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Medical Staff Peer Review: Qualifying the Qualified Privilege Provision

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MEDICAL STAFF PEER REVIEW: QUALIFYING THE QUALIFIED PRIVILEGE PROVISION

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I. INTRODUCTION

A. *The Doctor Under Review: A Hypothetical*

Dr. Amelia Adams¹ graduated from the University of Chicago Medical School. Following graduation she completed a one-year internship

1. Dr. Adams is a fictional plaintiff whose situation is a combination of incidents from case law and stories relayed during congressional hearings in 1986. *Health Care Quality Improvement Act: Hearings Before the Subcommittee on Civil and Constitutional Rights of the Committee on the Judiciary, House of Representatives, 99th Cong., 2d Sess. (1986)* [hereinafter *HCQIA Hearings*]. For example, see the testimony of Dr. W. Michael Byrd, which relayed the story of a physician who copied medical records prior to a peer review investigation. The

at Massachusetts General Hospital. At the end of that year, she entered a three-year internal medicine residency program at the University of California at Los Angeles. After successfully completing her residency, she undertook a two-year fellowship in cardiology at the University of Southern California. Dr. Adams qualified for and passed the internal medicine boards and cardiology boards—national examinations recognized as “‘excellent benchmark[s]’ for privilege delineation.”² Following her fellowship, she joined an established Los Angeles health maintenance organization (HMO) as a cardiologist.

Dr. Adams worked as a member of a three-person team of cardiologists. The HMO setting allowed her to see a wide variety of cardiac problems, and she was able to apply all aspects of her training. She noticed, however, that some of the skills and practices of the other cardiologists on the HMO staff were outdated. Having just completed a university training program,³ and realizing that these doctors, although also from excellent schools, had been out of training from five to twenty years, she decided to volunteer to speak to the medical staff at lunch-time lectures about new trends in cardiology. She believed this forum would disseminate information to the staff without specifically calling attention to any one doctor’s outmoded techniques.⁴

The senior cardiologist, Dr. James, rejected the techniques she discussed at the lectures; he felt they were too costly.⁵ Dr. Adams was disappointed by Dr. James’s decision and thought that cost containment,

records were altered during the peer review process to create an impression of incompetence on his part. His earlier copies, unaltered, prevented the hospital from succeeding in its action against him. *Id.* at 145.

2. ROBERT D. MILLER, *PROBLEMS IN HOSPITAL LAW* 113 (1990) (citation omitted). “Privileges” in the medical setting means “authorization by the governing body to provide specific patient care and treatment services in the organization, within well-defined limits, based on an individual’s license, education, training, experience, competence, and judgement.” JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., *ACCREDITATION MANUAL FOR HOSPITALS* 319 (1990) [hereinafter *ACCREDITATION MANUAL*] (defining clinical privileges). Hospital privileges must be renewed through a reapplication process every two years. *Id.* at 101.

3. *Cf. HCQIA Hearings, supra* note 1, at 108-09 (testimony of Dr. Richard Seymour regarding physicians with outstanding credentials who faced racial discrimination).

4. *See id.* at 56 (testimony of Dr. Sidney M. Wolfe relaying that oftentimes competent physician “shortly after complaining within the hospital about unnecessary surgery or other evidence of incompetence by other doctors . . . [is] thrown out of the hospital him or herself in obvious retaliation”); *see also Bolt v. Halifax Medical Ctr.*, 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990) (involving revocation of surgeon’s privileges after criticism of senior surgeon’s technique).

5. *Cf. Mark I. Pinsky, Doctor Awarded \$7.7 Million in Suit Over Firing by Cigna*, L.A. TIMES, May 20, 1993, at A3, A23 (discussing suit where doctor claimed Cigna had campaign to “replace better-paid, older doctors with younger, lower-salaried hires”).

such as economic and budgetary restraints, guided care more than current medical standards.⁶ Discouraged, she was occasionally blunt in expressing her frustration at the hospital administration's resistance to innovation. Consequently, Dr. Adams's aggressive style was perceived as threatening to the complacent senior staff, especially in light of the increasing demand for her services by patients expecting sophisticated, state-of-the-art diagnostic and therapeutic techniques.

The other cardiologists refused to do "rounds"⁷ on her patients and refused to let her do rounds on their patients. They gossiped to their colleagues that she was not competent. When one of her patients suffered an isolated incident of nonfatal bleeding after a pericardiocentesis,⁸ Dr. James ridiculed and maligned her. Dr. Adams was, thereafter, instructed not to perform the procedure on future patients, and to refer those patients needing the procedure to other staff cardiologists.⁹ Academic and ego rivalries fueled tensions within the cardiology department. Unbeknownst to Dr. Adams, Dr. James hired a fourth cardiologist, Dr. Hammond, and told him that Dr. Adams intended to leave the cardiology department. Dr. Adams was then asked to leave, and when she failed to depart voluntarily, the senior staff threatened her with an ad hoc peer review investigation.¹⁰ She was told that the administration would have her "screw-tanized" if she continued to practice cardiology. She was given the option, however, to transfer, at a substantially reduced sal-

6. See *HCQIA Hearings, supra* note 1, at 74 (testimony of Marilyn C. Farray relating that "I found in Mississippi particularly that physicians have found themselves under censure by medical staff committees . . . [for] the kinds of patients they admit to hospitals"). Particular reference was made to poor patients without insurance. *Id.*

7. Doctors are obligated to conduct daily visits known as "rounds" to their hospital inpatients. Doctors typically rotate rounding duties for weekend coverage. See *Austin v. McNamara*, 979 F.2d 728, 738 (9th Cir. 1992) (noting dispute among doctors over rounds).

8. Pericardiocentesis is a procedure in which the physician draws fluid from the heart sac. It is associated with complications, such as bleeding, which may occur infrequently even with the highest quality of care. 2 *THE HEART ARTERIES AND VEINS* 1365, 2185 (J. Willis Hurst et al. eds., 1990).

9. See *HCQIA Hearings, supra* note 1, at 77. Marilyn C. Farray testified:

They don't say get rid of doctors who serve the poor or minorities. They say he is not providing good patient care. And my goodness, he was a really good doctor until about a year ago. We just don't know what happened. He went bad, and take a look at these records which we've dug up.

Id.

10. See *id.* at 78-79 (testimony of Victor M. Glasberg telling of physician he represented who was subjected to ad hoc peer review investigation of physician's complete performance at hospital, without prior notice or input into process); see also *Austin*, 979 F.2d at 731-32 (discussing ad hoc peer review investigation).

ary, to the internal medicine department, where the HMO was overbooked with patient needs.¹¹

Dr. Adams attempted to relocate and seek other employment as a cardiologist. She was advised, however, that until she dealt with the cloud over her practice at the HMO, she would be unable to make a move.

Dr. Adams reapplied for her cardiology privileges at the HMO. Dr. James personally selected a group of patient charts, including the chart with the bleeding incident, and presented the charts to two cardiologists from another of the HMO's facilities. After meeting with Dr. James and reviewing the charts, the doctors wrote a report to the HMO executive committee describing Dr. Adams's cardiology care as below acceptable standards.

If Dr. Adams had been working in private practice,¹² she might have been able to bring an antitrust action against the doctors who conspired to exclude her from a cardiology practice at the hospital.¹³ Because the setting is an HMO, and the traditional competitive cost incentives essential for antitrust actions are not present, her only recourse is through traditional tort theories,¹⁴ which depend on her ability to prove that the medical staff or hospital acted in bad faith.¹⁵

Dr. Adams has an uphill battle before her: Because hospitals rarely discipline doctors, the courts are inclined—as are her future employers and patients—to think that the sanctions she received were justified.

11. Cf. Marc L. Rivo, *Internal Medicine and the Journey to Medical Generalism*, 119 *ANALS INTERNAL MED.* 146, 146-47 (1993) (discussing recommendation that 50% of medical school graduates become general internists; also discussing managed care organizational need to "retrain subspecialists as generalists"); James Flanigan, *Industrialization of Medicine Has Already Started*, *L.A. TIMES*, July 18, 1993, at D1 (discussing greater need for generalists than for specialists); Dana Priest, *What the Labels Mean*, *WASH. POST*, July 13, 1993, at Z13 (describing primary care doctors as "gatekeepers").

12. For a discussion of health care delivery models, see *infra* part I.D.

13. See, e.g., Clark C. Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 *CASE W. RES. L. REV.* 1117 (1986) (stating that collaboration involved in peer review may be defensible under antitrust principles).

14. Dr. Adams could bring actions in libel, defamation, and tortious interference with business relationships. *W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS* § 111, at 773-78, § 112, at 787-88, § 129, at 984 (5th ed. 1984).

As the practice of medicine evolves from a predominantly private-practice-based profession to a network-based profession (for example health maintenance organizations (HMOs) and preferred provider organizations (PPOs)), Dr. Adams's scenario will be repeated. See, e.g., Mark A. Kadzielski et al., *Peer Review Hearings: Nuts, Bolts and Flakes*, 14 *WHITTIER L. REV.* 147, 147-66 (1993) (discussing mechanics of dealing with physician peer review disputes).

15. See 42 U.S.C. §§ 11101-11152 (1988).

How, then, can she clear her reputation, return to her subspecialty practice and continue to practice state-of-the-art medicine?

B. The Health Care Quality Improvement Act of 1986

Prior to the implementation of the Health Care Quality Improvement Act of 1986 (HCQIA),¹⁶ Dr. Adams could have negotiated an amicable departure from the HMO and perhaps joined another HMO or private practice group.¹⁷ The HCQIA, however, was designed to eliminate this alternative.¹⁸ Historically, doctors have been responsible for self-policing the medical profession; thus, the profession has been open to much criticism.¹⁹ This previously unregulated disciplinary process allowed a doctor who had been excluded from one medical community for incompetence to relocate elsewhere and begin anew.²⁰ Concerned with this situation, Congress enacted the HCQIA.²¹ The Act established standards for a self-policing process, in the form of peer review, and created the National Data Bank reporting system for physicians whose competency had been questioned and whose care had been sanctioned.²² Hospitals that fail to report physicians to the National Data Bank are penalized,²³ as are hospitals that fail to consult the National Data Bank when they are granting privileges.²⁴

The HCQIA creates a national net in which to catch incompetent doctors.²⁵ This net, however, will catch more than it is designed to catch: Swept into the net and labeled as bad doctors will be those doctors, like Dr. Adams, who have been excluded from hospitals or HMOs for reasons unconnected to the quality of their patient care.²⁶ This small

16. Pub. L. No. 99-660, 100 Stat. 1784 (1986) (codified at 42 U.S.C. §§ 11101-11152 (1988)).

17. See 42 U.S.C. § 11101(2) (1988); Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 455, 464 (1990).

18. 42 U.S.C. § 11101(3) (1988); Horner, *supra* note 17, at 467.

19. Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 690-91 & n.26 (1991).

20. *HCQIA Hearings*, *supra* note 1, at 32-45 (statement of Richard P. Russerow, Inspector General of Department of Health and Human Services, regarding medical incompetence and discipline); Adler, *supra* note 19, at 691.

21. Pub. L. No. 99-660, 100 Stat. 1784 (1986) (codified at 42 U.S.C. §§ 11101-11152 (1988)); see 42 U.S.C. § 11101(2) (1988).

22. 42 U.S.C. § 11137 (1988).

23. *Id.* (providing that immunity is forfeited).

24. *Id.* (providing that entity that fails to consult National Data Bank is presumed to have knowledge of its contents).

25. Horner, *supra* note 17, at 454-56.

26. *HCQIA Hearings*, *supra* note 1, at 74, 85, 87, 96, 145 (testimony of Marilyn C. Farray, William A. Bogan, Victor M. Glasberg, David H. Weinstein, and Dr. W. Michael Byrd).

group of doctors now must vigorously litigate their cases to protect their reputations as well as their livelihoods.²⁷ Aiding their cause, the HCQIA recognizes the potential for peer review abuse and limits peer review participant immunity to only those actions taken

- (1) in the reasonable belief that the action was in the furtherance of quality health care,
- (2) after a reasonable effort to obtain the facts of the matter,
- (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
- (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts and after meeting the requirement of paragraph (3).²⁸

As codified, the HCQIA is entitled "Encouraging Good Faith Professional Review Activities."²⁹

C. California Peer Review Law

In 1989 the California Legislature enacted section 809 of the Business and Professions Code. These enactments codified and amplified the peer review aspects of the HCQIA, creating in California a state-tailored version of the federal statute.³⁰ On September 9, 1989, the California Legislature "opted out" of the federal system by enacting eleven additional sections to the California Business and Professions Code.³¹ The legislature expressed concern over perceived "deficiencies in the federal act and the possible adverse interpretations by [federal] courts of the fed-

27. Thaddeus J. Nodzenski, *Where is the Quality in the Health Care Quality Improvement Act of 1986?*, 22 LOY. U. CHI. L.J. 361, 371-72 (1991).

28. 42 U.S.C. § 11112 (1988).

29. *Id.*

30. The HCQIA permits states to tailor the code. *Id.* § 11111.

31. CAL. BUS. & PROF. CODE §§ 809, 809.05, 809.1-.9 (West 1990 & Supp. 1993). These provisions made California's due process requirements much more specific:

California still requires: 1) written notice of and reasons for the proposed action; [and] 2) the right to request a hearing before a mutually-acceptable arbitrator(s). The arbitrator should preferably be of the same specialty as the physician, but with no direct financial benefit from the outcome of the proceedings. The arbitrator should be someone who was not an accuser, investigator, factfinder or initial decisionmaker.

Other rights include a physician's challenge to impartiality and the right to witness lists and to inspect documentary evidence. Some provisions are identical to HCQIA, such as the imposition of the cost of the suit, including reasonable attorney fees if a suit challenging the action taken was "frivolous, unreasonable, without foundation, or in bad faith."

Horner, *supra* note 17, at 484 n.197 (citations omitted).

eral act,"³² and stated that "the laws [of California] provide a more careful articulation of the protections for both those undertaking peer review activity and those subject to review."³³ To encourage physicians to comply with these statutorily imposed evaluations, the California Legislature provided limited immunity to medical staff members participating in the peer review process. A peer review committee is immune to liability for its actions

if a member of the commission acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after the reasonable effort to obtain the facts.³⁴

California's grant of immunity is substantially similar to the immunity provided by the HCQIA; a key difference, however, is California's "without malice" provision.

Since 1990 California has required all medical staffs of twenty-five or more members to create procedures guaranteeing due process in medical staff disciplinary actions.³⁵ California statutes, therefore, now require virtually all hospitals to adhere to established California case law regarding fairness in the granting of medical staff privileges.

D. Health Care Delivery Models

Health care in the United States was traditionally delivered to patients through medical doctors working either in solo private practices or in group or multigroup specialty practices.³⁶ These private practice doc-

32. CAL. BUS. & PROF. CODE § 809(a)(2) (West 1990).

33. *Id.* § 809(a)(9) (West 1990).

34. CAL. CIV. CODE § 43.7(a) (West 1982 & Supp. 1993). Under the federal version of the Act, immunity is specifically not available for (1) civil rights actions, (2) failure to report the incident to the National Data Bank, (3) due process violations, and (4) suits brought in state court under the Federal Act, if the state (as California has) opted out of part A of the Act. 42 U.S.C. § 11111(a)(1),(b),(c) (1988). Part of the reason California chose to opt out of the federal scheme is that California, a leader in health care law, already had peer review immunity. *See* CAL. CIV. CODE § 43.7 (West 1982 & Supp. 1993). Additionally, California case law established many of the procedural due process requirements that the HCQIA details. *E.g.*, *Anton v. San Antonio Community Hosp.*, 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977); *Rosenblit v. Superior Court*, 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (1991), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991); *Tiholiz v. Northridge Hosp. Found.*, 151 Cal. App. 3d 1197, 199 Cal. Rptr. 338 (1984); *Haller v. Burbank Community Hosp. Found.*, 149 Cal. App. 3d 650, 197 Cal. Rptr. 45 (1983); *Hackenthal v. California Medical Ass'n*, 138 Cal. App. 3d 435, 187 Cal. Rptr. 811 (1982); *Appelbaum v. Board of Directors*, 104 Cal. App. 3d 648, 163 Cal. Rptr. 831 (1980).

35. CAL. BUS. & PROF. CODE §§ 805, 809-809.2 (West 1990 & Supp. 1993).

36. *See* Melinda Beck et al., *Doctors Under the Knife*, NEWSWEEK, Apr. 5, 1993, at 29.

tors relied on the hospitals of the community in which they practiced to provide them with facilities for the hospitalized care of their patients.³⁷ Hospitals contracted with doctors for the care of their patients through a hospital-controlled process known as "privilege granting":³⁸ A doctor allowed to admit patients to a particular hospital is said to have privileges at that hospital.³⁹ Privileges are renewed every two years.⁴⁰ If a hospital denies a doctor's privileges, he or she may not admit patients to that hospital.⁴¹

The first suits concerning the denial of a doctor's hospital privileges were brought under antitrust theories.⁴² A doctor contended that he or she has been excluded by his or her competition (other doctors who practice the specialty) for economic reasons and not for quality-of-care reasons.⁴³ These suits evolved into two areas of common law. One strand dealt with privately owned hospitals and allowed those facilities greater discretion in the selection of their physician rosters.⁴⁴ The other dealt with public hospitals and focused more on a doctor's right to practice the medical profession.⁴⁵

Private practice medicine is on the decline, and in its place various programs of managed care are emerging.⁴⁶ Most notable of these are the HMOs.⁴⁷ The HMOs have two primary models. The first is known as the "staff" model. In this model the HMO employs its own medical

37. MILLER, *supra* note 2, at 104.

38. *Id.*

39. *Id.*

40. ACCREDITATION MANUAL, *supra* note 2, at 101.

41. Horner, *supra* note 17, at 460-61.

42. Havighurst, *supra* note 13, at 1137-38.

43. *Id.* at 1117-21.

44. See Daniel H. White, Annotation, *Exclusion of or Discrimination Against Physician or Surgeon by Hospital*, 37 A.L.R. 3D 645, 659 (1992).

45. *Id.* at 666-69.

46. Because the Clinton administration has been promoting its health care reform, many articles have become available on this topic. See, e.g., Joseph S. Coyle, *Who Wins Under Clinton's Health-Care Plan*, MONEY, May 1993, at 98-105 (concluding that private practice doctors in big cities will become "losers" while private practice doctors in rural areas will become "winners"); Milt Freudenheim, *The Xerox Health-Care Model*, N.Y. TIMES, Feb. 16, 1993, at D1 (discussing Xerox's health care benefits as prototype for reforming ailing health care system); Nancy J. Perry, *A Report Card on HMOs*, FORTUNE, June 28, 1993, at 110 (promoting quality of health care at HMOs); Dana Priest, *Health Reform Fever? Pollsters Take the Public's Temperature on Various Proposals as the Debate Progresses*, WASH. POST, July 13, 1993, at Z7 (indicating that Arizona citizens accept sacrifices to further goals of health care reform); Rob Steitz, *All About Managed Care: The Political Tealeaves Point to Medical Networks*, N.Y. TIMES, Dec. 20, 1992, § 3 (Magazine), at 10 (discussing various health care options).

47. Beck et al., *supra* note 36, at 29.

doctors (MDs) and owns its own hospital facilities.⁴⁸ The premier example of this model is Kaiser Permanente (Kaiser).⁴⁹ Kaiser owns its own hospital and clinic facilities, and its medical staff of physician-partners is the Permanente Medical Group.⁵⁰ The second model is called the Independent Physician Association (IPA).⁵¹ In this situation individual MDs (who would be considered private practitioners) contract with a professional corporation, the IPA, which exists only to contract with the HMO.⁵² Southern California's Family Health Plan, Inc. (FHP) is an illustration of this model.⁵³ FHP subscribers visit physicians in their private medical suites and are admitted to independent hospitals. Through financial arrangements with these physicians and hospitals, FHP controls its costs.⁵⁴

Other systems of managed care consist of insurance carriers providing a selection of Preferred Provider Organizations (PPOs), which are doctors and hospitals that subscribers may use.⁵⁵ In some instances these doctors are paid a fee per capita,⁵⁶ and in others it is a fee for service.⁵⁷

The HCQIA did not anticipate the rapid evolution of medical care from private-practice-based to managed-care-based.⁵⁸ The HCQIA was developed, in part, as a result of the many suits by doctors against hospital-based peer review activities.⁵⁹ This Comment explores how the

48. *Id.* at 33; see also Tom Morganthau & Andrew Murr, *Inside the World of an HMO*, NEWSWEEK, Apr. 5, 1993, at 39 (profiling Family Health Plan, Inc. (FHP)); Priest, *supra* note 11, at Z13 (defining health care terms).

49. See Lisa Belkin, *Tradeoffs and Benefits of a California H.M.O.*, N.Y. TIMES, May 13, 1993, at B6 (characterizing Kaiser as nation's largest HMO); Kathleen Day, *Kaiser Permanente's Tax Break Challenged, Critics Say HMO, Usually Touted as Model, Doesn't Aid Poor Enough*, WASH. POST, May 27, 1993, at B13 (designating Kaiser as President Clinton's program model).

50. See Patrick Ford, *Medical Groups*, BUS. J.-SACRAMENTO, Aug. 27, 1990, at S31 (listing Permanente Medical Group of predominantly physician-partners as only practitioners for Kaiser Foundation Hospital Plan).

51. Beck et al., *supra* note 36, at 33.

52. *Id.*

53. Morganthau & Murr, *supra* note 48, at 39. FHP also has a few facilities that operate under the staff model. *Id.*

54. *Id. passim.*

55. Beck et al., *supra* note 36, at 33; see Coyle, *supra* note 46, at 98-105 (discussing HMOs, PPOs, and other modes of health care delivery).

56. The doctor receives a fixed fee per month for the patients he or she is expected to care for; in essence, the services have been retained by the insurer. Beck et al., *supra* note 36, at 33.

57. The doctors submit charges to the insurer at a reduced fee. *Id.*

58. Cf. Flanigan, *supra* note 11, at D1 (noting rapid increase in managed care).

59. See *HCQIA Hearings*, *supra* note 1, *passim.*

HCQIA, designed for the private-practice model, can be applied to the managed-care model of patient health care.⁶⁰

E. Scope of Discussion

This Comment presents a framework for analyzing claims—like Dr. Adams's—against the peer review committee members and the hospital, HMO, or IPA (all hereinafter referred to as hospital). Next, this Comment defines bad faith in the medical staff peer review setting by examining situations deemed indicative of malice.⁶¹ Finally, because most physician claims against hospitals have traditionally been disposed of at the summary judgment stage, this Comment proposes representative circumstances that establish a prima facie case of malice in the peer review process.

This Comment does not address situations in which alcohol, substance abuse, age, mental health, or physical disability have impaired a physician's ability to perform.⁶² This Comment's narrow focus is on the

60. Under California law, all HMOs, Independent Physician Associations (IPAs), and private practice groups that contract with or employ 25 or more physicians must provide peer review procedures. CAL. BUS. & PROF. CODE §§ 805, 809-809.2 (West 1990 & Supp. 1993); CATHERINE I. HANSON ET AL., CALIFORNIA MEDICAL ASS'N, CALIFORNIA PHYSICIAN'S LEGAL HANDBOOK 17:1 (1990). Methods to avoid this expense and aggravation have already been devised; for example, contracts with physicians often have "termination without cause" provisions. An IPA could then exercise this provision rather than conduct a hearing. Interview with Lauren W. Wilson, Health Law Adjunct Assistant Professor, Southwestern University School of Law, in Beverly Hills, Cal. (July 6, 1993). Depending on the facts, this practice could violate the California Business and Professions Code § 809. *Id.* Thus, part of a physician's ability to protect his or her position from improper peer review activity may evolve into a dependency on whether he or she is in a structure that creates physician employees, independent contractors, or partners.

61. See *infra* part IV.A. The California statute requires that the actions be taken "without malice," CAL. BUS. & PROF. CODE § 809 (West 1990 & Supp. 1993), and the HCQIA requires that the actions taken be "reasonable," 42 U.S.C. § 11112 (1988). For additional materials on bad faith, see Horner, *supra* note 17, at 468; Charles D. Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 196 n.126 (1988). In the area of malicious prosecution—the area most analogous to improper peer review activities, *Westlake Community Hosp. v. Superior Court*, 17 Cal. 3d 465, 483-84, 551 P.2d 410, 420-21, 131 Cal. Rptr. 90, 100-01 (1976)—"malice" means "the prosecution was instituted primarily because of a purpose other than that of bringing an offender to justice." BLACK'S LAW DICTIONARY 957 (6th ed. 1990). "Good faith" is the "state of mind denoting honesty of purpose, freedom from intention to defraud, . . . being faithful to one's duty or obligation." *Id.* at 693. Additionally, "good faith" is defined as an "absence of malice." *Id.*

62. See, e.g., CAL. BUS. & PROF. CODE § 820 (West 1990 & Supp. 1993) (providing suspension or limitation of activities due to mental or physical illness); *id.* § 490 (allowing suspension for conviction of crime related to qualifications); *id.* § 2237 (detailing suspension for narcotics, dangerous drugs, and controlled substances).

physician, like the hypothetical Dr. Adams, whose competence has been questioned for political, personal, or economic motivations.⁶³

This Comment also addresses the impact of the qualified immunity provisions of the peer review component of California's version of the HCQIA on California health care law, focusing on the litigation spawned by the qualified immunity provision.⁶⁴ These "Doctor v. Committee" suits typically involve due process, contract, antitrust, defamation, and tortious interference with business relationship claims.⁶⁵ The antitrust elements of the Doctor v. Committee suits are outside the scope of this Comment.⁶⁶

This Comment provides a legal model for determining which peer review actions rise to the level of malice and, therefore, should not receive qualified privilege.⁶⁷ This Comment concludes that the immunity provided is qualified and not absolute because there are circumstances when the participants, process, and documents of the peer review committee should not be shielded from the legal repercussions of the participants' actions.⁶⁸

II. DEFINING QUALITY HEALTH CARE

What is quality medical care? No one appears to know the answer. In April 1993 the American College of Physicians published the results

63. See *HCQIA Hearings*, *supra* note 1, at 74, 134 (discussing "physicians who are improperly before peer review committees" and explaining that "[p]hysicians are maliciously being deprived of their rights to practice medicine based on race, economics, social class, ethnicity and even their political views"); see also *supra* note 26 and accompanying text (profiling instances where physicians are inappropriately challenged through peer review activity).

This Comment does not address hospital decisions to create "closed groups," which occur when the hospital decides to contract, for instance, all X-ray work to one group of radiologists at the exclusion of all others. These decisions have been upheld by various courts. See, e.g., *Redding v. St. Francis Medical Ctr.*, 208 Cal. App. 3d 98, 255 Cal. Rptr. 806 (1989); *Letsch v. Northern S.D. County Hosp. Dist.*, 246 Cal. App. 2d 673, 55 Cal. Rptr. 118 (1965); *Anne Arundel Gen. Hosp. v. O'Brien*, 432 A.2d 483 (Md. Ct. Spec. App. 1981).

64. The peer review committee typically functions under the auspices of the hospital; therefore, the committee members, as well as the hospital, are generally sued. Throughout this Comment, the term "committee" will be used to refer to the hospital and committee member defendants as a group.

65. *Nodzinski*, *supra* note 27, at 366.

66. For a discussion of antitrust law applied in the medical peer review context, see *Havighurst*, *supra* note 13; William G. Kopit & Robert W. McCann, *Old Wine in New Bottles: The Increased Antitrust Risk of Hospital Diversification*, 26 WAKE FOREST L. REV. 601 (1991); Charity Scott, *Medical Peer Review, Antitrust, and the Effect of Statutory Reform*, 50 MD. L. REV. 316 (1991); John E. Graf, Comment, *Patrick v. Burget: Has the Death Knell Sounded for State Action Immunity in Peer Review Antitrust Suits?*, 51 U. PITT. L. REV. 463 (1990).

67. See *infra* part IV.A.

68. See *infra* part V.

of a study that "confirm[ed] that the way most physicians and review organizations do peer review to assess quality of care is unreliable."⁶⁹ A 1986 Rand Corporation attempt to develop protocols⁷⁰ for six diagnostic and surgical procedures revealed that "panels of experts could agree on only 3 to 41 percent of the possible indications for the procedures."⁷¹ Although significant research has been conducted in the last twenty-five years in an attempt to define quality medical care, the only certain conclusion of that research is that physicians vary greatly in their opinions as to proper patient care.⁷² Specifically, physicians have been found to differ regarding the appropriateness of diagnostic tests, the choice and need of treatment, the decision to admit a patient to the hospital, hospital-based therapies, and length of hospital stays.⁷³ As one commentator wrote:

There is a lot we do not know, despite the spectacular advances of medical science in the last half century, about how the body works, about the causes and natural history of many diseases, and even about the effectiveness of many medical treatment approaches. . . . In a recent Duke University study to develop a model to estimate the effectiveness of various strategies to screen high-risk individuals for colon cancer, the lack of research data made it necessary to rely for many critical elements of the model on the opinions of experts. . . . When asked to estimate the percent of polyps that bleed before becoming cancerous—the critical factor in judging the effectiveness of the most common screening technique for colon cancer which detects blood in the stool—the estimates ranged from 2 to 100 percent. Similar wide differences were exhibited for estimates of the percent of cancers that arise from polyps (10 to 90 per-

69. Peter E. Dans, *Clinical Peer Review: Burnishing a Tarnished Icon*, 118 ANNALS INTERNAL MED. 566, 566 (1993); Rodney A. Hayward et al., *Evaluating the Care of General Medicine Inpatients: How Good Is Implicit Review?*, 118 ANNALS INTERNAL MED. 550, 550 (1993).

70. "Protocols" are medical decision aids (for example, flow charts) for diagnosis and treatment. John Billings, *The Emergence of Quality as a Major Health Policy Issue*, in MEDICAL QUALITY AND THE LAW 21, 28 (John Billings et al. eds., 1990); e.g., *id.* at E-5.

71. *Id.* at 29 (citing R.E. PARK ET AL., Rand Corp. No. R-3280-CWF/HF/PMT/RWJ, PHYSICIAN RATINGS OF APPROPRIATE INDICATIONS FOR SIX MEDICAL AND SURGICAL PROCEDURES (1986)).

72. *Id.* at 31; see Clark C. Havighurst, *Practice Guidelines As Legal Standards Governing Physician Liability*, LAW & CONTEMP. PROBS., Spring 1991, at 87, 97 (discussing shortcomings of current legal methods to determine standard of care).

73. Billings, *supra* note 70, at 23.

cent) and of the time between detectability of a polyp and development of invasive cancer (6 months to 16 years).⁷⁴

Currently there are several competing methods to establish standards of medical quality.⁷⁵ Some analysts advocate national guidelines and protocols that would serve as reference points and, once complied with, would be presumed to have met the standard of care.⁷⁶ Others advocate adopting the medical malpractice standard in the peer review setting.⁷⁷

Even if doctors could agree on a format for standards, the development of a comprehensive set of such standards is still problematic.⁷⁸ Teaching hospitals, the American Medical Association, and professional specialty groups, such as cardiologists and oncologists, are attempting to resolve these issues and establish guidelines.⁷⁹ Some hospitals already monitor patient care—diagnostic tests indicated/used; predicted/actual outcomes; projected/actual hospital stay—through statistical analysis with the aid of computer profiles.⁸⁰

The question then becomes, if poor patient care would support a malpractice action, is it actionable under peer review? If not, is the doctor's care considered quality? It has been suggested that hospitals, which must compete for patients in an aggressive marketplace, have a right to set their particular standards at a superior level of care.⁸¹ May a doctor be excluded from a hospital staff because his or her patient treatment was not superior? These questions remain rhetorical because today there is

74. *Id.* at 23-24. The quoted paragraph is merely indicative of the author's analysis. Dr. Billings describes a number of examples of expert physicians' failures to agree on diagnostic tests, treatments, and predicted outcomes. *Id.*

75. For a general discussion of the various models, see Dans, *supra* note 69, at 566; Harry P. Selker, *Systems for Comparing Actual and Predicted Mortality Rates: Characteristics to Promote Cooperation in Improving Hospital Care*, 118 ANNALS INTERNAL MED. 820 (1993); *America's Best Hospitals, The 16 Specialties*, U.S. NEWS & WORLD REP., July 12, 1993, at 78.

76. See Clark C. Havighurst, *The Quality of Medical Care: Resolving Controversies over a Sacred Cow*, in MEDICAL QUALITY AND THE LAW, *supra* note 70, at 53, 63.

77. *Id.* at 61-65 (discussing various legal standards for determining quality of care).

78. *Id.* at 68.

79. Michael E. Carbine, *Bringing New Accountability to Health Care, A Report of the Discussion at the Warren Conference*, in MEDICAL QUALITY AND THE LAW, *supra* note 70, at 73, 77; see also Havighurst, *supra* note 72 (advocating national guidelines to establish standard of care for malpractice).

80. Billings, *supra* note 70, at 28-30.

81. Havighurst, *supra* note 76, at 58-60; see also *Oliver v. Board of Trustees*, 181 Cal. App. 3d 824, 830, 227 Cal. Rptr. 1, 5 (1986) (discussing hospital criteria requiring members of its consulting staff to be of "widely renowned professional ability and reputation in the area of their specialty" and concluding doctor's lack of board certification and eligibility, his paucity of publications, and overall lack of significant evidence to demonstrate superior qualifications showed him to be ineligible).

still as much art as science in the practice of medicine.⁸² Thus, any review of medical competence must recognize that the doctor-patient relationship has components that are phenomenological⁸³ rather than biophysical. A review of each doctor's medical judgment probably should compare it to what a reasonable doctor would consider the appropriate treatment for a particular patient.

III. IMMUNITY: DOCTOR V. COMMITTEE

A. *Defining Malice in the Peer Review Setting*

Although designed to thwart litigation, the "without malice" and "reasonable" components of the California immunity provisions may actually create more litigation than they will resolve.⁸⁴ These provisions "rais[e] false hopes of avoiding litigation" because, in reality, when a sanctioned doctor alleges such improprieties, the parties must engage in discovery—including document requests, interrogatories, and depositions of peer review committee members and hospital personnel—to have even a likelihood of resolving the allegations.⁸⁵ In the absence of established criteria, the ambiguity of the phrases "without malice" and "reasonable effort" in the peer review setting virtually precludes judges from disposing of the cases at the demurrer and summary judgment stages.⁸⁶

There is no published California case that defines malice in the peer review context.⁸⁷ Arizona and Delaware courts addressing the issue of

82. See generally Carbine, *supra* note 79, at 85 (discussing clinical judgment as "bedrock" of medical decision making).

83. "Phenomenology" refers to the nonphysical aspects of the treatment of patients and is receiving increasing attention in medical circles. See Dale A. Mathews et al., *Making "Connections": Enhancing the Therapeutic Potential of Patient-Clinician Relationships*, 118 ANNALS INTERNAL MED. 973 (1993).

84. See Nodzenski, *supra* note 27, at 373.

85. *Id.* at 373-75.

86. Sosi N. Biricki, *Reconciling Section 1157, Elam, and West Covina Hospital: Is the Sanctity of the Hospital Peer Review Committee Salvageable?*, 61 S. CAL. L. REV. 183, 202-03 & n.101 (1987); see also Ascherman v. San Francisco Medical Soc'y, 39 Cal. App. 3d 623, 663, 114 Cal. Rptr. 681, 707-08 (1974) (stating that application of immunity privilege "depended on resolution of factual issues and could not be determined as a matter of law").

87. Search of LEXIS, States library, California file (July 27, 1993); search of WESTLAW, California Cases library (July 27, 1993). One depublished case, however, is on point. Gannon v. Santa Ana-Tustin Community Hospital, 257 Cal. Rptr. 110, 120 (1989) (depublished May 18, 1989) used the principles derived in Manguso v. Oceanside Unified School District, 153 Cal. App. 3d 574, 200 Cal. Rptr. 535 (1984):

[T]he plaintiff had the burden to "show[] by a preponderance of the evidence [that the administrator] acted with malice, that is, that he acted with hatred or ill will toward [her], or he lacked reasonable grounds for believing the truth of the false statements or he made the statement for a reason other than to protect the interest of the one for whom the protection is given."

peer review motivated by malice have determined that malice exists when there is a "primary purpose [underlying the peer review committee action] other than the safeguarding of patients."⁸⁸ One court observed that although bad faith can be inferred from circumstances, "[p]rofessional criticism or disapproval does not constitute malice."⁸⁹ Similarly, a New York court determined that overcoming the qualified privilege provision requires malice that consists of "personal spite, ill will, or culpable recklessness or negligence. Mere falsity is not enough, unless it is also shown that the defendant knew, or at least was culpably reckless in not knowing, that the statement was false."⁹⁰ Additionally, some courts have looked to the failure to follow procedures and to provide a fair review process as indicators of bad faith or malice.⁹¹

In a similar vein, the Maine Supreme Judicial Court has held that either actual malice—ill will—or implied malice—reckless disregard for the truth or falsity of the slanderous element of a statement—will suffice to disregard the qualified privilege.⁹² The court said "[p]rofessional disagreement over the appropriate standard of care does not per se constitute malice, either express or implied."⁹³ And in construing the HCQIA, one commentator has concluded that "the test for good faith under the [Federal] Act . . . should be interpreted as 'reasonable belief,' a standard consistent with the 'rule of reason' test typically used in health care antitrust actions."⁹⁴

Nor has California case law been clear about what constitutes a peer review committee's lack of reasonable effort as a basis for denying immunity. Just as the term malice must be defined, the requirement that the committee act only after reasonable effort to obtain the facts and with a

Gannon, 257 Cal. Rptr. at 120 (quoting *Manguso*, 153 Cal. App. 3d at 580-81, 200 Cal. Rptr at 538-39).

88. *Scappatura v. Baptist Hosp.*, 584 P.2d 1195, 1201 (Ariz. Ct. App. 1978); see *Dworkin v. St. Francis Hosp., Inc.*, 517 A.2d 302, 304-05 (Del. Super. Ct. 1986), *appeal refused*, 521 A.2d 649 (Del. 1987).

89. *Gilbert v. Board of Medical Examiners*, 745 P.2d 617, 627 (Ariz. Ct. App. 1987).

90. *Greenfield v. Kanwit*, 546 F. Supp. 220, 227 (S.D.N.Y.), *aff'd*, 714 F.2d 113 (2d Cir. 1982).

91. *Qasem v. Kozarek*, 716 F.2d 1172, 1178-79 (7th Cir. 1983); *Ascherman v. San Francisco Medical Soc'y*, 39 Cal. App. 3d 623, 651, 114 Cal. Rptr. 681, 699 (1974) (discussing failure to provide hearing relevant to motive for exclusion).

92. *Onat v. Penobscot Bay Medical Ctr.*, 574 A.2d 872, 874 (Me. 1990) (citing *Tutle v. Raymond*, 494 A.2d 1353, 1361 (Me. 1985); *Gautschi v. Maisel*, 565 A.2d 1009, 1011 (Me. 1989)).

93. *Id.*

94. *Horner*, *supra* note 17, at 468; see F.M. Langley, *Does Medical Peer Review Immunity Exist After Patrick v. Burget? A Review of the Legal Fundamentals*, 2 U. FLA. J.L. & PUB. POL'Y 137, 164-65 (1989).

reasonable belief that their actions are justified requires clarification in the peer review setting.⁹⁵ Peer review committee members must comply with these statutory hurdles to qualify for immunity.⁹⁶

In December 1992 the Ninth Circuit Court of Appeals considered the issue of a committee's reasonable efforts in *Austin v. McNamara*.⁹⁷ Dr. Austin participated in both ad hoc and formal peer review meetings regarding his performance at Cottage Hospital.⁹⁸ The hospital initially responded by monitoring his work; later, however, his privileges were summarily suspended.⁹⁹ The hospital's bylaws provided an appellate mechanism, and Dr. Austin requested a Judicial Review Committee (JRC) hearing.¹⁰⁰ The JRC, comprised of impartial doctors and a former appellate judge, found that the hospital's suspension of Dr. Austin's privileges was unreasonable and reinstated him, subject to "procedural consultations."¹⁰¹

Due to his exoneration at the JRC hearing, Dr. Austin brought an antitrust claim in federal court. It was during the antitrust suit that the Ninth Circuit ruled on HCQIA provisions.¹⁰² Dr. Austin's privileges at Cottage Hospital were no longer at issue.¹⁰³ In looking only to the antitrust provisions of the HCQIA, the court held the applicable standard to be objective reasonableness: The "sufficiency for the basis of the defendant's actions" is the only factor a court must consider, and the alleged bad faith of participants is immaterial.¹⁰⁴ In dicta, however, the court commented on the reasonableness of the initial suspension of Dr. Austin's privileges by Cottage Hospital saying, "the refusals to 'cover' and, possibly, the verbal attacks cannot be brought within HCQIA's immunity."¹⁰⁵ This dictum indicates that the Ninth Circuit may find two levels of analysis within the HCQIA: one level, with an objective reasonableness standard for antitrust actions; and another, with a subjective reasonableness standard, for peer review actions.¹⁰⁶

95. See Nodzinski, *supra* note 27, at 374-75.

96. CAL. CIV. CODE § 43.7 (West 1982 & Supp. 1993).

97. 979 F.2d 728 (9th Cir. 1992).

98. *Id.* at 731-32.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.* at 732.

103. *Id.*

104. *Id.* at 734.

105. *Id.* at 738.

106. Although the suspension was "unreasonable," the court found it to be a "different question of 'reasonableness,' . . . than the issue of whether the defendants acted in the 'reasonable belief that the [suspension] was warranted by the facts known after reasonable effort to

B. California Case Law

Although no case law in California defines malice in the peer review context, California law has long recognized the need to balance a doctor's right to practice his or her profession against a hospital's obligation to ensure quality patient care. For example, in *Anton v. San Antonio Community Hospital*,¹⁰⁷ the California Supreme Court declared that a doctor's right to maintain hospital privileges at a hospital where he or she had such privileges is a "fundamental right."¹⁰⁸

California common law after *Anton* recognized a substantive due process right of a physician to practice his or her profession and developed criteria, tied to patient care, for exclusion.¹⁰⁹ Additionally, a procedural due process component of California case law also developed, establishing the process for excluding a doctor.¹¹⁰ Finally, California codified the substantive and procedural due process components of physician sanctions and, through section 809 of the California Business and Professions Code, provided immunity as a benefit to those entities complying with these provisions.

1. Duty to evaluate physician qualifications

In *Elam v. College Park Hospital*,¹¹¹ the Fourth District Court of Appeal imposed a duty on hospitals to ensure reasonable procedures to review and evaluate the qualifications of physicians.¹¹² The duty gives rise to corporate liability if breached.¹¹³ Thus, the *Elam* court imposed liability on a hospital if the hospital was negligent in "screening the competency of its medical staff."¹¹⁴ Sophia Elam was a surgical patient of

obtain facts' as required by section 11112(a)(4)." *Id.* at 735 (quoting 42 U.S.C. § 11112(a)(4) (1988)).

107. 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977).

108. *Id.* at 823-25, 567 P.2d at 1174-75, 140 Cal. Rptr. at 453-55.

109. See, e.g., *Miller v. Eisenhower Medical Ctr.*, 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980); *Marmion v. Mercy Hosp. & Medical Ctr.*, 145 Cal. App. 3d 72, 193 Cal. Rptr. 225 (1983); *Miller v. National Medical Hosp.*, 124 Cal. App. 2d 81, 177 Cal. Rptr. 119 (1981).

110. *Rosenblit v. Superior Court*, 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (1991), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991); *Tiholiz v. Northridge Hosp. Found.*, 151 Cal. App. 3d 1197, 199 Cal. Rptr. 338 (1984); *Miller*, 124 Cal. App. 3d 81, 177 Cal. Rptr. 119.

111. 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

112. *Id.* at 340, 183 Cal. Rptr. at 161.

113. Marcia A. Mobilia, *Hospital Corporate Liability—Toward a Stricter Standard for Administrative Services*, in HOSPITAL LIABILITY LAW AND PRACTICE 329, 337-39 (Mary M. Bertolet & Lee S. Goldsmith eds., 1987).

114. 132 Cal. App. 3d at 346, 183 Cal. Rptr. at 165. For a more complete discussion of the implications of *Elam*, see Biricki, *supra* note 86.

Dr. Martin Schur, a podiatrist.¹¹⁵ College Park Hospital had granted Dr. Schur staff privileges without inquiring into his malpractice history.¹¹⁶ Moreover, after discovering that Dr. Schur had been named in at least one malpractice suit, the hospital failed to conduct a review to ensure that his medical care was within the hospital's standards.¹¹⁷ The *Elam* court held that the hospital's "failure to insure the competence of its medical staff through careful selection and review creates an unreasonable risk of harm to its patients."¹¹⁸

California courts, however, have been careful to protect physicians from overzealous review committees. Though *Elam* requires hospitals to be diligent in reviewing physician qualifications, safeguards exist to ensure that hospitals do not arbitrarily deny privileges to a qualified physician.¹¹⁹ The hospital's, HMO's, or IPA's decisions must be based on the physician's professional competence—or lack thereof—and may not be arbitrary or capricious.¹²⁰

2. Duty to provide fair procedures

In *Ascherman v. San Francisco Medical Society*,¹²¹ the court determined that the defendant hospital improperly denied staff privileges to Dr. Ascherman, a surgeon.¹²² Dr. Ascherman had been a member of the hospital staff for approximately two years when his privileges were withdrawn.¹²³ During his tenure, he had admitted over 100 patients to the hospital.¹²⁴ Dr. Ascherman received no notice that the hospital was considering withdrawing his privileges, nor was he told that he had been dismissed.¹²⁵ In fact he learned of the hospital's action when a patient he

115. *Elam*, 132 Cal. App. 3d at 336, 183 Cal. Rptr. at 158.

116. *See id.*

117. *Id.* at 336-37, 183 Cal. Rptr. at 158.

118. *Id.* at 341, 183 Cal. Rptr. at 161.

119. *See, e.g., Ezekial v. Winkely*, 20 Cal. 3d 267, 572 P.2d 32, 142 Cal. Rptr. 418 (1977) (holding right to practice profession is protected from arbitrary interference); *Rosner v. Eden Township Hosp. Dist.*, 58 Cal. 2d 592, 375 P.2d 431 (1962) (holding hospital privilege denial must relate to quality of patient care); *Ascherman v. St. Francis Memorial Hosp.*, 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975) (finding decisions must be rendered pursuant to minimal requisites of fair procedures required by established common-law principles); *Wyatt v. Tahoe Forest Hosp. Dist.*, 174 Cal. App. 2d 709, 345 P.2d 93 (1959) (requiring present cause to deny applicant privileges).

120. *Miller v. Eisenhower Medical Ctr.*, 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980).

121. 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974).

122. *Id.*

123. *Id.* at 655, 114 Cal. Rptr. at 701-02.

124. *Id.*

125. *Id.* at 656, 114 Cal. Rptr. at 702-03.

sent to the hospital was denied admission.¹²⁶ The hospital subsequently told Dr. Ascherman he had been eliminated because of overcrowding.¹²⁷ It then denied his request for a hearing on the basis that the hospital bylaw requiring a hearing applied only in cases of dismissal or demotion and did not apply to the hospital's decision not to renew a staff doctor's privileges.¹²⁸

Generally, California courts will not second guess the actions of a hospital in disciplining a physician;¹²⁹ judicial review is limited to ensuring that the doctor received a fair hearing. In reviewing the process, the courts consider: (1) whether there was an impartial hearing panel; (2) the adequacy of notice; (3) the doctor's opportunity to respond; (4) the doctor's opportunity to present a defense; and (5) the doctor's opportunity to confront and examine witnesses.¹³⁰ Courts do not require that the proceeding contain all the elements of a court trial or that it resemble a formal hearing; instead the focus is on whether the doctor had a reasonable opportunity to respond.¹³¹ For instance, *Tiholiz v. Northridge Hospital Foundation*¹³² involved a hospital that suspended a doctor's privileges for 120 days for violating hospital bylaws requiring him to personally examine and care for inpatients.¹³³ The court held that the hospital's suspension of the doctor satisfied the requirements of "fair procedure"¹³⁴ even though Dr. Tiholiz was given only an informal opportunity, which he declined, to explain his actions prior to the disciplinary action.¹³⁵

The court in *Ascherman* was unwilling to permit a hospital to act entirely on hearsay information, without any further check of hospital records or independent corroboration.¹³⁶ The court determined that Franklin Hospital had failed to obtain and review hospital charts; in-

126. *Id.*

127. *Id.*

128. *Id.*

129. *See, e.g.,* *Pick v. Santa Ana-Tustin Community Hosp.*, 130 Cal. App. 3d 970, 182 Cal. Rptr. 85 (1982); *Miller v. National Medical Hosp., Inc.*, 124 Cal. App. 3d 81, 177 Cal. Rptr. 119 (1981).

130. *See Rosenblit v. Superior Court*, 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819, 824-27 (1991), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991); *Hackenthal v. California Medical Ass'n*, 138 Cal. App. 3d 435, 442, 187 Cal. Rptr. 811, 815 (1982).

131. *Rhee v. El Camino Hosp. Dist.*, 201 Cal. App. 3d 477, 488, 247 Cal. Rptr. 244, 249 (1988) (quoting *Pinkster v. Pacific Coast Soc'y of Orthodontists*, 12 Cal. 3d 541, 555, 526 P.2d 253, 263, 116 Cal. Rptr. 245, 255 (1974)).

132. 151 Cal. App. 3d 1197, 199 Cal. Rptr. 338 (1984).

133. *Id.* at 1200-01, 199 Cal. Rptr. at 340.

134. *Id.* at 1203, 199 Cal. Rptr. at 341.

135. *Id.*, 199 Cal. Rptr. at 341-42.

136. 39 Cal. App. 3d at 651, 114 Cal. Rptr. at 699.

stead, the hospital took the charges at face value and did not renew Dr. Ascherman's privileges.¹³⁷ The court found that the hospital was obligated to provide a proper hearing.¹³⁸

Additionally, California courts have long held that hospitals should not use stale charges of misconduct as a basis for disciplinary proceedings. For instance, in *Wyatt v. Tahoe Forest Hospital District*,¹³⁹ the court ruled that a physician or surgeon who is currently licensed to practice and in good standing cannot be denied the right to practice merely because of past conduct that subjected him or her to disciplinary action.¹⁴⁰ Dr. Wyatt's license had been revoked for performing abortions but was reinstated in 1940.¹⁴¹ According to the court, the hospital should consider "not [the] licensee's wrongful conduct in the past, but whether or not at the time of his application for staff membership he is competent in his field and worthy in character and professional ethics."¹⁴² Thus, if an applicant is to be excluded, it must be for recent violations or currently existing cause.¹⁴³

Finally, California courts have held that the record must demonstrate that the hospital's investigation was "dispassionate and thorough."¹⁴⁴ California Business and Professions Code section 809 provides a series of procedures to ensure that the disciplinary process comports with due process requirements.¹⁴⁵ Recently, for example, the court explored current fair procedures status in *Rosenblit v. Superior Court*.¹⁴⁶ Dr. Rosenblit was an endocrinologist who was summarily suspended from Fountain Valley Regional Hospital and Medical Center.¹⁴⁷ First, the hospital alleged that Dr. Rosenblit had left the hospital for seven days—a four day vacation, plus a three day medical conference—without arranging for another physician with privileges at the hospital to attend to his hospitalized patients.¹⁴⁸ This allegation was untrue.¹⁴⁹ Second,

137. *Id.*

138. *Id.*

139. 174 Cal. App. 2d 709, 345 P.2d 93 (1959).

140. *Id.* at 714, 345 P.2d at 96.

141. The abortions were performed during the 1930s and 1940s. *Id.* at 711, 345 P.2d at 95.

142. *Id.* at 714, 345 P.2d at 96.

143. *Id.*

144. *Ascherman*, 39 Cal. App. 3d at 656, 114 Cal. Rptr. at 702.

145. CAL. BUS. & PROF. CODE § 809 (West 1990 & Supp. 1993).

146. 231 Cal. App. 3d 1434, 1442-49, 282 Cal. Rptr. 819, 823-28 (1991), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991).

147. *Id.* at 1438, 282 Cal. Rptr. at 820.

148. Amicus Brief of California Medical Association in Support of Petitioner-Appellant at 1, *Rosenblit v. Superior Court*, 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (1991) (No. 58-78-77), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991).

149. *Id.*

the hospital stated that Dr. Rosenblit's care of thirty patients had been substandard.¹⁵⁰ Dr. Rosenblit, however, was suspended *before* any decision was made on the merits of his case.¹⁵¹ Indeed, the court of appeal concluded that Dr. Rosenblit, although he had received a hospital hearing and appellate review, did not have a proper, fair adjudication on the merits.¹⁵²

The court endorsed the reasoning set forth in the amicus brief of the California Medical Association,¹⁵³ which described Dr. Rosenblit's plight:

Most troublesome is the fact that this physician was never offered an opportunity to copy the medical records in the thirty cases. This basic unfairness was compounded by numerous other problems. First, Dr. Rosenblit never got a Notice of Charges which set forth specifically what aspects of his care in each of the thirty cases was alleged to be substandard. Second, the hearing officer conducted voir dire of the hearing panel off the record, in secret. Third, Dr. Rosenblit was required to bear the burden of proving his "innocence," an unfair burden made even more onerous not only by the lack of adequate notice of the charges and access to the medical records, but also by the actions of the hearing officer. For example, Dr. Kravitz, the "prosecutor," repeatedly stated that there were numerous medical journal articles that contradicted the articles which Dr. Rosenblit presented to defend his care, yet the hearing officer never required that even a single such journal article be introduced or even named. . . . We file this brief to bring to the Court's attention the profound importance of fair peer review for the delivery of quality patient care in this State.¹⁵⁴

After reviewing the trial record, the court stated that "[t]he record demonstrates [Fountain Valley] Hospital was dedicated to removing Rosenblit rather than providing a physician with a fair opportunity to defend his treatment regimen. [The] [h]ospital resisted fair treatment at every crucial step of the proceedings."¹⁵⁵ Emphasizing the importance of procedural fairness in peer review actions, the court of appeal chastised the

150. *Rosenblit*, 231 Cal. App. 3d at 1438, 282 Cal. Rptr. at 820.

151. *Id.*

152. *Id.* at 1445-49, 282 Cal. Rptr. at 825-28.

153. *Id.* at 1438, 282 Cal. Rptr. at 820 ("Having independently reviewed the fairness of the administrative proceedings as a question of law, we agree with CMA and reverse.")

154. Amicus Brief of California Medical Association in Support of Petitioner-Appellant at 1-2, *Rosenblit* (No. 58-78-77).

155. *Rosenblit*, 231 Cal. App. 3d at 1448, 282 Cal. Rptr. at 826-27.

hospital, pointing to the "notable stench of unfairness" which surrounded the entire sequence of events in the hospital's handling of Dr. Rosenblit.¹⁵⁶

3. Disciplinary actions must be related to medical care

In *Miller v. Eisenhower Medical Center*,¹⁵⁷ the California Supreme Court determined that a hospital's rule permitting exclusion from staff membership solely on the basis of a physician's inability "to work with others"¹⁵⁸ required a showing that the doctor posed a "real and substantial danger" to the quality of medical care.¹⁵⁹ The court held that exclusion was improper because the hospital could not establish a direct link between Dr. Miller's "controversial" and "flamboyant" personality,¹⁶⁰ his alleged propensity for litigation,¹⁶¹ and his readiness to express views on treatment practices of other doctors and on hospital administrative matters¹⁶² and their potential effect on patient care.¹⁶³

Generally, "[c]ourts will examine the standards used as the basis for corrective action to determine if they were irrational or susceptible to arbitrary or discriminatory application."¹⁶⁴ Thus, a hospital must present evidence that demonstrates a real and substantial threat to high quality medical care; otherwise, the courts are likely to overturn a hospital's disciplinary action.¹⁶⁵

However, when a hospital has compelling patient care reasons for denying staff privileges to a physician, California courts have been very willing to endorse the hospital's decision. Thus, in *Cipriotti v. Board of Directors of Northridge Hospital Foundation Medical Center*,¹⁶⁶ the court held that substantial evidence warranted the suspension of Dr. Cipriotti, a psychiatrist, from the staff of a private hospital.¹⁶⁷ The hospital concluded that Dr. Cipriotti's misconduct affected his and the hospital's

156. *Id.* at 1445, 282 Cal. Rptr. at 825. The facts of this case are discussed at length in the sections of this Comment that follow.

157. 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980).

158. *Id.* at 621, 614 P.2d at 261, 166 Cal. Rptr. at 829.

159. *Id.* at 629, 614 P.2d at 267, 166 Cal. Rptr. at 835.

160. *Id.* at 631, 614 P.2d at 268, 166 Cal. Rptr. at 836.

161. *Id.*

162. *Id.*

163. *Id.*

164. A. Robert Singer & Steven V. Schnier, *Initiating the Peer Review Process*, in ABA FORUM COMMITTEE ON HEALTH LAW: PEER REVIEW AND THE LAW tab 2, at 12 (1986).

165. *Miller*, 27 Cal. 3d at 627, 614 P.2d at 276, 166 Cal. Rptr. at 833.

166. 147 Cal. App. 3d 144, 196 Cal. Rptr. 367 (1983).

167. *Id.* at 157, 196 Cal. Rptr. at 374.

ability to care for patients.¹⁶⁸ Dr. Cipriotti regularly violated hospital regulations requiring attendance at staff conferences,¹⁶⁹ failed to keep mandatory patient admitting histories and progress notes,¹⁷⁰ improperly supplied hospital employees with dangerous controlled substances,¹⁷¹ condoned use of controlled drugs at parties at his residence, and engaged in other inappropriate behavior.¹⁷²

Similarly, in *Miller v. National Medical Hospital of Monterey Park, Inc.*,¹⁷³ the hospital suspended Dr. Miller's staff membership pending the outcome of an appeal of his conviction for conspiracy to murder his wife.¹⁷⁴ The hospital intended to review his suspension if his conviction was "modified."¹⁷⁵ The court concluded that the hospital acted properly by suspending Dr. Miller pursuant to its bylaws. The hospital correctly established that he had violated the standards of the professional staff and acted in a disruptive manner.¹⁷⁶ The hospital reasoned that the crime of murder was incompatible with the ethical and professional goals of a physician and that, due to the widespread publicity Dr. Miller's conviction had received, his continued presence at the hospital could disrupt the hospital's operation.¹⁷⁷ Although his competency in his treatment of patients was not a factor in the hospital's decision to suspend, the court rejected Dr. Miller's contentions that: (1) the suspension could not occur until his appeals from conviction had been exhausted;¹⁷⁸ (2) the crime of conspiracy to murder one's wife was not substantially related to the qualifications, functions, and duties of a physician;¹⁷⁹ (3) the bylaws were unconstitutionally vague;¹⁸⁰ and (4) the decision to suspend him was biased.¹⁸¹

Thus, once a doctor has privileges at a California medical facility, he or she has a fundamental right to retain those privileges.¹⁸² A medical

168. *Id.* at 151, 196 Cal. Rptr. at 369.

169. *Id.* at 149, 196 Cal. Rptr. at 368.

170. *Id.*

171. *Id.*, 196 Cal. Rptr. at 368-69.

172. *Id.*

173. 124 Cal. App. 3d 81, 177 Cal. Rptr. 119 (1981).

174. *Id.* at 83, 177 Cal. Rptr. at 120-21.

175. *Id.* at 89, 177 Cal. Rptr. at 124.

176. *Id.* at 92-93, 177 Cal. Rptr. at 126.

177. *Id.*

178. *Id.* at 89, 177 Cal. Rptr. at 124.

179. *Id.* at 92-93, 177 Cal. Rptr. at 126.

180. *Id.* at 93, 177 Cal. Rptr. at 126-27.

181. *Id.* at 90-91, 177 Cal. Rptr. at 125.

182. *Anton v. San Antonio Community Hosp.*, 19 Cal. 3d 802, 823, 567 P.2d 1162, 1174, 140 Cal. Rptr. 442, 454 (1977); *see also Rhee v. El Camino Hosp.*, 201 Cal. App. 3d 477, 488, 247 Cal. Rptr. 244, 250 (1988) (holding that hospital may not deprive physician of medical

entity seeking to curtail or eliminate a doctor's established practice may do so only if it can demonstrate that the doctor's actions negatively impact patient care.¹⁸³

IV. RECOMMENDATION

A. *Factors Indicating Malice*

How can administrators charged with the task of overseeing peer review activities ensure that this process is conducted fairly? How is an attorney faced with a potential peer review abuse claim to evaluate whether or not the claim has merit? When should a judge rule that peer review participants must defend an action arising from their peer review activities? This section presents a series of factual situations that can be viewed as indicating a lack of good faith or the failure to take reasonable actions on the part of the entity conducting the peer review.¹⁸⁴ When malice (California law) or unreasonableness (Federal HCQIA) is present, the peer review members are not immune from liability and may be compelled to defend lawsuits arising from their actions.¹⁸⁵

The following indicators should be useful for three potential parties: (1) the hospital administrators, as a checklist to prevent possible abuse of discretion and subsequent litigation; (2) an attorney who is counseling a would-be doctor plaintiff to determine if his or her situation mirrors any of the established fact patterns of abuse; and (3) a judge to distinguish between pleadings that describe bona fide actions taken in the interest of quality medical care and those that appear arbitrary, capricious or discriminatory. "In this unsettled environment, peer review is a concept under siege. . . . What should not be open for question is the need for individuals involved in the process to approach peer review with caution, care and concern."¹⁸⁶

Peer review should be an ongoing activity of a properly functioning hospital medical staff. The Joint Commission for the Accreditation of Healthcare Organizations requires quality assurance programs that

staff privileges without minimal due process protection); *Marmion v. Mercy Hosp. and Medical Ctr.*, 145 Cal. App. 3d 72, 90, 193 Cal. Rptr. 225, 236 (1983) (holding that due process and common-law right to fair procedure require that doctor be given notice when hospital is contemplating terminating physician's residency).

183. *Miller v. Eisenhower Medical Ctr.*, 27 Cal. 3d 614, 631-32, 614 P.2d 258, 269, 166 Cal. Rptr. 826, 837 (1980).

184. Factual situations are taken from cases in which the courts reviewing the actions of the peer review committee or hospital administration found improprieties.

185. See, e.g., *Langley*, *supra* note 94, at 181; *Nodzinski*, *supra* note 27, at 373; *Creech*, *supra* note 61, at 197.

186. *Singer & Schnier*, *supra* note 164, at 3.

achieve high quality medical care through "monitoring and evaluation of the quality and appropriateness of patient care."¹⁸⁷ Explicit peer review of objective parameters to identify circumstances at variance with established criteria may arise from: "the surgical review committee, which reviews surgical procedures; the pharmacy and therapeutics committee, which reviews drug use; the records committee, which reviews compliance with requirements for timely, complete documentation; the blood usage review committee; the antibiotic usage review committee; and similar committees [for] other functions."¹⁸⁸ Through this ongoing quality assurance process the goal is "to identify trends or patterns of care that may not be evident when only case-by-case review is performed."¹⁸⁹

In order to protect a doctor from unjust attacks on his or her professional reputation and livelihood while supporting legitimate peer review, courts will be obligated to try Doctor v. Committee suits to sort out the underlying facts. It is possible, however, that some of the litigation might be resolved at an earlier stage if the parties know at the onset what factors the court and jury might consider in determining whether abuse has occurred.

1. Complaint is outside normal channels

One of the first indications that a peer review action has begun in bad faith or with malice is that the complaint does not originate in the normal course of medical staff peer review quality assurance functions.¹⁹⁰ If the quality assurance system is working properly, patterns of questionable judgment or medical malpractice will emerge and be identified by the quality assurance team.¹⁹¹ The complaint that originates and is pursued from outside the normal quality assurance procedures is, therefore, generally suspect.

An exception to this general rule occurs when a physician witnesses questionable medical practice and brings it to the attention of the proper

187. ACCREDITATION MANUAL, *supra* note 2, at 115.

188. MILLER, *supra* note 2, at 114.

189. ACCREDITATION MANUAL, *supra* note 2, at 218.

190. *Cf.* Bolt v. Halifax Medical Ctr., 891 F.2d 810, 821 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990) (involving complaint not pursued through established peer review procedures); Havighurst, *supra* note 13, at 1130 (discussing proper peer review as collecting and disseminating information to appropriate decision makers).

191. *Cf.* Nodzinski, *supra* note 27, at 397-99 (presenting method to approach peer review as scientific activity and not as political, economic, or social pressures response).

authorities.¹⁹² The case *Rhee v. El Camino Hospital*¹⁹³ provides an example of how this element functions properly. Dr. Rhee was a new surgeon who applied for surgical privileges at El Camino Hospital.¹⁹⁴ Proctors were assigned to review his work and make recommendations regarding whether to grant Dr. Rhee privileges. One of the assigned proctors questioned Dr. Rhee's qualifications because of techniques he observed Dr. Rhee using during surgery.¹⁹⁵ The proctor notified the quality assurance team, which then met, reviewed the information, and took corrective action by counseling Dr. Rhee.¹⁹⁶ New proctors then monitored Dr. Rhee's surgeries and these proctors were asked to provide the committee with feedback.¹⁹⁷

This case exemplifies good faith peer review actions. The hospital's internal review process eventually culminated in the curtailment of Dr. Rhee's surgical privileges,¹⁹⁸ after considerable effort to help him meet the hospital's quality of care standards had been made.¹⁹⁹ Demonstrative also of the hospital's good faith is that Dr. Rhee's practice at El Camino Hospital was restricted but not eliminated.²⁰⁰

In *Bolt v. Halifax Hospital Medical Center*,²⁰¹ Dr. Bolt was also a new surgeon. He received staff privileges and began a successful practice at three Florida hospitals. Dr. Bolt questioned the care rendered by an older surgeon, Dr. Smith.²⁰² Subsequently, he found his own surgical practice under scrutiny,²⁰³ and this resulted in the revocation of his privileges at all three hospitals.

Dr. Bolt's case underscores the fact that an abnormal origination of a complaint may be motivated by a lack of good faith. Complaints that

192. This particular factor, the genesis of the complaint, should not be read to preclude the hospital or medical staff from choosing to review charts when a doctor is charged with malpractice—no matter how that information reaches the hospital. In fact, the hospital is under a duty to do so. See *supra* part III.B.1; see also *People v. Memorial Medical Ctr.*, 234 Cal. App. 3d 363, 389, 286 Cal. Rptr. 478, 494 (1991) (holding that court could review in camera peer review documents to evaluate charges of criminal negligence).

193. 201 Cal. App. 3d 477, 247 Cal. Rptr. 244 (1988).

194. *Id.* at 483, 247 Cal. Rptr. at 246.

195. *Id.*

196. New proctors were assigned to eliminate the possibility of a biased proctor and to allow Dr. Rhee a "fresh" chance. *Id.* at 485-86, 247 Cal. Rptr. at 248.

197. *Id.*

198. Dr. Rhee's surgical privileges were limited to specific, approved operations. *Id.* at 486, 247 Cal. Rptr. at 248.

199. *Id.*

200. *Id.*

201. 891 F.2d 810 (11th Cir.), cert. denied, 495 U.S. 924 (1990).

202. *Id.* at 821 n.16.

203. See *id.* at 817.

originate outside the hospital's established quality assurance functions are inherently suspect and should receive intensified review by the hospital and later by the courts. Although colleagues naturally have the best opportunity to review a doctor's work, concerns must be pursued through the established hospital procedures.²⁰⁴ Any charges emanating from a specific colleague should be reviewed for personal animus. Charges that arise from one doctor's desire to do another doctor harm fit squarely into the classic definition of malice.²⁰⁵ Therefore, it is conceivable that even in cases where patient care has been compromised, the doctor's motive for exposing it will defeat the peer review immunity provision.²⁰⁶

Additionally, this component of the analysis should also include the *recency* of the alleged questionable care. Peer review that relies on cases dredged up from years gone by must also be suspect.²⁰⁷

In summary, the initial inquiry for evaluating lack of good faith should consider the origin of the charges and the dates of the alleged quality of care incidents. Accusations regarding long-past conduct or originating outside established quality assurance functions are suspect and should be subjected to heightened review.

204. See American College of Physicians, *American College of Physicians Ethics Manual*, 117 ANNALS INTERNAL MED. 947 (1992), which provides the following guidelines for peer review:

It is unethical for a physician to disparage the professional competence, knowledge, qualifications, or services of another physician . . . without substantial evidence

. . . .

Of equal importance, it is unethical for a physician *not* to report fraud, professional misconduct, incompetence, or abandonment of a patient by another physician. . . .

. . . [I]n the absence of substantial evidence of professional misconduct, negligence, or incompetence, it is unethical to use the peer review process to exclude another physician from practice, to restrict clinical privileges, or to otherwise harm the physician's practice.

Id. at 956.

205. See *supra* note 61 for definitions of "malice" and "good faith."

206. *Austin v. McNamara*, 979 F.2d 728, 738 (9th Cir. 1992). The court commented that some of the conduct of the other doctors on the medical staff was not "within the HCQIA's immunity." *Id.* The doctors had refused to provide coverage of Dr. Austin's patients and had made verbal attacks on his professional competence to nurses and patients. *Id.*

207. *Cf. Wyatt v. Tahoe Forest Hosp.*, 174 Cal. App. 2d 709, 711, 345 P.2d 93, 95 (1959) (hospital attempting to rely on past revocation of license for performing abortions to deny privileges); *supra* notes 9, 26 and accompanying text (providing several accounts of physicians challenged for reasons unrelated to patient care).

2. Initial actions taken

The second factor indicative of good or bad faith in the peer review process focuses on the hospital's reaction to the initial allegations.²⁰⁸ How did the administration handle initial complaints and concerns? Was the doctor considered competent until proven incompetent, or was he or she considered incompetent—that is, summarily suspended or privileges revoked—until proven competent? Were the actions taken designed to ensure patient care as well as to maintain the practice of the doctor?

Situations in which the hospital or medical group's initial action is absolute expulsion from the hospital or from a subspecialty practice must be suspect. For instance, in *Rosenblit v. Superior Court*,²⁰⁹ the doctor was summarily suspended without any review of the allegations.²¹⁰ The appellate court later concluded that the hospital's actions were dedicated to removing him.²¹¹

The initial reaction of the health care delivery system to complaints about a doctor's care should be to investigate the matter.²¹² Whether this investigation should be by a committee comprised of colleague physicians or an independent physician review group is worthy of consideration.²¹³ Moreover, use of independent review committees assures all concerned of the most objective evaluation of the doctor's care.²¹⁴ Following the investigation, if concerns remain about the quality of the doctor's care, the hospital should consider the following additional steps before sanctioning a physician: education or training to correct the problem, mandatory consultations with other doctors, monitoring by qualified specialist physicians of certain procedures, or limitations or restrictions on the doctor's practice or procedures. Courts have gener-

208. See *Anton v. San Antonio Community Hosp.*, 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977); *Rosenblit v. Superior Court*, 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (1991), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991); *Tiholiz v. Northridge Hosp. Found.*, 151 Cal. App. 3d 1197, 199 Cal. Rptr. 338 (1984); *Hackenthal v. California Medical Ass'n*, 138 Cal. App. 3d 435, 187 Cal. Rptr. 811 (1982); *Appelbaum v. Board of Directors*, 104 Cal. App. 3d 648, 163 Cal. Rptr. 831 (1980).

209. 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819.

210. *Id.*, 282 Cal. Rptr. at 820.

211. *Id.* at 1448, 282 Cal. Rptr. at 826-27.

212. When the initial investigation indicates "imminent danger to the health of any individual," the HCQIA and California law provide for an immediate suspension. 42 U.S.C. § 11112(c)(b)(2) (1988); CAL. BUS. & PROF. CODE § 809.5(a) (West 1990 & Supp. 1993).

213. See William F. Minogue, *Who Speaks for the Patient?*, in *MEDICAL QUALITY AND THE LAW*, *supra* note 70, at 9, 11 (recommending independent peer review because "[e]ven in larger hospitals, internal peer review is full of legitimate impediments").

214. Nodzanski, *supra* note 27, at 401-05; see also SPENCER VIBBERT, *THE DOCTOR WATCHERS* (1991) (describing Federal Medicare Peer Review Organization program).

ally upheld hospital decisions to institute remedial actions.²¹⁵ These informal action plans may preclude the need to institute costly formal hearing procedures that generally must follow any revocation or reduction of staff privileges.

The hospital must make reasonable efforts to ascertain the facts and ensure that the allegations are rooted in patient care issues.²¹⁶ Once this has been determined, the hospital must provide the doctor with procedural due process.²¹⁷

3. Lack of due process

A third factor indicating bad faith is the denial of procedural protections to the accused physician.²¹⁸ In the peer review setting, due process requires both adequate notice of the accusations and a reasonable opportunity to respond to them.

a. notice

*Rosenblit v. Superior Court*²¹⁹ firmly established the requirement that the charges must detail the specific acts or omissions alleged to have negatively impacted the patient's care.²²⁰ In *Rosenblit*, the hospital listed thirty charts and gave a vague reference that fluid management, diabetic management, or clinical judgment was questioned in each one.²²¹ The court found that the hospital had not provided adequate notice to Dr. Rosenblit because the vagueness of the charges required him to painstakingly "uncover the basis and scope of the allegations."²²² In order to give the doctor an adequate opportunity to respond to the allegations, the

215. *E.g.*, *Suckle v. Madison Gen. Hosp.*, 499 F.2d 1364 (7th Cir. 1974) (requiring one year in postgraduate neurosurgical training); *Rhee v. El Camino Hosp.*, 247 Cal. App. 3d 477, 483-86, 247 Cal. Rptr. 244, 246-48 (1988) (limiting practice to specific surgical procedures); *see also Hays v. Scripps Memorial Hosp.*, 183 Cal. App. 3d 753, 288 Cal. Rptr. 416 (1986) (requiring obstetrics training program to perform dilation and curettage).

216. *See supra* part III.B.3.

217. *See infra* part IV.A.3.

218. *See Qasem v. Kozarek*, 716 F.2d 1172, 1177 (7th Cir. 1983) (finding reversible error when trial court did not inform jury of procedural elements that should have been considered in determining if peer review committee member acted in good faith).

219. 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (1991), *review denied*, No. G008913, 1991 Cal. LEXIS 4251 (Sept. 19, 1991).

220. *See id.* at 1445-46, 282 Cal. Rptr. at 825.

221. *Id.*

222. *Id.* at 1446, 282 Cal. Rptr. at 825.

court proposed that the notice of charges²²³ include the "specific acts or omissions which allegedly harmed his patients."²²⁴

As the *Rosenblit* court suggested, hospitals must tell physicians not only what aspect of their patient care is questioned, but also why it is questioned. When a doctor is given a notice of charges, the following six criteria should be provided for *each instance* of alleged improper care:²²⁵

(1) *Each patient's name and hospital chart number.*²²⁶ This information allows the physician to locate the proper chart and his or her own records.

(2) *The date of the alleged act or omission.*²²⁷ This detail assists the physician in evaluating his or her own conduct and in making appropriate information available to the experts to reevaluate the treatment event in question.

(3) *The specific act or omission of alleged substandard care.*²²⁸ This indication allows the physician to understand exactly what part of his or her care is being questioned.

(4) *The resulting negative impact on the patient's outcome.*²²⁹ Specifically, the reviewing entity must provide its opinion of the patient's

223. The hospital must notify the doctor that it questions his or her care and is contemplating disciplinary action:

A physician who is the subject of peer review . . . is entitled to written notice

The notice must state that an action against the physician has been proposed

The notice must also state the nature of the proposed action, that the physician has a right to request a hearing . . . and the time within which to request such a hearing.

HANSON ET AL., *supra* note 60, at 17:3. "If a hearing is requested, the peer review body must give the physician written notice stating the reasons for the proposed action, including the acts or omissions with which the physician is charged." *Id.*

224. *Rosenblit*, 231 Cal. App. 3d at 1446, 282 Cal. Rptr. at 825. It is also noteworthy that the California Medical Association filed an amicus curiae brief in this suit on Dr. Rosenblit's behalf. Amicus Brief of California Medical Association in Support of Petitioner-Appellant at 1, *Rosenblit* (No. 58-78-77).

225. See *HCQIA Hearings*, *supra* note 1, at 80-81 (testimony of Victor M. Glasberg); Dans, *supra* note 69, at 567 (discussing prescriptions for improving peer review); J. Robert Liset, *Conducting the Hearing: Legal Requirements and Practical Solutions*, in ABA FORUM ON HEALTH LAW, *supra* note 164, tab 3, at 11 (providing criteria for notice of charges).

226. See *Rosenblit*, 231 Cal. App. 3d at 1444, 282 Cal. Rptr. at 824.

227. *Cf. id.* at 1445, 282 Cal. Rptr. at 825 (describing Rosenblit's pleas that "guesswork" be eliminated).

228. See *HCQIA Hearings*, *supra* note 1, at 80-81 (testimony of Victor M. Glasberg relaying charges: "Here are 30 charts, they demonstrate you used bad medical judgment. . . . It is like telling a lawyer who has a trial record this thick, we reviewed your record, you exercised bad legal judgment. In what regard? How? When? In what particular?"); *Rosenblit*, 231 Cal. App. 3d at 1444, 282 Cal. Rptr. at 824 (remarking on "six letters pleading for a description of the acts or omissions").

229. *Cf. Rosenblit*, 231 Cal. App. 3d at 1447, 282 Cal. Rptr. at 826 (criticizing hospital's failure to provide "description of how Rosenblit endangered the patients entrusted to his care").

expected outcome and how the actual outcome differed because of the challenged doctor's act or omission.

This requirement allows the physician, expert witnesses, and physician's lawyer to know why the care is being questioned, and it also comports with California's medical malpractice law.²³⁰ In order to sustain an action for medical malpractice, the "evidence must be sufficient to infer that in the absence of defendant's negligence, there was a reasonable medical probability that plaintiff would have obtained a better result."²³¹ Additionally, California malpractice standards note that an "error in medical judgment is not considered in a vacuum but must be weighed in terms of the professional standard of care."²³²

(5) *The objective standard of preferred treatment to which the doctor's care is being compared.* Citations to relevant medical articles indicating the origin or support for the preferred treatment should be included.²³³ This information will enable the physician to identify and collect support for other methods of treatment, including the physician's own. Moreover, the hospital should be required to establish that the physician deviated from normal treatment procedures:

[I]n order to judge a physician's performance in any particular case, the norms of care for the condition in question must be identified. For peer review to be effective, a group of practitioners must be able to "predict what the outcomes should be for patients of a certain age and general health status with a particular diagnosis, if optimal achievable care is provided."²³⁴

One of the flaws recognized in *Rosenblit* was the hospital's failure to support—for example, through medical articles—its position that Dr. Rosenblit's treatment was erroneous;²³⁵ hospitals should be required to support their positions at the earliest possible occasion.

(6) *A proposed plan to correct such problems, including, for example, education, consultation, monitoring, or restriction of privileges.*²³⁶ Including these details in the notice of charges would show not only the hospi-

230. Cf. Havighurst, *supra* note 76, *passim* (proposing use of national guidelines as malpractice standards and as guidelines for peer review oversight generally).

231. *Alef v. Alta Bates Hosp.*, 5 Cal. App. 4th 208, 216, 6 Cal. Rptr. 2d 900, 905 (1992), review denied, No. S026727, 1992 Cal. LEXIS 330 (June 25, 1992).

232. *Fraijo v. Hartland Hosp.*, 99 Cal. App. 3d 331, 160 Cal. Rptr. 246 (1979).

233. Cf. Amicus of Brief California Medical Association in Support of Petitioner-Appellant at 1-2, *Rosenblit* (No. 58-78-77) (commenting on hospital's failure to support its position with medical journal articles).

234. Nodzinski, *supra* note 27, at 396-97 (footnotes omitted).

235. See Amicus Brief at 1-2, *Rosenblit* (No. 58-78-77).

236. Cf. Dans, *supra* note 69, at 567 (describing need for reeducation system and suggesting refresher mini-residencies).

tal's good faith intention to resolve patient care concerns in a mutually agreeable manner, but would also provide the doctor with some indication of the hospital's view of the seriousness of the charges.

b. opportunity to be heard

The second element of due process that courts should consider is whether the physician had an opportunity to respond to the allegations.²³⁷ This consideration encompasses not only that the physician has an opportunity, but that the opportunity is before fair adjudicators.²³⁸ For example, in *Rosenblit*, the court found that the selection of the hearing officer, the "jury" panel, and reviewers was all tainted.²³⁹ In *Appelbaum v. Board of Directors*,²⁴⁰ the court held that a physician subjected to a professional disciplinary hearing must be granted the right to an impartial tribunal.²⁴¹ In *Hackenthal v. California Medical Ass'n*,²⁴² the court added that the physician must be given the ability to meaningfully test the biases, if any, of the individuals who will hear and decide the charges against him.²⁴³

Specifically, California Business and Professions Code section 809.2 details the elements of a fair peer review hearing.²⁴⁴ The provisions include the right to an unbiased trier of fact and hearing officer; access to all the documentary evidence to be presented at the hearing; the right to have a record of the hearing; and the right to call, examine, and cross-examine witnesses.²⁴⁵

237. *Anton v. San Antonio Community Hosp.*, 19 Cal. 3d 802, 815, 567 P.2d 1162, 1168, 140 Cal. Rptr. 442, 448 (1977); *Rosenblit*, 231 Cal. App. 3d at 1441, 282 Cal. Rptr. at 823; *Tiholiz v. Northridge Hosp. Found.*, 151 Cal. App. 3d 1197, 1202, 199 Cal. Rptr. 338, 341 (1984); *Hackenthal v. California Medical Ass'n*, 138 Cal. App. 3d 435, 442, 187 Cal. Rptr. 811, 815 (1982); *Appelbaum v. Board of Directors*, 104 Cal. App. 3d 648, 658-59, 163 Cal. Rptr. 831, 837 (1980).

238. *Rosenblit*, 231 Cal. App. 3d at 1447, 282 Cal. Rptr. at 826; *Hackenthal*, 138 Cal. App. 3d at 444, 187 Cal. Rptr. at 816; *Appelbaum*, 104 Cal. App. 3d at 657, 163 Cal. Rptr. at 836.

239. *Rosenblit*, 231 Cal. App. 3d at 1448, 282 Cal. Rptr. at 826-27. The hearing panel conducted a private voir dire, and the committee chairman was a treating physician for one of the cases under investigation. *Id.*

240. 104 Cal. App. 3d 648, 163 Cal. Rptr. 831 (1980).

241. *Id.* at 659, 163 Cal. Rptr. at 837-38.

242. 138 Cal. App. 3d 435, 187 Cal. Rptr. 811 (1986).

243. *Id.* at 442, 187 Cal. Rptr. at 815.

244. CAL. BUS. & PROF. CODE § 809.2 (West 1990).

245. HANSON ET AL., *supra* note 60, at 17:3-4.

4. Unequal treatment

A fourth factor indicating bad faith is the disparate treatment of one doctor as compared to the doctor's colleagues.²⁴⁶ In *Bolt v. Halifax Hospital Medical Center*²⁴⁷ the court found reversible error when the trial court failed to allow the testimony of Dr. Bolt's expert.²⁴⁸ The expert, who was chair of the University of Florida's surgery department, intended to testify that "the conclusions [of the peer review committee] were so baseless that no reasonable medical practitioner, considering the same set of facts, could have reached those conclusions."²⁴⁹ From such testimony the jury arguably could have inferred that the peer review committee had an unreasonable and illegitimate intent.²⁵⁰ The court concluded that "the district court erred in prohibiting Dr. Bolt from introducing evidence that the peer review proceedings were a sham and that the . . . defendants' reasons for revoking his staff privileges were pretexts."²⁵¹

Taken from the defendant's point of view, the facts of the *Bolt* case are essentially that a doctor who criticized the care of another doctor is the one who is subjected to microscopic peer review and it is *that doctor*, not the doctor whose competence he called into question, whose privileges are revoked.²⁵² In this instance the expert also intended to speak to the competence, or in his opinion incompetence, of the care provided in the case that Dr. Bolt called into question.²⁵³

Thus, courts should consider whether the evaluation of a physician's competence should involve an examination of the care of other similarly situated doctors. If a hospital singles out one physician for discipline and ignores similar conduct by other physicians, it is likely that the hospital is acting in bad faith.²⁵⁴ Thus, some sort of comparison may be in order.

246. *Patrick v. Burget*, 800 F.2d 1498, 1503 (9th Cir. 1986), *rev'd on other grounds*, 486 U.S. 94, 98 (1988) (findings of bad faith and improper motive not considered; peer review immunity due to state-action doctrine reversed); *cf. HCQIA Hearings*, *supra* note 1, at 82 (testimony of Victor M. Glasberg regarding need to be able to call witness to testify "you submitted charts too late, but so has three-quarters of the staff").

247. 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990). For a discussion of the facts in this case, see *supra* part IV.A.1.

248. 891 F.2d at 821.

249. *Id.*

250. *Id.*

251. *Id.* at 822.

252. *Id.* at 815.

253. *Id.* at 821.

254. *Cf. Burget*, 800 F.2d at 1503 (findings of bad faith and improper motive acknowledged but not considered; Ninth Circuit's finding of peer review immunity due to state-action doctrine was reversed by U.S. Supreme Court); *Rosenblit*, 231 Cal. App. 3d at 1447, 282 Cal.

In *Hayden v. Bracy*,²⁵⁵ Dr. Hayden alleged that his care was as good or better than other doctors in the hospital and that the records of his colleagues were relevant to his claim of malice.²⁵⁶ The Eighth Circuit Court of Appeals determined that although the other physicians' medical records were relevant, the trial court had not abused its discretion in denying discovery of such records.²⁵⁷

Nonetheless, a physician who feels his or her competency is being judged by arbitrary or capricious standards may have a means by which to demand the review of similarly situated physicians' records.²⁵⁸ In the peer review setting, it is particularly appropriate to allow the questioned doctor to demonstrate that he or she is being unfairly singled out.²⁵⁹ Such comparisons allow the doctor to demonstrate that he or she has used the same diagnostic criteria and treatment regimens as other doctors whose care has not been questioned.²⁶⁰

Disciplinary actions based on the failure to complete medical records are also illustrative of the potential for abuse. Many hospitals routinely suspend a doctor's privileges when he or she fails to accurately complete patient medical records in a timely manner.²⁶¹ Conversely, however, if a hospital chooses to focus on this common medical staff problem in a particular physician's case or to impose greater sanctions on one doctor, then that action, too, must be suspect.

Another area which lends itself to arbitrary or discriminatory peer review action is the choice of particular medical treatment regimens. A

Rptr. at 826 (finding that failure to provide copies of charts in dispute violates fair hearing rights).

255. 744 F.2d 1338 (8th Cir. 1984).

256. *Id.* at 1342.

257. *Id.*

258. Dr. Hayden was an obstetrician whose performance of cesarian sections (surgical intervention to deliver a baby) was questioned. *Id.* at 1341. It would have been relatively easy to review all cesarian section delivery records for a particular time frame to determine if Dr. Hayden's decisions to use surgical intervention—based on progression of labor and fetal health—were markedly different from his colleagues, who retained their privileges.

259. *See supra* note 26 and accompanying text.

260. In the Dr. Adams hypothetical, for instance, she might request a review of all the pericardiocentesis performed by other doctors at her facility. Theoretically, such a review would reveal that the patients of the other cardiologists had similar complications, although those doctors had not been sanctioned.

261. MILLER, *supra* note 2, at 116.

Clinical privileges are frequently temporarily suspended when physicians fail to complete medical records within time limits established by hospital policy. Suspension of admitting privileges usually continues until overdue records are completed. Physicians who do not have time to complete records do not have time to accept responsibility for additional patients. Courts have generally upheld disciplinary actions for failure to complete records.

Id.

doctor should not be subject to discipline for following a different medical school of thought than committee members. Doctors may follow alternative schools of medicine. It is a well-established legal principle that the standard of care spectrum must include all legitimate approaches to patient care.²⁶² Thus, it is important to assess whether the review committee's critique is levied at *improper* care as opposed to its view of *preferred* care.²⁶³ As the court noted in *Rosenblit*, "we are concerned with fair play and fair treatment; with a physician's right to practice his profession; with the public's right to a diversity of opinion among competent specialists and a variety of treatment options."²⁶⁴

Consequently, any time a doctor is singled out for disciplinary action based not on the quality of care he or she provides but rather on what is, in effect, the discriminatory preferences of peer review participants, the actions should be suspect.

5. Disproportionate discipline

Malice may also be inferred from the severity of the hospital's disciplinary actions. The California Legislature had recognized reeducation as a corrective device for a physician whose care is questioned.²⁶⁵ This aspect is similar to the second factor, which focuses on the initial action taken by the hospital.²⁶⁶ Instead of focusing on how the hospital responded to a complaint, however, this factor considers how the complaint was *resolved*. Was the goal at this point education and restitution in the interests of patient care and medical diversity or was the goal dedicated to removing the doctor?

In deciding whether the hospital resolved the complaint appropriately, the court must balance three competing interests: the public's, the accused doctor's, and the hospital's.²⁶⁷ The public has an interest in quality medical care and in diverse medical care.²⁶⁸ The public also has

262. KEETON ET AL., *supra* note 14, § 32, at 187.

263. *Cf.* Havighurst, *supra* note 72, at 91 (discussing medical groups inclusion in practice guidelines of treatments "supported by an appreciable number of its members"); *id.* at 101 (describing benefits of guidelines that provide "room for alternative" treatment).

264. *Rosenblit*, 231 Cal. App. 3d at 1447, 282 Cal. Rptr. at 826.

265. *See* CAL. BUS. & PROF. CODE § 809(9) (West 1990); *see also HCQIA Hearings, supra* note 1, at 62-63 (testimony of Dr. Sidney M. Wolfe discussing success of corrective educational actions).

266. *See supra* part IV.A.2.

267. Paul L. Scibetta, Note, *Restructuring Hospital Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1029-30 (1990).

268. *Id.*; *see also Rosenblit*, 231 Cal. App. 3d at 1447, 282 Cal. Rptr. at 826 (noting public's "right to diversity of opinion among competent specialists and variety of treatment options").

an interest in keeping competent doctors in practice.²⁶⁹ The doctor obviously has an interest in protecting both his or her reputation and livelihood. Even an unjustly accused doctor's career is stalled until the review process is completed, and during that time he or she may be completely unable to practice medicine and, therefore, unable to earn income.²⁷⁰ Finally, of course, the hospital has an interest in protecting its *own* reputation and ensuring quality patient care; indeed, it is legally obligated to prevent incompetent doctors from practicing at its facilities.²⁷¹

The nexus of these three interests—patients, doctors, and hospitals—provides the proper meeting ground for effective, fair peer review. A peer review system that ensures competent physicians—who are not only personally diverse but who also provide a variety of medically sound treatment approaches—enriches the health care delivery system.

Although hospitals can and should avail themselves of insurance for peer review liability,²⁷² a prudent course of action is to develop guidelines that ensure immunity by identifying and eliminating malicious use of this disciplinary function. Furthermore, guidelines that provide a system for conducting a reasonable effort and that provide the basis for a reasonable belief will provide the safe harbor that hospitals require to examine legitimate patient care concerns. Simultaneously, adhering to these guidelines will provide safeguards to the doctors whose care is challenged.

B. Application: Hypothetical Resolved

Using these indicators of malice, a reviewing court would likely find in favor of our hypothetical Dr. Adams. First, the origin of the complaint against Dr. Adams was from outside the normal hospital medical quality review channels.²⁷³ Dr. James, not the hospital quality assurance

269. See, e.g., Shawn Tully, *America's Painful Doctor Shortage*, FORTUNE, Nov. 16, 1992, at 103.

270. For instance, Dr. Bolt scored a resounding victory in the Court of Appeals for the Eleventh Circuit. *Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990). Although the court criticized the hospital's procedures and remanded the case for trial, the hospital has not settled with Dr. Bolt. Professor Clark Havighurst, one of Dr. Bolt's attorneys, explained that this was a "vicious thing and very sad . . . Dr. Bolt is not practicing medicine still. His damages go on. There have been no offers to settle, the hospital expects him [Dr. Bolt] to go broke and quit." Telephone interview with Professor Clark C. Havighurst, Williams Neal Reynolds Professor of Law, Duke University School of Law (Nov. 5, 1992). For Dr. Bolt, Havighurst says, it has become a lesson in "how hard it is to get justice" and that he has "gotten philosophical." *Id.* Professor Havighurst stated that he has considered speaking with a reporter with the thought that some attention to this doctor's plight might help to get the case properly resolved. *Id.*

271. See *supra* part III.B.1.

272. HANSON ET AL., *supra* note 60, at 17:7.

273. See *supra* part I.

process, initiated the complaint. This genesis should shift the burden to the review committee to prove that its actions were based on quality of care issues and not on political issues.²⁷⁴ This would further the essential goal of properly conducted peer review, which should be a “constructive dialogue” to improve patient care.²⁷⁵

Second, the initial actions taken by the hypothetical medical staff were to suspend Dr. Adams’s right to practice certain procedures and then to transfer her to another department. These actions were taken *prior* to any investigation into the matter and without providing Dr. Adams with an opportunity to explain her patient care: She was presumed incompetent. As a result, the second factor weighs in favor of a finding of malice or unreasonableness.²⁷⁶

The third indicator of malice, lack of due process, also is present in Dr. Adams’s case. She was not allowed an opportunity to defend her medical care *before* disciplinary actions were instituted. Moreover, she was not allowed to practice her subspecialty, cardiology, long *before any official peer review process commenced*. Furthermore, she was not provided with any notice of the charges against her, nor was she given any specific information regarding patients’ names, charts, and alleged poor patient care.

Because Dr. Adams’s case was handled entirely without a formal peer review process, the fourth and fifth factors—unequal treatment²⁷⁷ and disproportionate discipline²⁷⁸—are not applicable. These indicators generally are useful only after a doctor has been accorded the peer review process with an opportunity to respond to charges. These indicators, therefore, relate to the administrative hearing itself.²⁷⁹ However, in this case, Dr. Adams received unequal treatment. A review of all the pericardiocenteses conducted in the HMO over the past year would likely reveal other incidents of complications with no censure of the treating physician.

274. See *supra* part IV.A.1.

275. HANSON ET AL., *supra* note 60, at 17:7; see also Dans, *supra* note 69, at 567 (discussing establishing better system for helping “marginal” doctors).

276. See *supra* part IV.A.2.

277. See *supra* part IV.A.4.

278. See *supra* part IV.A.5.

279. Generally, doctors are required to exhaust their administrative remedies. *Westlake Community Hosp. v. Superior Court*, 17 Cal. 3d 465, 551 P.2d 410, 131 Cal. Rptr. 90 (1976). However, this requirement does not apply if the doctor is able to demonstrate that the administrative remedies would be inadequate. *Anton v. San Antonio Community Hosp.*, 19 Cal. 3d 802, 567 P.2d 1162, 140 Cal. Rptr. 442 (1977).

Additionally, without any formal evaluation process—no attempt at reasonable investigation to form reasonable beliefs—Dr. Adams's cardiology practice was effectively extinguished. The failure to consider less dramatic measures indicates that the only interest considered was the hospital's desire to oust Dr. Adams. Dr. Adams's interests, as well as the public's interests, were disregarded. Legitimate concerns about disappointing care should be addressed through retraining, monitoring, or proctoring. Revocation of privileges, and the relinquishment of a subspecialty practice, should be the final measure, after all corrective actions have been exhausted.

Using the indicators of malice presented in this Comment, a judge reviewing Dr. Adams's complaint, which likely would seek injunctive relief—reinstatement to her position as a cardiologist on the medical staff, pending the HMO's compliance with procedural due process—would be able to rule in her favor with confidence. Dr. Adams's pleadings, considered in the light most favorable to her as plaintiff, would have presented enough information to require not only the peer review committee to defend its actions but to support the likelihood of her case succeeding on the merits.

V. CONCLUSION

Doctors are dependent on medical staff membership and its attendant privileges to function as healing arts practitioners. Unless a hospital has granted a doctor privileges at its facility, the doctor is unable to admit patients to the hospital. Privileges entail not only the right to admit patients to the facility, but specific rights to perform certain procedures, diagnostic tests, and surgeries. The spectrum of privileges granted to a doctor dictates the scope of his or her work at that hospital.

Historically, communities of doctors have used the granting of privileges as a means to control the profession. Even as late as the 1960s, a doctor's ability to practice medicine in a particular location depended on his or her ability to conform with the existing medical hierarchy.²⁸⁰

280. See *HCQIA Hearings*, *supra* note 1, at 70-73 (testimony of National Coalition of Hispanic Health and Human Services Organization discussing current discrimination practices).

In the 1950s and 1960s, local medical hierarchies of private practitioners ran the American hospital system. As in earlier years, informal networks of physicians, often using ethnic or religious grounds, effectively excluded outsiders, built up "dominant positions for elite physicians," granted and maintained professional status, controlled physician behavior, and minimized medical competition and conflict. Collective physician professional standardsetting during this period was weak.

Nodzinski, *supra* note 27, at 391 (footnotes omitted) (quoting R. STEVENS, *IN SICKNESS AND IN WEALTH* 242 (1989)).

The 1970s heralded antitrust litigation by doctors excluded from practice in certain communities and hospitals²⁸¹ as well as significant litigation under Title VII of the Civil Rights Act.²⁸² In the past five years, two Doctor v. Committee cases made their way to the United States Supreme Court.²⁸³ In both instances the Court found that the peer review process had been abused and ruled in favor of the privilege-denied physicians.²⁸⁴ As one commentator noted, it seems that the "Old Boys Network" is still operating in the hospital medical staff environment of the 1990s.²⁸⁵ In the most recent peer review case to reach the Supreme Court, Justice Scalia commented that "[d]isputes over the denial of hospital practice privileges are common."²⁸⁶ Therefore, as the medical profession continues to evolve from being private-practice-based to HMO and other network-based schemes that create closed situations, the peer review process must be guarded to ensure that discriminatory, arbitrary, and capricious practices are eliminated.

The immunity provided under the HCQIA and California statutes is qualified because there are instances when the conduct of the hospitals and committee members conducting peer review is and should be suspect. Particular events and situations appearing and substantiated in the pleadings of a Doctor v. Committee case should preclude summary judgment in favor of the hospital and peer review committee members, permitting the plaintiff doctor to proceed, at minimum, through discovery. Moreover, discovery in these instances should include access to the hospital's peer review records.

Heightened review is indicated by hospital decision makers, attorneys, and judges when the peer review process results in the denial of privileges to an apparently competent physician²⁸⁷ where (1) complaints are initiated outside of the normal hospital quality assurance channels; (2) actions are taken without affording the doctor due process; (3) due process—notice and opportunity to be heard—is a sham; (4) incompe-

281. See *supra* note 280 and accompanying text.

282. 42 U.S.C. §§ 2000e to 2000e-17 (1988); see Langley, *supra* note 94, at 165-71; Nodzenski, *supra* note 27, at 393.

283. Summit Health, Ltd. v. Pinhas, 111 S. Ct. 1842 (1991); Patrick v. Burget, 486 U.S. 94 (1988).

284. Pinhas, 111 S. Ct. at 1845, 1848; Patrick, 486 U.S. at 98.

285. Nodzenski, *supra* note 27, at 389, 390-92 (referring to "sponsorship" by established physicians). See generally *HCQIA Hearings*, *supra* note 1, at 26 (presenting several accounts of physicians whose privileges were challenged for reasons unrelated to patient care).

286. Pinhas, 111 S. Ct. at 1854 (Scalia, J., dissenting).

287. That is, a physician who has enjoyed privileges at the hospital or other hospitals, who has not been successfully sued for malpractice, who is board certified in a subspecialty, or who has not been identified through in-place health care monitoring processes.

tence is alleged notwithstanding the fact that the doctor's treatment represents an alternative, but recognized, medical school of thought; or (5) the hospital did not consider reeducation, required consultations, monitoring, or privilege restrictions as alternatives to a total revocation of privileges.

The California Legislature recognized the need to provide legal recourse to maliciously sanctioned doctors.²⁸⁸ To make that recourse meaningful, instances should be specified in which peer review committee actions cannot qualify for immunity.

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288. For example, only a qualified immunity is available to peer review committee members. CAL. CIV. CODE § 43.7 (West 1982 & Supp. 1993). Moreover, CAL. BUS. & PROF. CODE § 809(4) (West 1990) states that "Peer Review that is not conducted fairly results in harm both to patients and healing arts practitioners by limiting access to care." *Id.*

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