B167180

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT
DIVISION FOUR

ASSA WEINBERG, M.D.,

Appellant,

v.

CEDARS-SINAI MEDICAL CENTER,

Respondent

Appeal From The Superior Court Of The State Of California
For The County Of Los Angeles, Case No. BS080287
(The Honorable Dzintra Janavs, Judge Presiding)

APPLICATION TO FILE AMICUS CURIAE BRIEF; AMICUS CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF APPELLANT ASSA WEINBERG, M.D.

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APPLICATION TO FILE AMICUS CURIAE BRIEF

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.

Professional peer review is an essential function in California hospitals to assure quality of care and patient safety. The Legislature has mandated that peer review is the province of the medical staff and the medical professionals on the medical staff, who have the expertise required to perform peer review for the public's safety. This case raises a host of concerns for the continued validity of peer review, and the continued integrity of the quality assurance activities of the medical staff. If peer review findings and determinations of the medical staff may be readily substituted with those of the lay governing body of the hospital on review of those peer review activities, quality and patient safety will suffer, and patients' access to their physician of choice will be inappropriately restricted.

CMA has a great interest in assuring that, in this case and all others like it, the "great weight standard" under Business & Professions Code §809.05(a) is applied in a way that assures the governing body affords the high level of deference to peer review determinations that the Legislature intended. This deference must be applied without regard to hospitals' unfounded concerns in these cases for corporate liability under *Elam v. College Park Hospital,* or any other potential theories of liability. For the governing body to apply the great weight standard with any lesser deference violates the peer review statutes applicable in this case, violates the Legislative intent that peer review be performed by licentiates and be grounded exclusively in the interest of maintaining and enhancing quality patient care, and violates the due process rights of the physicians whose professional careers hang in the balance.

This case addresses an issue of first impression with respect to the review of determinations of peer review bodies by governing bodies of hospitals. The issues in this case, and the ruling to come from this court, will have a tremendous impact on physicians with hospital privileges throughout the state. In light of the amicus brief filed by the California Healthcare Association shortly after oral argument was noticed in this case, CMA believes it is critical that this court be

made aware of the physician point of view regarding the arguments set forth therein, and regarding other major issues raised by the parties.

For all the foregoing reasons, we respectfully request this Court to grant us leave to file the attached amicus curiae brief discussing these critical issues more fully.

DATED: April 27, 2004.

Respectfully,

California Medical Association
CATHERINE I. HANSON
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By:_____
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AMICUS CURIAE BRIEF

I. INTRODUCTION

The legal issue at the heart of this case relates to the standard of review the hospital governing body should apply in peer review actions of the medical staff of an acute care hospital.[1] Dr. Weinberg argues that, if the governing body is entitled to overturn the disciplinary recommendation of the peer review body in his case and can instead terminate his privileges, that this reversal of the peer review body's determination triggers hearing rights before the governing body as to the level of discipline that should be imposed. Amicus CMA agrees with Dr. Weinberg's analysis, and will not repeat that compelling argument in this brief. Dr. Weinberg agreed to the discipline determined by the medical staff, and did not appeal that result. The governing body's unilateral reversal of the medical staff's determination of discipline raises serious due process considerations regarding the ability of the physician to defend against loss of his vested rights in the privileges he had exercised for so many years at that hospital. However, for the reasons discussed below, we believe such a result should be extremely rare, as application of the appropriate standard of review by the governing body will almost never result in a change of penalty as occurred in this case.

The Respondent hospital ("hospital" or "Cedars") argues that substantial evidence review is "deemed" to be waived by the appellant in this case, and that the only issue is whether the governing body properly applied the "great weight" standard to the recommended discipline of the peer review body. The hospital

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[1]Because the peer review action in this case derives from both a Judicial Review Committee's and Medical Staff Executive Committee's involvement, amicus may refer to both these entities herein as either the "medical staff" or the "peer review body."

argues that little deference is warranted for the medical staff's recommendations after hearing (and in this case, also after an "intermediate" review by the MSEC)[2], and that the hospital should be given great leeway to determine the outcome of governing body reviews in these cases.

The governing body in this case terminated the Dr. Weinberg's privileges rather than accept the medical staff's recommendation for him to be referred to the medical staff well-being committee. It claims it gave "great weight" to the action of the medical staff, which it summarized as meaning "that the governing body give careful and serious consideration to the peer review body's recommendations." (Cedars' Respondent's Brief at p. 25.) Cedars argues, there was "substantial evidence in the record" to justify the governing body's decision to terminate Dr. Weinberg.

Cedars has mixed and misconstrued the review standards the *governing body* must employ in reviewing the administrative record of the peer review disciplinary proceedings in its hospital, including the meaning of the "great

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[2]Amicus CMA views the intermediary review provided by the Medical Staff Executive Committee in peer review disciplinary proceedings as suspect at best. The medical staff is the investigator and prosecutor of these cases. MSEC review of a peer review hearing panel's actions, in cases where the MSEC disagrees and overturns such actions, could constitute a violation of the physician's due process rights. (*See Howitt v. Superior Court* (1992) 3 Cal.App.4th 1575, 5 Cal.Rptr.2d 196 [combining advocacy and decision-making roles of a person or entity in employee discipline cases violates due process]; *see also Nightlife Partners v. City of Beverly Hills* (2003) 108 Cal.App.4th 81, 133 Cal.Rptr.2d 234 [due process violation from an overlap of advocacy and adjudicatory functions after hearing on business permit application].) In the instant case, however, there is no prejudice to the appellant by having intermediate review by the Cedar's Medical Staff Executive Committee. Quite the contrary, the Medical Staff Executive Committee's determination to uphold the decision of the hearing panel, not only once *but twice*, reaffirms the correctness of the medical professional determinations made in light of the charges levied by the medical staff against appellant.

weight" standard as set forth in Business & Professions Code §809.05(a).[3] The "great weight" standard requires that the governing body must give great weight to the *action*, i.e., disciplinary recommendation, of the peer review body. That is, providing the hearing procedure was fair and the factual findings are supported by substantial evidence in the hearing record, the governing body must affirm that penalty determination *unless it is clearly erroneous, i.e., evinces a manifest abuse of discretion.* Further, by all appearances as evidenced in its briefing, the hospital even failed to properly apply the substantial evidence test in reviewing the *findings* of the medical staff in this case.

The California Healthcare Association (CHA or the "hospital trade association"), as amicus in this case, argues that the great leeway in the peer review process sought by the hospital in this case would permit governing bodies to "ensure the quality of care," as well as help avoid further economic deterioration of a struggling hospital industry through increased liability under *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr 156. Medical professional decisions of the medical staff in peer review cases already "ensure the quality of care," particularly, as seen in this case, after a medical staff investigation and many hours of testimony and many days of hearing have ensued, including a relatively unusual process of "intermediate level" review by the Medical Staff Executive Committee (MSEC) wherein the MSEC agreed with the hearing panel's findings and conclusions. Moreover, for a number of reasons, arguments for greater leeway for the governing body to substitute its own judgments for those of the peer review body cannot be justified *to any degree* on the basis of the governing body's heightened concerns for potential and highly speculative future liability under *Elam*.

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[3]All statutory references are to the Business & Professions Code unless otherwise stated.

In this brief of amicus curiae, CMA will show:

1) that the hospital's position ignores the plain meaning of the words "great weight", as well as the numerous mandates of the legislature that peer review be performed by licentiates, that peer review actions be performed exclusively in the interest of maintaining and enhancing quality patient care, as well as other California law vesting tremendous deference in the medical expertise of the professionals on the medical staff, including the professional assessments they make in the peer review disciplinary process;

2) that the hospital industry's fears of corporate liability arising from the peer review disciplinary process are overblown at best, and simply misplaced at worst, and that these fears do not justify affording greater leeway to the governing body to overturn or modify a peer review action, or permitting adulteration of the governing body's review of peer review determinations made by the medical staff;

3) and that interpreting *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center*[4] as approving assessment of liability exposure of the corporate body as part of its analysis and review of peer review determinations of the medical staff misconstrues the meaning of that case and would violate both the language of the statute and legislative intent.

Approximately fifteen years ago, in 1989, amicus CMA sponsored SB 1211 and SB 1480, the bills which became the statutory scheme, Sections 809 et seq., that now governs the peer review disciplinary process in California. This law establishes the fair hearing rights of physicians in professional review actions such as the one in this case. Among the many safeguards included in that law is the requirement that it is the professionals who make peer review determinations in the first instance, and that hospital governing bodies generally act only as

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[4](1998) 62 Cal.App.4th 1123, 73 Cal.Rptr.2d 695.

appellate bodies, appellate bodies which are expressly required to give "great weight" to peer review actions.[5]

As will be explained below, the standard set forth in Section 809.05(a) means that the determination of the medical staff on physician peer review matters must be upheld by the governing body *unless it is clearly erroneous, i.e., evinces a manifest abuse of discretion* on the part of the peer review body. This interpretation of the statute is consistent with (1) the purposes of peer review; (2) maintaining the high degree of deference the Legislature intended for the professional peer review determinations of medical staffs; and further (3) provides a straightforward and workable standard for governing bodies to employ in reviewing medical staff peer review decisions, consistent with the limitations placed on the review powers of the governing body by the law, and consistent with the fair hearing statutes of §§ 809 *et seq.* and legislative intent embodied therein.

II. S.B. 1211 ENTITLES PHYSICIANS TO FAIR HEARINGS CONCERNING DISCIPLINE, RIGHTS THAT HAVE LONG BEEN GUARANTEED UNDER THE COMMON LAW.[6]

A. The Fair Hearing Requirements

California courts have long held, as a matter of the common law, that physicians may not be deprived of staff privileges without being granted a fair hearing. *See, e.g., Rosenblit v. Fountain Valley Regional Hosp. & Med. Center*

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[5]Section 809.05(a) reads:

> The governing bodies of acute care hospitals have a legitimate function in the peer review process. In all peer review matters, the governing body shall give weight to the actions of peer review bodies and, in no event, shall act in an arbitrary or capricious manner.

[6]Business & Professions Code §809 *et seq.* was the product of S.B. 1211, enacted in 1989. The operative Section 809.05, however, was enacted by a joinder bill, S.B. 1480, several weeks after S.B. 1211 was signed into law. For convenience, amicus will refer to "S.B. 1211" to include S.B. 1480 and the entirety of the current Sections 809 *et seq.*

(1991) 231 Cal.App.3d 1434, 282 Cal.Rptr. 819; *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826; *Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442; *Volpicelli v. Jared Sydney Torrance Memorial Hospital* (1980) 109 Cal.App.3d 242, 167 Cal.Rptr. 610; *Applebaum v. Board of Directors of Barton Memorial Hospital* (1980) 104 Cal.App.3d 648, 163 Cal.Rptr. 831; *Hackethal v. Loma Linda Community Hospital Corp.* (1979) 91 Cal.App.3d 59, 153 Cal.Rptr. 783; *Ascherman v. St. Francis Memorial Hospital* (1975) 45 Cal.App.3d 507, 119 Cal.Rptr. 507.

In 1989, the California Legislature recognized the important principles established by the common law in this area and enacted Business & Professions Code §§ 809 *et seq.*, a comprehensive statutory scheme governing medical staff peer review in California. (Stats.1989, hereafter "S.B. 1211.") The primary purpose of the legislation was to protect the health and welfare of the people of California by setting out procedures to ensure fairness in the peer review process.

Among the statements of legislative intent incorporated into the statutory provisions of S.B. 1211, are the following:

> (a)(3) Peer review, *fairly conducted* is essential to preserving the highest standards of medical practice.
>
> (a)(4) Peer review *which is not conducted fairly* results in harm both to patients and healing arts practitioners by limiting access to care.

(Business and Professions Code § 809(a)(3) & (a)(4).)

Thus, in S.B. 1211, the Legislature sought to preserve high standards of medical practice by requiring that peer review be conducted fairly, according to the requirements stated therein. In addition, the Legislature sought to avoid harm to both patients and healing arts practitioners by discouraging and safeguarding against unfair peer review.

S.B. 1211 sets out specific elements of fair procedures in peer review matters. Physicians are entitled to notice of a final proposed action of a peer review body. The notice must include the proposed action to be taken against the

licentiate, the right to request a hearing, and if a hearing is requested, the reasons for the final proposed action. Business & Professions Code §809.1.

If the physician requests a hearing, the trier of fact must be an arbitrator or panel of unbiased individuals. The physician has the right to *voir dire* the panel members, and to inspect and copy documents relevant to the charges. Business & Professions Code §809.2.

During the hearing (except for initial applicants), the peer review body bears the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable. Business & Professions Code §809.3(b)(3).)

B. The Governing Body May Take Action Under Very Limited Circumstances.

The governing body of a hospital is also authorized to take action against a physician when the peer review body *fails to act*. The governing body's authority is specifically limited by S.B. 1211, which requires that any such action of the governing body be taken *only if* the medical staff's failure to act is contrary to the weight of the evidence, the action is taken in a reasonable manner and the action is taken only after written notice to the medical staff and in full compliance with the procedures and rules applicable to peer review proceedings under Business & Professions Code §§ 809.1 to 809.6. Business & Professions Code §809.05(c).)[7]

In this regard, the Legislature has recognized the importance of the medical staff's expertise, and required that appropriate deference be given to its determinations in cases involving disciplinary actions against medical staff members. Thus, a hospital board has the authority to direct the medical staff to initiate an investigation or disciplinary action, but only where a medical staff's

[7]An example of this was seen in *Hongsathavij, supra.* The instant case is quite different than in *Hongsathavij.* This case involves an extensive investigation and peer review proceeding carried out by the medical staff.

failure to do so is contrary to the weight of the evidence, and even then, only after consultation with the medical staff. In addition the law provides "no such action shall be taken in an unreasonable manner." (Business & Professions Code §809.05(b).) Where the medical staff fails to abide by the hospital board's direction to act as set forth above, the hospital board may itself undertake an investigation or institute disciplinary action. If it does so, it must first notify the medical staff in writing, and follow the statutorily prescribed fair hearing requirements. (Business & Professions Code §809.05(c).)

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

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

1. the failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual;
2. the hospital board has first made reasonable attempts to contract the medical staffs; and
3. such a suspension terminates automatically if it is not ratified by the medical staff within two (2) working days.

(Business & Professions Code §809.5(b).)[8]

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[8]Note also that "it is the intent of the Legislature that written provisions implementing Sections 809 to 809.8, inclusive in the acute care hospital setting shall be included in medical staff bylaws which shall be adopted by a vote of the members of the organized medical staff and which shall be subject to governing

Finally, hospitals are entitled to a conditional immunity from damages (except specific economic damages) for any disciplinary action taken which must be reported to the Medical Board of California pursuant to Business & Professions Code §805, *only when the hospital takes action upon the recommendation of the medical staff.* The law expects the hospital board to rely upon the independent judgment of the medical staff in professional matters. Plainly, these statutes evince a legislative judgment that medical staff activities are critical to the ongoing performance of quality assurance, and entitled to significant deference.

C. When Properly Conducted, The Peer Review Process Ensures That Physicians Will Be Able To Provide Necessary Care To Patients, And, In Turn, That Patients Will Have Access To High Quality Medical Care.

Hospital medical staff membership and clinical privileges are of paramount importance not only to physicians but also to their patients, and ultimately to the community as a whole. Generally speaking, only a physician who has obtained medical staff membership has the power to admit patients to hospitals and to provide specific inpatient services. Consequently, medical staff membership is an integral part of a physician's practice. In addition to providing medical services to patients, medical staff members engage in quality assurance activities, including 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 "peer review process").

These peer review processes are essential to preserving high standards of medical practice within the hospital. *See* Business & Professions Code §809(a)(3)

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body approval, which approval shall not be withheld unreasonably." (Business & Professions Code §809(a)(8).)

(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 are seriously injured. *See generally Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156.

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. 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. Moreover, physicians generally are not paid for these activities, a factor of particular importance given current concerns over the escalating cost of health care.

Thus, if properly implemented, the peer review process ensures that a qualified physician will obtain and maintain medical staff membership and appropriate clinical privileges in a hospital which serves the community where his or her 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, effective peer review ensures that medical care will be both available and competent.

D. If The Peer Review Process Is Not Conducted Fairly, It Will Irremediably Harm Both Patients And Physicians And Will Jeopardize The On-Going Viability Of The Process Itself

Just as peer review is necessary to ensure quality patient care, it is critical that that process be accomplished lawfully and fairly. The goals of peer review will be *defeated*, not promoted, if qualified physicians are wrongfully excluded from hospital 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, 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."). Thus, arbitrary or unjust exclusion unfairly deprives patients of the ability to obtain necessary services from their chosen physician at an appropriate hospital and thereby seriously harms the delivery of healthcare.

III. THE APPROPRIATE STANDARD OF REVIEW FOR THE GOVERNING BODY, AND THE TRIAL AND APPELLATE COURTS.

The appropriate standard of review for the governing body and the courts in peer review cases affords tremendous deference to the peer review body's factual findings. The substantial evidence test, as discussed below, and as applied in *Hongsathavij*, *supra*, and *Huang v. St. Francis Hospital* (1990) 220 Cal.App.3d 1286, 270 Cal.Rptr. 41, show this clearly. Given such a deferential standard, it makes sense that the review standard applied by the governing body to the *action* of the peer review body, that is, the disciplinary recommendation, should be even *more* deferential, and thus it is no surprise that the legislature required that hospitals afford "great weight" to those penalty determinations. Any other result would open a back door for the governing body to avoid the results of the deferential substantial evidence review completely and permit it to insert its own

outcome over that of the peer review body. This will be discussed further below. First, however, a review of the application of the substantial evidence test as seen in *Hongsathavij* and *Huang*, illustrates just how deferential the substantial evidence review standard is to the *peer review body's factual findings*.

The Legislature has established a carefully articulated scheme governing both the burden of proof and the standard of review to be applied at the various levels of a peer review disciplinary process. We provide a summary of the review standards incumbent on the governing body, the trial court and the appellate court.

A. Governing Body Review

Cedars' has misconstrued the review standard the *governing body* must employ in reviewing the administrative record of the peer review disciplinary proceedings in its hospital. It is *not* that the governing body must find substantial evidence *in the record of the J.R.C. proceedings* (i.e., the administrative record) to support and justify the *governing body's* decision to overturn the peer review recommendation of the J.R.C. Instead, the governing body must *review the administrative record to determine whether the findings of the medical staff are supported by substantial evidence in light of that record.* (*Hongsathavij, supra,* 62 Cal.App.4th at pp. 1136-37.)

Thus, the governing body's charge on review of the J.R.C. record below is to see what evidence in the record *supports* the peer review body's determinations, and assess whether that evidence might be (1) irrelevant, (2) inherently improbable, or (3) comprised of opinion testimony of expert witnesses that does not constitute substantial evidence when it is based on conclusions or assumptions that themselves are not supported by evidence in the record. (*Hongsathavij, supra.* 62 Cal.App.4th at 1137.) If there is any substantial evidence, contradicted or uncontradicted, supporting the decision of the J.R.C. (and in the case of Cedars, the MSEC) the governing body must determine that the medical staff's peer review determinations "are supported by substantial evidence in light of the whole

record." As the court elaborated on the application of the substantial evidence test in *Huang v. St. Francis Hospital, supra:*

> The court must consider the evidence in the light most favorable to the prevailing party, giving him the benefit of every reasonable inference and resolving conflicts in support of the judgment. [Citations.] The court is without power to judge the effect or value of the evidence, weigh the evidence, consider the credibility of witnesses, or resolve conflicts in the evidence or in the reasonable inferences that may be drawn from it. [Citations.] Unless a finding, viewed in light of the entire records, is so lacking in evidentiary support as to render it unreasonable, it may not be set aside. [Citations.]

(*Huang v. St. Francis Hospital, supra,* 220 Cal.App.3d at 1294.)

If, on the other hand, the governing body determines that the record of the J.R.C. below *does not* contain substantial evidence to support the medical staff's findings, the governing body *must have substantial evidence to support its own (in this case, contrary) decision.*[9] Hospital governing bodies are mandated by law to uphold the findings of a peer review body so long as they are supported by substantial evidence. (*Hongsathavij, supra,* 62 Cal.App.4th at 1136-37.) Further, the governing body must give "great weight to the action," i.e., the recommended

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[9]Respondent's brief betrays that the hospital misconstrued the standards of review that apply to the peer review body's findings and recommendations. Respondent's brief at 14 remarks that, in the "final report" of the Hospital Board, it concluded that:

> . . . "even giving great weight to the *findings* of the Hearing Committee majority," the majority's *recommendations* were not supported "by substantial evidence contained in the record."

(Quotation marks in original; emphasis added.) The hospital has it all backwards. It is not the *recommendations* of the peer review body that are to be reviewed for *substantial evidence*, nor are the *findings* accorded *great weight.* Rather, the substantial evidence test is to be applied to the *findings,* and great weight is accorded the *recommendations* (i.e., *actions*) of the peer review body. It appears the governing body failed, in the first instance, to afford proper substantial evidence review of this matter.

discipline, of the peer review body. (Section 809.05(a) .) If the decision of the governing body is then challenged in court, the court must uphold the board's decision if it is supported by substantial evidence. (C.C.P. §1094.5.)

This scheme reflects the appropriate deference to professional expertise that permeates California law, as discussed further below. It also provides appropriate safeguards to ensure the fairness of the proceeding to the physician.

Two courts of appeal have reviewed this scheme and concluded, contrary to the suggestions of the hospital and its trade association in this case, that hospital governing bodies must apply the same "substantial evidence test" when they review the decisions of the peer review body that is applied by the court when it subsequently reviews their decisions pursuant to C.C.P. §1094.5.

In *Huang v. St. Francis Medical Center*, supra, the California Court of Appeal *reversed* a trial court decision which applied the substantial evidence test to the decision of the hospital's appeal board, rather than to the decision of the J.R.C. The *Huang* court stated that the trial court's finding that substantial evidence supported the decision of the hospital's appeal board was "meaningless," because the hospital's medical staff bylaws required the appeal board to apply the substantial evidence test to the findings of the J.R.C. The *Huang* court found that the hospital appeal board had *impermissibly applied its independent judgment* in reviewing the evidence and evaluating the credibility of witnesses. (*Huang, supra,* 220 Cal.App.3d at 1294.) The court thus invalidated the appeal board's rejection of those findings of the J.R.C.[10]

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[10]Other cases have also made the clear distinction between the decisions of medical staff judicial review committees (J.R.C.s) and decisions by hospital boards after review of J.R.C. decisions, most often in the context of superior or appellate court review. They are nonetheless instructive as to the deference paid to the J.R.C. decision. For example, in *Bonner v. Sisters of Providence Corp.* (1987) 194 Cal.App.3d 437, 239 Cal.Rptr. 530, the court considered the standard of superior court review in an administrative mandamus case under Code of Civil Procedure §1094.5(d). The court stated:

The substantial evidence standard of review, as described in *Huang*, is a very deferential standard. In peer review matters, the hospital governing body must apply this deferential standard of review to the decision of the peer review body, which consists of physicians who have the expertise to evaluate questions of quality of medical care and professionalism. This conclusion is mandated by the specific requirements of S.B. 1211, by California case law, and by the policy of deference to physician expertise as duly reflected in California statutory and regulatory provisions governing the health care system. (*See* Section IV.B., below.)

The *Huang* court's analysis was confirmed by the *Hongsathavij* court in requiring that the first question which must be addressed by a reviewing court is "whether the *governing body* applied the correct standard in conducting *its* review of the matter." (*Hongsathavij, supra,* 62 Cal.App.4th at 1136, emphasis added.)

> When the standard of review for the trial court is substantial evidence, i.e., when the trial court 'must uphold the hospital *judicial review committee's* decision unless administrative findings viewed in light of the entire record are so lacking in evidentiary support as to render them unreasonable,' *the standard of review for the appellate court is the same.* (*Gaenslen v. Board of Directors* (1985) 185 Cal.App.3d 563 at pp. 572-573, 232 Cal.Rptr. 239 and citations therein.) *Like the trial court, we also review the administrative record to determine whether its findings are supported by substantial evidence in light of the whole record, our object being to ascertain whether the trial court ruled correctly as a matter of law.*

Bonner, supra, 194 Cal.App.3d at p. 444 (emphasis added).

Both *Bonner* and *Gaenslen* cited the need to defer to the J.R.C. concerning matters of physician competency. " 'Under the substantial evidence test, it is not the function of reviewing courts to resolve differences of medical judgments'." *Bonner* at p. 447 citing *Cipriotti v. Board of Directors* (1983) 147 Cal.App.3d 144, 154, 196 Cal.Rptr. 367. These cases illustrate the deference the courts accord the medical staff hearing panel's findings and conclusions. It makes no sense that the governing body's review would be any less deferential than that afforded subsequently by the courts *in reviewing same exact administrative hearing record.*

Although the *Hongsathavij* court then went on to uphold the board's decision in that case, despite the fact that the board had rejected the peer review body's determinations, it did so only after it found that the board had properly reviewed the peer review body's decision. Consistent with the proper application by the hospital board of the deferential substantial evidence test it was mandated to apply, the court concurred with the hospital board that "the findings of the J.R.C. [were] so lacking in evidentiary support as to render them unreasonable." (*Hongsathavij, supra,* 62 Cal.App.4th at 1137.) Similarly, the court agreed with the hospital board that certain of the J.R.C.'s other findings were based on evidence irrelevant to the case, and were therefore likewise so lacking in evidentiary support "as to be unreasonable." (*Hongsathavij, supra,* 62 Cal.App.4th at 1140.) Specifically, the court found that there was plainly evidence in the record that Dr. Honsathavij had been informed of a particular responsibility under COBRA, and thus the JRC's finding that he had not been so informed was "unsupportable." Moreover, the court found that the JRC was wrong as a matter of law on the scope of that responsibility, and that thus "the facts elicited by Dr. Hongsathavij on the COBRA issue were essentially irrelevant" and that the "findings of the JRC [based on that irrelevant testimony] were thus of no consequence." (*Id.* at 1139, 1140.)

Thus, *Hongsathavij* provides no support for the suggestion that hospital boards are free to reweigh the evidence and substitute their own judgment for that of the peer review body as to the disciplinary recommendations made. It expressly reaffirms that the *Huang* court determined that they are not free to do so.

B. Mandamus Review by the Trial Court

The governing body's determinations are then subject to review by the trial court based on substantial evidence in light of the whole record. (C.C.P. §1094.5.) The *Hongsathavij* court described the task of the Superior Court in this regard:

> [T]he superior court essentially must determine two issues. First, it must determine whether the governing body applied the correct standard in conducting its review of the matter. Second, after determining as a preliminary matter that the correct standard was used, then the superior court must determine whether there was substantial evidence to support the governing body's decision.

(*Hongsathavij, supra,* 62 Cal.App.4th at 1136.)

Thus, the trial court does not review the administrative record for substantial evidence supporting the hospital board's decision unless and until it concludes the governing body applied the correct standard of review. It must first make sure the governing body correctly applied the substantial evidence test to the record supplied by the medical staff. If the trial court determines that the governing body properly performed its review obligations, then and only then does the trial court review *the entire record* to determine whether there was substantial evidence to support the governing body's decision.

Given the discussion above, it would be an *abuse of discretion* for the governing body, on review of the medical staff's determinations, to merely pick and choose evidence from the administrative record in order to justify imposing a different result. Such an exercise does not satisfy the legal review obligations of the governing body, and any different result imposed by the governing body by this subterfuge should not be sustained on review by any court.

C. Appellate Review Of The Trial Court's Decision

The appellate court's review standard is very similar to that of the governing body and trial court:

> As to the function of the Court of Appeal, our function in this context is the same as the superior courts, *which was the same as the hospital's governing body.* "Like the trial court, we also review the administrative record to determine whether its findings are supported by substantial evidence in light of the whole record, our object being to ascertain whether the trial court ruled correctly as a matter of law." (*Bonner v. Sisters of Providence Corp.* (1987) 194 Cal.App.3d 437, 444, 239 Cal.Rptr. 530; *see Pick v. Santa Ana-Tustin*

> *Community Hospital* (1982) 130 Cal.App.3d 970, 980, fn. 6, 182 Cal.Rptr. 85.) The appellate court thus does not review the actions or reasoning of the superior court, but rather conducts its own review of the administrative proceedings to determine whether the superior court ruled correctly as a matter of law. (*Gaenslen, supra,* 185 Cal.App.3d at p. 573, fn. 5, 232 Cal.Rptr. 239.)

(*Hongsathavij, supra,* 62 Cal.App.4th at 1137, emphasis added.)

In its review, neither the trial court nor the appellate court can overlook how the governing body performed *its* review prior to arriving at its determinations that are contrary to those of the medical staff. If the governing body simply selected evidence out of the administrative hearing record to *support its own very different decision* on the peer review matter, and the superior court sustains the governing body's determination by saying it had *"substantial evidence" to justify its alternative decision*, then this error in the governing body review process is perpetuated all the way up the line in the court system. While *Hongsathavij* remarks that the trial court is not to simply review the administrative record as it existed prior to governing body review, *Hongsathavij* also makes clear that review of the full record occurs only after the trial court confirms that the governing body engaged in the appropriate appellate task.

IV. ONCE THE SUBSTANTIAL EVIDENCE REVIEW IS SUCCESSFULLY APPLIED BY THE GOVERNING BODY, THE LAW REQUIRES THAT IT MUST APPLY GREAT WEIGHT TO THE ACTION OF THE PEER REVIEW BODY, AND IN NO EVENT SHALL THE GOVERNING BODY ACT IN AN ARBITRARY OR CAPRICIOUS MANNER.

A. The Application Of "Great Weight" To The Peer Review Body's Action Should Require That The Governing Body May Not Reverse Or Modify The Peer Review Body's Action Unless It Is Clearly Erroneous, i.e., Evinces A Manifest Abuse Of Discretion.

Section 809.05(a) states that:

> The governing bodies of acute care hospitals have a legitimate function in the peer review process. In all peer review matters, the governing body shall give great weight to the actions of the peer

review bodies and, in no event, shall act in an arbitrary or capricious manner.

Consistent with the use of the "great weight" standard used in other contexts of the law, the action, that is penalty, of the peer review body should not be overruled by the governing body unless the penalty is itself clearly erroneous, i.e., unless the peer review body has engaged in a manifest abuse of discretion.

B. A Standard Requiring That The Peer Review Body's Recommendation Be Given Great Weight Unless It Evinces Manifests Abuse Of Discretion Is Commensurate With The Deference That Should Be Provided Medical Professional Expertise In Peer Review Matters.

A medical staff and its Judicial Review Committee are vested with the duty to perform peer review because they have special expertise in the medical matters involved in such review. The Legislature has accounted for significant deference to the expertise and training of a physician's peers in a number of ways. The deference included in the peer review process established by S.B. 1211 is consistent with the deference shown to physicians' judgment in other contexts. 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 judicial 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 Board of Medical Quality Assurance, the state agency charged with the administration of the Medical Practice Act.

California's long-standing public policy against permitting lay persons to practice medicine or exercise control over decisions made by physicians is reflected throughout the law governing the provision of health care. For example, the corporate practice bar's public policy concerns were expressly incorporated into the Moscone-Knox Act (Corporations Code §§13400 *et seq.*) Specifically, that Act prohibits persons other than certain health professionals licensed under their respective licensing boards, from becoming shareholders or directors of corporations engaged in rendering medical services. (*See* Corporations Code §13401.5. *See also Marik v. Superior Court* (1987) 191 Cal.App.3d 1136, 1139, 236 Cal.Rptr. 751.) Additionally, while the Knox-Keene Health Care Service Plan Act (Health and Safety Code §1340 *et seq.*) enables health care service plans to employ or contract with physicians, the Act contains specific provisions prohibiting such plans from taking any other action which directly or indirectly constitutes the practice of medicine. (*See* Health and Safety Code §1395(b).)

Recognizing that one of the purposes of the Knox-Keene Act was to help "assure the best possible health care for the public at the lowest cost," the Legislature expressly declared that it was its intent to assure "the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional" and to assure "that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care." (*See* Health and Safety Code §1342.) Therefore, the law requires that all plans be able to demonstrate to the Department of Managed Health Care that "medical decisions are rendered by qualified medical providers; *unhindered by fiscal and administrative management.*" *See* Health and Safety Code §1367(g) (Emphasis added); *see also* 10 C.C.R. §1300.67.3 (stating that the organization of

a plan must include a "separation of medical services from fiscal and administrative management sufficient to assure the [DMHC] that medical decisions will not be unduly influenced by fiscal and administrative management.")[11]

Similarly, in medical malpractice cases, 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"].)

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 Health Services specifically require the medical staff of the hospital to be "self-governing" with respect to the professional work performed in the hospital. *See* Business and Professions Code §2282, Health and Safety Code § 1250, 22 C.C.R. §§ 70701 and 70703.[12]

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[11]Health care service plans typically consist of health maintenance organizations (HMOs) which are organizations that either directly furnish or assume responsibility for providing health services for their members who pay a fixed pre-paid monthly or annual sum for coverage. In return for such a fee, the member is guaranteed a defined set of benefits without regard to the type or frequency of service rendered.

[12]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

C. Deference Should Be Afforded The Medical Staff's Determination In These Cases.

In determining whether the peer review body's recommendation for discipline was appropriate, the medical expertise underlying that recommendation should be afforded great deference by the governing body, in other words, "great weight." The courts have applied the "great weight" standard to accorded significant deference to the expertise of various bodies when engaged in review of those body's activities. The deference afforded in these cases is far greater than that argued by the hospital in this case.

For example, the contemporaneous administrative construction of a statute by an administrative agency charged with the statute's enforcement and interpretation is entitled to great weight unless it is clearly erroneous or unauthorized. (*Wilkinson v. Workers' Comp. Appeals Bd.* (1977) 19 Cal.3d 491, 501, 138 Cal.Rptr. 696 Cal. 1977; *Tenet/Centinela* Hosp. *Medical Center v.*

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receive proper care, and because lay individuals have neither the expertise nor experience to render decisions regarding the provision of medical care, the Department of Health Services has set up an elaborate system designed to ensure that physicians on the medical staff are responsible for the variety of patient care "services" provided in the hospital. For example, the law demands that only a physician can be responsible for the "medical service," which consists of "those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff." 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).

Workers' Comp. Appeals Bd. (2000) 80 Cal.App.4th 1041, 1048, 95 Cal.Rptr.2d 858.)

Moreover, the deference a reviewing body must afford an expert body on *penalty* is, if anything, greater than that which must be afforded on review of questions of procedure or fact pursuant to the substantial evidence test. In the context of court review of agency decisions on penalty, a penalty determination may not be disturbed unless there has been a "manifest abuse of discretion." (*Landau v. Superior Court* (2000) 81 Cal.App. 4th 191, 217, 97 Cal.Rptr.2d 657.) If "reasonable minds could differ over the appropriateness of the penalty," *the penalty must be upheld.* (*Id.* at 218.) In *Landau, supra,* the court stated:

> In reviewing the severity of the discipline imposed, we look to the correctness of the agency's decision rather than that of the trial court. We review the actions of the Medical Board to determine whether the discipline imposed constituted a manifest abuse of discretion. [Citations.] "The penalty imposed by an administrative body will not be disturbed in mandamus proceedings unless an abuse of discretion is demonstrated. [Citations.] Neither an appellate court nor a trial court is free to substitute its discretion for that of the administrative agency concerning the degree of punishment imposed. [Citations.]

(*Landau v. Superior Court, supra,* 81 Cal.App. 4th at pp. 217-18.)

The administrative agency involved in *Landau* was the Medical Board itself, which had apparently adopted the decision of the administrative law judge. Therefore, it was not a case challenging a substitution of penalty by the Medical Board for that recommended by the ALJ. The deference afforded the Medical Board in disciplinary proceedings, however, is analogous to the deference the legislature mandated for the peer review body's penalty determination. The same deference accorded the Medical Board for its legislatively assigned duties in disciplining its licentiates imbues it with the expertise in such matters and thereby warrant such deference. As the legislature recognized in requiring that the penalty determinations of peer review bodies be afforded "great weight" in peer review

matters, the J.R.C. (and in this case, the MEC), as already discussed above, retains the requisite expertise in handling peer review matters, and not the lay administrative governing body of the hospital.

Consistent with the language of the statute, the statutory scheme and the panoply of related laws, regulations and court cases discusses above, the same deference afforded the Medical Board in *Landau* should adhere to the peer review body in peer review cases as to the nature of the peer review body's recommendation to the governing body. The governing body must defer to the disciplinary recommendation of the peer review body unless the recommendation is *clearly erroneous*, i.e., unless it evinces a *manifest abuse of discretion.* This means that if "reasonable minds could differ over the appropriateness of the penalty," *the penalty must be upheld by the governing body.* (*See Landau, supra*, 81 Cal.App. 4th at 218.)

V. ASSERTED FEAR OF HOSPITAL CORPORATE LIABILITY DOES NOT JUSTIFY THE HOSPITAL INDUSTRY'S DESIRE TO HAVE VIRTUALLY UNFETTERED DISCRETION IN DETERMINING PHYSICIAN DISCIPLINE.

One thing that is abundantly clear from the briefing in this case, including that of the CHA, is that the hospital industry has grave concerns for *potential future corporate liability* under *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr 156. (Hospital brief at p. 34, CHA brief at pp. 7-9.) Cedars points to *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center* (1998) 62 Cal.App.4th 1123, 73 Cal.Rptr.2d 695, as not only giving sanction to its fears of liability, but giving sanction to incorporate those fears into its considerations on review of a disciplinary action against a physician medical staff member handed down by a committee of peer physicians. (Respondent's Brief at 34.)

Hospital corporate liability for negligence for failing to properly credential its providers, or more precisely, for "failing to provide careful selection and

review" of its physicians was brought to life in the case of *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 183 Cal.Rptr 156. *Elam* does not posit strict liability, however. In fact, the potential for *Elam* liability is nonexistent after the careful and meticulous medical staff peer review that is seen in the instant case. Nor can *Elam* liability arise solely from a peer review determination of the medical staff with which the governing body simply disagrees.

A. As Shown By The Briefing Of The Hospital And Its Trade Association, The Governing Body Sees The Hospital's Economic Well-Being As Intertwined With The Fate Of The Physician Involved In A Peer Review Proceeding. Therefore, Consistent With The Fair Hearing Rights Of Physicians, The "Great Weight" Standard Afforded The Actions Of Peer Review Bodies Must Be Interpreted To Require The Governing Body To Adopt The Penalty Determination Of The Medical Staff Unless That Determination Is Clearly Erroneous, i.e., Evinces A Manifest Abuse Of Discretion.

As both the Hospital and its trade association have demonstrated in their respective briefs, *Elam* liability considerations, rightly or wrongly, may be part of the hospital's considerations in governing body review of medical staff activities intended to assure the quality of care in the hospital. CHA intimates that dire financial consequences for hospitals may occur if governing bodies of hospitals do not have great discretion to overturn a peer review body's determination that is anything less than termination of a physician from the medical staff. (*See* CHA Amicus Brief at 7-9.)

Whether or not these concerns describe a true conflict of interest for the hospital governing body in reviewing peer review determinations, the hospital and CHA have revealed that *Elam* considerations are clearly a part of the governing body's mindset when it engages in such review. There can also be little doubt that when economic interests of a review body are entwined with, and contrary to, a physician's interests to avoid arbitrary deprivation of medical staff privileges, the

fairness of the governing body review process in peer review matters becomes highly suspect.

B. The Facts of Elam v. College Park Hospital Compared To This Case

Elam was a podiatric malpractice case in which a hospital plaintiff also alleged independent liability against the hospital corporate body for negligence in failing to assure the competence of the defendant podiatrist on staff. The hospital admitted it was aware of at least one malpractice case by the podiatrist that occurred prior to the alleged malpractice in *Elam*, though the podiatrist was not removed from the staff and ultimately was alleged to have injured the plaintiff. (*Elam v. College Park Hospital*, *supra*, 132 Cal.App.3d at 337.)

Contrary to Respondent's Brief at p. 25, the *Elam* court did not impose liability on the hospital, but instead remanded the case for further determinations in order to assess whether liability should be imposed. The very fact of remand is instructive, because in doing so the *Elam* court provided guidance as to the panoply of facts that must be determined and applied before *Elam* liability can be potentially imposed. These inquiries go to whether there was negligence in the medical staff processes which the hospital corporate body, through its own inaction or other negligence, failed to recognize or remedy in order to avoid later but foreseeable harm to a patient.

Secondly, there were routine periodic reviews of the podiatrist over a number of years in *Elam*, but a *peer review disciplinary proceeding against the podiatrist apparently never occurred.* (*Elam v. College Park Hospital*, *supra*, 132 Cal.App.3d at 336.) In the instant case, however, the medical staff's review of the physician was extensive, even grueling over many hours of testimony and many days of hearing. The peer review was made even more exhaustive as the medical staff Executive Committee was asked to "re-review" its own assessment of the hearing panel, with specific questions drawn up by the governing body directing

that re-review. There is no question that the medical staff appropriately reviewed the physician in this case, a factor that of itself completely removes this case from the traditional *Elam* context. The fact that the hospital may disagree with the results of the peer review body does not mean that *Elam* liability potential becomes heightened, much less that the *Elam* criteria for liability are somehow met.

Third, the very questions posed by the *Elam* court on remand to evaluate whether *Elam* negligence occurred also show that such liability could not accrue to the hospital in this case, or in any cases where the medical staff was diligent in its investigation, prosecution, hearing and intermediate review (if any) of the hearing panel's determinations and conclusions. The minimum questions in a case where peer review proceedings did not occur, as posed by the *Elam* court included the following:

> For example, [1] whether Hospital should have conducted an investigation through its [medical staff] peer review committee upon notice of the [prior unrelated malpractice] case? [2] Whether the [medical staff] committee had conducted its periodic reviews of [the involved podiatrist on staff] in a non-negligent manner? [3] Assuming a review was made after notice of the [prior unrelated malpractice] case, was it performed in a non-negligent manner? [4] If it had been made in a careful and proper manner, would the committee have recommended revocation or suspension [the podiatrist's staff privileges]?

(*Elam v. College Park Hospital*, *supra*, 132 Cal.App.3d at 348, bracketed numbering added.)

Applying those questions to this case, there is plainly no cause for the Cedar's *Elam* concerns here. In this case, the hospital, through its medical staff, [1] conducted an investigation that resulted in a hearing for the physician to address the charges determined from the facts derived from the investigation. [2] Periodic reviews of the physician in this case were not an issue; rather the results of the peer review disciplinary proceedings are at issue. [3] Were the proceedings

conducted in a "non-negligent" manner as required by *Elam* once there cause for a proceeding was identified? Plainly there was a surfeit of "due care" exercised by the medical staff in this case, and indeed, the governing body has not raised an issue of "negligent" hearing *process*. [4]. Having performed the disciplinary peer review in the proper manner, the decision of the MSEC/hearing panel was to retain the physician on staff with involvement of the medical staff well-being committee. The governing body disagrees with the judgments (action) of the medical staff in this case, despite the MSEC twice affirming its position with respect to the outcome.

Elam question #4 is the crux of the potential for *Elam* liability for the hospital industry, and raises the fear of economic disaster discussed in the CHA amicus brief: whether the plaintiff in some future malpractice case involving the physician can raise before a jury the *suspicion* that, had the medical staff done its job "correctly" (i.e., non-negligently), the hospital would have removed the practitioner from the medical staff. To avoid that result in the specter of some future malpractice case, the inference to be derived from the CHA argument is that the best and safest thing a governing body can do is *presume that anything less than revocation recommended by the medical staff must be overturned.* Thus, the argument goes, notwithstanding the Legislature's clear mandate that hospital governing boards afford significant deference to the medical staff's decision in this case, that mandate should give way in the face of any specter of *Elam* liability, however frivolous or overblown.

In peer review disciplinary actions that ensue after a medical staff investigation and appropriate and fair hearings, the potential for *Elam* liability simply cannot accrue. This is especially true in this case, where thorough review by an intermediary body, the MSEC occurred not only once, but twice, bringing the same result. *Elam* very properly evaluated the potential for liability in a factual scenario where the medical staff may have failed to take action of any kind

against a practitioner who allegedly delivered substandard care. The hospital bar, its clients, and the hospital association may understandably fear corporate liability among other financial concerns in many areas of hospital operations. Their concerns for *Elam* liability in the context of properly exercised investigations and fully evaluated and completed peer review disciplinary actions, however, are misplaced.[13]

C. The Potential For Elam Liability Is Further Reduced Due To The Legislature's Determination That Records And Proceedings Of Peer Review Bodies Are Exempt From Discovery.

Evidence Code Section 1157 protects the records and proceedings of medical staff peer committees from discovery in malpractice and other civil actions. Even in the face of an *Elam* negligence claim against a hospital, records and proceedings of peer review bodies remain exempt from discovery. The courts have noted this dichotomy between the right of a plaintiff to assert *Elam* claims, and the denial of the plaintiff the right to obtain peer review records that would undoubtedly serve as evidence to support the claim:

> [D]iscovery of the sought material would in all likelihood lead to very material and admissible evidence. But the Legislature has made the judgment call that an even more important societal interest is served by declaring such evidence 'off limits.' * * * Nothing in the prior cases interpreting the statutes suggest a different result in the case at bar.

(*West Covina Hospital v. Superior Court* (1984) 153 Cal.App.3d 134, 139, 200 Cal.Rptr. 162.)

The protections of Evidence Code Section 1157 add further weight to the argument that there can be no well-founded concerns for *Elam* liability as raised in

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[13] *See also Bell v. Sharp Cabrillo Hospital* (1989) 212 Cal.App.3d 1034, 260 Cal.Rptr. 886. (*Elam* claim based on the medical staff's *failure to investigate* another hospital's termination of a long-time medical staff member).

the hospital's and CHA's briefs, particularly in cases where properly performed peer review disciplinary proceedings have been concluded.

D. Greater deference to the medical staff's peer review determination, not lesser, will reduce any potential for future Elam Liability for the Hospital.

Cedars' and CHA's briefs decry the potential for increased *Elam* liability unless the governing body is afforded great latitude to impose its own final determination in peer review cases. In fact, the potential for *Elam* liability is *increased* if the hospital assumes the measure of responsibility that comes with the greater freedom to determine for itself the outcome of peer review cases.

Cases imposing *Elam* liability against the hospital are predicated on the finding of breach of a separate duty of the hospital to provide oversight of what the medical staff does, not on a theory of vicarious liability, such as *respondeat superior* for the physician's negligence. (*See. e.g., Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 166-168, 41 Cal.Rptr. 577 [hospital may be held liable for physician malpractice when physician is actually employed by the hospital or is ostensibly the agent of the hospital].) *Elam*-type cases have almost uniformly recognized the separate nature of the medical staff and the hospital's duty to defer to the medical staff in the first instance. (*See, e.g., Johnson v. Misericordia Community Hospital* (1981) 301 N.W.2d 156, 174-75, 99 Wis.2d 708 [hospitals are not insurers of the competence of their medical staff, "for a hospital will not be negligent if it exercises the noted standard of care in selecting its staff", and "The final appointing authority resides in the hospital's governing body, although it must rely on the medical staff and in particular the credentials committee (or committee of the whole) to investigate and evaluate an applicant's qualifications for the requested privileges"]; and *Elam v. College Park Hospital,* 132 Cal.App.3d at 343-44 [citing to Title 22 regulations requiring medical staff self-governance].)

Hospital governing boards are specifically insulated from liability if they reasonably rely on the medical staff's professional judgment. (*See, e.g.*, Corporations Code §309 [directors of corporation may rely on appropriate other persons as to matters which the director believes to be within such person's professional or expert competence, and may rely on appropriate committees in which the director has confidence].) As discussed above, hospitals are immunized from liability.[14] California law simply does not authorize governing board's to substitute their decisions for those of the medical staff except in the extraordinary case where there is no substantial evidence to support the medical staff's factual findings, or where the discipline recommended is clearly erroneous, i.e., constitutes a manifest abuse of discretion.

E. Fear Of Elam Liability On The Part Of The Hospital Bar, Its Clients, And The Hospital Industry Will Not Disappear Just Because The Medical Staff Properly Engages In Peer Review Disciplinary Actions. A Concern Always Remains That Factors Unrelated To Negligence Of The Medical Staff Could Result In A Later Jury Imposing Corporate (Elam) Liability.

When a malpractice case is brought before a jury, or even when the parties contemplating a settlement of such a case evaluate which issues may be brought before a jury, many factors go into the analysis of whether liability may be imposed. Some of those factors are beyond, outside, and unrelated to any actual alleged negligence on the part of either the defendant physician or corporate defendant. Some of these factors influencing a jury's decision whether to impose liability include, for example, the personality of the plaintiff; the personalities of

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[14]Hospital governing boards are specifically insulated from liability if they reasonably rely on the medical staff's professional judgment. (*See*, e.g., Corporations Code §3209 [directors of corporation may rely on appropriate other persons as to matters which the director believes to be within such person's professional or expert competence, and may rely on appropriate committees in which the director has confidence].) As discussed above, hospitals are immunized from liability.

the physician and others involved; the "presentability" of various witnesses; the severity of demonstrated damages to the plaintiff notwithstanding whether those damages were caused by the defendant(s); the social standing (or lack thereof) of the plaintiff and many other factors understood by competent plaintiff attorneys.

As already discussed, the likelihood of actual *Elam* negligence being found in a case where the medical staff was as diligent as they typically are in carrying out investigations and peer review disciplinary actions (such as seen in this case) is, to understate the matter, highly unlikely. Nonetheless, as the briefing in this case evinces, the hospital, the hospital bar and the state hospital association have claimed their right to be fearful of potential *Elam* liability in these cases.

Sections 809 *et seq.* codify a medical staff member's due process rights in disciplinary actions in hospitals. The hearing rights at issue in this case, including the "great weight" review standard embodied in §809.05(a) , evinces the Legislature's intent that the physician brought in to any medical staff disciplinary hearing process be given a "fair shake" through fair procedures.

Section 809 *et seq.* requires that the physician be given a notice of charges. The physician must be provided with an opportunity to address those charges in a hearing where witnesses can be presented, documents can be exchanged and argument may be made to one or more neutral fact finders. (*See* §§809.1-809.4.). These fair hearing procedures are the embodiment of a long list of rights provided in case law prior to the adoption of SB 1211 in 1989. (*See e.g., Rosenblit v. Superior Court* (1991) 231 Cal.App.3d 1434, 282 Cal.Rptr. 819 [due process violations in physician's common law disciplinary fair hearing].) The basic right to notice and a hearing, the ability to present witnesses and defend against clear charges are essential elements of a physician's constitutional due process rights. (*Ibid.*)

The physician's due process rights do not end at the conclusion of the peer review hearing or at the conclusion of, in this rare kind of case, the intermediary

evaluation of the Medical Executive Committee. The physician has a right to the proper review of the case by the appellate body(ies) within the institution, usually only the governing body. The physician who has defended against charges in a fair hearing has no control over the "fears" of liability of the governing body that may come into play during its later review of the case. The physician at issue has no ability to combat the governing body's fear that a potential future malpractice case may find a jury sufficiently charged emotionally to ignore the question whether claimed *Elam* negligence was real.

The physician cannot argue to the hearing panel below whether damages that might be demonstrated by a plaintiff in some potential future malpractice case against the physician can in any way actually be attributed to "hospital" negligence under *Elam* theory because the physician was not terminated from the medical staff. Nor can the physician argue to the panel that the governing body would not succumb to an unfair settlement demand based on *Elam* considerations arising out of the physicians retention on the medical staff simply because the hospital determines it is cheaper to settle than to litigate its liability in the *potential future* malpractice case. Nor can the physician argue in the hearing that the governing body should not fear adverse marketing implications in the community if such an *Elam* case were brought in a public forum before a jury.

The absurdity of these images arises from the patent unfairness suffered by the reviewed physician when the hospital corporate body injects *Elam* considerations into its review of peer review disciplinary proceedings. The physician has no control over the economic fears of the governing body, and has no ability to defend against them during the only opportunity he is given in peer review proceedings before a hearing panel.

F. *Hongsathavij* Does Not State The Governing Body May Influence Its Decisions By Incorporation of *Elam* Considerations In Its Review Of Peer Review Body Actions.

The *Hongsathavij* court rejected the argument by the physician in that case that because the governing body had initiated the peer review action rather than the medical staff, it created an irreconcilable conflict of interest for the governing body to also make the final decision in the case and overturn the medical staff's Judicial Review Committee action. (*Hongsathavij, supra.* 62 Cal.App.4th at 1142-43.) The court strongly disagreed, responding:

> In essence, Dr. Hongsathavij's position is that if the governing body believes an action against a physician is necessary, and if the medical staff disagrees, then the medical staff gets to make the final decision, since the governing body is tainted by its initial position on the matter. Such a proposition establishing medical staff sovereignty is untenable. Ultimate responsibility is not with the medical staff, but with the governing body of the hospital.

(*Hongsathavij, supra*, 62 Cal.App.4th at 1143.)

The court then launched into an explanation of the hospital corporate obligations and liability potentials, including personal fiduciary and *Elam*-type liabilities, leading to its declaration that "hospital assets are on the line." (*Id.*) At no time, however, did the *Hongsathavij* court *sanction* the incorporation of liability concerns of the governing body into its review of a medical staff peer review decision. Rather, the court's discussion reflected the very unusual procedural posture of the *Hongsathavij* case, and the court's efforts to harmonize a statutory scheme which did not expressly address how appeals should be handled in the rare circumstance that the hospital itself took over the prosecution of a peer review disciplinary matter. The *Hongsathavij* dicta here merely states that, in that extraordinary circumstance, the hospital must not be foreclosed from its appellate role, despite its prior involvement. The *Hongsathavij* dicta here should not be interpreted as an appellate court permitting subordination of a physician's fair

hearing rights to the very speculative future liability potential of the hospital corporate body.

The *Hongsathavij* dicta and discussions about *Elam* raised by the hospital and its trade association are not at all relevant to the facts in the instant case. They should not have been raised herein by either the hospital or its trade association. The fact that they did include briefing on *Elam*, however, even extensively so in the CHA brief, bodes poorly for fairly conducted review of peer review cases by governing bodies that share such liability concerns.

To the degree that *Hongsathavij* is erroneously interpreted to permit or sanction injection of *Elam* concerns in governing body review of peer review actions, the case would not only be wrongly decided on that point, but it would flatly violate statutory law and legislative intent as embodied in the peer review mandate that "a governing body and the medical staff shall act *exclusively* in the interest of maintaining and enhancing quality patient care." (Section 809.05(d).), emphasis added.)

G. The Governing Body Need Not Be Deemed To Stand In An Inherent Conflict Of Interest In Reviewing Peer Review Determinations For This Court To Enforce The Statutory Mandate That The Governing Body Must Afford Great Weight To The Peer Review Body's Disciplinary Determination.

This court need not find that the hospital stands in a true or formal conflict of interest regarding its liability issues in reviewing peer review proceedings. As the briefing in this case makes clear, the lay corporate governing body, most often led by hospital counsel, will be tempted to incorporate liability considerations and perhaps other financial concerns into its review of the peer review determinations of its medical staff. The fact these financial considerations, when incorporated into the review process, involve an act by the governing body that is not "exclusively in the interest of maintaining and enhancing quality patient care" in violation of section 809.05(d) obviously cannot be legislated out of existence. But this court can help minimize the untoward effects of those economic

considerations (whether those considerations are explicit or merely *sub rosa* in any one case) by fully enforcing the great weight standard embodied in section 809.05.) and requiring that no disciplinary determination of the medical staff under sections 809 *et seq.*).be reversed by the governing body unless the peer review penalty determination is shown by substantial evidence to be *clearly erroneous, or stated another way, evinces a manifest abuse of discretion.*

VI. ALL RECOMMENDATIONS OF THE MEDICAL STAFF ARISING FROM PEER REVIEW DISCIPLINARY PROCEEDINGS REQUIRE THE SAME LEVEL OF DEFERENCE UPON REVIEW BY THE GOVERNING BODY. THEY CANNOT BE PARSED INTO THOSE THAT "INVOLVE" THE STANDARD OF CARE, AND THOSE THAT "DO NOT."

The brief of CHA announces a novel approach to the analysis of peer review body recommendations: It declares that a peer review committee's recommendations are entitled to less deference by the governing body when the do not "involve the standard of care." In this case, the brief states, the recommendation for Dr. Weinberg to submit for evaluation of the medical staff's well-being committee "is beyond the presumed expertise of the peer review committee." Sections 809 *et seq.* make no such distinction. Further, Sections 809 *et seq.* are very clear that when the medical staff provides a final proposed action for which a report is required to be filed under Section 805, hearing rights under Sections 809 *et seq.* accrue. There is no dispute that the hearing of the peer review body in this case falls under Sections 809 *et seq.* There is nothing in Sections 809 *et seq.* that permit a distinction between differing kinds or classes of recommendations based on the standard of care or not.

The hospital industry's argument on this point fails for another reason as well. Expertise of the medical staff is not limited to assessing the standard of care or evaluating whether that standard was violated. Physicians are eminently qualified and have the expertise to determine, particularly after the extensive

hearing process in this case, whether one of their colleagues may benefit from well-being committee evaluation and intervention, and indeed, Title 22 regulations governing hospitals expressly designate well-being committee activities under the auspices of the self-governing medical staff. (22 C.C.R. §70703(d).) The decision rendered by the peer review body was made by medical staff members who served on the J.R.C. and on the MSEC and who are colleagues of Dr. Weinberg. They know the physician, have worked with him, and have been exposed either directly to his own testimony and the testimony of others at the hearing if they were on the J.R.C., or to the extensive record developed from the hearing if they are on the MSEC. It defies logic to assert, based on both the expertise and first-hand knowledge of the physician by members of the medical staff involved in the peer review body's decision in this case, that the governing body would know better whether Dr. Weinberg would benefit from compelled involvement with the well-being committee or not. The medical staff absolutely knows better than the governing body on this point from a practical standpoint. In any case, the law requires the governing body to afford the same level of deference for the medical staff's determination in this case regardless whether the determination involves referral to the well-being committee or involves assessing professional standard of care. If reasonable minds could differ as to the appropriateness of the penalty, the peer review body's disciplinary recommendation must be upheld.

Dated: April 27, 2004

Respectfully submitted,

California Medical Association
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Certification Under Section 14 of the California Rules of Court

I, Gregory M. Abrams, am an attorney at law licensed to practice before all courts of the State of California. I am Counsel of Record for amicus curiae herein, the California Medical Association. I hereby certify that the word counting feature on the computer word processing program with which this brief was written indicates that the actual text of this brief, excluding the cover page and addresses of counsel, the Table of Authorities, the Table of Contents, this certification, and the Proof of Service, is 10679 words.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge and that this Declaration was executed on April 27, 2004, in San Francisco, California.

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