For docket see E046969

Court of Appeal, Fourth District, Division 2, California.
Harold LUKE, M.D., Petitioner and Appellant,
v.
REDLANDS COMMUNITY HOSPITAL, Defendants and Respondents.
No. E046969.
April 28, 2009.

Appeal from the Judgment of the Superior Court, San Bernardino County, Honorable Joseph R. Brisco, Judge Presiding - Case No. SCVSS123244, (Consolidated with Case No. 503943)

Appellant's Opening Brief

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***1 I.**

INTRODUCTION

The instant proceedings arise out of a suspension and eventual termination of Appellant's medical staff privileges at Redlands Community Hospital. It is claimed on appeal that the underlying administrative proceedings were invalid for reasons of invalid notice, improper hearing procedures, and abject violations of constitutional ***2** law principles.

More specifically, this case involves one of the most intimate decisions which can be made by a dying patient, a patient's family, and a medical doctor. As will be shown below, this case involves not only the rights of the Appellant, a caring physician, but those of thousands of California patients facing imminent life and death decisions with the assistance of compassionate healthcare providers such as Appellant.

More specifically, this case deals with a horrifically false accusation that Appellant Harold Luke, M.D., intentionally killed his patient (hereinafter "M.E.") {CT 20-21} by a morphine overdose, even though the obvious intent was only to provide palliative care to the patient. {CT 19}. This claim by RCH that Dr. Luke "killed somebody" was maintained all the way through the final hearing that led to this appeal. {RT 19: 16-17}.

As one can well imagine, the allegation that a physician has intentionally killed an innocent human being is about as powerful a moral indictment as one could ever make against a medical professional. This is exactly what Respondents did, but yet refuse to ***3** recognize the valid and necessary interest in providing Due Process to Appellant. Even when repeatedly proven wrong, Respondents continue to this day to punish Appellant by termination of his valuable staff privileges at Redlands Community Hospital.

It is undisputed, that Appellant had a 25-year history with RCH without so much as a single patient/staff complaint. {CT 933:16-17}. Dr. Luke had also been in geriatric and general practice for over 30 years without so much as a single patient complaint to the Medical Board or otherwise. {CT 781:14-15}. Additionally, it is important to note that Dr. Luke was even offered a faculty position with Loma Linda University just prior to the actions by RCH. {784: 14- 20}.

As the California Medical Board put it:

"[DR. LUKE] is credible when he states that Morris E. was in distress and pain in spite of his failure to properly document Morris E.'s condition. Dr. Luke has the trust and respect of his colleagues and patients. Dr. Luke has never had any discipline imposed against his license by the Medical Board. Dr. Luke has never been the subject of a malpractice action. [...]

4** There is a need to provide effective pain relief to patients who are actively dying, and ***imposing discipline in cases involving physicians who care for such patients might have a chilling effect on other practitioners similarly situated and result in the* undertreatment *of actively dying patients. [...]

Incompetence was not established. Dr. Luke, an experienced practitioner, knew what he was doing." [emphasis and italics added]." {CT 785}.

None of the Medical Board's findings mattered to Respondents and the horrific situation conjured up by Respondents simply never happened.

In fact, it was fairly obvious, to the Honorable Judge Robert Krug, that an "inexperienced" nurse working for Respondents simply overreacted to a legitimate medical decision made by Appellant. {CT 388:9-27; RT 6:1-7}. However, the young nurse's actions made a good catalyst for firing up existing interpersonal problems maintained by fellow physicians who compete with Appellant. {*Id.*}.

Indeed, it appears that certain Redlands Community Hospital ***5** peer review committee members were already looking for an excuse to get rid of Dr. Luke from the hospital staff. Now that Respondents come before this Court, they will rely heavily on the 'substantial evidence' standard of review in claiming that it doesn't even matter if they wrongly accused Dr. Luke of murder and continued to steal his reputation and potential from him. The harm caused to Appellant by the actions of Respondents is not disputable and continues to this very day. {CT 790, citing AR 00010-11}.

While the patient's family, California Medical Board, San Bernardino County Coroner's Office, San Diego County Coroner's Office, and the San Bernardino Superior Court have vindicated Appellant on many levels, the Respondents simply refuse to do so by reinstating Dr. Luke's staff privileges at Redlands Community Hospital. {CT 913-915}. They refuse to do so even though the Court specifically commanded them to grant a full rehearing on exculpatory evidence and to give good reasons for any failure to reinstate Dr. Luke's hospital privileges. {*Id.*}.

Unfortunately for Appellant, the Honorable Judge Joseph Brisco seemed only motivated by the number of hearings that ***6** Appellant was subjected to and concluded by stating as follows:

"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?" {RT 20: 21 -23}.

The obvious error of law here is that Due Process is not measured by the number of hearings it took for Dr. Luke to restore what was left of his honor and reputation. The real question in a Due Process context is whether the quality of the hearings were sufficient to have respect the Constitution, the *Business & Professions Code*, and other guarantees of a fair process. As shown below, the quality of the hearings left much to be desired in terms of fairness, actual review of evidence, or a respect for the findings of the California Medical Board.

This case is important as it deals directly with the issue of how far a hospital peer review committee can go in punishing a doctor for making a most difficult decision about a patient's quality of life and end of life. Also, this case begs of decision-making on the important issue of how much and what kind of notice must be given on a rehearing procedure following the issuance of a writ of mandate by a ***7** court (i.e., does the hospital need to consider all evidence anew, offer testimony, or more/less).

II.

STATEMENT OF ISSUES

Issues Concerning Fair Hearing Processes

1. Does being a business competitor of a party to peer review proceedings disqualify the competitor from hearing the matter? {CT 783 § C; AR 100}. May a peer review committee member have any financial interest in the outcome of the proceedings?

2. May a peer review committee review on only hearsay evidence in determining a staff privileges matter?

3. May Appellant's opposing counsel serve as the neutral hearing officer in a peer review proceeding to determine the suspension or revocation of staff privileges? {CT 783}.

4. Does a "rehearing" after issuance of a writ of mandate by the Superior Court require a full evidentiary hearing, or may a Respondent conduct only a cursory review of the underlying proceedings in order to meet the burden of Due Process?

***8** *Issues Concerning Healthcare of Patients*

1. Does *California Business & Professions Code* §§ 805, 809.1 require that all charges against a physician be laid out in the original notices before a committee may proceed? Along these same lines, does California law require that advance notice of intended hospital action be given before *each* hearing on the merits of a staff

privileges matter?

2. May a private hospital circumvent the provisions of *California Probate Code* § 2241.5, which are intended to protect patient rights and quality of life, by applying lesser burdens of proof in peer review hearings?

3. Do the findings of the California Medical Board have a preclusive effect against actions by a hospital peer review committee?

4. May a quasi-judicial committee, such as RCH's review committee, place a substantial burden or otherwise interfere with the lawful private decision-making between a physician and his/her patient?

***9 III.**

STANDARD OF REVIEW

The standard of review herein is *de novo* because this. Court is being asked to interpret California statutes concerning the due process rights of a physician facing peer review proceedings which could result in termination or suspension of staff privileges. *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 483. *Also see, Ghirardo v. Antonioli* (1994) 8 Cal.4th 791, 799; *People ex rel. Lockyer v. Shamrock Foods Co.* (2000) 24 Cal.4th 415, 432.

There does not seem to be any dispute between the parties as to what standard of review applies with respect to questions law concerning the fairness of the hearing process or related matters. {CT 124:4-15}.

Where an interpretation of RCH's regulations is necessary, especially in light of the special due process rights afforded to a physician facing peer review, the standard of review should be *de novo*. *Adoption of Arthur M.* (2007) 149 Cal.App.4th 704, 717; *Estate of Powell* (2000) 83 Cal.App.4th 1434, 1439- 1440 [applicability of ***10** standards to undisputed or stipulated facts]. Presumably, review of what it was that RCH was required to do under Judge Krug's writ of mandate should also be viewed in a *de novo* light.

As to factual issues, it appears that an abuse of discretion standard is provided for under the direct authority of *California Code of Civil Procedure* § 1094.5. Because of the draconian effect that a suspension or termination of privileges has

on a physician's ability to practice, Appellant respectfully disagrees with RCH as to whether a simple "substantial evidence" standard can be used in lieu of a higher standard of review. There is just too much at stake to allow only for something "more than a mere scintilla," but less than a "preponderance." {CT 124}.

Finally, it is up to this Honorable Court to objectively determine the standards of review that ought to apply in light of the facts and law presented in this specific case. *El Dorado Meat Co. v. Yosemite Meat & Locker Service, Inc.* (2007) 150 Cal.App.4th 612.

IV.

STATEMENT OF RELEVANT FACTS ON APPEAL

The following facts, except where otherwise indicated, are taken ***11** from the Court's comments at CT 933-939. A further and more detailed description of the medical evidence is presented at CT 99:21 -104:17.

The Appellant, Harold Luke filed a petition for writ of mandate against the Respondents on February 5, 2007. The writ was brought pursuant to *California Code of Civil Procedure* 1094.5.

Appellant had been on the staff of Redlands Community Hospital for some 25 years {CT 297-298} and was working in the emergency room on September 12, 2005. {CT 141-142}.

On this date, Patient M.E., a patient who had been treating with Appellant for some five months prior, was admitted with a diagnosis of pneumonia and septic shock. {CT 19: 20-27}. What is important about this fact is that RCH has consistently acted as though Appellant knew nothing of M.E.'s situation and acted with rash judgment. In fact, this was an existing patient with a history of problems and everyone pretty much knew that this trip to the hospital was a last stop for M.E. before he could pass on. {*Id.*}.

Patient M.E. was resuscitated in the emergency room and various procedures were performed on him, including, but not limited to, the placement of an IV morphine drip. M.E. died on September 14, 2002. ***12** He was moribund at the time of admission. {CT 19:20-27}. It is also important to note that M.E.'s family had also issued do-not-resuscitate instructions to RCH staff. {CT 20:1- 7}. In the end, M.E.'s family was appreciative and supportive of the tough decisions made by Dr: Luke. {CT

109, citing AR 03418}.

M.E.'s original death certificate listed the cause of death as sepsis due to pneumonia and advanced cardiomyopathy, and Guillain-Barre syndrome. The death certificate was amended some four months later to indicate that the cause of death was morphine toxicity. There was no autopsy performed at any time. {CT 20: 12-22; 180; 181}. As shown below, the death certificate was changed one more time after Dr. Luke was proven to be vindicated. There were a total of three death certificates issued by the Coroner.

Apparently, during the active treatment of M.E., Dr. Luke increased the morphine sulphate dosage from 1mg per hour, to 5mg, to 50mg. M.E. died an hour after the increase to 50mg. The evidence in the underlying proceedings demonstrates that Appellant increased the patient's palliative medication personally. There is also no doubt that M.E.'s family supported the decisions made by Dr. Luke. So much so ***13** that they were willing to testify on behalf of Dr. Luke at any necessary time. {CT 20: 1-22; CT 142-149 ¶¶ 6-39}.

Four days after M.E.'s death, a toxicology report was completed which indicated elevated morphine concentration in post-mortem blood supposedly from the aorta. Appellant properly contended that the aorta was not a proper source for determining the blood levels of morphine and that any tests should have been done from peripheral blood. The difference between blood sources can make a material difference in the determination of morphine levels in the blood. {CT 20: 12-22}.

On September 25, 2002, the RCH Medical Evaluation Committee recommended that Appellant be proctored for six months and that his prescribing of narcotics be monitored. It should be noted that no intent to reverse the allegation that Dr. Luke murdered his patient was demonstrated by RCH. Also, RCH had made a written accusation against Appellant as well. Oddly, the accusation only addressed alleged medical records violations and little more. {RT 15:11-21}. Under RCH's own rules, a medical records violation can only result in a suspension of privileges and no more. {RT 13:10-25; 15:12-16}.

The Appellant requested a hearing after this initial determination ***14** and one was had in February of 2003. {CT 20-21}. On May 24, 2004, RCH forwarded a copy of the JRC's decision to terminate the staff privileges of Appellant. {CT 33-34}. The reasoning of the JRC and MEC was set forth at CT 35-48.

A final decision by RCH was rendered on January 6, 2005. {CT 51-53}. The decision employed a "substantial evidence" standard of review and does not reflect any

deliberative process. {*Id.*}. In subtle terminology, the final decision maintains in the horrifying claim that Dr. Luke murdered his patient by morphine overdose. {CT 52}. While somewhat diluted for purposes of National Practitioner Data Bank report, one need not speculate as to what the allegations were. Dr. Luke has remained steadfast in his defense against the horrific and false allegations that he killed his patient. RCH seemingly accuses Dr. Luke of overreacting, even though common sense dictates that Dr. Luke should be willing to fight these allegations to every extent possible.

As a result of the draconian action taken against Dr. Luke, a report was made concerning the process to the National Practitioner Data Bank and the Medical Board of California on January 18, 2005. {CT 50}. Once this is done, without reversal, damage to Appellant's ***15** reputation, honor, ability to get prime insurance contracts, and ability to maintain privileges elsewhere, were jeopardized beyond repair. No effort is made to stay such action, regardless of whether there is any actual threat to patients, even if the responding physician challenges the process or findings.

With respect to the staff privileges committee (the "Medical Executive Committee or "MEC"), which heard Dr. Luke's appeal to maintain his privileges, more than one of the review members were business competitors of Dr. Luke's. Accordingly, Dr. Luke did not feel that he was getting a fair hearing before the RCH Judicial Review Committee (JRC).

Appellant was also concerned about the fact that absolutely no character witnesses were allowed in the staff privileges hearing, even though the loss of hospital privileges can have a profound effect on a doctor's insurance, his reputation in the community, and his ability to seek privileges at other institutions. Certified transcripts memorializing the process can be found at CT 190-289.

On or about May 26, 2005, during the course of California Medical Board hearings initiated against Petitioner/Appellant by ***16** Respondents, it was discovered that the blood samples had been mislabeled by the investigating coroner!!! Therefore, the toxicity data was not reliable as previously rendered. {CT 184-186, 188, 309-317}. This was a position supported by a nationally known forensic expert, who provided written testimony in support of Dr. Luke's position. {CT 329-334, Declaration of Cyril Wecht, M.D., J.D. and other declarations}.

Upon receipt of this exculpatory evidence, counsel for Appellant immediately took action to make the information known and usable to all involved. {CT 286:25; 291-296}.

A simple mislabeling of information nearly cost Dr. Luke his entire career and 30 years of unblemished reputation. {CT. 106:4-108:6}. This also resulted in a successful writ of mandate petition being filed by Appellant against the Coroner. {CT 368-374, 378-379}.

Indeed, the evidence was a shocking vindication of Dr. Luke's position in the RCH proceedings. {See generally, CT 380-413}. What started off as a simple mislabeling {CT 57-58} gave rise to the RCH witch hunt against Appellant.

Given that the JRC decision at CT 35-48 heavily relied on the ***17** assumption that a lethal dose of morphine {CT 39} had been given to M.E., this evidence was critical and should have resulted in a voluntary reconsideration of the case against Dr. Luke. Instead, RCH remained steadfast in its desire to rid the hospital of Dr. Luke and persisted through all proceedings in the claim that, in any event, Dr. Luke's record-keeping was somehow sloppy and sufficient for purposes of terminating all staff privileges. {CT 515, fn. 11}.

On March 10, 2006, the Medical Board of California exonerated Dr. Luke from any liability for an alleged morphine overdose. {CT 137-172}. In the end, the Medical Board only found fairly minor violations as to records-keeping and took appropriate action. {171-172}. Even by RCH's own standards, no more than a limited suspension of privileges should have occurred, even if there was a records violation. {CT 579-603 or 749-773 (RCH Bylaws)}.

Finally, it is important to note the lengths to which the Medical Board went to explain the importance of non-interference with the sacrosanct relationship between a patient and physician in making end-of-life decisions, including the decision to use morphine in the course of palliative care. {CT 154 ¶ 55-155 ¶ 57; Also see, 167 ¶ 13-171 ¶ ***18** 20}. Indeed, the Medical Board provided the parties with a deep analysis of state and federal decisions on the issue of how and when certain end-of-life decisions can be made. {*Id.*}.

The Medical Board found heavily in favor of the decision-making process engaged in by Appellant. Regardless, RCH fails to recognize the difficult decision that Appellant was a part of and chooses, instead, to treat Appellant as a murderer. Not only is this morally wrong for RCH to do, the course of conduct taken in this action also violates basic Due Process and clearly disrespects the rights of patients such as M.E.

While RCH gave a rehearing to Dr. Luke, his opposing counsel ruled on all objections, no evidence was actually presented by Dr. Luke's accusers, and absolutely no showing was made that Dr. Luke posed an actual threat to any patient. {CT 964-981}. These failures were in direct violation of Judge Krug's orders at CT 936-938.

V.

RELEVANT PROCEDURAL HISTORY

A detailed description of the administrative actions taken by RCH against Appellant is set forth at CT 102:18 -104:17 and at CT 149 ¶ 40-154 ¶ 54.

***19** Following exhaustion of all administrative remedies, Appellant filed an Amended Petition for Writ of Mandamus on June 24, 2005. {CT 19}. The petition, as filed, specifically challenged the following: a.) The lack of neutrality with respect to RCH's Medical Executive Committee ("MEC") and Judicial Review Committee ("JRC"); b.) The unfairness of the JRC hearing; c) The failure of RCH to consider new evidence concerning the blood toxicology reports; and, d.) Other various issues raised by the conduct of Respondents in the MEC and JRC processes. {CT 19-24}. The petition was brought specifically per *California Code of Civil Procedure* § 1094.5, which provides a relief mechanism for the types of harms alleged herein.

Respondents filed an Answer on August 10, 2005. {CT 90}.

A memorandum of points an d authorities in support of the Petition was filed on October 6, 2005. {CT 95}. The papers specifically identified the claims of error asserted by Appellant with respect to the JRC and MEC proceedings. {CT 7}. More importantly, the exculpatory evidence found in May 2005 was discussed. {CT 104-108}.

An opposition to the supporting papers was filed by Respondents on November 11, 2005. {CT 114}.

***20** A supporting declaration, with a number of exhibits, to the Petition was filed on May 5, 2006. {CT 133-380}.

A supplemental points and authorities was filed on August 14, 2006, in favor of Petitioner's position. {CT 380}.

Opposition to the supplemental materials was filed by Respondents on November 20, 2006. {CT 504-578}.

An appendix of outside authorities and declaration of counsel in support of the opposition was filed on November 27, 2006. {CT 624, 688}.

A reply to the opposition of Respondents was filed on December 5, 2006. {CT 778}.

A request for judicial notice in support of Petitioner's position was filed on December 19, 2006. Judicial notice related only to records and regulations of RCH. {CT 858}.

Opposition to the request for judicial notice of RCH's records was filed by Respondent RCH on December 26, 2006. {CT 885}.

A surreply was filed by Respondents on December 26, 2006. {CT 891}.

On January 2, 2007, Judge Robert Krug issued a writ of ***21** mandamus requiring a rehearing of the underlying matter. {CT 913, 923; Also see, RT 14:11-15:5}. The parties, in an effort to define the issues, prepared and filed a jointly submitted writ of mandamus on April 25, 2007. {CT 923}. More specifically, Judge Krug ordered that RCH do the following:

A. That RCH actually reconsider its actions against Appellant with respect to the new evidence on the blood test results;

B. That the Board make specific findings as to what threat Dr. Luke then (as of the hearing) presented, if any, to RCH's patients. {RT 9:7-10:2}.

Eight months later, RCH filed a return to the writ of mandamus on December 27, 2007.

The original petition was supplemented by Appellant on January 23, 2008. It is important to note that this supplement made demand for a jury trial as to unresolved issues against Appellant. {CT 1000}.

Petitioner's opening brief was filed on March 13, 2008. {CT 1005}.

A notice of lodging of the Administrative Record {"AR"} was filed by Respondents on March 25, 2008. {CT 1016}. Objections to the ***22** untimeliness of the Respondents' lodging of the administrative record were made by Counsel herein. {RT 15:22-16:5}.

Respondents filed their response to Petitioner's opening brief on March 25, 2008. {CT 1020}.

Petitioner filed a reply to the opposition on April 4, 2008. {CT 1039}.

The Honorable Judge Joseph Brisco, presiding, rendered a judgment denying relief to Appellant on July 21, 2008. {CT 1044}.

Notice of entry of the judgment was on August 27, 2008. {CT 1047}.

Notice of appeal was timely filed by Petitioner/Appellant on October 24, 2008. {CT 1056}.

The record on appeal was designated on November 14, 2008. {CT 1067}. The Clerk's Affidavit was filed on December 16, 2008, as to completion of the record on appeal. {CT 1073}.

The Register of Actions is set forth at CT 1-18.

VI.

ARGUMENT

Throughout the years of litigation and administrative hearings, ***23** Appellant has consistently maintained his objections to the unfairness of RCH's process {CT 104, 108}, the bias of the adjudication panel {109-111}, the failure to actually consider the exculpatory blood evidence from the Coroner {105-107}, RCH's reliance on uncorroborated hearsay throughout the proceedings {108-109 }, and the unconstitutional burden placed upon patient autonomy and physician judgment {99-101; 386:9-19}.

As shown below, each of the substantive areas of opposition should have been given credence and the suspension and ultimate termination of Dr. Luke's medical privileges at RCH should have been set aside entirely.

As a backdrop to the analysis of this case are a number of general principles or rules of law governing peer review processes with respect to hospital staff privileges. These governing principles are as follows:

A. A physician is entitled to minimum due process in the context of an attempt to terminate staff privileges. *Anton v. San Antonio Community Hospital* (1977) 19 C.3d 802;

B. Hearsay evidence may not be used as the sole basis for making a determination on staff privileges. *Government Code* § 11513(d) ***24** and *Cipriotti v. Board of Directors* (1983) 147 Cal.App.3d 144, 155;

C. Members of a hearing body may not have any pecuniary, interest in the outcome of the peer review proceedings. *Applebaum v. Board of Directors of Barton Memorial Hospital* (1980) 104 Cal.App.3d 648, 657; *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1026-1021; *Brown v. City of Los Angeles* (2002) 102 Cal.App.4th 155 (any financial interest in the outcome is given the utmost scrutiny when reviewed by a Court of Law);

D. The rights of patients and their physicians are of critical importance to public policy and must be given respect by the Courts and the California Medical Board. {CT 825-829}.

E. Actions against a physician, by a peer review committee, must be supported by adequate notice as to the charges and notice as to the specific intended actions to be taken against the physician. *Business & Professions Code* §§ 805, 809.1.

***25 A.**

THE RECORD BELOW *DOES NOT* SHOW DR. LUKE TO BE A THREAT TO PATIENTS: THE RECORD ACTUALLY SHOWS HIM TO BE A GOOD & COMPASSIONATE DOCTOR

RCH has continually claimed that exculpatory evidence in favor of Dr. Luke was not relevant regardless of the fact that, throughout the proceedings below, RCH had absolutely no problem using any evidence they thought to be adverse against Dr.

Luke. {AR 00041}.

The exculpatory evidence find's itself in the reversal of the coroner's decision and in the reconsideration that the Medical Board of California gave to Dr. Luke. {CT 796-830, Exh. 3 to Opposition, Medical Board of California Decision on Reconsideration}.

While claiming that Coroner's evidence had no bearing on their decision, RCH completely left out the fact that it was the Coroner's *second* report that came in during the actual JRC proceedings and was used as the ostensibly *exclusive* basis {AR 000214}for immediately denying privileges to Dr. Luke. {AR 00045-48}.

In technical terms, the "substantial evidence" that might have otherwise justified the actions of RCH turned out to be evidence that ***26** was reversed by its very author (i.e., the coroner). It is also noteworthy that an autopsy was never deemed necessary and the California Medical Board has made the *finding of fact* that Dr. Luke "testified he does not believe in physician-assisted suicide or euthanasia. Dr. Luke believes he has a duty to provide as much comfort as possible to actively dying patients." {CT 800, § 5}. These key philosophical beliefs and credibility of Dr. Luke have not been successfully challenged by anyone.

Moreover, contrary to the inflammatory and false suggestions by RCH and its counsel, Dr. Luke did nothing in the medical records to hide his 9/14/02 15:40 decision to administer 50mg per hour of morphine to M.E. as is indicated by the fact that he made a written order for the same and confirmed it to the attending nurse. {CT 807-809, §§ 31-32; 12:§§ 35-36; AR 00119, 00194}. Dr. Luke also did not agree with time references indicated by nurse. Moreover, the reasons for providing the morphine at such a level, as indicated in M.E.'s Second Discharge Report {AR03423-24; 03426-27; 05306} were completely consistent with the findings of the California Medical Board when it concluded that Dr. Luke's medical treatment of M.E. was appropriate. {*Id.* at §§ 84-85; 30-34: §§ 13-20}.

***27** Nevertheless, much higher doses had been given to RCH patients in the past by other physicians or nurses and the ranking nurse on duty "directed the infusion to continue." {*Id.* at 37; Also see AR 00573 *ll.* 3-19}. Punitive action was not taken against Nurse Parenteau, to Luke's knowledge, regardless of the alleged protocol which supposedly mandates that nursing staff do otherwise. {See Standing Order at CT 832-833} Nor did the MBC or RCH dispute that Patient M.E. did *not* want his life prolonged and that he wanted palliative care only, even if it hastened death. {CT 800 § 7}. *Prior* to admission to RCH, Patient M.E. was already independently deemed to be "obvious[ly] terminal." {CT 800805}.

Taken as a whole, the record below clearly demonstrates that Dr. Luke did not kill his patient as alleged. As such, there was no basis whatsoever for the action taken by RCH to forever terminate Dr. Luke's 25 years of unblemished hospital privileges at RCH.

B.

THE APPEARANCE OF BIAS IN THE ADMINISTRATIVE PROCEEDINGS WAS IMPERMEABLE

Respondents expected all to believe that the underlying ***28** proceedings were unquestionably fair and reasonable. {CT 891-901}. The problem with this characterization of the JRC proceedings is that RCH continually glossed over the following facts that damaged the potential for a legally fair hearing:

1. While almost unbelievable, the "Presiding Officer" at the appellate level of the JRC proceedings {CT 600, Per RCH Bylaws § 7.5-5} was and is the legal advocate for RCH (i.e., the McDermott, Will & Emery law firm "MWE"). It is simply impossible that MWE or one of its attorneys served as a Presiding Officer {CT 971 at p. 27-29; 979 at 59:2-13; 981, at pp. 66-68} for a hearing intended to provide fairness to Dr. Luke *and* RCH while, at the same time, serving as the zealous paid, and sworn advocate for the exclusive interests of RCH throughout this entire process. Obviously, the appeal/writ process herein would also financially benefit MWE since they are presumably paid by the hour and were retained at or about the time of the RCH internal appeal that preceded the filing of the Supplemental Writ herein.

2. Lead accuser Theodore Shankel, M.D., had to recuse himself from the Board of Directors consideration of the findings of the ***29** JRC. {AR 06237, fol}.

3. Members of the JRC were direct and admitted competitors of Dr. Luke's medical group {CT 836, p. 8, *ll*. 3-7} and admitted as much to the Medical Board. {AR 00100}. This obvious conflict affected the lead RCH investigator (Shankel) and two members of the JRC (Brockman and Dexter). {See Exh. 836, p. 31, *ll*. 11-18; 34:1-10; 37:21-25}.

4. The alleged "protocol" for palliative care, referenced at AR 06239 is only for nursing staff, was not circulated to doctors, and as can be seen from this protocol, any questions a nurse may have regarding dosage and patient comfort issues are ultimately the physician's responsibility. {CT832-833}; CT 836-844, p. 10, *ll*. 9-12; 11:23-25; 12:1-8}. Using a protocol applicable only to nursing staff to prosecute a

doctor is unfair and biased.

5. Dr. Luke was denied access to the chart during critical times. {CT 811 at p. 15-16, §51}.

6. Dr. Dexter, a JRC member, was materially involved in matters that affected the disposition of Dr. Luke staff privileges. Specifically, Dr. Dexter had specialized knowledge about {CT ***30** 832-833}, the key RCH internal document used to criticize Dr. Luke, since he helped develop it. {AR 00155 p. 21 *ll*. 23- 25; 22:1-4}. As though this weren't bad enough, Dexter repeatedly poisoned the record with the slanderous allegation that Luke had administered a 80mg bolus of morphine to Patient M.E.. This was just a false claim that was prejudicial and inflammatory, referenced at AR 01413. {CT 837-844, 38:4-10}.

7. RCH violated the spirit and letter of *California Business & Professions Code* § 809.1(c)(1) and its own bylaws inasmuch as the original "charges" in the first portion of the Administrative Record look nothing like what eventually formed the basis for termination of privileges. Also see, *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 634, 166 Cal.Rptr. 826, 838. The full scope of charges was never set forth in any specific detail at a meaningful time.

It is also noteworthy that Dr. Luke has continuously maintained staff privileges at other hospitals during this whole episode. {CT 799, § 4}. Moreover, Dr. Luke was invited to serve on the faculty of the Loma Linda University School of Medicine just prior to the incidents ***31** giving rise to these proceedings. {*Id.*}. Frankly, it is indisputable that Dr. Luke is a very well respected physician with deep and meaningful ties to the Inland Empire and thousands upon thousands of patients over a thirty-year period of time. His beneficial interest in a fair hearing process by the JRC is beyond any reasonable dispute.

C.

THE RECORD BELOW SHOWS THAT RCH JUST SIMPLY DID NOT LIKE DR. LUKE AND PUNISHED APPELLANT BECAUSE HE DID NOT RESPOND WELL TO A FALSE ALLEGATION THAT HE KILLED A PATIENT

Throughout the record below are references to the notion that Dr. Luke should have just accepted whatever it was that RCH wanted to do to him. However, one should readily not forget the fact that RCH had accused one of its own of murder. The fact that Dr. Luke should be defensive or unwilling to cooperate fully should be no shock and should not have been used against him as a basis for adverse action against his

privileges.

The Medical Board was rather simple in its explanation of DR. ***32** LUKE's attitude toward the history of their care when it stated:

"Dr. Luke had ***never faced a disciplinary action*** brought by the Medical Board before. ***A great deal was at stake.*** **His concern and resentment at being on trial was obvious and UNDERSTANDABLE,** [emphasis added]."

{CT 821, p. 26, §79}.

In sum, it should be no shock that Dr. Luke desires that this Court complete the process of vindication that has marked this entire series of unfortunate events.

The underlying proceedings were so replete with confusion, changes of direction, and inconsistency, that it would be nearly impossible to ever provide a fair hearing and there is no evidence that shows that Dr. Luke could have been *fairly* deprived of his medical privileges based on the evidence as it actually was.

To sum up Dr. Luke's position herein:

"[Dr. Luke] is credible when he states that Morris E: was in distress and pain in spite of his failure to properly document Morris E.'s condition. Dr. Luke has the trust and respect of his colleagues and patients. Dr. Luke has never ***33** had any discipline imposed against his license by the Medical Board. Dr. Luke has never been the subject of a malpractice action. [...]

There is a need to provide effective pain relief to patients who are actively dying, and **imposing discipline in cases involving physicians who care for such patients might have a chilling effect on other practitioners similarly situated and result in the *undertreatment* of actively dying patients.** [...]

Incompetence was not established. Dr. Luke, an experienced practitioner, knew what he was doing."

[emphasis and italics added]." {CT 821-823}.

With respect to RCH's handling of JRC proceedings regarding treatment of actively dying patients, the public policy principles set forth by the MBC are no less compelling. {CT 825-829}. Abiding by RCH's wishes that this Court sustain the punishment of Dr. Luke for his treatment and comfort of an actively dying patient will result in a chilling effect on other RCH physicians facing similar circumstances.

***34 D.**

RCH IGNORED PRESUMED BIAS ESTABLISHED IN THE RECORD BELOW

1. RCH Violated Its Own Bylaws with Respect to Neutral Hearing Officers

RCH's own bylaws indicate that the Judicial Review Committee members, "shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, and initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action." {AR 02695 § 7.3-5}. Moreover, Section 7.4-3 specifically provides:

"[A]ttorneys from a firm regularly utilized by the hospital, the Member Staff, or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as a hearing officer." {CT 595}.

Conveniently, this incredibly important portion of the bylaws was left out of the letter-notice sent to Dr. Luke at the beginning of the proceedings against him. {AR 00004-5}. From writings contained in ***35** the administrative record, it appears that at least one of the involved legal firms was providing behind-the-scenes advocacy/advice at the time of the initial inquiry into Dr. Luke's conduct. {AR 00103 p. 64, *ll*. 16-25; Also see AR 00103, 00200}.

RCH, through its counsel, violated the protections afforded all parties to judicial or administrative proceedings by way of *California Rules of Professional Conduct* § 5-200 and 5-210, RCH Bylaws § 7, 4-3, and the holdings of *Comden v. Superior Court* (1978) 20 Cal.3d 906, 145 Cal.Rptr. 9. Also see, *Lyle v. Superior Court (Rancho Cucamonga)* (1981) 122 Cal.App.3d 470, 482, 175 Cal.Rptr. 918, 926 [counsel may be disqualified where involvement leads to a convincing demonstration of detriment to the opposing party or injury to the integrity of the judicial process]; *California*

Business & Professions Code § 809.2(a)(c).

First, the law firm of Christensen & Auer was apparently already providing "*confidential attorney-client*" advice to the JRC's members before asserting itself as the "hearing officer." In this same correspondence, Christensen indicates that the JRC members can meet him and he will personally answer any of their individual questions on ***36** an *ex parte* basis. Obviously, the same offer of advice was not extended to Dr. Luke. {AR 00004}. No transcript seems to be available as to how this ostensible conflict between a "hearing officer" role and attorney role was resolved fairly.

Secondly, the attorney-advocate law firm for RCH, also served as the "neutral" Presiding Officer in the Redland Community Hospital Board of Directors Appeal Board matter that partially gives rise to this action. This internal appeals process at RCH, headed by one of the lead attorneys herein (Donald Goldman, Esq.), was part and parcel of the JRC proceedings. {See Transcript excerpts at CT 836-844; Also RCH Bylaws §7.5-1 at AR 02701}.

Obviously, the office of the Presiding Officer, a "neutral" quasi-judicial officer within the meaning of administrative law (CCP § 1094.5), cannot serve simultaneously as both advocate and neutral officer. This is ethically unsound and it violates the very principles that are at stake in this *California Code of Civil Procedure* § 1094.5 proceeding.

Indeed, just about any reasonable member of the public could question the fairness of a proceeding where the Presiding Officer is also ***37** an advocate for one's enemy *Haas, infra*.

Moreover, as to the fairness of the underlying proceedings, all of the handling attorneys for the firm of McDermott, Will & Emery, LLP, were potential witnesses in the action and, as a matter of professional ethics, prohibited from engaging in advocacy where their advocacy and witness-status could have a prejudicial effect on the opposing party.

Finally, as shown in *Haas* (2002) 27 Cal.4th 1017, 1025, 1.19 Cal.Rptr. 2d 341 any future interest in pecuniary compensation related to one's role as a hearing officer is enough to create the impression of bias per se'. A financial interest, as the presiding officer's firm had in the process and outcome of the RCH Board Appeal, is enough to reverse the actions of RCH outright. *Id.* at 1025-1027.

While RCH and counsel have claimed that the presiding officer only controls the *process* of the RCH Board appeal, the reality is that *process* and *substance* are always equally important in any adjudicatory proceeding. Here, there is little doubt that Donald Goldman was paid by the hour for his services and there is no doubt that the firm is now being presently compensated for its advocacy against Dr. Luke, an administrative litigant that appeared before Goldman (while he was still ***38** with the firm) in his capacity as the "presiding officer" over an adjudicatory appeal process. While Goldman and his firm have likely made much more than just a few dollars on the proceeding and the instant litigation, as little as $5.00, $10.00 or $15.00 has been enough to set aside the findings of an administrative adjudicator because of bias. *Id.* at Headnote 4 and 1027-1028.

Here, the fundamental issue before the Court is whether the *proceedings* before RCH were fair and proper. As can be seen from CT 836-844 there is absolutely no doubt that RCH's attorney purported to serve as the "Presiding Officer" at the hearings that are now the subject of litigation and, more particularly, the subject of whether the Presiding Officer was in fact fair as to the conduct and affairs of the very proceedings in question.

Indeed, the continuing involvement of the McDermott firm does indeed call into question the very integrity of the judicial review process and convincingly demonstrates detriment to Dr. Luke, M.D., as he attempts to challenge the very neutrality of the proceedings taken against him whilst opposing counsel was at the helm of such proceedings and advocating at the same time.

***39 2. Initiator Shankel & JRC Members were Competitors of Petitioner**

A fundamental rule for JRC proceedings, or other quasi-judicial proceedings, is that the hearing officers be independent, neutral and bear no financial interest in the outcome of the proceedings. Respondent RCH admits as much at AR 00030. {Also see, CT 109:8-110:111:28}.

However, outside counsel for RCH indicated that bias may not be imputed and that there were no issues of competition. This is directly contrary to California law directly addressing this key issue. More specifically, the Court in *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1025-1028, 119 Cal.Rptr. 2d 341 [FN1] held that:

FN1. Decided two years after the case relied on by RCH at AR 00029.

. While adjudicators challenged for reasons other than financial interest are afforded a presumption of impartiality, adjudicators challenged for financial interest are not. The law is emphatically to the contrary. A reviewing court is not required to decide whether in fact an adjudicator challenged for financial interest was influenced, but only whether sitting on the case would offer a possible temptation to the average judge to lead him or her not ***40** to hold the balance nice, clear, and true.

. A showing of actual bias is not required, and neither is a cost-benefit analysis. The possibility of bias is not cured by an independent review of the record. An interest as small as $5.00 is sufficient to create the indelible appearance of bias/unfairness.

. The appearance of bias that has constitutional significance is not a party's subjective, unilateral perception; it is the objective appearance that arises from financial interests.

Here, Dr. Shankel readily admits to his financial interest in the outcome of the proceedings against Dr. Luke {AR 00100 at p. 49 *ll*. 12-19; MBC Transcript at 217}. The same interest is held by Dr. Dexter of the JRC after all, Dexter and Shankel had been personal friends for more than 10 years. {AR 00090}. *Hass* prohibits such close connections. {Also compare to AR 00093, at Transcript pp. 22-25}. Nevertheless, this did not prevent Shankel and his cohorts from testifying in and overseeing a hearing that had the potential to completely destroy Dr. Luke and the reputation of those. closely associated with Dr. Luke.

While RCH claimed that there is no concern to be found here, ***41** because there are 140 members of the Beaver Medical Group, one can be certain that if Dr. Luke's group only lost a few patients at RCH because of his suspended privileges that thousands of dollars in net benefit to Drs. Shankel, Brockman and Dexter's group would occur in violation of holdings of *Haas* and the holdings in other cases expressly relied on by that Court.

The issue of Dr. Shankel's obvious conflict of interest was properly raised early in the proceedings. {AR 00021-22, 93}. Not only did RCH violate law enunciated by our local Court of Appeal, it also violated its own bylaws. This is reversible error per se. *California Business & Professions Code* § 805.9.

3. The Lack of an Actual Reconsideration Process Creates Fundamental Unfairness

First, RCH's own bylaws make it clear that the JRC *shall* consider the "exculpatory or inculpatory" nature of any evidence sought to be brought into the JRC proceedings and to provide "safeguards," consistent or necessary to the protection of the process and justice, to the parties to the proceedings. This also includes an opportunity to challenge the fairness of the hearing officers. {AR 02697 § 7.4-1d}.

***42** Secondly, as indicated at AR 02685 (§6.1-4), RCH had plenty of less draconian measures to deal with the fact that they believed Dr. Luke was simply guilty of not maintaining the amount of detail RCH wanted on his first discharge report. As shown in the Medical Board's ultimate decision, the issuance of a second discharge report was essentially insignificant. {CT 823, at p. 28, § 85}.

Thirdly, as indicated at AR02686, summary suspension of a staff member's privileges {as indicated at AR 00006-8} is only appropriate where it is necessary to "protect the life or well-being of patient(s) or to reduce substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient [etc.]." Here, RCH admits that this whole case now only boils down to whether an adequate medical record was maintained for Patient M.E.. {CT509:1-16}.

As the Medical Board of California indicated, the betterment of records would only have benefitted Dr. Luke personally/professionally (by staving off baseless patient claims) and this was *not* an issue about the health or safety of M.E. per se' {CT 822, § 80}.

Alleged records violations are mentioned nowhere in the summary ***43** suspension of privileges at AR 00006-8. More grievously, the mention of records-keeping is nowhere to be found in the CMB Health Facility Reporting Form that will forever damage this doctor's reputation. {AR 00010-11}.

Next, when one looks at AR02690 (§ 6.3-3), one finds that the punishment for late or incomplete records is a "limited suspension" that results in reinstatement upon completion of the record. Here, Dr. Luke did not have access to M.E.'s chart after RCH management began questioning his treatment of M.E. and the Medical Board found the issuance of a second discharge report to be insignificant from a standard of care perspective and that no witness had proved that Dr. Luke ever removed the first discharge report from the chart. {CT810-811, § 51}. At most, RCH's own bylaws suggest that Dr. Luke should have only suffered a temporary suspension of his privileges that should have been lifted once he turned in his second discharge report. {AR 02691}.

Finally, it is noteworthy that problems with the administrative process began right way when the JRC was repeatedly scheduling hearing dates without notification to Dr. Luke's counsel {AR 00012-15}, the failure of material witnesses to show at the hearing {AR 00061-***44** 64, 68}, RCH's desire to completely suppress testimony from the coroner's office {AR 00065, 69}, the denial of character evidence even though professionalism is an aspect of peer review proceedings {AR 00072-75}, denying the cross-examination of a material witness who also happened to be clearly connected financially to members of the JRC {AR 00076-84a}, Dr. Dexter's replete references to egregious facts that never happened {AR 01412-1435}, and having JRC finders-of-fact serve even though they are partners and friends with material witnesses {AR 00090-93 at Transcript pp. 11-12, 22}.

E.

UPHOLDING RCH'S JRC HEARING PRACTICES IS SQUARELY AGAINST PUBLIC POLICY

California Business & Professions Code § 2241.5. states in pertinent part:

"Notwithstanding any other provision of law, a physician and surgeon may prescribe or administer controlled substances to a person in the course of the physician and surgeon's treatment of that person for a diagnosed condition causing intractable pain." [...] No ***45** physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain."

Furthermore, *California Probate Code §§ 4650*-4653 recognize the right of patients to direct the conditions by which they will face end-of-life issues in the hospital setting. These statutes make it abundantly clear that California recognizes the rights that Dr. Luke and his patient could exercise when Patient M.E. faced death. {CT 846-856}.

Notwithstanding the fundamental property right of DR. LUKE that is at stake here, [FN2] if this Court is used to bless the reprehensible conduct of RCH, the reality is that many patients will bear the risk of being unfairly and unconstitutionally deprived of physician-approved and necessary treatment. Indeed, this is a point that was made very clear by the California Medical Board when it specifically found that Dr. Luke and other physicians, working under similar or same circumstances with an actively dying patient, must be given the latitude to do what Dr. Luke did.

FN2. *Anton v. San Antonio Community Hosp.* (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442.

***46** In a most basic sense, RCH cannot deny the existence of *California Probate Code* §§ 4650-4653 and nor can it deny that patients' constitutional rights to receive appropriate medical treatment are at stake when physicians are punished for making difficult judgment calls. See generally, *Cruzan v. Missouri Department of Health* (1990) 497 U.S. 261, 267, 110 S.Ct. 2841 [right to control medical treatment is a constitutional right]; MBC Rec at p. 41- 44].

Indeed, two things are certain with respect to the issue about patients' rights and the impact of any injunction on their healthcare choices.

First, the RCH patients have a legislatively created right under California law to receive palliative care once the patient has reached death's doorstep. *Probate Code* §§ 4650-4653. Without much philosophical difficulty one can readily see that this right, as recognized by the Legislature, can be directly associated with the well-recognized right of self determination when making decisions about one's body and the physician-directed treatments that are medically appropriate to remedy any health conditions.

Moreover, the right to patient autonomy in end-of-life decisions ***47** is a right that was created by the People of the State of California by express legislation-unlike rights that have been generically created by courts under a 'penumbra' analysis of the Ninth or Fourteenth Amendments. See generally, *Whalen v. Roe* (1977) 426 U.S. 589, 97 S.Ct. 869, 876-878; *In Re Lifschutz* (1970) 2 Cal.3d 415, 431-432,fn 12, 85 Cal.Rptr. 829; U.S. Constitution, Amendment 10. RCH seemingly couldn't care less about the fact that it seeks to maintain the punishment and excommunication of a physician who was clearly within his rights.

Secondly, the right to seek and achieve medical treatment, without administrative interference by RCH, is a fundamental right that should not be treaded on without good reason. Also see, *California Constitution, Art. I, § 1* [right of privacy]; Beauchamp & Childress, *Principles of Biomedical Ethics* (Oxford University Press, 1993) 4th.Ed pp. 120-181 [discussion on patient autonomy]. Even the Medical Board suggests that punishment of DR. LUKE for the decisions he made in M.E.'s care would be tantamount to interfering with the most difficult and private decisions that a doctor, patient and patient's representative ever have to make.

Indeed, California law recognizes that, "medical care decisions ***48** must be guided by the individual patient's interests and values [juxtaposed to the protocols, unfounded fears of an errant nurse, or administrative whims of RCH]. Allowing

persons to determine their own medical treatment is a way in which society respects persons as individuals." *Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 208, cert.denied, 488 U.S. 958, 109 S.Ct. 399.

Indeed, this important right implicates a fundamental right to due process before that right may be taken away and any actual deprivation of the patient's due process right will also necessarily interfere with the private and sacrosanct relationship between a doctor and his/her patient. See generally, *Hodgson v. Minnesota* (1990) 497 U.S. 417, 435, 110 S.Ct. 2926, 2937; *Carey v. Population Services International* (1977) 431 U.S. 678, 97 S.Ct. 2010.

Here, there is no doubt that RCH wanted to bring an immediate end to Dr. Luke's ability to provide for the expression and realization of patient rights relative to end-of-life palliative care. They will also ask this Court to approve of summary administrative proceedings that can be used to justify an outright intrusion upon fundamental rights through the guise of minor alleged records-keeping violations or an ***49** unwillingness to simply submit to a reprobate conclusion that one's treatment of a patient was per se' murderous and unprofessional.

RCH has made absolutely no attempt to show that this Court has a legitimate, substantial, *or* compelling state interest in violating the expressed will of the Legislature and the People. Moreover, Respondents have made no attempt to describe how they might actually work with RCH physician-staff members to ensure that patient rights can be exercised within the meaning and intention of the death-with-dignity provisions of California law.

RCH, by enforcing its substandard nursing protocol allows no means by which a patient can exercise the right of self-determination in choosing appropriate and state-approved modalities of treatment recognized by law and, rather apparently, any physician who runs afoul of RCH's world view will be punished. Such punishment thereby sends a very clear message to any other RCH physician willing to take a courageous approach to the compassionate care of a dying patient. This Court must protect patients and physicians from the chilling effect that necessarily flows from RCH's attitude toward the care and treatment rendered by Dr. Luke to a dying patient.

***50** At the end of the day, one well knows that this is not a case about simple records-keeping violations as now conveniently suggested by RCH at CT 509. This case has always been about an alleged cause of death and the treatment that was actually rendered by DR. LUKE to his dying patient, M.E., over four years ago. This case is really about preserving fundamental rights and fairness for all players in the

end-of-life drama that faces California physicians and patients on a regular basis at RCH and in every hospital.

VII.

CONCLUSION

The judgment denying a writ of mandate against RCH must be reversed.

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