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Medical Staff Special Edition

In this special edition of Health Law Perspectives, members of HLB's Medical Staff Practice Group provide analysis of select key medical staff issues confronting hospitals and medical staffs. The following articles touch on new updates to statutes and case law as well as important considerations in credentialing and reporting by medical staffs.

California Senate Bill 798 and its Impact on Section 805.01 Reporting Requirements

By Andrea Frey and Ruby Wood

California law has long imposed reporting requirements for restrictions or termination of a physician's clinical privileges for "medical disciplinary cause or reason."[1] The duty to report is set forth in both Sections 805 and 805.01 of the California Business and Professions (B&P) Code. On October 13, 2017, California Gov. Jerry Brown signed Senate Bill 798 (SB 798) into state law, which included a variety of provisions, but of relevance to the current discussion is its amendment to Section 805.01.[2] While the triggering factors for a report under Section 805.01 have not been altered, SB 798 now authorizes the Medical Board of California (MBC) to impose fines on individuals who fail to comply with the reporting obligations under this section.[3]

The amendment went into effect January 1, 2018. SB 798 corrected what was perceived as an oversight in Section 805.01 as violations of the reporting obligations contained in Section 805 have long carried a penalty provision while Section 805.01 carried no such provision. This article discusses the legal analysis and practical considerations for medical staffs, hospitals, health plans, and other peer review bodies following SB 798's enactment.

Distinguishing Between "805" and "805.01" Reports

Both Sections 805 and 805.01 require certain representatives of a "peer review body" to make reports of adverse actions against licentiates to the MBC under certain circumstances. Such reports must be signed by (1) the chief of staff of a medical or professional staff/peer review body and (2) by the chief executive officer or administrator of that entity.[4]

The primary distinction between these two reporting requirements is the action which triggers the need to submit a report. Section 805 reports apply to a broader set of actions as they stem from a variety of proposed adverse actions premised on "a medical disciplinary cause or reason."[5] Section 805.01 reports, on the other hand, arise only when a formal investigation results in a finding that at least one of the four following specific events have occurred:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;

- The use of, or prescribing for or administering to himself or herself, any controlled substance, or the use of any dangerous drug or of alcoholic beverages to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the licentiate's ability to practice safely;
- Repeated acts of excessively prescribing, furnishing, or administering of controlled substances or repeated acts to a patient with or without an appropriate prior examination of the patient and medical reason therefor (this is not applicable to prescribing, furnishing, or administering controlled substances for intractable pain, as consistent with lawful prescribing); or
- Sexual misconduct with one or more patients during a course of treatment or an examination.[6]

The 805.01 reporting requirement only applies when a "formal investigation" has been completed and concluded that one of the reportable situations has occurred. For most Medical Staffs, this should mean when the Medical Staff Executive Committee has concluded its investigatory process and reached a decision. This is important in assessing when and under what circumstances an 805.01 report needs to be filed.

Another distinction between the reporting requirements is the time frame by which a report needs to be submitted to the MBC. Under Section 805, a report would be due "within 15 days after the action's effective date."[7] This allows the peer review body some flexibility in setting the effective date and, by extension, the reporting deadline. Section 805.01, by comparison, requires a report "within 15 days after a peer review body makes a final decision or recommendation [after investigation] regarding the disciplinary action" to be taken.[8] This means that once the peer review body concludes that one of the four scenarios has occurred and that adverse action needs to be taken, the 15 day reporting deadline has been triggered.

The rationale behind Section 805.01 is that these four triggering events are so egregious that the MBC should be notified as soon as possible and not have to wait until there has been a hearing pursuant to individual medical staff bylaws or Business and Professions Code Section 809.2. In practical application, these scenarios almost uniformly result in a summary suspension, which necessitates a report under Section 805. However, Section 805.01 makes clear that this report must be filed even if there is a separate 805 report required. Given the fine structure now present under both statutes, peer review bodies must comply with this seemingly needless duplication.

SB 798 to Deter Lack of Compliance With Section 805.01

Since its enactment, failure to report under Section 805 carried substantial penalties (up to $50,000 for each required signer and $100,000 per signer for willful violations).[9] Section 805.01, on the other hand, did not. In its 2016 Sunset Review Report, the MBC asserted that it "believes entities are not submitting 805.01 reports as required."[10] The MBC noted, for example, that in FY2015/2016, only five reports were submitted under 805.01 as compared to 127 reports under Section 805.[11] Seeking additional tools to address what it saw as a lack of compliance by health care entities, the MBC requested legislative change to require penalties for failing to report under 805.01.[12] The Legislature responded by passing SB 798 and imposing the same fines for reporting failures under Section 805.01 as under Section 805.

In February 2018, the MBC coordinated with the California Department of Public Health (CDPH) to develop an All Facilities Letter regarding SB 798 and Section 805.01 reports (AFL 18-14).[13] AFL 18-14 first makes clear that SB 798 allows MBC to impose fines and then sets forth the circumstances that require reporting, who is responsible for reporting, and which disciplinary actions must be reported as discussed above.

AFL 18-14 neglects to include language that a "formal investigation" must first be conducted and completed before 805.01 reporting requirements are triggered. However, AFL 18-14 specifically states that "SB 798 does not change the existing reporting requirements" and notes that facilities with reporting obligations are responsible for following "all laws and regulations." AFL 18-14 refers entities to the "full text of all applicable sections of the B&P Code to ensure compliance." AFL 18-14 should, however, be read as a clear indication that MBC intends to exercise its ability to impose fines for failure to submit reports under Section 805.01 (even if doing so duplicates a reporting requirement under Section 805, which will often be the case).

Takeaways From SB 798 and What it Means for Peer Review Bodies

The same circumstances which require a report under Section 805.01 will likely continue to also trigger a summary suspension and, thus, a Section 805 report. Therefore, from a practical standpoint, the amendments to Section 805.01 will likely result in an increased number of Section 805.01 reports, which was the goal of the amendments from the MBC's perspective.[14] Determining when a "formal investigation" has concluded and resulted in an 805.01 reportable decision will continue to be a key issue for 805.01 reporting and the necessity

of undertaking this analysis has been heightened now that the MBC has the ability to impose fines. Peer review bodies should take time to evaluate their current practices and ensure that they have made efforts to remain in compliance with both Section 805 and Section 805.01.

[1] *See* Cal. Bus. & Prof. Code § 805(b); *see also* § 805(a)(6).
[2] A complete copy of SB 798 can be found at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?billid=201720180SB798
[3] The fines can be up to $50,000 per violation for failing to file an 805.01 report to the MBC, and up to $100,000 per violation for willful failures to report to file an 805.01 report. Cal. Bus. & Prof. Code § 805.01(g), (h). These amounts mirror the fines that can be imposed for violations under Cal. Bus. & Prof. Code § 805(k), (l).
[4] Cal. Bus. & Prof. Code § 805(b), (c); § 805.01(b).
[5] Section 805 includes incidents where a licentiate resigns or withdraws an application "after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason." Cal. Bus. & Prof. Code § 805(c).
[6] Cal. Bus. & Prof. Code § 805.01(b).
[7] *See* Cal. Bus. & Prof. Code § 805(b).
[8] Cal. Bus. & Prof. Code § 805.01(b).
[9] Cal. Bus. & Prof. Code § 805(k), (l).
[10] Medical Board of California, *Sunset Review Report 2016*, available at http://www.mbc.ca.gov/Publications/Sunset_Report/sunset_report_2016.pdf, pp. 97-98; *see also* p. 156.
[11] *Id.*, at p. 204.
[12] *Id.*, at p. 205.
[13] California Department of Public Health, *All Facilities Letter (AFL 18-14)*, available at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-18-14.aspx
[14] *See* Medical Board of California, *Sunset Review Report 2016*, available at http://www.mbc.ca.gov/Publications/Sunset_Report/sunset_report_2016.pdf, pp. 204-205.

Lessons From California Appellate Court Decision in *Powell v. Bear Valley Community Hospital*

By Jennifer Hansen and Katherine Dru

On March 26, 2018, the California Court of Appeal affirmed a judgment denying a physician's petition for writ of mandate in *Powell v. Bear Valley Community Hospital.*[1] The physician had sought a writ to challenge a hospital board of directors' (Board) decision to deny his request for advancement to active staff privileges and reappointment after discovering the physician had misrepresented the reasons why his privileges were revoked at a previous hospital. The case is significant for a number of reasons described below, including but not limited to providing valuable lessons in credentialing, clarifying existing laws, and recognizing a Board's exercise of independent judgment to reach a conclusion at odds with that of the Medical Executive Committee (MEC).[2]

Background

Dr. Powell is a general surgeon who practiced medicine in both Texas and California. In 2000, the MEC of Brownwood Regional Medical Center (Brownwood) terminated his staff membership and clinical privileges, finding Dr. Powell a) failed to advise a young boy's parents that he severed the boy's *vas deferens* during a hernia procedure, and b) falsely represented that he fully disclosed the circumstances to the parents, which Brownwood's MEC considered to be dishonest and obstructive, and which prevented appropriate follow-up care. The Texas State Board of Medical Examiners completed an investigation but closed the case "with no action recommended because the evidence d[id] not indicate a violation of the Texas Medical Practice Act," as documented in a 2001 letter.

Dr. Powell thereafter filed a lawsuit against Brownwood. However, this lawsuit was dismissed by the trial court on Brownwood's motion for summary judgment, and this dismissal was affirmed on appeal.[3]

In October 2011, Dr. Powell applied for appointment to the medical staff at Bear Valley Community Hospital (Bear Valley) and was provisionally appointed as a member of the medical staff for one year. During the application process, Dr. Powell told several Bear Valley MEC members that Brownwood terminated his privileges because management disagreed with his use of advanced and/or costly surgical procedures, essentially pointing to an unfavorable political and/or economic environment. In his application, he disclosed that "Brownwood . . . terminated my privileges without factual or legal justification." He disclosed that the action was reported to the Texas Board and that all allegations were dismissed with no disciplinary action.

After Dr. Powell had been practicing at Bear Valley under provisional status for a number of months, an external surgeon reviewed the charts of 12 patients treated by Dr. Powell at Bear Valley. Eight of these charts were found to be problematic by the external reviewer. This information was not considered by the MEC, however, when it thereafter made a recommendation in the spring of 2012 to advance Dr. Powell to active medical staff membership. Instead, the MEC relied only on two peer-reviewed charts. Bear Valley's Board expressed concerns with the MEC's decision to advance Dr. Powell despite the external reviewer's findings, and the MEC then retracted its recommendation so it could review all peer-reviewed charts.

The MEC again recommended advancing Dr. Powell to active status in summer of 2012. But the Board still had lingering concerns about Dr. Powell's qualifications, and requested additional information from Dr. Powell, including the 2001 "exonerat[ion]" letter from the Texas Board. Dr. Powell did not have (or would not produce)

the letter. Bear Valley's general counsel then researched and located a copy of the Texas court opinion from Dr. Powell's unsuccessful lawsuit against Brownwood, which contradicted Dr. Powell's explanations regarding why his privileges at Brownwood were terminated. and provided the court opinion to Bear Valley's chief of staff and the Board members. On behalf of the MEC, the chief of staff thereafter withdrew the MEC's recommendation, deeming the application "incomplete" due to the missing 2001 letter. The MEC then notified Dr. Powell that his provisional privileges had expired due to an incomplete application, but encouraged him to reapply.

Dr. Powell later provided the MEC a copy of a separate 2002 letter from the Texas Board noting the investigation against him had been closed, and in December 2012, the MEC again recommended Dr. Powell be granted active staff privileges. Yet, the MEC still had not received a copy of the 2001 letter from the Texas Board. Despite the MEC's recommendation, the Bear Valley Board asked Dr. Powell to attend a meeting and present additional documentation, but he declined to meet and did not provide any other materials. Specifically, he failed to produce a copy of the 2001 Texas Board letter. Following this, Bear Valley's Board reached a tentative final decision to deny Dr. Powell's request for active privileges, triggering Dr. Powell's right to a hearing.

The Judicial Review Committee Found Justification in Denial of Dr. Powell's Advancement to Active Privileges After Administrative Hearing

Following a full administrative hearing, the Judicial Review Committee (JRC) unanimously found that the Board substantiated its charges against Dr. Powell by a preponderance of the evidence and that the Board's tentative final decision to deny his request for active privileges was both reasonable and warranted.

The JRC would not have upheld the Board's decision based solely on the first charge relating to external peer review issues, but found that Dr. Powell willfully failed to produce the 2001 letter and attempted to deceive the Board by producing a different 2002 letter instead and misrepresented the reasons why his Brownwood privileges were terminated. The JRC found Dr. Powell displayed dishonesty and deceitfulness justifying the Board's tentative final decision.

The Court of Appeal Upheld the Lower Court's Decision on Writ of Mandate, Holding the Board Acted Within its Authority and a Fair Hearing was Provided

Dr. Powell challenged the Board's decision on writ of mandate under California Code of Civil Procedure, section 1094.5, seeking to void the JRC/Board's decision and have his privileges at Bear Valley reinstated. The trial court denied the petition, and the Court of Appeal affirmed.

The Court of Appeal noted that the Board properly exercised independent judgment based on the information presented, all the while according due weight to the MEC's recommendations.[4] The Board greatly deferred to the MEC on matters of which the MEC had expertise and was fully informed. The Court of Appeal did not find substantial evidence in the record that the Board had any ulterior motive. Dr. Powell failed to demonstrate that the Board exceeded its authority.

The Court of Appeal further found that Dr. Powell's eight alleged challenges to the fairness of procedure lacked merit.[5]

Significance of Case

This case is a prime example of why medical staffs must perform their own credentialing rather than merely taking a practitioner's word on an application, especially when a red flag is raised, such as in this case where the physician's privileges were previously revoked elsewhere. A physician's dishonesty on an application for medical staff membership and privileges has been long recognized as a factor that may adversely impact patient care and may justify termination of a physician's membership and privileges.[6] The *Powell* opinion goes even further by mentioning that dishonesty could also negatively impact other physicians' provision of medical care.[7]

This case highlights why medical staffs should include an attestation statement in applications for privileges and reappointment whereby the signing physician acknowledges that dishonesty on the application can serve as grounds for denial of appointment or termination of medical staff membership or privileges.

The Court of Appeal held in *Powell* that a hospital is not required to renew or extend an existing appointment pending an internal peer review administrative hearing if no adverse action has been taken that is reportable to the Medical Board pursuant to Business and Professions Code 805(b).[8] The Court of Appeal also confirmed the existing statutes by holding that a physician is not entitled to a hearing when the reason for the adverse action is not a "medical disciplinary cause or reason."[9]

In addition, the Court of Appeal held that a lapse in clinical privileges based on submitting an incomplete application is neither reportable under section 805 nor does it trigger the right to a hearing.[10] Note that, when the Board ultimately decided to deny Dr. Powell's reappointment for a medical disciplinary cause which would trigger the reporting requirements (i.e., dishonesty, and not merely an incomplete application), it was required to, and it did, afford him hearing rights.

The case also demonstrates the importance of the Board's independent judgment. Notably, the general counsel's diligent research and follow up in this case resulted in the findings contradicting the physician's explanations, which the MEC had previously missed. It is a reminder that Boards should not rubber stamp MEC recommendations without exercising their own independent judgment. The Court of Appeal in *Powell* recognized that an MEC which is comprised of physicians might not necessarily have insight or expertise to detect dishonest and unethical conduct, and held that the Board decision was a proper exercise of its independent judgment while still giving proper deference to the findings of the MEC.[11]

Finally, one of the most common challenges to peer review proceedings is an alleged lack of fair procedure. The *Powell* opinion demonstrates that minor procedural errors that are not prejudicial do not require reversal.

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[1] 22 Cal.App.5th 263, 231 Cal.Rptr.3d 381 (March 26, 2018), certified for publication April 16, 2018. At the time of this publication, the page cites were only available for the California Reporter.

[2] *See Weinberg v. Cedars-Sinai Medical Center* (2004) 119 Cal.App.4th 1098, 1109 (upholding a conclusion at odds with the MEC where "great weight" was given to the MEC findings).

[3] *See Powell v. Brownwood Reg'l Hosp., Inc.*, Tex. App. Case No. 11-03-00171-CV, 2004, Tex. App. LEXIS 8202, p. *1 (Sept. 9, 2004).

[4] 231 Cal.Rptr. at 393.

[5] *Id.*

[6] *Ellison v. Sequoia Health Services* (2010) 183 Cal.App.4th 1486, 1498; *Oskooi v. Fountain Valley Regional Hospita*l (1996) 42 Cal.App.4th 233, 248.

[7] 231 Cal.Rptr. at 393.

[8] 231 Cal.Rptr. at 391.

[9] *Id. See* California Business & Professions Code § 809.1 and § 805(b).

[10] 231 Cal.Rptr. at 391.

[11] *Id.* at 393.

Late Career Practitioner Policies and the Role of Wellbeing Committees in Credentialing Procedures

By Ross Campbell and Ruby Wood

As a significant portion of healthcare providers approach the age of retirement, there is an increasing demand for qualified and experienced practitioners.[1] This demand is juxtaposed against an awareness that some factors associated with aging may negatively impact physicians' cognitive and physical abilities.[2] Industry and medical staff leadership have therefore expressed increasing interest in the development and implementation of policies regarding the credentialing of "aging" or "late career" practitioners.[3]

Should a medical staff choose to develop such a policy, which we recommend for both appointment and reappointment purposes, a series of decisions regarding the policy's framework and implementation must be made.[4] In 2015, the California Public Protection & Physician Health (CPPPH) published a comprehensive analysis of this issue entitled *Assessing Late-Career Practitioners: Policies and Procedures for Age-based Screening, A Guideline from California Public Protection & Physician Health.* It includes a thoughtful analysis of issues and considerations regarding this type of policy. For the most part, the authors agree with the guidance provided by CPPPH and recommend this publication as a resource to any medical staff contemplating this type of policy. However, there is one area where there is fundamental disagreement, which is the focus of this discussion.

CPPPH has taken the position that "[b]ecause of its charge to advise and assist the members of the medical staff and to maintain confidentiality of the information except when the safety of a patient is threatened, the Wellbeing Committee is the most appropriate committee to be responsible for implementation of the policy up to the delivery of its recommendation to the practitioner and to the Credentials Committee."[5] Placing the Wellbeing Committee (Wellbeing) as the focal point of the assessment is, in our view, misguided.

First, there is no legal distinction between these committees regarding the scope of confidentiality protection that applies to their records.[6] In addition, Wellbeing already plays an important role with respect to the members of the medical staff with identified health problems. It would be problematic to expand that role to include operating as an additional Credentials Committee. Credentialing is not a function of Wellbeing and a senior physician being sent to a committee that deals with established health issues sends the wrong signal. CPPPH's recommendation to make Wellbeing responsible for processing credential applications for members of a certain age also undermines the medical staff's ability to defend against potential legal challenges.

The potential for discrimination claims when age is used as an initial criterion for increased scrutiny is readily apparent.[7] Federal and state laws which prohibit age discrimination declare that age shall not be used to adversely affect any individual.[8] But the laws are noteworthy for their exceptions.[9] Unlike race, religion, nationality and other immutable characteristics, physical and cognitive decline associated with age have been recognized by Congress, state legislatures and courts as posing risks in the workplace, particularly where public safety is at issue.[10] Any policy which incorporates age-based screenings must carefully consider the law in this area.

Generally speaking, there is legal support for the proposition that a healthcare entity may establish a stan-

dard for granting or maintaining medical staff appointment if that standard is rationally related to the delivery of quality health care to patients.[11] For example, under the Age Discrimination Act of 1975, there is an exception if "in the program or activity involved [ ] [s]uch action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity; or [ ] the differentiation made by such action is based upon reasonable factors other than age."[12] Efforts must therefore be made to minimize the changes to existing credentialing procedure. The policy should augment, not completely alter, the medical staff's existing application process. Further, the changes implemented must be rationally related to improving the quality of care.

The Credentials Committee is the entity typically responsible for the collection, verification and evaluation of information relating to the determination of whether to grant appointment and reappointment to the medical staff. It has the experience and expertise to process reapplications to the medical staff.[13] It is ill advised, upon deciding to implement what may already be a controversial policy, to put the processing of critical information into the hands of a committee which plays no role in the credentialing process.

According to the California Medical Association and CPPPH, Wellbeing acts as an educational resource "for medical and other organization staff in matters related to maintenance of health and prevention of impairment."[14] It "provides an informal, confidential access point for persons who voluntarily seek their counsel and assistance" and is "a source of expertise whereby the medical staff may identify health factors underlying a clinical performance problem for which corrective action is under consideration."[15] Thus, Wellbeing is utilized once the practitioner or medical staff leadership has already identified an issue with clinical performance.[16]

Because "the effect of age on any individual physician's competence can be highly variable," age – by itself – is not rationally related to CPPPH's recommendation to have the application processed by Wellbeing.[17] CPPPH's recommended approach would create a medical staff with two committees processing applicants where the only difference between pending applications is the age of the applicant. Even if Wellbeing were to be given additional support staff and adequately trained in processing the applications, there is still significant risk of inconsistent recommendations between the two committees when faced with similar facts.

There is an argument that Wellbeing is focused on the individual practitioner while the Credentials Committee emphasizes patient care, the medical staff, and governance.[18] Even if this is true, there is no need for any increased focus on the practitioner until a specific issue is identified. It unnecessarily undermines the medical staff's ability to defend against claims of disparate treatment when a practitioner with a long and successful career is subjected to a different committee's review based solely on age.[19] The problem is compounded by the reality that, to some practitioners/potential plaintiffs, there is a stigma attached to being sent to Wellbeing.

Should a medical staff choose to adopt a late career policy, it is recommended that it be implemented in a manner that minimizes disparate treatment based on age and focuses instead on identifying and addressing actual concerns which may arise. It is only at this juncture that involvement of Wellbeing should be contemplated.

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[1] According to the Association of American Medical Colleges (AAMC), 30.3% of the active physician population is 60 years of age or older. *2017 State Physician Workforce Data Report*, AAMC (2017), p. 25.

[2] *See* McDade, *Competency and the Aging Physician, Report of the Council on Medical Education* (2015) ("AMA Report"); California Public Protection & Physician Health, *Assessing Late-Career Practitioners: Policies and Procedures for Age-based Screening, A Guideline from California Public Protection & Physician Health* (2015) ("CPPPH Guideline"); *see also* E.P. Dellinger, et al., *The Aging Physician and the Medical Profession, A Review*, (July 19, 2017) JAMA Surgery, October 2017, Volume 152, Number 10, p. 968 (declaring that "[a] robust literature has developed regarding the effect of age on physicians' performance. […] Thus, while age alone may not be associated with reduced competence, the substantial increase in variation around cognitive skills as physicians age suggests the issue cannot be ignored.").

[3] The vocabulary in the area is varied and evolving. The American Medical Association, for example, uses "Aging Physician" while Stanford Health Care, one of the early adopters of this type of policy, and CPPPH use "Late Career Practitioners." (The authors disclose that they represent Stanford Health Care on a variety of matters, including its Late Career Practitioner policy).

[4] The authors are not taking a position as to the threshold question of the appropriateness of late career policies in any given set of circumstances. Determining whether such a policy is a viable option for a medical staff requires a case by case analysis, including consideration of the location, size, and practice area composition of the respective medical staff, among other issues. The role of various political dynamics should also be taken into consideration. It is recommended that any medical staff interested in exploring this issue seek legal counsel.

[5] CPPPH Guideline, p. 7 at ¶ 9.

[6] *See* California Evidence Code § 1157 (referencing "organized committees" and "peer review body" without specific reference to distinct committees).

[7] This article is not intended to be a comprehensive review of laws relating to potential age discrimination claims. It is instead focused on a specific aspect of the procedural implementation of these types of policies.

[8] *See, e.g.*, 42 U.S.C. § 6101; Cal. Gov't Code § 12940(a); *Alch v. Superior Court*, 122 Cal.App.4th 339, 392, n.53 (2004).

[9] This article expresses the opinion of the authors and is presented for general discussion and consideration. It does not constitute legal advice nor should it be used as a substitute for obtaining legal counsel. A review of the specific language of a proposed policy in connection with applicable law – which varies by jurisdiction – must be undertaken by each medical staff prior to any efforts to draft and adopt this type of policy.

[10] For example, pilots, air traffic controllers, and federal law enforcement and firefighters all have mandated retirement ages. *See, e.g.*, 49 U.S.C. § 44729; 29 U.S.C. § 623(j). Indeed, pilots are subjected to increased review as young as age 40. https://www.gpo.gov/fdsys/pkg/FR-2008-07-24/pdf/E8-16911.pdf.

[11] *See Miller v. Eisenhower Medical Center*, 27 Cal.3d 614, 628 (1980); *Oliver v. Board of Trustees*, 181 Cal.App.3d 824, 830 (1986). "A rule or policy decision of general application adopted by the governing authority of a hospital [...] impinging on the right of a physician to practice his or her profession fully will not be set aside by a court unless it is substantively irrational, unlawful or contrary to established published policy or procedurally unfair." *Lewin v. St. Joseph Hospital of Orange*, 82 Cal.App.3d 368, 385 (1978); *see also Hay v. Scripps Memorial Hospita*l, 183 Cal.App.3d 753, 761 (1986).

[12] 42 U.S.C. § 6103(b)(1); *see also* 34 C.F.R. §§ 110.12.

[13] K. Rieger, *The Medical Staff Guidebook: Minimizing Risks and Maximizing Collaboration* (American Health Lawyers Association, Fourth Edition) (2016), pp. 69, 83.

[14] CMA Legal Counsel and CPPPH, *Guidelines for Physician Well-Being Committees Policies and Procedures* (CMA On-Call Document #5177) (September 2013).

[15] *Id.*

[16] The authors are not advocating for the Wellbeing Committee's involvement every time an issue is identified. For example, if the identified issue can be addressed through training or physical rehabilitation and strengthening, there would be no need to involve the Wellbeing Committee.

[17] *See* AMA Report, Executive Summary.

[18] The authors do not take a position as to the validity of this assertion.

[19] Any analysis of potential claims or assessment of liability is highly fact dependent. This possible argument is raised here only for the purpose of this hypothetical discussion and without regard to the viability of such a claim.

Hooper, Lundy & Bookman's Medical Staff Practice Group

Jennifer Hansen
Practice Group Chair

Jodi Berlin

Ross Campbell

Katherine Dru

Andrea Frey

Laurence Getzoff

Harry Shulman

Catherine Wicker

Ruby Wood

For more information about our Medical Staff Practice Group, please visit our website at http://www.health-law.com/practices-Medical-Staff-Affairs.html

HLB
HOOPER, LUNDY & BOOKMAN, PC
HEALTH CARE LAWYERS & ADVISORS

1875 Century Park East, Suite 1600
Los Angeles, California 90067-2799

CALENDAR

California Association of Medical Staff Services (CAMSS) 47th Annual Educational Forum, San Francisco, CA — **May 25**
Ross Campbell and Ruby Wood present *How much is too much? Sharing Peer Review Information – Rules & Approaches*

SAVE THE DATE — **October 9,16**
Hooper, Lundy & Bookman's Annual Medical Staff Seminar
Oakland City Center Marriott – October 9
The Westin Los Angeles Airport — October 16