EXHIBIT 1

No. B150337
(Los Angeles Super. Ct. No. BC 233153, BS 056525)

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION 4

GIL N. MILEIKOWSKY, M.D.,

Plaintiff and Petitioner,

v.

SUPERIOR COURT FOR THE COUNTY OF LOS ANGELES,

Respondent,

TENET HEALTHSYSTEM, ET AL.,

Real Parties in Interest and Defendants.

Related Appeal Pending

APPLICATION OF THE AMERICAN MEDICAL ASSOCIATION AND THE CALIFORNIA MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICI CURIAE IN SUPPORT OF GIL N. MILEIKOWSKY, M.D.

Catherine I. Hanson, SBN 120896
Astrid G. Meghrigian, SBN 104506
California Medical Association
221 Main Street, Third Floor
San Francisco, CA 94105
Telephone: (415) 541-0900
Facsimile: (415) 882-5143

Attorneys for Amicus Curiae
California Medical Association

Leonard A. Nelson
American Medical Association
AMA Litigation Center
515 North State Street
Chicago, IL 60610
Telephone: (312) 464-5000
Facsimile: (312) 464-4184

Attorneys for Amicus Curiae
American Medical Association

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

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

Amicus the California Medical Association ("CMA") is a non-profit, incorporated professional association of more than 30,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purposes are "...to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

Both the AMA and the CMA are committed to safeguarding the ability of physicians to treat their patients, free of arbitrary disruptions. Amici are intimately familiar with the issues presented in this case and their effect on patient medical care, and believe that this brief is necessary because it explains the important policy reasons underlying the California courts' protection of physicians from being arbitrarily excluded from access to facilities which deny them of their right to fully exercise their profession. Amici will discuss the need for proper peer review in the context of today's health care system and the fact that, due to a number of factors, the peer review system can and has been abused. The brief discusses the protections the California courts and legislature have provided to protect against peer review abuse, and why the exhaustion of remedies doctrine must be excused under appropriate circumstances to ensure that the physician has received a fair process as guaranteed by California law.

Summary suspensions often result in the destruction of a physician's livelihood, and thus, established physician/patient relationships, all without any notice or hearing to the affected physician whatsoever. Because of the haste in which they are imposed, summary suspensions often lack adequate protections to protect against improper disruptions of care. To protect physicians (and their patients) from irreparable harm arising from the erroneous imposition of a summary suspension, it is imperative that they be afforded an expedited hearing solely on the issue of whether the summary suspension, as opposed to a

termination of staff privileges following a full hearing, is absolutely necessary to protect patients from imminent danger. The sole question to be decided in such a bifurcated hearing is whether the physician represents an "imminent danger" to patients, that is, whether the charges are sufficiently egregious and immediate to warrant the restriction of a physician's privileges without prior notice or hearing. Such a hearing assures that a physician will receive fair process and would involve minimal resources. Amici believe that a failure to provide an expedited hearing on the issue of the propriety of summary suspension makes the administrative process inadequate, and therefore excuses the exhaustion of administrative remedies.

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

Dated: May 15, 2001

Respectfully submitted,
American Medical Association
LEONARD A. NELSON
California Medical Association
CATHERINE I. HANSON
ASTRID G. MEGHRIGIAN

By: _____
Astrid G. Meghrigian
Attorneys for Amici Curiae
American Medical Association
California Medical Association

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RELATED APPEAL PENDING

AMICI CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PETITIONER

Catherine I. Hanson, SBN 120896
Astrid G. Meghrigian, SBN 104506
California Medical Association
221 Main Street, Third Floor
San Francisco, CA 94105
Telephone: (415) 541-0900
Facsimile: (415) 882-5143

Attorneys for Amicus Curiae
California Medical Association

Leonard A. Nelson
American Medical Association
AMA Litigation Center
515 North State Street
Chicago, IL 60610
Telephone: (312) 464-5000
Facsimile: (312) 464-4184

Attorney for Amicus Curiae
American Medical Association

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

California State Cases

Other State Cases

Federal Statutes

State Statutes

Other Authorities

I. INTRODUCTION

This case involves the propriety of a medical staff's "summary suspension" of a physician's medical staff privileges—an action which immediately and without prior notice severs a physician's ability to care for patients in a hospital, destroys patients' rights to be cared for by the physician of their choice, disrupts established relationships in the most sensitive and most important area of personal service, and often devastates the physician's ability to practice medicine. Because of these draconian ramifications, "summary suspensions" must not be utilized routinely to deal with concerns arising from a physician's medical practice or behavior. Normal peer review channels with pre-suspension hearing procedures are tailored to handle these cases appropriately and expeditiously.[1] Rather, such suspensions should only be imposed as a last resort—in those extreme cases where absolutely necessary to protect patients from real and impending harm.

Peer review, if properly conducted, is "essential to preserving the highest standards of medical practice," but if not, "results in harm to patients and healing arts practitioners by limiting access to care." *See* Business & Professions Code §809(a). Because of this potential for harm, California courts for forty years have

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[1]In fact, proper peer review should be "done efficiently, on an on-going basis, with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions." Business & Professions Code §809(a)(7). Thus, given the emphasis on early intervention and correction, any termination of staff privileges, let alone summary suspensions, should rarely be imposed.

protected physicians from being arbitrarily excluded from access to facilities which deny them of their right to fully exercise their profession. Entities which control that right, such as medical staffs and, as recently extended by the California Supreme Court, managed care plans must ensure a fair hearing process is accorded. Rosner v. Eden Township Hospital District (1962) 58 Cal.2d 592, 22 Cal.Rptr. 551; Potvin v. Metropolitan Life Insurance Company (2000) 22 Cal.4th 1060, 95 Cal.Rptr.2d 496.

Peer review abuse and the destruction of a physician's professional life and established physician/patient relationships, and thus injure the very people that peer review is designed to protect—patients. In that regard, continuity of care with a patient's regular physician is not an academic value. Studies have demonstrated the clinical benefits that flow when patients maintain a regular physician, and that regular relationships result in, among other things, fewer and/or shortened hospitalizations and decreased use of emergency departments for care.[2] Indeed, the California legislature has recognized the importance of continuity of care between a patient and her obstetrician. Health plans are mandated by law to give pregnant patients the right to continue to be treated by their obstetricians "until post-partum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider" even after the health plan terminates the obstetrician from the health plan's provider

[2]*See* Cal. Managed Care Health Improvement Task Force, Rep. to Leg. (December 13, 1999), Recommendations on the Physician-Patient Relationship.

panel for reasons other than medical discipline, or fraud or other criminal activity. Health & Safety Code §1376.96; Insurance Code §10133.56. These concerns are particularly acute where, as here, the health of women who may have undergone extensive fertility treatments to achieve pregnancy, and are often nearing the end of their childbearing years, is at stake. Such women may have more difficulty during pregnancy and face more risk in childbirth then would ordinarily be the case.[3]

Both the California courts and legislature have provided additional safeguards against, and checks to prevent, peer review abuse. First, the courts recognize that the concept of fair procedure is not fixed, but rather must expand and develop as new circumstances arise. Ezekial v. Winkley (1977) 20 Cal.3d 267, 142 Cal.Rptr. 418. Second, in 1989, the California Legislature recognized the important principles established by the common law in this area, and enacted Business & Professions Code §§809 et seq. (S.B. 1211), which sets forth a statutory scheme setting forth minimum requirements for fair peer review in California. Finally, the courts excuse the exhaustion of administrative remedies requirement where the remedy provided is inadequate and forcing the physician to complete it would be futile, idle, or useless. Bollengier v. Doctors Medical Center (1990) 222 Cal.App.3d 1115, 272 Cal.Rptr. 273. These safeguards recognize that

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[3]*See* American College of Obstetricians' and Gynecologists' Medical Library Statement entitled, "Later Childbearing," a true and correct copy is located on the Internet at www.medem.com/search/article_display.cfm?path=n:&mstr=/222477wc87c.html&soc=acog&srch_typ=NAV_SERCH

the "exhaustion" and "fairness" doctrines go hand-in-hand—the less procedural fairness that is afforded, the greater the possibility that exhaustion should be excused so that the affected physician can avoid being subjected to an unfair process which serves no purpose but to cause unnecessary delay at the expense of the physician's ability to pursue his/her profession.

Because of the haste in which they are imposed, summary suspensions often lack adequate protections to protect against improper disruptions in care. While the law specifically requires that a summary suspension which lasts fifteen (15) days or more is reportable to the Medical Board (Business & Professions Code §805(b)) (and one which lasts longer than thirty (30) is reported to the National Practitioner Data Bank (42 U.S.C. §11133(a)(1)(A)),) the notice and hearing rights of Business & Professions Code §§809.1-809.4 are only provided to the suspended physician **after** the suspension takes place and the damage has been done. While the law states that summary suspension may only be imposed "where the failure to take that action may result in an imminent danger to the health of any individual," these suspensions are sometimes imposed, as in this case, on the basis of charges which appear to be too stale to warrant the immediate removal of medical staff privileges. Moreover, while the law requires that the hearing commence within sixty (60) days after receipt of a request and that the process be completed "within a reasonable time"—these requirements may also be breached, as they have in this case.

To protect physicians (and their patients) from irreparable harm arising from the erroneous imposition of a summary suspension, it is imperative that they be afforded an expedited hearing **solely** on the issue of whether summary suspension, as opposed to termination of staff privileges following a full hearing, is necessary to protect patients from imminent danger. Following the conclusion of the limited hearing, the physician would still need to defend him/herself in the underlying peer review proceeding.

This bifurcated approach protects everyone involved. Because such a hearing would be limited in scope, it could and should be handled quickly. If the hearing concludes that the physician poses no imminent danger, then needless disruptions in care are prevented and the physician maintains his/her ability to practice medicine until the underlying charges can be fairly and fully judged. Regardless of the outcome of the first hearing, the hospital, medical staff, and patients are protected since the affected physician still must defend him/herself as to whether the physician's conduct is "reasonably likely to be detrimental to patient or to the delivery of patient care," and thus warrants termination of staff privileges. Business & Professions Code §805(a)(6); §§809 et seq. However, if the medical staff fails to act fairly and expeditiously on the first question, that is, whether the physician "represents an imminent danger," a physician's ability to practice medicine will be irreparably injured, even if the physician ultimately

succeeds at the hearing, a result which violates every notion of fairness the California courts and legislatures have tried so hard for years to protect.

While Amici generally support the peer review process and the doctrine of exhaustion of administrative remedies, these concepts, when abused, can unfairly destroy a physician's practice. Where a medical staff refuses to provide a fair and expedited hearing solely as to whether a summary suspension is justified, the court should intervene to protect the peer review process, to protect physicians and their patients, and to determine whether the summary nature of the disciplinary action is warranted.[4]

II. LEGAL ARGUMENT

Given the importance of medical staff membership to a physician's ability to practice medicine, both the Legislature and courts insist that affected physicians be afforded a fair process. This case jeopardizes far more than Dr. Mileikowsky's personal interests. It jeopardizes the peer review system itself. The following discussion puts this case into perspective. We explain why the peer review process must be conducted fairly and the jeopardy in which patients, physicians, and the peer review process itself will be placed if it is not.

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[4]By making this appearance, Amici seek only to insure that Dr. Mileikowsky will be subject to a fair peer review process. The AMA and CMA take no position with respect to Dr. Mileikowsky's personal qualifications. For the purpose of this brief, we assume the facts stated in the writ petition are true.

A. Given The Importance Of Hospital Medical Staff Membership To A Physician's Ability To Practice Medicine, Both The California Courts And Legislature Insist That The Affected Physician Be Afforded A Fair Process

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

Hospital medical staff membership and clinical privileges are of paramount importance not only to physicians but also to their patients, and ultimately to the community as a whole. Generally speaking, only a physician who has obtained medical staff membership has the power to admit patients to hospitals and to provide specific inpatient services. Consequently, medical staff membership is an integral part of a physician's practice. In addition to providing medical services to patients, medical staff members engage in quality assurance activities, including credentialing (the process of reviewing the initial and ongoing competence of every physician and other health care practitioner who practices independently in the hospital) and patient care review (the review of the ongoing quality of care provided throughout the hospital) (hereinafter referred to collectively as the "peer review process").

These peer review processes are essential to preserving high standards of medical practice within the hospital. *See* Business & Professions Code §809(a)(3) (stating "peer review, fairly conducted, is essential to preserving the highest standards of medical practice"). Health care services must be regularly monitored

and evaluated in order to resolve problems and to identify opportunities to improve patient care. Protocols and procedures must be continuously analyzed and revised to reflect new information and technologies. The clinical performance of physicians and other health care providers must be repeatedly assessed so that appropriate educational information and training may be provided, and impaired or incompetent individuals may be identified before patients are seriously injured. *See generally* Elam v. College Park Hospital (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156.

To be effective, this monitoring function must be performed by individuals who have both the expertise necessary to conduct these quality-assurance activities and the ability to implement indicated changes. An effective peer review system provides the optimal solution. Medical staffs have both the expertise and familiarity with the health care facility and the physicians and other health care providers involved to conduct effective peer review. Moreover, physicians generally are not paid for these activities, a factor of particular importance given current concerns over the escalating cost of health care.

Thus, if properly implemented, the peer review process ensures that a qualified physician will obtain and maintain medical staff membership and appropriate clinical privileges in a hospital which serves the community where his or her patients reside. Further, it will "aid the appropriate state licensing boards in their responsibility to regulate and discipline errant health arts practitioners."

Business & Professions Code §809(a)(5). Thus, from the patient's perspective, effective peer review ensures that medical care will be both available and competent.

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

Just as peer review is necessary to ensure quality patient care, it is critical that that process be accomplished lawfully and fairly. The goals of peer review will be defeated, not promoted, if qualified physicians are wrongfully excluded from hospital medical staffs. Such an exclusion of a competent physician does nothing to promote quality care. To the contrary, an improper exclusion limits access by patients to competent medical care, and by other physicians to competent consultation, coverage and other assistance. *See* Business & Professions Code §809(a)(4) (stating "Peer review which is not fairly conducted results in harm to both patients and healing arts practitioners by limiting access to care."). Thus, arbitrary or unjust exclusion unfairly deprives patients of the ability to obtain necessary services from their chosen physician at an appropriate hospital and thereby seriously harms the delivery of healthcare.

3. The Current Economic Pressures And Turmoil In The Health Care Services Industry Are Unprecedented, Further Increasing The Risk Of Error Or Abuse

Physicians, recognizing the desirability of reviewing the competence of the physicians with whom they work, first developed peer review as a means of professional self-policing. In the context of medical staff credentialing, this system grew up entirely without statutory or other guidance as the result of the cooperative effort of physicians and hospitals. The formative years of peer review occurred when there was little competition and little divergence of interest between hospitals and physicians. All parties were interested in good patient care, and good faith in peer review was a presumed premise. All sought to create informal physician-to-physician review that could freely deal with "bad doctors" and thereby protect the public. Unfortunately, as times changed, abuses began to occur. Forces causing abuse include:

- **Liability and Competitive Concerns Of Hospitals**

Over the past years, hospitals have been exposed to liability for credentialing decisions on two fronts. First, Elam v. College Park Hospital (1982) 132 Cal.App.3d 332, held that a hospital could be held corporately liable for allowing an incompetent physician to be on the medical staff. As a result of this decision, the hospitals' interest in avoiding legal exposure resulting from improper screening of medical staff members has become increasingly important. Unfortunately, the imposition of liability for credentialing decisions has resulted in

added pressure on hospitals to make conservative staff credentialing decisions, and as a result, it has been noted that "hospitals, as a preventative measure, may turn away candidates with even minor blemishes on their record or in cases where any doubt exists." Craig W. Dallon, *Understanding Judicial Review of Hospitals, Physician Credentialing and Peer Review Decisions* (Summer 2000) Temple L.Rev. 622.

Second, courts have imposed liability for substantive and procedural errors in the peer review process. *See, e.g.,* Ascherman v. St. Francis Memorial Hospital (1975) 45 Cal.App.3d 407; Patrick v. Burget (1988) 486 U.S. 94, 100 L.Ed.2d 83 (physicians engaged in anticompetitive peer review subject to antitrust treble damages). Thus, hospitals, through their attorneys, may take control of peer review proceedings for the purpose of minimizing the likelihood of a successful legal challenge, rather than for seeking the truth.

In addition, competitive pressures can cause peer review abuse. For example, physicians with large Medi-Cal case loads may be denied access to hospitals. Physicians working in ambulatory surgical centers which compete with hospitals could find their hospital privileges curtailed not for quality but for economic reasons. Pressure via the peer review system can be put on physicians who advocate expensive technologies or changes in the hospital that benefit the patient but cost the hospital money. This is particularly true with the advent of cost containment pressures brought on by DRGs (diagnosis-related groups) and

other systems which pay a flat amount per type of case, regardless of the costs of the particular case, capitated payments, which are based on the number of patients, again without regard to actual utilization and cost, and other financial risk shifting payment schemes which encourage a "less not more" approach to the provision of medical care. With pressures increasing to allow only the most "cost-effective" physicians to practice in the hospital, professional qualifications can be subordinated to both economic and legal considerations.

This threat of liability and increasing competition to the hospital has dramatically altered peer review by changing the role of attorneys from advisory to adversary. Attorneys have become involved earlier and more vigorously, even at the lowest level peer review committee. Peer review has moved farther and farther away from its roots as a collegial physician proceeding toward a quasi-legal proceeding in which the attorney representing the medical staff (and often the hospital as well) becomes an active prosecutor conducting a preliminary investigation, identifying the charges, building the case, selecting the hearing officer, and even drafting the decision for the hospital board when the case is considered by that board on appeal. Now there remains little of the original model of physicians informally reviewing their colleagues; what does remain are the serious questions as to whether having the same attorneys representing both the prosecuting (medical staff) and ultimate adjudicatory (hospital) body, as appears

to be the case here, violates fair procedure. *See* Howitt v. Superior Court (1992) 3 Cal.App.4th 1575, 5 Cal.Rptr.2d 196.

There has also been a change in the tone of peer review proceedings as attorneys have come to realize that the best protection for the hospital against liability is to try to assure that some form of disciplinary action is imposed.[5] It is now routine for many attorneys to advise the medical staff to "pile on" as many charges as possible, even though many of the charges may be old, insubstantial, unsubstantiated, or even previously dismissed by the medical staff. This multiplication of charges without regard to their merit or gravity has the effect of making the accused physician look like a "bad apple" and has subtle "where there is smoke, there must be fire" effects on the physician's colleagues.

Hospitals have also come to realize that if the physician appeals the case, the more counts charged, the more onerous and costly the appeal for the physician, and under the substantial evidence test, the more likely the hospital will be to prevail on at least one count. Indeed, if a case goes to court, hospitals routinely use the **number** of charges against the physician to imply that the doctor is bad, fueling the argument that the court should defer to the hospital's expertise in matters relating to patient care.

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[5]Unless the physician secures a petition for writ of mandate, and obtains a court ruling that the peer review proceeding was procedurally unfair or the discipline was substantively irrational (based on the substantial evidence test), the hospital is immune from liability. Westlake Community Hospital v. Superior Court (1976) 17 Cal.3d 465, 131 Cal.Rptr. 90.

► Racial Discrimination

The peer review process must not be utilized for improper motives, such as racial discrimination. Unfortunately, racial discrimination has been a problem in the peer review context. See, for example, Janda v. Madera Community Hospital (E.D. Cal. 1998) 16 F.Supp.2d 1181 (in case alleging exclusion of Indian born physician due to hospital's decision to limit orthopedic department to Caucasian physicians constituted racial discrimination, hospital bylaws prohibiting race and national origin discrimination with respect to staff privileges were enforceable). Indeed, the United States Congress refused to provide any peer review immunity for unfair actions taken because of race. *See* Health Care Quality Improvement Act, 42 U.S.C. §11111(a) (limitation of damages does not apply to damages under any state or federal law relating to the civil rights of any person).

► Retribution Against Whistle Blowers

Retribution against physicians who advocate for medically appropriate care has also been a known problem in California, and subject to legislative protection. *See* Business & Professions Code §2056. Nonetheless, despite this protection, a physician who complains of conditions that threaten patient safety and/or which impair the physician's ability to practice medicine still may face retaliatory actions through abusive peer review. Such retaliation can limit patient access to care by the aggrieved physician, and can restrict the flow of information from all physicians, which endangers patient care for everyone.

4. The Imposition of a Summary Suspension Is Devastating To A Physician's Ability To Practice Medicine

The ramifications of a summary suspension of clinical privileges cannot be considered in isolation. Those ramifications far transcend a physician's inability to treat and admit patients in a particular hospital. A summary suspension catastrophically impacts the professional life of a physician. As the courts have recognized:

> Summary deprivation of this right amounts to a stigma of medical incompetence. It clearly affects the doctor's ability to maintain his income during the period of time between suspension and a hearing, and, because of the loss of reputation attendant to a summary suspension, may affect his earning capacity subsequent to the hearing.

McMillan v. Anchorage Community Hospital (1982) 646 P.2d 857 (summary suspension of physician's privileges not justified under hospital's bylaws since it was not clear that physician's behavior adversely affected patient care or that immediate action of summary suspension was necessary).

California courts also have long recognized that the refusal of access to a hospital can have the effect of denying to a qualified licensed physician the right to practice fully his or her profession. *See* Volpicelli v. Jared Sydney Torrance Memorial Hospital (1980) 109 Cal.App.3d 242, 248, 167 Cal.Rptr 610, 613 (observing "It is a generally accepted principle that a hospital's refusal to permit a physician to conduct his practice in the hospital, as a practical matter, may well have the effect of denying him the right to capably practice his profession.").

These catastrophic consequences are more likely to occur now than they were in the past. Legislation and court cases over the years have rendered the deprivation of medical staff membership or clinical privileges devastating to the professional life of a physician. As a result of the operation of both California and federal law, such adverse action imposes a stigma on a physician's good name, honor, reputation and integrity which, at a minimum, will require that physician to defend himself or herself on a number of fronts. These fronts potentially include every other medical staff where the physician has or desires to obtain privileges, the state licensing board, managed care plans, the Medi-Cal fraud and abuse unit, Professional Review Organizations, professional liability carriers, and various enforcement arms of the federal government, including the Department of Health and Human Services' Office of the Inspector General and the Justice Department.

Pursuant to California law, if a physician has had medical staff privileges curtailed or restricted, including a summary suspension lasting fifteen (15) days or more, for reasons allegedly relating to professional competency, this suspension must be reported to the Medical Board of California, the California agency responsible for licensing physicians. *See* Business & Professions Code §805. This report must be made even though the physician did not receive a pre-suspension hearing. When physicians seek to obtain or renew their staff privileges at any hospital, California law requires that this hospital contact the Medical Board of California to determine whether or not an "805 report" has been filed by

any other hospital. *See* Business & Professions Code §805.5. Failure to comply with these requirements is a misdemeanor. *Id.*

Thus, under California law, a physician who joins a medical staff runs the substantial risk that reportable adverse peer review actions will be investigated by the MBC and by any hospital where he or she presently enjoys medical staff membership or seeks to enjoy such membership. Indeed, hospitals have a duty to ensure that the medical staff is appropriately credentialing its members and the failure to do so may be negligence. *See* Elam v. College Park Hospital (1982) 132 Cal.App.3d 332, 183 Cal.Rptr. 156. Hospitals understandably are reluctant to grant medical staff membership to any physician who has been denied membership or had membership suspended/restricted at another hospital, and the Elam obligation may well impose an affirmative duty on medical staffs to investigate carefully all 805 reports filed by other hospitals on existing medical staff members.

Furthermore, the effects of an adverse privileges determination are not limited to the physician's ability to practice medicine in California. To the contrary, pursuant to the Health Care Quality Improvement Act (HCQIA), 42 U.S.C. §§11101-11152, hospitals and other health care entities that take adverse actions based on a physician's competence or professional conduct that adversely affects a physician's membership or clinical privileges, such as a summary suspension which lasts longer than thirty (30) days, must report these actions to

the state board of medical examiners, which in turn must report them to DHHS. 42 U.S.C. §§11133, 11133(b), 11134(b). Again, assuming the suspension lasted more than thirty (30) days, it must be reported, regardless if the affected physician received any hearing whatsoever—a departure from the general rule that matters should only be reported once the physician has had the opportunity to have the matter fairly resolved.[6]

Additionally, hospitals have a duty, pursuant to the HCQIA, to request information about a physician from DHHS before they initially grant the physician privileges, and every two years thereafter. 42 U.S.C. §11135. Once information concerning an adverse privilege determination is reported to DHHS, DHHS is empowered, through the Medicare and Medicaid Patient and Program Protection Act and the Peer Review Improvement Act, 42 U.S.C. §§1320a-7 *et seq.*, and 42

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[6]The Secretary of the Department of Health and Human Services (who is responsible for implementation of the NPDB) has recognized the unusual nature of summary suspensions, stating:

> "The requirement to report summary suspensions **prior to the exhaustion of all internal administrative appeals** may be viewed as an exception to the prior guidance which indicates that adverse actions on clinical privileges are not reportable prior to internal appeals. **Summary suspensions are considered to be final when they become professional review actions through action of the authorized hospital committee or body, according to the hospital bylaws.**" (*National Practitioner Data Bank Guidebook*, p. E-17.)

The *Guidebook* states further that:

> "In establishing this policy on the reporting of summary suspensions, HHS assumes that hospitals use summary suspensions for the purpose stated in Part A of the Act: to protect patients from imminent danger, rather than for reasons that warrant routine professional review actions."

U.S.C. §§1320c *et seq.*, to initiate investigations of physicians and exclude them from the Medicare and/or Medicaid programs.

Even without the operation of California or federal law, the simple realities of the medical profession today place great importance upon the granting and retention of medical staff privileges. Physicians who lose privileges will probably find their opportunities to provide care to patients who receive health care benefits from HMOs, PPOs and other managed care delivery systems severely curtailed, if not entirely foreclosed. Managed care organizations, like medical staffs, "credential" physicians for participation, and participation in these organizations can be essential for a physician to survive economically. Potvin v. Metropolitan Life Insurance Company (2000) 22 Cal.4th 1060, 95 Cal.Rptr.2d 496. Like medical staffs, these organizations are also loath to allow physicians on their panels where an adverse peer review action has been taken.

Lack of privileges may also hamper a physician's attempts to maintain professional liability insurance. Virtually all professional liability carriers ask on their applications about denial or restriction of hospital staff privileges, which may lead the insurance company to re-rate or even cancel the physician's malpractice insurance. Furthermore, privilege restrictions may permanently disrupt referral and consultation practices of other physicians.

5. Because of the Need for Effective and Fair Peer Review, California Law Protects Physicians from Arbitrary Exclusions

For over forty years, California courts have repeatedly protected physicians from the arbitrary deprivation of medical staff or other privileges necessary to practice medicine for reasons that lack a demonstrable nexus to quality patient care,[7] or by procedures that are not fundamentally fair.[8] Most recently, the

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[7] *See, e.g.*, Wyatt v. Forest Hospital District, et al. (1959) 174 Cal.App.2d 709, 345 P.2d 93 (past improper conduct not a sufficient basis to exclude a physician from public hospital where Board of Medical Examiners determined that physician could practice in state); Willis v. Santa Ana Community Hospital (1962) 58 Cal.2d 806, 26 Cal.Rptr. 640 (exclusion from hospital for allegedly anti-competitive purposes could be improper); Rosner, *supra* at 599 (fact that physician "unable to get along" with some physicians was not sufficient grounds to exclude physician from hospital medical staff); Ascherman v. Saint Francis Mem. Hosp. (1975) 45 Cal.App.3d 507, 109 Cal.Rptr. 507 (hospital bylaw permitting summary rejection of application of physician for staff membership where application is not accompanied by three letters of recommendation is not substantively rational); Miller v. Eisenhower Medical Center (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826 (bylaw permitting exclusion on basis of physician's "ability to work with others" when read to include "real and substantial danger" to quality patient care not substantively irrational); Unterthiner v. Desert Hospital of Palm Springs (1983) 33 Cal.3d 285, 188 Cal.Rptr. 590 (hospital could deny physician's initial application for staff privileges where substantial evidence sustained finding that physician submitted untruthful answers on application).

[8] Pinsker v. Pacific Coast Society of Orthodontists (1969) 1 Cal.3d 160, 81 Cal.Rptr. 245 ("Pinsker I") (applicant for membership in dental orthodontists society had a judicially enforceable right to have application considered in a manner comporting with the fundamentals of due process, including the showing of cause for rejection); Pinsker v. Pacific Coast Society of Orthodontists (1974) 12 Cal.3d 541, 116 Cal.Rptr. 245 ("Pinsker II") (violation of standards set by professional association prohibiting of delegation of orthodontic services to dentists not educationally qualified for membership in professional association permissible basis to reject applicant for membership, though applicant must be afforded an opportunity to respond to charges); Anton v. Board of Directors of San

California Supreme Court affirmed the right to fair process in the context of a managed care plan by concluding that a physician's membership on such a panel is at least as significant as membership in a hospital medical staff or medical society. *See* Potvin v. Metropolitan Life Insurance Company (2000) 22 Cal.4th 1060, 95 Cal.Rptr.2d 496.

The Legislature similarly has provided safeguards for physicians against unfair peer review activities. As is mentioned above, in response to significant concerns about peer review abuse, the Legislature enacted a comprehensive scheme setting forth minimal standards for peer review proceedings. Business & Professions Code §§809 et seq., Stats. 1989, ch. 336 §1 (S.B. 1211). The primary

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Antonio Comm. Hosp. (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442 (decision to suspend physician's medical staff privileges affected a fundamental vested right and physician entitled to due process); Ezekial v. Winkley (1977) 20 Cal.3d 267, 142 Cal.Rptr. 418 (surgical resident required to receive fair procedure prior to discharge from residency program); Volpicelli v. Jared Sydney Torrance Memorial Hospital (1980) 109 Cal.App.3d 242, 167 Cal.Rptr. 610 (termination of physician membership from medical staff without notice and hearing deprived physician of due process right); Applebaum v. Board of Directors of Barton Memorial Hospital (1980) 104 Cal.App.3d 648, 163 Cal.Rptr. 831 (suspension of family practitioner's obstetrical privileges violated fair procedure rights); Hackethal v. California Medical Association (1982) 138 Cal.App.3d 435, 187 Cal.Rptr. 811 (disciplinary proceeding conducted by medical society did not comply with the principle of fair procedure); Bergeron v. Desert Hospital Corp. (1990) 221 Cal.App.3d 146, 270 Cal.Rptr. 379 (physician's participation on emergency department on-call roster constituted fundamental property right which could not be suspended or revoked without notice and an opportunity to respond); Rosenblitt v. Superior Court (Fountain Valley Regional Hospital) (1991) 231 Cal.App.3d 1434, 282 Cal.Rptr. 819 (physician denied fair hearing in medical staff summary suspension proceedings).

purpose of this legislation was to protect the health and welfare of the people of California by setting up procedures to insure fairness in the peer review process.

More recently, the Legislature enacted Business & Professions Code §2056, which provides that it is the public policy of the State of California that a physician be encouraged "to advocate for medically appropriate health care" for his or her patients. The law further states that a decision to terminate employment or other contractual relationships with or otherwise penalize a physician for advocating for medically appropriate care violates the public policy of this state.

All of these laws recognize the catastrophic impact that allowing arbitrary and capricious "privileging" decisions have on health care, and particularly the devastating effect such decisions have on the ability of patients to receive continuing care from the physicians of their choice. For that reason, the law insists that physicians be treated fairly.

Because summary suspensions are imposed without any pre-deprivation hearing whatsoever, fundamental fairness dictates that physicians be able to resolve expeditiously the issue as to whether the summary suspension was warranted. If not, physicians whose ability to practice medicine has been virtually foreclosed will be forced to languish needlessly, through an often lengthy and time-consuming process, with its attendant administrative delay. No legitimate interest is served by this result.

6. In Order To Protect The Physician And His/Her Patients From Unnecessary Injury, The Issue Of Whether A Summary Suspension Is Warranted Should Be Resolved Prior To The Hearing On The Merits Of The Underlying Charges

Summary revocation or suspension of medical staff privileges is a drastic action. Because of its gravity, this action may only be taken in the most extreme circumstances, that is, "where the failure to take that action may result in an imminent danger to the health of any individual." Business & Professions Code §809.5.[9] California law does not define "imminent danger," but since this section was passed as part of a legislative package which included a provision "opting out of" the HCQIA (*see* Business & Professions Code §809), the language probably comes from that federal act's qualification on the procedure generally required to obtain immunity. *See* 42 U.S.C. §11112(c)(2) (allowing "an immediate suspension or restriction of clinical privileges, subject to the subsequent notice and hearing or other adequate procedures, where the failure to take such action may result in an imminent danger to the health of any individual"). Significantly, when Congress enacted this provision, it was mindful of the abuse that could occur with respect to summary suspensions and cautioned that such suspensions should only be used in the most appropriate cases, and not lead to peer review proceedings

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[9]Section 809.5 was enacted in 1989 as part of S.B. 1211. For that reason, cases discussing when it is appropriate to impose a summary suspension prior to the enactment of this law are not controlling. *See, for example,* Cipriotti v. Board of Directors of Northridge (1983) 147 Cal.App.3d 144, 198 Cal.Rptr. 367.

which are "interminable." As the Committee on Energy and Commerce stated in House Report No. 99-903:

> The Committee felt strongly that it was necessary to establish these exceptions to provide for appropriate protection during an investigation, and to allow quick action where it would be reasonable to conclude that someone's health might otherwise suffer. Nevertheless, these exceptions are not meant to provide a backdoor for harassment of physicians through repeated short-term suspensions or interminable investigations never leading to a professional review action. Such actions could not meet the "reasonable belief" tests in subsection 101(a). *See* 1986 U.S. Code Cong. and Admin. News, p. 6394.

Yet, unless physicians are given a timely right to a hearing on whether a summary suspension was justified, they are forced to endure precisely what the Committee was so concerned about—lengthy, unnecessary investigations.

Of course, "interminable investigations" are always unfair, even in the context of a routine peer review action. But at least in those cases, the physician is still free to treat his/her patients and has not had his/her professional reputation destroyed. The same cannot be said with respect to summary suspensions. To the contrary, serious due process implications are raised if the issue is not resolved expeditiously. Again, the practical effect of a summary suspension is to strip from the physician the ability to care for patients and to stigmatize irreparably the physician's professional reputation, all without any process whatsoever. To ensure that the process is fair, physicians must be afforded an expedited hearing on the issue as to whether the **summary** suspension was warranted. Such a hearing, where properly limited to a review of the exigent circumstances which purportedly

warranted such a draconian punishment, would not require the expenditure of substantial resources and time, but rather could be completed in a relatively short period of time in order to protect the interests of all parties involved.

The principle question to be decided in such a bifurcated hearing is whether the physician represents an "imminent danger" to patients, whether the charges are sufficiently egregious and immediate to warrant the restriction of a physician's privileges without prior notice or hearing. Where no imminent danger exists, summary suspension should not be upheld. Indeed, in a case decided prior to adoption of the Health Care Quality Improvement Act, but utilizing similar standards, a court refused to uphold a summary suspension in the absence of evidence that a physician's conduct posed a realistic or recognizable threat to patient care which would require immediate action. *See* McMillan v. Anchorage Community Hospital (Alaska 1982) 646 P.2d 857. In McMillan, the physician's privileges were summarily suspended for "disruptive behavior." There, the court refused to uphold a summary suspension of staff privileges based on a charge of disruptiveness or inability to work with others, because there was no related charge concerning medical competency.

McMillan is in accord with current California law, which requires that medical staff privileges not be denied a physician on the grounds of general "unsuitability, ability to work with others, or personality traits" unless there is a demonstrable nexus between the personality trait and quality of medical services.

See Yellen v. Board of Medical Quality Assurance (1985) 174 Cal.App.3d 1040. Thus, the fact that an applicant for medical staff privileges has an abrasive personality or does not get along with others is not a sufficient ground for exclusion from the medical staff, let alone a summary suspension. *See* Pick v. Santa Ana-Tustin Community Hospital (1982) 130 Cal.App.3d 970, 182 Cal.Rptr. 85.

"Imminent danger" is not something that is expected, that is ongoing, or that occurs in the ordinary course of events. To the contrary, it is something so unusual that it will generally be obvious even to a lay person that the individual is engaging in activities which severely threaten the public safety. For this reason, the Legislature took the unprecedented step of allowing a person not licensed as a physician and surgeon, specifically the governing body of an acute care hospital or its designee, to issue a summary suspension, even in the absence of a recommendation of a peer review body. Business & Professions Code §809.5(b). Thus, if conduct is egregious, under certain circumstances a non-physician may make this determination.[10]

Not only must the danger be obvious and egregious, but the imminency requirement means that the charges cannot be old, unsubstantiated, or previously adjudicated. Old or unsubstantiated charges, if they are appropriate at all, plainly

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[10]To protect against clinical error, the legislature requires medical staff review and ratification of such suspensions within two working days or the suspension lapses. Business & Professions Code §809.5(b).

should be handled through normal peer review channels. A previously adjudicated charge is not a proper basis for discipline under any circumstances under the doctrines of res judicata and collateral estoppel. *See* People v. Sims (1982) 32 Cal.3d 468, 484, 186 Cal.Rptr. 77.

In light of the due process implications of a summary suspension and in light of the minimal resources required to provide the bifurcated hearing on the issue of the summary suspension, physicians must be afforded an expedited, bifurcated hearing on the issue of whether the situation presents a reasonable possibility of "imminent danger" to the health of an individual. This hearing would be devoted exclusively to the issue of whether a summary suspension is warranted. At this point, the affected physician can request that the hearing officer lift the summary suspension, pending the final outcome of any hearing in an appeal. Procedures implementing this policy have been adopted as part of CMA's Model Medical Staff Bylaws (*see* CMA Policy on Medical Staff Suspensions (November 1991), including model medical staff bylaws, section 6.2, attached as an Addendum to this brief.) The AMA supports in this policy.

A failure to provide an expedited hearing on the issue of propriety of the summary suspension makes the administrative process inadequate and therefore excuses the exhaustion of administrative remedies.

B. Exhaustion of Administrative Remedies Is Not Required When The Peer Review Process Is Inadequate, Unfair Or Futile

1. The Peer Review Process Is Generally Enhanced By The Requirement That Aggrieved Physicians Exhaust The Remedies Provided In The Medical Staff Bylaws Before Obtaining Access To The Courts

In general, an aggrieved party in an administrative proceeding must pursue all available administrative remedies to completion before seeking judicial review of an administrative decision. This "exhaustion" doctrine normally serves a number of salutary and interrelated functions. First, the doctrine ensures that the administrative body will be able to apply its special expertise to the factual issues involved. Therefore, allowing the body to develop a full factual record will assist the court in its ultimate review of the body's action. Second, the doctrine affords the body the first opportunity to discover and correct its own mistakes, thereby promoting competent administrative decisionmaking. Third, the doctrine promotes judicial efficiency. If the complainant is successful in vindicating his or her rights in the administrative process, the courts may never have to intervene. Fourth, requiring exhaustion has the effect of reducing a claimant's damages. If given the opportunity, the body may quickly determine that it has committed error and reverse its initial decision, thereby eliminating or mitigating the individual's harm. *See* Westlake Community Hospital v. Superior Court (1976) 17 Cal.3d 465, 475-6 & n.3, 131 Cal.Rptr 90; McKart v. United States (1969) 395 U.S. 185, 193-5; 23 L.Ed.2d 194; McGee v. United States (1971) 402 U.S. 479, 484, 29 L.Ed.2d 47.

The exhaustion doctrine normally applies to medical peer review proceedings. Westlake Community Hospital v. Superior Court, (1976) 17 Cal.3d 465, 476-7, 131 Cal.Rptr 90. In the peer review process, a physician is judged by other members of his or her profession who possess the necessary expertise to assess the physician's competence and performance. When that process functions properly, it provides the physician an opportunity for a fair hearing, and the medical staff an opportunity to correct itself if the original decision was erroneous. It also permits the development of a record which allows the court to defer to the medical expertise of the physician's peers. Indeed, courts are no longer free to exercise their independent judgment[11] but must uphold the medical staff's decision as long as that decision is supported by substantial evidence in the record.

However, the exhaustion doctrine "has not hardened into inflexible dogma." Ogo Associates v. City of Torrance, (1974) 37 Cal.App.3d 830, 834; 112 Cal.Rptr. 761. In each case the court must balance the policies served by the exhaustion doctrine against "the policy of providing reasonably prompt and effective judicial protection to important legal rights." Westlake, *supra*, at 475 n. 3, *quoting* Summers, *The Law of Union Discipline: What the Courts Do In Fact*, 70 Yale L.J. 175, 207 (1960). Thus, courts waive the exhaustion requirement where the administrative remedy is unavailable or inadequate, or where its pursuit

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[11]In 1979, the legislature overturned that aspect of the court's ruling in Anton v. San Antonio Community Hospital (1977) 19 Cal.3d 802, 140 Cal.Rptr. 444, which required independent review of hospital medical staff determinations by a court. *See* Code of Civil Procedure §1094.5(d)

would result in irreparable harm. *See* Anton v. San Antonio Community Hospital (1977) 19 Cal.3d 802, 828, 140 Cal.Rptr. 442. *See also* Westlake Community Hospital v. Superior Court (1976) 17 Cal.3d 465, 131 Cal.Rptr. 90; Volpicelli v. Superior Court (1976) 17 Cal.3d 465, 131 Cal.Rptr. 90; Volpicelli v. Jared Sydney Torrance Memorial Hospital (1980) 109 Cal.App.3d 242, 167 Cal.Rptr. 610; Haller v. Burbank Community Hospital Foundation (1983) 149 Cal.App.3d 650, 197 Cal.Rptr 45; Joel v. Valley Surgical Center (1998) 68 Cal.App.4th 360,80 Cal Rptr.2d 247.

For this reason, the exhaustion of administrative remedies requirement must be considered in the context of what the administrative remedy is. Indeed, to the extent the administrative remedy provided does not provide sufficient due process, the exhaustion requirement does not apply. Bockover v. Perko (1994) 28 Cal.App.4th 479, 34 Cal.Rptr.2d 423 (quoting Roth v. City of Los Angeles (1975) 53 Cal.App.3d 679, 688, 126 Cal.Rptr. 163 "if the remedy provided does not itself square with the requirements of due process the exhaustion doctrine has no application"). Due process, in the context of peer review, is not fixed but must expand and develop as new circumstances arise. Ezekial, *supra*. Particularly now that the stakes and risks of an adverse peer review decision are higher than ever, courts should closely scrutinize the administrative remedy to ensure that it comports with due process. Courts should and must intervene to insure that the

process is protected, and fundamental physician-patient relationships are not wrongfully disrupted.

2. This Case Falls Within Well-Established Exceptions To The Exhaustion Doctrine

Dr. Mileikowsky has exhausted his administrative remedies on the issue of whether the summary suspension is proper. Several months have passed and, through no fault of his own, he has been forced to languish in an administrative morass—all the while his established patient relationships and professional reputation are being destroyed, but with no meaningful opportunity to have the issue as to whether he represents an "imminent danger" resolved. Under these circumstances, he has no remedies to exhaust. *See* California Administrative Hearing Practice (2nd) §4.14 (Cal CEB 2000); Shively v. Stewart (1966) 65 Cal.2d 475, 480, 55 Cal.Rptr. 217.

In Shively,[12] the Board of Medical Quality Assurance (the predecessor to the current licensing agency for physicians—the Medical Board of California) had initiated license revocation proceedings against two physicians. The physicians presented *subpoenas duces tecum* to the hearing officer requesting pre-hearing depositions and production of documents. The hearing officer refused to sign the subpoenas. The physicians filed petitions for writs of mandate to compel issuance

[12]Shively was decided before the California Administrative Procedure Act was amended in 1968 to provide for prehearing discovery. The Legislature subsequently codified and expanded the Shively holding. *See* Government Code §§11507.5-6.

of the subpoenas, which the trial court denied. On appeal, the Attorney General contended that the agency's denial of the subpoenas was an "interlocutory decision of an administrative agency that cannot be reviewed until administrative remedies are exhausted." Rejecting that argument, the California Supreme Court granted the writs and directed the hearing officer to issue subpoenas for the pre-hearing production of certain documents. In so doing, the Court stated unequivocally that "[t]here is no administrative remedy . . . for the erroneous denial of a subpoena before a hearing." *Id.* at 480.

Shively controls the outcome of this case. Dr. Mileikowsky has exhausted all available administrative avenues to have the issue of whether the summary suspension was warranted decided. He has no other administrative avenue to challenge the erroneous denial of the prompt, post-deprivation fair procedure to which he is entitled.[13] Furthermore, as will be discussed below, the policy considerations supporting judicial intervention in this case are far stronger than they were in Shively.

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[13]Bollengier v. Doctors Medical Center (1990) 222 Cal.App.2d 1115, 272 Cal.Rptr. 273, has no application in this case. The events underlying the Bollengier case preceded S.B. 1211 and thus the procedural protections, including the requirement that summary suspensions be taken "where the failure to take that action may result in an imminent danger to the health of any individual" did not exist. Business & Professions Code §809.5. Unlike in Bollengier, Dr. Mileikowsky is challenging the adequacy of the hearing since he is still involved in an "interminable" proceeding with no opportunity to resolve the issue as to whether the conduct in question was so sudden and so horrible, he was an "imminent danger" to his patients. And, as each day goes on, his professional practice comes closer to complete destruction.

Dr. Mileikowsky is challenging procedurally defective remedies that vitiate their very purpose. It is well established that an administrative remedy is inadequate if the administrative process itself was procedurally defective. "[I]f the remedy provided does not itself square with the requirements of due process the exhaustion doctrine has no application. [Citation omitted.]." Haller v. Burbank Community Hospital Foundation (1983) 149 Cal.App.3d 650, 656, 197 Cal.Rptr. 45. *See also* Horn v. County of Ventura (1979) 24 Cal.3d 605, 156 Cal.Rptr. 718. In Horn, a landowner brought a petition for writ of mandate to set aside the county's approval of subdivision on the basis that affected landowners had not been provided proper notice and an opportunity to be heard. The county argued that the landowner should have pursued his complaint through the available administrative process. Rejecting that contention, the California Supreme Court emphasized that the county's argument "ignores the essence of the plaintiff's complaint, which is that these very procedures were constitutionally inadequate." *Id.* at 611.[14]

Similarly, in Sunnyvale Public Safety Officers Association v. City of Sunnyvale (1976) 55 Cal.App.3d 732, 127 Cal.Rptr. 863, the Court of Appeal permitted city police officers and fire fighters to bring an action against the city

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[14]While it is true that Dr. Mileikowsky's claim is to "fair procedure" and not "due process" since Encino-Tarzana Regional Medical Center is a private hospital, "[t]he distinction between fair procedure and due process rights appears to be one of origin and not of the extent of protection afforded an individual." Applebaum v. Board of Directors (1980) 104 Cal.App.3d 648, 657, 163 Cal.Rptr. 831.

without pursuing administrative remedies. The court ruled that such procedures were ineffective because, *inter alia*, they did not allow testimony to be taken or legal briefs to be submitted, both of which were essential to resolve properly the issues in that case. See also Glendale City Employees' Association Inc. v. City of Glendale (1975) 15 Cal.3d 328; 124 Cal.Rptr. 13 (same).

3. Proper Application Of The Exhaustion Doctrine Requires Careful Consideration Of The Peer Review System And The Impact That Application Of The Doctrine Will Have On That System

The exhaustion doctrine is "intensely practical." Bowen v. City of New York (1986) 476 U.S. 467, 484, *quoting* Matthews v. Eldridge (1976) 424 U.S. 319, 331.

When applying the exhaustion doctrine, it is imperative that the court consider the particular administrative system in question. McKart v. United States (1969) 395 U.S. 185, 203; 23 L.Ed. 194. The doctrine should be applied differently in a scheme that contains a wide panoply of statutorily and/or constitutionally required procedural protections than in a system where such formal and specific protections are lacking or uncertain. Such specific protections significantly increase the likelihood that administrative decisionmaking will be fair and accurate and that subsequent judicial review will be meaningful, thus reducing or eliminating any justification for judicial intervention.

A medical staff summary suspension proceeding should be governed by adequate procedural safeguards. There are no specific statutory standards to guide the peer review body when imposing this draconian sanction. While the affected physician is entitled to the notice and hearing rights set forth in Business & Professions Code §§809.1-809.4, these rights are not available until after the summary suspension takes places, and after the matter has been reported to the Medical Board. *See* Business & Professions Code §805(b); Business & Professions Code §809.2(h). But, because of the catastrophic ramifications of a summary suspension, it is critical that the medical staff act swiftly and determine (1) that the physician in fact represents an imminent danger to patients, (2) that the draconian remedy is the least restrictive alternative to protect patient care, and (3) that the concerns could not more appropriately be aired through the formal pre-deprivation notice and hearing process set forth in Business & Professions Code §§809.1 et seq. For this reason, as is discussed above, public policy demands bifurcation of medical staff hearings involving summary suspensions to determine whether there is a reasonable likelihood of imminent danger such as to warrant the suspension.

When considered in the specific context of the peer review system, application of the exhaustion requirement to cases involving serious procedural deficiencies, such as unjustifiable delay, does not promote the purposes of that doctrine and may indeed harm the peer review system. In such a case, a court's

refusal to intervene will in fact subvert the purposes of the exhaustion doctrine. First, judicial economy will not be served where the procedures are patently flawed. A physician who is forced to endure seemingly endless delays on the issue of whether he/she represents an "imminent danger," and thus face complete destruction of his/her professional practice can never receive the prompt post-deprivation hearing to which the physician is entitled, and, indeed, may never have confidence in receiving any fair hearing at any stage of the proceeding. Under these circumstances, the hearing and any decisions rendered therein may well be inherently deficient and subject to subsequent judicial invalidation. It would be unnecessarily wasteful of both judicial and administrative resources to require the completion of proceedings that are destined to be judicially challenged and overturned. Moreover, because courts must review these decisions under the substantial evidence test, the court will generally be precluded from correcting these deficiencies outright, but will rather be required to remand the matter. Therefore, judicial efficiency would be better served by judicial intervention on the issue of "imminency" before the full hearing on the underlying charges takes place.

Second, in this case, it is unlikely that application of the exhaustion requirement will, as a practical matter, give the peer review body an opportunity to correct its mistakes. Substantial time has already passed and despite Dr. Mileikowsky's requests, there has been no hearing on whether he represented an

"imminent danger" to patients. In effect, his requests were either ignored or refused. If after a physician makes numerous efforts to resolve these matters at the administrative level and the administrative body refuses to cooperate in a timely and meaningful manner, it is evident that the administrative errors will not be rectified.

In addition, by challenging the fairness of the administrative policy and procedures, that is, the failure to provide an expedited hearing solely on the issue of whether summary suspension is warranted, a physician raises legal issues that lie beyond the purview of peer review participants' medical training and expertise. Indeed, in this regard, "administrative determination" may be a misnomer. Often the peer review participants themselves are not involved in such pre-hearing procedural disputes. Rather, as is discussed above, it is generally the medical staff's (hospital's) attorney who prepares the notice of charges, decides what information will be disclosed, and sets the time period for hearing, including whether and if so, when, there should be a hearing on the summary suspension. Procedural appeals are decided by the hearing officer, who is often selected by this same attorney.

Further, requiring exhaustion will not only not reduce the aggrieved physician's damages, but it may greatly increase them. Depending on the circumstances, a summary suspension may devastate a physician's ability to practice medicine. As was also discussed above, the mere existence of a section

805 report seriously inhibits a physician's ability to practice his or her profession. Even if the underlying administrative decision is subsequently invalidated, it may not be easy to overcome the section 805 report in the Medical Board's and National Practitioner Data Bank's files. *See* Haller v. Burbank Community Hospital Foundation (1983) 149 Cal.App.3d 650, 659-60, 197 Cal.Rptr. 45. Moreover, in the meantime, the report may have been disseminated pursuant to section 805.5 and requests to the National Practitioner Data Bank. Thus, the damages suffered by a physician wrongfully suspended from the medical staff will be dramatically greater than those the physician would suffer if a court corrected serious procedural deficiencies expeditiously.

There are additional reasons militating in favor of court intervention under these circumstances. First, the harm suffered by the physician and his or her patients is irreparable. Every day a summary suspension continues is another day that the physician cannot care for the physician's patients in the hospital. As was discussed above, a physician wrongfully reported under Business & Professions Code §805 will suffer irreparable harm. In addition, requiring a physician to obtain a final administrative decision under such circumstances may, as a practical matter, seriously jeopardize the physician's ability to obtain effective judicial review of the administrative decision. It may be difficult for a trial court to assess the importance of information brought to the court's attention initially pursuant to Code of Civil Procedure §1094.5(e). It may even be difficult objectively to assess

the procedural fairness of an administrative process when the record of the hearing contains multiple charges of misconduct and evidence heavily weighted in favor of the negative determination. Of course, the administrative "evidence" may be so adverse precisely because of the pre-hearing procedural irregularities. Nevertheless, a court might understandably be reluctant to overturn a final administrative decision on procedural grounds, because the court fears that it will be protecting a "bad doctor" and thereby endangering patient welfare.

In addition, when the physician loses access to a particular hospital, his or her patients may suffer irremediable harm. Dr. Mileikowsky's patients are being denied the right to continuity of care with their chosen physician. As discussed above, this is of particular concern with respect to the physician's high risk obstetrical patients. Certainly a court should consider such harm when evaluating the need for prompt judicial intervention in a particular case.

III. CONCLUSION

The American Medical Association and the California Medical Association and their physician members are committed to quality patient care and the effective peer review process necessary to maintain that high level of care. The Associations firmly believe, however, that neither peer review nor quality care is promoted by the wrongful suspension of competent physicians from hospital medical staff membership and appropriate clinical privileges. To the contrary, in

both the short and long-term, the highest quality of care and the most diligent performance of quality assurance activities depend upon accurate clinical assessments, assessments which can be made only if physicians facing adverse medical staff membership or privileges determination have a real opportunity to defend themselves. The Associations respectfully request that this Court ensure that Dr. Mileikowsky be given that chance.

Dated: May 15, 2001

Respectfully submitted,
American Medical Association
LEONARD A. NELSON
California Medical Association
CATHERINE I. HANSON
ASTRID G. MEGHRIGIAN

By: _____
Astrid G. Meghrigian
Attorneys for Amici Curiae
American Medical Association
California Medical Association

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LEONARD A. NELSON
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By: _____
Astrid G. Meghrigian
Attorneys for Amici Curiae
American Medical Association
California Medical Association

CMA POLICY
Medical Staff Summary Suspensions
(Policy adopted by CMA Board of Trustees, November, 1991)

CMA recognizes the necessity for a mechanism under which a medical staff may immediately suspend or restrict clinical privileges of a member where the failure to take such action may result in imminent danger to the health of any individual (as is reflected in Business & Professions Code §809.5). Although the law requires that a medical staff member whose clinical privileges have been restricted or suspended summarily be entitled to full notice and hearing rights under SB 1211, exhaustion of those notice and hearing rights can take months or years, during which the affected practitioner is prohibited from exercising the restricted or suspended privileges. As the law provides no express mechanism for challenging the necessity for summarily imposing restrictions or suspensions (i.e., on the question of whether there is, in fact, "imminent danger"), the use of the summary suspension alternative may be subject to abuse and additional safeguards should be required.

Accordingly, any mechanisms for the imposition of summary restrictions or suspensions should include the following elements, at a minimum:

1. Any practitioner who is summarily suspended or restricted should be provided with formal written notification of such summary action within one working day from the date the action was taken.

2. Such initial written notification shall state facts, including descriptions of specific incidents, giving rise to the medical staff's determination that failure to restrict or suspend the practitioner's privileges summarily could reasonably result in an imminent danger to an individual. This notice will not substitute for any formal notice of charges required under the bylaws.

3. The medical executive committee or a subcommittee appointed by the chief of staff shall meet within one week after imposition of the summary suspension and take action at that meeting to affirm, revoke or modify such suspension. Upon request of either the medical executive committee or the affected practitioner, the affected practitioner may attend a portion of this meeting and make a statement concerning the issues under consideration.

4. The affected practitioner shall be provided with written notice of the medical executive committee's action within one week of the MEC meeting.

5. Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the medical executive committee at the meeting held within one week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing officer [or hearing panel] stay the summary suspension, pending the final outcome of the hearing and any appeal.

6. At the conclusion of the procedural portion of the hearing, the hearing officer [or hearing panel] shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a reasonable determination that failure to summarily restrict or suspend could result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the MEC within one week of the date of the procedural hearing.

7. If the hearing officer's [or hearing panel's] determination is that the facts stated in the notice required by §6.2-2[15] do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

8. If the hearing officer [or hearing panel] determines that the facts stated in the notice required by §6.2-2 support a reasonable determination that the summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

[15]Section numbers refer to specified provisions of the CMA Model Medical Staff Bylaws.

CMA'S MODEL MEDICAL STAFF BYLAWS ON SUMMARY RESTRICTION OR SUSPENSION, 2000

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the chief of staff, the medical executive committee, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the board of [trustees/directors], the medical executive committee and the administrator. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

6.2-2 Written Notice of Summary Suspension

Within one working day of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial

notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.2-3 Medical Executive Committee Action

Within one week after such summary restriction or suspension has been imposed, a meeting of the medical executive committee [or a subcommittee appointed by the chief of staff] shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The medical executive committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two working days of the meeting.

6.2-4 Procedural Rights

Unless the medical executive committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article VII. In addition, the affected practitioner shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the medical executive committee at the meeting held within one week of imposition of the suspension. If the medical executive committee's decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing officer [or hearing panel] stay the summary suspension, pending the final outcome of the hearing and any appeal.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer [or hearing panel] shall issue a written opinion on the

issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the medical executive committee within one week of the date of the procedural hearing.

(c) If the hearing officer's [or hearing panel's] determination is that the facts stated in the notice required by Section 6.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer [or hearing panel] determines that the facts stated in the notice required by Section 6.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

6.2-5 Initiation By Board of [Trustees/Directors]

If the chief of staff, members of the medical executive committee and the head of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the board of [trustees/directors] (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the board of [trustees/directors] (or designee) made reasonable attempts to contact the chief of staff, members of the medical executive committee and the head of the department (or designee) before the suspension.

Such a suspension is subject to ratification by the medical executive committee. If the medical executive committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the medical executive committee does ratify the summary suspension, all other provisions under Section 6.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the medical executive committee for purposes of compliance with notice and hearing requirements.