

Court of Appeal Case No. B209056

**IN THE COURT OF APPEAL
FOR THE STATE OF CALIFORNIA**
SECOND APPELLATE DISTRICT
DIVISION FOUR

Osamah El-Attar, M.D.,
Petitioner and Appellant

vs.

Hollywood Presbyterian Medical Center,
Defendant and Respondent

Appeal from the Superior Court of the State of California
for the County of Los Angeles

Honorable Mary Ann Murphy, Judge Presiding

**AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN
SUPPORT OF PETITIONER AND APPELLANT**

FRANCISCO J. SILVA, State Bar No. 214773
ASTRID G. MEGHRIGIAN, State Bar No. 120896
CALIFORNIA MEDICAL ASSOCIATION
1201 "J" Street, Suite 200
Sacramento, California 95814
Telephone: (916) 444-5532
Facsimile: (916) 551-2885

Attorneys for Amicus Curiae California Medical Association

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I. INTRODUCTION

At issue in this case is whether Dr. El-Attar received the minimal due process protections required by California law when he was denied the right to renew his medical staff privileges—an action which severed his ability to care for patients in that hospital, destroyed his patients’ rights to be cared for by the physician of their choice, disrupted established physician-patient relationships in the most sensitive and important area of personal service, and devastated his ability to practice medicine.

Decisions concerning medical staff membership and privileges are made through a process called peer review. Peer review involves the continuous assessment of a physician’s competency, the provision of recommendations for improvement and education, and when necessary, the initiation of disciplinary measures against a physician who poses a threat to patient care.

Peer review, if properly conducted, is “essential to preserving the highest standards of medical practice” by removing those physicians who provide substandard care from health care facilities. See Business & Professions Code §809 (a)(6); see also *Mileikowsky v. West Hills Hospital and Medical Center* (2009) 45 Cal.4th 1259, 91 Cal.Rptr.3d 516.¹ But “another purpose, also if not equally important” is to protect physicians from being barred from practicing at those facilities for arbitrary or discriminatory reasons. See *Mileikowsky, id.* at 521; see also Business & Professions

¹ The Supreme Court in *Mileikowsky*, siding with CMA’s amicus curiae brief filed in that case, concluded that a hearing officer in a peer review disciplinary hearing lacked the authority to terminate a physician’s disciplinary hearing as the statutory process reserved that right to the hearing panel members.

Code §809(a) (stating that if not fairly conducted, peer review “results in harm to patients and healing arts practitioners by limiting access to care.”).

The ramifications of a negative review determination, such as the one that occurred here—a refusal to renew medical staff privileges, are draconian. California law requires, among other things, certain persons associated with "peer review bodies" to file with the Medical Board of California an "805" report whenever a physician's application for medical staff privileges or membership is denied for a medical disciplinary cause or reason. (Business & Professions Code §805(b)(1).) An 805 report does not lie idly in the Medical Board's data base. A copy of the 805 report will be forwarded by the Medical Board to any licensed health care facility, health care service plan or medical care foundation, group of more than 25 physicians, or medical staff of a health care facility in California that requests such information. These entities are *required by law* to "query" the Medical Board to obtain a copy of the 805 report before granting membership or clinical privileges to a physician. (Business & Professions Code §805.5(a).)² Further, the fact of an "805 report" is disclosed to the general public on the Medical Board's website indefinitely, unless privileges are restored, in which case it is disclosed for 10 year from the date of restoration. (Business & Professions Code §2027.)

For over fifty years, California courts have repeatedly protected physicians from the arbitrary deprivation of medical staff or other privileges necessary to practice medicine for

² Federal law imposes a reporting requirement similar to California's reporting requirement under Section 805. (42 U.S.C. §11133.)

reasons that lack a demonstrable nexus to quality patient care,³ or by procedures that are not fundamentally fair. Most recently, the California Supreme Court affirmed the right to fair process in the context of the right of a physician to have his case decided by his or her peers, as opposed to a hearing officer. See *Mileikowsky, supra*. See also *Smith v. Selma Community Hospital* (2008) 164 Cal.App.4th 1478, 80 Cal.Rptr.3d 745 (medical staff may not rely solely on the results of peer review proceedings from another hospital when considering whether to terminate a physician's medical staff privileges where anticompetitive, as opposed to patient care, motivations may be driving privileging decisions); see also *Nasim v. Los Robles Regional Medical Center* (2008) 165 Cal.App.4th 1538 (retroactive application of board certification applied unreasonably to deny medical staff membership); *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 18 Cal.Rptr.3d 780 (hearing officer presiding over physician's disciplinary hearing had potential conflict of interest giving the appearance of bias).⁴

³ See, e.g., *Wyatt v. Forest Hospital District, et al.* (1959) 174 Cal.App.2d 709, 345 P.2d 93 (past improper conduct not a sufficient basis to exclude a physician from public hospital where Board of Medical Examiners determined that physician could practice in state); *Willis v. Santa Ana Community Hospital* (1962) 58 Cal.2d 806, 26 Cal.Rptr. 640 (exclusion from hospital for allegedly anti-competitive purposes could be improper); *Rosner v. Eden Township Hospital District* (1962) 58 Cal.2d 592, 599, 22 Cal.Rptr. 551 (fact that physician “unable to get along” with some physicians was not sufficient grounds to exclude physician from hospital medical staff); *Ascherman v. Saint Francis Mem. Hosp.* (1975) 45 Cal.App.3d 507, 109 Cal.Rptr. 507 (hospital bylaw permitting summary rejection of application of physician for staff membership where application is not accompanied by three letters of recommendation is not substantively rational); *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826 (bylaw permitting exclusion on basis of physician’s “ability to work with others” when read to include “real and substantial danger” to quality patient care not substantively irrational).

⁴ Additional cases condemning unfair peer review procedures include *Pinsker v. Pacific Coast Society of Orthodontists* (1969) 1 Cal.3d 160, 81 Cal.Rptr. 245 (“*Pinsker*

The Legislature similarly has provided safeguards for physicians to protect them against unfair peer review activities. To increase the “peer reviewer’s willingness to participate in peer review,” to promote fairness in the system, and to reduce the risk of erroneous peer review decisions, CMA sponsored legislation that enacted a comprehensive scheme setting forth minimal due process standards for peer review proceedings. (Business & Professions Code §§809 *et seq*, Stats. 1989, ch. 336 §1 (S.B. 1211).)⁵ This statutory scheme vests with “peer review bodies” the responsibility to

I”) (applicant for membership in dental orthodontists society had a judicially enforceable right to have application considered in a manner comporting with the fundamentals of due process, including the showing of cause for rejection); *Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 116 Cal.Rptr. 245 (“*Pinsker II*”) (violation of standards set by professional association prohibiting delegation of orthodontic services to dentists not educationally qualified for membership in professional association permissible basis to reject applicant for membership, though applicant must be afforded an opportunity to respond to charges); *Anton v. Board of Directors of San Antonio Comm. Hosp.* (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442 (decision to suspend physician’s medical staff privileges affected a fundamental vested right and physician entitled to due process); *Ezekial v. Winkley* (1977) 20 Cal.3d 267, 142 Cal.Rptr. 418 (surgical resident required to receive fair procedure prior to discharge from residency program); *Volpicelli v. Jared Sydney Torrance Memorial Hospital* (1980) 109 Cal.App.3d 242, 167 Cal.Rptr. 610 (termination of physician membership from medical staff without notice and hearing deprived physician of due process right); *Applebaum v. Board of Directors of Barton Memorial Hospital* (1980) 104 Cal.App.3d 648, 163 Cal.Rptr. 831 (suspension of family practitioner’s obstetrical privileges violated fair procedure rights); *Hackethal v. California Medical Association* (1982) 138 Cal.App.3d 435, 187 Cal.Rptr. 811 (disciplinary proceeding conducted by medical society did not comply with the principle of fair procedure); *Bergeron v. Desert Hospital Corp.* (1990) 221 Cal.App.3d 146, 270 Cal.Rptr. 379 (physician’s participation on emergency department on-call roster constituted fundamental property right which could not be suspended or revoked without notice and an opportunity to respond); *Rosenblitt v. Superior Court (Fountain Valley Regional Hospital)* (1991) 231 Cal.App.3d 1434, 282 Cal.Rptr. 819 (physician denied fair hearing in medical staff summary suspension proceedings).

⁵ See Analysis of Assembly Committee on the Administration of Justice, SB 1211

“provide fairly conducted peer review in accordance with due process, including notice, discovery and hearing rights, all specified in the statute.” See *Unnamed Physician v. Board of Trustees of St. Agnes Medical Center* (2001) 93 Cal.App.4th 607, 622, 113 Cal.Rptr.2d 309 (mandate petition not barred by doctrine requiring exhaustion of administrative remedies where physician asserted that the peer review body failed to comply with procedural safeguards required by the statute). Further, it “allows for and encourages peer review, while at the same time . . . balances the interests of both the physician and the public in ensuring fair, non-arbitrary, and non-discriminatory procedures.” (*Id.*)

If a peer review body fails to act in accordance with these laws concerning peer review, as well as bylaws properly implementing them, a physician’s ability to practice medicine could be irreparably injured—a result which violates every notion of fairness the courts and Legislature have tried for years to protect. Accordingly, amicus urges the Court to carefully scrutinize this case and the application of California law to ensure that the peer review process was conducted fairly.⁶

(Keene) for hearing July 19, 1989, a true and correct copy of which Amicus respectfully requests judicial notice of pursuant to Evidence Code §§451 and 452. See attached Motion for Judicial Notice and Supporting Declaration of Astrid G. Meghriyan.

⁶ By making this appearance, Amicus seeks only to ensure that Dr. El-Attar will be subject to a fair peer review process. CMA does not review these cases from a standard of care perspective and therefore takes no position on that issue in this case.

II. MEDICAL STAFFS ARE REQUIRED TO ABIDE BY THEIR BYLAWS, WHICH MUST BE CONSISTENT WITH BUSINESS & PROFESSIONS CODE §§809 ET SEQ.

In his appeal, Dr. El-Attar asserts that his rights were violated because the bylaw provisions requiring that the medical executive committee (MEC) of the medical staff appoint the hearing officer and hearing panel were disregarded because these individuals were appointed by the hospital's lay governing board. On appeal, the hospital does not appear to deny that it violated the bylaws, but rather, argues that the activity was permissible in light of the MEC's purported delegation of authority to it to engage in these critical activities. CMA believes that neither the bylaws nor California law supports such an interpretation.

As is discussed in more detail below, both the courts and California Legislature have demanded that all those involved in prosecuting a physician's disciplinary action, including the hearing officers and hearing panel members, be "impartial." See Business & Professions Code §809.2; see also *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 18 Cal.Rptr.3d 780 (presiding officer at hearing to revoke physician's privileges had potential conflict of interest, giving appearance of bias).

While current law demands impartiality, it is silent as to who selects the hearing officer, leaving no assurance that the person selected is not impermissibly biased, as required by *Yaqub, supra*. To compound the problem, the law enables the hearing officer to rule on the issue of his or her own alleged bias, making it difficult for the physician

who is subject to review to conduct a strenuous voir dire for fear of retribution. See Business & Professions Code §809.2(c).

This issue of potential bias on the part of hearing officers and panel members has, and continues to raise serious due process concerns for physicians. Indeed, when the law was being debated, one attorney wrote to the author of the Legislation, Senator Barry Keene, the following:

The most elementary element of due process of law provides that any person who is charged with finding facts should be neutral to the proceeding. He should not have an interest, one way or the other, in the determination of the matter. He should not have a disposition or economic connection with the matter.

Contrary to this elementary notion of due process, hearing officers, as distinguished from hearing panels, are generally not neutral. Unfortunately, when I represented hospitals . . . , hearing officers were selected from “our side.” We would always select a hearing officer who we knew would not be controlled, whose interest in reappointment or whose interest in the legal positions asserted by the hospital would be consistent with the hospital’s position. Consequently, there is a process . . . that hospitals appoint hearing officers who know they will achieve proper results for them.”⁷

Similar concerns were expressed with respect to the hearing panel members themselves, that is, that they are “handpicked by the administrators of this hospital” and who can reliably bring in a determination that is “desired by the hospital.” (*Id.*) Thus, far from inconsequential, the issue of who selects hearing officers and hearing panel members is fundamental to the question of impartiality.

⁷ See June 24, 1988 letter to Senator Barry Keene, a true and correct copy of which Amicus respectfully requests judicial notice of pursuant to Evidence Code §451 and 452. See attached Motion for Judicial Notice and Supporting Declaration of Astrid G. Meghrigian.

A. The Medical Staff Bylaws Requiring That The MEC, As Opposed To The Board Of The Governing Body, Select The Hearing Officer And Hearing Panel Members Are Binding

Given the importance of the impartiality of both the hearing officer and the hearing panel members, as well as the remaining fair hearing procedures set forth in Business & Professions Code §§809 *et seq.*, the Legislature required that written provisions implementing those sections in acute care hospitals be included in medical staff bylaws. (Business & Professions Code §809 (a)(8).) It is these bylaws that “govern the party’s administrative rights.” See *Unnamed Physician v. Board of Trustees of St. Agnes Medical Center*, *supra* at 617.

Medical staff bylaws are an indispensable and binding agreement between the hospital, the medical staff, and its individual members. In essence, these bylaws memorialize the hospital’s agreement to allow physicians who become a part of the medical staff to admit patients and utilize the facility’s equipment and other resources, in exchange for the medical staffs’ agreement to work with each other and with the hospital to perform the extensive quality assessment activities needed to maintain the requisite performance standards to maintain quality of care. Medical staffs are required to abide by their bylaws when they take disciplinary action against physicians.

Significantly, while the law requires that the basic protections be set forth in those bylaws, the law gives medical staffs “broad discretion” to adopt appropriate bylaws that are tailored to serve their needs. See *O’Byrne v. Santa Monica UCLA Medical Center* (2001) 94 Cal.App.4th 797, 114 Cal.Rptr.2d 575. As a result, there is a variation in the content of different bylaws, variation which can substantially affect a physician’s analysis

as to whether to apply for membership and privileges at one particular institution rather than another.

Thus, because of the importance of the bylaws to the circumstances under which a physician may practice medicine at a hospital, medical staffs must abide by their bylaws and aggrieved physicians can require their enforcement. See *O'Byrne, supra*, at 810. See also *Janda v. Madera Community Hospital* (E.D.Cal. 1998) 16 F.Supp.2d 1181. See also 22 C.C.R. §70703, that provides, in part:

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

B. Medical Staffs Cannot “Designate” the Governing Body to Act on Its Behalf, Except in Rare Circumstances

In the absence of any law purporting to authorize the activity expressly, the hospital argues that the medical staff in this case could lawfully designate it to appoint the hearing officer and hearing panel members for Dr. El-Attar’s disciplinary matter. There is no basis in the law for such a result.

In support of its position, the hospital incorrectly relies upon Business & Professions Code §809 (b), which provides that for the purposes of the fair hearing laws (Business & Professions Code §§809 *et seq.*) a peer review body also “includes any designee of the peer review body.” This definition does not and cannot provide carte blanche for a medical staff, the body that has been charged by law to be “self-governing”

with respect to the professional work performed in the hospital, to delegate any and all of its peer review responsibilities under California law to the hospital.⁸

Along with California's long history of laws declaring medical staffs as "self-governing," there are also **limited** laws providing the governing body with oversight authority over peer review, but only in carefully defined and limited circumstances. Those laws require that the governing board may not take action in quality matters **unless and until** the medical staff has acted and failed to assure quality, or otherwise failed to act at all. For example, Business & Professions Code §809.05 provides that where the peer review body's failure to investigate, or initiate, disciplinary action is contrary to the weight of evidence, the governing board has the authority to direct the medical staff to initiate an investigation of a medical staff member, or initiate a disciplinary action against a member, as long as the governing board first consults with the peer review body. The governing board's request for an investigation and/or prosecution may not be made unreasonably. (Business & Professions Code §809.05(b).) Importantly, however, the

⁸ There are multitude laws that specifically require the medical staff of the hospital to be "self-governing" with respect to the professional work performed in the hospital. See, e.g., Business & Professions Code §2282 (it is unprofessional conduct to practice in hospital with more than five physicians if rules do not require a medical staff that is self-governing with respect to the professional work performed in the hospital); Business & Professions Code §2453 (requiring physicians to assure medical staff self-governance); 22 C.C.R. §70701 (a)(1)(F) (governing board must provide for self-governance of the medical staff with respect to the professional work performed in the hospital); 22 C.C.R. §70703 (each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital); 22 C.C.R. §§71501, 71503 (same for acute psychiatric hospitals); 22 C.C.R. §97530.1 (in post-surgical recovery care facility, governing board must provide for self-governing medical staff); Health & Safety Code §32128 (district hospital rules must provide for medical staff self-government).) See also *Anton v. San Antonio Community Hosp.* (1977) 19 Cal.3d 802, 809 (noting medical staff is self-governing unincorporated association.)

governing board **has no authority to take its own review action** against a medical staff member unless the medical staff “fails to take action in response to a direction from the governing board.” (Business & Professions Code §809.05 (c).)

Further, Business & Professions Code §809.5 authorizes the peer review body to impose summary suspensions, and confers only a limited power on the governing body to do so and **only** in those circumstances where those on the peer review body who are authorized to suspend are unavailable and the governing body has “made reasonable attempts to contact the peer review body.” See Section 809.05(b) .

Under these circumstances, the use of the word “designee” in the definition of peer review, is not a wholesale grant of authority for the peer review body to license the governing body to act whenever or on whatever it wants in peer review matters. To the contrary, as the legislative intent surrounding a codification of the medical staff’s right to self-governance as set forth in Business & Professions Code §2282.5 states:

It would be a violation of the medical staff self-governance and independent rights for the hospital governing body to assume a duty or responsibility of the medical staff precipitously, unreasonably, or in bad faith.

See Section 1, SB 1325, Stats. 2004, ch. 699.

Given the specificity in which the Legislature expressly granted governing bodies authority to act in peer review cases, had it intended for a governing body to be included within the definition of a peer review body for any and all purposes, it clearly would have done so. See *People v. Cole* (2006) 38 Cal.4th 964 (holding that Knox-Keene Act did not exempt HMOs from statutes restricting certain commercial relationships between providers).

III. THE LAW REQUIRES THAT PHYSICIANS HAVE THE RIGHT TO IMPARTIAL HEARING PANEL MEMBERS AND AN ADEQUATE OPPORTUNITY TO VOIR DIRE

A. Actual Bias Is Not Required

The hospital in this case suggests that because the hearing panel members in this case did not have an economic interest in the outcome of Dr. El-Attar's disciplinary hearing, they were not sufficiently biased to cause their disqualification from the hearing. Respondents rely upon the wrong standard.

Business & Professions Code §809.2 demands the following qualifications for hearing panel members, that is, that they be a:

...panel of unbiased individuals who gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact finder, or initial decisionmaker in the same manner, and which shall include, where feasible, an individual practicing in the same specialty as the licentiate.

See Business & Professions Code §809.2 (a). Thus, the statute presumes that hearing panel members will be biased in the two situations spelled out: (1) where they have a direct financial benefit from the outcome of the case, or (2) where have had prior participation in it.

The law also, however, assures impartiality by requiring that in addition to those circumstances where bias is presumed, there are other circumstances where a hearing member's potential to be partial rises to a constitutional dimension. The legislative history surrounding the enactment of Business & Professions Code §809.2 makes this clear.

When the bill was debated, the Legislature expressly understood that what was at issue was the right to impartial hearing panel members. The legislative files make reference to the fact that the bill was attempting, in part, to codify existing fair hearing rights that existed under the law at the time. A summary of the law in the legislative files expressly referred to *Applebaum v. Board of Directors of Barton Memorial Hospital* (1980) 104 Cal.App.3d 648, 163 Cal.Rptr. 831. In addition, the legislative files included a copy of the court's decision in *Hackethal v. California Medical Association* (1982) 138 Cal.App.3d 435, 187 Cal.Rptr. 811.⁹ As is discussed below, those cases did not require that hearing panel members have an actual economic interest in the outcome of the case before they could be disqualified; and the Legislature did not intend that such a requirement should exist. Indeed, a committee analysis of the bill reveals that the Legislature demanded impartiality as a whole, nothing more, nothing less. For example, the Senate Rules Committee analysis provided as follows:

Due process and procedure relative to the peer review hearing

The bill would be the following procedures and due process requirements relative to the hearing:

1. Unbiased hearing panel—A mutually acceptable arbitrator or panel of uninvolved, unbiased individuals, and include, where feasible, an individual practicing the same specialty as the licentiate.

⁹ A true and correct copy of the *Hackethal* decision as it appeared in the legislative files, as well as the cross-referencing of the proposed legislation to then current California law are attached to the Supporting Declaration of Astrid G. Meghrihan as Exhibits C and D, respectively. See Motion for Judicial Notice.

2. Voir dire and challenges for cause—Practitioner would have the right to voir dire and challenge the impartiality of panel members.¹⁰

There was no suggestion anywhere in the legislative history that only actual bias for economic reasons would disqualify a hearing panel member. What was clear from the Legislature and the courts at the time SB 1211 was enacted was the fact that impartiality was decided “given the circumstances” of the case. Thus, for example, in *Applebaum*, the court did not issue a hard and fast rule concerning the circumstances under which a hearing panel member should be disqualified. Rather, the court found fair procedure lacking because the committee investigating a physician’s incompetence included the complaining physician who had prompted the investigation. Thus, according to the court, the procedure at issue in that case “given the circumstances in which it was accomplished, violated this standard of fairness.” (*Id.* at 660.)

The *Applebaum* court was also concerned with "prevailing standards" when explaining impartiality. As the court stated:

When due process requires an administrative hearing, an individual has the right to a tribunal ‘which meets at least the currently prevailing standards of impartiality.’ (Citations omitted.) Biased decisionmakers are constitutionally impermissible and even the probability of fairness is to be avoided. (Citations omitted.) The factor most often considered destructive of administrative board impartiality is the bias arising from pecuniary interests of board members. (Citations omitted.) (*Id.* at 657.)

These concepts were further examined in *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 119 Cal.Rptr.2d 341 and *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 18 Cal.Rptr.3d 780. In *Haas*, the

¹⁰ A true and correct copy of the Senate Rules Committee Analysis is attached to the Declaration of Astrid G. Meghriyan as Exhibit E. See Motion for Judicial Notice.

Supreme Court held that a temporary administrative hearing officer had a pecuniary interest requiring disqualification under due process guarantees where the hearing officer had an impermissible financial interest in the outcome of the litigation arising from his future prospect of employment. The Court stated that the rule disqualifying adjudicators with pecuniary interests applies with full force in the administrative context, and that “experience teaches that the probability of actual bias on the part of the judge or decisionmaker is too high to be constitutionally tolerable” when the adjudicator has a financial interest in the outcome. (*Haas, supra* at 1027.) Thus, the *Haas* court acknowledged that the test does not assess where the individual **actually** succumbs to temptation, but whether “the economic realities make the design of the . . . system vulnerable to a “possible temptation” to the “average man” is judged. (*Haas, supra* at 1029.)

The *Haas* ruling was applied in a physician peer review setting in *Yaqub, supra*. In *Yaqub*, the hearing officer for a physician’s peer review hearing was a retired court judge unilaterally appointed and paid for by the hospital. The hospital disclosed to the physician that the judge was not affiliated with the MEC, or the hospital, but he used to be a member of the Board of Governors of the non-profit Salinas Valley Memorial Hospital Foundation, whose mission is fundraising for the Hospital. It was further explained that the Foundation had no involvement in any medical staff matters, which were the responsibility of the board of directors. However, the board of directors elected the board of governors of the Foundation. (*Yaqub, supra*, 122 Cal.App.4th at 484.)

The physician objected to the appointment of the retired judge, adding that the judge had presided over three fair hearing proceedings at the hospital in the past, including his own suspension hearing, and there was the potential for further appointments in the future. The *Yaqub* court ruled that these facts were sufficient to create a "possible temptation" to favor the hospital, and ordered the peer review decision against Dr. Yaqub to be set aside.

The court noted that there was no evidence of actual bias on the part of the retired judge, and even acknowledged that the administrative record showed the judge handled the hearing "fairly and even-handedly." (*Id.*) But the appellate court reiterated the Supreme Court's statement in *Haas* that:

[T]he risk of bias caused by financial interest need not manifest itself in overtly prejudiced, automatic rulings in favor of the party who selects and pays the adjudicator. 'The Court's inquiry ... is not whether a particular man has succumbed to temptation, but whether the economic realities make the design of the fee system vulnerable to a 'possible temptation' to the 'average man' as judge.'

(*Yaqub, supra*, 122 Cal.App.4th at 485, internal citations omitted.)¹¹

Put another way, the proper test is not whether someone is "actually biased," but whether "a person aware of the facts might reasonably entertain a doubt that the judge would be able to act with integrity, impartiality, and competence." (*Id.* at 486.) Thus, the test is whether someone has the "appearance" of bias. (*Id.*)

¹¹ While *Haas* and *Yaqub* dealt with the selection and payment of a hearing officer who not only hears the matter, but also provides the ruling in the matter heard, in peer review matters, it is usually the physician hearing panel members that provide the ruling itself. Therefore, these cases are relevant in the bias analysis of a physician panel member who is simultaneously paid by the hospital for various services.

B. Physicians Must Be Able to Meaningfully Voir Dire Hearing Panel Members

Given that "impartiality" is determined on a case-by-case basis in light of "prevailing standards," physicians must be able to meaningfully voir dire prospective hearing panel members to ensure that they will decide the case in a fair manner. See, for example, Business & Professions Code §809.2, stating:

The licentiate shall have the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer.

The need for a meaningful opportunity to voir dire panel members is particularly important given the fact that bias is not presumed, and the burden is on the physician to establish the probability of unfairness. See *Rhee, M.D., v. El Camino Hospital District* (1988) 201 Cal.App.3d 447, 247 Cal.Rptr. 244 (bias cannot be presumed in the absence of facts). Without an adequate opportunity to voir dire potential adjudicators, physicians are deprived of their right to uncover possible bias. See *Hackethal, supra* (right to voir dire was unduly limited where the referee limited the amount and manner of the examination which "had the effect of reducing [the physician's] opportunity to expose facts that would require disqualification of individuals on the panel."). (*Id.* at 443.) See also *Rosenblit v. Superior Court* (1991) 231 Cal.App.3d 1434, 282 Cal.Rptr. 819 (secret voir dire of hearing panel impermissibly compromised the physician's ability to obtain a fair hearing); see also *Lasko v. Valley Presbyterian Hospital* (1986) 180 Cal.App.3d 519, 225 Cal.Rptr. 603 (where hearing officer altogether prevented the physician from asking

any questions of the members of an ad hoc hearing committee, the physician was denied a fair procedure).

The need for voir dire in the instant case is particularly important. Even apart from the substantial issues concerning Dr. Mynatt's impartiality (who himself at one point admitted a conflict of interest and recused himself),¹² it is essential that adequate voir dire take place with respect to those who receive financial remuneration from the hospital, such as those who hold exclusive contracts.

"Exclusive contracts" are agreements between a hospital and a medical group that entitles only the medical group to have the exclusive right to practice that specialty in that hospital. While there are undoubtedly times where exclusive contracts are justified by patient care exigencies, the potential for abuse is apparent. Explaining the concerns with exclusive contracts, and their impact on quality care and physician autonomy, one observer commented as follows:

For example, a facility may place an emphasis on economic efficiency over quality of care if it contracts solely on the basis of cost. The possible result of this trend is to "lean toward the mean" (or less), that is, physician performance may move progressively toward bare competence rather than high quality. Excellence would not be considered an incentive in these contractual arrangements because, theoretically, physicians with the lowest cost (the lowest bid) would win the contract and perform at a minimal acceptable level in an effort to maximize their profits. Exclusive contracts could also be seen as a form of economic credentialing. Further disadvantages include physician discontent and insecurity in maintaining a consistent practice, lack of continuity of care, and lack of patient

¹² CMA is also concerned about the reconstitution of the hearing panel weeks after Dr. Mynatt recused himself. For the reasons set forth by Appellant, hearing officers do not enjoy such broad powers as Respondents suggest to allow them to reconstitute a hearing panel following recusal. Once a decisionmaker, such as a hearing panel member, becomes disqualified, the appearance of impropriety is too great to allow reconstitution.

choice of physicians or termination of an existing physician-patient relationship in service areas covered by the exclusive contract.

See Brian A. Liang, M.D., Ph.D., J.D., "An Overview and Analysis of Challenges to Medical Exclusive Contracts" 18 J.Leg.Med. 1 (1997).

Termination of an exclusive contract can be devastating to a physician's practice. A physician who loses a contract typically loses his or her privileges and can no longer provide services at that hospital.

While the fact that a physician provides care in a hospital pursuant to an exclusive contract should not result in his or her automatic disqualification from a hearing panel, the factual circumstances underlying that contract, such as who **holds** the contract, how many physicians are in the group, when does the contract end, whether the physician has concerns for job stability, must be examined thoroughly. Voir dire must be adequate to ensure that a physician who practices under an exclusive contract can be impartial.

VI. CONCLUSION

The California Medical Association and its physician members are committed to quality patient care and the effective peer review process necessary to maintain that high level of care. The Association believes, however, that neither peer review nor quality care is promoted by unfair disciplinary procedures which result in a wrongful suspension of competent physicians from medical staff membership and appropriate clinical privileges. To the contrary, in both the short and long term, the highest quality of care and the most diligent performance of quality assurance activities depend upon accurate clinical assessments, assessments which can be made only if physicians facing adverse

medical staff membership or privilege determinations have a real opportunity to defend themselves.

Dated: May 15, 2009

Respectfully Submitted,

FRANCISCO J. SILVA
ASTRID G. MEGHRIGIAN

Astrid G. Meghrigian
Attorney for Amicus Curiae
California Medical Association

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Respectfully Submitted,

FRANCISCO J. SILVA
ASTRID G. MEGHRIGIAN

Astrid G. Meghriqian
Attorney for Amicus Curiae
California Medical Association