Case No. S156986

SUPREME COURT

FOR THE STATE OF CALIFORNIA

Gil N. Mileikowsky, M.D.,

Petitioner/Appellant,

v.

West Hills Hospital Medical Center and Medical Staff of West Hills Medical Center, Medical Staff of West Hills Hospital Medical Center, Hospital Corporation of America a/k/a HCA, Inc., John D. Harwell, and James R. Lahana,

Respondents/ Respondents

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After a Decision by the Court of Appeal
Second Appellate District, Division Eight
Case No. B186238

_____

APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF AND AMICI CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFF/APPELLANT

_____

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Amici the American Medical Association and the California Medical Association respectfully request leave, pursuant to California Rule of Court 14(b), to file the enclosed brief as amici curiae in support of Gil N. Mileikowsky, M.D.

Amicus the American Medical Association ("AMA"), is a private, voluntary, nonprofit organization of physicians and medical students. It is the largest such organization in the United States. The AMA was founded in 1847 to promote the science and art of medicine and the improvement of public health. Today, its members practice in all fields of medical specialization and in all states. The AMA files this amici curiae brief as a member of the Litigation Center of the American Medical Association and the State Medical Societies ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. Fifty state medical societies and the Medical Society of the District of Columbia join the AMA as members of the Litigation Center.

Amicus the California Medical Association ("CMA") is a non-profit, incorporated professional association of more than 30,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purposes are "to promote the science and art of medicine, the care and well-

being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

Both the AMA and the CMA are committed to safeguarding the ability of physicians to treat their patients, free of arbitrary disruptions. Amici are familiar with the issues presented in this case and their effect on patient medical care, and believe that this brief is necessary because it explains how California's carefully crafted health care system, the law, and policymakers recognize that it is the hospital's medical staff, or "peer review body,"[1] that is the only body with the medical expertise and daily experience with the factors unique to a particular hospital necessary to conduct the peer review activities integral to effective quality assurance and the health and welfare of the public. Amici will discuss the proper role of the hearing officer in peer review cases, as accorded by California law, and why the termination of a peer review hearing by such an officer is tantamount to allowing a lay individual to *render a final determination on the merits* thereby:

- making the clinical judgment as to what clinical evidence was necessary to determine the physician's medical competency;
- in effect, making the medical determination that the physician is medically incompetent to practice at the hospital; and thus
- depriving the physician of a fair hearing before his medical peers.

[1] *See* Business & Professions Code §805(a)(1).

As is discussed in amici's brief, a termination of a peer review hearing in this fashion is wholly unfair, contrary to California law, and almost invariably devastating to the physician's professional livelihood.

The brief explains that granting hearing officers the powers Respondents seek violates and runs counter to a myriad of California laws protecting the rights of physicians, and physicians alone, to be responsible for medical decision-making. *See, for example,* Business & Professions Code §2400 (California's corporate practice of medicine bar ensuring that lay entities not directly or indirectly practice medicine). These laws recognize the practical fact that lay individuals do not have the expertise to second guess a physician's professional judgment. For that reason, the law demands that medical staffs be self-governing with respect to the professional work performed in the hospital. *See, for example,* Business & Professions Code §2282 and other authorities cited in the brief.

Finally, the brief discusses the implications of an adverse peer review determination. Because a termination of a peer review hearing constitutes a final determination on the merits regarding a denial of clinical privileges for a medical disciplinary cause or reason, it may not be made by a hearing officer consistent with the corporate practice of medicine bar, or the laws requiring medical staff self-governance. For that reason, only a peer review hearing

committee made up of licentiates can properly make the clinical determinations warranting such consequences to the reviewed physician.

Wherefore, the AMA and the CMA respectfully request that leave be granted to file the enclosed brief in support of Petitioner/Appellant Gil N. Mileikowsky, M.D.

Dated: August 25, 2008

Respectfully submitted,

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I. INTRODUCTION

It is both the law and policy of the State of California that peer review be performed by appropriately licensed health care professionals, i.e., "licentiates" as stated in the law. *See* Business & Professions Code §809.05. Hearing officers are not licentiates. As this Court recently stated:

> Peer review is the process by which a committee *comprised of licensed medical personnel* at a hospital "evaluate[s] physicians applying for staff privileges, establish[es] standards and procedures for patient care, assess[es] the performance of physicians currently on staff," and reviews other matters critical to a hospital's functioning.

See Kibler v. Northern Inyo County Local Hospital District (2006) 39 Cal.4th 192, 46 Cal.Rptr.3d 41, quoting *Arnett v. Dal Cielo* (1996) 14 Cal.4th 4, 10, 56 Cal.Rptr.2d 706 (italics added).

California's carefully crafted health care system, the law, and policymakers recognize that it is the hospital's medical staff, or "peer review body,"[2] that is the only body with the medical expertise and daily experience with the factors unique to a particular hospital necessary to conduct the peer review activities integral to effective quality assurance and the health and welfare of the public.

Respondents seek a profound change in this aspect of the state's quality assurance structure, the only structure that makes sense from both a clinical and legal perspective. If Respondents were to have it their way, "hearing officers,"

[2] *See* Business & Professions Code §805(a)(1) .

usually attorneys, but always individuals who are not members of the peer review body, could exercise the overarching power to declare finality to peer review hearings, deeming the physician under review to have committed every medical disciplinary charge that served as basis of the proceeding. Thus, Respondents argue that a hearing officer should be empowered to terminate a peer review hearing and *render a final determination on the merits* and thereby:

- making the clinical judgment as to what clinical evidence was necessary to determine the physician's medical competency;
- in effect, making the medical determination that the physician is medically incompetent to practice at the hospital; and
- depriving the physician of a fair hearing before his medical peers.

As is discussed below, a termination of a peer review hearing in this fashion is wholly unfair, and almost invariably devastating to the physician's professional livelihood.

In this case, not only was the lay hearing officer's termination of the hearing itself effectively a "medical decision,"[3] but so was the reason purportedly underlying that termination. Dr. Mileikowsky was appealing the

[3] *Lee v. Blue Shield of California* (2007) 154 Cal.App.4th 1369, 1377, 65 Cal.Rptr.3d 612, 617, stating "Terminating Lee's provider status for failing to cooperate in discovery is equivalent to terminating him for medical incompetency because the *effect* of the termination sanction is to let stand the plan's proposed termination or suspension based on alleged medical incompetency which was the cause of the request for a hearing in the first place."

West Hills medical executive committee's[4] (MEC) decision to deny his application for reappointment to the West Hills medical staff so that this initial denial, which not only had the effect of precluding him from practicing at West Hills Hospital Medical Center, but potentially anywhere else, could be reviewed by a Judicial Review Committee (JRC), or peer review hearing committee, of his peers. As part of that hearing, the attorney for the medical staff requested that Dr. Mileikowsky furnish documents relating to a proceeding involving him at the Cedars-Sinai Medical Center. He declined to do so, according to the lower court's opinion, on the basis that Cedars-Sinai's attorney had instructed him not to, but Dr. Mileikowsky did sign releases authorizing Cedars-Sinai to furnish the requested information.

The proceedings concerning Dr. Mileikowsky at Cedars-Sinai did not appear to be a basis for the MEC's decision to deny him reappointment to the medical staff and staff privileges. The sought-after information was only one of many pieces of clinical evidence that might be relevant in determining the physician's qualifications to practice at the hospital. It was already a matter of record, known to everyone involved in the peer review process, that Dr.

[4] The medical executive committee, or MEC, is the governing committee of the hospital's medical staff. All charges of substandard care or unprofessional conduct, and denials or restrictions of membership and privileges originate from, and in hearings are prosecuted by, the MEC. *See* 22 C.C.R. §70703 (d) requiring this committee as the governing and oversight committee of the medical staff.

Mileikowsky had lost his privileges at Cedars-Sinai. At most, that particular information might have some slight bearing on whether the Cedars-Sinai action should be given weight as a predictor of behavior at West Hills. *See Smith v. Selma Community Hospital* (2008) 164 Cal.App.4th 1478, 1519, 80 Cal.Rptr.3d 745. Unable to obtain the information for whatever reasons, the hearing officer in this case made the medical judgment that Dr. Mileikowsky's failure to produce the Cedars-Sinai documents should result in the denial of clinical privileges and membership on the medical staff, immortalizing as true and correct West Hills' *medical* disciplinary charges against him.[5]

The law does not provide hearing officers with such powers. They are not acting as medical professionals engaged in peer review, e.g., by analyzing the veracity of charges found against the physician in another hospital and determining the predictive value of such findings for their own medical staff. Rather, the role of hearing officers simply (but importantly) is to preside over

[5] Indeed, because of the different clinical standards of performance required by different hospitals, and because of the plethora of clinical information that peer review bodies need to consider when admitting or reappointing applicants to a medical staff, findings from other hospitals should not always be considered conclusive when considering whether to terminate a physician's staff privileges. *See Bonner v. Sisters of Providence Corporation* (1987) 194 Cal.App.3d 437, 239 Cal.Rptr. 530 (medical staffs may establish more stringent standards than followed in other institutions), *see also Smith v. Selma Community Hospital, supra at 1481* ("in the circumstances of this case [as determined by the physicians on the JRC], the results of peer review proceedings at the other hospitals were not enough" to serve as *the sole basis to terminate the physician's privileges and staff membership*)

peer review cases to ensure they proceed in an orderly fashion. Indeed, by statute, a hearing officer cannot act as a prosecuting officer, advocate, or be entitled to vote. (Business & Professions Code §809.2(b).) Further, it is up to the medical staff, not a hearing officer or any lay entity or person, to establish the quality controls to practice at the hospital and be satisfied that a physician can competently practice there. *See, for example,* Business & Professions Code §2453(f); *see also* Business & Professions Code §2282.5 (medical staff bylaws must establish criteria and standards for medical staff membership, privileges, and clinical standards and enforcement thereof).

Naturally enough, the hearing officer here focused solely on his mission of facilitating procedural regularity. It was not his role—and indeed, he was not qualified—to weigh the interest in such regularity against the medical and personal consequences of the termination order. Only the JRC had that role and those qualifications.

Granting hearing officers, and not the members of the JRC, the powers Respondents seek violates and runs counter to a myriad of California laws protecting the rights of physicians, and physicians alone, to be responsible for medical decision-making. *See*, *for example*, Business & Professions Code §2400 (California's corporate practice of medicine bar ensuring that lay entities not directly or indirectly practice medicine). These laws recognize the practical fact that lay individuals do not have the expertise to second guess a physician's,

or in this case, the JRC physicians', professional judgment. For that reason, the law demands that medical staffs be self-governing with respect to the professional work performed in the hospital. *See, for example,* Business & Professions Code §2282 and other authorities cited below.

As a self-governing medical staff, it is the medical staff through the impartial JRC, subject to limited governing body oversight,[6] that evaluates a physician's medical competency in peer review hearings, and makes the fundamental decision as to whether a physician's skills meet the standard of care at that hospital. Allowing hearing officers to thwart the medical staff's rightful power, vested with the JRC, to make these medical determinations by terminating the hearing on grounds of a "discovery abuse" or any other reason, while nonetheless resulting in deeming medical disciplinary charges to be true and applicable to the physician, inappropriately infringes upon the medical staff's legal role and responsibility to oversee and maintain appropriate standards of care.

[6] Governing bodies have an oversight role over the peer review process. However, their powers are limited. *See Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156 (hospital does not assure the quality of medical staff members on its own accord, but rather oversees the medical staff in its quality assurance activities). For example, state law requires the medical staff to include provisions for the performance of peer review consistent with Business & Professions Code §§809 *et seq*. in the medical staff bylaws. The governing body must subsequently approve such provisions, and not withhold approval unreasonably. (Business & Professions Code §809(a)(8).)

The training and expertise of a physician are assets of the community served by the physician. *See Smith v. Selma Community Hospital*, *supra at 1496-1497*, and expert testimony cited by that court therein. In keeping with current California law, the decision whether those assets should be made unavailable to the community should be in the sole discretion of the JRC after hearing all the evidence, and not the hearing officer.

Under these circumstances, amici curiae respectfully urges this Court to affirm the Court of Appeal's decision.

II. BECAUSE A TERMINATION OF A PEER REVIEW HEARING CONSTITUTES A FINAL DETERMINATION ON THE MERITS REGARDING A DENIAL OF CLINICAL PRIVILEGES FOR A MEDICAL DISCIPLINARY CAUSE OR REASON, IT MAY NOT BE MADE BY A HEARING OFFICER CONSISTENT WITH THE CORPORATE PRACTICE OF MEDICINE BAR, OR THE LAWS REQUIRING MEDICAL STAFF SELF-GOVERNANCE

The licensed professionals on the medical staff are vested with the duty to perform peer review because they have special expertise in the medical matters involved in such review. California law has accounted for significant deference to the expertise and training of a physician's peers in a number of ways. Laypersons are not adequately trained or equipped to make medical decisions nor do they understand the quality of care implications of those decisions.

For that reason, California's statutory and common law also contains strong prohibitions against permitting laypersons to practice medicine or

otherwise exercise control, directly or indirectly, over a physician's informed professional judgment. For example, California law prohibits the corporate practice of medicine. (Business & Professions Code §2400.) The proscription against the corporate practice of medicine provides a fundamental protection against the potential that the provision of medical care and treatment will be subject to commercial exploitation. The corporate practice bar ensures that those who make decisions which affect, generally or indirectly, the provisions of medical services (1) understand the quality of care implications of those decisions; (2) have a professional ethical obligation to place the patient's interest foremost; and (3) are subject to the full panoply of the enforcement powers of the Medical Board of California, the state agency charged with the administration of the Medical Practice Act.

The strength of California's policy against permitting laypersons to practice medicine or to exercise control, directly or indirectly, over medical practice cannot be questioned. *See, for example*, Business & Professions Code §§2052, 2400, 2408, 2409, 2410.[7]

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[7] *See also* Corporations Code §13400; *Parker v. Board of Dental Examiners* (1932) 216 Cal. 285, rehg. den. September 28, 1932 (lay persons may not serve as directors of professional corporations); *Pacific Employers Ins. Co. v. Carpenter* (1935) 10 Cal.App.2d 592, 594-596 (holding that for-profit corporation may not engage in business of providing medical services and stating that "professions are not open to commercial exploitation as it is said to be against public policy to permit a 'middle-man' to intervene for a profit in establishing a professional relationship between members of said professions and the members of the public"); *Benjamin Franklin Life Assurance Co. v.*

The important public policy considerations underpinning the corporate practice bar have been expressly incorporated into the statutes governing the practice of medicine in hospitals. Indeed, both the Legislature and the Department of Public Health specifically require the medical staff of the

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Mitchell (1936) 14 Cal.App.2d 654, 657 (same); *People v. Pacific Health Corp.* (1938) 12 Cal.2d 156, 158-159 (same); *Complete Service Bureau v. San Diego Medical Society* (1954) 43 Cal.2d 201, 211 (non-profit corporations may secure low-cost medical services for their members only if they do not interfere with the medical practice of the associated physician); *California Physicians Service v. Garrison* (1946) 28 Cal.2d 790 (same); *Blank v. Palo Alto-Stanford Hospital Center* (1965) 234 Cal.App.2d 377, 390, 44 Cal.Rptr. 572 (non-profit hospital may employ radiologists only if the hospital does not interfere with the radiologists' practice of medicine); *Letsch v. Northern San Diego County Hospital District* (1966) 246 Cal.App.2d 673, 677, 55 Cal.Rptr. 118 (district hospital may contract with radiologists under restriction imposed in *Blank* above); *California Association of Dispensing Opticians v. Pearle Vision Center, Inc* (1983) 143 Cal.App.3d 419, 427, 191 Cal.Rptr. 762, 767 (Pearle Vision Center, Inc.'s franchise program violates California's prohibition against the corporate practice of medicine); *Conrad v. Medical Board* (1996) 48 Cal.App.4th 1038, 55 Cal.Rptr.2d 901 (hospital district may not employ physicians); *Steinsmith v. Medical Board* (2000) 85 Cal.App.4th 458, 102 Cal.Rptr.2d 115 (physician who worked for clinic not owned by licensed physicians as an independent contractor aided the unlicensed practice of medicine); *People ex rel. Monterey Mushroom, Inc. v. Thompson* (2006) 136 Cal.App.4th 24, 38 Cal.Rptr.3d 677 (insurance fraud conviction affirmed for false claims submitted by sham medical corporation); 55 Ops.Cal.Atty.Gen. 103 (1972) (hospital may not control the practice of medicine); 57 Ops.Cal.Atty.Gen. 231, 234 (1974) (only professional corporations are authorized to practice medicine); 63 Ops.Cal.Atty.Gen. 729, 732 (1980) (for-profit corporation may not engage in the practice of medicine directly nor may it hire physicians to perform professional services); 65 Ops.Cal.Atty.Gen. 223 (1982) (general business corporation may not lawfully engage licensed physicians to treat employees even though physicians act as independent contractors and not as employees); 83 Ops.Cal.Atty.Gen. 170 (2000) (management services organization may not select, schedule, secure, or pay for radiology diagnostic services).

hospital to be "self-governing" with respect to the professional work performed in the hospital.[8] *See, e.g.*, Business & Professions Code §2282 (it is unprofessional conduct to practice in hospital with more than five physicians if rules do not require a medical staff that is self-governing with respect to the professional work performed in the hospital); Business & Professions Code §2453 (requiring physicians to assure medical staff self-governance); 22 C.C.R. §70701 (a)(1)(F) (governing board must provide for self-governance of the medical staff with respect to the professional work performed in the hospital); 22 C.C.R. §70703 (each hospital shall have an organized medical staff

[8]The corporate practice bar mandates not only medical staff self-governance in the hospital, but also physician control over the medical services provided. Because physicians bear the ultimate responsibility for ensuring that patients receive proper care, and because lay individuals have neither the expertise nor experience to render decisions regarding the provision of medical care, the Department of Public Health has set up an elaborate system designed to ensure that physicians on the medical staff are responsible for the variety of patient care "services" provided in the hospital. For example, the law demands that only a physician can be responsible for the "medical service," which consists of "those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff." (22 C.C.R. §§70201, 70205.) Similarly, physicians are responsible for other "services" provided by the hospital. *See* 22 C.C.R. §70225 (surgical service), 70235 (anesthesia service), 70245 (clinical laboratory service), 70255 (radiological service), 70405 (acute respiratory care service), 70415 (basic emergency medical service), 70425 (burn service), 70435 (cardiovascular surgery service), 70445 (chronic dialysis service), 70455 (comprehensive emergency medical service), 70465 (coronary care service), 70485 (intensive care newborn nursery service), 70495 (intensive care service), 70509 (nuclear medicine service), 70539 (pediatric service), 70549 (perinatal unit service), 70589 (radiation therapy service), 70599 (rehabilitation center service), 70609 (renal transplant center), 70619 (respiratory care service).

responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital); 22 C.C.R. §§71501, 71503 (same for acute psychiatric hospitals); 22 C.C.R. §97530.1 (in post-surgical recovery care facility, governing board must provide for self-governing medical staff); Health & Safety Code §32128 (district hospital rules must provide for medical staff self-government).) *See also Anton v. San Antonio Community Hosp.* (1977) 19 Cal.3d 802, 809 (noting medical staff is self-governing unincorporated association).)

Permitting a hearing officer to terminate a peer review hearing violates the letter and spirit of these laws designed to ensure that medical decisions are made by medical professionals. Any doubt about this conclusion is removed by a consideration of S.B. 1325 (Ch. 6.99, Stats 2004), the Legislature's reiteration of and amplification to the self-governance mandate.[9] This legislation succinctly clarifies not only the minimum rights of the self-governing medical staff, but also provides a clear synthesis of the rule that has imbued quality-related medical statutes for many years. It provides, among other things, that a medical staff's right of self-governance includes, but is not limited to:

[9] The Legislature, when it was considering S.B. 1325, understood that the purpose of the self-governance doctrine is to "insulate medical decision-making from influence by hospital administrative staff who are primarily concerned with the administrative needs of the hospital, and its profitability." *See* Senate, Third Reading, Bill Analysis, a true and correct copy of which can be found at www.leg.info.ca.gov.

> Establishing, in medical staff bylaws, rules or regulations, criteria and standards, . . .for medical staff membership and privileges, and *enforcing those criteria and standards*. (Business & Professions Code §2282.5.) [Emphasis added.]

The Legislature, therefore, left no doubt that the determinations concerning the standards themselves, as well as which practitioners meet them, fall within the province of the medical staff.

III. ONLY THE MEDICAL STAFF, AND IN THIS CASE THE JRC ACTING ON BEHALF OF THE MEDICAL STAFF, IS QUALIFIED TO DETERMINE WHETHER A PHYSICIAN WILL BE GRANTED CLINICAL PRIVILEGES, AND THUS WHETHER THE PHYSICIAN IS COMPETENT TO PROVIDE THE NECESSARY CARE AT THE HOSPITAL.

Medical staffs engage in quality assurance activities on a constant basis to assure that care meets required standards, and to assure patient safety. These activities involve a huge variety of different tasks that could be considered subsumed under two major headings: "credentialing" (the process of reviewing the initial and ongoing competence of every physician and other health care practitioner who practices independently in the hospital) and patient care review (the review of the ongoing quality of care provided throughout the hospital) (hereinafter referred to collectively as the "quality review system"). This system recognizes that patient welfare depends on the ongoing review, evaluation and monitoring of the quality of patient care and treatment rendered in each of California's hospitals. It further recognizes that each hospital's

medical staff is the only body with the necessary medical expertise and experience to properly conduct these credentialing and patient review functions.

The many processes involved in implementing a quality assurance system are essential to preserving high standards of medical practice within the hospital. *See* Business & Professions Code §809(a)(3) (stating "peer review, fairly conducted, is essential to preserving the highest standards of medical practice"). Health care services must be regularly monitored and evaluated in order to resolve problems and to identify opportunities to improve patient care. Protocols and procedures must be continuously analyzed and revised to reflect new information and technologies. The clinical performance of physicians and other health care providers must be repeatedly assessed so that appropriate educational information and training may be provided, and impaired or incompetent individuals may be identified *before* patients may be seriously injured. *See generally Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156.

Both the courts and the Legislature have concluded that, to be effective, this monitoring function must be performed by individuals who have both the expertise necessary to conduct these quality-assurance activities, and the ability to implement indicated changes. *See* Business & Professions Code §809.05 and authorities cited below. As was recognized by the court in *People v. Memorial Medical Center of Los Angeles* (1991) 234 Cal.App.3d 363, 286 Cal.Rptr. 478:

> The maintenance of high medical standards depends on the effectiveness of the oversight of such [medical staff] committees, and thus on the accuracy of the information which the committees can obtain concerning the operations of the facility with which they are affiliated. *Moreover, it is crucial that the committees be made up of health care professionals of the highest possible qualifications*. (*Id.* at 373.) [Emphasis added.]

An effective peer review system provides the optimal solution. Medical staffs have both the expertise and familiarity with the health care facility and the physicians and other health care providers involved to conduct effective peer review.

Peer review is conducted through mostly the volunteer efforts of dedicated professionals. While the activity is unpaid and can present challenges for busy professionals, it nonetheless remains the law that it be performed by "peers" (Business & Professions Code §809.05), not hearing officers or other lay entities. Respondents' suggestions that having hearing officers play an enlarged role in a hearing could relieve these physicians of some of the work of a peer review hearing amounts, in this case, to a suggestion for the JRC panel members to abrogate their lawful duty to carry out peer review. Certainly, compensating medical staffs for their peer review activities would go a long way in relieving the "burdens" Respondents' claim are of concern. The Legislature, however, has spoken on this issue, and Respondents' remedy, resulting in a wholesale abrogation of a duty under the state's required health care quality assurance system, is one for the Legislature, not this Court.

The law demands that the medical staff, not a lay entity, establish the medical criteria that must be met to be granted medical staff membership and privileges. *See* Business & Professions Code §2282.5 (the medical staff's right to self-governance includes the right to establish, in medical staff bylaws, standards and criteria for medical staff membership). *See also* The Joint Commission,[10] Hospital Accreditation Standard (HAS) MS.1.20) (medical staff bylaws must include the definition of the criteria and qualifications for appointment to the medical staff). By law, the medical staff must develop, adopt and enforce "formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeal mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate." 22 C.C.R. §70703(b).)

Significantly, when it comes to setting the standard of practice that a physician must meet in order to obtain clinical privileges, medical staffs have great leeway, and indeed, the courts have recognized that medical staffs may establish more stringent standards than those followed in other institutions. *See*

[10] The Joint Commission accredits hospitals in a host of areas, all related to assuring quality of care and patient safety. Its mission is "to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations." (The Joint Commission, "Comprehensive Accreditation Manual for Hospitals: The Official Handbook," January 2008.)

Bonner v. Sisters of Providence Corporation (1987) 194 Cal.App.3d 437, 239 Cal.Rptr. 530. As that court stated:

> Clinical privileges are hospital-specific. So long as there is a rational basis for the medical staff's requirements for clinical privileges, a hospital may make its requirements as stringent as it deems reasonably necessary to assure adequate patient care. (*Id*. at 446.)

Further, it is up to the medical staff to determine whether these standards have been met. The law requires that the **medical staff** establish controls that are:

> [D]esigned to ensure the achievement and maintenance of high standards of professional and ethical practices including a provision that all members of the medical staff be required to demonstrate their ability to perform surgical and other procedures competently and *to the satisfaction of an appropriate committee or committees of the staff*, at the time of original application for appointment to the staff and at least every two years thereafter. (22 C.C.R. §70701(a)(7), *see also* Business & Professions Code §2453.) [Emphasis added.]

Under these circumstances, the determination to grant clinical privileges to a particular physician is neither rote nor a mechanical determination. Based upon the standard of practice demanded by the medical staff, the awarding of "clinical privileges" requires consideration of a host of medically-based factors, such as license, stature, education, training, experience, current competence and ability to perform the required privilege. *See* The Joint Commission, HAS, MS.4.20 (2008). *See also* CMA Model Medical Staff Bylaws, Section 4.5, requiring that the application form used for the physician seeking medical staff membership include, but not be limited to, such things as peer references

familiar with the applicant's professional competence, past or pending professional disciplinary actions, and the applicant's qualifications.

But again, credentialing determinations must be made by peers and "to the satisfaction of an appropriate committee for committees of the [medical] staff." (22 C.C.R. §70701.) Lay entities are simply "ill-equipped" to assess the judgment of qualified physicians on matters requiring study and extensive training in medical specialties. *See, for example, Unterthiner v. Desert Hospital District* (1983) 33 Cal.3d 285, 188 Cal.Rptr.590.[11]

If properly implemented, the peer review process ensures only qualified physicians will obtain and maintain medical staff membership and appropriate clinical privileges in a hospital that serves the community where their patients reside. Further, it will "aid the appropriate state licensing boards in their responsibility to regulate and discipline errant health arts practitioners." Business & Professions Code §809(a)(5). Thus, from the patient's perspective,

[11] Similarly, the question of whether a physician breached the appropriate standard of care is generally resolved by other expert physicians, because neither the courts nor lay persons "possesses the specialized knowledge necessary to resolve the issue as a matter of law." (*Landeros v. Flood* (1976) 17 Cal. 3d 399, 410, 131 Cal.Rptr. 69; *see also Barton v. Owen* (1977) 71 Cal.App. 3d 484, 495; 139 Cal.Rptr. 494 [stating "when the alleged negligence concerns involved matters of treatment and diagnosis, expert witnesses must state their opinion on the matter because only experts would ordinarily know the applicable standards of skill, knowledge and care prevailing in the medical community"].)

properly conducted peer review ensures that medical care will be both available and competent.

IV. DENYING AN APPLICANT CLINICAL PRIVILEGES FOR REASONS OF MEDICAL INCOMPETENCY HAS DEVASTATING CONSEQUENCES. ONLY A PEER REVIEW HEARING COMMITTEE MADE UP OF LICENTIATES CAN PROPERLY MAKE THE CLINICAL DETERMINATIONS WARRANTING SUCH CONSEQUENCES TO THE REVIEWED PHYSICIAN

Just as peer review is necessary to ensure quality patient care, it is critical that the process be accomplished lawfully and fairly. The goals of peer review will be defeated, not promoted, if qualified physicians are wrongfully excluded from medical staffs. Such an exclusion of a competent physician does nothing to promote quality care. To the contrary, an improper exclusion limits access by patients to competent medical care from physicians they have often come to trust and rely upon,[12] and by other physicians to competent consultation, coverage and other assistance. *See* Business & Professions Code §809(a)(4) (stating "Peer review which is not fairly conducted results in harm to both patients and healing arts practitioners by limiting access to care").

[12] In this regard, it should be noted that improperly excluding physicians from California's workforce is not something that this state can afford. Physician supply trends indicate a serious shortage will soon occur, if it has not already. While over 27 percent of California's physicians are over the age of 60, only 18 percent are under the age of 40. *See Physician Supply and Demand: Projections to 2020,* U.S. Department of Health & Human Services (October 2006).

At least as to a physician whose clinical privileges are denied, but who does not have the opportunity to have that decision fully considered by the peer review body, the result can be disastrously unfair. A mark on a physician's record that he or she was denied clinical privileges due to a medical disciplinary cause or reason lasts on a physician's record his/her entire life and can ultimately have the practical effect of precluding the physician from practicing medicine at all.

California law requires, among other things, certain persons associated with "peer review bodies" to file with the Medical Board of California an "805" report whenever a physician's application for medical staff privileges or membership is denied for a medical disciplinary cause or reason. (Business & Professions Code §805(b)(1).) An 805 report does not lie idly in the Medical Board's data base. A copy of the 805 report will be forwarded by the Medical Board to any licensed health care facility, health care service plan or medical care foundation, group of more than 25 physicians, or medical staff of a health care facility in California that requests such information. These entities are *required by law* to "query" the Medical Board to obtain a copy of the 805 report before granting membership or clinical privileges to a physician. (Business & Professions Code §805.5(a).) The public safety implications of this "query" requirement are important enough to make it a misdemeanor when an entity fails to make the 805 query. (Business & Professions Code §805.5(c).)

The impact of this report becomes clearer in light of what the Medical Board is required to do upon receipt of the report. The Medical Board is required to investigate each 805 report within 30 days of its receipt to determine if action of its own is required. It must determine whether it should obtain either an interim suspension order or temporary restraining order to effectively "summarily suspend" the license of the physician. (Business & Professions Code §2220(a).) Whether it obtains such an order or not, it must then determine if the matter investigated warrants further prosecutorial action. (*Id*.)

Thus, once an 805 report has been sent to the Medical Board, a state investigation must ensue. If the Board finds that the facts underlying the report do not warrant action, then the Board is required to stop sharing the report when responding to mandated inquiries under Section §805.5(a). (Business & Professions Code §805.5(b).) Because Medical Board investigations can take many months or even years, even if the Board ultimately determines no action is required, the 805 report is forwarded to queriers for that lengthy period of time, up to a maximum of three years. (Section 805(i), Section 805.5(b).)

Further, federal law imposes a reporting requirement similar to California's reporting requirement under Section 805. Each hospital must submit to the National Practitioner Data Bank (NPDB) a report of any adverse action it takes that affects the clinical privileges of a physician for a period

longer than 30 days. (42 U.S.C. §11133(a)(1)(A).) A denial of clinical privileges for medical reasons is thus an "adverse action" that must be reported.

Hospitals are required to request information from the NPDB on a physician any time the physician applies for a position on its medical staff (courtesy or otherwise), or for clinical privileges at the hospital, and every 2 years thereafter. (42 U.S.C. §11135(a), 45 C.F.R. §60.10(a)(1), (a)(2).) Further, many other entities, such as federal and state licensure and other government agencies, and other health care entities may query the NPDB. (*Id.*)

Under these circumstances, it is absolutely essential that any decision denying clinical privileges be made only following all the relevant safeguards and protections contained in state law that ensures that such medical decisions are made by medical professionals, following a fair hearing where requested. A ruling that permits the hearing officer to terminate a peer review hearing, effectively turning medical disciplinary allegations into administrative and legal findings of fact without the benefit of JRC evaluation, simply throws those critical safeguards and protections out the window.

V. CONCLUSION

California law protects against the real danger that lay entities may interfere with medical decision-making as well as encroach upon medical staff self-governance. Allowing a hearing officer to make the necessary medical determinations, such as whether to and the circumstances under which a peer

review proceeding can be terminated, violates every tenet of California law to protect patients. For the foregoing reasons, we respectfully urge this Court to affirm the lower court's decision.

DATED: August 25, 2008

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

Counsel for amici curiae hereby certifies that pursuant to Rule 8.204(c)(1) or 8.360(b)(1) of the California Rules of Court, the brief of amici curiae American Medical Association and the California Medical Association is produced using 13-point Roman Type including footnotes and contains approximately 4,096 words as counted by the Microsoft Word 2007 word-processing program used to generate the brief.

Date: August 25, 2008

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