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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION TWO

HAROLD LUKE,	
Plaintiff and Appellant,	E046969
v.	(Super.Ct.No. SCVSS123244)
REDLANDS COMMUNITY HOSPITAL,	OPINION
Defendant and Respondent.	

APPEAL from the Superior Court of San Bernardino County. Joseph R. Brisco, Judge. Reversed.

Ackerman, Cowles & Associates and Richard D. Ackerman for Plaintiff and Appellant.

McDermott Will & Emery, Thomas A. Ryan and Jessica J. Thomas for Defendant and Respondent.

INTRODUCTION

Harold Luke, M.D., (Dr. Luke) is a board certified family practice physician who was a member of the medical staff of Redlands Community Hospital (RCH or the hospital) for 25 years, until 2002 when the hospital suspended his privileges.[1]

On September 12, 2002, one of Dr. Luke's nursing home patients, 76-year-old M.E., was admitted to RCH in the final stages of a terminal illness. Two days later, he died. After his death, what began as a dispute between Dr. Luke and a nurse over the dose of morphine administered in the final hours of the patient's life—and which of the two of them was authorized to adjust his intravenous (IV) line—erupted into a full-scale confrontation between the hospital and Dr. Luke. Eventually, the RCH Board of Directors (the hospital board) terminated Dr. Luke's medical staff privileges, and the Medical Board of California (State Medical Board) decided to revoke his license to practice medicine.

However, after San Bernardino County Coroner Dr. Frank Sheridan (Dr. Sheridan) issued a third death certificate for M.E. and gave the State Medical Board additional information about the toxicology report upon which the amended (second) death

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[1] Born in China, English is Dr. Luke's second language. He came to the United States when he was 19 years old, graduated from college in Massachusetts in 1968, and received his medical degree from Loma Linda University in 1972. He was first certified by the American Board of Family Practice in 1978. By 2002, he had been recertified three times, most recently in 2000. Before the events giving rise to this case, he had never been the subject of a complaint filed with the State Medical Board or with the medical staff office of RCH. He has never been sued for malpractice.

certificate had been based, the State Medical Board rescinded its revocation decision.[2] Instead, on April 10, 2006, it issued Dr. Luke a "Public Reprimand" for failure to "maintain adequate and accurate records in his care of [M.E.]"

On June 24, 2005, Dr. Luke filed a Code of Civil Procedure section 1094.5 petition for a writ of administrative mandate (1094.5 petition) seeking to compel the hospital board to reinstate his privileges. On April 25, 2007, San Bernardino County Superior Court Judge Bob N. Krug granted the 1094.5 petition and remanded the matter to RCH for reconsideration in light of the third death certificate and the State Medical Board's decision not to revoke Dr. Luke's license. The court retained jurisdiction for purposes of review of the hospital board's reconsideration.[3]

On December 17, 2007, the hospital board reaffirmed its decision to terminate Dr. Luke's privileges. At a return hearing on July 21, 2008, the trial court, with San Bernardino County Superior Court Judge Joseph R. Brisco presiding, denied the writ. This appeal followed.

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[2] Over a period of two years, there were three death certificates: the first, on May 12, 2003, listed the causes of M.E.'s death as "sepsis," "pneumonia," "advanced cardiomyopathy," and "Guillain Barre Syndrome" (GBS); the second, an amendment to the first, on August 13, 2003, listed the causes of death as "morphine toxicity" and "homicide," by "physician administered overdose of morphine"; and the third and final death certificate, a further amendment issued on January 24, 2006, listed the cause of death as "undetermined."

[3] On June 29, 2007, Dr. Luke filed a notice of appeal to Judge Krug's writ order with this court. On August 2, 2007, we dismissed the appeal without prejudice. When a trial court retains jurisdiction while remanding a matter to an administrative agency for further hearing, the order is not a final appealable order. (*Village Trailer Park, Inc. v. Santa Monica Rent Control Bd.* (2002) 101 Cal.App.4th 1133, 1139-1140.)

Dr. Luke argues here, as he did below, that the underlying peer review and hospital board proceedings were unfair and the findings unsupported by substantial evidence.

The case reaches us seven years after the initial event, having generated over 7,000 pages of legal records. In an effort to determine whether the proceedings below were fair and, if so, whether there was substantial evidence to support the hearing bodies' findings and actions, we have undertaken a close review of the record. We answer the first, dispositive, inquiry in the negative.

FACTS AND PROCEDURAL HISTORY[4]

Because our conclusion that the underlying proceedings were unfair is closely related to details of the original facts and the sequence of subsequent events, we recite them at some length.

M.E.'s Admission and Hospital Course:

The parties agree that when M.E. was transferred from a local nursing home to the emergency room of RCH on September 12, 2002, he was a very sick man. He had been admitted to Loma Linda University Medical Center (LLUMC) four times that year, and the admission to RCH was his second to that facility that month.

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[4] The facts are taken from the appellate record documents and transcripts, as well as the clerk's transcript in this case. With some repetition as necessary to maintain clarity, we have recited events in chronological order of their occurrence wherever possible, even when they became evident at different points in the proceedings.

Robert A. Klein, M.D., who examined M.E. in consultation at the nursing home the day before his admission to RCH, described his physical condition in detail. The patient lay in bed with "head hyperextended, mouth hanging open." He had "lower facial weakness" and a protruding tongue. He had "minimal ability to nod the head yes or no," with "moderate weakness of the arms with decreased muscle tone," and "marked weakness of the legs." He had some sensation to pinprick in his arms and in his legs above the knees, but none below the knees. He had no reflexes in his arms, knees, or ankles.[5]

M.E.'s condition had not improved by the next day, when he was taken to RCH with a complaint of respiratory distress. Emergency treatment record notes of September 12, 2002, show that he had a feeding tube, a Foley catheter in his bladder, a pacemaker, was unresponsive, and appeared chronically ill. His past history, later confirmed by his son J.E. to investigators from the State Medical Board, included repeated bouts of pneumonia; a heart attack requiring resuscitation and bypass surgery; kidney stones; and, most recently, GBS. After contracting "beret [*sic*] [in May 2002, he] just kept getting worse and worse and worse . . . weaker and weaker and sicker and sicker and sicker and sicker and sicker." When J.E. saw his father in the emergency room, M.E. was in pain

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[5] Dr. Klein believed that M.E. was suffering from "chronic inflammatory demyelinating polyneuropathy" (CIDP), rather than GBS, as previously diagnosed. Dr. Klein indicated M.E.'s condition could be treated with intravenous immunoglobulin (IVIG). Dr. Luke's first discharge summary, dictated on September 17, 2002, said that M.E. had been given IVIG at LLUMC during an earlier admission, with "some improvement." Dr. Luke's second discharge summary, dictated on October 18, 2002, said that IVIG had been considered at LLUMC, but was not given because of the patient's renal problems. M.E.'s neurologic condition had instead been treated with "plasmapheresis."

and suffering from a severe, deep cough: "every breath was torture." M.E. also had "dysphagia" and "dysphasia" (difficulty swallowing and speaking), and a "stage 3 decubitus" with "clear foul smelling drainage" on his "coccyx" (a deep bedsore on his tailbone).

M.E.'s "Advance Health Care Directive" (Prob. Code, § 4701) named his children as surrogate healthcare decision makers. On admission, the patient and his family confirmed his "DNR" (do not resuscitate) status. J.E. and his sister wanted their father made comfortable with fluids and morphine, but otherwise given no life-sustaining treatment.

M.E. was diagnosed with "sepsis" (bacteria or their toxins in blood) and "pneumonia" and admitted to RCH by Dr. Luke, who had been overseeing his care in recent months. Initial treatment included the placement of an IV line through which antibiotics, a medication to support blood pressure (dopamine), and morphine for pain and respiratory distress, were infused. Oxygen was administered via a nonrebreather mask (NRM) and blood and urine cultures were ordered.[6] The preliminary report on the blood culture was positive, as was a chest X-ray, which showed "[w]orsening . . . left lower lung infiltrate with effusion." Initially, M.E. was to be admitted to a "partial" intensive care unit (ICU) or telemetry unit (where patients' vital signs are electronically monitored), but, for reasons not stated in the record, he was sent to a regular floor, where electronic monitors were not used.

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[6] The NRM has been included with the records sent to us.

Dr. Luke's orders on September 13, 2002, included one to discontinue the dopamine "per family request" and one for the administration of an "MS drip" at a rate of "1-2 mg/hour."[7] Nursing notes of September 12 and 13, 2002, indicated that the morphine drip was adjusted to "15 cc" (1.5 mg) per hour and that the patient did not appear to be in pain. Nursing notes for September 12, 13, and 14, indicated that he continued to receive oxygen via the NRM.

Sometime in the early morning hours of September 14, 2002, apparently in response to a request from a nurse concerned about the patient's dropping blood sugar, Dr. Luke ordered feedings through M.E.'s gastric tube. When J.E. was informed of this, he adamantly requested that the feedings be stopped and said that he did not want Dr. Luke to "come near his father." Dr. Luke spoke to the family and acceded to their request to discontinue tube feedings, but continued to check on M.E. throughout the day. Thereafter, the family refused medications other than morphine and refused to allow the nurses to take M.E.'s vital signs. Nurses who checked him on September 14, 2002, did visual assessments of his status but, apparently, did not lift the NRM to directly observe his face.

In the afternoon of September 14, 2002, Dr. Luke wrote two additional orders regarding morphine: (1) to increase the dosage to "5 mg/hour for pt comfort," and (2) to increase the drip rate to "50 cc/hour." The "50 cc/hour" order was noted as "done." The

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[7] As used throughout the record, "MS" is an abbreviation for morphine sulfate, or morphine; "mg" is an abbreviation for milligrams, a unit of weight; and "cc" is an abbreviation for cubic centimeter, a unit of volume.

first nursing note referencing the increase was written by Nurse Thomas and indicated that the morphine rate had been increased to "5mg/hour" at 2:00 p.m. In a progress note at 3:00 p.m.,[8] Dr. Luke described M.E. as "comatose" and "not responsive" and indicated that he would give "MS for comfort."

According to later testimony by Nurse George, Dr. Luke interrupted the nursing shift change report about 3:20 p.m. and asked her to increase the morphine dose to "5cc/hr." She wanted to wait until the report was finished, but Dr. Luke insisted that it be increased immediately, and she made the change at 3:25 p.m. At 4:05 p.m., the unit secretary called Dr. Luke's second order to Nurse George's attention. Alarmed, she telephoned him. The doctor confirmed that the order was for "50cc/hr," said that he had already increased the rate himself, and told her to forward the new order and his notes to the pharmacy. Still concerned, at 4:20 p.m., Nurse George called her supervisor, Nurse Parenteau. Nurse Parenteau told Nurse George that he had seen doses of that magnitude before, that the doctor must see something she did not, and to continue the infusion as ordered.

Dr. Luke pronounced M.E. dead at 5:05 p.m. Following Nurse Parenteau's instructions, Nurse George left the IV morphine line in place, removing it some unknown number of hours later.

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[8] The medical and legal records variously use both military (24-hour) and civilian (12-hour) time designations. For convenience and uniformity, we will use civilian time throughout this opinion, even when the original designations are in military time.

Events Following M.E.'s Death:

Almost immediately, people at the hospital began to contact each other about the case.

Within minutes, Nurse Parenteau called Risk Manager Pam Loscutoff (Loscutoff) to ask whether M.E.'s death would be a "coroner's case." Loscutoff , who had worked at RCH for 14 years, the last five in risk management, and in law firms for 14 years before that, advised Nurse Parenteau to call Dr. Theodore Shankel (Dr. Shankel) with this question. Dr. Shankel was "Chairman of the Medicine Department." When Nurse Parenteau called Dr. Shankel to ask if the coroner should be notified, Dr. Shankel said, "No, I don't think so. I wouldn't notify the Coroner."

At 6:35 p.m., "Gretta O. Cook" (Cook) sent an e-mail to "Timothy E. Norris" (Norris), stating that increasing morphine from five milligrams per hour to 50 milligrams per hour was "not making the patient comfortable." It was "euthanasia."[9] Cook's e-mail ended with "[q]uite frankly, this is not the kind of liability to which the hospital wants to be exposed."

Shortly after midnight on Sunday, September 15, 2002, about an hour after her shift ended, Nurse George recorded nursing notes for M.E.'s chart and documented her version of the afternoon's events in an e-mail. This e-mail was forwarded to Loscutoff at 11:39 a.m., on Monday, September 16, 2002.

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[9] Cook and Norris are not clearly identified in the record, but may have been members of the pharmacy staff.

After Nurse Parenteau's call on Saturday night, Loscutoff contacted several people: she called Quality and Medical Staff Services Director Cathleen Bell (Bell) to advise her of the situation; she interviewed Nurse George; still concerned that the case might be a homicide, she consulted with legal counsel about how to notify the coroner; she called the coroner's office; and she spoke to Dr. Luke, who told her that he had used morphine for compassionate care, not to assist a suicide. Had he wanted to assist a suicide, he said, he would have used potassium chloride to stop the heart.

Loscutoff documented Dr. Luke's statement in a handwritten note and relayed it to Bell, Dr. Shankel, and Dr. Carolann Rosario (Dr. Rosario), RCH's chief of staff and chair of the Medical Executive Committee (MEC).

On Monday, September 16, 2002, after talking with Dr. Rosario, Loscutoff, Bell, and legal counsel,[10] Dr. Shankel reviewed M.E.'s hospital chart and called Dr. Luke on the telephone to discuss the case. In a memorandum dictated right after their conversation, Dr. Shankel wrote that Dr. Luke had said he increased the dose because the family was upset that M.E. had not passed away after they refused other treatment. "[T]he family was unhappy because their family member was still alive and . . . they wanted the morphine drip increased and he increased the morphine drip."

On Tuesday, September 17, 2002, Drs. Shankel and Rosario met in Bell's office with Bell and Loscutoff. Together they decided that Dr. Luke posed an imminent threat

[10] The identities of the attorneys or law firms consulted by Loscutoff and Dr. Shankel are not specified in the record.

of harm to patients, and that his hospital privileges should be summarily suspended. Their assessment of danger was based on Dr. Shankel's memorandum.

In the days following his death, M.E.'s body was kept at the hospital in anticipation of action by the coroner's office. After an initial review of M.E.'s record, Dr. Sheridan concluded that, in view of M.E.'s well-documented diseases and terminal condition, an autopsy was not indicated. However, after Loscutoff asked Dr. Sheridan to look again and, particularly, to review the medication administration record, Dr. Sheridan ordered a blood sample to rule out death from morphine toxicity. The sample was taken by a San Bernardino County Coroner's Office employee on September 18, 2002, four days after M.E.'s death. Because San Bernardino County did not have the capability to do postmortem blood tests, the sample was sent to the County of San Diego Department of the Medical Examiner's toxicology laboratory (San Diego laboratory) for analysis. At some point in this process, but apparently in the San Diego laboratory and unbeknownst to anyone in the San Bernardino County Coroner's Office, the form indicating the site from which the sample had been obtained was changed from "aorta" to "peripheral."[11]

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[11] The "aorta" is the largest artery in the body and exits directly from the heart. The femoral artery is a large "peripheral artery" that transmits blood to the leg. The femoral artery is the site where most blood samples are drawn. (See About.com Web site, <http://biology.about.com> [as of Feb. 10, 2011].)

Meanwhile, Drs. Shankel and Rosario called a special meeting of the MEC on September 19, 2002.[12] At the meeting, the MEC formalized Dr. Luke's suspension and appointed a special subcommittee (the MEIC) to investigate the matter and make recommendations for corrective action.[13] Dr. Luke attended the September 19 meeting. He told the MEC that he had increased the dose of morphine because when he examined M.E., the patient was in distress and grimacing under the NRM. After the second increase, M.E. had given him a smile. Dr. Luke did not explain why he had failed to document the signs of distress in the chart. The minutes of the meeting indicated that the coroner was reviewing M.E.'s medical records and the blood to determine the cause of death and that a report could be expected in about three weeks.

The MEC met for a second time on the evening of September 24, 2002.[14] Earlier that day, Dr. Luke had written two letters reiterating what he had told Loscutoff on September 16 and the MEC members at the September 19 meeting. The first letter, addressed to Dr. Rosario, said that his comfort care for M.E. had been misinterpreted as assisted suicide and requested that the suspension be terminated. The second letter,

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[12] Members of the MEC included, among others, Drs. Shankel, Rosario, and Pranav Mehta, and Bell. All were to become witnesses to the judicial review committee (JRC).

[13] The MEIC members were Drs. Mehta, Ivan Maeda, Paul Ennis, Dennis Hilliard, and Monroe Seiberling. Dr. Mehta was in an independent private practice in Redlands. Dr. Seiberling was a partner in the Beaver Medical Group (BMG). The status of the other physicians in relationship to BMG is unclear.

[14] Attorney Peter Rank of the K&R Law Group was also present at the September 24 meeting.

addressed to Drs. Rosario and Shankel, said, "I did not intend to do anything to endanger the health of the patient. Neither would I ever terminate a patient's life on a family relative's order or wishes." He had increased the morphine because M.E. was "in distress and gasping for air under the [NRM]." After the increase, the patient, who could not speak or move, had given him a big smile. At the end of the meeting, the MEC voted to terminate Dr. Luke's suspension effective the next day, September 25, 2002, pending the report of the MEIC.

On October 29, 2002, the San Bernardino County Coroner's Office received the toxicology report from the San Diego laboratory. At some point, the result was conveyed by telephone to Loscutoff. Loscutoff was later unable to remember the date she received the verbal report.

On November 14, 2002, in a "confidential" report to the MEC, the MEIC summarized its findings: (1) the tenfold increase in morphine dosage, from five to 50 milligrams per hour, was "clearly outside the realm of good judgment or any MS administration protocol for the terminally ill patient"; (2) Dr. Luke's intention in ordering the increase was not only to provide pain relief or patient comfort. He was "under pressure by the family" and the increase was "also intended to hasten the patient's death"; and (3) Dr. Luke had "demonstrated a lack of concern that his decision-making was in error and inappropriate." The MEIC recommended that, for the next six months, all of Dr. Luke's hospital admissions be subject to concurrent proctoring by another physician and that the pharmacy alert a proctor whenever Dr. Luke prescribed a narcotic. In

addition, within six months, Dr. Luke was to take continuing medical education (CME) courses in the "use of narcotics for pain relief and end-of-life care."[15] When the action became final, a report would be filed with the State Medical Board.

On November 15, 2002, the day after the MEIC's confidential report to the MEC, San Bernardino County Supervising Deputy Coroner Randall Emon (Emon) called Loscutoff to say that the cause of death listed on M.E.'s death certificate would be "acute morphine toxicity." Shortly after that call, a supervising investigator from the State Medical Board, Kathleen Nicholls (Nicholls), called Bell to say that the coroner's office had reported the same information to them: that the patient had received a "lethal" dose of morphine, "ten times the usual dose." Nicholls said the State Medical Board would be conducting its own investigation into the matter.[16]

As soon as Bell received the call from Nicholls, she called Dr. Rosario and they scheduled another meeting of the MEIC for December 3, 2002. At the meeting, Bell told the MEIC members about the calls from the coroner's office and the State Medical Board. The MEIC members, who had initially intended to proctor Dr. Luke themselves, were very concerned about "the logistics of concurrent proctoring" and with their own

[15] On November 13, 2002, Dr. Luke completed a one-hour CME course on "End of Life Care" at St. Bernardine Medical Center. On February 1, 2003, also at St. Bernardine, he attended a six-hour pain management seminar.

[16] The State Medical Board's case synopsis said the toxicology report said that M.E. had received "ten times the legal limit" of morphine.

potential legal liability. Unanimously, they decided to withdraw the offer to proctor and to advise the MEC to suspend Dr. Luke's privileges.

In the interim between the November 15 and December 3 meetings of the MEIC, on November 20, 2002, Dr. Rosario wrote Dr. Luke a letter informing him of the findings and recommendations of the MEC. Dr. Rosario's letter said that the MEC had adopted the MEIC's findings that Dr. Luke had increased the morphine dose for "a terminally ill patient who subsequently expired," and had changed the IV rate himself without first including or notifying the registered nurse assigned to care for the patient. The MEC had also adopted the MEIC's recommendations regarding proctoring, pharmacy notification, and CME requirements. The letter stated that, when final, the action would require reports to the State Medical Board and to the National Practitioner Data Bank (NPDB),[17] and that Dr. Luke had a right to request a hearing. The letter did not mention the MEIC finding that Dr. Luke had been under pressure from M.E.'s family and had acted intending to hasten the patient's death.

On December 16, 2002, Dr. Luke retained physician/attorney Philip S. Cifarelli (Cifarelli) and requested a JRC hearing to dispute the MEC's action.

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[17] National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners. (See 42 U.S.C. §§ 11131–11137; 45 C.F.R. §§ 60.1–60.14 (2008).)

After Dr. Luke requested a hearing, Bell "secured" M.E.'s medical records for a second time.[18] Reviewing them sometime in early January 2003, she discovered that Dr. Luke had dictated two discharge summaries: one on September 17, 2002, and another on October 18, 2002. Both discharge summaries were in the hospital's computer system, but only the second, which appeared to be longer than the first, was signed and in the chart.[19]

Bell reported her discovery that there were two discharge summaries to David Stanley (Stanley), the RCH Director of Health Information Management, to the State Medical Board, to legal counsel, and to the MEC. On January 7, 2003, Stanley spoke to Dr. Luke. Dr. Luke told Stanley that the first discharge summary had been inadequate so he had prepared another. He neither confirmed nor denied having removed the first one from the chart.

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[18] She later testified that she had first "secured" and copied the medical records on September 27, 2002. The location of M.E.'s medical records at various times while this case was pending is unclear. Apparently, on September 16, 2002, they were in Bell's office where Dr. Shankel reviewed them. Dr. Luke later wrote that he did not have them available the following day when he dictated the first discharge summary.

[19] The second discharge summary said that Dr. Klein's recommended treatment for CIDP, "IVIG," had been considered during M.E.'s admission to LLUMC, but not actually given, as had been stated in the first summary. In addition, the second discharge summary repeated the statements Dr. Luke had made to Loscutoff on September 16, 2002, to the MEC on September 19, and in his letters to Drs. Shankel and Rosario on September 24: that he had increased the morphine dose because he had seen that M.E. was in distress under the NRM. Finally, the second discharge summary stated that M.E. had received morphine in the past and "would have developed a tolerance" such that a higher dose "would be necessary. . . ."

Three days later, on January 10, 2003, the MEC notified Dr. Luke in a second letter that his medical staff privileges at RCH had been summarily suspended as of that date. All the recommendations in the letter of November 20, 2002, including concurrent proctoring, were being withdrawn as "insufficient to adequately protect patients in the hospital." The assessment of "immediate danger" to patients was based on Dr. Luke's treatment of M.E. as related by Dr. Shankel in his September 16, 2002, memorandum. The second letter added, "We have received evidence from the San Bernardino County Coroner's Office that there was a toxic level of morphine in the patient's system. We have also received evidence that indicates that you have inappropriately altered the medical record of this patient." The second letter stated that there would be another meeting of the MEC on January 16, 2003, "to review and consider [the] suspension."

On January 22, 2003, the MEC sent Dr. Luke a third letter. This letter notified him that, as of January 16, his medical staff privileges had been suspended for one year. Although not so specified, as findings the third letter said: he had administered morphine to a terminally ill patient who subsequently expired; he had increased the dose from one to five to 50 milligrams per hour, a dose that was "clearly outside the standard of care or any known MS administration protocol for the terminally ill patient"; he had changed the rate of the IV without first notifying the registered nurse; the county coroner had found that the patient's death resulted from morphine toxicity; he had inappropriately amended the medical record by substituting a revised discharge summary "substantially after the

events described"; and he had "demonstrated a lack of recognition and understanding that [his] decision-making was in error and inappropriate."

The third letter informed Dr. Luke that he could reapply for privileges between July 15, 2003, and January 15, 2004, conditioned upon his taking and passing approved courses in end-of-life care, pain management, medical ethics, and medical record documentation. Reinstatement would depend in part on his providing evidence of his current status with the State Medical Board and any evidence discovered in its investigation. Compliance with the imposed requirements would not guarantee reinstatement. If he failed to request or receive a termination of the suspension by January 15, 2004, his privileges would be terminated.

On or about May 7, 2003, and in accordance with sections 7.3-2 to 7.3-5 of the hospital bylaws, the MEC recommended and the hospital board appointed a hearing officer, Jay Christensen of Christensen & Auer (the hearing officer), and a committee of five physician members of the RCH medical staff (the JRC) to hear the matter. Drs. Douglas C. Brockmann, Manuel A. Cantun, James R. Dexter, Chang Wang, and Heather West were the physicians appointed to the JRC. A week earlier, on April 28, Cifarelli had sent opposing counsel and the hearing officer a letter objecting to the inclusion of "two of the three members" of the JRC because of their membership in BMG, the same medical group as Dr. Shankel, a witness against his client. On May 5, the law firm representing the MEC opposed the disqualifications of Drs. Dexter and

Brockmann in a letter to Cifarelli and the hearing officer. Challenge to the two members was deferred to voir dire.

On May 12, 2003, three days before the JRC hearings began, the San Bernardino County Department of Public Health issued the first death certificate for M.E, listing sepsis, pneumonia, cardiomyopathy, and GBS as the causes of his death. On May 22, 2003, in answer to an inquiry from State Medical Board investigator Nicholls, Emon said the coroner's office was waiting for the State Medical Board's decision to complete an amendment to the death certificate.

The JRC Hearings:

The JRC met on 11 evenings between May 15, 2003 and April 29, 2004. At the first session, the parties stipulated that the MEC's letter of January 22, 2003, would constitute the "notice of charges."

May 15, 2003

Voir dire

As the hearings opened, and after questioning the five panel members about their relationships to four of the MEC's scheduled witnesses—BMG physicians Shankel, Rosario, Seiberling, and Klein—Cifarelli formally objected to the presence of Drs. Dexter and Brockmann on the panel. Like Dr. Shankel, Dr. Dexter was a pulmonary critical care specialist. He had been a BMG partner since 1989 and had known and worked with Dr. Shankel for "more than 10 years." Dr. Brockmann was an anesthesiologist who provided pain management services at the hospital and at the Inland

Surgery Center. Dr. Brockmann had been a BMG partner since 1993. It was likely, counsel argued, that as longtime colleagues and business partners with reciprocal fiduciary duties, it would be difficult for the two panel members to be objective and to rely solely on evidence presented during the hearing. Drs. West, Cantun, and Wang were unrelated to BMG, and Cifarelli did not object to them.

Counsel for the MEC, Peter Roan (Roan) asked panel members if they could be fair and impartial, and each responded in the affirmative. Roan then argued that BMG was too big for the relationships between Drs. Dexter and Brockmann and the four witnesses to present a risk of prejudice. "[T]here's many, many physicians on this staff [who] are affiliated with [BMG]. That in and of itself does not demonstrate bias." Learning from Dr. Dexter that there were approximately 140 physicians in the group, the hearing officer overruled Cifarelli's objections: "I don't believe that their association as partners in this very large medical group gives rise to an impression of bias or prejudice, and they've indicated that they are not biased."

Dr. Shankel

Dr. Shankel testified that he had learned of the incident from "Richard" (Nurse Parenteau), had "reviewed the chart," and had spoken with the "medical staff office" and "risk management," before he called Dr. Luke on September 16, 2002. Dr. Shankel verified the information in his September 16, 2002, memorandum: that after speaking with family members, Dr. Luke said he had placed M.E. on "comfort care." All of M.E.'s medications were discontinued and he was "started on a morphine drip." The

family became angry "that M.E. was still living," so Dr. Luke increased the rate of the morphine drip. Dr. Shankel could not remember Dr. Luke saying anything during their telephone conversation about the patient's having been in pain or distress as a reason for the increase.

Dr. Shankel said he had never seen a morphine dose as high as 50 milligrams per hour and had never seen a dose increased so quickly. In his view, this amount and rate of increase did not comport with the standard of care at RCH or with the comfort measures only protocol, which was "available to all physicians who want to use it" as "a guideline for titrating a morphine drip if somebody has requested or the family has requested comfort care."[20]

Because of time constraints, cross-examination of Dr. Shankel was deferred to a later session.

July 8, 2003

Nurse Parenteau

Nurse Parenteau testified, as recounted *ante*, about his telephone conversations with Loscutoff, Nurse George, and Dr. Shankel. When Nurse George called him about Dr. Luke's morphine orders, he told her that he knew of patients on doses of 150 or 200 milligrams, that the doctor may have seen something that she did not see, and for her not

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[20] The comfort measures only protocol is referred to in a variety of ways at different points in the record. We will call it either by its printed title "the comfort measures only protocol" or "the protocol." According to a notation on the copy in our record, the protocol was approved in September 2001 and revised in August 2002, about one month before this case.

to worry about the amount. Loscutoff had advised him to call Dr. Shankel, who had said he did not think the coroner needed to be notified about the case.

Nurse Parenteau knew about the hospital's comfort measures only protocol but was unfamiliar with its details. When he needed information about it, he called the ICU.

Risk Manager Loscutoff

Loscutoff confirmed that after talking to Nurse Parenteau, she had called legal counsel to find out how to notify the coroner because she was concerned that the case might be a homicide. On "Tuesday or Wednesday" (Sept. 17 or 18, 2002), she had spoken to M.E.'s son and daughter. They were unhappy that their father's body was not being released, but were not upset with Dr. Luke's care.

In the weeks after the postmortem blood sample was taken, Loscutoff had made a number of calls to the coroner's office trying to get the toxicology report. Emon had eventually responded and told her that the coroner's office had received the report and that it showed "10 times the normal amount [of morphine]." Loscutoff was uncertain of the date of Emon's call, but knew it was "quite a long time" before December 26, 2002, the day her office obtained a facsimile copy.

<u>September 29, 2003</u>

Admission of the amended (second) death certificate

The third session of the JRC hearing began with argument by Cifarelli that the August 13, 2003, amendment to M.E.'s death certificate should not be admitted into evidence. The amended (second) death certificate changed M.E.'s cause of death from

"pneumonia" and other disease conditions to "homicide" by "physician administered overdose of morphine."

In a written motion signed on September 29, 2003, Cifarelli had characterized the amended (second) death certificate as both prejudicial and irrelevant to the charges against his client as specified in the January 22, 2003, letter. If the amended certificate was admitted, Cifarelli intended to call Emon and a forensic pathologist as witnesses. Roan answered that the amended (second) death certificate was "certainly probative of the issues and the charges involving this particular patient, and it should be admitted."

The amended (second) death certificate was admitted.

Dr. Shankel

Dr. Shankel was recalled and examined first by Roan about the hospital's comfort measures only protocol. The protocol, Dr. Shankel testified again, was available for use "to give a physician guidance on comfort care." On cross-examination, Dr. Shankel said that "Dr. Dexter was one of the physicians involved in" the development of the protocol, but he did not recall anyone else who had been involved. As far as Dr. Shankel knew, the protocol was "on the computer" along with other protocols and policies but had not been distributed to the medical staff or discussed in any medical staff meetings. He thought the nursing staff was familiar with it.

Dr. Shankel said that he had reviewed M.E.'s chart before he called Dr. Luke on September 16, 2002, when they spoke for "a matter of minutes." He had dictated the memorandum of their conversation right after they hung up. He was certain he had not

misunderstood Dr. Luke on the telephone. Dr. Luke had said he increased the morphine dose because "the family was unhappy because their family member was still alive." Dr. Shankel did not recall that the patient had been started on morphine on September 12, not September 14 as stated in his memo. Dr. Shankel did not speak to Dr. Luke in person, did not review M.E.'s chart with Dr. Luke, did not show his memorandum of their conversation to Dr. Luke, and did not speak to M.E.'s family.

Director of Health Information Management David Stanley

Stanley was in charge of medical records and transcription at RCH. Stanley confirmed that there were two discharge summaries for M.E. in the hospital's computers, one (unsigned) dictated on September 17, 2002, and one (signed by Dr. Luke) dictated on October 18, 2002, but that only the latter was in the chart. Because it was signed, the second discharge summary was the only official discharge summary. Stanley testified that doctors who made corrections to medical entries, including discharge summaries, were supposed to amend rather than replace the first entry.

<u>September 30, 2003</u>

Dr. Mehta

Dr. Mehta was a family physician in private practice and chairman of the family medicine department at RCH. Dr. Mehta was on the MEC and had been the chair of the MEIC. The MEIC met four times. After much discussion, members had concluded that the increase in morphine dosage from five to 50 milligrams without titration was outside the standard of care for physicians practicing at RCH. The MEIC did not recommend

immediate suspension of Dr. Luke's hospital privileges because members thought that, with proctoring, his prescribing habits could be changed.

Dr. Luke had told MEC members on September 19, 2002, that he had increased the morphine to provide palliative and comfort care, and that he did not believe Dr. Shankel's memo of their telephone conversation was accurate. At first, the five physicians on the MEIC had intended to proctor Dr. Luke themselves. However, after they received a verbal report that the coroner planned to list M.E.'s cause of death as "acute morphine toxicity," they decided proctoring was too difficult and their legal liability was too great. The impending report "played a big part in [their] decision-making. [¶] . . . [¶] Because here we have a case where the death has occurred . . . intentionally from overdose of morphine."

In Dr. Mehta's opinion, it was not possible to see a patient's facial grimacing through an NRM because "[i]t is all fogged up and really you can't see that well."

Dr. Rosario

Dr. Rosario was an internal medicine specialist and a partner and colleague of Dr. Shankel at BMG. As chair of the MEC, she had participated in the various decisions regarding the suspension of Dr. Luke's privileges. Dr. Rosario, who had also been a registered nurse for 14 years before becoming a physician, said she found no documentation of any respiratory distress or pain in the nursing notes that would justify the use of morphine. She believed that none had ever been needed.

On cross-examination, Dr. Rosario acknowledged that this was the first time a problem with Dr. Luke's care had ever come to the attention of the MEC. She said that Dr. Luke told the MEC members that he had lifted the patient's NRM and observed signs of distress that no one else had seen. Dr. Rosario agreed that the nurse's notes did not indicate anywhere that the NRM had been removed to evaluate the patient's respiratory status. At first, the MEC members had not wanted to "end his career" on the basis of a single incident and believed they could work with him and avoid reporting the incident "as an 805."[21] On further examination, however, it seemed that Dr. Luke did not understand the community standard of care regarding morphine dosage or the ethics of medical record documentation. It was a surprise to Dr. Rosario when the death certificate showed "sepsis" as the cause of M.E.'s death because someone at the hospital had received a verbal report from the coroner's office indicating that the cause of death would be given as morphine toxicity. After learning that the coroner was going to list morphine toxicity as the cause of death, the MEIC members decided proctoring was too difficult and would subject them to liability and recommended to the MEC that Dr. Luke's privileges be suspended.

Because of the amended (second) death certificate, Dr. Rosario believed that M.E. died from morphine toxicity.

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[21] Business and Professions Code section 805.

October 2, 2003

Dr. John Hsu[22]

Dr. Hsu was an anesthesiologist and specialist in pain management in private practice, who was called as an expert witness by the MEC. Dr. Hsu was aware of recent recommendations by the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association regarding the use of high-dose morphine and appropriate management of pain and suffering in dying patients, and agreed that doses of morphine as high as 150 milligrams per hour were being used in these circumstances. However, because neither pain nor respiratory distress had been documented in the chart, he did not believe the increase in the dose used for M.E. was appropriate or within the standard of care. Dr. Hsu knew of physicians who adjusted IV infusion rates themselves.

Based on the level of morphine in M.E.'s postmortem toxicology report, Dr. Hsu believed M.E. had died from morphine toxicity.

Nurse George

Nurse George testified that M.E. was "nonverbal" and had not complained to her of pain when she cared for him on either September 13 or 14, 2002. She had increased the rate of M.E.'s morphine to "5 cc's per hour" at 3:35 p.m. She had no explanation for the fact that a nurse on the previous shift had indicated that the morphine had been increased to five milligrams at 2:00 p.m. Her assessment of M.E. had been "visual." To

[22] The reporter's transcript shows the spelling "S H U." Dr. Hsu's curriculum vitae shows "HSU."

her, the patient "seemed calm," there was "no moaning," and she did not see him "squinting" or "flailing" his arms. Nurses do not usually remove a patient's NRM when assessing a patient. After M.E. died, the IV lines were left in place for several hours; she did not remember when the morphine pump had been turned off.

Quality and Medical Staff Services Director Bell

Bell confirmed some details of the MEC and MEIC meetings with Drs. Rosario and Shankel. When the coroner's office first called and asked if the hospital was going to report the matter to the State Medical Board, she and Loscutoff did not respond because they wanted to think about it more. However, when State Medical Board investigator Nicholls told her that the coroner's office had already reported the matter and said that M.E. "had received 10 times the usual dose of morphine," she notified Dr. Rosario and the MEIC reconvened.

Bell discovered early in January 2003 that there were two discharge summaries. When she saw the first discharge summary, it was not signed. The proper procedure for changing a dictated medical record entry was to dictate an addendum to the original.

When counsel for Dr. Luke attempted to question Bell about her relationship to Dr. Dexter, whom she said she knew "very well," and about whether she had ever worked for BMG, the hearing officer deflected the inquiry: "Counsel . . . this line of questioning is really more appropriate to voir dire, which you've already had . . . ."

December 1, 2003

Dr. Ronald Katz

A physician and professor of anesthesiology at the University of California at Los Angeles and University of Southern California, Dr. Katz had testified in other cases where doctors were being prosecuted for murder for giving dying patients too much morphine.

Morphine, Dr. Katz said, is a "first-line drug" for the treatment of pain and respiratory distress. Dr. Luke's use of morphine for M.E. had been within the standard of care; an increase from five to 50 milligrams per hour was not unusual; Dr. Katz had seen doses of 100 to 300 milligrams per hour. Postmortem morphine levels are essentially "worthless" because morphine leeches from tissue into blood after a person dies, making blood levels falsely high. The only accurate postmortem blood levels are those in "vitreous humor," which was not obtained in this case.[23]

According to Dr. Katz, Dr. Shankel's September 16, 2002, memorandum was inaccurate in three ways: (1) it stated that M.E.'s morphine drip was started on September 14, 2002, when it was actually started on September 12; (2) it stated that the family was angry with Dr. Luke, when J.E. had denied this; and (3) it stated that Dr. Luke first increased the morphine and then wrote the order, when Dr. Luke had told him those events occurred in reverse order.

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[23] Vitreous humor is "the clear colorless transparent jelly that fills the posterior chamber of the eyeball." (See Princeton University WordNet Web site, <http://wordnetweb.princeton.edu/perl/webwn> [as of Feb. 10, 2011].)

Dr. Katz believed M.E. died from “multiorgan failure,” not “morphine toxicity.”

December 2, 2003

Dr. Raffi Simonian

Raffi Simonian, Pharm.D., was the Director of the Pharmacy at the University of California at San Diego hospital.

Based on the fact that M.E. had been on morphine for two days and that the increase to five milligrams per hour did not relieve the symptoms of distress observed by Dr. Luke, Dr. Simonian believed M.E. was morphine tolerant. Dr. Simonian testified that postmortem morphine blood levels are unreliable.

In Dr. Simonian’s opinion, there was generally a significant problem with physicians “undertreating” pain in dying patients.

Dr. Simonian testified about a number of published studies demonstrating that, because of their intense fear and anxiety, patients facing imminent death are able to tolerate much higher doses of morphine—up to 350 milligrams per hour and 1,120 milligrams per day—without suffering the respiratory depression that might occur in other patients.

December 4, 2003[24]

Dr. Ben Rich

Ben Rich, J.D., Ph.D., was a bioethics professor at the University of California at Davis. Dr. Rich testified that the "principle of double effect" can justify the use of a high-risk medical intervention in an actively dying patient when the potential benefit outweighs the risk of a bad side effect, and the benefit is what the doctor intends to confer. In response to questions from Dr. Dexter, Dr. Rich discussed the various forms of euthanasia, all of which, by definition, require intent to bring about someone's death.[25] In Dr. Rich's opinion, Dr. Luke's actions did not amount to euthanasia under any definition because the evidence showed that he intended to relieve M.E.'s suffering, not bring about his death.

Dr. Henrik de Jager

Henrik de Jager, M.D., a specialist in ear, nose, and throat surgery, had been a RCH medical staff member since 1977, when he first became acquainted with Dr. Luke. He had referred patients to Dr. Luke over the years because he knew him as "a competent, empathetic physician with a good reputation in the community." Dr. Luke's

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[24] Cifarelli attempted to call Dr. Stanisai, an RCH medical staff physician and longtime colleague of Dr. Luke, to testify as to his client's character for truthfulness, which he felt was a central issue in the hearing. However, the hearing officer excluded the witness on the grounds that Dr. Stanisai's testimony would be irrelevant and a waste of time.

[25] The categories are voluntary passive, voluntary active, nonvoluntary passive, and involuntary or criminal.

practice was "heavy . . . in the geriatric area." There was much competition for elderly and Medicare patients, and at one time, there had been many solo general practitioners in the Redlands area who cared for them. However, because of competition from large managed-care groups, most of these private practice physicians had left and their patients had been taken over by large groups: "In this town it's [BMG]." Dr. de Jager had never seen or heard of the RCH comfort measures only protocol; to his knowledge, it had never been discussed in any medical staff or in-house service meetings.

Between December 2003 and January 2004 Sessions

In a January 5, 2004, letter, Cifarelli requested the hearing officer's help in obtaining the testimony of Emon and Dr. Sheridan about the amended (second) death certificate. Cifarelli had arranged to have them appear, but the two had failed to show up as scheduled and, thereafter, had not returned his telephone calls. In a letter dated January 8, 2004, Roan responded that he considered their testimony "unnecessary" because the cause of M.E.'s death was "an interesting side issue," but "unimportant" to the reasons for Dr. Luke's discipline by the MEC. The central issue, Roan stated, was whether Dr. Luke's actions in increasing the rate of administration of morphine "1000%" comported with professional standards at the hospital, and testimony by the coroner and deputy coroner was "simply not probative" of those issues.

<u>January 15, 2004</u>

Dr. Solomon Liao

Solomon Liao, M.D., was an assistant clinical professor and hospitalist at the University of California at Irvine Medical Center and was board certified in "[i]nternal medicine, geriatrics medicine, and hospice and palliative medicine." Dr. Liao testified about Dr. Luke's overall management of M.E., about the use of NRM's and morphine, about the two discharge summaries, about M.E.'s pain, about the nurses' inability to detect respiratory distress, and about the likely cause of M.E.'s death.

Dr. Liao believed that Dr. Luke's management of M.E. at RCH from September 12 to September 14, 2002, had been appropriate in that it included pharmacological (opioid) and nonpharmacological (visits and discussions with patient and family) interventions and comfort care.

NRM's are used for the sickest patients because they provide the highest possible concentration of oxygen short of intubation. The NRM was appropriate for M.E. because of his shortness of breath, hypoxia, sepsis, and multisystem organ failure. It is necessary to remove the NRM to observe facial expressions, especially in a patient whose face is partially paralyzed. Dr. Luke had told Dr. Liao that he removed the NRM when he examined M.E.

Morphine is the drug of choice for patients in respiratory distress. Dr. Luke's use of morphine, including his increase in the dosage from five to 50 milligrams to relieve respiratory distress, pain, and anxiety in a patient dying from multisystem organ failure

and untreated sepsis, was appropriate. Fifty milligrams per hour was medically acceptable for a patient like M.E., as was Dr. Luke's having adjusted the IV himself when a nurse was not available to do so.

In Dr. Liao's opinion, the two discharge summaries were not significantly different. Additions in the second discharge summary included a statement that a "50 cc dose" of morphine was not unusual, that the patient was in respiratory distress and gasping for air under the NRM, that the patient smiled after the increased dose, that the patient showed no signs of morphine toxicity, that the nursing supervisor had told the nurse that he had seen rates as high as "150 cc's per hour," and that Dr. Luke believed the patient would have developed a tolerance to morphine because he had been receiving it continuously. The word "shocky" in the second summary meant essentially the same thing as the words "septic shock" in the first summary.

M.E., Dr. Liao said, had several reasons for pain and a significant condition that kept him from communicating that pain. Facial weakness made it difficult for him to demonstrate commonly seen signs like "grimacing or knitting of the eyebrows." Similarly, M.E. was "an endstage neurological patient . . . [who] oftentimes do not have the . . . strength to demonstrate accessory muscle use," which "typically nurses look for when they look for labored breathing."

As Dr. Liao testified, Dr. Dexter asked him several questions, first posing a hypothetical about whether an 80 milligram "bolus" of morphine would be a reasonable dose of morphine in a patient who had been on five or six days of morphine

at a rate of one to two milligrams per hour. Dr. Dexter said he thought that whether euthanasia had been committed was "the question," and he queried Dr. Liao as to how one could distinguish between "active euthanasia and comfort measures." "[I]f you look just at the documents in the chart and then add Dr. Shankel's note, that would suggest family-instigated active euthanasia."

Dr. Liao responded by noting that Dr. Luke had instituted curative measures, including tube feedings and IV antibiotics: "That's not the pattern . . . of a physician who wanted to perform active euthanasia." Dr. Liao would not expect a physician to do such a thing by infusion, and "certainly not write it into the chart." Health care professionals who euthanize patients generally do it in "secret, without discussion with a patient's family" and by means of boluses rather than by drip.

In Dr. Liao's opinion, the postmortem toxicology report was of "[n]o clinical significance whatsoever," and M.E. had not died from morphine toxicity. He "died from sepsis and multiorgan failure."

Nurse Caron Goller

Caron Goller, R.N., was employed by Hoag Memorial Hospital in the neurological and neurosurgical units. Nurse Goller had seen morphine doses as high as 300 milligrams per hour administered by IV drip to dying patients.

April 28, 2004

Admission of additional documents

At the beginning of this session, Cifarelli offered the transcript of the State Medical Board's March 18, 2003, interview with J.E. into evidence, while Roan offered a copy of the State Medical Board's "Accusation" (filed 2/18/04). The hearing officer ruled both documents admissible for any purpose, including for impeachment and for their substance.

The "Accusation"

The accusation charged Dr. Luke with four violations of the Business and Professions Code: gross negligence (§ 2234, subd. (b)), repeated negligent acts (§ 2234, subd. (c)), acts of dishonesty (§ 2234, subd. (e)), and failure to maintain accurate and adequate records (§ 2266). The first three charges were based on allegations that he: (A) "intentionally and deliberately hastened the death of a terminally ill patient by administering a lethal dose of morphine sulfate"; (B) "administered a lethal dosage of morphine sulfate to a terminally ill patient without a documented medical necessity"; and (C) "failed to inform the Records Department of [RCH] of his intention to dictate a second discharge summary on the patient, or of his intention to substitute the second discharge summary for the first discharge summary." The accusation based the fourth charge on a failure "to maintain adequate and accurate medical records on patient [M.E.], as more particularly alleged in paragraph 5, above." The relevant part of paragraph 5 specified that Dr. Luke's statements that he increased the morphine dose because the

patient '"was in distress and gasping for air under the [NRM],'" and that the increase "was necessary because the patient had developed a tolerance," were not documented in the medical record.

<u>J.E.'s interview with the State Medical Board</u>

In the interview, J.E. stated that he had had many conversations with M.E. and knew that his father "wished not to suffer." He reiterated M.E.'s extensive medical history and ill condition, which included extreme difficulty breathing and a severe cough on the day he was admitted to RCH. After morphine was started, the cough abated, M.E. calmed down and breathed easier, and smiled and held hands with family members. During the day on September 14, 2002, Dr. Luke was "in and out" of M.E.'s room several times to check on him. Neither J.E. nor any member of the family ever expressed anger that their father was still living or put pressure on Dr. Luke to increase the morphine.

Dr. Cyril Wecht

Cyril Wecht, M.D., J.D., was the Allegheny County Coroner in Pittsburgh, Pennsylvania, and in private practice as a forensic pathologist. Dr. Wecht had published hundreds of articles in his field and had performed about 15,000 autopsies.

In Dr. Wecht's opinion, the postmortem blood sample must have been obtained from central (heart) blood because it would have been extremely difficult to get blood from a peripheral source on the body of a person who had been dead for several days. IV morphine will continue infusing after death if the line is left open because "there's no

venous pressure to overcome." The fact that morphine is redistributed from tissue into blood and from peripheral blood into central blood after death, in conjunction with the fact that the IV lines were not removed, meant that the morphine level in the toxicology report was of no credible value in ascertaining the cause of death.

To Dr. Wecht, the fact that an autopsy had not been performed was "abominable" and "an atrocious example of poor medical-legal investigation by an official governmental agency." "For a medical examiner to sign a case like this out as a homicide without having done an autopsy is malpractice . . . ." When Dr. Dexter asked how an autopsy would have helped determine the cause of death, Dr. Wecht answered that gross and microscopic tissue examination could have more accurately measured the degree of sepsis and pneumonia, as well as the severity of M.E.'s heart disease. In addition to a more accurate drug level, the effect of morphine on the brain might also have been seen.

In Dr. Wecht's opinion, M.E. died of "multiorgan system failure."

<u>April 29, 2004</u>

Dr. Luke's failure to testify

At the beginning of the final session, Cifarelli told the hearing officer and the panel that, because of the language in the amended (second) death certificate, he had advised his client not to testify. Instead, Cifarelli offered a declaration by Dr. Luke explaining his position. Roan objected, and the hearing officer ruled the document inadmissible, reasoning that it would be "patently unfair" to allow a declaration by a

witness who was present and could testify and be cross-examined by counsel and the panel members. The hearing officer suggested that in closing argument, counsel should "provide any guidance . . . on any inferences that can or should not be drawn from Dr. Luke's decision not to testify . . . ." Dr. Luke was not called by either side and did not testify.

Closing arguments

Roan for the MEC

Roan first asserted that the case was not about moral and ethical issues related to euthanasia, not about physician assisted suicide, and not even about whether an overdose of morphine had caused M.E.'s death. It was about Dr. Luke's judgment in administering a "lethal dose" of morphine to a "frail, elderly patient" and then "redoing the discharge summary to add information in an apparent attempt to justify the unjustifiable . . . ." Counsel told the panel that the information in the memo from "Ted" Shankel was "the best evidence you have" of Dr. Luke's intentions: He "succumbed to the pressures brought to bear on him by the family and . . . administered the lethal dose of morphine."

Roan compared the two discharge summaries and described the second as an "alteration of the medical record."

Counsel said that the MEC had not received any evidence that Dr. Luke had attempted to comply with the CME requirements.[26] Instead, he had "hired counsel and

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[26] It is not clear whether counsel was aware of the CME courses Dr. Luke had completed.

decided to challenge those actions." The fact Dr. Luke had chosen not to testify at the hearing meant either that he had provided false information to all his own experts and now "feared" cross-examination or that, if he testified, he would do so "falsely."

Summing up, Roan compared Dr. Luke to Dr. Jack Kevorkian.[27] "[A]t least Dr. Kevorkian devised methods where the persons who were looking to commit suicide performed the last act that would result in their death. Here patient ME didn't perform that last act. It was Dr. Luke that performed it."

Cifarelli for Dr. Luke

Cifarelli told the panel members again, "as an officer of the court," he had advised his client not to testify because of the "opinions and conclusions expressed in the amended [second] death certificate." He urged them not to draw negative conclusions from the fact that Dr. Luke was following his advice and reminded them that Emon and Dr. Sheridan had ignored repeated requests to appear and testify.

Cifarelli reiterated M.E.'s wishes, expressed to his son and to his physician, that he not suffer "an agonizing death" and emphasized that this was what his client had been trying to prevent.

Counsel pointed out that Dr. Shankel's testimony had been contradicted by M.E.'s family and by Dr. Luke. He repeated his objections to Drs. Dexter and Brockmann

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[27] Jack Kevorkian, M.D., is a right-to-die activist best known for publicly championing a terminal patient's right to die via physician-assisted suicide. (See Biography.com Web site, <http://www.biography.com/articles/Jack-Kevorkian-9364141>, [as of Feb. 10, 2011].)

having been on the panel, stressing their long professional relationships and personal friendships with Dr. Shankel as well as what counsel considered specific evidence of Dr. Dexter's lack of objectivity.

The JRC Decision:

The JRC found the MEC recommendations of January 16, 2003, to suspend Dr. Luke's hospital privileges "reasonable and warranted." A report of the decision was transmitted to Dr. Luke on May 28, 2004.

Regarding the use of morphine: the JRC's findings differed somewhat from the charge in the MEC's letter of January 22, 2002. The JRC found that Dr. Luke had increased the morphine dose from five to 50 milligrams per hour without properly titrating the dose, and that the increase was a violation of the "standard of practice at this facility for end of life, comfort care medical management[,]" rather than, "outside of any known MS protocol for the terminally ill patient." In the JRC's view, the increase would have been justified only if Dr. Luke had properly determined that M.E. was morphine tolerant by doubling the dose at 30-minute intervals and "evaluating the resulting affect [*sic*] on the patient's pain, discomfort or distress."[28] Because Dr. Luke had failed to contemporaneously document the patient's pain or respiratory distress, the increase was also outside the standard of care.

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[28] These criteria are those specified in the preprinted physician orders for nurses in the comfort measures only protocol. (See fn. 42, *infra*.)

Regarding the IV pump: the JRC found that, although it would have been better if Dr. Luke had "consulted with other caregivers" before adjusting the machine, he was qualified to do so.

Regarding the toxicology report: the JRC found "[i]t is undisputed that the County Coroner's Office did determine that M.E. had received a lethal dose of morphine. Indeed, the Coroner's offices issued a revised death certificate identifying the cause of M.E.'s death as physician administered morphine." The decision acknowledged that "the level of morphine . . . as measured by the Coroner's office may have been unreliable" and that "the evidence was inconclusive as to whether M.E., in fact, received a lethal dose of morphine" as stated on the amended (second) death certificate. Nonetheless, the JRC concluded, "it [is] much more likely than not that Dr. Luke administered a potentially lethal dose of morphine to M.E. in response to actual or perceived pressure from M.E.'s family."

Regarding the second discharge summary: the decision devoted its longest section to a discussion of this issue, concluding that Dr. Luke had "violated an Administrative Policy on Medical Record Documentation" by failing to identify the second summary as an addendum to the first one. The revised summary, the decision stated, was not prepared "'in or around the time services were actually rendered'" and appeared to have been "intended to buttress Dr. Luke's position in an on-going disciplinary action." Because of his silence in the face of a question from the Director of Health Information Management, and because "he chose not to testify during the hearing" and "be cross-

examined on this point" the JRC found it "substantially more likely than not" that Dr. Luke had removed the initial discharge summary from the chart himself.

Finally, the JRC decision affirmed that its hearings had been fair in that Dr. Luke had received "adequate notice" of the charges against him and had been afforded "ample opportunity" to respond, and that the hearing had been conducted "in accordance with the Medical Staff bylaws." The report acknowledged that Dr. Luke had objected to the appointments of Drs. Dexter and Brockmann because they "are both partners in a large medical practice group in which a key witness, Dr. Shankel, is also a partner." However, it concluded that Drs. Dexter and Brockmann would "derive no personal, financial or professional benefit from the outcome of the hearing" and had "no bias or prejudice against Dr. Luke." "[T]he fact that they are partners in a medical group with well over 100 other physicians including Dr. Shankel, does not suggest that they have been unduly influenced by Dr. Shankel."

Each of the JRC panel members signed the report separately. Dr. Dexter, chronologically the second panel member to sign the report,[29] added a handwritten comment to his signature page: "Dr. Dexter would benefit from Dr. Luke remaining on staff as Dr. Luke has historically referred patients for critical care consultation to him." The statement was not on any of the individual signature pages signed by panel members

[29] Dr. Wang signed on May 19, Dr. Dexter on May 24, Dr. West on May 26, and Drs. Cantun and Brockmann on May 27, 2004.

other than Dr. Dexter, but was included in the printed report, which stated that it had been "adopted by unanimous vote of the members of the [JRC]."

Internal Appeal:

On June 7, 2004, Dr. Luke appealed the JRC decision to a seven-member "Appeal Board," appointed by the hospital board from among its members. Only one of the seven was a physician. Attorney Donald A. Goldman of McDermott, Will, and Emery, was selected as the "presiding officer." Oral argument was held on November 17, 2004.

In the internal appeal, Dr. Luke continued to maintain that the JRC proceedings had been unfair because of the inclusion of Dr. Shankel's friends and colleagues, Drs. Dexter and Brockmann, on the panel. Dr. Dexter, in particular, had worked closely with Dr. Shankel on an ongoing basis for many years and because of that relationship could not be reasonably expected to be a "fair and impartial" judge of the facts.

In addition, Dr. Luke argued, for various reasons, that the evidence presented at the hearing was insufficient to support the panel's conclusions.

On December 3, 2004, the appeal board affirmed the findings and decision of the JRC. The process, the recommendation stated, had provided Dr. Luke with procedural fairness and the decision of the JRC was supported by substantial evidence. The inclusion of Drs. Dexter and Brockmann on the panel had not rendered the process unfair because Dr. Luke failed to show that either doctor would gain any direct financial benefit from the outcome of the hearing. The fact that Dr. Dexter asked "difficult" questions during the JRC hearings did not demonstrate "even the probability of unfairness . . . ."

On January 6, 2005, the hospital board adopted the recommendation of the appeal board, and issued a final decision terminating Dr. Luke's privileges. On January 28, 2005, the action was reported to the NPDB.

The Concurrent State Medical Board Investigation:

The investigation by the State Medical Board, which continued throughout the period of the JRC hearings, was opened upon the referral from the coroner's office when, on November 15, 2002, "Emon . . . hand delivered the case and related documents." The investigation report was signed on August 13, 2003, the date the coroner issued the amended (second) death certificate.

On February 18, 2004, three months before the JRC reached a decision, the Deputy State Attorney General Samuel Hammond filed the "Accusation" against Dr. Luke on behalf of the State Medical Board. As already stated *ante*, the accusation charged the doctor with gross negligence, repeated negligent acts, acts of dishonesty, and failure to maintain accurate and adequate records.

State Medical Board Administrative Law Judge James Ahler heard the matter in a series of sessions in May and June 2005. Dr. Sheridan, who testified on May 24, 2005, said that he had not performed an autopsy because M.E.'s underlying illnesses were well documented and "[w]e knew that he was actually in a terminal state." Dr. Sheridan also confirmed that the phenomenon of postmortem redistribution makes drug levels in blood taken from the heart less reliable than those in peripheral blood and particularly difficult

to interpret. "Because if there is going to be a discrepancy, the heart will always be higher."

Nonetheless, based on the morphine level in the toxicology report from the San Diego laboratory, it was Dr. Sheridan's opinion that M.E. had died from "acute morphine toxicity." It was because of the toxicology report that he had amended M.E.'s first death certificate. Dr. Sheridan did not know why so much time had elapsed between his office's receipt of the toxicology report and the issuance of the amended (second) death certificate or why the certificate had been amended only after receipt of the State Medical Board's report.[30]

Emon testified two days after Dr. Sheridan, on May 26, 2005. He too could not explain why the amended (second) death certificate had not been issued until the exact date the State Medical Board report was signed. Emon acknowledged, however, that his office had waited to issue the amended certificate until it learned the State Medical Board's position in the case. In response to queries from Judge Ahler, Deputy Attorney General Samuel Hammond, and Cifarelli, Emon admitted that he did not know the site on the body of the deceased from which the blood sample for the toxicology test had been drawn. The form said "peripheral," but he thought the actual site may have been written on the vial.

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[30] The coroner's office received the toxicology report on October 29, 2002. The death certificate was amended on August 13, 2003, the day the State Medical Board issued its report.

On June 22, 2005, Judge Ahler submitted a decision proposing to revoke Dr. Luke's license, the State Medical Board's most severe penalty, effective September 6, 2005.[31] On August 19, 2005, Dr. Luke wrote a detailed personal letter to the State Medical Board, explaining his actions in the case and requesting a reconsideration of the proposed decision. On September 14, 2005, the State Medical Board agreed to reconsider the matter.

On January 18, 2006, Dr. Sheridan wrote a second addendum report regarding the death certificate for M.E., changing the cause of death from "morphine toxicity" to "undetermined." This addendum or "third" death certificate explained that the source of the blood drawn from M.E.'s body was central rather than peripheral and that the form had apparently been changed by an employee at the San Diego laboratory. The level of morphine in M.E.'s postmortem blood sample, as reported by the San Diego laboratory, was about "three times" the level generally considered toxic. After reconsideration "at considerable length" and "[w]eighing all the elements of the case," including the history of the patient's illness, the events leading up to his death, the high level of morphine, the possibility of postmortem redistribution, and the fact that the morphine pump had been left on for an undetermined amount of time following death, Dr. Sheridan concluded that the appropriate action was to change the cause and manner of death to reflect uncertainty.

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31 Disciplinary measures the State Medical Board may take against a licensee, in descending order of severity, include: revocation, suspension, probation with monitoring, public reprimand with required educational courses, and "any other action" deemed proper. (Bus. & Prof. Code, § 2227, subd. (a)(1) – (a)(5).)

On February 2, 2006, the State Medical Board, with Judge Ahler again presiding, heard oral argument at the reconsideration hearing. On March 10, 2006, the State Medical Board issued a final "Decision After Reconsideration." The decision stated that Dr. Luke had committed a "simple departure from the standard of care by increasing the morphine sulfate drip infusion . . . from 5 mg./hour to 50mg./hour without gradually titrating the dose . . . ." The evidence had not established gross negligence, dishonesty, or repeated acts of negligence. However, there was cause to discipline Dr. Luke because he "failed to maintain adequate and accurate records" regarding the care of M.E. For this failure, the State Medical Board issued Dr. Luke a "Public Reprimand" and imposed a requirement that he enroll in and complete a course in medical record keeping.

The 1094.5 Petition:

Meanwhile, on June 24, 2005, two days after Judge Ahler submitted his original proposed decision, Dr. Luke filed an amended 1094.5 petition. On November 14, 2005, the hospital filed an opposition.

The 1094.5 petition argued again that the proceedings below had been unfair because Drs. Dexter and Brockmann had been allowed to remain on the JRC panel despite their close relationship with Dr. Shankel, the key witness against Dr. Luke. The three physicians were "friends and colleagues as well as partners in practice." As a result, Dr. Luke argued, Drs. Dexter and Brockmann could not be "fair, unbiased, and impartial" when evaluating Dr. Shankel's evidence. The 1094.5 petition cited Business and Professions Code section 809.2, which requires JRC panel members to be "unbiased

individuals who shall gain no direct financial benefit from the outcome." (Bus. & Prof. Code, § 809.2, subd. (a).) The petition also suggested that the provision had been violated because BMG was in direct economic competition with Dr. Luke's Quality Medical Group.

As part of the 1094.5 petition, Dr. Luke submitted evidence, discovered during and after the State Medical Board hearings, that the blood sample for the report issued by the San Diego laboratory had in fact been drawn from central rather than peripheral blood, and that the reported morphine level was therefore unreliable. The 1094.5 petition noted that the level had been relied upon by the coroner as the basis for the amended (second) death certificate, by the JRC in its findings related to Dr. Luke and the standard of care, and by the State Medical Board in its investigations. In addition, rather than conduct an independent investigation, the coroner had relied improperly on the State Medical Board's decision.

In opposition, the hospital maintained that the proceedings had been fair because Drs. Dexter and Brockmann were associated with Dr. Shankel in a very large medical group and would gain no direct financial benefit from the outcome of this case. The new evidence of the source of the blood used to determine the morphine level was not relevant because the JRC decision had acknowledged that the toxicology report might be wrong and that the evidence was "'inconclusive'" as to whether M.E. had in fact received a lethal dose of morphine or had died from a morphine overdose. Thus, "the JRC did not rely on the Coroner's report in making its determination."

On April 25, 2007, having heard oral argument from both parties on December 29, 2006, Judge Krug denied the 1094.5 petition on grounds that Dr. Luke was prejudiced by: Dr. Shankel testifying as a witness at the JRC hearing; the exclusion of character witnesses; or the admission of Dr. Shankel's memorandum.[32] In the court's view, the fact that Dr. Shankel "was in a business partnership with two of the board members was not an indication of any prejudice."[33]

However, the court found merit in Dr. Luke's arguments about new evidence. Judge Krug issued a peremptory writ of mandate commanding the hospital board to reconsider its decision to terminate Dr. Luke's medical staff privileges in light of the evidence regarding the source of blood for the toxicology report and in light of the State Medical Board's decision not to revoke his license. If, after consideration of these two items, the hospital board reaffirmed its decision to revoke Dr. Luke's privileges, it was to state specific concerns about his remaining on staff.

Judge Krug admonished the parties about how to proceed: "Now if the [hospital] board follows the Court's order in reconsideration of this matter as it is ordered to do, it is to make specific findings if they decide to continue with the suspension of Dr. Luke as to why they are suspending him, what particular concerns they have regarding his staying on the staff, and what remedies should be taken." The court also advised Dr. Luke to

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[32] The reporter's transcript of the oral argument appears to be mislabeled as December 29, 2007, rather than December 29, 2006.

[33] The court appears to have meant JRC "panel" members, not "board" members.

cooperate, without resistance, in whatever supervision or proctoring program the hospital might impose.

The court retained jurisdiction for purposes of review of the hospital board's reconsideration decision.

The Hospital Board Proceedings on Remand:

The hospital board held the reconsideration hearing on November 29, 2007. Richard Ackerman represented Dr. Luke.[34] The 12-member board included three physicians and nine nonphysicians. Roan again represented the MEC. Thomas A. Ryan of McDermott, Will, and Emery, represented the hospital. As the hearing opened, hospital board chairperson Patricia Gilbreath announced, "I'm the hearing officer." Ryan introduced himself and spoke three more times during the hearing: twice regarding the numbering of exhibits, and once to agree that Ackerman's argument would count as an objection raised in the record. The hearing consisted only of oral argument by counsel.[35]

Ackerman's substantive arguments were that the defective toxicology report had formed the foundation of the amended (second) death certificate, which had, in turn, fueled suspicion that his client had intentionally killed M.E. Counsel noted that the State

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[34] Cifarelli, who died in April 2008, was apparently ill. (See The Cifarelli Law Firm Web site, <http://www.cifarellilaw.com/CM/Custom/Philip.Cifarelli.asp> [as of Feb. 10, 2011].)

[35] Ackerman made two unfair procedure arguments: (1) that he had not been informed beforehand of the hospital board's intended action at the remand hearing as required by the Business and Professions Code; and (2) that Ryan, rather than Gilbreath, was actually functioning as the hearing officer, and that as a paid advocate for the hospital, he could not be neutral.

Medical Board had found Dr. Luke guilty only of a "records keeping infraction." Finally, he argued that conformity to Judge Krug's order meant that the hospital board must consider what *present* danger, if any, the hospital board believed Dr. Luke posed to patients.

Roan answered that neither the toxicology report nor the State Medical Board's decision had any relevance to its review of the matter, which should be based only on substantial evidence to support the prior decisions. Counsel emphasized the differences between the first and second discharge summaries and Dr. Luke's lack of cooperation with the MEC recommendations: he had done "nothing" counsel said, in the intervening five years, "no [CME] and no end of life care, none in managing narcotics in such patients, none. He didn't do any of it. He chose, he made a judgment not to do it."[36] Thus, counsel argued, Dr. Luke continued to "pose a threat to the life or well-being of patients in the hospital."

On December 27, 2007, the hospital filed a return to the 1094.5 petition stating that it had followed the court's command and decided to again uphold the JRC decision and to affirm its own earlier decision to revoke Dr. Luke's privileges. In the hospital board's opinion, neither the revised death certificate nor the State Medical Board's decision affected its conclusion that Dr. Luke posed an ongoing danger to patients. The revised death certificate did not change the hospital board's decision because the JRC

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[36] Again, it is unclear whether Roan was aware of the pain management and end-of-life courses Dr. Luke had completed at St. Bernardine Medical Center in November 2002 and February 2003.

decision had acknowledged that the cause of death was uncertain. The State Medical Board's decision did not affect the hospital board's decision because it had an "independent duty" to determine whether Dr. Luke should remain on staff.

The hospital board remained concerned about: (a) Dr. Luke's improper record keeping, particularly the existence of the two discharge summaries; (b) evidence of his improper administration of morphine shown by the lack of documentation of pain in the nursing notes, Dr. Shankel's testimony regarding his telephone call with Dr. Luke during which Dr. Luke had said he increased the morphine because the family was upset that M.E. was still alive, and Dr. Luke's failure to follow the titration schedule outlined in the comfort measures only protocol; and (c) Dr. Luke's lack of cooperation with the MEC's recommendations and his failure to attend the reconsideration hearing.

On June 19, 2008, with Judge Brisco presiding, the parties presented oral argument at a return hearing on the 1094.5 petition. Regarding due process, Judge Brisco commented, "I can't see that Dr. Luke's due process rights have been violated. I mean, he's had more than, what, how many—three, four hearings?" On July 21, 2008, the court denied the 1094.5 petition.

Dr. Luke filed a notice of appeal on October 24, 2008. Briefing was complete on August 17, 2009.

DISCUSSION

Throughout this case, Dr. Luke has maintained that the proceedings below were unfair. With little variation, he has rested his argument on two major points: (1) the

likelihood of adjudicator bias on the parts of Drs. Dexter and Brockmann because of their close professional, business, and personal relationships to the primary witness against him; and (2) the detrimental effect of unreliable reports from the coroner's office.

Because we find merit in these arguments and the answer to the question of fairness dispositive, we do not reach either party's many other concerns regarding substantial evidence to support the JRC and the hospital board's decisions or any of their respective public policy concerns.[37]

Relevant to the question of fairness, we consider, in the following order: (1) background information about the relationship between hospitals and medical staff; (2) state and federal law pertaining to the peer review process; (3) Code of Civil Procedure section 1094.5; and (4) due process and adjudicator bias issues specific to this case.

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[37] For example, we either do not reach or do not find persuasive Dr. Luke's suggestion that the change of position by the coroner's office and the State Medical Board was based on "exculpatory" evidence or "vindicated" his actions; or that it is necessarily against public policy for the hospital to be involved at all in treatment decisions between physicians and their dying patients. We also see no prejudice to Dr. Luke from the exclusion of character evidence, which came in anyway with the testimony of Dr. de Jager. Nor do we agree with the hospital's own public policy argument that a physician is not authorized to "take any affirmative action in trying to alleviate the pain" of a patient who has refused other medical treatment "particularly where it would hasten death." We do agree, however, that hospitals have the authority to "regulate their medical staffs to ensure competent staffing."

Because it is unclear from the record or the parties' briefs what role his law firm had or later assumed in relationship to RCH, we also do not address attorney Goldman's role as hearing officer at the internal appeal hearing or Dr. Luke's argument that it constituted a conflict. Ryan's role at the hospital board's rehearing was de minimis.

The Relationship Between Hospitals and Medical Staff:

Under California law, every acute care hospital must have an "organized medical staff responsible to the governing body for the adequacy and quality of the care rendered to patients." (Cal. Code Regs., tit. 22, § 70703, subd. (a); see also *Smith v. Selma Community Hospital* (2008) 164 Cal.App.4th 1478, 1482 (*Smith*); *Mileikowsky v. West Hills Hospital & Medical Center* (2009) 45 Cal.4th 1259, 1267 (*Mileikowsky*).) The medical staff is a self-governing association and a separate legal entity from the hospital. (*Medical Staff of Doctors Medical Center in Modesto v. Kamil* (2005) 132 Cal.App.4th 679, 685.) Its purpose is to oversee physicians who practice at the hospital. (*Hongsathavij v. Queen of Angels etc. Medical Center* (1998) 62 Cal.App.4th 1123, 1130, fn. 2 (*Hongsathavij*).) Medical staff responsibilities include the adoption of written bylaws that establish formal procedures for appointing and reappointing staff physicians and other practitioners and a means of enforcement of those bylaws. (Cal. Code Regs., tit. 22, § 70703, subd. (b).) "In other words, the bylaws must establish a peer review process." (*Smith*, at p. 1482.)

The Peer Review Process:

Peer review is grounded in both state and federal law. At all levels, procedural and substantive fairness are required.

<u>Federal Law</u>

Finding that "medical malpractice and the need to improve the quality of medical care" had become nationwide problems, that could be "remedied through effective

professional peer review," in 1986 the United States Congress enacted the Health Care Quality Improvement Act (the Act). (42 U.S.C. § 11101 et seq.) Under the Act, such a review is to be taken, among other things, "after a reasonable effort to obtain the facts of the matter," and "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 . . . ." (42 U.S.C. § 11112, subd. (a)(1), (a)(2), italics added.)

The Act established a databank (the NPDB) to which health care entities (including hospitals, insurance companies, & state medical boards) must report medical malpractice payments and adverse actions taken against a physician's clinical privileges. A hospital must check the NPDB every two years for information about physicians currently on its staff. (42 U.S.C. §§ 11135-11137.) Failure to report or to inquire is punishable by a fine of up to $10,000 for each offense as well as loss of immunity from civil damages. (42 U.S.C. § 11131, subd. (c).) Because of these monitoring and disclosure requirements, a negative report to the NPDB can have a devastating "snowball" effect on a physician's career. (Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals* (2004) 38 U.S.F. L.Rev. 301, 304, 318.)

State Law

Purpose and History

Concerned about "possible adverse interpretations by the courts," California elected to opt out of the federal statute and in 1989 designed its own peer review system,

codified in Business and Professions Code sections 805 through 809. (Bus. & Prof. Code, § 809, subd. (a)(2); see also *Smith*, *supra*, 188 Cal.App.4th at p. 1519, fn 22.)

The primary purpose of the peer review process in California is to protect the people of the state from substandard care by incompetent physicians. (*Mileikowsky*, *supra*, 45 Cal.4th at p. 1267, citing Bus. & Prof. Code, § 809, subd. (a)(4), (a)(6).) A second purpose is to protect hospitals from exposure to malpractice liability. (*Mileikowsky*, at p. 1267.) A third purpose, "also if not equally important, is to protect competent practitioners from being barred from practice for arbitrary or discriminatory reasons." (*Ibid.*)

The state's system "recognizes not only the balance between the rights of the physician to practice his or her profession and the duty of the hospital to ensure quality care, but also the importance of a fair procedure, free of arbitrary and discriminatory acts." (*Unnamed Physician v. Board of Trustees* (2001) 93 Cal.App.4th 607, 616-617 (*Unnamed Physician*); see also *Kaiser Foundation Hospitals v. Superior Court* (2005) 128 Cal.App.4th 85, 97.)

Business and Professions Code section 805

Business and Professions Code section 805 specifies that adverse actions against a physician's medical staff privileges must be reported to the State Medical Board "within 15 days after the effective date . . . [¶] . . . [r]estrictions are imposed . . . for a medical disciplinary cause or reason," or if a "summary suspension . . . remains in effect for [more than] 14 days." (Bus. & Prof. Code, §§ 805, subds. (b)(3), (e).) As with the

NPDB at the federal level, every institution granting or renewing staff privileges for any physician must request a report from the State Medical Board to determine if a Business and Professions Code section 805 report has been filed. (Bus. & Prof. Code, § 805.5.) Persons responsible for filing Business and Professions Code section 805 reports are: "The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility." (Bus. & Prof. Code, § 805, subd. (b).)

Business and Professions Code section 809

Business and Professions Code sections 809 though 809.2 outline the specific requirements of the peer review process. Incorporation of the statutory provisions into the medical staff bylaws is mandatory, not advisory or discretionary. (Bus. & Prof. Code, § 809, subd. (a)(8)); *Unnamed Physician*, *supra*, 93 Cal.App.4th at p. 622; *Sahlolbei v. Providence Healthcare, Inc.* (2003) 112 Cal.App.4th 1137, 1147 [Fourth Dist., Div. Two].) Subject to the requirements of the statute, through which the Legislature has delegated to the private sector to provide fairly conducted peer review, a hospital's bylaws govern the proceedings. (*Payne v. Anaheim Memorial Medical Center, Inc*. (2005) 130 Cal.App.4th 729, 739, fn. 5; *Kaiser Foundation Hospitals v. Superior Court*, *supra*, 128 Cal.App.4th at p. 97; *Unnamed Physician*, at p. 622.)

Business and Professions Code section 809.2 specifies that a peer review hearing "shall be held . . . before a trier of fact, which shall be an arbitrator or arbitrators selected

by a process mutually acceptable to the licentiate and the peer review body, *or* before a panel of *unbiased* individuals who shall gain no direct financial benefit from the outcome, [and] who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the same matter." (Bus. & Prof. Code, § 809.2, subd. (a), italics added.) Business and Professions Code sections 809.4 and 809.8, respectively, provide for the possibility of internal appeal rights and the availability of judicial review via Code of Civil Procedure section 1094.5.

The fact that a physician has been accorded all of the procedural rights specified in the bylaws does not necessarily make the process fair. (*Payne v. Anaheim Memorial Medical Center, Inc*., *supra*, 130 Cal.App.4th at p. 742, fn. 7.) In addition to unbiased adjudicators, "[A] basic ingredient of the 'fair procedure' required . . . is that an individual who will be adversely affected by a decision be afforded some meaningful opportunity to be heard in his defense." (*Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 555.)

Code of Civil Procedure section 1094.5

Code of Civil Procedure section 1094.5 provides, in relevant part:

"(a) Where the writ is issued for the purpose of inquiring into the validity of any final administrative order or decision . . . .

"(b) The inquiry . . . shall extend to the questions whether the respondent has proceeded without, or in excess of jurisdiction; *whether there was a fair trial*; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established

if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.

[¶] . . . [¶]

"(d) . . . [I]n cases arising from private hospital boards, . . . abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record. . . .

"(e) Where the court finds that there is relevant evidence that, in the exercise of reasonable diligence, could not have been produced . . . at the hearing before respondent, it may enter judgment . . . remanding the case to be reconsidered in light of that evidence . . . .

"(f) . . . Where the judgment commands that the order or decision be set aside, it may order the reconsideration of the case in the light of the court's opinion and judgment and may order respondent to take such further action as is specifically enjoined upon it by law, but the judgment shall not limit or control in any way the discretion legally vested in the respondent." (Italics added.)

Scope and Standard of Review:

Scope

In reviewing an order regarding a 1094.5 petition, an appellate court does not review the trial court's ruling, but the final administrative decision. In doing this, "we consider all relevant evidence in the administrative record." (*TG Oceanside, L.P. v. City of Oceanside* (2007) 156 Cal.App.4th 1355, 1371.)

The task involves two questions: (1) whether the proceedings before the hearing panel and any appellate review bodies were fair; and (2) whether, if so, substantial evidence supported the findings. (Code Civ. Proc., § 1094.5, subd. (b); *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 483; *Cipriotti v. Board of Directors* (1983) 147 Cal.App.3d 144, 154; *Yakov v. Board of Medical Examiners* (1968) 68 Cal.2d 67, 72.)

Standard of Review

Determination of whether proceedings were fair is a question of law upon which we exercise our independent judgment. (*Ellison v. Sequoia Health Services* (2010) 183 Cal.App.4th 1486, 1496; *Sinaiko v. Superior Court* (2004) 122 Cal.App.4th 1133, 1141.) Mere technical compliance is not sufficient to ensure fairness. "'Due process requires a fair trial before an impartial tribunal . . . due process is not interested in mere technical formalism. It is the substance that is determinative of whether due process has been afforded.'" (*Ventimiglia v. Board of Behavioral Sciences* (2008) 168 Cal.App.4th 296, 310.) While the required independent review of fairness and due process issues is not a "'trial de novo' . . . the court renders its independent judgment on the basis of the administrative record plus such additional evidence as may be admitted under [Code of Civil Procedure] section 1094.5, subdivision (e)." (*Pomona Valley Hospital Medical Center v. Superior Court* (1997) 55 Cal.App.4th 93, 101.)

During oral argument, counsel for the hospital suggested that our tentative opinion "shot at the wrong target" by focusing on questions of fairness rather than on substantial

evidence to support the underlying factual charges against Dr. Luke. In counsel's opinion, the appropriate standard of review is stated in *Hongsathavij*, *supra*, 62 Cal.App.4th 1123. We disagree.

On the issue of fairness, *Hongsathavij* is not apt here. *Hongsathavij* dealt with the appropriate standard (substantial evidence) to be used by a reviewing court to determine whether a hospital's board of directors, in turn, had used the correct standard in reviewing a peer review body's decision on a substantive issue (whether a physician had abandoned a patient by admitting her to the hospital and then refusing to treat her for financial reasons). (*Hongsathavij*, *supra*, 62 Cal.App.4th at pp. 1135-1138.) Similarly, neither *Kumar v. National Medical Enterprises, Inc.* (1990) 218 Cal.App.3d 1050 nor *Huang v. Board of Directors* (1990) 220 Cal.App.3d 1286 (*Huang*)—the two cases upon which *Hongsathavij* primarily relied—dealt with fairness issues analogous to ours. *Kumar* concerned the requirement that administrative remedies must be exhausted before a party may seek relief in the courts. (*Kumar*, at pp. 1056-1057.) *Huang* concerned the standard of review to be used by a hospital board in reviewing the *factual* findings of a judicial review committee. (*Huang*, at pp. 1295-1296.)

The hospital's brief is structured much like its oral argument, concluding that Dr. Luke "has received more than a fair hearing, as he had several fair opportunities to present his position on the charges against him." Unfortunately, on this point, the hospital is simply wrong.

Two factors—a mislabeled and very possibly erroneous laboratory test, and the composition of the JRC—virtually guaranteed that Dr. Luke had no significant opportunity to "be fully and fairly heard before an impartial decisionmaker." (*Catchpole v. Brannon* (1995) 36 Cal.App.4th 237, 245 (*Catchpole*), overruled in part on another ground as stated in *People v. Freeman* (2010) 47 Cal.4th 993, 1006, fn. 4.) Once the amended (second) death certificate was admitted, stating that the cause of M.E.'s death was "homicide" due to a "physician-administered" overdose of morphine, it became impossible for Dr. Luke to testify in his own defense in the administrative hearing. And, whether all of his adjudicators were impartial is, at best, seriously open to question.

Fair Procedure, Due Process, and Adjudicator Bias:

Because hospital staff privileges represent a fundamental, vested right, an individual physician who is being divested of this right by expulsion from a hospital staff is "entitled to a fair procedure by which to challenge the action taken." (*Lasko v. Valley Presbyterian Hospital* (1986) 180 Cal.App.3d 519, 528; see also *Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, 825.) A basic requirement of fair procedure is that adjudicators must be fair and impartial or unbiased. While "a trier of fact does not have to be completely indifferent to the general subject matter of the claim presented to be impartial" (*Cohan v. City of Thousand Oaks* (1994) 30 Cal.App.4th 547, 559), it is still the case that "due process requires fair adjudicators in courts and administrative tribunals alike." (*Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1024-1025 (*Haas*);

see also *Rosenblit v. Superior Court* (1991) 231 Cal.App.3d 1434, 1448; *Goldberg v. Kelly* (1970) 397 U.S. 254, 267, 271).)

"The distinction between fair procedure and due process rights appears to be one of origin and not of the extent of protection afforded an individual; the essence of both rights is fairness." (*Applebaum v. Board of Directors* (1980) 104 Cal.App.3d 648, 657 (*Applebaum*).) "Whatever disagreement there may be in our jurisprudence as to the scope of the phrase 'due process of law,' there is no dispute that it minimally contemplates the opportunity to be fully and fairly heard before an impartial decisionmaker." (*Catchpole*, *supra*, 36 Cal.App.4th at p. 245.) "Due process . . . *always* requires . . . a fair hearing before a neutral or unbiased decision maker." (*Nightlife Partners, Ltd. v. City of Beverly Hills* (2003) 108 Cal.App.4th 81, 90.)

In *Pacific Etc. Conference of United Methodist Church v. Superior Court* (1978) 82 Cal.App.3d 72, 86-87 (*Pacific*), Division One of this district reviewed a number of cases relating to adjudicator bias and discussed its definitions and manifestations at some length. "Bias is defined as a mental predeliction [*sic*] or prejudice; a leaning of the mind; 'a predisposition to decide a cause or an issue in a certain way, which does not leave the mind perfectly open to conviction.' [Citation.] Bias or prejudice consists of a 'mental attitude or disposition of the judge towards a party to the litigation, . . .' [¶] . . . 'Bias equates here with partiality. . . .' [¶] . . . 'Prejudice imports the formation of a fixed anticipatory judgment . . . although it does not necessarily indicate any ill feeling.'"

(*Id.* at pp. 86-87; see also *Evans v. Superior Court* (1930) 107 Cal.App. 372, 380; *Adoption of Richardson* (1967) 251 Cal.App.2d 222, 232.)

Partiality or bias toward a particular view or party can be based on a variety of factors. Some, like direct financial benefit from the outcome of the case, or prior involvement "as an accuser, investigator, factfinder, or initial decisionmaker," are explicit in the statute. (Bus. & Prof. Code, § 809.2, subd. (a).) However, personal embroilment in the dispute may also disqualify the results reached by an administrative body. (*Applebaum*, *supra*, 104 Cal.App.3d at p. 657.)

Code of Civil Procedure section 170.1 outlines the grounds for the disqualification of judges and other "dispute resolution neutral[s],"[38] and is enlightening on what kinds of relationships may affect an adjudicator's ability to be impartial in a proceeding. These include: family connections; a close relationship to a material witness; close and recent professional relationships; financial interest in the subject matter of the proceeding or a fiduciary relationship to a party (Code Civ. Proc., § 170.1, subd. (a)(1)(A-B), (a)(5)); or any situation where "[a] person aware of the facts might reasonably entertain a doubt that the judge would be able to be impartial" (Code Civ. Proc., § 170.1, subd. (a)(6)(A)(iii)).

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[38] A "'[d]ispute resolution neutral'" is an arbitrator, mediator, temporary judge, referee, special master, neutral evaluator, settlement officer, or settlement facilitator. (Code Civ. Proc., § 170.1, subd. (a)(8)(B)(iii).) Code of Civil Procedure section 170.1 is also applicable to administrative hearing officers. (*Andrews v. Agricultural Labor Relations Bd.* (1981) 28 Cal.3d 781, 794, superseded by statute on a different point as stated in *Catchpole*, *supra*, 36 Cal.App.4th at p. 246; *Gray v. City of Gustine* (1990) 224 Cal.App.3d 621, 632.)

Pecuniary Interest

Dr. Luke's challenge to Drs. Dexter and Brockmann is based first on their alleged financial interest in the matter being adjudicated.

It has long been established under both state and federal law that when an adjudicator has a pecuniary interest in the outcome of the proceedings, the possibility of bias is "'too high to be constitutionally tolerable.'" (*Haas*, *supra*, 27 Cal.4th at p. 1027; see also *Tumey v. Ohio* (1927) 273 U.S. 510, 533-535; *Gibson v. Berryhill* (1973) 411 U.S. 564, 578-579 (*Gibson*).) "Not only is a biased decisionmaker constitutionally unacceptable but 'our system of law has always endeavored to prevent even the probability of unfairness.'" (*Withrow v. Larkin* (1975) 421 U.S. 35, 47; see also *Haas*, at p. 1026.) The standard for measuring the impropriety of pecuniary interest is "whether the adjudicator's financial interest would offer a possible temptation to the average person as judge not to hold the balance nice, clear and true." (*Haas*, at p. 1026; see also *Aetna Life Ins. Co. v. Lavoie* (1986) 475 U.S. 813, 824-825.) "[T]he risk of bias caused by financial interest need not manifest itself in overtly prejudiced, automatic rulings in favor of the party who selects and pays the adjudicator. The 'possible temptation' [citation] not to be scrupulously fair, alone and in itself, offends the Constitution." (*Haas*, at p. 1030.)

In *Gibson*, the United States Supreme Court affirmed a district court's conclusion that, because of a possible pecuniary interest in the reduction of competition, it was constitutionally impermissible for a state optometry board composed only of private

practice optometrists to judge whether the licenses of optometrists employed by corporate entities (which made up almost half of all licensed optometrists in the state) should be revoked. "It is sufficiently clear from our cases that those with substantial pecuniary interest in legal proceedings should not adjudicate these disputes." (*Gibson*, *supra*, 411 U.S. at p. 579.) "It has also come to be the prevailing view that 'most of the law concerning disqualification because of interest applies with equal force to . . . administrative adjudicators.' (K. Davis, Administrative Law Text § 12.04, p. 250 (1972)." (*Ibid*.)

In *Haas*, the California Supreme Court affirmed a decision by this court that the procedure used by a government agency in selecting a hearing officer who was hired and paid by the agency to adjudicate a case in which it was a party was unconstitutional. (*Haas*, *supra*, 27 Cal.4th at pp. 1029-1030.) The court reasoned that, like a direct-fee system long rendered obsolete in other state and federal cases, the system used by the county gave hearing officers an incentive—or what would be an appearance of an incentive to an average person as judge—to favor frequent litigants. (*Id.* at pp. 1026, 1028-1029.) The hearing officer in *Haas* had a direct pecuniary interest in future commissions from the agency. (*Id.* at pp. 1020-1021.) Such "outcome-dependant compensation" is unacceptable. (*Id.* at p. 1028.)

Here, while there was possibly a measure of pecuniary interest in play, evidence that any particular JRC panel member's income was directly dependent on the outcome

of the decision in the manner prohibited by Business and Professions Code section 809.2 or by *Gibson* or *Haas* was scanty.

There is no doubt that BMG is a very large—perhaps even dominant—player in the Redlands medical practice market. This was evident from the May 5, 2003, letter written by the firm representing the MEC, opposing the disqualification of Drs. Dexter and Brockmann. According to the letter, because of the great difference in the relative sizes of their practice groups, the two physicians could not possibly be prejudiced against Dr. Luke. BMG's size was confirmed at voir dire by Dr. Dexter, who told the hearing officer that there were about 140 physicians in the group. According to Dr. de Jager's unrebutted testimony, BMG's dominance was related to the loss of a number of solo practitioners who, like Dr. Luke, had formerly cared for elderly patients in the area.

In addition, Dr. Dexter's note specifying that he would benefit by keeping Dr. Luke on staff because Dr. Luke referred patients to him demonstrated that, on some level, there was a financial relationship between Dr. Luke's practice and benefit to BMG, or at least to Dr. Dexter. No doubt Dr. Dexter meant to suggest that any bias he might harbor would have worked in Dr. Luke's favor. However, such a referral pattern also put Dr. Dexter in a position to know the volume and value of Dr. Luke's practice and, thus, the potential benefit of eliminating him from the medical staff. Since BMG was in competition with Dr. Luke's group, even if the latter group was very small by comparison to the former, it is not impossible that the competition was important to BMG. The fact that a "Goliath" is big does not mean that a "David" is insignificant.

Nonetheless, there is little overt evidence that the challenged physicians were motivated by *direct* pecuniary interest or were in some way consciously acting on behalf of the financial interest of their group. Unlike the hearing officer in *Haas*, the JRC panel members were not paid for their service. (*Haas*, *supra*, 27 Cal.4th at p. 1021.) And unlike the optometry board in *Gibson*, their decision would not have eliminated half their competitors. (*Gibson*, *supra*, 411 U.S. at p. 578.) Beyond Dr. Dexter's disclaimer, there was no evidence that their individual incomes, the income of their colleague Dr. Shankel, or the overall income to the group, would change, or by how much, if BMG captured all of Dr. Luke's patient admissions and generated critical care consultations to Drs. Dexter, Shankel and/or Brockmann on each of them.[39]

<u>Personal and Professional Interest</u>

While bias stemming from an adjudicator's pecuniary interest is the factor most often considered destructive of impartiality, personal or professional embroilment in the dispute may have the same effect. (*Applebaum*, *supra,* 104 Cal.App.3d at p. 657; Code Civ. Proc., § 170.1.) Business and Professions Code section 809.2 mandates that the trier of fact in a peer review hearing "shall" either be "selected by a process mutually acceptable to the licentiate and the peer review body" or be an "unbiased individual[] who shall gain no direct financial benefit from the outcome" and who has not been

[39] M.E. was apparently initially scheduled for admission to an ICU-type unit, but instead was sent to a regular hospital floor, but there is no evidence in the record that the change in assignment would have had any financial effect on the income of BMG or Dr. Dexter.

involved in the same matter as the "accuser, factfinder, or decisionmaker." (Bus. & Prof. Code, § 809.2, subd. (a).)

In interpreting the meaning and effect of a statute, our task is to give significance to every word, to harmonize provisions, and to avoid interpreting any provisions or words as surplusage. (*Sahlolbei v. Providence Healthcare, Inc.*, *supra*, 112 Cal.App.4th at p. 1150; *Weinberg v. Cedars-Sinai Medical Center* (2004) 119 Cal.App.4th 1098, 1114; *Mir v. Charter Suburban Hospital* (1994) 27 Cal.App.4th 1471, 1483.) Under these principles, we must assume that the Legislature included the word "unbiased" to indicate that physician adjudicators in peer review cases must, as nearly as possible, be unbiased for any reason, not *only* because of the possibility of direct financial gain or prior involvement in the case. Although the section specifies various grounds which may generate bias, we do not find it an exhaustive list. There would be no need for the adjective if the itemized factors were the only possible grounds for bias. Race, ethnicity, gender, national origin, language impediments, and disability status are all possible sources of bias, for example, even though they are not mentioned in the statute.

There is little doubt that the trier of fact in this case was not selected by a process mutually acceptable to Dr. Luke and the MEC. That the trier of fact may not have been unbiased is also a possibility. Inexplicably, the relevant provision of RCH's medical staff bylaws omits the word "unbiased" and so fails to provide for the contingency of bias based on factors other than financial interest and prior involvement in the case. The bylaw reads simply: "The [JRC] members shall gain no direct financial benefit from the

outcome, and shall not have acted as accusers, investigators, fact finders, and initial decision makers . . . in the consideration of the matter . . . ." (RCH Medical Staff Bylaws and General Rules and Regulations (rev. 1/2003) (RCH bylaws) § 7.3-5, p. 60.)[40] Despite the omission, however, the bylaws provide for an alternative pool of potential panel members and, thus, implicitly recognize that the selection of a panel of unbiased individuals may be difficult. "In the event it is not feasible to appoint a judicial review committee from the active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff." (RCH bylaws § 7.3-5.)

It is true that there is more flexibility in the rules requiring disqualification in administrative proceedings than in court proceedings, and a claim of possible bias must "'overcome a presumption of honesty and integrity in those serving as adjudicators.'" (*Haas*, *supra*, 27 Cal.4th at p. 1026; *Withrow v. Larkin*, *supra*, 421 U.S. at p. 47.) It is also true that there was no evidence—and we do not suggest—that any of the panel members in this case lacked integrity. However, in our view, several factors combined so as to create an appearance of bias and "a possible temptation to the average [physician] as judge not to hold the balance nice, clear and true." (*Haas*, at p. 1026.) These included the close personal and professional relationship between Drs. Dexter and Shankel, the history of the development of the comfort care protocol and its use at the hearing, and

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[40] RCH's medical staff bylaws were approved in July 2002 and revised in January 2003, as this case was framing up. Because we do not have any earlier versions, we cannot tell what, if any, changes were made at that time.

direct evidence of Dr. Dexter's fixed leaning of mind and predisposition to decide the issue in a certain way. Any one of these factors, standing alone, might not have been enough to generate an appearance of unfairness or a temptation "not to be scrupulously fair." (*Id.* at p. 1030.) Together they did.

The first indication of possible professional bias lay in the MEC's selection of physicians for the JRC. By virtue of his position as "Chairman of the Medicine Department," Dr. Shankel was responsible, along with other physicians on the MEC—including chairperson Dr. Rosario, who was also a BMG partner—for choosing the members of the panel. Per se, there was nothing wrong with this procedure. The MEC and the hospital board had discretion under the peer review statute and the related RCH bylaw to choose the JRC panel members; the mere exercise of that discretion did not necessarily give rise to an appearance of bias. (Bus. & Prof. Code, § 809.2, subd. (a); RCH bylaws § 7.3-5.) Nevertheless, because of his relationship to Dr. Shankel, the choice of Dr. Dexter was problematic.

Dr. Shankel was more than an adverse witness and an MEC member; he was also the primary physician investigator of the matter and the *chief* witness in the case against Dr. Luke. And Dr. Dexter was Dr. Shankel's longtime, close colleague. It is clear from the record that the two were not, as counsel for the MEC argued or inferred to the hearing officer at voir dire, to the hospital board during the internal appeal, and to trial Judges Krug and Brisco, simply loosely associated members of a very large, 140-physician group. They had worked together for years as specialists in pulmonary critical care, a

highly technical area of medicine. It appears from the record that there were only three such specialists on the RCH staff at the time. The appointment of a close specialist colleague of Dr. Shankel's to a judicial committee before which he was set to testify as a material adverse witness created a strong appearance—and perhaps even a probability—of professional and personal bias.[41]

Counsel for Dr. Luke made several, ultimately unsuccessful, attempts to draw the potential for conflict arising from the relationship between the physicians to the attention of the hearing officer: first in his prehearing letter and later at voir dire. In adopting the argument of the MEC and denying the motion to replace the two, the hearing officer stated that he had inquired, separately, of each panel member, before voir dire began, and all had said they were not biased or prejudiced. However, "if the juror honestly, but falsely, believes he/she is impartial, no amount of questioning will lead to an admission of bias." (*People v. Diaz* (1984) 152 Cal.App.3d 926, 939.) And tenacious voir dire in a situation where the hearing officer has examined peer review committee members off the record and formed an opinion that they are not biased, can be particularly fraught with peril. "The person whose rights are being determined should not be placed in a position of being required to object and thereby spur hostility" (*Hackethal v. California Medical Assn.* (1982) 138 Cal.App.3d 435, 444 [Fourth Dist., Div. Two]), or to "risk the wrath of

[41] We express no opinion about Dr. Brockmann on this point. There was no evidence that he had ever practiced with Drs. Shankel and Dexter in pulmonary critical care.

those sitting in judgment by challenging their representation of impartiality" (*Rosenblit v. Superior Court*, *supra*, 231 Cal.App.3d at p. 1448).

A second area suggesting "personal embroilment in the dispute" and an appearance of professional bias, relates to the production and use of the comfort measures only protocol. The protocol was repeatedly referenced by counsel for the MEC to show that Dr. Luke's management of M.E.'s morphine administration violated the standard of care.[42] In his testimony to the JRC, Dr. Shankel said that Dr. Dexter was "involved" in the protocol's development, and that he did not know anyone else who was involved. Under these circumstances, while it would not be unnatural for Dr. Dexter to measure Dr. Luke's treatment decisions by a protocol he had been involved in creating, even to an average observer the possibility creates an appearance of professional bias.

The other problem with the protocol was that, despite RCH's position that it defined the standard of morphine administration for all medical personnel at the hospital, it does not seem ever to have been actively brought to the attention of either the medical or nursing staff. The Chairman of the Medicine Department, Dr. Shankel, did not know if it had been disseminated to the medical staff or discussed at medical staff meetings, but

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[42] The protocol has two parts: a preprinted progress note and a set of preprinted orders for increasing the morphine for patients with DNR orders. Both parts require a physician's signature, but the orders appear to delegate evaluations of pain and distress, upon which increases in morphine doses are to be based, to a nurse. If, as in this case, a physician is directly monitoring the patient, it is not clear that, or how, the preprinted orders apply. Dr. Luke had apparently been checking M.E.'s status continually throughout the day, while Nurse George had just come on duty for her shift and was in "report" when Dr. Luke wrote his orders. It is not evident that the protocol would have been appropriate in these circumstances.

thought maybe the nursing staff knew about it. Dr. de Jager had never seen or heard of it. Nurse Parenteau was unfamiliar with it and called the ICU when he wanted information about it. If the protocol was meant to represent an absolute rule for morphine administration for both physicians and nurses throughout the facility, as the hospital argues, it is difficult to explain why it had not been more widely distributed.
Dr. Shankel's statements that the protocol was for the "guidance" of physicians "who want to use it," indicates use of that the protocol was subject to physician discretion in any given case.

We are aware that some courts have held that "[i]n administrative proceedings, 'a party claiming that the decision maker was biased must show actual bias, rather than [just] the appearance of bias, to establish a fair hearing violation[,]' [and that] 'the mere suggestion or appearance of bias is not sufficient.'" (*Weinberg v. Cedars-Sinai Medical Center*, *supra*, 119 Cal.App.4th at p. 1115; see also *Southern Cal. Underground Contractors, Inc. v. City of San Diego* (2003) 108 Cal.App.4th 533, 549; *Hongsathavi*, *supra*, 62 Cal.App.4th at p. 1142.) Here, however, Dr. Dexter's remarks and questions throughout the hearing tended to show that he harbored a "leaning of the mind" and a predisposition to decide important issues in the case "in a certain way." (*Pacific*, *supra*, 82 Cal.App.3d at pp. 86-87.)

In telling Dr. Liao that whether euthanasia had been committed was "the question," Dr. Dexter demonstrated that he believed that the fundamental issue in the case was not whether Dr. Luke had simply raised a morphine dose with accelerated or

improper titration, but whether he did it in order to kill his patient. Dr. Dexter's belief that this was the central issue was evident at several points in the proceedings. He posed a counterfactual hypothetical to Dr. Liao, asking whether a "bolus" of 80 milligrams of morphine—an amount we find nowhere in the record—was an appropriate dose. He opined that "the documents in the chart," combined with "Dr. Shankel's note," indicated that Dr. Luke had committed "family-instigated active euthanasia." Evidence to the contrary appeared to carry little weight, including the fact that family members and Dr. Luke had all repeatedly denied such a purpose.

The court in *Pacific* summarized its position as follows: """The truth of few, if any, ultimate 'facts' of human existence are established to that point of complete certitude which eliminates all plausible doubt. A fact as difficult of ascertainment as any person's 'prejudice' is seldom, if ever, proven so completely that reasonable persons might not still disagree. And the mere allegation or good faith belief that a fact is true may be sufficient to cause reasonable doubt. Since the legitimacy of the Court's role is essentially a perception of the people, in whose secure confidence the courts must remain if their powers are to be maintained, it follows that merely probable or even alleged facts or a good faith belief in such facts may be sufficient to disqualify a judge.""" (*Pacific*, *supra*, 82 Cal.App.3d at p. 88.) "No persuasive reason exists to treat administrative hearing officers,"—in this case JRC panel members—"differently." (*Haas*, *supra*, 27 Cal.4th at p. 1025.) The position of physician adjudicators in peer review proceedings is clearly analogous to the role of judges in courts of law as described in *Pacific*: their

legitimacy lies in the perception of their neutrality to the average observer or member of the discerning public. (*Pacific*, at pp. 87-88.) Dr. Dexter's open articulation of his belief that Dr. Luke had killed M.E. at the behest of family members undermined his appearance of neutrality.

Effect of the Toxicology Report and Amended (Second) Death Certificate:

More pernicious than the possibility or appearance of bias on the part of any single adjudicator was the probability of pervasive bias generated by the unreliable toxicology report and the amended (second) death certificate based on that report.

"Due process questions are raised when the administrative agency's initial view of the facts based on evidence derived from nonadversarial processes as a practical or legal matter forecloses fair and effective consideration of the merits at an adversary hearing leading to the ultimate decision." (*Applebaum*, *supra*, 104 Cal.App.3d at pp. 657-658.)

Despite its ultimate acknowledgment that the morphine level might be unreliable, it is clear that the JRC's initial view of the facts, like that of the MEIC and the MEC, was based in significant part on evidence (the toxicology report and the amended (second) death certificate that the report generated); derived from a nonadversarial process (laboratory testing of a mislabeled specimen); that as a practical matter foreclosed a fair and effective consideration of the merits (of Dr. Luke's observation of M.E.'s condition and his decision to increase the dose of morphine at an accelerated rate); at the

evidentiary and adversarial hearings (of the MEC, MEIC, and JRC); that led to the ultimate decision (by the hospital board).

RCH's argument—that the JRC decision's acknowledgment that the toxicology report and amended (second) death certificate might be unreliable meant that it had not relied upon them, and that therefore the hospital board did not need to do more than reaffirm its own previous decision—ignores the practical realities of the documents' effect and dodges the essence of Judge Krug's writ order.

A close look at the timeline of events shows that the report and the amended (second) death certificate based upon the report influenced every level of investigation and decision from the beginning of the case.

Inception of the Order for the Toxicology Test

After Cook's e-mail suggested that Dr. Luke's treatment amounted to euthanasia rather than comfort care and could result in liability for the hospital, Loscutoff became concerned that a homicide had been committed.[43] Thereafter, the risk manager actively sought an order for a blood test and made repeated calls to the coroner's office until it was ordered. M.E.'s body was then held at the hospital until September 18, 2002, four days after his death, so that the sample could be drawn. When the MEC met for the first

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[43] In 2001, the California Legislature increased the fines for a responsible individual's failure to file a Business and Professions Code section 805 report by a factor of 10: from $10,000 to $100,000 for a "willful" or "intentional" failure; and from $5,000 to $50,000 for a failure due to any other reason. (Bus. & Prof. Code, § 805, subds. (k), (l); see former Bus. & Prof. Code, § 805 subds. (g), (h), Stats. 2001, ch. 614, § 2.) It is unclear whether Cook was referring to liability for these penalties, or to the possibility of a civil lawsuit by M.E.'s family, or to possible criminal liability.

time the next day, September 19, its minutes specified that the coroner was reviewing "the blood" to determine the cause of death and that the result could be expected in about three weeks.

Subsequently, Bell and Loscutoff made sustained efforts to obtain a copy of the toxicology results. When Loscutoff received the verbal report of the results from the coroner's office, she notified Drs. Rosario and Shankel, who called additional meetings of the MEC and MEIC. At the JRC hearing, Loscutoff said that she could not remember when she received the verbal report, beyond the fact that it was "quite a long time" before she received the faxed copy on December 26, 2002. However, from testimony by Drs. Rosario and Mehta, it appears that Loscutoff most likely received and transmitted the verbal report to the MEIC some time before November 14, 2002.

Effect on the MEIC

For the MEIC, the projected cause of the patient's death based on the toxicology report was pivotal. It was not, as later characterized by counsel for the MEC, merely "unimportant" or "an interesting side issue." The timing and draconian nature of the committee's recommendations indicate that they were based largely upon the toxicology report and impending changes to the death certificate, not upon anything that had occurred up to that point.

At no point in the initial investigations did Dr. Luke deny that he had increased the morphine from 5 to 50 milligrams per hour and readily admitted that he had adjusted the IV infusion rate himself. Dr. Shankel had talked to Dr. Luke and dictated the

memorandum of their telephone conversation three days before he and the other members of the MEC met for the first time. Despite all this, once he explained his observations of the patient's condition and his reasons for the increase, Dr. Luke's privileges were restored less than a week after they had been suspended.

Five weeks after the restoration—sometime between the day (Oct. 29, 2002) that Dr. Sheridan's office received the toxicology results from the San Diego laboratory and conveyed the information to Loscutoff, and the day (Nov. 14, 2002) it issued its first report—the MEIC adopted a different stance. When MEIC committee members learned that the coroner intended to list the cause of death as "homicide," proctoring had become too difficult and legal liability too great, "[b]ecause here we have a case where the death has occurred . . . intentionally from overdose of morphine."

It is evident that it was the toxicology report and planned amendment to the death certificate—not the increased rate of morphine administration, not the fact that the family had allegedly pressured him, not the fact that Dr. Luke had turned up the IV without notifying the nurse assigned to the case, and not even the fact that he had dictated a second discharge summary (which was unknown at the time)—that spurred the recommendation for an immediate and long-term suspension of his hospital privileges.

The recommendation was not simply a proctoring and continuing education requirement with which Dr. Luke stubbornly and unreasonably refused to cooperate. Because of state and federal reporting requirements, the extended suspension would almost certainly have affected all of his other hospital affiliations, his ability to obtain

malpractice insurance, and possibly his ability to receive payments for treatment of Medicare patients. (Bus. & Prof. Code, §§ 805, subds. (b)(3), (e); 805.5; 809, subd. (a)(9)(B); 42 U.S.C. 11131 et seq.; Merkel, *Physicians Policing Physicians*, *supra*, 38 U.S.F. L.Rev. at p. 304.) He thus had little choice but to contest the suggestion that he had raised the morphine dose for a dying patient beyond that recommended by "any known protocol" in order to kill him.

Effect on the MEC and the JRC Hearing

As the JRC proceedings unfolded, it became clear that it was not only the MEIC that considered the toxicology report and the cause of death of great significance. It was the MEC that sought admission of the amended (second) death certificate. And it was counsel for the MEC who asked almost every MEC witness for an opinion as to the cause of death. Because of the toxicology report, Drs. Hsu, Rosario, and Mehta all believed that M.E. had died from a morphine overdose rather than from multisystem organ failure.

It is true that after Drs. Katz and Simonian questioned the laboratory results, the MEC began to minimize the significance of the cause of death and to discount the importance of Dr. Sheridan's testimony. But in closing argument, the MEC returned to the issue by pointedly comparing Dr. Luke, unfavorably, to Dr. Kevorkian: "[A]t least Dr. Kevorkian devised methods where the persons who were looking to commit suicide performed the last act that would result in their death. Here patient M.E. didn't perform that last act. It was Dr. Luke that performed it." This was not merely an argument about

a local standard of practice for morphine titration. It was an accusation of intentional killing.

Effect on Dr. Luke and His Attorney

Dr. Luke and his counsel were also affected by the toxicology report and changes to the death certificate. As he admitted early on to the MEC, and as later found by the State Medical Board, he *had* failed to properly record his observations of M.E.'s condition or his reasons for increasing the rate of morphine administration. And, although unknown to the MEIC or the MEC on November 14 or 15, 2002, or even on December 3, he had dictated a second discharge summary a month after the first in an apparent effort both to make corrections and to create the omitted chart notes after the fact.[44] He put into the second summary all the things about M.E.'s condition and his reasons for accelerating the rate of morphine administration that he had told Loscutoff on September 16, told the MEC on September 19 and 24, and the MEIC in his meetings with

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[44] In his letter to the State Medical Board requesting reconsideration of the plan to revoke his license, Dr. Luke claimed that he dictated the first summary from memory at a time when he did not have the chart available, and that he dictated the second summary after he had it in hand. We do not address the hospital's arguments that there is no evidence that Dr. Luke was ever denied access to M.E.'s chart except to note that the doctor's claim that the chart was unavailable to him on September 17, 2002, when he dictated the first version of the discharge summary, is not inconsistent with other information in the record. Bell had M.E.'s chart in her office for Dr. Shankel to review on the 16th. According to her testimony, she also "secured" and copied it on September 27 and again at the end of December. There is no indication of where the chart was in the intervening time period or exactly when it was returned to the medical records department. In view of these uncertainties, and in view of the absence of any specific number of days for discharge summary dictation specified in the relevant hospital policies (RCH Adm. Policy Nos. A10, A19; Gen. Rules & Regs. §§ 8.2, 8.3), it is unclear whether the second summary was dictated "substantially after" the events described.

them. But it was only after the toxicology results became known, along with the fact that the coroner was going to list the cause of death as "homicide," that Dr. Luke retained counsel. From that point on, because of the language in the amended (second) death certificate, his attorney would not let him testify.[45] This opened the way for opposing counsel to argue that all of Dr. Luke's statements had been and would continue to be false and that he was a physician of the Kevorkian variety.

Effect on the State Medical Board

As noted *ante*, at the hearing before the State Medical Board on May 24, 2005, Dr. Sheridan acknowledged the postmortem redistribution phenomenon and stated that it is necessary to be "especially cautious" in interpreting postmortem blood levels of morphine because, when the sample is taken from the heart rather than from a peripheral site, the heart will always be higher. Nonetheless, based on the toxicology report whose credibility he had just discounted, Dr. Sheridan testified that he believed M.E. had died from an overdose of morphine rather than from his underlying diseases. Nine months later, in January 2006, realizing that the blood sample was actually taken from a central rather than a peripheral site, Dr. Sheridan changed his mind and issued what amounted to a third death certificate. As a result, the State Medical Board reversed its decision to revoke Dr. Luke's license.

[45] At oral argument, counsel for the hospital appeared to acknowledge that, given the circumstances, his attorney's refusal to allow Dr. Luke to testify was appropriate.

RCH is correct that it was not required to adopt the State Medical Board's findings and was not bound by its decision. RCH is also correct that a peer review committee dealing with hospital privileges and a State Medical Board dealing with licensure issues use different, escalating, standards of proof when considering charges against a physician. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) But Judge Krug ordered the hospital board to consider the State Medical Board's decision not to adopt its findings. The order made sense because, on a general level, both entities have as concurrent goals the protection of patients and fairness to practitioners; their proceedings and findings are thus not unrelated. In this particular case, both entities conducted investigations and, as we have seen, freely exchanged information; both relied upon the coroner's laboratory report and opinion as to the cause of the patient's death; and both considered the cause of death significant to their ultimate decisions.

Moreover, unlike the JRC and the hospital board, the State Medical Board had interviewed Dr. Luke directly and had heard testimony and obtained written evidence from the coroner and deputy coroner. And unlike the JRC and the hospital board, the State Medical Board had already held a rehearing. As a result, the State Medical Board had accumulated significant evidence that was relevant to the peer review issues, even if its decision about licensure was not controlling.

Summary

The toxicology report and the amended (second) death certificate were so intimately entwined with actions and decisions in this case as to undermine the fairness of the peer review proceedings and hospital board decisions. The effect was completely separate from, and in addition to, the potential for individual adjudicator bias based on business, personal, or professional relationships.

CONCLUSION

The task before this court in reviewing a matter with medical and legal issues of the magnitude and complexity present in this case has not been easy. Even without the cumulative effect of factors suggesting a possibility of adjudicator bias, the influence of a death certificate based upon a mislabeled and very possibly erroneous laboratory report, rendered the proceedings unfair. As a result, the accused physician did not have the meaningful "opportunity to be fully and fairly heard before an impartial decisionmaker" that fair procedure and due process require. (*Catchpole*, *supra*, 36 Cal.App.4th at p. 245.) Accordingly, the hospital board's reaffirmation of the JRC decision cannot stand.

The question now is what is to be done. At oral argument, counsel for Dr. Luke urged us to grant his petition for a writ of mandate ordering an unconditional reinstatement to the RCH hospital staff. Counsel argued that too much time has passed for his client ever to receive a fair hearing and that the expense and burden involved in retaining new experts and witnesses is so great as to work additional unfairness. Counsel

for the hospital, on the other hand, urged us to either affirm Judge Briscoe's denial of the petition for a writ of mandate or to simply remand the matter to the hospital board for a second reconsideration. Board members, he believed, would be happy to take any "additional evidence" Dr. Luke might wish to present.

We find none of these suggestions appropriate. A fair peer review hearing before an unbiased and impartial fact finder is what is required. (Bus. & Prof. Code, § 809.2, subd. (a).) As we have determined, Dr. Luke has not yet had such a hearing, which can only be held before a full complement of his peers. Neither the hospital board (which included only three physicians), nor the internal appeal body (which included only one physician), are adequate for such a hearing. (*Bode v. Los Angeles Metropolitan Medical Center* (2009) 174 Cal.App.4th 1224, 1235-1236.) Under the relevant statute, interpretive case law, and RCH medical staff bylaws, these bodies are bound by a "substantial evidence" standard of review and cannot not sit as triers of fact. (Code Civ. Proc., § 1094.5 subd. (d); *Huang*, *supra*, 220 Cal.App.3d at p. 1293; RCH bylaw 7.5-6 (a).) Accordingly, we will instruct the hospital to provide Dr. Luke with a fair peer review hearing, not simply another reconsideration by a board composed largely of lay persons bound by a deferential standard of review.

Although the procedural posture of this case is somewhat different, our reasoning is similar to that of the court in *Applebaum*: "Since we [reverse] the judgment on the basis of fair procedure defects in the administrative process," where the "fatal flaw in the proceedings before us was the lack of impartiality in the fact-finding process," combined

with the effect of unreliable evidence obtained from a nonadversarial process, this is the only remedy. (*Applebaum*, *supra*, 104 Cal.App.3d at pp. 657-658, 660-661.)

We emphasize that we do not intend our order to infringe upon the hospital's legally vested discretion, as provided for Code of Civil Procedure section 1094.5, subdivision (f), and in sections 809 through 809.8 of the Business and Professions Code, to exclude from its staff physicians that it has properly concluded, after fair proceedings, do not meet its standards. "Fair hearings," however, "are not a matter of discretion but are required by law." (*Applebaum*, *supra*, 104 Cal.App.3d at p. 661.)

At oral argument, the parties indicated that they had tried to resolve this dispute before reaching us; we trust that these efforts were made in good faith and will continue. If, however, they remain unable to reach resolution and choose to proceed to a new peer review hearing, the hospital is to provide Dr. Luke with a new hearing officer and an unbiased panel of impartial physician adjudicators unrelated to any material witness.

Otherwise, we do not specifically direct the parties how to proceed in structuring the fair hearing, but note that there are sections of the RCH bylaws, like section 7.3-5 (specifying that adjudicators may be selected from outside the hospital's medical staff); section 7.5-7 (providing for more than one hearing under unusual circumstances, as when ordered by a court); and section 7.7 (providing for expunction of a staff member's credentialing file); that may aid them to achieve the required result. The parties may, of course, find others that are also relevant.

DISPOSITION

The judgment is reversed. Consistent with the views expressed in this opinion, the trial court is ordered to issue a writ of mandate compelling respondent Redlands Community Hospital afford appellant Dr. Harold Luke a fair hearing.

In the interests of justice, the parties are each to bear their own costs on appeal.

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

RAMIREZ
P. J.

We concur:

KING
J.

MILLER
J.