arbitrary action, the

association must be both substantively rational and procedurally fair." [FN42] Although the courts sometimes use the words "fair procedure" and "due process" interchangeably, the California Supreme Court has clarified that the terms are not synonymous. Fair procedure does not derive from the constitutional guarantees of due \*310 process, but rather from established common law principles of fairness. [FN43]

The California Supreme Court held that fair procedure applied in medical settings in *Pinsker v. Pacific Coast Society of Orthodontists* (*Pinsker I*), [FN44] after a private society of dentists had rejected an orthodontist's application for membership. Although membership in the group was not a requirement for orthodontic practice, the supreme court found that it would be a practical necessity for one wishing to make a living in the specialty.

The supreme court later reviewed the same facts in *Pinsker II*. [FN45] In this opinion, it held that fair procedure has both substantive and procedural components. An organization cannot reject a member's application based on "a rule which is substantively capricious or contrary to public policy." [FN46] As to the process required, the court held that the association must give the applicant notice of the reason for rejection and afford him an opportunity to respond. [FN47] These procedures need not include "all the embellishments of a court trial." [FN48] Rather than fix a rigid procedure that must invariably be observed, the court left it to the association to devise the process, subject to judicial review. [FN49]

The requirement of fair procedure, as it applies to a hospital when it wishes to expel a physician from its medical staff, was first established in *Ascherman v. San Francisco Medical Society*, [FN50] a widely cited California Court of Appeal case. The *Ascherman* court held that fair procedure includes the right to notice of the charges against the individual and a meaningful hearing to contest them. [FN51]

Three years later, in *Anton v. San Antonio Community Hospital*, [FN52] the supreme court cited *Ascherman* with approval. It held that a physician may neither be refused admission to, nor expelled from, the staff of a hospital, unless the institution followed minimum common law requirements of procedural due process. [FN53] Fair procedure must be accorded in public and private hospitals alike. [FN54] The *Anton* court also \*311 discussed the fair procedure process. Borrowing from *Pinsker II* and fair procedure opinions in other contexts, it favored a flexible approach, refusing to establish rigid rules to be applied in all cases. The court gave hospitals the discretion to formalize their own procedures, but stated that the courts would step in if hospitals abused their discretion. [FN55]

The California Supreme Court also examined the substantive side of fair procedure in medical staff decisions. In *Miller v. Eisenhower Medical Center*, [FN56] a hospital rejected an applicant for staff membership and privileges based on a bylaw requiring the applicant to demonstrate his ability to work with others. The physician challenged his exclusion, arguing that the bylaw was so vague and uncertain that it created the danger of arbitrary and discriminatory application. Although the court agreed that exclusion may not be based on arbitrary or irrational criteria, [FN57] it found that the bylaw in question was valid because the ability to work with others affects the quality of patient care. [FN58]

Miller and Anton established the parameters of the substantive and procedural requirements of common law fair procedure in hospital credentialing decisions. These decisions set broad guidelines, but left many specific questions unanswered. In subsequent years, the appellate courts issued numerous opinions fleshing out the meaning of fair procedure, both substantive and procedural. These cases are examined in the following sections.

#### A. The Substantive Component of Fair Procedure

The Miller court held that standards for admission to medical staff membership or privileges may not "permit exclusion on an arbitrary or irrational basis." [FN59] There must be a nexus between hospital requirements and established professional standards. Hospital standards must be rationally based. A review of the case law shows that the appellate courts have been very reluctant to find hospital standards irrational. In most instances, the courts have accorded great deference to the judgment of the medical profession. [FN60]

\*312 The appellate cases challenging hospital decisions on the basis of irrational standards can be grouped into two broad categories. The first category involves the situation where a physician's application was rejected or she was disciplined for reasons not directly related to medical competence, such as personality traits, criminal activity, or dishonesty. The second is where the aggrieved physician claims that the institution's medical standards for admission or privileges were unreasonable. Neither argument has been very successful.

The first group of cases concerns physicians who were denied admission or were disciplined because they could not work well with others. On one hand, hospitals claim the right to exclude obstreperous doctors whose personal characteristics may interfere with patient care. On the other hand, the affected doctors argue that when hospital authorities exclude a doctor because of claims that she cannot "get along with others" or is "disruptive," their

assertions often mask the authorities' sinister purposes. These may include carrying out their personal animosities, stifling economic competition, punishing whistle blowers, or perpetuating ethnic and racial discrimination.

The appellate courts initially struggled in deciding the point at which exclusion of a doctor, based on the doctor's personal traits, becomes arbitrary. In *Rosner v. Eden Township Hospital District*, [FN61] a district hospital rejected a physician's application for medical staff membership because he was not temperamentally suitable for hospital staff practice, as he could not "get along" with others. [FN62] Noting that the applicant had a track record of criticizing the quality of patient care at other hospitals, the court held that "[c]onsiderations of harmony in the hospital must give way where the welfare of patients is involved, and a physician by making his objections known, whether or not tactfully done, should not be required to risk his right to practice medicine." [FN63] Otherwise, the requirement of temperamental suitability could be "a subterfuge" for decisions not based on fitness qualifications. [FN64] A subsequent supreme court case limited *Rosner* to local district hospitals because the decision turned on a statute that established qualifications for physicians at such institutions. [FN65]

\*313 As stated earlier, the supreme court addressed personal characteristics as a standard for private hospital medical staff membership in *Miller*. At issue was a bylaw focusing on the physician's "ability to work with others." [FN66] The court noted that this bylaw was different from the provision at issue in *Rosner*, where the doctor had been required to be able to "get along" with others. [FN67] It found that the bylaw was not substantively irrational because the ability to work with others can affect patient care. The *Miller* court asserted that to ensure that bylaws are not used as a subterfuge for rejecting otherwise qualified applicants, the hospital must show that the physician's inability to work with others presents "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." [FN68] The fact that the doctor has an annoying personality is not enough in itself to exclude him from staff membership. The hospital must present evidence of "a more concrete and specific nature" to establish the nexus between the physician's personality and its negative effect on patient care. [FN69]

*Miller's* message to hospital authorities is that it is proper to exclude members based on personal traits if the characteristics are detrimental to patient care. Subsequent appellate court cases show that hospitals have been able to establish this necessary connection. In *Pick v. Santa Ana-Tustin Community Hospital*, [FN70] the hospital produced evidence that an applicant had engaged in "disruptive conduct" at other institutions. [FN71] The court of appeal held that the doctor failed to meet the burden of proving he was

qualified for medical staff membership. [FN72] Courts have also sanctioned the dismissal of a doctor from a residency program [FN73] and the suspension of the privileges of another, [FN74] where the decisions were based on personality characteristics that might affect patient care. As one court put it, "we are in no position to undermine the opinion of the judicial review committee concerning the appropriateness of appellant's conduct at the Hospital. Hospitals \*314 are usually in a unique position to police themselves." [FN75] Other personal deficiencies, including conviction of a felony [FN76] and dishonesty, [FN77] have also been held to be grounds for disciplinary action.

Medical staffs also must establish medical standards for membership and clinical privileges. Hospitals require applicants to establish that their patients will receive "quality medical care." [FN78] Requests for clinical privileges are evaluated based on the physician's "education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate." [FN79] The meaning of terms like "quality medical care" and acceptable "education," "training," and "experience" are inherently ambiguous and open to interpretation.

In general, the appellate courts have given hospitals great leeway to set their own medical standards. They have held that a hospital may establish more stringent standards than those followed at other institutions. The award of clinical privileges is hospital-specific; so long as there is a rational basis for the medical staff's requirements for clinical privileges, a hospital may make them as stringent as it deems reasonably necessary to assure adequate patient care. [FN80] Thus, a physician may qualify for membership or privileges at one hospital and may not qualify for them at another.

Physicians have resorted to the courts to challenge medical staff requirements that they claim are arbitrary. They have had some success regarding requirements that are facially exclusionary. In *Ascherman*, [FN81] for example, a physician challenged a bylaw requiring an applicant for medical staff membership to obtain three letters of reference \*315 from current members. The court found that the bylaw was not substantially rational. [It had] the inherent grave danger that members of the active staff may seek to exclude certain applicants because they are of a certain race, religion, ancestry, because they have testified against them in malpractice suits, . . . simply because they do not like them[, or because the applicants do not] know three members of the staff of a particular hospital . . . . [FN82]

However, the great weight of authority maintains that hospitals have wide latitude in setting requirements for physicians at their institutions. The courts generally defer to the judgment of hospital authorities when resolving these cases because "[c]ourts are ill-equipped to assess the judgment of qualified physicians on matters requiring advanced study and extensive training in medical specialties." [FN83] This discretion afforded to hospitals has been solidified through case law. Exclusion or discipline is proper when a physician violates specific medical staff rules. For example, it is appropriate to deny membership to an applicant who has not met the burden of establishing his qualifications as required by the medical staff bylaws. [FN84] A physician may be denied medical staff privileges for failing to cooperate in obtaining information concerning his performance at another hospital, as required by the bylaws. [FN85] A physician who fails to attend mandatory meetings or to keep mandatory patient histories and progress reports may be suspended. [FN86] Failure to provide proof of liability insurance, as required by the hospital, is grounds for suspending privileges. [FN87] Disciplinary action is appropriate when a doctor has a substance abuse problem. [FN88] Furthermore, a hospital may remove a physician from its emergency room call panel for abandoning a patient and violating COBRA. [FN89]

\*316 The more controversial cases are those in which the medical staff denies membership or privileges to an otherwise competent physician who does not measure up to its elevated standards for providing quality medical care. These decisions are upsetting to physicians who enjoy privileges at other institutions and do not have a history of medical negligence or discipline. In these cases, the courts have favored the hospitals. The fact that the physician is licensed to practice medicine does not mean that she has the right to be admitted at any hospital.

The doctor's license . . . does not determine qualification for hospital privileges or establish competence to engage in specialties in the hospital . . . The determination of the standards to be applied in granting privileges involves a legislative judgment, and just as courts have largely deferred to administrative expertise in determining whether an applicant is qualified to practice a profession in the first instance, they should defer to administrative expertise in determining whether the professional is qualified to take on the additional responsibilities involved in a grant of hospital privileges. [FN90]

An appellate court found that requiring a surgeon to complete a residency program as a condition to receiving a clinical privilege, even where a "grandfather clause" allowed for other doctors to have the privilege without such training, was not unreasonable or arbitrary. [FN91] Because clinical privileges are hospital specific, a hospital may make its requirements as stringent as it deems reasonably necessary to assure adequate patient care.

[FN92]

## B. Fair Procedure Process Requirements

Under common law precedent, a physician's procedural rights, when contesting an adverse medical staff decision, are rudimentary, as the courts give hospitals a free hand to devise their own procedures. \*317 Fair procedure does not mandate any "fixed format." [FN93] So long as some hearing is provided, a hospital is not "hampered by formalities" [FN94] and need not follow "formal proceedings with all the embellishments of a court trial." [FN95]

The case law establishes that a physician is entitled to notice of the reasons for the decision and an opportunity to defend herself. [FN96] If the hospital's bylaws establish hearing procedures, then the institution is bound to follow its own rules. [FN97] There must also be an opportunity to confront and cross examine accusers and to examine and refute evidence. [FN98]

Furthermore, the physician is entitled to unbiased decision-makers [FN99] and an unbiased hearing officer, if one has been appointed. [FN100] However, bias is not presumed and the burden is on the physician to establish the probability of unfairness. [FN101] Courts have held that bias exists when persons who participated in an investigation served on the panel that decided the case. [FN102] The physician must raise the bias issue during the proceedings or it is waived. [FN103] Additionally, the doctor must be afforded the opportunity to voir dire potential adjudicators to uncover possible bias. [FN104]

Common law fair procedure does not entitle the physician to be represented by an attorney during hearings at the hospital. [FN105] One court expressed antipathy toward lawyers and discounted their importance to peer review hearings:

The purpose of the proceeding is to review highly technical documents and medical reports dealing with the doctors' performance in an area where experts in the same field can arrive at a decision without the controversial and contentious atmosphere which \*318 would likely be created by the participation of attorneys. Medical staff hearings involve highly educated individuals. There is little risk that a physician will be erroneously deprived of staff privileges if he is not allowed counsel at the hearing. [FN106]

Common law fair procedure does not require formal discovery, [FN107] but the physician is entitled to disclosure of the evidence forming the basis of the charges and any information that would be made available to the hearing panel. [FN108] Finally, the hospital must give the physician the opportunity to make copies of medical records so she can prepare her defense. [FN109]

## II. Formalization of the Peer Review Process Through Legislation

As a result of legislation enacted in the late 1980s, peer review in California hospitals has changed dramatically. The catalyst for the change was the federal Health Care Quality Improvement Act of 1986 [FN110] which, among other things, envisioned minimal due process rights for those involved in the peer review process. [FN111] This legislation permitted the states to opt out of the federal law so long as their plans included certain basic procedural requirements. [FN112] The California legislature exercised this option by enacting a series of laws that set forth the procedures hospitals must, at a minimum, follow in certain peer review proceedings. [FN113] These provisions, codified in sections 809 through 809.9 of the Business and Professions Code, became effective on January 1, 1990.

Hospitals must now comply with specifically delineated formal rules when peer review may result in the filing of a Section 805 report. [FN114] The law mandates that medical staffs incorporate the laws' \*319 provisions into their bylaws. [FN115] Essentially, the legislature delegated responsibility for peer review to the private sector, with the caveat that hospitals act in accordance with specific guidelines. [FN116] From a procedural perspective, the legislation gives the physician many rights that were not recognized by the courts under common law fair procedure. The statute has subsumed or clarified other common law rules. The new law was designed to set minimum procedural requirements for peer review; it does not affect a hospital's right to set substantive standards for medical staff membership.

The legislation mandates that a hospital go through a number of steps before reaching a final adverse credentialing decision based on a medical disciplinary cause. [FN117] It envisions that the hospital will first conduct informal investigations or pre-hearing meetings to determine if disciplinary action is necessary. If the medical staff [FN118] decides to proceed, it must give the physician a number of required notices. These include written notice of the final proposed action which, if adopted, will be reported pursuant to Section 805, [FN119] the right to request a hearing, [FN120] and the time limit within which to request a hearing. [FN121] If the physician makes a timely hearing request, the hospital must give written notice [FN122] stating the reasons for the decision, including the acts or omissions with which she is charged, [FN123] and the time, place, and date of the hearing. [FN124]

The legislation governs appointment of the fact finder and pre-hearing procedures. The trier of fact must be an arbitrator or arbitrators mutually acceptable to the physician and hospital or a panel of \*320 unbiased individuals who shall gain no direct benefit from the outcome and who have not acted as an accuser, fact finder, or initial decision maker in the same

matter. [FN125] When feasible, an individual practicing the same specialty as the doctor should be a member of the peer review body. [FN126] If a hearing officer is selected to preside over the hearing, the individual may gain no direct financial benefit from the outcome, may not act as the prosecutor, and cannot vote. [FN127] The doctor must be given a reasonable opportunity to voir dire panel members and the hearing officer to uncover possible bias. [FN128] Challenges to the impartiality of any member or hearing officer are ruled on by the presiding officer or hearing officer. [FN129]

The law provides for a limited type of informal discovery. Each side has the right to inspect and copy relevant documentary information in the other's possession, subject to confidentiality limitations. [FN130] Upon request, each side must provide the other with a witness list and copies of documents expected to be introduced at the hearing. [FN131] The law details the time within which the hearing must be held and the procedure for granting continuances. [FN132]

The legislation also describes how the hearing will proceed and sets the burdens of proof. Both sides have a right to all information made available to the trier of fact, [FN133] to have a record made of the proceedings, [FN134] to call, examine, and cross examine witnesses, [FN135] to present and rebut relevant evidence, [FN136] and to submit a written statement at the close of the hearing. [FN137] The medical staff has the initial duty to present evidence supporting the charge or recommended action. [FN138] Initial applicants have the burden of proving, by a preponderance of the evidence, that they are qualified for membership or privileges. The applicant may not introduce evidence that had been requested by the medical staff during the application process but \*321 which the applicant did not provide, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence. [FN139] For those other than initial applicants, the medical staff must prove, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted. [FN140] Whether the physician has the right to counsel at the hearing is left to the judgment of the medical staff, but the staff must have written provisions setting out its preference. [FN141]

The trier of fact must issue a written decision, including findings of fact and a conclusion, articulating the connection between the evidence produced at the hearing and the decision. [FN142] If the hospital's rules authorize an appeal, both sides must be notified of the right and can appear before the appellate body. [FN143] Both have the right to be represented by an attorney or any other representative during the appeal. [FN144] The parties are entitled to a written decision from the appellate body. [FN145]

The law also recognizes that a hospital may confer rights that go beyond those required by the legislature. "The parties are bound by any additional notice and hearing provisions contained in any applicable . . . medical staff bylaws which are not inconsistent with Sections 809.1 to 809.4, inclusive." [FN146] It is illegal for a hospital to attempt to waive any of the legislative requirements. [FN147]

The legislation is binding on most hospitals in the state. The only exempt institutions are state and county hospitals, those operated by the Regents of the University of California, health facilities that serve as the primary teaching facilities for state-approved medical schools, or hospitals engaged in postgraduate medical education under the auspices of a state approved medical school. [FN148]

Section 809.8 codifies that judicial review is available by way of administrative mandamus pursuant to California Code of Civil Procedure, section 1094.5. [FN149] The statutory scheme allows a prevailing party \*322 to recover court costs and attorney fees when a party brings or defends a lawsuit that was "frivolous, unreasonable, without foundation, or in bad faith." [FN150]

### III. Medical Staff Bylaws and the Peer Review Process: The California Medical Association Model Bylaws Example

The process that a hospital follows in peer review today also depends to a great extent on the institution's medical staff bylaws. California law requires a medical staff to adopt bylaws that include the procedure for evaluating applicants, granting privileges, and disciplining members. [FN151] The medical staff must follow the bylaws when conducting peer review, as they govern the parties' administrative rights. [FN152] The legislature's intent in enacting the Business and Professions Code sections governing peer review was to set minimum procedural rights. [FN153] When medical staff bylaws confer rights beyond those mandated by the law, they are binding. [FN154]

To illustrate how medical staff bylaws can affect the peer review process, the article will use, as an example, the procedures outlined in the California Medical Association's Annotated Model Medical Staff Bylaws ("CMA Model Bylaws"). The California Medical Association is a statewide organization representing the interests of its over 30,000 members. For many years, it has taken a very active role in advising medical staffs embarking on the task of creating or revising medical staff bylaws. The CMA sponsors a Bylaw Analysis Service, whereby an attorney assists medical staffs with bylaws issues. [FN155] According to a CMA publication, the Bylaw Analysis Service "is physician and medical staff oriented and is designed to highlight and protect important rights." [FN156] The CMA has also drafted the CMA Model Bylaws for

use in California hospitals. [FN157] The CMA Model Bylaws are "physician-\*323 friendly" because they include procedural protections beyond those required by statute and case law.

Information showing the number of institutions using the CMA Model Bylaws as the basis for their bylaws was not available when this article was written.

[FN158] Each hospital's medical staff adopts its own bylaws, and there is no central collection point for this information. Nevertheless, there are good reasons to believe that the CMA Model Bylaws--at least so far as they relate to peer review--are widely used in California hospitals. First, the CMA Model Bylaws are prepared by the largest physician advocacy group in the state. It makes sense that medical staffs comprised of physicians would consider and follow physician-friendly recommendations of their own advocacy group. Second, the CMA actively promotes the Model Bylaws and the Bylaw Analysis Service on its website and in its publications. It provides the Model Bylaws to members of the CMA Organized Medical Staff Section at no charge, and it assesses only nominal fees for the Bylaw Analysis Service. [FN159] Third, many appellate court opinions involving medical staff bylaws and credentialing decisions show that the bylaws were based on the CMA Model Bylaws. In some cases, the courts specifically mention the nexus, [FN160] while in others, the bylaw text mirrors current or former versions of the CMA Model Bylaws. [FN161]

\*324 The following subsections describe the basic peer review process under the CMA Model Bylaws, placing special emphasis on procedural requirements beyond those required by statute.

#### A. Overview of the Steps Leading to a Judicial Review Committee Hearing Under the CMA Model Bylaws

The CMA Model Bylaws set the framework whereby the medical staff makes credentialing decisions regarding members and applicants--decisions that may trigger the right to a judicial review committee ("JRC") hearing. [FN162] They govern applications for medical staff membership, as well as set rules for reapplications, requests for additional clinical privileges, and discipline of existing members. The decision-making process is based on a committee system, whereby matters are considered and decided by a number of committees in the hospital's chain of authority.

The most powerful group within the medical staff hierarchy is the medical executive committee ("MEC"). In a departmentalized hospital, the MEC consists of a number of individuals, including elected officers (the chief of staff, the vice chief of staff, and secretary treasurer), [FN163] department chairs, and elected at-large medical staff members. [FN164] The MEC is the governing body of the medical staff. [FN165]

The CMA Model Bylaws envision that the medical staff will be organized into clinical departments reflecting specialty areas of practice, such as surgery or cardiology. When a physician applies for medical staff membership, the application is sent to the appropriate committee for consideration. In the case of applicants, the department has the discretion to conduct a personal interview. [FN166] The department makes a recommendation as to appointment and, if the recommendation is positive, membership category, department affiliation, clinical privileges, and any special conditions to be attached. [FN167] The recommendation is forwarded to the credentials committee, [FN168] which conducts its own review.

\*325 The credentials committee may elect to interview the applicant and seek additional information. [FN169] Once its review is complete, the credentials committee submits a written report and recommendation to the MEC. The MEC may request additional information or it may return the matter to the credentials committee. It also has the option of interviewing the applicant. When the review has been completed, the MEC sets forth its decision, in writing. [FN170] If it is favorable, the decision is sent to the hospital governing board for approval. If it is adverse, the MEC must give written notice to the applicant, informing her that she is entitled to a JRC hearing. [FN171] The process is very similar when an existing member applies for reappointment or for a modification of staff status or clinical privileges. [FN172]

A different procedure is followed when the medical staff wishes to take disciplinary or "corrective action" against a member. [FN173] A request for investigation can be instituted by the chief of staff, a department chair, or the MEC, through the filing of a written request to the MEC. [FN174] If the MEC concludes that an investigation is warranted, it may direct that one be undertaken. The MEC may conduct the investigation itself or refer the matter to a medical staff officer, department, or standing or ad hoc committee of the medical staff. The member must be notified of the investigation and be given an opportunity to provide information. [FN175] If the MEC selects an officer or committee to conduct the investigation, the officer or committee must generate a written report regarding its findings. [FN176]

The MEC then makes its determination. If it decides corrective action is warranted, the MEC sends the recommendation to the hospital's governing board. [FN177] The board must adopt the MEC's recommendation if it is supported by substantial evidence. If the board approves the recommendation, the member has the right to a JRC hearing to contest the decision. [FN178]

\*326 B. Grounds for a JRC Hearing Under the CMA Model Bylaws

The CMA Model Bylaws entitle an applicant or member to a JRC hearing in many situations not covered by the statutory mandates. Under section 809.1(a) of the Business and Professions Code, a physician is entitled to notice and a hearing when the proposed action "is required to be filed under Section 805 . . ." A hospital is required to file a Section 805 report only if a decision is based on "a medical disciplinary cause or reason." [FN179] A medical disciplinary cause or reason is defined as "that aspect of a licentiate's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care." [FN180] In other words, a physician only has a right to a hearing under the statute when her conduct imperils patient safety.

The CMA Model Bylaws provide the right to a hearing for a wide range of potential adverse actions, including the following: denial of medical staff membership; denial of requested advancement in staff membership status or category; denial of medical staff reappointment; demotion to lower medical staff category or membership; suspension of staff membership; revocation of staff membership; denial of requested clinical privileges; involuntary reduction of current clinical privileges; suspension of clinical privileges; termination of all clinical privileges; or involuntary imposition of significant consultation or monitoring requirements. [FN181] Thus, a physician who may not pose a threat to patient safety, but who does not meet the institution's standards for admission, advancement, or clinical privileges, has the right to a hearing under the CMA Model Bylaws.

### C. Selection of the JRC and the Hearing Officer

The MEC has broad power to select the fact finders and hearing officer for the JRC hearing. The MEC must recommend to the hospital's governing board no fewer than five members of the active medical staff to serve as a JRC. Membership must consist of one member who has the same healing arts licensure as the accused, and where feasible, include an individual practicing the accused's same specialty. If it is not feasible to appoint members from the active medical staff, the MEC may appoint practitioners from other staff categories or non-\*327 members. The recommended members are deemed acceptable unless the board objects within five days. [FN182]

The MEC also recommends a hearing officer to the governing board. The governing board is deemed to have approved the selection unless it files a written objection within five days of the recommendation. The hearing officer may be an attorney at law, but an attorney from a firm regularly utilized by the hospital, the medical staff, or the involved medical staff member or applicant, for legal advice regarding their affairs and activities is not

qualified to serve. [FN183] In addition to presiding over the hearing, the hearing officer, if requested by the JRC, may participate in deliberations of the committee and be a legal advisor to it. However, the hearing officer is not entitled to vote. [FN184]

#### D. Conduct of the JRC Hearing

The CMA Model Bylaws give the hearing officer authority to control the conduct of the hearing, including the admission and exclusion of evidence. [FN185] A court reporter transcribes the proceedings at the hospital's expense. [FN186] The physician is entitled to representation by legal counsel in any phase of the hearing. The MEC may not be represented by an attorney if the physician is not similarly represented. [FN187] The parties have the right to present witnesses, cross examine witnesses, and introduce documentary evidence. [FN188] Judicial rules of evidence and procedure do not apply and hearsay evidence is admissible "if it is of the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs." [FN189] The burdens of presenting evidence and proof conform to the requirements of the relevant Business and Professions Code section. [FN190]

#### E. Decision and Right of Appeal to the Governing Board

Under the CMA Model Bylaws, the JRC must issue a written decision within thirty days of the conclusion of the hearing and deliver copies of it to the MEC, the hospital administrator, the governing board, and the physician. The decision must contain a concise statement \*328 of the reasons underlying it, including findings of fact and a conclusion articulating the connection between the evidence presented and the conclusion. If the decision is of the type that must be reported to the Medical Board, it must so state. Both the MEC and the physician must be notified of the right to appeal. [FN191]

The MEC or the physician may appeal the JRC decision by filing a written request for review within ten days of receipt of the decision. [FN192] The request must specify the grounds for appeal and must include a supporting statement of facts. The grounds for governing board review are very narrow. The first ground is that substantial noncompliance with the procedures required by the bylaws or applicable law has created demonstrable prejudice. The second is that the decision was not supported by the substantial evidence, based upon the hearing record [FN193] or the discovery of new evidence. The third is that the text of the report to be filed with the Medical Board and/or National Practitioner Data Bank is not accurate. [FN194]

The governing board may hear the appeal, or designate an appeal board of no fewer than three of its members, to undertake this responsibility. Knowledge

of the matter does not preclude any person from serving on the appeal board, so long as the person did not take part in a prior hearing on the same matter. [FN195] The bylaws prescribe the time within which the hearing must be held. [FN196] Each party has the right to be represented by legal counsel, may submit a written statement, and may personally appear and make oral argument. [FN197] The appeal board then makes a recommendation to the full governing board, which may affirm, modify, or reverse the JRC decision, or remand the case for further review and decision. [FN198] The governing board must issue a written decision and include the text of any report that will be made to state and federal authorities. [FN199]

At this point, the hospital peer review process is finished and the parties have exhausted their administrative remedies. A party dissatisfied \*329 with the decision may seek judicial review in the superior court through a petition for writ of administrative mandamus, pursuant to California's Code of Civil Procedure, section 1094.5. In this event, the superior court reviews the decision of the governing board, not that of the JRC, because the governing board's ruling is the "final administrative order or decision" referred to in the statute. [FN200]

#### IV. Peer Review Today: Shortcomings, Solutions, and Concerns

The additions to the Business and Professions Code have made peer review a much more formalized process than it was under the common law fair procedure rules. Today's law is based on settled fair procedure requirements, which include the right to notice of charges and an opportunity to be heard before unbiased decision-makers. However, the current law goes well beyond these rudimentary rights by requiring specific written notices and decisions, providing the opportunity for informal discovery, setting burdens of proof, and allowing for the possibility of legal representation at peer review proceedings. The result is that peer review is more predictable and fair for the physician.

In addition, as the analysis of the CMA Model Bylaws reveals, hospital medical staffs, through their bylaws, often go beyond the minimum legislative requirements, by granting additional rights and standardizing the process. From a procedural perspective, the physician is in a better position to fully present her case than she was under the judicial precedents. It is important to recognize that the legislative changes do not bear on the substantive side of common law fair procedure. Thus, the fair procedure precedents relating to qualifications for medical staff membership retain their importance, and the judicial policy of deferring to the decisions of health care professionals, unless the decisions lack a rational basis, remains intact.

Although the current peer review process is fairer to the individual

physician, some problems remain. The following subsections will address these issues. The first is whether the statutes and bylaws give hospital authorities too much power to control peer review hearings. The second problem, which is closely related to the first, concerns the lack of any meaningful opportunity for judicial review of hospital decisions. The article concludes with thoughts on whether formalized \*330 peer review has become so cumbersome and expensive that hospitals may be discouraged from instituting formal investigations.

#### A. Leveling the Playing Field in Peer Review

When medical staff authorities make an adverse credentialing decision that triggers the physician's right to a peer review hearing, the relationship between the staff and the affected member or applicant becomes adversarial. The earlier examination of the CMA Model Bylaws establishes this point. After department and credential committee review, the MEC makes the final decision on credentialing. With respect to an applicant, the MEC decides if the physician meets the medical staff's minimum qualifications and it makes a written report supporting the decision. [FN201] The MEC also makes written decisions involving the discipline of staff members or limits on privileges. [FN202] Thus, the MEC has reviewed the evidence and taken a stand, and the physician who requests a hearing is attacking the conclusions of the MEC.

At the peer review hearing, the MEC takes on the role of prosecutor for the medical staff. The chief of staff, who is responsible for enforcing the bylaws and implementing sanctions, [FN203] is the MEC's representative. Because the Business and Professions Code and CMA Model Bylaws place the burden of proof on the MEC in most instances, the hearing is a forum where the MEC must justify and defend its decision, while the doctor tries to prove that the MEC was wrong.

Because the MEC and the doctor are adversaries at the JRC hearing, neither party should have an advantage. Still, the Business and Professions Code and the CMA Model Bylaws give the MEC far too much control over important hearing decisions, thereby creating the danger of unfairness. The first potential for bias under the CMA Model Bylaws lies in that the MEC selects the members of the JRC. [FN204] This task falls to the chief of staff, in consultation with the MEC. [FN205] The MEC recommends panel members to the governing body, which

is deemed to approve the selections unless it objects in writing within five days. [FN206] This process has great potential for abuse. The MEC has a free hand to appoint members who are friendly to the administration \*331 and to exclude those who are not. [FN207] Arguably, the physician can uncover the impartiality of JRC appointees through voir dire, [FN208] but this is not a very meaningful right, especially for new applicants who may not know the

panel members. Even if the physician or her attorney is adept at voir dire and asks probing questions, she may not uncover reasons if would lead a JRC member to favor the MEC's position.

The danger of bias also surrounds the appointment of the hearing officer. The hearing officer acts as the judge in JRC proceedings. This individual (who is usually an attorney) rules on legal questions, including the admissibility of evidence. Although the hearing officer cannot vote, the JRC may invite the officer to "participate in [its] deliberations . . . and be a legal advisor to it," [FN209] under the CMA Model Bylaws. The MEC selects the hearing officer, subject to veto by the governing body. [FN210] If the MEC retains an attorney to act as the hearing officer, the hospital pays the attorney's fee. The physician can challenge the impartiality of the hearing officer, but the bylaws give the hearing officer authority to rule on her own qualifications. [FN211] This system, whereby the prosecutor has broad power to select the fact finders and the judge for the JRC hearing, creates, at the very least, the appearance of impropriety. It should come as no surprise that hospital authorities appoint panel members and hearing officers who are sympathetic to the hospital's position.

There are alternative approaches to the selection of fact finders and hearing officers. These approaches would limit the power of the MEC, thereby lessening the danger of bias. With respect to fact finders, one alternative is to have an arbitrator or arbitrators who are mutually acceptable to the medical staff and physician decide the case. The Business and Professions Code specifically authorizes the use of \*332 arbitrators, [FN212] and there is no limitation on individuals who can serve. They could be medical staff members or nonmembers, although, as a practical matter, a medical staff may be unwilling to leave final credentialing decisions to outsiders.

A second alternative is to follow the CMA Model Bylaws approach of using medical staff members as JRC fact finders, but to eliminate the MEC's exclusive right to select them. JRC members could be chosen randomly from a pool of medical staff members who are qualified to serve under the Business and Professions Code guidelines. [FN213] A variation on this option is to have the MEC and the affected physician join in on selecting the panel from the pool of qualified members, similar to voir dire in a trial.

If the medical staff wishes to have a hearing officer preside at JRC hearings, there are ways to ensure that the individual is truly neutral. Rather than having the MEC choose the hearing officer, both sides could participate in the selection. Private judging and arbitration services would seem to be an ideal source of qualified hearing officers. In the event that medical staffs resist sharing the power to appoint the hearing officer, the

officer's ability to affect outcomes should be checked. The portion of the bylaws that allows the hearing officer to advise the JRC and participate in its deliberations should be repealed. The medical professionals on the JRC must decide the facts, and the decision should be theirs alone. The hearing officer's neutrality is undermined when the MEC-selected individual participates in JRC deliberations.

## B. The Lack of Meaningful Judicial Review of Peer Review Decisions

After the peer review body makes its decision, the physician may appeal the ruling to the hospital's governing board, if the bylaws provide for such an appeal. If the governing board affirms the decision, or if the bylaws do not authorize board review, the decision is final \*333 and the physician has exhausted her administrative remedies at the hospital. [FN214] The doctor can then challenge the decision in the courts. [FN215]

In *Anton*, [FN216] the California Supreme Court held that section 1094.5 of the Code of Civil Procedure governs judicial review in peer review cases. [FN217] Because the hospital's finding is a final adjudicatory decision [FN218] of an administrative agency, the aggrieved physician must bring a petition for a writ of administrative mandamus to challenge it. [FN219] The court found that section 1094.5 review applies to private, as well as public, hospital decisions. [FN220] Years later, when the legislature codified the peer review process in the Business and Professions Code, it recognized that administrative mandamus is the avenue for judicial review. [FN221] The reviewing court may grant the writ and command the hospital to set aside the decision or deny the petition. If it grants the writ, it may order the hospital to reconsider the case or take other action required by the judgment. [FN222]

Although an aggrieved physician has the right to judicial review, the standard of review today is too confining, so as to make the right hollow in cases where the physician is challenging findings of fact. This is because the legislature rejected the standard of review adopted in *Anton*, which gave the courts wide latitude to review hospital decisions, and replaced it with a much more restrictive standard. Because peer review may impair a physician's fundamental vested right to practice at a hospital, the *Anton* court held that the reviewing court must evaluate hospital decisions under the "independent judgment" standard, \*334 rather than the "substantial evidence" test. [FN223] The effect of this holding was to give the courts greater discretion to examine the appropriateness of hospital decisions through a review of the case record. In a hospital peer review case, the record usually includes transcripts of the hearing and any arguments before the hospital governing board, as well as medical exhibits and other evidence. Under the independent

judgment standard, the judge could review the record and reweigh the evidence when considering whether to grant or deny the writ.

The Anton rule on the standard of review was short-lived. In 1979, two years after the decision, the legislature amended section 1094.5 to change the standard of review. The amendment applies only to decisions of private hospitals. It provides that "in cases arising from private hospital boards or boards of directors of districts organized pursuant to The Local Hospital District Law[,] abuse of discretion [FN224] is established if the court determines that the findings are not supported by substantial evidence in light of the whole record." [FN225] Appellate courts applying the amendment have held that the standard of review depends on the nature of the petitioner's grievance. If the petition questions whether peer review was procedurally fair, the court uses its independent judgment to determine the legitimacy of the claim. The independent judgment standard governs issues of law, including whether the hospital acted in excess of its jurisdiction or whether there was a fair trial. [FN226] But if the physician is challenging the factual basis for the hospital's decision, the court may grant relief only if the findings are not supported by substantial evidence in light of the whole record. This amendment negated the Anton rule, which required independent review of the facts, and replaced it with one that severely restricts the discretion of the court.

As a result, administrative mandamus is not a meaningful remedy for physicians challenging factual determinations by a hospital. The \*335 courts may not second-guess hospital authorities--they recognize a "strong public policy" in favor of effective peer review by hospitals. [FN227] Just as courts have largely deferred to administrative expertise in determining whether an applicant is qualified to practice a profession, they also defer to administrative expertise in determining whether the professional is qualified for hospital privileges. [FN228] Under the substantial evidence test, it is not the function of reviewing courts "to resolve differences in medical judgment," but "to view the evidence in the light most favorable to the [agency's] findings and indulge all reasonable inferences in support thereof." [FN229] In *Huang v. Board of Directors, St. Francis Medical Center*, [FN230] the court of appeal explained the extent to which the substantial evidence rule circumscribes the power of a reviewing court:

"The substantial evidence rule provides that where a finding of fact is attacked on the ground it is not sustained by the evidence, the power of an appellate court begins and ends with a determination whether there is any substantial evidence, contradicted or uncontradicted, which supports the finding." The court must consider the evidence in the light most favorable to the prevailing party, giving him the benefit of every reasonable inference and resolving conflicts in support of the judgment. The court is without power to

judge the effect or value of the evidence, weigh the evidence, consider the credibility of witnesses, or resolve conflicts in the evidence or in the reasonable inferences that may be drawn from it. Unless a finding, viewed in light of the entire record, is so lacking in evidentiary support as to render it unreasonable, it may not be set aside. [FN231]

The amendment to section 1094.5 and the limitations of the substantial evidence standard leave physicians with little chance of overturning hospital decisions through judicial review. Except in cases where hospital authorities make procedural errors or where there is no factual basis for a decision, the policy of judicial deference makes judicial review of peer review decisions a meaningless remedy for aggrieved professionals.

The restrictive standard of review not only insulates most hospital decisions from court challenge, but it has the added effect of barring the physician from bringing tort claims for any injuries related to peer \*336 review. [FN232] Before the legislature imposed the substantial evidence standard of review, [FN233] the supreme court held, in *Westlake Community Hospital v. Superior Court*, [FN234] that a physician must first succeed in setting aside the hospital's decision in a mandamus action before bringing a damages suit for termination or denial of hospital privileges. [FN235]

Subsequent decisions have read *Westlake* as requiring an aggrieved party to exhaust the judicial remedy of administrative mandamus--and to do so successfully--as a precondition to suing in tort. [FN236] The *Westlake* court gave three reasons for its decision. First, it wanted to preclude an aggrieved party from circumventing mandamus review; second, it wished to encourage a uniform practice of judicial, rather than jury, review of quasi-judicial administrative decisions; and third, it wanted to protect individuals who participate in judicial review (who only enjoyed a conditional privilege from liability at the time) from having to defend lawsuits. [FN237] It is questionable whether the reasoning behind the second factor holds true today, when the reviewing court's authority to grant mandamus relief is so limited. [FN238] Legal rules, giving hospital authorities sweeping control over the peer review process without allowing for meaningful judicial review of their factual findings, coupled with *Westlake's* requirement of a success in administrative mandamus as a precondition to bringing suit, are likely to preclude the physician from ever being able to present her case to an independent fact finding body.

\*337 There is a solution to this problem, one that can be made without undercutting *Westlake's* policy of judicial exhaustion. The legislature could once again make administrative mandamus a meaningful remedy by reverting to the independent judgment standard when the petition challenges the factual

basis for the hospital's decision. This is the standard of review that has always applied in cases challenging the credentialing decisions of public hospitals. [FN239] As things stand, the reviewing judge is bound to affirm the hospital's decision when there is any substantial evidence in the record to support it. A court should be more than a rubber stamp for an administrative body's decision. Giving judges broader discretion to review the evidence will encourage hospitals to make supportable decisions and will ensure that physicians have their cases evaluated by impartial judges who are not affiliated with the hospital.

### C. A Concern: Is Peer Review Too Cumbersome to Really Work?

This article has examined the development of medical staff peer review law, placing a special emphasis on whether it is fair to the affected physician. Although one can argue that the present system elevates form over substance because hospital authorities control key aspects of the hearing process, the formalization of peer review still gives physicians many rights beyond common law fair procedure protections. The fact, alone, that hospitals must account for credentialing decisions by giving specific written reasons reduces the possibility of arbitrary and unfair actions. The danger of bias and the lack of meaningful judicial review remain troubling issues but, nevertheless, the legislative changes to peer review have increased the likelihood that a physician will receive fair treatment.

As often happens with change, there may be a downside to the current system. Formalization has made peer review more time-consuming and onerous for everyone involved. Medical staff officials, including the MEC and chief of staff, have additional responsibilities. They must know, understand, and follow applicable statutes and bylaws, carefully document the reasons for decisions, and give timely written notices as required by the rules. If the physician requests a hearing, the MEC must identify qualified members to act as fact finders and convince them to take time from their practices and personal lives to serve. From the peer review committee member's perspective, being on a panel can be an inconvenient, thankless task. Because it is \*338 difficult to meet during business hours, hearings are often held in the evenings or on weekends. A hearing may last for days or even weeks. Serving on a peer review panel places one in an uncomfortable position, especially when a decision can destroy professional and personal relationships. Formalized peer review can also be unpleasant for physicians who are witnesses. If the parties are represented by attorneys, witnesses may be forced to justify their criticisms and opinions under cross examination.

Peer review is also very costly. The medical staffs at many hospitals retain legal counsel to provide regular advice on bylaws and their application. If a

hearing is held, the hospital must pay for the services of a court reporter and a hearing officer, if one is used. It is not uncommon for the parties to use the testimony of compensated medical expert witnesses. Where the bylaws allow for legal representation at the hearing, each side must bear the cost. Legal fees can add up, especially for a case that is appealed to the courts.

Because peer review is cumbersome and expensive, there is the danger that hospital authorities may try to avoid investigations requiring them to report to state and federal authorities, and may instead attempt to "settle" cases informally. For example, they could use the threat of an investigation to force a physician to resign or surrender privileges voluntarily. This could be an attractive alternative to a doctor with a record of quality problems who wants to avoid being reported. If this happens, hospitals will fail in their duty to identify doctors who pose a danger to patients and they will neglect to alert other hospitals, insurers, and the public, who are all entitled to the revealing information about such doctors. Regulatory agencies should monitor hospitals and close any reporting loopholes that they may uncover.

Despite these possible drawbacks, the formalization of peer review has helped accomplish the law's goal of balancing the interests of the public, the hospital, and the physician. Medical staffs are free to set standards and can police the profession by excluding or disciplining doctors who endanger patient safety. At the same time, the physician can expect a more predictable peer review process--one that does not depend on the caprices of hospital authorities.

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[FN1]. The discussion does not cover peer review in state or county hospitals or hospitals affiliated with the University of California, as they are bound by due process requirements. Cal. Bus. & Prof. Code 809.7 (West 2003).

[FN2]. Cal. Health & Safety Code 1250(a) (West Supp. 2003) (regulating general acute care hospitals):

The rules of the hospital, established by the board of directors pursuant to this article, shall include all of the following: (1) Provision for the organization of physicians and surgeons, podiatrists, and dentists licensed to practice in this state who are permitted to practice in the hospital into a formal medical staff, with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.

Id. 32128(a)(1) (regulating district hospitals); see also Cal. Code Regs. tit. 22, 70703(a) (2002), which provides in pertinent

part: "Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital." The regular practice of medicine in a licensed general or specialized hospital having five or more physicians and surgeons, which does not have rules established for the organization of "a formal medical staff with appropriate officers and bylaws[,]" constitutes "unprofessional conduct." Cal. Bus. & Prof. Code 2282.

[FN3]. *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Med. Ctr.*, 73 Cal. Rptr. 2d 695, 699 n.2 (Ct. App. 1998).

[FN4]. See Cal. Code Regs. tit. 22, 70703(b).

The medical staff, by vote of the members and with the approval of the governing body, shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its by-laws.

*Id.* There is a split of authority over whether medical staff bylaws create an enforceable contract between the physician and the hospital. In *Janda v. Madera Community Hospital*, 16 F. Supp. 2d 1181, 1188 (E.D. Cal. 1998), a United States District Court, applying California law, held that they do. A panel of the California Court of Appeal disagreed in *O'Byrne v. Santa Monica-UCLA Medical Center*, 114 Cal. Rptr. 2d 575, 585 (Ct. App. 2001). Nevertheless, courts agree that medical staff bylaws are binding on physicians and hospitals because the law requires it. *Id.* at 583.

[FN5]. Cal. Code Regs. tit. 22, 70703(b). "Clinical privileges" means: "Authorization granted by the appropriate authority (for example, a governing body) to a practitioner to provide specific care services in an organization within well-defined limits, based on the following factors, as applicable: license, education, training, experience, competence, health status, and judgment." Joint Comm'n on Accreditation of Healthcare Orgs, 2002 Comprehensive Accreditation Manual for Hospitals: The Official Handbook GL-5 (2002).

[FN6]. A hospital's governing body is "[t]he individual(s), group, or agency that has ultimate authority and responsibility for establishing policy, maintaining care quality, and providing for organization management and planning." *Id.* at GL-9. This governing body may also be called "the board, board of trustees, board of governors, board of commissioners, and partners (networks)." *Id.*

[FN7]. The governing body of the hospital, in its bylaws, must provide for "self-government by the medical staff with respect to the professional work performed in the hospital." Cal. Code Regs. tit. 22, 70701(a)(1)(F).

[FN8]. The hospital must make a report if a licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason; if staff privileges, membership, or employment are terminated or revoked for a medical disciplinary reason; or if restrictions are imposed or voluntarily accepted on staff privileges for a cumulative total of thirty days or more for any twelve-month period for a medical disciplinary reason. See Cal. Bus. & Prof. Code 805(b) (West 2003). ("Licentiate' means a physician and surgeon, podiatrist, clinical psychologist ... or dentist." Id. 805(a)(2).) It must also file a report if, following notice of an impending investigation based on information indicating medical disciplinary cause or reason, a member resigns or takes a leave of absence; an applicant withdraws or abandons the application; or a member withdraws or abandons a request for renewal of privileges. Id. 805(c).

[FN9]. Id. 805(b) (setting out the requirements for the report).

[FN10]. Id. 2220-2220.6.

[FN11]. 42 U.S.C. 11101-11152 (2000).

[FN12]. Subchapter I of the legislation is entitled "Encouraging Good Faith Professional Review Activities." Id. 11111. Congress's findings on the need for effective peer review are stated in 11101(3). For a discussion of events leading to the passage of HCQIA, see Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 *Am. J.L. & Med.* 455 (1990).

[FN13]. The reporting requirements are found at 42 U.S.C. 11131-11137.

[FN14]. Id. 11133(a).

[FN15]. Id. 11151(3).

[FN16]. *Edwards v. Fresno Cmty. Hosp.*, 113 Cal. Rptr. 579, 580-81 (Ct. App. 1974).

[FN17]. *Anton v. San Antonio Cmty. Hosp.*, 567 P.2d 1162, 1173-75 (Cal. 1977).

[FN18]. *Westlake Cmty. Hosp. v. Superior Court*, 551 P.2d 410 (Cal. 1976).

[FN19]. See *Rhee v. El Camino Hosp. Dist.*, 247 Cal. Rptr. 244, 250 (Ct. App. 1988).

[FN20]. Susan O. Scheutzow, *State Medical Peer Review: High Cost but No Benefit--Is It Time for a Change?*, 25 Am. J.L. & Med. 7, 25 (1999).

[FN21]. "Prejudicial actions" are those resulting in loss of license or licensed privilege, restriction of license or license privilege, or modification of a license or privilege that results in a penalty or reprimand. The Fed'n of State Med. Bds. of the United States, Inc., *Summary of 2002 Board Actions tbl.I* (2003).

[FN22]. *Id.* 113,208 physicians held licenses, but not all of the physicians were engaged in the practice of medicine. *Id.*

[FN23]. This figure does not take into account that more than one prejudicial action may have been taken against a single physician. *Id.*

[FN24]. *Id.* at tbl.II. The Composite Action Index ("CAI") takes into account nonprejudicial as well as prejudicial actions. "Nonprejudicial actions" include actions that do not result in modification or termination of a license or licensed privileges. This action is frequently administrative in nature, such as a license denial due to lack of qualification or a reinstatement following disciplinary action. The CAI history for California, with regard to the number of physicians disciplined, is as follows (where the figures are based on averages regarding the different types of disciplinary action taken in the state throughout the year): 1993, 3.02; 1994, 3.46; 1995, 5.86; 1996, 5.01; 1997, 5.45; 1998, 5.82; 1999, 6.10; 2000, 5.73; 2001, 4.62; 2002, 5.21. *Id.*

[FN25]. Pub. Citizen, *Ranking of State Medical Board Serious Disciplinary Actions in 2002* (HRG Publication #1658) tbl.1 (2003), [http://www.citizen.org/publications/print\\_release.cfm?ID=7234table\\_1](http://www.citizen.org/publications/print_release.cfm?ID=7234table_1) (last accessed Nov. 22, 2003). Public Citizen is an organization founded by Ralph Nader. Pub. Citizen, *About Pub. Citizen*, <http://www.citizen.org/about>. It bases its rankings on data obtained from the Federation of State Medical Boards. Pub. Citizen, *Ranking of State Medical Board Serious Disciplinary Actions in 2002* (HRG Publication #1658), [http://www.citizen.org/publications/print\\_release.cfm?ID=7234](http://www.citizen.org/publications/print_release.cfm?ID=7234). Public Citizen defines "serious disciplinary actions" as "revocations, surrenders, suspensions, and probation/restrictions." *Id.* California ranked twenty-fourth in serious disciplinary actions in 2002. *Id.* tbl.1. Over the previous ten years, California's ranking has ranged from a high of 18 (1997) to a low of

34/35 (1994). Id. tbl.2.

[FN26]. See generally Laura-Mae Baldwin et al., Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports, JAMA, July 28, 1999, at 349-55 (1999) (presenting results of a five-year study showing that low and declining levels of hospital privileges actions were reported to NPDB). According to the authors, more than 65% of all hospitals reported no privilege actions during the five-year study period. Id. at 351.

[FN27]. Med. Bd. of Cal., 2001-2002 Annual Report iv (2002).

[FN28]. Scheutzow, *supra* note 20, at 54. The author concludes that more severe penalties for non-reporting may encourage hospitals to report to the NPDB. Id. at 57.

[FN29]. Cal. Bus. & Prof. Code 805(k) (West 2003). Under the previous law, the maximum fine for an "intentional" failure to file was \$10,000.

[FN30]. Id. 805(l). Under the previous law, the maximum fine for an unintentional failure to file was \$5,000.

[FN31]. See *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 161 (Ct. App. 1982).

[FN32]. See *id.* at 161; see also Gary F. Loveridge & Betsy S. Kimball, Hospital Corporate Negligence Comes to California: Questions in the Wake of *Elam v. College Park Hospital*, 14 Pac. L.J. 803 (1983).

[FN33]. See generally The Ctr. for Peer Review Justice, Inc., at <http://www.peerreview.org> (last accessed Nov. 8, 2003) (discussing physician complaints about peer review); see also Brock D. Phillips, A Guide to Physician Disciplinary Hearings, Cal. Physician, July 1994, at 36-39.

[FN34]. Jill K. Silverman, Will Economic Credentialing Invade Your Hospital?, Cal. Physician, Dec. 1991, at 52-55.

[FN35]. See generally Cal. Med. Ass'n, Annotated Model Medical Staff Bylaws (1985-2003) [hereinafter Bylaws].

[FN36]. See Cal. Civ. Proc. Code 1094.5 (West Supp. 2003).

[FN37]. See generally *Otto v. Journeymen Tailors' Protective & Benevolent Union of S.F.*, 17 P. 217 (Cal. 1888); see also *Von Arx v. S.F. Gruetli Verein*, 45 P. 685 (Cal. 1896).

[FN38]. See generally *Cason v. Glass Bottle Blowers Ass'n*, 231 P.2d 6 (Cal. 1951).

[FN39]. *Taboada v. Sociedad Espanola de Beneficencia Mutua*, 215 P. 673 (Cal. 1923).

[FN40]. *James v. Marinship Corp.*, 155 P.2d 329 (Cal. 1944).

[FN41]. *Pinsker v. Pac. Coast Soc'y of Orthodontists*, 526 P.2d 253, 259- 60 (Cal. 1974) [hereinafter *Pinsker II* ].

[FN42]. *Id.*

[FN43]. *Id.* at 259 n.7.

[FN44]. 460 P.2d 495 (Cal. 1969) [hereinafter *Pinsker I* ].

[FN45]. *Pinsker II*, 526 P.2d 253.

[FN46]. *Id.* at 262.

[FN47]. *Id.* at 264 n.13.

[FN48]. *Id.* at 263.

[FN49]. *Id.* at 263-64.

[FN50]. 114 Cal. Rptr. 681 (Ct. App. 1974).

[FN51]. *Id.* at 696.

[FN52]. 567 P.2d 1162, 1168 (Cal. 1977).

[FN53]. See *id.* at 1168.

[FN54]. See *id.* at 1168 n.12.

[FN55]. See *id.* at 1178.

[FN56]. 614 P.2d 258 (Cal. 1980).

[FN57]. *Id.* at 265.

[FN58]. Id. at 266-67.

[FN59]. Id. at 265.

[FN60]. See generally Gill v. Mercy Hosp., 245 Cal. Rptr. 304 (Ct. App. 1988); see also Cipriotti v. Bd. of Dirs. of Northridge Hosp. Found. Med. Ctr., 196 Cal. Rptr. 367 (Ct. App. 1983).

[FN61]. 375 P.2d 431 (Cal. 1962). Rosner involved a doctor who applied for privileges at a public hospital.

[FN62]. Id. at 432.

[FN63]. Id. at 435.

[FN64]. Id.

[FN65]. Miller v. Eisenhower Med. Ctr., 614 P.2d 258, 266 n.14 (Cal. 1980).

[FN66]. Id. at 266.

[FN67]. Id.

[FN68]. Id. at 267.

[FN69]. Id. at 269.

[FN70]. 182 Cal. Rptr. 85 (Ct. App. 1982).

[FN71]. Id. at 93.

[FN72]. Id. at 94.

[FN73]. Marmion v. Mercy Hosp. & Med. Ctr., 193 Cal. Rptr. 225 (Ct. App. 1983) (involving resident who was expelled for poor communication, poor attendance, poor consultation, and his adverse effect on morale).

[FN74]. Cipriotti v. Bd. of Dirs. of Northridge Hosp. Found. Med. Ctr., 196 Cal. Rptr. 367 (Ct. App. 1983).

[FN75]. Gaenslen v. Bd. of Dirs. of St. Mary's Hosp. & Med. Ctr., 232 Cal. Rptr. 239, 244 (Ct. App. 1985).

[FN76]. See Miller v. Nat'l Med. Hosp., 177 Cal. Rptr. 119 (Ct. App. 1981)

(concerning the suspension of a physician's privileges after he was convicted for conspiracy to murder his wife, based on hospital's finding that his continued membership would disrupt the hospital).

[FN77]. See *Unterthiner v. Desert Hosp. Dist.*, 656 P.2d 554 (Cal. 1983) (finding that falsehood on an application for medical staff privileges is good cause for denial of privileges); *Oskooi v. Fountain Valley Reg'l Hosp. & Med. Ctr.*, 49 Cal. Rptr. 2d 769 (Ct. App. 1996) (finding that omission of information requested on an application is grounds for suspension).

[FN78]. See *Bylaws*, *supra* note 35, art. II, 2.2-1(a).

[FN79]. *Id.* art. V, 5.2-2.

[FN80]. See *Bonner v. Sisters of Providence Corp.*, 239 Cal. Rptr. 530, 537 (Ct. App. 1987).

[FN81]. 119 Cal. Rptr. 507 (Ct. App. 1975).

[FN82]. *Id.* at 511.

[FN83]. *Bonner*, 239 Cal. Rptr. at 538.

[FN84]. *Pick v. Santa Ana-Tustin Cmty. Hosp.*, 182 Cal. Rptr. 85, 94 (Ct. App. 1982).

[FN85]. See *Webman v. Little Co. of Mary Hosp.*, 46 Cal. Rptr. 2d 90, 97 (Ct. App. 1995); see also *O'Byrne v. Santa Monica-UCLA Med. Ctr.*, 114 Cal. Rptr. 2d 575 (Ct. App. 2001).

[FN86]. See *Cipriotti v. Bd. of Dirs. of Northridge Hosp. Found. Med. Ctr.*, 196 Cal. Rptr. 367, 368 (Ct. App. 1983).

[FN87]. See *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Med. Ctr.*, 73 Cal. Rptr. 2d 695, 706 (Ct. App. 1998). California law authorizes health facilities to require every member of the medical staff to have professional liability insurance as a condition of membership. Cal. Health & Safety Code 1319 (West 2000). The statute's constitutionality was upheld in *Wilkinson v. Madera Community Hospital*, 192 Cal. Rptr. 593 (Ct. App. 1983).

[FN88]. See *Goodstein v. Cedars-Sinai Med. Ctr.*, 78 Cal. Rptr. 2d 577, 582 (Ct. App. 1998).

[FN89]. See *Hongsathavij*, 73 Cal. Rptr. 2d at 704.

COBRA is the acronym for the federal Comprehensive Omnibus Budget Reconciliation Act of 1986, ... which is also referred to as the Emergency Medical Treatment and Active Labor Act ... [42 U.S.C. 1395dd]. COBRA was enacted to prevent 'dumping,' the refusal to treat indigent patients in medical emergencies .... Congress intended that patients with emergency medical conditions receive proper medical care for their emergency conditions, regardless of their financial resources.

Id. at 699 n.3.

[FN90]. *Unterthiner v. Desert Hosp. Dist.*, 656 P.2d 554, 562-63 (Cal. 1983) (citations omitted).

[FN91]. *Smith v. Vallejo Gen. Hosp.*, 216 Cal. Rptr. 189, 193 (Ct. App. 1985); see also *Oliver v. Bd. of Trs. of Eisenhower Med. Ctr.*, 227 Cal. Rptr. 1 (Ct. App. 1986) (regarding a physician who was denied membership to consulting staff because there was no evidence that he was nationally or internationally renowned in his area of specialty).

[FN92]. *Hay v. Scripps Mem'l Hosp.*, 228 Cal. Rptr. 413, 419 (Ct. App. 1986).

[FN93]. *Tiholiz v. Northridge Hosp. Found.*, 199 Cal. Rptr. 338, 341 (Ct. App. 1984).

[FN94]. *Bollengier v. Doctors Med. Ctr.*, 272 Cal. Rptr. 273, 280 (Ct. App. 1990).

[FN95]. *Huang v. Bd. of Dirs., St. Francis Med. Ctr.*, 270 Cal. Rptr. 41, 46 (Ct. App. 1990).

[FN96]. See *Pinsker II*, 562 P.2d 253, 263 (Cal. 1974); *Rhee v. El Camino Hosp. Dist.*, 247 Cal. Rptr. 244, 250 (Ct. App. 1988).

[FN97]. See generally *Volpicelli v. Jared Sydney Torrance Mem'l Hosp.*, 167 Cal. Rptr. 610 (Ct. App. 1980).

[FN98]. See *Hackethal v. Cal. Med. Ass'n*, 187 Cal. Rptr. 811, 815 (Ct. App. 1982).

[FN99]. See *Applebaum v. Bd. of Dirs. of Barton Mem'l Hosp.*, 163 Cal. Rptr. 831, 836 (Ct. App. 1980).

[FN100]. See *Gill v. Mercy Hosp.*, 245 Cal. Rptr. 304, 317 (Ct. App. 1988).

[FN101]. See *Rhee*, 247 Cal. Rptr. at 253.

[FN102]. Applebaum, 163 Cal. Rptr. at 837-38.

[FN103]. Anton v. San Antonio Cmty. Hosp., 567 P.2d 1162, 1176-77 (Cal. 1977); Gaenslen v. Bd. of Dirs. of St. Mary's Hosp. & Med. Ctr., 232 Cal. Rptr. 239, 243 (Ct. App. 1985).

[FN104]. Rosenblit v. Superior Court, 282 Cal. Rptr. 819, 827 (Ct. App. 1991); Lasko v. Valley Presbyterian Hosp., 225 Cal. Rptr. 603, 608-09 (Ct. App. 1986)

[FN105]. Anton, 567 P.2d at 1176-77.

[FN106]. Gill v. Mercy Hosp., 245 Cal. Rptr. 304, 311 (Ct. App. 1988).

[FN107]. Id. at 315; Smith v. Vallejo Gen. Hosp., 216 Cal. Rptr. 189, 194 (Ct. App. 1985).

[FN108]. Hackethal v. Cal. Med. Ass'n, 187 Cal. Rptr. 811, 816-17 (Ct. App. 1982).

[FN109]. Rosenblit, 282 Cal. Rptr. at 826.

[FN110]. 42 U.S.C. 11101-11152 (2000).

[FN111]. The federal notice and hearing requirements are found at id.

[FN112]. Id. 11111(c)(2)(B). The legislature declared it was opting out of the federal law "because the laws of this state provide a more careful articulation of the protections for both those undertaking peer review activity and those subject to review, and better integrates public and private systems of peer review." Cal. Bus. & Prof. Code 809 (a)(9)(A) (West 2003).

[FN113]. The California Medical Association claims responsibility for the legislation, which is codified in Cal. Bus. & Prof. Code sections 809-809.9, and is referred to as "CMA's peer review legislation." Cal. Med. Ass'n, 4 California Physician's Legal Handbook 31:34 (2002).

[FN114]. Cal. Bus. & Prof. Code 809(a)(8), (b).

[FN115]. Id. 809(a)(8); Unnamed Physician v. Bd. of Trs. of St. Agnes Med. Ctr., 113 Cal. Rptr. 2d 309, 320 (Ct. App. 2001).

[FN116]. Unnamed Physician, 113 Cal. Rptr. at 316.

[FN117]. The law provides for the immediate suspension of privileges in emergency cases "where the failure to take that action may result in an imminent danger to the health of any individual." Cal. Bus. & Prof. Code 809.5. The hospital must subsequently give the physician notice of the charges and of his or her right to a hearing. Id.

[FN118]. Throughout the law, the statute refers to the instigator of the peer review process as the "peer review body." The medical staff is listed within the definition of peer review body. Id. 805(a)(1)(A), 809(b). In practice, the medical staff instigates most investigations. In rare cases where the medical staff fails to investigate or institute disciplinary proceedings, the hospital's governing board has authority to require the medical staff to initiate an investigation or a disciplinary action. Id. 809.05(b).

[FN119]. Id. 809.1(b)(1)-(2).

[FN120]. Id. 809.1(b)(3).

[FN121]. Id. 809.1(b)(4).

[FN122]. Id. 809.1(c).

[FN123]. Id. 809.1(c)(1).

[FN124]. Id. 809.1(c)(2).

[FN125]. Id. 809.2(a).

[FN126]. Id.

[FN127]. Id. 809.2(b).

[FN128]. Id. 809.2(c).

[FN129]. Id.

[FN130]. Id. 809.2(d).

[FN131]. Id. 809.2(f).

[FN132]. Id. 809.2(g)-(h).

[FN133]. Id. 809.3(a)(1).

[FN134]. Id. 809.3(a)(2).

[FN135]. Id. 809.3(a)(3).

[FN136]. Id. 809(a)(4).

[FN137]. Id. 809(a)(5).

[FN138]. Id. 809.3(b)(1).

[FN139]. Id. 809.3(b)(2).

[FN140]. Id. 809.3(b)(3).

[FN141]. Id. 809.3(c).

[FN142]. Id. 809.4(a)(1).

[FN143]. Id. 809.4(a)(2), (b)(1).

[FN144]. Id. 809.4(b)(2).

[FN145]. Id. 809.4(b)(3).

[FN146]. Id. 809.6(a).

[FN147]. Id. 809.6(c).

[FN148]. Id. 809.7.

[FN149]. Id. 809.8.

[FN150]. Id.

[FN151]. See *supra* note 4; see also *Oliver v. Bd. of Trs. of Eisenhower Med. Ctr.*, 227 Cal. Rptr. 1, 2 (Ct. App. 1986).

[FN152]. *Unnamed Physician v. Bd. of Trs. of St. Agnes Med. Ctr.*, 113 Cal. Rptr. 2d 309, 316 (Ct. App. 2001).

[FN153]. Id. at 320.

[FN154]. Cal. Bus. & Prof. Code 809.6(a) provides: "The parties are bound by any additional notice and hearing provisions contained in any applicable professional society or medical staff bylaws which are not inconsistent with Sections 809.1 to 809.4, inclusive."

[FN155]. See Cal. Med. Ass'n, 3 California Physician's Legal Handbook 28:1 (2002).

[FN156]. *Id.*

[FN157]. The CMA has drafted separate model bylaws for departmental and nondepartmental hospitals. *Id.* at 28:1 n.1081; see also telephone interview with Elizabeth Snelson, Bylaw Analyst, California Medical Association (Aug. 13, 2003) [hereinafter Snelson interview]. Peer review protections are similar under both plans. Snelson interview. Because most California hospitals are departmentalized, the article will focus on the model bylaws for use at these institutions.

[FN158]. CMA's bylaw analyst, Elizabeth Snelson, Esq., stated that she is unaware whether the CMA collects data relating to the use of the Model Bylaws. She confirmed that, as bylaw analyst, she recommends medical staffs base their peer review rules on the CMA provisions. *Id.* In response to an email inquiry about the use of the CMA Model Bylaws in the state, a CMA official replied: "[M]ost hospitals use the model by-laws to some degree or another (some in total, others adopting sections of it)." E-mail from Robin Flagg Strimling, Associate Director, Government Programs and Medical Staff Section, Center for Medical and Regulatory Policy Economics, California Medical Association, to the author (Aug. 15, 2003) (on file with author).

[FN159]. See Cal. Med. Ass'n, The CMA Bookstore, Model Medical Staff Bylaws--Hard Copy (2003), available at <http://www.cmanet.org/bookstore/product.cfm?catid=3&productid=168> (last accessed Dec. 1, 2003); see also Cal. Med. Ass'n, The CMA Bookstore, Medical Staff Bylaw Analysis Service (2003), available at <http://www.cmanet.org/bookstore/product.cfm?productid=52> (last accessed Dec. 1, 2003).

[FN160]. See, e.g., *Anton v. San Antonio Cmty. Hosp.*, 567 P.2d 1162, 1171 (Cal. 1977); *Smith v. Vallejo Gen. Hosp.*, 216 Cal. Rptr. 189, 193 (Ct. App. 1985).

[FN161]. See, e.g., *Unnamed Physician v. Bd. of Trs. of St. Agnes Med. Ctr.*, 113 Cal. Rptr. 2d 309, 314 (Ct. App. 2001); *Joel v. Valley Surgical Ctr.*, 80

Cal. Rptr. 2d 247, 248 (Ct. App. 1998); Rhee v. El Camino Hosp. Dist., 247 Cal. Rptr. 244, 254 (Ct. App. 1988); Cipriotti v. Bd. of Dirs. of Northridge Hosp. Found. Med. Ctr., 196 Cal. Rptr. 367, 370-71 (Ct. App. 1983).

[FN162]. The peer review hearing is referred to as the "judicial review committee hearing" throughout the bylaws. Bylaws, *supra* note 35.

[FN163]. The qualifications, election process, and terms of these officers are found at *id.*, art. IX.

[FN164]. See *id.* art. XI, 11.3-1.

[FN165]. *Id.* art. I, 1.2-9.

[FN166]. *Id.* art. IV, 4.5-4.

[FN167]. See *id.*

[FN168]. Credentials committee members are appointed by the chief of staff, in consultation with the MEC. See *id.* art. IX, 9.2-1(f).

[FN169]. *Id.* art. IV, 4.5-5.

[FN170]. See *id.* art. IV, 4.5-6.

[FN171]. See *id.* art. IV, 4.5-7.

[FN172]. See generally *id.* art. IV, 4.6-3.

[FN173]. See generally *id.* art. VI, 6.1.

[FN174]. See *id.* art. VI, 6.1-1, 6.1-2.

[FN175]. See *id.* art. VI, 6.1-3.

[FN176]. See *id.*

[FN177]. See *id.* art. VI, 6.1-5(a).

[FN178]. See *id.* art. VI, 6.1-5(b).

[FN179]. Cal. Bus. & Prof. Code 805(b)(1)-(3) (West 2003).

[FN180]. *Id.* 805(a)(6).

[FN181]. Bylaws, supra note 35, art. VII, 7.2(a)-(k).

[FN182]. Id. art. VII, 7.3-5.

[FN183]. Id. art. VII, 7.4-3.

[FN184]. Id.

[FN185]. See id.

[FN186]. See id. art. VII, 7.4-4.

[FN187]. Id. art. VII, 7.4-2.

[FN188]. See id. art. VII, 7.4-5.

[FN189]. Id. art. VII, 7.4-6.

[FN190]. See generally id. art. VII, 7.4-7.

[FN191]. Id. art. VII, 7.4-10.

[FN192]. Id. art. VII, 7.5-1. This bylaw does not specify to whom the request must be made, but context shows that it is to the governing board.

[FN193]. The governing body may not reweigh the evidence and exercise its independent judgment when reviewing the JRC decision. *Huang v. Bd. of Dirs., St. Francis Med. Ctr.*, 270 Cal. Rptr. 41, 45-46 (Ct. App. 1990).

[FN194]. Bylaws, supra note 35, art. VII, 7.5-2.

[FN195]. Id. art. VII, 7.5-4.

[FN196]. See generally id. art. VII, 7.5-3.

[FN197]. Id. art. VII, 7.5-5.

[FN198]. See id.

[FN199]. See id. art. VII, 7.5-6(c).

[FN200]. Cal. Civ. Proc. Code 1094.5(a) (West Supp. 2003); *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Med. Ctr.*, 73 Cal.

Rptr. 2d 695, 702 (Ct. App. 1998).

[FN201]. See generally Bylaws, *supra* note 35, art. IV, 4.5-6.

[FN202]. See generally *id.* art. VI, 6.1-5(a).

[FN203]. *Id.* art. IX, 9.2-1(a).

[FN204]. See *id.* art. VII, 7.3-5.

[FN205]. See *id.* art. IX, 9.2-1(f).

[FN206]. See *id.* art. VII, 7.3-1 n.90, 7.3-5.

[FN207]. Although the rule prohibits JRC members from having a "direct financial benefit from the outcome" and excludes those who "acted as accusers, investigators, fact finders, initial decision makers" or those who "actively participated in the consideration of the matter leading up to the recommendation or action," *id.* art. VII, 7.3-5, it does not account for the fact that the MEC may appoint "its people"--friends, professional colleagues, doctors who are hospital employees, and those sympathetic to the MEC for other reasons--to serve on the panel.

[FN208]. See *id.* art. VII, 7.4-1(e).

[FN209]. *Id.* art. VII, 7.4-3.

[FN210]. See *id.* Attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member, or the applicant are not eligible to serve. Statute and the bylaws also prohibit the hearing officer from gaining a direct financial benefit from the outcome and must not act as prosecutor or advocate. *Id.*

[FN211]. See *id.* art. VII, 7.4-1(e).

[FN212]. The hearing shall be held, as determined by the peer review body, before a trier of fact, which shall be an arbitrator or arbitrators selected by a process mutually acceptable to the licentiate and the peer review body, or before a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact finder, or initial decision maker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.

Cal. Bus. & Prof. Code 809.2(a) (West 2003).

[FN213]. *Id.* If feasible, the pool would include members who practice in the same specialty as the licentiate. *Id.*

[FN214]. For a discussion of the exhaustion requirement and exceptions in the peer review context, see generally *Bollengier v. Doctors Medical Center*, 272 Cal. Rptr. 273 (Ct. App. 1990).

[FN215]. The medical staff is also entitled to judicial review of an adverse decision, but as the decisions discussed in this article reveal, the physician is the petitioner in most cases.

[FN216]. *Anton v. San Antonio Cmty. Hosp.*, 567 P.2d 1162 (Cal. 1977).

[FN217]. *Id.* at 1167-68.

[FN218]. An "adjudicatory" decision is one in which the administrative body's action affecting an individual is determined by facts peculiar to the individual case, as opposed to a "legislative" decision involving broad, generally applicable rules of conduct on the basis of general public policy. Section 1094.5 is used to review adjudicatory, not legislative, decisions. The latter are reviewable by traditional mandamus. *Bollengier*, 272 Cal. Rptr. at 277. Traditional mandamus is governed by Cal. Civ. Proc. Code 1085 (West 1980).

[FN219]. *Anton*, 567 P.2d at 1167 (Cal. 1977).

[FN220]. *Id.* at 1167-68.

[FN221]. Cal. Bus. & Prof. Code 809.8 (West 2003) states in pertinent part, "Nothing in Sections 809 to 809.7, inclusive, shall affect the availability of judicial review under Section 1094.5 of the Code of Civil Procedure ...."

[FN222]. Cal. Civ. Proc. Code 1094.5(f).

[FN223]. *Anton*, 567 P.2d at 1172-75.

[FN224]. "Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence." Cal. Civ. Proc. Code 1094.5(b).

[FN225]. *Id.* 1094.5(d).

[FN226]. *Id.* 1094.5(b). In *Tiholiz v. Northridge Hospital Foundation*, 199 Cal. Rptr. 338, 343 (Ct. App. 1986), the court of appeal held: "[A] litigant has a fundamental interest at stake in procedural fairness, including but not limited to an interest in the compilation of an accurate hearing record and having the disposition made by unbiased individuals. [Citation omitted.] Fundamental interests are protected best by employment of the independent judgment standard in superior courts undertaking review of administrative dispositions."

[FN227]. *Gill v. Mercy Hosp.*, 245 Cal. Rptr. 304, 308 (Ct. App. 1988).

[FN228]. *Unterthiner v. Desert Hosp. Dist.*, 656 P.2d 554, 563 (Cal. 1983).

[FN229]. *Cipriotti v. Bd. of Dirs. of Northridge Hosp. Found. Med. Ctr.*, 196 Cal. Rptr. 367, 372-73 (Ct. App. 1983).

[FN230]. 270 Cal. Rptr. 41 (Ct. App. 1990).

[FN231]. *Id.* at 45 (citations omitted).

[FN232]. Typical tort claims include defamation, interference with economic relationship, unfair business practices, and intentional infliction of emotional distress. See, e.g., *Joel v. Valley Surgical Ctr.*, 80 Cal. Rptr. 2d 247 (Ct. App. 1998).

[FN233]. The amendment requiring the substantial evidence test became law in 1978, two years after the *Westlake* decision. *Cipriotti*, 196 Cal. Rptr. at 372.

[FN234]. 551 P.2d 410 (Cal. 1976).

[FN235]. *Id.* at 411.

[FN236]. See *Johnson v. City of Loma Linda*, 5 P.3d 874, 879-80 (Cal. 2000) (discussing the application of the *Westlake* rule where a city employee was suspended and delayed in pursuing administrative mandamus). For application of the rule in hospital peer review, see *McNair v. Pasadena Hospital Association*, 169 Cal. Rptr. 39 (Ct. App. 1980).

[FN237]. *Westlake*, 551 P.2d at 421-22.

[FN238]. The third rationale for the *Westlake* rule is also undermined because the legislature subsequently gave absolute immunity to peer review members who report to the Medical Board, Cal. Bus. & Prof. Code 2318 (West

2003), and to persons who communicate information to a peer review committee to aid in the evaluation of a physician's qualifications, Cal. Civ. Code 43.8 (West Supp. 2003). One court held that a hospital is a "person" under the latter code section and enjoys its immunity. *Hassan v. Mercy Am. River Hosp.*, 118 Cal. Rptr. 2d 81 (Ct. App. 2002). But see *Axline v. St. John's Hosp. & Health Ctr.*, 74 Cal. Rptr. 2d 385, 388 (Ct. App. 1998). Witnesses at peer review hearings also enjoy absolute immunity. Cal. Civ. Code 47(b) see *Axline*, 74 Cal. Rptr. 2d at 388-89.

[FN239]. *Cipriotti*, 196 Cal. Rptr. at 372.

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