

S156986

**In the
Supreme Court of California**

=====
GIL N. MILEIKOWSKY, M.D.,
Plaintiff and Appellant

vs.

WEST HILLS HOSPITAL MEDICAL CENTER ET AL.,
Defendants and Respondents.

=====
AFTER A DECISION BY THE COURT OF APPEAL
SECOND APPELLATE DISTRICT, DIVISION EIGHT
CASE NO. B186238
=====

**BRIEF OF AMICI CURIAE IN SUPPORT OF
PLAINTIFF/APPELLANT**

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Association of American Physicians & Surgeons
Consumer Attorneys of California
The E-Accountability Foundation
Government Accountability Project
Health Administration Responsibility Project, Inc.
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ARGUMENT

I. To Give “Implied” or “Inherent” Power to Hearing Officers to Terminate a Medical Physician’s Peer Review Hearing Without a Decision by the Medical Staff Undermines the Legislature’s Intent and the Strong and Historic Public Policy Relying on the Independent Judgment of Physicians to Oversee the Quality of Hospital Medical Care.

Few issues are of greater importance to the People of California than maintaining and improving the quality of medical care for themselves and their families. This Court’s resolution of the question presented in this case will affect the people of this State far beyond the interests of the parties.

The parties do not dispute that Dr. Mileikowsky was entitled to a hearing before the medical staff on his application for renewal of privileges at West Hills Hospital Medical Center, where he had been a member in good standing since 1986. *See* Opening Brief on the Merits [“OBOM”] at 12.

But Dr. Mileikowsky was denied that hearing. First, his clinical privileges were summarily suspended by the hospital with no finding that he posed an imminent threat to any patient – the only statutory basis for such a suspension. Bus. & Prof. Code § 809.5. Then the proceeding on his application for reappointment was terminated by the hearing officer before any hearing had begun on the ground that Dr. Mileikowsky “refused to comply with the hearing officer’s

orders to produce documents detailing another hospital's summary suspension and termination of Dr. Mileikowsky's staff privileges." OBOM at 2.

The Issue Presented, as the hospital frames it, is whether the hearing officer exceeded his authority by terminating the peer review proceeding. *See* OBOM at 1. Amici concur, but suggest that a broader question is before this Court: Whether the quality of hospital medical care shall remain entrusted to physicians, or whether it shall be turned over to hospital owners and administrators.

Amici agree with Dr. Mileikowsky that the hearing officer exceeded his authority in this case and that a writ of administrative mandamus should issue. West Hills admits that it can point to no statutory provision authorizing the hearing officer to terminate a medical peer review hearing as a discovery sanction. OBOM at 41-42. Nevertheless, Petitioners ask this Court to recognize an "implied" or "inherent" authority to do precisely that. OBOM at 37-44.

Amici contend that to bestow such unwritten powers upon the hearing officer selected and paid by the hospital violates the guarantee of fair procedure that is the foundation for § 809 peer review hearings. More broadly, and more importantly for patient care, such unwritten authority would undermine the legislature's policy that supervision of the quality of care rendered by hospital physicians is the responsibility of an independent medical staff.

A. Peer Review by Independent Medical Staff Has Proven the Most Effective Way to Maintain and Improve the Quality of Hospital Medical Care.

Most Americans receive their medical care at the hospital. So it is a matter of utmost concern that an estimated 98,000 hospital patients in the United States are killed each year by negligence. Institute of Medicine of the National Academies, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM*, Division of Health Care Services 1 (Linda T. Kohn et al. eds., 1999).

Congress has declared: “The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems.” 42 U.S.C. § 11101 (1). That problem, Congress stated, “can be remedied through effective professional peer review.” 42 U.S.C. § 11101 (3).¹

The relationship between doctors and hospitals in America has developed over the course of more than two centuries. A key lesson learned during that history is that the maintenance and improvement of the quality of hospital medical care should not be left in the hands of the owners or administrators of hospitals, whose loyalties are necessarily claimed by the institution and its economic health. Instead, the supervision of medical care delivered to hospital patients has been entrusted to the hospital’s medical staff through its conduct of peer review, acting

¹ Peer review is defined as: “a process by which members of a hospital’s medical staff review the qualifications, medical outcomes and professional conduct of other physician members and medical staff applicants to determine whether the reviewed physicians may practice in the hospital and, if so, to determine the parameters of their practice.” Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit--Is it Time for a Change?* 25 Am. J.L. & Med. 7, 7 (1999).

independently of the hospital's economic interests and in favor of the welfare of patients.

“The extensive, indeed almost exclusive, reliance on large medical institutions which characterizes the current health care delivery system is a quite recent development.” Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. Rev. 835, 846 (1983). From the very beginning of the relationship between doctors and hospitals, the question of who should supervise the quality of hospital medical care has been a matter of concern.

Hospitals in America trace their origins to the charitable almshouses of colonial times. For much of the 19th Century they served as little more than philanthropic endeavors to house the impoverished sick. George Rosen, *The Hospital: Historical Sociology*, in *THE HOSPITAL IN MODERN SOCIETY* 24-25 (Eliot Freidson ed., 1963). Those early American hospitals “bore little resemblance to the modern institution of the same name.” Jost, *supra*, at 846. “Until late in the nineteenth century a hospital was primarily a charitable institution that provided housing, moral nurture, and health care for the worthy poor, usually for free. Middle and upper class patients received medical care, including surgery, in their own homes and seldom entered hospitals. Morris J. Vogel, *The Transformation of the American Hospital 1850-1920* in *HEALTH CARE IN AMERICA* 105-110 (Susan Reverby & David Rosner eds., 1979).

Nineteenth century hospitals allowed any physician to treat patients within their walls. Indeed, they were little more than boarding houses and “refuges mainly for the homeless poor and insane.” Paul Starr, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 147-54 (1949). Doctors conducted most of their work in their own offices or in the homes of their patients. Physicians even performed surgeries in homes, often in the kitchen. Vogel, *supra*, at 105. Barely two percent of doctors had any hospital privileges, “and the infections that periodically swept through hospital wards made physicians cautious about sending patients there.” Starr, *supra*, at 157.

Scientific and technical advances in the late nineteenth and early twentieth centuries, however, especially the development of antisepsis and anesthesia, made hospitals safer and more attractive to the middle class. Jost, *supra*, at 846. “With new technology came increases in hospital costs. In response, hospitals began to charge for care.” *Id.* Hospitals essentially transformed themselves into “doctors’ workshops.” Starr, *supra*, at 146. They came to rely upon the revenue from fees paid by private patients. Craig W. Dallon, *Understanding Judicial Review of Hospitals’ Physician Credentialing and Peer Review Decisions*, 73 *Temple L.Q.* 597, 606-07 (2000). Doctors, in turn, “became increasingly dependent on the diagnostic and therapeutic facilities which only a hospital could provide.” *Id.* at 601.

Thus the focus of concern about the quality of medical care shifted from the doctor’s office to the hospital. Because hospitals were open to patients of “almost

any private physician,” any effort to supervise the quality of care was the responsibility of the hospital board or hired administrators. Dallon, *supra*, at 607. Yet, almost no effort was made to assure the quality of care rendered to hospital patients by private doctors. *Id.* While some hospital boards were committed to patient care, many were committed primarily to profits. *See, e.g.,* Starr, *supra*, at 166-67 (observing that hospitals were inclined to seat on their boards prominent “feeders” who could help fill their beds with paying patients).

Quality-of-care concerns led to the founding of the American College of Surgeons in 1912. Working with a grant from the Carnegie Foundation, the ACS conducted an extensive survey of hospitals, focusing on medical staff organization, complete and accessible medical records; and provision of diagnostic and therapeutic facilities. So few facilities met the ACS requirements that, “[t]o avoid embarrassment to the prominent hospitals that had failed the examination, the list of approved hospitals was burned the night before its scheduled presentation in October 1919.” Jost, *supra*, at 848.

The shocking results of the 1919 survey led the ACS to establish the Hospital Standardization Program (HSP), the precursor of the JCAH. “The HSP standards stressed self-regulation of the medical staff, but left ultimate responsibility for granting staff privileges with the hospital administration and governing board.” *Id.* However, governing boards proved unable to pursue patient care as a top priority. “[M]any hospitals continued to rely on unqualified staff,”

and “most hospitals were open to almost all physicians at least until the late 1930s.” *Id.*, at 849 & 872.

Soon, however, largely due to the ACS initiative, 90% of hospitals had organized medical staffs. Dallon, *supra*, at 602. Significant improvements in patient care did not come by following the industrial model – treating the hospital as a factory and the medical staff as subservient employees. *Id.* at 606 (“Viewing medical staff members as non-employees of the hospital is consistent with the historical development of modern American hospitals”). Instead, “the authority of lay trustees declined as physicians began to exert greater control over the day-to-day services provided their private patients” *Id.* at 607 & n.55. The hospital medical staff came to be defined as “licensed independent practitioners” who are authorized “to provide care and services without direction or supervision,” consistent with individually granted clinical privileges.” Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals: The Official Handbook MS-2 (1999).² Thus, the “assumption that individual medical staff members act independently and therefore without undue interference from the hospital serves as the foundation for the concept of an organized medical staff.” Dallon, *supra*, at 606.

² Hospital (clinical) privileges are defined by the Joint Commission as the “permission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual’s professional license and his experience, competence, ability, and judgment.” Jonathan P. Tomes, MEDICAL STAFF PRIVILEGES AND PEER REVIEW 13 (1994).

Supervising the quality of care rendered by physicians was entrusted not to hospitals, but to the physicians themselves and the professional tradition of peer review. According to the American Medical Association, the “basic concept of peer review is as old as organized medicine itself” and has been practiced by the medical community in America since the colonial period. Gregory S. Gosfield, Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 Temple L.Q. 552, 563 (1979), quoting 1 AMA PEER REVIEW MANUAL at 1 (1972).

The AMA and American College of Surgeons, in an amicus brief in support of a physician whose privileges were summarily suspended, stated the rationale for the universally held policy of placing the responsibility for the oversight of medical practice in the hands of other doctors:

Due to the complex, technical nature of medicine, it is extremely difficult for lay persons to oversee the quality of a physician’s medical practices. As a practical matter, that oversight must be provided by another physician. Accordingly, peer review, a process by which physicians evaluate the quality of work performed by their colleagues, has been developed as a mechanism for determining compliance with appropriate standards of health care.

Brief of Amici Curiae American Medical Assn. and American College of Surgeons, *Crow v. Penrose-St. Francis Healthcare System*, (Colo. 2007) 169 P.3d 158, at 11-12.

Accordingly, state regulation of the medical profession has long recognized that untrained lay persons are unqualified to oversee the professional medical care. Jonathan P. Tomes, *MEDICAL STAFF PRIVILEGES AND PEER REVIEW* 10 (1994). As

the Supreme Court of Minnesota has observed, the wisdom of legislative policy that encourages peer review “is obvious.” *Campbell v. St. Mary’s Hosp.* (Minn. 1977) 252 N.W.2d 581, 587.

The states therefore adopted standards developed by physicians themselves through their professional organizations. The American Medical Association was itself founded in 1847 to set minimum standards for medical practice. Gosfield, *supra*, at 554. In this fashion, self-regulation through peer review came to serve as “the foundation of professionalism in American medicine” and is “essential to the existence of medicine as a profession.” Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 JAMA 958, 958 (1991).

Following World War II, employer-based medical insurance increased the demand for hospital services, while the Hospital Survey and Construction Act of 1946 (the Hill-Burton Act) made generous federal assistance available for hospital construction. Peer review was easily adapted to the hospital environment to provide oversight of quality of care.

In 1951, the Joint Commission for the Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), was formed as a private regulator and required hospitals to perform peer review to qualify for accreditation. “JCAH standards assure, therefore, that accredited hospitals will primarily rely on physicians to be responsible for patient care and to provide governance through the medical staff structure.” Jost, *supra*, at 873. Until very recently, the federal government held out a powerful incentive for hospitals

to meet those standards by deeming a hospital with JCAHO accreditation as automatically qualified to receive federal Medicare reimbursements. 42. U.S.C. § 1395(bb)(a)(1).³

Thus, by mid-century, peer review had “developed into the primary method of evaluating the quality of physician services at a hospital.” Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit - Is it time for a Change?* 25 Am. J.L. & Med. 7, 13 (1999). Loss of effective peer review as the first line of defense for assuring the quality of health care would require greater reliance on aggressive regulation by government and medical malpractice litigation.

Christopher S. Morter, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?* 74 Va. L. Rev. 1115, 1139 (1988); Troyen A. Brennan, *Hospital Peer Review and Clinical Privileges Actions: To Report or Not Report*, 282 JAMA 381, 381 (1999).

This historical overview makes clear the virtually universal view that the quality of physician care in hospitals is best supervised by other doctors, exercising independent medical judgment. It was in this context that federal and state legislatures enacted safeguards to protect the independence of physicians, both peer reviewers and subjects of peer review, from abuse and retaliation.

³ The unique deeming authority of the Joint Commission was repealed by Pub. L. 110-275, Title I, § 125(a), (b)(1), 122 Stat. 2519. (July 15, 2008).

B. The Health Care Quality Improvement Act Enacted a National Policy of Encouraging Good Faith Peer Review to Promote Better Patient Care in Hospitals.

Although peer review has been called “indisputably the greatest guardian of the health and well-being of hospital patients,” Cuneo, *Disclosure v.*

Confidentiality of Hospital Peer Review Committee Records, Med. Trial Tech. Q., 1985 Annual, at 172, peer review with no legal accountability invites abuse. This is particularly true in the hospital setting where the peer review process is generally dominated by the non-medical hospital board, hospital administrators, and hospital attorneys.

The Supreme Court of the United States in *Patrick v. Burget* (1988) 486 U.S. 94, upheld a jury verdict of \$2.2 million in favor of Dr. Timothy Patrick, a general surgeon whose hospital privileges were withdrawn, not in an effort to improve patient care, but in a “shabby, unprincipled, and unprofessional” attempt to get rid of a competitor. *Id* at 98 n.3. The U.S. Supreme Court held that medical staff peer review procedures are not immune under the state action doctrine from antitrust scrutiny. *See id.* at 105.

Doctors’ organizations vigorously lobbied Congress for protection against liability under *Patrick*.⁴ Although peer review had previously been a matter left

⁴ See Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary, 99th Cong., 2d Sess. 27 (1986) (statement of Rep. Edwards) (the “primary impetus for [HCQIA’s] immunity was the substantial damage award, including treble damages, made by an Oregon Federal district court jury in the case of *Patrick v. Astoria Clinic*.”); 132 Cong. Rec. H11-590 (daily ed. Oct. 17,

entirely to the states, Congress enacted the Health Care Quality Improvement Act of 1986 [“HCQIA”] Pub. L. No. 99-660, codified at 42 U.S.C. §§ 11101-11152 (1988), with the express purpose of encouraging good faith peer review. *Id.* at § 11101(5). *See also Austin v. McNamara* (9th Cir. 1992) 979 F.2d 728, 733 (In enacting the HCQIA, Congress intended to provide for effective peer review of the competency of physicians and thereby improve the quality of medical care).

Congress explicitly found that the “increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems” which “can be remedied through effective professional peer review.” 42 U.S.C. § 11101 (1) & (3). Rather than compel doctors to participate in peer review, Congress enacted an incentive in the form of limited immunity from liability for peer review participants engaged in good faith peer review.⁵ 42 U.S.C. §§ 11111(a)(1) provides that persons participating in professional review activities “shall not be liable in damages under any law of the United States or of any State

1986) (statement of Rep. Waxman) (similar). *See also* Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 *J. Contemp. Health L. & Pol’y* 419, 433 (1993) (“Undoubtedly, the jury verdict in *Patrick* was the primary impetus for medical professionals to testify before Congress for legal protection.”).

⁵ Even before HCQIA, nearly all state legislatures “tried to encourage good faith peer review by providing immunity from damages suits for participants, making peer review information privileged against discovery and admission in court, and by requiring participants to keep peer review information confidential.” Susan O. Scheutzow and Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined Than Real*, 7 *J. Law & Health* 169, 169-70 (1992-93).

(or political subdivision thereof)” if those activities meet the standards imposed by § 11112(a) (requiring that the professional hold a reasonable belief that his or her actions are warranted by factual findings, incompetence, or misconduct and are in furtherance of quality health care).⁶

Congress also made clear that it did not intend the limited immunity under the statute to protect hospitals. Instead, Congress stated that “[t]he threat of private money damage liability . . . unreasonably discourages *physicians* from participating in effective professional peer review. 42 U.S.C. § 11101 (4) (emphasis added). Congress therefore saw “an overriding national need to provide incentive and protection for *physicians* engaging in effective professional peer review.” 42 U.S.C. § 11101 (5) (emphasis added). Nothing in the congressional findings nor in the legislative history suggests any legislative intent to confer immunity on the hospital, its governing board or its administrators.⁷

⁶ The HCQIA also requires health care entities to report professional review actions that adversely affect a physician’s clinical privileges for more than 30 days to the National Practitioner Data Bank (NPDB). 42 U.S.C. §§ 11131-11134.

⁷ Although statutory immunity was intended as an incentive for physicians to participate in peer review, it is obviously not essential. Hospitals, which must have a peer review process for licensing and accreditation purposes, could agree to indemnify physicians for liability arising out of their peer review activities. Callahan, *Patrick and the Medical Staff Credentialing Aftermath*, *Antitrust Health Care Chron.*, 10, 10-13 (1988). Indeed, even prior to the statute, physicians were often indemnified against liability. *See Hammack, supra*, at 449 & n.204 (“In California, professional liability insurance coverage maintained by hospitals typically provides indemnity coverage for peer review participants acting in accordance with medical staff bylaws.”).

California lawmakers, however, were determined to provide even greater protections for physicians. The California legislature recognized that the best assurance of quality hospital medical care is not through oversight by administrators, but through good faith peer review by doctors. The legislature enacted Business and Professions Code § 809 *et seq.* to guarantee a peer review process that is substantively and procedurally fair. The decision by the court of appeals in this case, limiting the authority of a peer review hearing officer to those powers specifically enumerated by the legislature in § 809, is faithful to the legislature’s intent to keep the supervision of hospital physicians in the responsible hands of the independent medical staff.

C. Business and Professions Code Section 809 Reflects the Legislature’s Intent Not To Authorize A Hearing Officer to Terminate a Medical Peer Review Proceeding Without a Decision By the Hearing Panel.

In California, every acute care hospital must 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.” Cal. Code Regs., tit. 22, § 70703, subd. (a); *Unnamed Physician v. Board of Trustees of Saint Agnes Medical Center* (2001) 93 Cal.App.4th 607, 616. The medical staff is a separate legal entity from the hospital, generally organized as an unincorporated association. *Medical Staff of Doctors Medical Center in Modesto v. Kamil* (2005) 132 Cal.App.4th 679, 685.

California’s legislature was not satisfied with the peer review protections in HCQIA. Because of “deficiencies in the federal act” and possible adverse judicial

interpretations, the lawmakers found it “preferable for California to ‘opt-out’ of the federal act and design its own peer review system.” § 809(a)(2). In 1989, therefore, the lawmakers enacted California Business and Professions Code section 809 *et seq.* The premise of the statute, the legislature declared, is that “Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.” *Id.* § 809(a)(3). “Peer review that is not conducted fairly,” however, “results in harm both to patients and healing arts practitioners.” *Id.* §809(a)(4).

The statutory scheme imposes on the private sector the duty of conducting fair peer reviews in accordance with the fair procedure rights specified in §§ 809 to 809.8 of the statute. *Shacket v. Osteopathic Medical Board* (1996) 51 Cal.App.4th 223, 231. Significantly, the lawmakers did not seek to expand or strengthen the authority of hospitals in peer review proceedings. Rather, the legislature intended to “provide a more careful articulation of the protections for those undertaking peer review activity and those subject to review.” Bus. & Prof. Code §809(a)(9)(A). In short, the legislature acted to protect doctors, not hospitals.

In designing a peer review system for California, the legislature specified a narrowly circumscribed role for hearing officers. The clearest indicator of legislative intent, of course, is the legislature’s own language, and in this case, the statutory text is quite clear: The legislature intended to vest decision-making authority in the peer review body alone. It did not intend to allow a hearing officer to interfere with that responsibility by terminating the proceeding.

1. The legislature restricted peer review to physicians only.

The statute provides no role for hearing officers in the decision whether privileges shall be granted, restricted or revoked. Instead, legislature declared: “It is the policy of this state that peer review be performed by licentiates.” § 809.05.

West Hills acknowledges that medical staffs in California hospitals are “responsible for ‘the adequacy and quality of the medical care rendered to patients in the hospital,’” and that “[o]ne of the medical staff’s most important duties in this regard is conducting ‘peer review’ . . . of every physician who practices at the hospital.” OBOM at 5. A hearing officer, if one is selected, “shall not be entitled to vote.” § 809.2(b). Yet, West Hills insists that medical staff may only conduct peer review if the hearing officer is willing to allow the hearing to go forward. OBOM at 37-39. The legislature, having denied the hearing officer a vote on whether to grant privileges, surely did not intend the hearing officer to exercise a veto by preventing the panel from making a decision on the matter.

2. The legislature did not invite judicial additions to its comprehensive hearing authorities in Section 809.

As West Hills concedes, the statute makes no provision for hearing officers to impose terminating sanctions for failure to engage in discovery. OBOM at 39-41. Contrary to the hospital’s assumption, the absence of express authority is not proof of implied authority. It is proof of no authority. The legislature did not intend to enact a “skeletal” procedure with gaps to be filled in by the courts, as

West Hills baldly asserts. Reply Br. at 3. Rather, as this Court has made clear, the statute “sets out a comprehensive scheme” of peer review procedures. *Kibler v. Northern Inyo County Local Hosp. Dist.* (2006) 39 Cal.4th 192, 199. *See also Sahlobei v. Providence Healthcare, Inc.* (2003) 112 Cal.App.4th 1137, 1147 (in § 809, “the Legislature set forth a *comprehensive* procedure governing adverse action by a hospital against a staff physician.”) (emphasis added).

The legislature gave no indication that it welcomed courts to revise or rewrite its handiwork. Indeed, it was lawmakers’ fear that physicians’ peer review rights might be undone by “possible adverse interpretations by the courts” that prompted the legislature to opt out of HCQIA in the first place. § 809(a)(2).

3 The legislature did not vest hearing officers with judicial powers, but limited them to an optional role of presiding at hearings.

Much of West Hills’s argument for giving implied powers to hearing officers rests on the hospital’s repeated insistence that a hearing officer is equivalent to a trial judge, *see* OBOM at 38, 42, 44 and 45, or an appellate court, *id.* at 43. Therefore, the hospital reasons, the hearing officer must necessarily be vested with the inherent powers of a judge.⁸

If the legislature had intended the unusual result of conferring judicial powers on an administrative hearing officer, it surely would have so stated. In fact,

⁸ See also OBOM at 46: “Assessing the appropriate response for a party’s misconduct in disobeying lawful discovery and other procedural orders is a *judicial* function.” (emphasis in original).

the statutory text clearly indicates quite the opposite: that the hearing officer is not vested with broad judicial powers.

Section 809 spells out the very limited functions of a hearing officer at such proceedings. Addressing perhaps one of HCQIA's "deficiencies," California's legislature specifically eliminated any statutory authorization for holding a Section 809 hearing before a hearing officer. The federal statute provides that, to meet statute's notice and hearing requirements, the hearing must be held "before an arbitrator who is mutually acceptable to the physician and the health care entity, *or before a hearing officer,*" or before a panel of individuals who are not in direct economic competition with the physician. 42 U.S.C. § 11112(b)(3) (emphasis added). California's statute permits hearings only before an arbitrator or peer review panel, but not a hearing officer. It is the judicial review committee (JRC), composed of physician licentiates – not an attorney selected and paid by the hospital – that is equivalent to a civil judge. The role of the hearing officer is merely to assist that body in reaching a decision.

In addition, § 809.2(b) provides that a hearing officer may – but need not be – "selected to preside at a hearing held before a panel." Obviously if the "implied" power to impose a terminating sanction were deemed essential to the proceeding, as West Hills contends, the legislature would not have made the presence of a hearing officer optional.

4. *Legislature made express provisions for failure to provide documents, and did not include terminating sanctions.*

Section 809.2, subdivisions (d) and (f), already make provision for dealing with a party's failure to engage in discovery. Subdivision (d) provides that "failure by either party to provide access to this [relevant documentary] information at least 30 days before the hearing shall constitute good cause for a continuance." Subdivision (f) states that failure to produce copies of all documents expected to be introduced at the hearing "shall constitute good cause for a continuance." The fact that the legislature made provision for a specific consequence for a party's failure to provide discovery documents is a strong indicator that the legislature rejected other possible remedies. For this Court to add a new "implied" remedy countermands the intent of the legislature.

This is a straightforward application of the familiar principle of statutory construction *unius est exclusio alterius*, which this Court has translated as "the expression of certain things in a statute necessarily involves exclusion of other things not expressed." *Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1386, 1391 n.13. "Thus by setting forth a specific penalty provision in [a statute], it can be inferred that the Legislature intended to exclude all other penalties." *De Anza Santa Cruz Mobile Estates Homeowners Assn. v. De Anza Santa Cruz Mobile Estates* (2001) 94 Cal.App.4th 890, 911. "[T]he Legislature, if it intends a stated remedy to be nonexclusive or cumulative, knows how to express such a concept, and its silence on the subject therefore indicates a contrary intent." *Id.*

5. *The Legislature intended pre-hearing rulings on documents to be open to reconsideration and not serve as a ground for ending the proceeding.*

The legislature enacted § 809.2 in the context of the well-settled principle that pre-hearing rulings on relevance and need for documents are necessarily conditional and subject to future revision in light of other developments. For example, the court in *Unnamed Physician v. Board of Trustees, supra*, 93 Cal.App.4th at p. 620, emphasized that a hearing officer “may change his or her mind about the production of documents, or decide to tailor the admission of evidence in light of earlier discovery-type orders to ensure fairness.” The hearing officer acted correctly in informing the parties that he “would continue to evaluate” the need for the disputed documents, because “the hearing officer’s rulings on procedural matters were open to reconsideration whenever new developments impacted the fairness of a prior ruling or required reevaluation.” *Id.* at 620 & 627. The responsibility of the hearing officer to safeguard the peer review process, stated in § 809.2(d), envisions procedural rulings that preserve the decision on the merits for the peer review body. It does not permit the hearing officer to preempt that decision for himself.

6. *The legislature did not intend to authorize the hearing officer to deny a physician’s right to a hearing for failure to provide documents where the hospital has ignored its own duty to obtain the documents.*

Amici disagree with the decision by the court of appeal in *Mileikowsky v. Tenet Healthsystem*, (2005) 128 Cal.App.4th 531, upholding a hearing officer’s decision to terminate a peer review proceeding due to physician misconduct.

However, that court cautioned that such authority must be used sparingly, only as a last resort where there is “no viable alternative” other than terminating the hearing. *Id.* at 564.

West Hills appears to concede this point, but insists that “when a medical staff seeks information regarding peer review proceedings at another hospital, the physician who was the subject of those proceedings is often the *only* source of that information” OBOM at 32. Quite obviously in this case there were at least two “viable alternative” sources for the desired information. One was Cedars-Sinai hospital. West Hills apparently made no request to Cedars-Sinai for the documents after Dr. Mileikowsky submitted his 2001 reappointment application. See Answer Brief on the Merits [“ABOM”] at 20-21. The second source was Mr. Lahana, West Hills’s attorney, who was the hearing officer at the Cedars-Sinai peer review and who therefore had access to the documents or at least knowledge of their contents. *See id.* at 6-7 & 9.

West Hills makes the erroneous assertion that, although “a medical staff securing another hospital’s peer review information serves an important public interest,” OBOM at 31-32, the hospital has no duty to do so. *Id.* at 33. West Hills clearly had such a duty. *See, e.g., Webman v. Little Co. of Mary Hospital* (1995) 39 Cal.App.4th 592, 600 (“In order for LCMH to fulfill *its legal duty to its patients*, it was obliged to investigate any disclosures made in an application for reappointment, or uncovered in the ensuing review process, which raised questions

about a professional staff member's quality of care at another hospital.”)

(emphasis added).

West Hills relies on *Bell v. Sharp Cabrillo Hosp.*(1989) 212 Cal.App.3d 1034, for the proposition that hospitals are “reticent about voluntarily disclosing their confidential peer review documents.” OBOM at 32, quoting *Bell, supra*, at 1040 & n. 5, 1043. In point of fact, the quoted passage is the court's paraphrase of the excuse given by the hospital for not seeking such documents. The court of appeal, however, went on to hold that the hospital *was* under a duty to seek out the peer review information from a hospital that had withdrawn the doctor's privileges. Indeed, the court upheld a medical malpractice verdict against the hospital based on the hospital's negligent failure to do so. The court also referenced expert testimony that the standard practice in California is for hospitals to make peer review documents available where the doctor in question has signed an authorization, as Dr. Mileikowsky did in this case. In fact, counsel for Cedars-Sinai, Gordon Simonds, had indicated in a letter that Cedars-Sinai would release the documents if directly requested by West Hills. ABOM at 9-10 (citing supporting documents in the Administrative Record). West Hills, however, like the hospital held liable in *Bell*, made no request to Cedars-Sinai. ABOM at 20-21, citing supporting documents in the Administrative Record.

7. *The legislature intended the hearing officer to protect the peer review process.*

Section 809.2 (d) allows a hearing officer, in ruling on requests for access to information, to impose “safeguards [for] the protection of the peer review process.” Plainly the hearing officer does not protect the peer review process by terminating it. Nor does he protect the process by preventing the peer review panel from making any decision as to its need for the documents or the merits of the application.

Even if in an extreme case it may be necessary to end a peer review proceeding because the physician refused to disclose documents that were essential to the panel’s decision and contained information the panel could not otherwise obtain, that decision belongs to the panel, and may not be pretermitted by the hearing officer. The court of appeal in *Lee v. Blue Shield* (2007) 154 Cal. App.4th 1369, correctly noted that the decision as to when the time has arrived to terminate a hearing due to the doctor’s persistent refusal to cooperate in discovery “must be made by the hearing panel in the course of the 809 hearing itself after affording the doctor notice and an opportunity to be heard.” *Id.* at 1377. Otherwise, “nothing would prevent a plan from jettisoning the hearing process whenever it believed it was going to lose the hearing.” *Id.*

The legislature’s meaning is inescapable: It did not intend to allow hearing officers to terminate peer review proceedings as a discovery sanction.

II. Insufficient Legal Protections For Physicians Exercising Independent Medical Judgment Has Allowed Hospitals to Use Malevolent Peer Review As A Weapon Against Physicians Who Threaten the Hospital's Economic Interests.

A. Denial of Hospital Privileges Has Become a Devastating Weapon Against Doctors.

Hospitals no longer resemble the eleemosynary institutions of yesteryear. Both non-profit and for-profit hospitals face tremendous economic pressures. The personnel costs, operating expenses and necessary investments in technology for the modern hospital are considerable. At the same time revenues from government reimbursements and private insurance payments make hospital operations potentially very lucrative.

Corporate hospital chains have evolved over the past 25 years, buying up non-profit hospitals, recasting them as for-profits, and consolidating them to achieve economies of scale, greater control for administrators, and greater returns for investors. Donald L. Bartlett & James B. Steele, *CRITICAL CONDITION: HOW HEALTH CARE IN AMERICA BECAME BIG BUSINESS AND BAD MEDICINE* 94-96 (2004). "Profit became policy" for those huge corporate hospital chains, and soon "American health care became a profit center for Wall Street." *Id.* at 88.⁹

For example, in 2007, Hospital Corporation of America, which owns West Hills, owned 169 hospitals and 108 other medical facilities, and had revenues of

⁹ Studies have consistently shown that investor-owned hospitals cost patients 3 to 11 percent more than non-profits. "When Money is the Mission: The High Costs of Investor-Owned Care," 341 *New Eng. J. Med.* 444 (Aug. 5, 1999).

\$27 billion according to the company's Annual Report. Available online at:
http://media.corporate-ir.net/media_files/irol/63/63489/4Q07HCAEarnings%20ReleaseCOMPLETE.pdf

Tenet Healthcare, the second-largest chain, operates more than 55 acute care hospitals with about 15,000 beds in 12 states. Tenet has reported net operating revenues in excess of \$8 billion annually for 2003 to 2007. *See* <http://www.tenethealth.com/TenetHealth/InvestorCenter> (click on Form 10K for year ended 12-31-07) at p. 26.

Much of that revenue flows from the sale of surgical procedures, drugs, and other medical commodities. From the hospital's viewpoint, whether the patient needs these goods and services is less important than that they are paid for. If physicians are not sufficiently independent and protected against retaliation, they cannot serve as advocates for quality care nor act as a brake on the hospital's drive for profits.

Unchecked, that drive can lead hospitals to engage in overbilling, fraudulent diagnoses, and even unnecessary surgeries. Recent recoveries arising out of fraud investigations are staggering. *See, e.g.,* Press Release, Department of Justice, Largest Health Care Fraud Case in U.S. History Settled HCA Investigation Nets Record Total of \$1.7 Billion, June 26, 2003. Available online at: http://www.usdoj.gov/opa/pr/2003/June/03_civ_386.htm;

Press Release, Department of Justice, Tenet Healthcare Corporation to Pay U.S. more than \$900 Million to Resolve False Claims Act Allegations, June 29, 2006. Available online at: http://www.usdoj.gov/opa/pr/2006/June/06_civ_406.html

An infamous example in California occurred at Tenet HealthSystems' Redding Medical Center. The hospital's highly profitable cardiac care department was based on persuading thousands of patients to undergo coronary bypass operations and other cardiac procedures for which it was paid hundreds of millions of dollars by Medicare and private insurance and which were in fact entirely unnecessary. *See generally*, Stephen Klaidman, CORONARY – A TRUE STORY OF MEDICINE GONE AWRY (2007). See also the report by CBS' 60 Minutes, Unhealthy Diagnosis, July 27, 2003, available online at: <http://www.cbsnews.com/stories/2003/07/17/60minutes/main563755.shtml>

Physician and patient whistleblowers led to a federal criminal investigation and ultimately to \$54 million in fines levied against Tenet, in addition to private civil claims by patients. CRITICAL CONDITION, *supra* at 108. The scandal led to an investigation by Blue Cross of California of heart surgeries at several Tenet hospitals. The conclusion reached by outside medical experts was that 73% of surgical procedures performed on patients were unnecessary. Melissa Davis, *Tenet Tangles With California Blue Cross*, TheStreet.com, Nov. 4, 2003, available online at http://www.thestreet.com/_yahoo/stocks/melissadavid/10124365.html.

Another example at a California hospital involved Dr. Charles Rosen, who was chief of surgery at Tenet's Garden Grove Hospital. He learned that the sterilizers used to clean surgical instruments had repeatedly failed tests and had apparently been broken for several months. Rosen informed the Joint Commission that hospital administrators knew of the malfunctions but concealed the information from surgeons.¹⁰ See, Melissa Davis, *Whistleblower Wants Tenet to Come Clean*, TheStreet.com, July 25, 2003, available online at <http://www.thestreet.com/story/10103544/1/whistleblower-wants-tenet-to-come-clean.html>.

Protecting profits provides a strong incentive for hospitals to take action against doctors who pose a threat to the economic interests of the hospital. The seminal case decided by this Court involved an outspoken and independent doctor. *Rosner v. Eden Township Hospital District* (1962) 58 Cal.2d 592. Among the incidents described by this Court was one in which Dr. Rosner told one of the owners of the hospital "that a nurse-anesthetist who had assisted him in an operation was incompetent Two days later a baby died as a result of an

¹⁰ Two of the authors of the IOM study, *supra* note 1, have pointed out that, absent strong legal accountability, hospitals actually have no economic incentive to avoid medical mistakes.

In most industries, defects cost money and generate warranty claims. In health care, perversely, under most forms of payment, health care professionals receive a premium for a defective product; physicians and hospitals can bill for the additional services that are needed when patients are injured by their mistakes.

Lucian L. Leape and Donald M. Berwick, *Five Years After To Err is Human: What Have We Learned?* 293 JAMA 2384, 2388 May 18, 2005.

anesthetic given by the nurse.” *Id.* at 595. Another conflict arose, after the hospital had determined that nothing could be done for a gunshot victim. “Dr. Rosner insisted that the patient be taken to the operating room and efforts made to save him. Dr. Rosner prevailed, and the patient survived and testified at the hearing.” *Id.* at 595-96. In addition, the court pointedly noted, Rosner “apparently testified for plaintiffs in malpractice cases.” *Id.* at 599. For his bluntness Dr. Rosner was denied privileges at Eden Hospital on the ground that he was “unable to get along with” members of the medical staff. *Id.* at 595.

This Court, upholding the doctor’s petition for a writ of mandate to compel his admission to the medical staff, emphasized the importance of protecting doctors who speak out for patients. “The goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital practices are being followed.” *Id.* at 598. The Court held that hospitals may withhold clinical privileges only on the basis of doctors’ lack of ability “to perform the medical and surgical treatments and diagnoses in connection with which they seek to use the hospital” and may not apply such standards “as a subterfuge where considerations having no relevance to fitness are present.” *Id.* at 597-98.

Now more than ever, the doctor who advocates on behalf of patients rather than profits is risking his or her career. Because of the dependence of doctors upon the ability to admit patients into a hospital for treatment, withdrawal of hospital privileges can be devastating to a physician’s practice. The practitioner database,

which prevents substandard or incompetent doctors from easily relocating to a different hospital, also means that a doctor who has been unfairly denied privileges at one hospital faces complete loss of the ability to practice medicine.

Mateo-Woodburn v. Fresno Cmty. Hosp. (1990) 221 Cal.App.3d 1169, 1185.

As one scholar has pointed out:

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.

Philip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals*, 38 U.S.F.L. Rev. 301, 304 (2004).

As a practical matter, the hospital – the hospital board, its administrators, and its legal counsel – can dominate the peer review process. They are armed with a powerful weapon in the denial of privileges and shielded by immunity under federal and state law. The result all too often is sham peer review that only ostensibly aims to protect patients. Its true objective is to further the economic aims of the hospital by punishing, for example, economic competitors or whistleblowers who call attention to poor patient care. Hospitals have both motive and opportunity to rid themselves of troublesome doctors who might undermine the hospital's economic objectives. Equally important, they can intimidate other physicians and prevent them from upsetting a profitable applecart.

It is true that under the law of California and many other states, the decision to deny or revoke hospital privileges much be based on some nexus to patient welfare. *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614. Hospitals often attempt to provide the requisite link by branding the targeted physician a “disruptive doctor.” According to one physician, hospitals have pursued a deliberate strategy adopted in 1990 of eliminating doctors for economic, political, or personal reasons or who are whistleblowers by tagging them as disruptive. Lawrence R. Huntoon, *Abuse of the “Disruptive Physician” Clause*, 9 J. Am. Physicians & Surgeons 68 (2004), available online at: <http://www.jpands.org/vol9no3/huntoon.pdf>.¹¹

It is pointed out by hospital attorneys that the disruptive doctor is not necessarily a bad doctor. “It is not uncommon to find that a disruptive practitioner is, in fact, highly intelligent, clinically superior, even medically outstanding.” Eric W. Springer and Henry M. Casale, *Hospitals and the Disruptive Health Care Practitioner-Is the Inability to Work with Others Enough to Warrant Exclusion?* 24 Duq. L. Rev. 377, 384 (1985). Nevertheless, the doctor who does not work for the greater good of the hospital “must be handled by the hospital management.” *Id.* at 394-95.

¹¹ The AMA has expressed concern over the use of this tactic and has warned that criticism “offered with the aim of improving patient care should not be construed as disruptive behavior.” American Medical Association, Report of the Council on Ethical and Judicial Affairs 2-A-00 (2000) at 2.

Management's tactics often include insisting that the physician submit to a psychiatric exam and be accompanied by a security guard at all times. Not only do such tactics suggest that the doctor could suddenly and violently attack patients or hospital staff, they do not trigger the requirement of fair procedure. Mark T. Kawa, "Taming the Disruptive Physician," *Los Angeles Bus. J.*, Oct. 14, 2002 at 36. Also available as Exhibit 1, Petitioner's Opening Brief in Support of Petition for Writ of Mandate filed in the Superior Court in this case on Jan. 21, 2005.

Another tactic has been denounced by the California Medical Association:

It is now routine for many [hospital] attorneys to advise the medical staff to "pile on" as many charges as possible, even though many of the charges may be old, insubstantial, unsubstantiated, or even previously dismissed by the medical staff. This multiplication of charges without regard to their merit or gravity has the effect of making the accused physician look like a "bad apple" and has subtle "where there is smoke, there must be fire" effects on the physician's colleagues.

Amicus Curiae Brief of the California Medical Assn., *Medical Staff of Sharp Memorial Hospital v. Superior Court* (2004) 121 Cal.App.4th 173 at p. 14. Often, there is no fire at all – only the hospital's smoke machine.

B. Malevolent Peer Review Has Become A Widespread Problem.

Hospitals have used their control over peer reviews to hijack the process for their own purposes. Noting the increasing litigation arising out of malevolent peer review and the "substantial literature on the topic," one commentator concludes: "What we are seeing is not just a few isolated instances of peer review abuse, but a disturbing pattern of reliance on peer review to remove unwanted doctors,

frequently for underlying financial reasons.” John H. Fielder, *Abusive Peer Review and Health Care Reform* in HEALTH CARE CRISIS? THE SEARCH FOR ANSWERS (Robert I. Misbin, et al., eds. 1995) at 115. A survey of 1,000 peer review concluded that more than 50% were motivated by economic or other abusive reasons, not the need to improve patient care. Verner Waite and R. Walker, *Medical and Surgical Peer Review*, 168 Am. J. of Surgery 1 (July 1994) (reporting study results).

For this reason, “[m]any in the medical community argue that the peer review process often has little to do with the actual pursuit of quality of care; but rather it is used as a tool for economic or political motives.” Yann H.H. van Geertruyden, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. of Contemp. Health Law and Policy 239, 241 (2001). Indeed, an increasing number of doctors are concerned that peer review “has been transformed into a weapon that enables established physicians and hospital administrators to dispatch mavericks, whistleblowers, rivals, and other nonconformists.” Gail Garfinkel Weiss, *Is Peer Review Worth Saving?* Med. Econ., Feb. 18, 2005, at 46, 47 (2005).

1. Use of Malevolent Peer Review to Eliminate Competitors.

Peer review is often employed as a weapon against doctors who might attract paying patients away from the hospital or from established physicians

avored by the hospital. One commentator has found that, “Rather than using peer review committees for analyzing and attempting to correct adverse events or to discipline health care providers who deserve to be disciplined, a current trend among hospitals is to use the committees as a way to weed out competition.”

Leigh Ann Lauth, *The Patient Safety and Quality Improvement Act of 2005: An Invitation for Sham Peer Review*, 4 Indiana Health L. Rev. 151 (2007). Targets are frequently younger, better trained, and less expensive, but less established doctors. Such abuse, states a doctor-attorney who represents physicians, turns the process “corrupt.” “Rather than being used to weed out bad doctors, peer review as it exists today is used primarily as a weapon against young, vulnerable practitioners.” Weiss, *supra*, at 48. As the U.S. Supreme Court indicated in *Patrick v. Burgett, supra*, immunity from liability invites malevolent peer review.

A recent decision by the court of appeal illustrates this abuse as well as the power of hospital authorities to dominate the process. *Nasim v. Los Robles Regional Medical Center*, 2008 WL 3823977 (Cal.App. 2 Dist., Aug. 18, 2008). In 2001, Dr. Nasim was granted privileges at the hospital in internal medicine and nephrology. He later opened a private nephrology practice in competition with nephrologists at the hospital. He was notified in 2003 that a new departmental rule required that staff members be board certified within two consecutive board exams, a time limit that made it impossible for Dr. Nasim to comply. For this reason, his privileges in nephrology were revoked. The court of appeal upheld the

superior court's ruling that retroactive application of the rule was unreasonable and interfered with Nasim's vested right to maintain his privileges. *Id.* at *1.

In another recent California decision, *Smith v. Selma Community Hosp.* (2008) 164 Cal.App.4th 1478, the court found evidence to support the physician's allegation that the hospital had revoked his privileges because the hospital was seeking to purchase the physician's practice and was "using the possibility of loss of hospital privileges as a bargaining chip in its efforts to secure favorable terms." *Id.* at 1517 n.21.

Another example that has garnered considerable attention is the case of Dallas cardiologist Dr. Lawrence Poliner. A Texas jury found that he was the victim of "trumped up charges of substandard care against him to eliminate him as a competitor" and awarded \$366 million in damages. Jeff Chu, "Peer Review: Doctors Who Hurt Doctors," *Time*, Aug. 15, 2005, at 52. The federal court of appeals overturned the award, not because it found the hospital innocent, but because the hospital and peer review committee were immune from liability under HCQIA. *Poliner v. Texas Health Systems*, ___ F.3d ___, 2008 WL 2815533 (5th Cir., July 23, 2008).

Similarly, neurosurgeon Roland Chalifoux has alleged that "his financial competitors used a sham peer-review process in an attempt to destroy him" by trumping up charges and revoking his hospital privileges. In that case, the decision was placed before the peer review panel, which exonerated Dr. Chalifoux and recommended that the hospital restore his privileges. John Zicconi, *Due Process*

or Professional Assassination? Unique Opportunities (March/April 2001), available online at <http://www.peerreview.org/PEERREVIEW.pdf>.

Further examples are provided by the editor-in-chief of the Journal of the American College of Cardiology and chairman of the ethics committee at the College. He reviewed the documentation regarding three cardiologists whose clinical privileges had been suspended. In one, he found that accusations of excessive catheterizations were demonstrably false. As to the second, four outside experts concluded that the doctor had met the standard of care for all 37 allegedly mistreated patients. The third was cleared of any wrongdoing, but suffered large financial losses. He concluded that the peer reviews were simply “a competitive hatchet job” directed at doctors competing with the hospital and its medical staff. William W. Parmley, *Clinical Peer Review or Competitive Hatchet Job?* 36 J. American College of Cardiology 2347 (2000). Dr. Parmley added, “Are these isolated cases? As I have explored these cases and talked to different individuals, it seems probable that this scenario is far more common than is appreciated.” *Id.* Even the hearing officer involved in this case has written that “immunity afforded participants in peer review has emboldened groups to use the peer review process as a weapon to control competition.” Edward H. Livingston and John D. Harwell, *Peer Review*, Am. J. of Surgery 103, 103 (May 2001).

Use of malevolent peer review as a weapon against competitors is not simply an economic crime that ruins the careers of the targeted physician. It harms

the public – as all illegal anticompetitive conduct does – by limiting consumers’ choices and increasing the cost of medical care.

2. Use of Malevolent Peer Review to Punish Whistleblowers.

Even more troubling is the growing use of malevolent peer review to punish physicians who speak out on behalf of patients against harmful hospital practices. One investigative journalist has found this type of malevolent peer review has become a disturbing trend. “Doctors who are sworn to protect their patients from harm increasingly face investigation, sanctions, and even financial ruin if they challenge hospital practices because they believe those practices adversely impact on patient care.” Steve Twedt, “The Cost of Courage,”

Pittsburgh Post-Gazette, October 26, 2003, available online at:

www.postgazette.com/pg/03299/234499.stm.5

One might expect hospitals, who routinely decry medical malpractice litigation as a scourge, to offer commendations to physicians who call attention to potentially harmful practices or conditions before they ripen into a malpractice lawsuit. Instead, as a sampling of malevolent peer review incidents illustrates, hospitals often punish the messenger.

For example, Dr. John Ulrich Jr., a general practitioner at a county hospital in San Francisco, protested against staff cuts as “an injustice to patients.” Two weeks later, the hospital began an investigation of Dr. Ulrich for alleged incompetence. Although the California Medical Board found no problems with his

patient care, the hospital's report to the National Practitioners Data Bank effectively destroyed Dr. Ulrich's medical career. Berkeley Rice, *Peer Review: Dr. Ulrich's Battle*, Medical Economics, Feb. 18, 2005; see also Steve Twedt, "Doctor who voiced protest wins \$4.3 million judgment," Pittsburgh Post-Gazette, June 24, 2004, available online at

<http://www.peerreview.org/whistleblowers/6242004postgaz.pdf>.

Dr. Thomas Wieters, a general surgeon in Charleston, S.C., complained to the hospital's CEO that his elderly patient, who was scheduled for surgery for an aneurysm, had been in the hospital for eleven hours without having any blood work or a cardiogram done and without having received his cardiac medicines. Two weeks later, Dr. Wieters received a certified letter charging him with disruptive behavior. When he continued to call attention to examples of hospital negligence, he was required to undergo psychiatric evaluation and his privileges were summarily suspended. Jeff Chu, "Peer Review: Doctors Who Hurt Doctors," *Time*, Aug. 15, 2005, at 52. Another doctor lost privileges at the Community Memorial Health Center in South Hill, Va. after he reported dangerous obstetrics policies to state authorities. The hospital stated that the physician had "disrupted [its] efficient operation." *Id.*¹²

¹² Other examples are reported in David W. Townsend, *Hospital Peer Review is a Kangaroo Court*, 3 Med. Econ. 133 (2000); and William M. Johnston, *Shammed I Am*, In *Peer Review: Due Process Does Not Apply for Physicians Facing Sham Peer Review*, Gen. Surgery News, June 2004, at 1, available online at: http://www.semmelweis.org/Acrobat/article_sham%20i%20am.pdf.

In some instances, courts have intervened to protect physicians painted by hospitals as “disruptive doctors” for advocating better patient care. For example, in 2002, shortly after Dr. Debi Chaudhuri, a trauma surgeon, publicly criticized a Fayetteville, S.C. hospital for failing to have a neurosurgeon on call in its emergency department, the hospital launched an investigation – of Dr. Chaudhuri. Two months later, the hospital suspended his privileges without a hearing, asserting that he “presented a risk to patient safety” and required that he undergo a mental health evaluation. A court ordered the hospital to allow Dr. Chaudhuri to resume practice in the hospital’s emergency department.¹³

In *Feyz v. Mercy Memorial Hosp.* (Mich. 2006) 475 Mich. 663, 719 N.W.2d 1, the Michigan Supreme Court upheld a cause of action by a physician who instructed nurses to obtain medication information from patients themselves, rather than follow hospital practice of simply copying the information from patients’ prescription bottles. The hospital placed the physician on probation and referred him for a psychiatric exam. The Michigan Supreme Court held that the state’s immunity statute did not bar the doctor’s cause of action, noting that “the hospital itself is not a protected review entity under the legislatively enacted peer review immunity statute.” *Id.* at 10. In *Clark v. Columbia/HCA* (Nev. 2001) 25

¹³ The facts of this case are contained in the pleadings in *Chaudhuri v. Cumberland County Hospital System, Inc.*, 02 CVS 1785, Cumberland County Superior Court and in an article by his attorneys, Elizabeth F. Kuniholm and Lucy S. Inman, *South Carolina’s Medical Review System: Protecting Patients . . . or Physicians?*, Trial Briefs, February 2003, available online at: <http://www.kuniholmlaw.com/resources>.

P.3d 215, a hospital revoked the privileges of a psychiatrist who had notified JCAHO of substandard child psychiatric care at the hospital. The court held the hospital was not immune from liability where hospital's motive was retaliation for "good faith reporting of perceived improper hospital conduct to the appropriate outside agencies, or whistleblowing." *Id.* at 222.

One physician has noted an increase in retaliation against doctors for speaking out for better patient care, and places the blame on statutory immunity:

HCQIA has also made it difficult for physicians to be strong patient advocates. With the increasing stories of physicians' careers being adversely impacted by hospital revocation for "disruptive" behavior, perhaps it is time to modify HCQIA by allowing a careful disinterested review of hospital decisions, labeling physician behavior as "disruptive." Without this modification, physicians may be forced to remain silent when confronting substandard patient care rather than risk the loss of their professional career.

Michael J. Panella, *The Legal Ramifications under the Health Care Quality Improvement Act of Physicians Labeled Disruptive for Advocating Patient Quality of Care Issues*, 24 J.L. & Com. 281, 298 (2005). Dr. Mary H. Johnson, a pediatrician who lost her job after reporting a colleague's mismanagement of a newborn's care, stated that "abuse of peer review for economic reasons or to perpetuate a cover-up is medicine's dirtiest little secret." Lauth, *supra*, at 168.¹⁴

¹⁴ See also van Geertruyden, *supra*, at 239, referring to bad faith peer review as "a problem in the medical profession which is known by many, but spoken of by few."

III. This Court Should Interpret Section 809 *et seq.* Strictly Against Hospitals and Hearing Officers and In Favor of Preserving the Role of Doctors In Deciding Peer Review Actions.

A. The Interference With the Role of the Medical Staff in this Case Reflects a Broader Trend Among Hospitals to Assert Control Over Professional Medical Staff in Contravention of California’s Statutory Peer Review Fairness Protections.

Bus. & Prof. Code § 809 *et seq.* reflects the historical lesson that doctors, exercising independent judgment, are the best assurance of delivering quality medical care to hospital patients. The legislature has therefore placed in the hands of the medical staff the responsibility of conducting good faith peer review of doctors’ hospital care. In this case, the legislative scheme was short-circuited by the hearing officer appointed and paid by West Hills. The decision whether Dr. Mileikowsky’s privileges would be renewed was seized out of the hands of the medical staff and was made solely by a hearing officer who was not permitted by the statute even to vote on the matter. Prior to the denial of his right to a hearing, Dr. Mileikowsky’s privileges were terminated by hospital attorney Mr. Lahana without any legal basis. ABOM at 12. Dr. Mileikowsky was rendered unable to pursue his profession and his livelihood.

Amici are concerned that this was not an isolated instance of oppression of one doctor by one hospital. The history of hospital care in America, summarized in Part I, involves the tension between the interests of hospital owners and administrators, whose concern is with the institution’s financial wellbeing, and the

professional medical staff, whose primary commitment is to the welfare of their patients.

California has long led the nation in protecting the ability of physicians to exercise independent professional judgment by requiring that medical peer review be both procedurally and substantively fair. The judiciary's role in enforcing these standards of fairness protects not only the fundamental rights of doctors, it serves a vital public interest. As the legislature has recognized, "Peer review, fairly conducted, is essential to preserving the highest standards of medical practice." Bus. & Prof. Code § 809(a)(3). Malevolent peer review wastes a precious societal resource, limits patients' access to medical care, and drives up the cost of medical services for all. *See id.* § 809(a)(4).

As Americans spend ever more for hospital care, the stakes have become ever higher for owners and administrators seeking to maximize revenues. "For better and worse, the era of corporate medicine is upon us," states one scholar who has written extensively on ethical issues facing modern medicine. John H. Fielder, *Abusive Peer Review and Health Care Reform*, in *HEALTH CARE CRISIS? THE SEARCH FOR ANSWERS*, *supra*, at 119.

Hospital attorneys, particularly those representing investor-owned hospitals, openly argue for the elimination of the independence of medical staff. In their view, modern hospitals cannot afford to allow medical staff to function as an independent unit. Rather, the hospital is "in reality a single institution [and] the governing board, like the board of any corporation, [is] its supreme authority."

John F. Harty and Daniel M. Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 St. Louis U. L. Rev. 485, 488 (1978). Although a short time ago the “hospital management and governing board knew little of what went on in the hospital,” and did not interfere with “the doctor’s workshop,” the “balance today must be in favor of the institutional imperative.” Eric W. Springer and Henry M. Casale, *Hospitals and the Disruptive Health Care Practitioner-Is the Inability to Work with Others Enough to Warrant Exclusion?* 24 Duq. L. Rev. 377, 423 (1985).¹⁵

Hospital advocates have urged that traditional role of physicians as the primary assurers of the quality of care for their patients “must be reevaluated” and turned over to hospital management along with control over the peer review process. Paul L. Scibetta, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends On the Health of Hospital Peer Review*, 51 U. Pitt. L. Rev. 1025, 1030 (1990). In this “modern” view, the hospital doctor is viewed as little more than an at-will employee.

In today’s hospital, the clashing interests of the purveyors of care (physicians) and the overseers of quality (hospital management through credentialing and peer review) have caused a situation where traditional due process protection afforded physicians can be antithetical to the interests of “hospital quality.”

¹⁵ Harty Springer & Mattern of Pittsburgh, Pa. is a leading law firm representing hospitals. According to an attorney who represents physicians, “Their objective is clear: they want to place unfettered power and economic control over doctors in the hands of hospital administrators.” Charles Bond, *The War Is On: Why Your Medical Staff Needs to Incorporate and Obtain Its Own Independent Counsel*, 6 MedGenMed 57 (March 2004).

Scibetta, *supra*, at 1030-31. In particular, they argue, “Disciplining the disruptive doctor must be handled by the hospital management, not the medical staff.”

Springer and Casale, *supra*, at 394-95.

California law has long rejected this view of medicine as a purely private corporate enterprise. Section 809 itself rests upon a foundation of judicially declared principle that hospitals “must never lose sight of the fact that the hospitals are operated not for private ends but for the benefit of the public.” *Greisman v. Newcomb Hospital* (N.J. 1963) 192 A.2d 817, 825. The California Court of Appeal in *Ascherman v. San Francisco Medical Society*, (1974) 39 Cal.App.3d 623, quoted extensively from *Greisman* in holding a private hospital must grant a physician minimum due process when considering staff privileges. The court stated that the hospital’s powers to grant medical staff privileges “are deeply imbedded in public aspects, and are rightly viewed, for policy reasons . . . as fiduciary powers to be exercised reasonably and for the public good.” *Id.* at 644. *See also Medical Staff of Sharp Memorial Hospital v. Superior Court* (2004) 121 Cal.App.4th 173, 181-182 (“the overriding goal of the state-mandated peer review process is protection of the public.”).

This Court has also rejected the persecution of the targeted “disruptive doctor.”

The goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel treatment of patients is improper or that negligent hospital practices are being followed. Considerations of harmony in the hospital must give way where the welfare of patients is involved, and the physician

by making his objections known, whether or not tactfully done, should not be required to risk his right to practice medicine.

Rosner, supra, 58 Cal.2d at 598.

For this reason, California law places the primary responsibility for oversight of hospital physicians, through the grant or withdrawal of clinical privileges, in the hands of the medical staff, “which is required to be self-governing and independently responsible from the hospital for its own duties and for policing its member physicians.” *Hongsathavij v. Queen of Angels* (1998) 62 Cal. App. 4th 1123, 1131 n.2.

Amici agree with the assessment rendered by the AMA and CMA of California’s statutory peer review regime:

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

Brief of Amici Curiae American Medical Assn. and California Medical Assn, *Medical Staff of Comm. Mem. Hosp. of San Buena Ventura v. Community Mem. Hosp. of San Buena Ventura*, Ventura County Super. Ct., No. CIV219107, at 17.

In order to advance the intent of the legislature in enacting Section 809 and preserve the independence of physicians working on behalf of good patient care,

amici urge this Court to make clear that the authority of hearing officers and hospital administrators is narrowly confined by the statute.

B. This Court should protect the independence of hospital doctors in maintaining quality care by strictly construing the authority of both hospitals and hearing officers to interfere with decisions by medical staff.

It is this Court's responsibility to delineate standards of fairness under the statute and the "minimal requisites of fair procedure required by established common law principles." *Miller v. National Medical Hosp.* (1981)124 Cal.App.3d 81, 90, quoting *Anton v. San Antonio Community Hosp.* (1977) 19 Cal.3d 802, 825. Those standards necessarily evolve with changing circumstances. This Court recognizes that the concept of fair procedure is not fixed, but rather must expand as new circumstances arise. *Ezekial v. Winkley* (1977) 20 Cal.3d 267, 279.

In view of the disturbing abuse of the peer review process to advance hospitals' economic interests rather than the welfare of patients, and the use of ostensibly patient-care reasons "as a subterfuge" against doctors, *Rosner, supra*, 58 Cal.2d at 598, Amici urge this Court to further delineate its construction of Section 809 *et seq.* and the fair procedures guaranteed to hospital physicians.

1. *This Court should hold that a physician who has been granted staff privileges at a California hospital retains those privileges unless they are suspended or revoked in accordance with the statute.*

This Court has made it clear that a "previously admitted physician, . . . may not be denied reappointment to the medical staff absent a hearing and other procedural prerequisites consistent with minimal due process protections." *Anton*

v. San Antonio Community Hospital (1977) 19 Cal.3d 802, 824. *See also, Sahlolbei v Providence Healthcare, Inc.*, (2003) 112 Cal App 4th 1137, 1146-47. “Due process in this context requires, at least, that a physician be afforded, among other rights, ‘a hearing before the deciding board’.” *Sahlolbei* at 1146, quoting *Anton*, 19 Cal.3d at 815-816 n.12.

The lower court did not reach this issue because on the state of the record before it, the court was uncertain as to the status of Dr. Mileikowsky’s hospital privilege “and what action, if any, respondents took with respect to that privilege.” Slip Op. at 32.

Dr. Mileikowsky’s statement of facts before this Court clarifies matters by stating that on May 18, 2001, Dr. Mileikowsky submitted his biannual reappointment application to West Hills. He was informed that the MEC had recommended denial and that he had a right to a judicial review hearing. Shortly after Dr. Mileikowsky requested a hearing, “West Hills’ Medical Staff’s attorney Mr. Lahana terminated Dr. Mileikowsky’s privileges, without cause.” In a letter dated June 17, 2002, Mr. Lahana stated, “Currently, Dr. Mileikowsky does not hold privileges and is not able to practice at West Hills . . . during the pendency of this hearing.” ABOM at 12. West Hills does not appear to dispute these facts.

This Court should instruct the lower courts that a doctor’s hospital privileges, once granted, continue in force unless withdrawn or restricted by the hospital in accordance with § 809.5. That provision permits a summary suspension or restriction of privileges *by the peer review body* only where “failure to take that

action may result in an imminent danger to the health of any individual.” *Id.*, subdiv. (a). The hospital board or its designee may summarily suspend privileges only “[w]hen no person authorized by the peer review body is available” to do so. *Id.*, subdiv. (b). Only in those circumstances is summary action is permitted, and only if failure to act “is likely to result in an imminent danger to the health of any individual.” *Id.*

The purported suspension of a physician’s clinical privileges by the hospital for any other reason – as apparently occurred in this case – is illegal and invalid. By essentially locking the doctor out, the hospital is able to prevail not by being right, but by prolonging the process and outlasting the physician who has lost his or her career and livelihood.

This narrow construction of the authority of hospital attorneys or administrators to summarily suspend a physician’s clinical privileges is consistent with “the policy of this state that peer review be performed by licentiates” *Id.* at § 809.05. It also conforms with other statutory protections put in place by the legislature to protect doctors who have advocated on behalf of better patient care from retaliation. The legislature has mandated:

The application and rendering by any person of a decision to terminate an employment or other contractual relationship with, or otherwise penalize, a physician and surgeon principally for advocating for medically appropriate health care ... violates the public policy of this state. No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate health care.

Business & Professions Code § 2056(c). *See also id.* § 510 (similar).

In 2007, the legislature amended Health and Safety Code § 1278.5 to extend whistleblower protections to physician members of a hospital medical staff. Section 1278.5 (a) states: “The Legislature finds and declares that it is the public policy of the State of California to encourage . . . members of the medical staff, and other health care workers to notify government entities of suspected unsafe patient care and conditions.” Subdivision (b)(1) prohibits any health facility from discriminating or retaliating against any member of the medical staff who has reported the facility to a responsible authority or who has participated in an investigation of the quality of care at the facility.

In addition, Welfare and Institutions Code § 14087.28 (a) provides: “A hospital contracting with the Medi-Cal program pursuant to this chapter shall not deny medical staff membership or clinical privileges for reasons other than a physician’s individual qualifications as determined by professional and ethical criteria.”

Amici urge this Court to prevent abuse of the provision for summary denial of clinical privileges as a weapon to punish physicians who exercise independence of judgment.

2. *This Court should hold that summary suspension of privileges should be used only rarely and only upon fair procedures, including a prompt hearing on the question of whether the physician presents an imminent danger to an identifiable individual.*

To protect patients, a hospital is authorized to immediately suspend or restrict a physician's clinical privileges to avoid "imminent danger to the health of any individual." Bus. and Prof. Code § 809.5, subdivs. (a), (b). However, the physician must be "subsequently provided with the notice and hearing rights set forth in §§ 809.1 through 809.4." *Id.*

Too often, hospitals summarily suspend privileges as a first, not last, resort to rid themselves of a disruptive doctor. Often the suspension is based on allegations of the most tenuous link to danger to a patient.

A physician facing allegations of a false or insubstantial threat to the health of a patient has no recourse but to undertake his or her defense at the subsequent hearing. For the physician who has been deprived of privileges, and perhaps the ability to practice medicine at all, the exhaustion of administrative remedies means in reality exhaustion of the physician's resources. Even if vindicated, it may be far too late to repair the damage to the physician's practice, patient relationships, relations with other doctors and hospitals, and solvency.

Amici therefore urge this Court to make clear that summary suspension of privileges under § 809.5 is available only as a last resort. The affected physician should be afforded an expeditious hearing limited to the sole issue of whether the doctor's continued presence in the hospital poses an imminent danger to the health

of an identifiable individual patient. Amici urge this Court to adopt these procedural protections, which the California Medical Association and the American Medical Association have strongly endorsed.

[T]he practical effect of a summary suspension is to strip from the physician the ability to care for patients and to stigmatize irreparably the physician's professional reputation, all without any process whatsoever. To ensure that the process is fair, physicians must be afforded an expedited hearing on the issue as to whether the summary suspension was warranted. Such a hearing, where properly limited to a review of the exigent circumstances which purportedly warranted such a draconian punishment, would not require the expenditure of substantial resources and time . . .

Amici Curiae Brief of the California Medical Ass'n and American Medical Ass'n, *Mileikowsky v. Tenet Healthsystem* (2005) 128 Cal.App.4th 262 (No. B150337), at

23. CMA and AMA further contend:

In light of the due process implications of a summary suspension and in light of the minimal resources required, . . . physicians must be afforded an expedited, bifurcated hearing on the issue of whether the situation presents a reasonable possibility of "imminent danger" to the health of an individual. This hearing would be devoted exclusively to the issue of whether a summary suspension is warranted.

Id. at 27.¹⁶

3. *This Court should hold that the powers of a medical hearing officer are limited to those enumerated in the statute, strictly construed to protect the prerogative of the medical staff to render a decision on the merits of the peer review action.*

Amici urge this Court to hold that hearing officers presiding over medical peer review hearings under § 809.2 may exercise only those powers expressly set

¹⁶ Procedures implementing this policy have been adopted as part of CMA's Model Medical Staff Bylaws, Section 6.2 (November 1991).

forth in the statute. It is undisputed that the statute contains no express authorization to impose terminating sanctions.

Should the legislature determine that it has omitted some necessary authority, it is equipped to amend the statute. However, as amici argued in Part I.C. above, the statutory text plainly indicates that the legislature did not intend for hearing officers to wield this power. West Hills asks this Court to ignore the statute and the legislative intent and pretend this is purely a question for the common law. *See* OBOM at 34 & 53.

To confer “implied” or “inherent” powers on hearing officers invites a similar resort to unwritten powers whenever the hearing officer has exceeded the express authority under the statute.¹⁷ This opens up the prospect of extensive litigation over the use and extent of such unwritten authority. In addition, it invites the hearing officer to stand upon “implied powers” as a pretext to prevent the peer review body from making a decision in a proceeding that is not going favorably for the hospital.

The unfairness in this case is not that Dr. Mileikowsky was entitled to have his application for privileges granted, rather, he was entitled to have it considered. The hearing officer ended the peer review hearing before the JRC could even be

¹⁷ Indeed, West Hills acknowledges that the “implied” powers it seeks for hearing officers go beyond terminating sanctions to include an open-ended range of orders and sanctions as deemed appropriate by the hearing officer or as ordered by the hospital board. OBOM at 39-40 n.16.

appointed to consider the matter, violating the fair procedures guarantee which this Court developed and on which the legislature based § 809.2.

Thus, for example, in *Ascherman v. San Francisco Medical Society*, (1975) 45 Cal.App.3d 507, the court held that a bylaw, requiring an application for privileges include three letters of recommendation from current staff members, violated fair procedure. As the court stated, without the letters, the hospital would not consider the application, so that “the effect of the by-law was to prevent the physician’s application from being considered and rejected. Thus, he never had the benefit of . . . hearing procedures for rejected applications.” *Id.* at 514. Similarly, in this case, the hearing officer prevented Dr. Mileikowsky from receiving a hearing on the merits of his application, in violation of the guarantee of fair procedure.

* * *

California’s lawmakers clearly intended the courts to construe § 809 *et seq.* strictly in favor of protecting doctors who may be subjected to malevolent peer review. As one scholar has pointed out, if strong protections are not enforced, “many outstanding physicians who become the target of an adverse peer review and are unable to afford costly litigation to clear their name, will simply be eliminated as they will have no alternative but to quit the medical profession.” van Geertruyden, *supra*, at 270-71.

Even more important, amici contend, is the impact on all of us, as potential patients, when the most effective voice on behalf of quality patient care can be silenced. Bioethics professor John H. Fielder has aptly observed:

As healthcare takes on more characteristics of a corporate enterprise, it tends to turn doctors into employees and patients into consumers. . . . [B]ut health care cannot be treated as just another business. The professional and social values of medicine, particularly physician advocacy of the patient's health interests, must be protected in order to have a humane system that does not forget that caring for sick and vulnerable people is the heart of health care.

Fielder, *supra*, at 119-20.

CONCLUSION

For the foregoing reasons, Amici urge this Court to affirm the judgment of the court of appeal below. and restore Dr. Mileikowsky's clinical privileges, as he exercised them at the time of the denial of his 2001 reappointment application, until exhaustion of his administrative remedies.

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

As required by Cal. Rule of Court 8.504(d)(1)

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