No. E-006571 Civ.

IN THE COURT OF APPEAL OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION TWO

EISENHOWER MEMORIAL HOSPITAL,
a California Nonprofit Public
Benefit Corporation, etc.,

Plaintiffs and Respondents,

v.

DAVID STOLTZMAN, STUART BARTON
W. RANDALL BLAKELEY, KARL BURETZ,
WILLIAM BURLEIGH, LAWRENCE CONE,
JOHN DELLER, KENNETH HARRIS,
RONALD LAMB, RICHARD LYNCH,
KARL SCHULZ, and MARK SONNESHEIN,
individuals, and DOES 1 through
200, inclusive,

Defendants and Appellants.

AMICUS CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF APPELLANTS

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I. INTRODUCTION

This case involves an arbitrary decision by Eisenhower Memorial Hospital's Board of Trustees to refuse to recognize the officer chosen by the medical staff to lead the medical staff in the performance of its professional work. The Board's action was based on a bylaw which purports to grant the Board unchecked power to decide who can and cannot lead the medical staff. This bylaw, however, is invalid. It cannot be reconciled with the medical staff's legal responsibility to be self-governing and to continuously review, evaluate and monitor quality patient care rendered in the hospital. The Board's action is contrary to law and inimical to the public welfare.

While the issue presented by this case may seem unimportant, it is not. Understood in the context of the role a hospital's medical staff plays in the organization and delivery of health care, the ramifications of the Eisenhower Board's action are profound. As is discussed below, the Board's action transgresses, and the bylaw at issue violates, the laws designed to ensure the people of California that their interests in receiving quality health care will be placed first and foremost. The system in which health care is delivered in this state depends on physicians exercising their professional judgment without improper lay interference. This court is being asked to recognize and safeguard the medical staff's legal right and ability to perform functions essential to the provision of quality patient care.

The laws governing the performance of professional work within California hospitals comprise a carefully crafted system designed to assure the quality of patient care through-out the state. This system recognizes both that patient welfare depends on the ongoing review, evaluation and monitoring of the quality of patient care and treatment rendered in each of California's hospitals. It further recognizes that each hospital's medical staff is the only body with the necessary medical expertise and experience to properly conduct these credentialing and patient review functions. Indeed, pursuant to California law, members of the medical staff are responsible for

possessing, securing, and implementing the professional expertise necessary to assure the delivery of quality care.

This comprehensive "peer review" system depends on effective medical staff leadership. Medical staff leaders must have the initiative and vision to lead and motivate the staff to devote the untold hours of service on these peer review committees which medical staffs members (and their leaders) generally provide without compensation. They must also have the temerity to advocate for quality patient care before the hospital's board of directors. The board's decision to disrupt the medical staff's ability to perform the peer review and quality assurance functions mandated by law is not only illegal but also unconscionably jeopardizes the welfare of patients in the hospital.

In this context, the relationship between physicians and their patients must be considered. Because patients generally know little about the practice of medicine, patients are dependant on physicians. Among other things, they rely on physicians to protect their confidences, to aid them in their medical decision-making processes, to provide quality care, and to advocate on their behalf in order to assure that high standards are met.

By the same token, deference to a physician's judgment is essential to the goal of providing quality care. Given the trusting and intimate relationship between the physician and patient, only the physician can reasonably be expected to fully understand the patient's medical condition and take whatever steps are necessary to ameliorate it. Consequently, the law recognizes the complexities and intricacies of the practice of medicine and does not permit second guessing of physicians by persons other than their peers.

Concomitantly, both the courts and the Legislature have been extremely solicitous of patient welfare and have prohibited third parties, including hospital boards, from interfering with the physician-patient relationship. Indeed, as early as 1938, the California Supreme Court recognized the evils of lay control over the practice of medicine. Despite (or perhaps because of)

increasing pressure to reduce costs, the courts and the Legislature have consistently reaffirmed the principle barring the "corporate practice of medicine", that is, lay control over physicians' determinations when providing medical care. See, for example, Business and Professions Code Section 2400. The concerns reflected in this prohibition extend to hospital boards, both by the corporate practice bar itself and the derivative requirement that medical staffs be "organized" and "self-governing". See Business and Professions Code Section 2282; Health and Safety Code Section 1250(a). The bylaw at issue, as well as the Board's refusal to seat Dr. Stoltzman, violate in letter and spirit these vital laws which protect against the potential that the provision of medical care and treatment will be subject to commercial exploitation.

This is not to suggest that the hospital board has no role in this activity. However, that role has been and must remain carefully circumscribed. A hospital board has neither medical expertise nor clinical experience to interfere with a medical staff's informed professional judgment. Moreover, as federal and state reimbursement programs and other policies subject hospital boards to increasing economic pressures, there is the heightened risk that the push for cost containment may threaten patient welfare.

The California Medical Association emphatically supports the positions of the appellants in this case and we will not repeat the compelling arguments which have been presented. We submit this brief to bring to this court's attention additional authority demonstrating that the trial court's order is contrary to the law. Indeed, if that order is permitted to stand, the ability of hospital medical staffs to provide quality care in hospitals will be jeopardized throughout the state.

Moreover, we fully support appellant Stoltzman's request that summary judgment on his cross-complaint be entered in his favor. A hospital board may not lawfully refuse to seat a duly elected medical staff officer. Where, as here, the result is "foreordained", this court should exercise

its power to direct entry of judgment in favor of Dr. Stoltzman without further proceedings. See Harlow v. Carleson (1976) 16 Cal. 3d 731, 129 Cal. Rptr. 298.

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II. ORGANIZED MEDICAL STAFFS AND THEIR MEMBERS MAY PERFORM THE ONGOING PROFESSIONAL FUNCTIONS NECESSARY TO QUALITY PATIENT CARE.

In order to appreciate what is at issue in this case, the role of the medical staff in a hospital must be understood. Medical staff officers are not merely figureheads; the title president or president elect is not merely honorary. In order to ensure quality patient care, professional services in the hospital must be regularly monitored and evaluated. A comprehensive quality assurance process is critical to the resolution of problems as well as the identification and opportunity 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 substandard performance and impaired or incompetent individuals may be identified before patients are seriously injured.

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 any indicated changes. An effective medical staff peer review system provides the optimal solution. Medical staffs, comprised of physicians and certain other health professionals, have both the necessary expertise and familiarity with the health care facility and the physicians and other health care providers involved to conduct effective peer review.[1] These quality assurance activities

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It should also be noted that physicians do not work in isolation. They must work cooperative
n performing their duties, both in the performance of quality assurance activities as well as th
dering of medical care and treatment to individual patients. See generally, Miller v. Eisenhowe
ical Center (1980) 27 Cal. 3d 614, 166 Cal. Rptr. 826 (physicians must work cooperatively with
bers of the medical staff to ensure quality patient care). Moreover, for their own protection,
sicians must perform these activities diligently. For example, physicians performing necessary
perative activities such as providing consultations or coverage may face increased potential

depend on effective medical staff leadership. It should be noted that members of the medical staff, whether officers or not, generally are not paid for these activities. This factor is of particular importance given current concerns over the escalating cost of health care.

The importance of medical staff activity cannot be understated. Indeed, recognizing the fundamental importance of medical staff activity to quality patient care in hospitals throughout California, the Legislature and the Department of Health Services have established a comprehensive scheme requiring medical staffs and their physician members to perform direct patient care activities and perform ongoing review, evaluation and monitoring functions of the care rendered.

A. The Law Vests Within The Medical Staff's Realm Of Responsibility Activities Which Are Critical To The Provision Of Quality Care.

1. Patient Care Services

First and foremost, each physician member of the medical staff is responsible for overseeing the general medical condition of every patient that physician admits to the hospital. This is not only a moral and ethical obligation, it is required by legal standards. See e.g. 22 California Code of Regulations Section 70703(a) (physician responsible for adequacy and quality of medical care rendered to patients in hospital). Indeed, the standards established by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO), the private association which accredits hospitals nationwide, require that physicians perform a "comprehensive physical examination" on all hospitalized patients and that physicians be responsible for "each patient's general medical condition." Joint Commission, Accreditation Manual for Hospitals, Page 114, Medical Staff Standard MS.4.3.3 (1989) [2]

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bility if the individual they must work with is professionally unqualified.

[2] Of course, this court may properly take judicial notice of the JCAHO's standards pursuant to Evidence Code Section 452 (h). See Anton v. San Antonio Community Hospital, (1977) 19 Cal. 3d 802, 819; 140 Cal. Rptr. 442. Moreover,

By the same token, physicians are legally responsible for the care and treatment provided to their patients and must take steps to reduce the risk that their patients are subject to known or reasonably suspected unsafe conditions at the hospital. In caring for their patients, physicians' conduct must conform to the appropriate standards all times. Although the standard of care in California for physicians and surgeons does not call for them to use the highest skill known to medical science, Sinz v. Owens (1949) 33 Cal. 2d 749, it does require that they exercise that degree of skill, knowledge and care ordinarily possessed and exercised by other members of the profession under similar conditions and circumstances. See Landeros v. Flood (1976) 17 Cal. 3d 399, 408, 131 Cal. Rptr. 69. Physicians are required to possess and exercise that same standard of care in both diagnosis and treatment. Id at 408.

Additionally, because medicine is a continually evolving science, physicians must be continually aware of, employ, and strive to improve the developing medical procedures and technology. Patients expect, and the law requires, such ongoing activity. See Cobbs v. Grant (1972) 8 Cal.3d 229, 104 Cal. Rptr. 505. See also the American Medical Association Principles of Medical Ethics V (which provides: "A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.")

Of course, physicians are not limited to the "diagnosis" and "treatment" of their patients. As is discussed more fully below, as a result of the physician/patient relationship, physicians have a number of unique and important responsibilities towards their patients which exist separate and apart from their duty to conform to the standard of care involving clinical determinations. For

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it should be noted that institutions accredited as hospitals by the JCAHO are generally deemed to meet all of the Medicare conditions of participation. See 42 U.S.C. Section 1395bb(a)(1); 42 CFR Section 488.5. See also Health and Safety Code Section 1282 (authorizing quality of care inspections of hospitals by the JCAHO).

example, physicians must protest improper third party cost containment decisions, Wickline v. State of California, (1986) 183 Cal. App. 3d 1064, make full disclosure to their patients, see Cobbs v. Grant (1977) 8 Cal 3d 229 and protect their patients' confidences, Evidence Code §995, Business and Professions Code §2263. In sum, physicians on the medical staff have a number of direct patient care responsibilities which are designed to ensure that patients receive quality care. Neither hospitals nor their trustees have parallel duties.[3]

2. Credentialing

Aside from the responsibility of medical staff members the provision of medical care to patients for both the medical staff and its members are responsible for credentialing, that is, assuring the initial and ongoing competence of every physician, dentist, podiatrist, and in some cases clinical psychologist who practices in the hospital. See, generally, Unterthiner v. Desert Hospital District (1983) 33 Cal. 3d 285, 188 Cal. Rptr. 590.

The Department of Health Services has emphasized the importance of the medical staff's expertise in the credentialing area. Thus, DHS specifically requires hospital boards to have the medical staff establish peer review and credentialing procedures. 22 CCR section 70701(a)(7). It is the medical staff which must develop, adopt and enforce "formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeal mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate". 22 CCR section 70703(b). Moreover, these procedures must be:

> [D]esigned to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical

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[3] Notably, the courts refuse to extend duties to hospitals or third party payers where the duty could jeopardize the physician-patient relationship. For example, in Derrick v. Ontario Community Hospital (1975) 47 Cal. App. 3d 145, 120 Cal. Rptr. 566, a patient with an infectious disease was not advised about the nature of her condition, resulting in another person contracting the infection. There, the court held that the hospital where she was admitted had no legal duty to advise as to her condition. The court found that the duty was solely the responsibility of the treating physician. Otherwise, the court added, imposing such a legal duty on the hospital "might substantially interfere with the relationship between the patient and her attending physician." Id. at 174

staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. 22 CCR §70701(a)(7).

3. Patient Care Review

Finally, medical staff is also primarily responsible for assuring the ongoing quality of patient care throughout the hospital. Indeed, hospital licensing regulations specifically require that the medical staff maintain one or more committees formally organized to monitor the care and treatment rendered to hospital patients. 22 CCR §§70203 and 70703(d). For example, pursuant to the law, the medical staff is obligated to perform the following patient care review functions on a regular basis:

1. Medical records review: the evaluation of medical records for their timely completion and adequate reflection of the patient's condition and treatment which is necessary to ensure that others will be able to assume the patient's care if required. 22 CCR §§70703(d), 70749 and 70751.

2. Surgery review: the evaluation of surgeries performed to determine whether the surgery was both indicated and properly executed. 22 CCR §§70703(d) and 70223 subdivisions (b) and (h).

3. Utilization review: the evaluation of the allocation of the hospital's health care resources to monitor and address overutilization, underutilization and inefficient scheduling. 22 CCR §70703(d).

4. Infection control and antibiotic usage review: the evaluation of the clinical use of antibiotics and the ongoing prevention, surveillance, and control of infections from whatever source, throughout the hospital. 22 CCR §70703(d) and 70739.

5. Pharmacy and therapeutics review: the evaluation of pharmacy and therapeutics practice and the development of a drug formulary and policy relating to the safe handling, distribution, and administration of drugs. 22 CCR §70703(d) and 70263.

6. Interdisciplinary practice committee: the development of written "standardized procedures" and supervision requirements which permit nurses and physicians' assistants to perform extended functions in the hospital. Business and Professions Code §2725. 22 CCR §§70706 et seq.

7. Clinical laboratories/radiology/anesthesiology review: the evaluation of, and the development of procedures governing clinical laboratory, radiology and anesthesiology practice. 22 CCR §§70233, 70243, and 70253.

8. Disaster planning: the development of a written disaster and mass casualty program. 22 CCR §70741.

9. Hospital safety planning: the development of a written program to deal with internal disasters such as fires. 22 CCR §§70743, 70745 and 70746.

10. Continuing education: the development of and participation in a mandatory, ongoing program of continuing education addressing the problems discovered during the foregoing patient care review activities. 22 CCR §70703(g).

B. The Importance Of Medical Staff Functions Is Further Evidenced By The Various Statutory Protections For This Activity.

The California Legislature has enacted a number of statutes specifically protecting members of the medical staff engaged in quality assurance activity. These statutes include:

(1) Civil Code §43.7 which provides a conditional immunity for actions taken by members of medical staff committees engaged in quality assurance activities;

(2) Civil Code §43.8 which provides a conditional immunity for those who communicate information to medical staff committees "intended to aid in the evaluation of the qualifications, fitness, character or insurability of the practitioner of the healing arts";

(3) Civil Code §47 subdivision 2 (4) which provides an absolute privilege for any "publication or broadcast" made "in the initiation or course of . . . proceedings authorized by law and reviewable" by way of administrative mandamus. This section applies to medical staff

disciplinary hearings such as those conducted as a result of credentialing disputes. Long v. Pinto, (1981) 126 Cal. App. 3d 946, 179 Cal. Rptr. 182.

(4) Evidence Code §1157 which provides a broad protection for the confidentiality of the proceedings in records of medical staff committees by generally insulating them from discovery.

(5) It is significant that Civil Code §43.97, which affords a conditional immunity from damages (except specific economic damages) for hospitals, for any disciplinary action taken which must be reported to BMQA pursuant to Business & Professions Code §805, applies only when the hospital takes action upon the recommendation of the medical staff. The law expects the hospital to rely upon the independent judgment of the medical staff in professional matters.[4]

The existence of these protections clearly demonstrates the Legislature's recognition of the importance of medical staff quality assurance activity, and the Legislature's intention to take those steps necessary to ensure that medical staffs continue to perform these functions, without interference from third parties, including the courts. Indeed, the courts have recognized the important policy underlying the protection of medical staff activities. As the court stated in Matchett v. Superior Court (1974) 40 Cal. App. 3d 623, 628-629, 115 Cal. Rptr. 317, an opinion upholding the protection for discovery afforded by Evidence Code §1157 (a statutory protection which has been upheld in an unbroken line of cases):

> When medical staff committees bear delegated responsibility for the competence of staff practitioners, the quality of in-house medical care depends heavily upon the committees members' frankness in evaluating their associates' medical skills and their objectivity in regulating staff privileges. Although composed of

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[4] Recently, a bill designed to enhance the peer review process, Senate Bill 1211 was signed by the Governor and will become the law on January 1, 1990. Section 809.05 will be added to the Business & Professions Code to read in pertinent part: "In all peer review matters, the governing body shall give great weight to the actions of peer review bodies and, in no event, shall act in an arbitrary or capricious manner."

volunteer professionals, these committees are affected with a strong element of public interest.

Plainly, the statutory protections afforded to medical staff activities evinces a legislative judgment that these activities are critical to the ongoing performance to quality care throughout hospitals. The reason is simple: medical staff activities serve the public, not the corporate interests of the hospital's owners.

III. TO PROPERLY PERFORM THEIR VITAL FUNCTIONS, MEDICAL STAFFS MUST RETAIN THEIR SEPARATE IDENTITY AND BE SELF-GOVERNING.

Recognizing the fundamental importance of medical staff activity to quality patient care in hospitals throughout California, and recognizing that only medical staff members can make the requisite determinations concerning the provision of quality care, the Legislature and the Department of Health Services have established a comprehensive scheme requiring medical staff performance of ongoing review, evaluation and monitoring of the quality of patient care and treatment rendered in hospitals. See Business and Professions Code §2282, Health and Safety Code §1250(a), 22 CCR §§70701 and 70703. See discussion above. Recognizing that these conditions are necessary to assure that medical staffs properly carry out their functions, the law demands that medical staffs be (a) separate and (b) self-governing.

A. A Medical Staff Is A Separate Entity Whose Legal Existence Is Independent Of A Hospital's Governing Body.

It cannot seriously be disputed that the medical staff is a separate entity within the hospital corporate structure. Indeed, the California Supreme Court has expressly recognized the legal status of the medical staff. Anton v. San Antonio Community Hospital (1977) 19 Cal. 3d 802, 809, 140 Cal. Rptr. 442 (defining a medical staff as "an unincorporated association organized under the auspices of the hospital's board of directors"). As an unincorporated association, the medical staff is an entity which has enforceable legal rights. See California Code of Civil Procedure §388. See also St. John's Hospital Medical Staff v. St. John's Regional Medical Center (1976) 245 N. W. 2d

472 (holding that hospital medical staff was a proper party to bring an action for declaration of rights and duties under the medical staff bylaws).[5]

The fact that a medical staff may be under the auspices of the hospital's board of directors does not deprive it of its status as a separately recognizable entity. Organizations of all types are subject to varying degrees of control, ranging from requirements imposed by federal and state law to operational limitations imposed by parent corporations or associations. Nevertheless, both California and federal courts have recognized the separate legal status of unincorporated associations subject to at least the measure of control exercised by a hospital's governing body over the medical staff. See, e.g., Killeen v. Hotel and Restaurant Employees, etc. League (1948) 84 Cal. App. 2d 87 (recognizing independent legal existence of local union even though it was bound by bylaws and constitution of parent association); Associated Students of University of California Riverside v. Kleindist (C.D. Cal. 1973) 60 FRD 65 (student organization is not a mere sub-unit of the Regents of the University of California). Under California law, all that is required for a determination of separate legal status is "(1) a group whose members share a common purpose, and (2) who function under a common name under circumstances where fairness requires the group be recognized as a legal entity." Barr v. Union Methodist Church (1979) 90 Cal. App. 3d 259, 153 Cal. Rptr. 322; Corporations Code §§24000; 20001; 21000.

A medical staff's independence from the hospital corporate structure is further demonstrated by the fact that both California and federal laws specifically require that hospitals have "organized" medical staffs. See Health and Safety Code §32128; Health and Safety Code §1250(a); Business and Professions Code §2282, 22 CCR §§70701 and 70703; 42 CFR §405.1023; 42 CFR §440.10. Additionally, JCAHO standards similarly require that the medical staff be "organized". See, Joint Commission "Accreditation Manual for Hospitals" (1989) MS. 1.

There is no room for doubt about the meaning of the term "organized". Accordingly, the term must be given its plain meaning. Shippen v. Department of Motor Vehicles (1984) 161 Cal. App. 3d 1119, 208 Cal. Rptr. 13. The term "organized" is defined as "having a formal organization to coordinate and carry out activities". Webster's Ninth New Collegiate Dictionary (1988).[6]

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[5] Because of the medical staff's separate legal identity, the case so wholeheartedly relied upon by appellees below, Lewin v. St. Joseph Hospital of Orange (1978) 82 Cal. App. 3d 209, 146 Cal. Rptr. 892 is inapplicable. Plainly, this matter does not involve an "in-ternecine" dispute, that is, a conflict within a single group, such as a board of directors. Moreover, the Lewin court made it clear in its analysis that the conduct being challenged involved a "quasi-legislative" determination made by the hospital. As Eisenhower's board of trustees decision to refuse to seat Dr. Stoltzman involved a "quasi-adjudicative" determination, Lewin has no relevance to this case.

[6] When ascertaining the "plain meaning" of a word of a statute, courts must

Similarly, the term "organize" means "to cause to develop an organic structure", "to organize or form into a coherent unity or functioning whole". Id. Given the plain meaning of the statutes governing the existence of a medical staff, it is abundantly clear that the medical staff is a separate legal entity which exists independent of the hospital governing body. As such, the medical staff plainly has the right to govern its own affairs.

B. California Law Prohibits The Practice Of Medicine By Physicians In Hospitals And Licensure Of Hospitals Unless The Medical Staff Is "Self-Governing With Respect To The Professional Work Performed".

As will be discussed in greater detail below, California law generally prohibits lay persons from exercising control or otherwise interfering with the professional judgment of physicians and other health care professionals. The reason for this prohibition is simple: lay individuals, including hospital trustees, have neither the expertise nor experience to render, implement, or exercise control over decisions made by physicians and medical staffs.

Recognizing these practical realities, both the Legislature and the Department of Health Services have specifically concluded that the public welfare depends on medical staff control and regulation of the professional work performed in hospitals. Accordingly, California statutes mandate the establishment of organized, self-governing medical staffs to control the performance of that work. In fact, physicians are prohibited by law from practicing medicine in hospitals without such medical staffs. Business and Professions Code §2282 provides, among other things, that it shall be unprofessional conduct for a physician to practice medicine in a hospital which does not have the rules providing for at least the following:

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first look at the dictionary meaning. Cf. Rosenfield v. Superior Court (1983) 143 Cal. App. 3d 198, 191 Cal. Rptr. 611.

1. [T]he organization of physicians and surgeons licensed to practice in this state who are permitted to practice in the hospital into a formal medical staff with appropriate officers and bylaws . . .

2. [T]hat membership on the medical staff shall be restricted to physicians and surgeons and other licensed practitioners competent in their respective fields . . . and

3. [T]hat the medical staff shall be self-governing with respect to the professional work performed in the hospital . . . . (Emphasis added)

Parallel provisions regarding self-governing medical staffs apply to hospitals. Health and Safety Code §1250(a) defines "general acute care hospitals" as health facilities having "an organized medical staff." Department of Health Services regulations governing acute care hospitals expand on this definition. 22 CCR §70701 provides, in relevant part:

(a) The governing body shall:

(1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:

* * *

(D) Formal organization of the medical staff with appropriate officers and bylaws.

* * *

(F) Self-government by the medical staff with respect to the professional work performed in the hospital, periodic meetings of the medical staff to review and analyze at regular intervals their clinical

experience and requirement that the medical records of the patient shall be the basis for such review and analysis.

. . .

(7) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. [Emphasis added].

§70703 further defines the role and responsibilities of an "organized medical staff". Relevant subdivisions of §70703 include:

(d) The medical staff bylaws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff's members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made

to the executive committee and the governing body as frequently as necessary and at least quarterly.

(e) The medical staff shall provide in its bylaws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospitals. . . . "

JCAHO standards mirror California law. These standards clearly mandate that organized medical staffs be responsible for the control and provision of professional services provided at the hospital. JCAHO Medical Staff Standards 1, 2 and 3 provide:

MS 1: There is a single organized staff that has overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accountability therefore to the governing body. . . .

MS 2: The medical staff develops and adopts bylaws and rules and regulation to establish a framework for self-governance of medical staff activities and accountability to the governing body.

MS.3: The medical staff is organized to accomplish its required functions.

(Emphasis added)

This carefully crafted scheme ensures that medical staffs and their members independently exercise their professional expertise with respect to the professional work performed in the hospital. Neither the law nor public policy countenance unlawful or otherwise unwarranted intrusions into matters which are exclusively within the medical staff's (and its physician members) proper domain.

In order to fully understand the critical role performed by the medical staff, the terms "self-governance" and "professional work" must be analyzed. Indeed, without an "organized" "self-

governing" medical staff which controls the "professional work performed in the hospital", California laws designed to maintain quality care in hospitals become meaningless.

1. Self-governance requires control over one's own affairs.

Like the term "organized", the meaning of the term "self-governance" is not subject to dispute. "Self-government" is defined in Webster's Ninth New Collegiate Dictionary (1988) to mean "1: SELF-COMMAND, SELF-CONTROL. 2: government under the control and direction of the inhabitants of a political unit rather than by an outside authority; broadly: control of one's own affairs". Given the breadth of this term, it could not be more clear that medical staffs and their physician members must exercise their lawful right and responsibility to assure quality care, without interference or control by a hospital's board of trustees.

The conclusion that medical staffs must operate free from the imposition of external control is compelled by a consideration of other cases discussing "self-governing" entities in other contexts. For example, the United States Supreme Court has declared that "a collective bargaining agreement is an effort to erect a system of industrial self-government." United States Steel Workers v. Warrior & G. Nav. Co., (1960) 363 U.S. 574, 580, 4 Led 2d 1409. With respect to collective bargaining agreements, therefore, self-government means complete control over internal grievances without resort to external powers. Id. Similarly, Indian tribes, as "distinct political communities", operate under a system of "self-government". Estate of Johnson, (1981) 125 Cal. App. 3d 1044, 178 Cal. Rptr. 123. Therefore, the state may not lawfully impose estate taxes on self-governing Indian tribes. The Regents of the University of California enjoy a similar status as a "self-governing" entity. Regents of Univ. of Cal. City of Santa Monica (1978) 77 Cal. App. 3d 130, 143 Cal. Rptr. 276. Accordingly, when constructing improvements for educational purposes, the Regents are exempt from local building codes and zoning regulations. Id. The California State Bar has also been described as "an organization of members of the legal profession of the state with a

large measure of self-government performing such functions as examining applicants for admission, formulating rules of professional conduct, disciplining members for misconduct, preventing the unlawful practice of law, and engaging in the study and recommendation of changes in procedural law and improvement of the administration of justice." See Saleeby v. State Bar (1985) 39 Cal. 3d 547, 557, 216 Cal. Rptr. 367. See also Rapid Transit Advocates, Inc. v. Southern California Rapid Transit District (1986) 185 Cal. App. 3d 996, 230 Cal. Rptr. 225 (holding that transit district, a governmental body with "virtual autonomy and self-governance" was not subject to regulations propounded by city or county).

At the very least, therefore, the term "self-governance" in the context of medical staffs, means a substantial degree of independence and discretion, particularly in regard to its own inner workings, and clearly encompasses the election of medical staff officers.

2. "Professional work performed in the hospital" encompasses not only clinical and other determinations necessary to the practice of medicine, but also all decisions regarding the medical staff's right and responsibility to conduct quality of care and patient review activities.

The Legislature mandated the broad grant of authority to medical staffs to be self-governing in the "professional work performed in the hospitals", recognizing that medical staffs and their members are not only responsible for providing quality medical care to their patients, but also for the performance of quality assurance functions (thereby assuring the quality of care) in hospitals. Only through this broad authority granted to medical staffs can the letter and spirit of California's strong protections prohibiting the commercial exploitation of the practice of medicine and protecting the integrity of the physician/patient relationship be maintained.

It should be noted that the practice of medicine is not limited to the diagnosis and treatment of disease. Indeed, as the court in Marik v. Superior Court (1987) 191 Cal. App. 3d 1136,

236 Cal. Rptr. 751, correctly observed, the practice of medicine includes a host of considerations ranging from the type of equipment needed, skill levels required by operators of the equipment, scope of practice, and medical ethics, to business considerations which encompass factors that have medical ramifications. Marik, supra at 1140, see discussion below. In addition, as is discussed below, physicians have a number of obligations arising from their relationships with patients which do not necessarily constitute "treatment measures" but do constitute the practice of medicine, such as the duty to obtain informed consent, protect confidences, make appropriate referrals, protest improper third party cost-containment decisions, etc. With increasing numbers of technologies and health care delivery systems available to patients, the realities of the practice of medicine today require that physicians exercise their informed professional judgment in a variety of matters, including, but not limited to, 1) where the patient will receive the requisite care, 2) who, other than the treating physician, will provide that care, and 3) under what circumstances the patient should receive that care. The courts have made it clear that inextricably intertwined with these medical determinations are business and administrative concerns which cannot be addressed in isolation. Marik, supra, see also Wickline, supra.

Aside from the "practice of medicine", medical staffs and their members are required by law to perform ongoing review, evaluation and monitoring functions. As is discussed more fully above, medical staffs are not only responsible for assuring the initial and ongoing competence of all of its members, but are also primarily responsible for assuring the ongoing quality of patient care throughout the hospital. See generally 22 CCR §70703. Medical staffs regularly maintain one or more committees formally organized to monitor the care and treatment rendered to hospital patients, and regularly perform numerous patient care review functions. See discussion above.

The phrase "professional work performed in the hospital", therefore, encompasses an extensive range of matters such as patient care and quality assurance activities, as well as

administrative concerns in furtherance of those activities. Accordingly, in light of the mandate that medical staffs be "self-governing", California law clearly grants the organized medical staff the right and responsibility to maintain the integrity of the physician-patient relationship (and the unique constellation of rights and responsibilities which are attendant thereto) to initiate, develop and establish criteria and standards governing its "professional work" and to enforce those standards to ensure that appropriate practices are observed in all medical staff departments and committees. Thus, the medical staff's right to self-governance includes, but is not limited to, the medical staff's ability to:

(a) initiate, develop and adopt its own bylaws;

(b) select and remove its own officers;

(c) set the standards of patient care;

(d) establish and enforce criteria and standards for medical staff membership;

(e) approve or disapprove amendments to medical staff bylaws, rules and regulations;

(f) take corrective action, and when necessary disciplinary action, against its own members,

(g) protect patients' interests in obtaining quality care;

(h) maintain the confidentiality of patient information; and

(i) manage its own financial and legal affairs.

See authorities set forth above.

The right of a medical staff to choose its own representatives goes to the very heart of California's system of medical staff self-governance. Plainly, the medical staff election process itself comes within the purview of the medical staff's "professional work" and consequently cannot be intruded upon by a hospital's board of trustees.

C. Recognizing That Hospital Board Of Trustees Are Not Qualified To Make Medical Judgments, The Board's Authority Over Functions Vested In The Medical Staff Is Extremely Limited.

In sharp contrast to the comprehensive scheme vesting the medical staff with broad authority over the performance of professional work in the hospital, the board of trustees' role is extremely limited and does not extend to the exercise of control, direct or indirect, of the medical staff's professional judgment. Thus, while the board of trustees must assume the "overall administrative responsibility" for the hospital, Health and Safety Code §1250(a); and to adopt bylaws governing the hospital's general conduct, 22 CCR §70701; the board is required to provide for an "organized medical staff which provides 24-hour inpatient care", Health and Safety Code §1250(a), including "formal organization of the medical staff with appropriate officers and bylaws," and "self-government by the medical staff with respect to the professional work performed in the hospital". 22 CCR §70701(a)(1)(D)(F). Moreover, hospital boards are specifically mandated to require that the medical staff establish and perform the credentialing function of the hospital. 22 CCR §70701(a)(7). Similarly, hospital boards must approve all reasonable medical staff bylaws, 22 CCR §70701(a)(8), and may not impose unreasonable restrictions on staff membership. Cf. Miller v. Eisenhower Medical Center (1980) 27 Cal. 3d 614, 166 Cal. Rptr. 826.

Any remaining doubt as to the limits of the hospital board's role in matters concerning the medical staff's affairs which involve the exercise of informed professional judgment is removed by a consideration of those areas in which hospital board has been expressly authorized to act by the Legislature. For example, the Legislature has delegated to the board of trustees the authority to determine whether to impose a professional liability insurance requirement as a condition of staff privileges - a decision which, while clearly affecting medical staff members, does not involve the exercise of the medical staff's informed professional judgment. Health and Safety Code §1319. In fact, following the reasoning of the court in Wilkinson v. Madera Community Hospital (1983) 144

Cal. App. 3d 436, 192 Cal. Rptr. 593 (upholding §1319 against a challenge that the statute unconstitutionally delegated legislative power to a private entity), it is unclear whether the court would uphold a statute delegating unchecked legislative power to hospital boards to control the professional work in the hospital. As the Wilkinson court stated:

> "An unconstitutional delegation of legislative power occurs when the legislature confers with . . . unrestricted authority to make fundamental policy decisions. [Citations] In order to avoid an unlawful delegation of its authority, the legislature must first resolve the "truly fundamental issues" and must then 'establish an effective mechanism to assure the proper implementation of its policy decisions.' [Citation]
>
> Thus, a delegation of authority must be accompanied by safeguards that ensure that the delegatee does not act arbitrarily. Id at 442. [Emphasis added]."[7]

Accordingly, California law governing the provision of "professional work" performed in hospitals provides safeguards against improper action by mandating medical staff participation and self-governance over matters involving patient welfare which may be outside of the board of trustees' area of expertise, contrary to the hospital's financial interest, or both. These safeguards severely restrict the board's authority to act, particularly where matters properly within the realm of the medical staff's control are involved.

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[7] Notably, in Rosner v. Peninsula Hospital District, (1964) 224 Cal. App. 2d 115, a hospital board adopted an emergency resolution requiring medical staff members to maintain professional liability insurance. The court in that case struck down the requirement, on the facts before it and in the absence of any statutory authorization for the requirement. In reaching its holding, the Rosner court prudently recognized that hospital boards may take self-interested action without due concern for the rights of physicians or their patients. As the court stated, "[a] power to determine who shall have the right to engage in an otherwise lawful enterprise may not be delegated to a private body unless such power be accompanied by adequate safeguards which afford the applicant protection against arbitrary or self-motivated action." Id at 337.

This limitation on the board's role and authority is further emphasized by the omission of any protection in Evidence Code §1157 for records other than those of medical staff committees. As the court stated in Matchett v. Superior Court, (1974) 40 Cal. App. 2d 623, 115 Cal. Rptr. 317, "§1157 does not embrace the files of the hospital administration (as distinguished from the staff). The trial court should have inquired into the existence of a hospital administration file concerning the doctor and, if such file existed, should have permitted its inspection excluding any portions which reflected the proceeding of staff committees conforming to the specifications of the immunity statute." Id at 628.

Consistent with the law, the governing body, though it has certain "oversight" responsibilities, does not and cannot have unchecked power over the medical staff. To the contrary, both the medical staff and the governing board have mutual duties of surveillance and serve as a check and balance on each other in order to assure an appropriate symmetry between corporate and patient care interests. We fully acknowledge that Elam v. College Park Hospital (1982) 132 Cal. App. 3d 332, 183 Cal. Rptr 156 imposes tort liability of hospitals for negligently screening the competency of its medical staff. However, just as Elam imposes a duty upon governing boards to non-negligently screen medical staff members and applicants, the principles of the Wickline case would appear to, impose on medical staffs a parallel duty to oversee actions of the board. Neither entity has unchecked power over the other.[8] For example, while the governing body has the responsibility to review and see to it that the medical staff conducts its activities in a fair and unbiased fashion consistent with its bylaws and the law, it relies upon the medical staff for ensuring

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[8] It should be noted that the original Elam decision imposed a duty of supervision. In its final modified opinion, the court removed the duty of supervision when formulating the statement of the hospital's duty. Thus, in medical malpractice actions, hospitals may be held liable either on a "negligent oversight" of the medical staff's credentialing process theory or on the theory of "ostensible agency" when the facts support that theory. See Elam, supra.

the quality of care provided to patients in the hospital since only the latter can make the necessary determinations.

Agencies within government similarly have been allocated specific duties relating to their own expertise. To illustrate the point, the Department of Consumer Affairs in California is comprised of a number of state agencies, including, among others, the Board of Dental Examiners, the Board of Medical Quality Assurance, the State of Board of Optometry, the State Board of Accountancy, and the State Board of Barber Examiners. Business and Professions Code §101. The various boards within the department are established for the "purpose of ensuring that those private businesses and professions deemed to engage in activities which have potential impact upon public health, safety, and welfare are adequately regulated in order to protect the people of California." Business and Professions Code §101.6. Each of the boards within the Department exists as a separate unit, and have the responsibility for, among other things, setting standards, holding meetings, preparing and conducting examinations, passing upon applicants and conducting investigations of violations of laws under its jurisdiction. Business and Professions Code §108. While the Legislature has granted the Director of the Department of Consumer Affairs broad powers and duties, Business and Professions Code §310, he or she has virtually no power with respect to matters which are peculiarly within the knowledge and expertise of the boards. Indeed, the decisions of any of the boards with respect to setting standards, conducting examinations, passing candidates, and revoking licenses are not even subject to review by the director. See Business and Professions Code §109. Similarly, the boards may adopt rules and regulations relating to examinations and qualifications for licensure without the Director's review or approval. Business and Professions Code §313.1.

Like medical staffs within hospitals, therefore, the various boards within the Department of Consumer Affairs have been granted exclusive powers over matters within their own expertise and

control. While the Department and the governing body of a hospital, have certain oversight authority, boards and medical staffs alike are "self-governing" with respect to the professional work that they perform.

In sum, the governing body of a hospital cannot delegate or otherwise control those functions of the medical staff which that body itself may not lawfully perform. Enabling the governing body to have complete veto power over a medical staff decision, such as the ability to emasculate completely a medical staff's electoral process, in effect enables the hospital board to have unchecked power to control all responsibilities of the medical staff, power which the governing board plainly does not possess.[9]

IV. THE MEDICAL STAFF'S RIGHT TO CHOOSE ITS OWN REPRESENTATIVE GOES TO THE VERY HEART OF SELF-GOVERNANCE AND ANY BYLAW WHICH ABRIDGES THAT RIGHT IS INVALID.

A. The Statutory And Regulatory Scheme Governing The Delivery Of Health Care In Hospitals Demands That Medical Staffs Elect Their Own Leaders, Free From Third Party Interference.

Based on the mandate that medical staffs be "self-governing with respect to the "professional work performed in the hospital", the only conclusion that the law recognizes is that medical staffs are empowered to choose their own representatives. See also JCAHO Standard GB. 1.2.9 (stating "the medical staff has the right of representation (through attendance and voice), by one or more medical staff members, selected by the medical staff, at meetings of the governing body.") (Emphasis added). While this decision must be made consistent with the medical staff's

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[9] In this regard, it is worthy of note that hospital governing boards are specifically insulated from liability if they reasonably rely on the medical staff's professional judgment. See Corporations Code §309.

own standards, it must be made without interference from third parties, including a hospital's board of trustees.

The ability to choose its own leader lies at the core of the medical staff's right to self-government. It is a safeguard against arbitrary or otherwise self-interested acts by lay entities which experience and common sense has taught are likely to come from increasing economic pressures to reduce healthcare costs. The most basic principle of California's scheme governing the professional work performed in hospitals is destroyed when the right of medical staffs to select their leaders is taken from the staff and given to the governing body. Such an action results in the governing body having unchecked power over the medical staff, by vesting within the governing body the power to be essentially the medical staff's "boss". Recognizing that the public welfare depends upon protections from this form of abuse, the law plainly forbids this result. See Business and Professions Code §2282; Health and Safety Code §1250(a); 22 CCR §§70701, 70703. See also discussions below.

Strong medical staff leadership is critical to the staff's ability to function effectively. As its representatives, the president and president-elect of the medical staff are the medical staff's voice. They serve not only to unite the medical staff itself, which is often comprised of hundreds of individual physicians, but also to ensure the proper functioning of the medical staff's quality assurance activities and to act as liaison between the medical staff and hospital board to ensure that the medical staff's policies are properly implemented. Furthermore, medical staff leaders serve in these capacities with no or minimal compensation.

The importance of the president and president-elect of a medical staff cannot be understated. Indeed, Eisenhower Memorial Hospital's own medical staff bylaws require that the president-elect be a member of the Executive Committee of the medical staff, the Joint Conference Committee, and the Chairman of the Credentials Committee and Quality Assurance Committee.

Additionally, the president-elect assumes the responsibilities and has the authority of the president in the latter's absence. The bylaws vest a plethora of powers in the president, including, but not limited to, the power to enforce both the hospital's and medical staff's bylaws, to act in coordination and cooperation with the administrator of the hospital in all matters of mutual concern, to represent the views, policies and needs of the medical staff to the governing body of the hospital, and to be responsible for the educational activities of the medical staff. These responsibilities vested in both the president and president-elect of the medical staff, by their very nature constitute "professional work". See Eisenhower Medical Staff Bylaws §9.7.

Consequently, based on principles of self-governance alone, Eisenhower's medical staff's bylaws which purports to enable the board of trustees to "disqualify" a duty elected medicine staff officer, is invalid.

B. Courts Routinely Invalidate Bylaws Which Grant Too Much Discretion To A Board Of Trustees.

Eisenhower argues that it is fully empowered to refuse to seat a duly medical staff officer because pursuant to the medical staff bylaws, it has the power to "approve" elected officials.[10] This argument ignores the fact that a bylaw cannot, consistent with California law, grant such unchecked power to the hospital's governing body.

Any doubt about this conclusion is removed by a consideration of cases invalidating bylaws which dilute the power of separate entities, such as medical staffs, or vests too much discretion within the governing body. In Health Maintenance Network of Southern California v. Blue Cross of Southern California, (1988) 202 Cal. App. 3d 1043, 249 Cal. Rptr. 220, for example, a health maintenance organization brought an action seeking declaratory and injunctive relief

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[10] Because of its limited duty of oversight, a hospital board arguably has the power to "disapprove" an elected official when the latter does not meet the requirements of the medical staffs bylaws to hold office. It is beyond dispute that the refusal to seat Dr. Stoltzman was not predicated on this ground.

prohibiting a non-profit health insurer (Blue Cross) from interfering in the HMO's corporate operations. In a nutshell, Blue Cross formed the HMO in 1977 in order to obtain a marketing advantage from a federal law requiring employers to offer employees a qualified HMO program if requested. Pursuant to federal law, HMOs must maintain an independent, legal existence in order to obtain certification. 42 U.S.C. §300e. However, the HMO's bylaws contained a provision permitting Blue Cross to appoint HMO corporate members.[11] In 1980, the California Corporations Code was amended to allow non-profit corporations to eliminate members. In 1983, the HMO's board amended the bylaws by providing there would be no members at all. Once Blue Cross discovered the significance of the bylaw amendment, it undertook a number of actions designed to reinstate its control of the HMO such as appointing new members who purported to replace the existing HMO board with new directors. Those actions forced Health Net to seek judicial intervention. The Superior Court granted preliminary and permanent injunctive relief and an appeal was taken. On appeal, the court held, among other things, that the HMOs' bylaw provision permitting Blue Cross to appoint the HMOs corporate members was inconsistent with federal and state law requiring that the HMO maintain an independent legal existence, and so that the bylaw could be properly eliminated. See also In the Matter of Osteopathic Hospital Association of Delaware (1963) 191 A 2d 333, aff'd 195 A.2D 759 (holding bylaw amendment which was duly adopted by board of trustees of non-profit Osteopathic Association but which would substantially change structure of organization and would dilute power of physician members to control boards through elections was unreasonable in operation and void.)

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[11] The court explained the role of corporate members as "the functional equivalent of stockholders in for-profit corporations." Health Maintenance Network, supra at 1048, footnote 3. Such members usually have the right to elect the board of directors and to vote on changes to the corporate articles of incorporation or bylaws. Id.

Moreover, bylaws which are so vague and ambiguous as to permit arbitrary or capricious decision-making have been repeatedly struck down by the courts where medical staffs members' rights are concerned. For example, in Wyatt v. Tahoe Forest Hospital Dist. (1959) 174 Cal. App. 2d 709, a court invalidated a bylaw which read, in pertinent part, "membership to the medical staff shall be limited to those physicians and surgeons licensed to practice in the state of California, whose background, experience and training ensures, in the judgment of the Board of Directors, that any patient admitted to or treated in the Tahoe Forest Hospital will be given the best possible care and professional skill." (Emphasis added.) Id at 712, 713. The court held that under that standard, admission to medical staff membership can depend on the "whim and caprice of the directors" and, after noting that no statute authorized a bylaw of that type, held that the rule was too vague and uncertain to be valid. Id at 715. See also Rosner v. Peninsula Hospital District, supra (invalidating bylaw requiring malpractice insurance in the absence of statutory authorization.)

Similarly, in Rosner v. Eden Township Hospital Dist., (1962) 58 Cal. 2d 592, the board of directors of the hospital excluded a physician from membership on the grounds, among others, he was not "temperamentally suitable for hospital staff practice". The court invalidated this action and held that a public hospital district was not statutorily authorized to adopt such a standard for staff admission. Additionally, as the court observed:

> . . . a hospital district should not be permitted to adopt standards for the exclusion of doctors from the use of its hospital which are so vague and ambiguous as to provide a substantial danger of arbitrary discrimination in their application. In asserting their views as to proper treatment and hospital practices, many physicians will become involved in a certain amount of dispute and friction, and the determination that such common occurrences have more than their usual significance and show

temperamental unsuitability for hospital practice of one of the doctors is of necessity highly conjectural. In these circumstances there is the danger that the requirement of temperamental suitability will be applied as a subterfuge where considerations having no relevance to fitness are present. Id. at 598.

The dangers recognized by the Wyatt and Rosner courts are equally present here. Just as in both Rosner cases, there is no statutory authorization for (and indeed, the statutes mandating self-governance prohibit) a unilateral and arbitrary decision of the hospital's governing body to bar a duly-elected physician from serving as a medical staff leader. Moreover, as in Wyatt, the ability to seat a duly elected medical staff officer depends on the "whim and caprice" of Eisenhower's board of trustees. Accordingly, the bylaw purportedly authorizing the Eisenhower board to "approve" elected medical staff officials is void. See also Westlake Community Hospital v. Superior Court, (1976) 17 Cal. 3d 465, 131 Cal. Rptr. 90 (invalidating exculpatory clause in bylaw as void against public policy).

C. Election Law In Other Contexts Prohibits The Rejection Of Election Results Except In Extraordinary Circumstances.

Even apart from the laws mandating medical staff self-governance and a medical staff's right to choose its own officers, general principles of law concerning elections in other contexts compel the conclusion that the bylaw on its face in this case (and particularly as applied) is invalid. Of course, both the federal and state constitutions protect the rights of all qualified citizens to vote, a right which is "preservative of other basic civil and political rights." See Reynolds v. Sims, (1964) 377 U.S. 533, 562, 12 Led 2d 1029; Stanton v. Panis (1980) 28 Cal. 3d 107, 167 Cal. Rptr. 587 (holding that under certain circumstances, constitution required that office for Superior Court judge be filled by completion of the election process rather than by appointment). Given the fundamental nature of the right to vote, courts will only set aside election results in extraordinary circumstances. By the same token, the right to hold office is a fundamental right which may not be abridged absent plain provisions of the law. See Helena Rubenstein Intern v. Younger, (1977) 71 Cal. App. 3d 406, 139 Cal. Rptr. 473.

With respect to the electoral process itself, elections must be upheld as valid unless plainly illegal. See Wilks v. Mouton, (1986) 42 Cal. 3d 400, 229 Cal. Rptr. 1. Elections Code §20021 sets forth narrow and specific grounds which an elector of a county may contest in election, including, where the person who had been declared elected to an office was not, at the time of election, eligible to office, where illegal votes were cast, and where bribery was involved. With respect to actually disqualifying or otherwise ousting elected officials, the Constitution specifically empowers

the Legislature to disqualify electors under extremely limited circumstances - mental incompetence, imprisonment, or parole for the conviction of a felony. See Article II §4 of the California Constitution. Accordingly, the Legislature granted to the Attorney General the authority to bring a quo warranto proceeding against any person who, among other things, unlawfully holds or exercises any public office. See Code of Civil Procedures §803. Situations potentially precipitating such a proceeding include mental or physical incapacitation, failure to discharge duties of office for a period of three consecutive months, conviction of a felony or any other offense involving a violation of officials duties, and final commitment to a hospital or sanitarium, by order of a court, as a drug addict, dipsomaniac, inebriate, etc. Elections Code §1770. Therefore, under general election law, only under rare circumstances can a duly elected individual be disqualified from office.

An even closer analogy is the right of unions, also "self-governing" entities, to choose their representatives. This right is embedded in Labor Code §923 which provides in relevant part:

> ". . . [I]t is necessary that the individual workman have full freedom of association, self-organization, and designation of representatives of his own choosing, to negotiate the terms and conditions of his employment, and that he shall be free from the interference, restraint, or coercion of employers of labor, or their agents, in the designation of such representatives or in self-organization or in other concerted activities for the purpose of collective bargaining or other mutual aid or protection."

The statute on its face emphasizes that the individual employee has full freedom of choice in the designation of his or her representative. Thus, for example, it is unlawful to discriminate against employees if they designate an attorney to represent them for the purposes of negotiating terms and conditions of employment. See Montalvo v. Zamora, (1970) 7 Cal. App. 3d 69, 75, 86 Cal. Rptr. 401.

Given these general principles of law, it could not be more clear that the bylaw at issue in this case defies the very meaning and purpose of self-government. No matter what the context, non-electors must not be permitted to disqualify an elected official at their "whim and caprice."

V. THE MANDATE THAT MEDICAL STAFF'S BE SELF-GOVERNING DERIVES ITS GENESIS FROM CALIFORNIA'S LONG STANDING POLICY OF

AFFORDING DEFERENCE TO A PHYSICIAN'S PROFESSIONAL JUDGMENT AND REFUSING TO PERMIT LAY INTERFERENCE WITH THAT JUDGMENT.

As the foregoing discussion illustrates, the laws governing the delivery of health care in hospitals mandate that the hospital board play a very narrow role in the oversight of the medical staff's functions. This scheme reflects the practical fact that lay members of the board of trustees do not have the experience to second guess the medical staff's professional judgment. Indeed, California law has long recognized that the complexities of the practice of medicine and the fiduciary nature of the physician/patient relationship requires that third parties be prohibited from interfering with that relationship. The mandate for medical staff self-governance stems from this recognition. Accordingly, the right of a medical staff to select its own leaders becomes even clearer upon consideration of the relationship between physicians and their patients.

A. Quality Patient Care Depends On Deference To A Physicians's Judgment

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

The American Medical Association Principles of Medical Ethics, Principle No. 1. This principle of medical ethics is a standard of conduct which defines an essential element of both legal and ethical behavior for physicians. This principle reflects a physician's special obligations to both his or her patients and society to continually strive to provide high quality care notwithstanding forces in society that threaten medical professionalism and jeopardize the provision of quality medial practice in providing medical services to individual patients.

As the discussion below demonstrates, the quality of health care provided to patients today requires that the judgment of the physician be respected. Only physicians have the requisite skill, education, experience and loyalties to make the relevant assessments concerning the provision of health care.

1. The physician-patient relationship places unique obligations upon physicians which apply regardless of the policies instituted or maintained by a hospital.

The necessity for deference to a physician's judgment can easily be understood in the framework of the physician-patient relationship: a patient's interest in obtaining quality care lies at the heart of that relationship. Patients are generally less knowledgeable than physicians about their health needs and about the alternative means of meeting those needs. To obtain optimal care, patients must not only trust their physicians with their bodies, but they must disclose intimate and often painful details of their lives. Patients in turn depend on their physicians to help them understand and choose what care and treatment they will receive, to deal with hospitals and third party payers that may seek improperly to impede the provision of costly, but medically necessary care, to protect their confidences, and generally to advocate on their behalf.[12] As was recognized by the court in Jones v. Fakehany (1968) 26 Cal. App. 2d 268:

> Most important among the many features distinguishing the practice of medicine from other commercial enterprises is the extremely dependant and trusting role assumed by the patient. Very often he is unable fully to understand the nature of his ailment even after the diagnosis has been made and explained to the fullest extent that explanation is desireable or helpful. His faith and confidence in the individual who prescribes treatment to alleviate his conditions are often as greatly contributive to his recovery as the medication or therapy prescribed. [Emphasis added].[13]

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[12] Indeed, as one commentor stated:
The physician, not the patient, combines the components of care into a treatment. In other markets the consumer, with varying degrees of knowledge, selects the goods and services he desires from the available alternatives. In medical care, however, the patient does not usually make this choice directly. . . [H]e selects a physician who then makes . . . . choices for him.
Feldstein, Research on the Demand for Health Services, 44 Milbank Memorial Fund Q 128, 138 (1966).

[13] Interestingly, in Jones v. Fakehany, supra, the court held that a patient may not properly be regarded as a subject of ownership and he or she may not be denied the right to seek and obtain treatment from a licensed physician of his choice in order to protect purported "property rights" of any competing physician or clinic. Neither patients themselves nor the delivery of health care to them may be considered as chattel and/or mere commercial ventures.

Implicit in the physician-patient relationship is the essential component of trust. The patient must not only trust that the physician's primary goal is to enhance the patient's well-being, but also that the physician is competent to make clinical decisions and to evaluate correctly the adequacy of the facility in which the treatment is to be administered. As the California Supreme Court recognized in Cobbs v. Grant (1972) 8 Cal. 3d 229, 104 Cal. Rptr. 505, "The patient, being unlearned in the medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician which transcends arms-length transactions." Id. at 242. Patients depend on their physicians to help them understand and make critical decisions such as what care and treatment they receive, where they receive it, what diagnostic tests are essential, and what therapy is appropriate.

In order to further promote quality care, and recognizing the unique and fiduciary nature of the physician-patient relationship, the courts and the legislature have imposed numerous duties on physicians to protect their patients from harm. Just a sampling of the obligations imposed upon physicians demonstrates the legislative and judicial recognition of the unique nature of the physician-patient relationship and its role as the cornerstone of quality health care. These obligations only further demonstrate what the courts and the Legislature have recognized and the conclusion which common sense compels: physicians, when providing health care, are imbued with a public trust such as to make them qualitatively different from other professionals.

For example, absent a termination of the physician-patient relationship, a physician's relationship with his or her patient is a continuing one that imposes ongoing obligations. Cf. Tresemer v. Barke (1978) 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (holding that a patient stated a cause of action against a physician who had inserted an intrauterine device on the grounds that the physician, who had seen the patient only once, failed to warn her of its dangerous side effects of which he learned after its insertion). The failure to provide medical care to a patient with whom a

relationship has been established may result in liability for "abandonment", a form of professional negligence recognized by the courts. Payton v. Weaver (1982) 131 Cal. App. 3d 38, 182 Cal. Rptr. 225 (holding that physician and clinic had no duty to provide a patient with dialysis treatment who had been provided with due notice of the termination of the relationship and ample opportunity to secure alternative medical care.)

Moreover, physicians have a number of duties to their patients with respect to the "non-treatment" aspects of the practice of medicine. For example, physicians are obligated to obtain "informed consent", that is a patient's consent after receiving material information before performing certain medical procedures. Cobbs v. Grant (1972) 8 Cal. 3d 229, 104 Cal. Rptr. 505. Additionally, if a physician discovers, or with reasonable diligence could have discovered, that his or her patient requires more specialized care, that physician has a duty to refer that patient to or consult with an appropriate specialist. Sinz v. Owens (1949) 33 Cal. 2d 749.

Similarly, a physician has the duty to, among other things, protect his or her patient's confidentiality. Generally speaking, the "physician-patient privilege" dictates that confidential communications between physicians and patients in the course of a professional relationship are privileged, and hence non-disclosable. See Evidence Code §992. This privilege recognizes a zone of privacy - the purposes of which are to protect the patient from possible humiliation or embarrassment and to encourage the patient to fully disclose to the physician all information necessary for his or her effective diagnosis and treatment. Cf. Division of Medical Quality v. Gheradini (1979) 93 Cal. App. 669, 679, 156 Cal. Rptr. 55. Physicians have an affirmative obligation to raise the privilege on their patients' behalf. See Evidence Code 995.[14]

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[14] Moreover, physicians are subject to a host of requirements in connection with the acquisition and disclosure of patient records and medical information, all designed to ensure that patients are protected. See for example Health and Safety Code §§25250 et seq. (patient access to medical records); Code of Civil Procedure Section 1985.3 (subpoena for medical records); Civil Code Sections 56 et seq (Confidentiality of Medical Information Act); Insurance Code Sections 791

At the very heart of the physician-patient relationship lies the physician's right and responsibility to advocate standards pertaining to quality patient care. As was recognized by the California Supreme Court in Rosner v. Eden Township Hospital District (1962) 58 Cal. 2d 592, 598 25 Cal. Rptr. 551:

> "The goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital practices are being followed. Considerations of harmony in the hospital must give way where the welfare of patients is involved, and the physician by making his objections known, whether or not tactfully done, should not be required to risk his right to practice medicine". (Emphasis added).

More recently, the Rosner Court's recognition that physicians must be free to advocate on their patient's behalf has been extended by the courts to encompass an affirmative legal duty, on the part of physicians, to speak up and challenge cost containment decisions which jeopardize a patient's health. In the landmark case of Wickline v. State of California (1986) 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810, the court strongly suggested that an injured party is entitled to recover compensation from all persons responsible for the deprivation of care, including third payers, when medically inappropriate decisions result from defects in the design or implementation of cost containment programs. The court held, however, that the treating physician who complies without protest with the limitations imposed by a third party payor when the physician's medical judgment dictates otherwise, cannot avoid ultimate responsibility for the patient's care. Id. at 1645.

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et seq (Insurance Information and Privacy Protection Act); Welfare and Institutions Code Sections 5328 et seq (restriction on access to mental health records).

Physicians must fight for their patients by protesting decisions made by lay persons which jeopardize proper medical care. While the court expressly recognized that " cost consciousness has become a permanent feature of the health care system," it stressed that "cost limitations not be permitted to corrupt medical judgment." Id.

Physicians and their patients have a relationship which not only engenders mutual trust and confidence, but also serves as an important protection for patient (and public) welfare and safety.

2. The medical judgment of the attending physician is controlling, unless clearly contrary to good medical practice.

Medicine is an inexact science and cannot be practiced by an application of universal rules to individual cases. Quality health care requires that a physician's medical judgment arise not only from scientific principles and informed consent, but also from past experiences, custom and even professional intuition. Thus, given a physician's familiarity with a patient's medical history and physical condition, and given the existence of the physician-patient relationship itself, deference to the attending physician's judgment concerning a course of treatment and other issues involving the care provided the patient is essential to the goal of providing quality health care. It is the physician's responsibility, in conjunction with a patient's informed consent, to decide a patient's course of treatment.[15]

As both a practical and legal matter, therefore, only a physician may properly decide what is or is not best for his or her patients, what treatment facilities are appropriate, and what conditions are safe and meet medical standards. No other person is adequately trained, skilled, or knowledgeable about the patient's condition to make these critical health determinations.

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[15] Of course, generally speaking, patients are the ultimate arbiters of the health care they receive. Conservatorship of Drabick (1988) 200 Cal. App. 3d 104, 205; 245 Cal. Rptr. 840.

California courts recognize that the decision of the treating physician is controlling, unless it is unreasonable or contrary to good medical practice. See Sarchett v. Blue Shield of California (1987) 43 Cal. 3d 1; 233 Cal. Rptr. 76 (stating, "we trust, that with doubts respecting coverage resolved in favor of the subscriber, there will be few cases in which the physician's judgment is so plainly unreasonable, or contrary to good medical practice, that coverage will be refused.") Similarly, federal courts accord "special weight" to a treating physician's judgment. As was recently summarized by the Ninth Circuit case of Rodriguez v. Bowen (1989) 876 F. 2d 759:

> The medical opinion of a claimant's treating physician is entitled to `special weight.' (Citation omitted). The treating physician's opinion is given that deference because `he is employed to cure and has a greater opportunity to know and observe the patient as an individual.' (Citations omitted)[16]

See Blum v. Yaretsky 457 U.S. 991, 1008-1009 & n. 19 (1982) (the decision to transfer or discharge a Medicaid patient is a medical judgment made by physicians in accordance with professional standards). See also 42 U.S.C. §1395 (stating "Nothing in this title (medical health insurance for the aged and disabled) shall be construed to authorize any federal officer or an employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . .").

When the physician's judgment is called into question, only a physician's peer, that is, another physician, has the necessary expertise and training to conduct the appropriate review. In medical malpractice cases, for example, the question of whether a physician breached the appropriate standard of care is generally resolved by other expert physicians, because neither the

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[16] The treating physician's opinion on the issue of disability is not always conclusive, however. As the Rodriguez court further stated "The ALJ (in a disability case) may disregard the treating physician's opinion, but only by setting forth `specific, legitimate reasons for doing so, and this decision must itself be based on substantial evidence'."

courts, nor lay persons "possess[] the specialized knowledge necessary to resolve the issue as a matter of law." Landeros v. Flood (1976) 17 Cal. 3d 399, 410; 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 ordinary know the applicable standards of skill, knowledge and care prevailing in the medical community.")[17]

In sum, lay persons, that is non-physicians, simply cannot override the reasoned and informed judgment of physicians on issues of medical need and quality of care. Lay persons are neither adequately trained nor equipped to make medical decisions nor understand the quality of care implications of those decisions. For that reason, California's statutory and judicial law contains strong prohibitions against permitting lay persons to practice medicine or otherwise exercise control, directly or indirectly, over a physician's informed professional judgment. The requirement for medical staff self-governance stems from this prohibition and flatly prohibits a board of trustees from usurping the lawful right of a medical staff to appoint its own leaders.

B. The Corporate Practice Bar Serves To Insure That The Physician-Patient Relationship, Which Places Unique Obligations Upon Physicians Regardless Of The Policies Instituted Or Maintained By Third Parties, Including Hospitals, Is Not Disrupted.

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[17] Notably, Barton also approved BAJI jury instruction No 6.03, an instruction which itself reflects the fact that deference to a physician's best judgment is not only logical, but is also required by the law. In a nutshell, that instruction provides that where there are several recognized methods of approved diagnosis or treatment which could be made available to the patient, it is for the treating physician to use his best judgment to choose the proper one and, a physician is not negligent if the method chosen later turns out to be a wrong selection or one not favored by other practitioners. Thus, even the opinions of other physicians (as opposed to lay persons) concerning a method of treatment generally should not supersede those of the treating physician.

1. Lay interference with the professional judgment of physicians is prohibited by California law.

Recognizing the potential for improper invasions into the physician-patient relationship and the need for deference to the physician's professional judgment, the California courts and Legislature have protected physicians from the pressures of the commercial marketplace for many years. As early as 1938, the California Supreme Court in People v. Pacific Health Corp. (1938) 12 Cal. 2d 156, 158-159 recognized that:

> We are unable to agree that the policy of the law may be circumvented by technical distinctions in the manner in which doctors are engaged, designated or compensated by the corporation. The evils of divided loyalty and impaired confidence would seem to be equally present whether the doctor received benefits from the corporation in the form of salary or fees. Any freedom of choice is destroyed, and the elements of solicitation of medical business and lay control of the profession are present whenever the corporation seeks such business from the general public and it turns it over to a special group of doctors.

This prohibition, known as the "corporate practice of medicine bar" is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine. As the Attorney General's office correctly noted, the reasons underlying this proscription are two-fold:

> [F]irst, that the presence of a corporate entity is incongruous in the workings of a professional regulatory licensing scheme which is based on personal qualification, responsibility and sanction, and second that the interposition of a lay commercial entity between the professional and his/her patients would give rise to divided loyalties on the part of the professional and would destroy the professional relationship into which it was cast.

See 65 Ops Cal. Atty. Gen. 223, 225 (1982).

This general prohibition against the corporate practice of medicine is now codified in Business and Professions Code §2400 (initially enacted in 1937 as Business and Professions Code §2008), a provision which denies corporations and other artificial legal entities professional rights, privileges or powers pursuant to California's Medical Practice Act. Business and Professions Code Sections 2000 et seq.

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.

The strength of California's policy against permitting lay persons to practice medicine or to exercise control, directly or indirectly, over medical practice cannot be questioned. See e.g. Business and Professions Code §§2052, 2400, 2408, 2409; Corporations Code §§13400 et seq; Parker v. Board of Dental Examiners (1932) 216 Cal. 285, rehearing den'd. September 28, 1932 (lay persons may not serve as directors of professional corporations); Pacific Employers Ins. Co. v. Carpenter (1935) 10 Cal. App. 2d 592, 594-596 (holding that for-profit corporation may not engage in business of providing medical services and stating that "professions are not open to commercial exploitation as it is said to be against public policy to permit a `middle-man' to intervene for a profit in establishing a professional relationship between members of said professions and the members of the public"); Benjamin Franklin Life Assurance Co. v. Mitchell (1936) 14 Cal. App. 2d 645, 657

(same); People v. Pacific Health Corp. (1938) 12 Cal. App. 2d 156, 158-159 (same); Complete Service Bureau v. San Diego Medical Society (1954) 43 Cal. 2d 201, 211 (non-profit corporations may secure low cost medical services for their members only if they do not interfere with the medical practice of the associated physician); California Physician Service v. Garrison (1946) 28 Cal. 2d 790 (same); Blank v. Palo Alto-Stanford Hospital Center (1965) 234 Cal. App. 2d 377, 390 (non-profit hospital may employ radiologist only if the hospital does not interfere with the radiologists' practice of medicine); Letsch v. Northern San Diego County Hospital District (1966) 246 Cal. App. 2d 673, 677 (district hospital may contract with radiologists under restriction imposed in Blank above); California Association of Dispensing Opticians v. Pearle Vision Center, Inc. (1983) 143 Cal. App. 3d 419, 427 (Pearle Vision Center Inc.'s franchise program violates California's prohibition against the corporate practice of medicine); 65 Cal. Op. Atty. Gen. (1982) (general business corporation may not lawfully engage licensed physicians to treat employees even though physicians act as independent contractors and not as employees); 63 Cal. Op. Atty. Gen. 729, 732 (1980) (for-profit corporation may not engage in the practice of medicine directly nor may it hire physicians to perform professional services); 57 Cal. Op. Atty. Gen. 213, 234 (1974) (only professional corporations are authorized to practice medicine); 55 Cal. Op. Atty. Gen. 103 (1972) (hospital may not control the practice of medicine).

Moreover, the corporate practice bar has been interpreted broadly, consistent with its protective purposes to encompass "business" and "administrative" decisions which have medical implications. In Marik v. Superior Court (1987) 191 Cal. App. 3d 1136; 236 Cal. Rptr. 751, for example, the court recognized that it is difficult if not impossible in the health care area to isolate "purely business" decisions from those affecting the quality of care. Notably, in holding that a provisional director of a medical corporation was required either to be a physician or other qualified

licensed person, the Marik court recognized the interrelated nature of these concerns and correctly observed:

> For example, the prospective purchase of a piece of radiological equipment could be implicated by business considerations (cost, gross billings to be generated, space and employee needs), medical considerations (type of equipment needed, scope of practice, skilled levels required by operators of the equipment, medical ethics) or an amalgam of factors emanating from both business and medical areas. The interfacing of these variables may also require medical training, experience, and judgment.

Marik, supra, fn.4 at 1140.

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 Sections 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, supra at 1139. Additionally, while the Knox-Keene Health Care Service Plan Act (Health and Safety Code Sections 11340 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 Corporations 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 CCR §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 Commissioner that medical decisions will not be unduly influenced by fiscal and administrative management.")[18]

As is discussed above, 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, Title 22 CCR §§70701 and 70703.[19]

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[18] 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.

[19] The corporate practice bar mandates not only medical staff self-governance in the hospital, but also physician control over the varying services. Consequently, because physicians bear the ultimate responsibility for ensuring that patients receive proper care, and because lay individuals have neither the expertise nor experience to render decisions regarding the provision of medical care, the Department of 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 CCR §70201, 70205. Similarly, physicians are responsible for other "services"

2. The concerns which gave rise to the long standing proscription of the corporate practice of medicine apply with even greater urgency at the present time.

While hospital boards have an interest in patient welfare, they also have other, potentially conflicting interests. For example, in response to soaring costs and unprecedented competition, health care facilities have been forced to enter into an era of cost containment. Governmental and private insurance reimbursement programs for hospitals have shifted from cost-based retrospective reimbursement to prospective reimbursement based on specific categories of conditions known as diagnosis-related groups (DRG's). See, generally Rethinking Medical Malpractice Law in Light of Medicare Cost Cutting, 98 Harvard L. Rev. 1004 (1985). Hence, hospital reimbursements are now largely based on a predetermined rate which purports to define what the illness is worth in financial terms, regardless of the services actually rendered or the actual length of hospitalization. Costs incurred over the designated rate must be absorbed by the hospital. Id. Hospitals thus have strong incentives to reduce their costs to or below DRG rates by, for example, shortening a patient's stay, ordering fewer tests and limiting ancillary services. Id. See also Shortell and Hughes, The Effects of Regulation, Competition and Ownership on Mortality Rates among Hospital Inpatients, 318 New Eng. J. Med. 1100, 1101 (1980) (stating, "Under the Medicare prospective payment system, for instance, hospitals have incentives to discourage the admission of beneficiaries with high costs, to reduce the diagnostic and therapeutic resources used for these beneficiaries, and to discharge them sooner.") The potential conflict is especially severe with for-profit hospitals, where hospital boards have a separate duty to their shareholders to maximize profits (and therefore, for reasons wholly unrelated to quality of care, may wish to limit the services rendered to the poor).

A medical staff's right to self-governance must be scrupulously safeguarded, particularly in light of the fact that increasing emphasis on cost containment in the delivery of health care could seriously jeopardize the quality of care. In fact, a recent study strongly suggests that cost savings programs dramatically effect the quality of care and indicates that there are higher mortality rates among patients who are admitted to hospitals in highly regulated areas and to hospitals in relatively competitive markets. See Shortell and Hughes, The Effects of Regulation, Competition, and Ownership and Mortality Rates Among Hospital Inpatients, 318 New Eng. J. Med. 1100 (1987). The findings of that study "[U]nderscore the need for improved monitoring on the issue of the quality of care and patients' outcomes as regulatory and competitive approaches to hospital cost containment continue to become more stringent." Id. 1106. Consequently, it is more critical now than ever that medical staffs be able to perform their quality assurance activities free of lay interference.

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provided by the hospital. See 22 CCR §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).

Moreover, studies suggest that in light of increasing economic pressures, hospital boards may take retaliatory actions against physicians. Because physicians control approximately 60% to 70% of health care expenditures, their participation is essential to the success of cost containment programs, that is, cost cutting measures. See Spivey, The Relationship Between Hospital Management and Medical Staff Under a Prospective Payment System, 310 New Eng. J. Med. 984 (1984). Accordingly, techniques are being implemented by hospitals and health care payors to pressure physicians to cut costs by, for example, performing more procedures on an outpatient basis and discharging hospital patients earlier. Morriem, Cost Containment and the Standard of Care, 70 Cal. Law Rev. 1719, 1724 (1987). With the increasing development and utilization of information systems, hospitals can identify physicians who engage in "costly and inefficient" behavior and subject them to "education, peer pressure, or conceivably, even restrictions of privileges, if their costly behavior persists." Spivey, supra at 985.

Courts have recognized that this economic environment is rife for the potential to jeopardize quality patient care. Indeed, as discussed above, the courts have indicated that physicians have a legal duty to act as a buffer between the patient and third parties and to challenge cost containment decisions which jeopardize the patient's health. Wickline v. State of California (1986) 183 Cal. App. 3d 1064. Under these circumstances, this court must be especially solicitous of patient welfare, and must not give hospital boards any unchecked power over the proper determinations of a medical staff.

Moreover, hospital boards may have interests that conflict with individual physicians on their medical staffs. In order to provide alternative and more cost effective health care services, physicians increasingly are participating in alternative delivery systems, such as ambulatory care health facilities which perform certain surgeries on an outpatient basis. Hospital boards may attempt to eliminate competition from these innovative systems by attempting to exclude physicians who work in them.

In light of these conflicting interests, it is critical that this court prohibit lay intrusions into the medical staff's legitimate and proper realm of decision-making. The regulation of professional work performed in the hospital and the establishment of patient care standards is an inherent professional right which can only be initiated and implemented by duly licensed physicians. Eisenhower's Board has severely abridged that right and has unjustifiably intruded into the medical

staff's decision-making process and quality assurance activities essential to providing quality patient care.

In sum, whatever its outer limits, the corporate practice prohibition plainly applies to prohibit Eisenhower's board of trustees from refusing to seat a duly-elected leader of the medical staff, the body charged by law to perform quality assurance activities critical to the quality of care. Any bylaw which purports to grant such authority is invalid.

VI. CONCLUSION

Medical staff members are entitled by law to elect their own representatives. Moreover, a rule which would permit a hospital board to refuse to recognize a duly elected medical staff officer would jeopardize the quality of care received by patients in California hospitals. The lower court's order granting summary judgment in favor of Eisenhower and denying it with respect to Dr. Stoltzman was wrong. We urge this Court to reverse that decision and grant summary judgment in favor of Dr. Stoltzman.

DATED: Respectfully submitted,

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