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Med mal: Holding hospitals liable under *Elam* for doctors' negligence

HOSPITALS CAN BE HELD LIABLE FOR NEGLIGENCE OF THE DOCTORS, INCLUDING INDEPENDENT CONTRACTORS SUCH AS ER DOCS

This year marks the 25th anniversary of one of the greatest California opinions for medical- malpractice plaintiffs, *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332. Most attorneys who have litigated medical-malpractice cases for any length of time know of *Elam* claims. However, far fewer have a good understanding of the contours of *Elam* and the full benefits the case can afford. Fewer still understand the interplay between *Elam* and the major limiting factor on *Elam* claims against the hospitals – California Evidence Code section 1157, setting forth the peer review privilege – and how to minimize the impact of that statute.

This article provides a roadmap of what *Elam* can provide, the limitations of Section1157, and how best to handle those limitations.

Elam giveth...

The specific holding of *Elam*, and the aspect of *Elam* most commonly recognized and understood by plaintiff's attorneys, is that hospitals are responsible to exercise reasonable care in selecting and periodically evaluating the competence not only of their employees but of all medical staff physicians (including independent contractors) allowed to use the hospital's medical facilities. (*Id*. at 346.) *Elam* supports the notion that hospitals can be held liable for negligent selection, supervision, or oversight or evaluation of the doctors who practice at that hospital.

In fact, the holding of *Elam* is much broader than this, and provides much greater opportunities for plaintiffs seeking liability against hospitals. *Elam* was the first published opinion in California to: (1) recognize hospital corporate negligence; that is, a hospital's liability for breach of its duties directly owed to its patients; and (2) extend this responsibility to whatever harm these doctors may cause. The *Elam* court recognized an affirmative duty by hospitals to ensure the quality of care rendered by the physicians practicing within that hospital.

It is true the *Elam* court found hospital accountability for negligently screening the competency of its medical staff to ensure the adequacy of the

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medical care rendered to patients at its facility. (*Id*. at 346.) And it held that hospitals have a duty to evaluate the quality of medical treatment rendered on its premises (*Id*. at 347.) But, notably, it went further: it held hospitals have a duty to *ensure* the competency of its medical staff. (*Id*. at 347.) Thus, *Elam* sets forth a much broader brush of hospital institutional corporate responsibility by which to find liability against hospitals based on a breach of the hospital's duties, not on an agency theory.

Elam did not create law

To strengthen plaintiff's arguments in this regard, it is important to understand that *Elam* did not create law, but rather summarized it. *Elam* reflects pre-existing and subsequent case law, California statutory law, federal statutory law and even California jury instructions.

For over 70 years, the case law of California has made clear that hospitals owe their patients a general duty of protection. (See e.g., *CEG Thomas v. Seaside Memorial Hospital* (1947) 80 Cal.App.2d 841, 847.) Hospitals in California have a duty to provide a safe environment in which diagnosis, treatment and recovery can be carried out. (*United Western Medical Centers v. Superior Court of Orange County* (1996), 42 Cal.App.4th 500, 504.) Three years after *Elam*, the Court of Appeal confirmed this general "independent responsibility of a hospital as an institution, as opposed to the responsibility of its medical staff." (See *Santa Rosa Memorial Hospital v. Superior Court* (1985) 174 Cal.App.3d 711, 724-725.) "Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility. Although hospitals do not practice medicine in the same sense as physicians, they do provide facilities and services in connection with the practice of medicine, and for negligence in doing so they can be held liable." (*Leung v. Verdugo Hills Hospital* (2012) 55 Cal.4th 291, 310.)

The *Leung* decision is a source authority for CACI 514, which provides that "a hospital is negligent if it does not use reasonable care towards its patient. A hospital must provide *procedures, policies, facilities, supplies and qualified personnel* reasonably necessary for the treatment of its patients." (Emphasis added.) It seems obvious that, although the second sentence provides examples, those are not limitations on the hospital's responsibility, but rather examples.

This responsibility is both embodied and extended by California statutory law, and the intent of the California Legislature is seen further in the implementing regulations.

For example, California Health and Safety Code section 1250 states that hospitals shall have a "governing body with overall administrative and professional responsibility" for the hospital. Health and Safety Code section 32128 provides that hospitals have a duty to operate "in the best interest of the public health."

The implementing regulations under Title 22 of the California Code of Regulations clarifies the overall responsibility of the hospital. They provide that whenever a hospital brings in a professional to render services in the hospital (in addition to its employees for which it is obviously responsible) the "agreement shall specify that the hospital retains professional and administrative responsibility for the services rendered." (22 C.C.R. § 70713.) Further, the hospital's governing body has the duty to adopt bylaws to ensure: (a) the preparation and maintenance of accurate records for all patients; and (b) the achievement and maintenance of high standards of professional ethical practices, including (but not limited to) required demonstrations of competence. (22 C.C.R. § 70701.) Even more generally, the medical staff is responsible to the "governing body for the fitness, adequacy and quality of medical care rendered to patients in the hospital." (22 C.C.R. § 70703.)

Federal statutory law even more clearly places this responsibility on hospitals. For hospitals participating in Medicare or Medi-Cal (which is all of them), "the hospital must have an effective governing body legally responsible for the conduct of the hospitals and institution." (42 C.F.R. § 482.12.) The governing body "must be responsible for services furnished in the hospital whether or not they are furnished under contracts" and "must ensure that the services ... are provided in a safe and effective manner." (42 C.F.R. § 482.12(e).) The Federal Register "intended to clarify that the hospital has *ultimate responsibility* for services" whether provided by employees, formal contracts or informal agreements, and that the "hospital cannot abdicate its responsibility simply by providing that service through a contract with an outside resource." (51 Fed. Reg. 22015 (emphasis added.).)

Moreover, that the doctrine generally referred to as corporate negligence is intended to indicate that the hospital business entity has responsibility for its patients, and not that the hospital's potential wrongdoing is limited to negligence (much less be wrongdoing within the ambit of MICRA). California case law has made clear that punitive damages are available so long as plaintiff establishes that the hospital elected not to completely perform its duty of inquiring and evaluating physicians' reappointment application and knew, or should have known, the probable dangerous consequences of that failure, and willfully failed to avoid those consequences. (*Bell v. Sharp Cabrillo Hospital* (1989) 212 Cal.App.3d 1034, 1047.) There can be punitives for "non-intentional torts," in this context, as long as the conduct constitutes conscious disregard of the rights or safety of others. (*Ibid*).

The big-time doctors

This is important because a hospital's failures to oversee its staff often extend to the most powerful doctors in the hospital. Those doctors, through ownership, their status as cash cows because of their ability to bring in business, or other influence, work in concert with the hospital to allow them to wreak havoc as long as they continue to provide the hospital with these benefits.

This provides at least three ways to avoid MICRA. First, failure to control a well-situated doctor, even if not capable of being classified as intentional

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wrongdoing, at least rises to the level of egregious negligence. There is a long line of cases, primarily nursing-home cases, demonstrating that such egregious (and primarily administrative) wrongdoing is outside of the purview of MICRA. (See e.g., *Guardian North Bay, Inc. v. Superior Court* (2001) 94 Cal.App.4th 963, 697; *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, 790; *Delaney v. Baker* (1990) 20 Cal.4th 23, 31; *Mack v. Soung* (2000) 80 Cal.App.4th 966, 975.)

Similarly, these torts often represent willful misconduct. They often reflect collusive schemes between the hospital and such physicians, often in violation of federal and state anti-kickback statutes, and in many ways endangering patients for profit (ranging from intentional and knowing understaffing to permitted abandonment to intentional and knowing failure to investigate or provide oversight over the offending physicians).

...And Evidence Code section 1157 taketh away

California Evidence Code section 1157 is California's peer-review privilege. It holds that all records of the hospital's medical staff peer review committee are immune from discovery.

This statute presents a direct conflict with the medical-malpractice claimant's interest in discovering the evidence necessary to prove an *Elam* claim. Though under *Elam*, the governing body of the hospital has the responsibility to ensure competence, under Health and Safety Code section 32128, the governing body must do so through committees composed of medical staff.

In general, Section 1157 protections have taken preeminence over plaintiffs' *Elam* rights. By rules of statutory construction, this should not have occurred.

The policy basis for so promoting section 1157 has always been said to improve health quality by increasing candor in such medical-staff committees. (See e.g., *Matchett v. Superior Court* (1974) 40 Cal.App.3d 623, 629 (stating the Legislature determined that public interest in medical staff candor through peer review outweighs the discovery needs of plaintiffs.).)

However, the *Elam* case, eight years later, and 14 years after enactment of section 1157 (1982 vs. 1968), which by all rules of statutory and case construction is held to have known of the existence of Section 1157 and its progeny case law, stated that imposing the duty of care on the hospital under *Elam* serves the same purposes as section 1157, namely, the "prophylactic effect of supplying hospitals with greater incentive to ensure the competence of its medical staff." (*Elam*, *supra*, at 346.) Indeed, the *Elam* court held specifically that its holding "does not interfere with the legislature's comprehensive efforts to ameliorate the integrity and quality of the healthcare system." (*Id*. at 347.) And *Elam* has stood and been reconfirmed for 25 years. (See, e.g., *Walker v. Sonora Regional Medical Center* (2012) 202 Cal.App.4th 948, 960.)

Nonetheless, as often occurs, before plaintiffs were fully familiar with the proper contours of section 1157 protection, the defense elicited from the courts a couple of favorable (and unfortunately) long-standing decisions that over-broadened the application of section 1157. Even worse, hospitals have routinely (and disingenuously) attempted to shield from discovery many things clearly outside of statutory protection, asserting the privilege only to frustrate plaintiffs' discovery rights under *Elam*, but often prevailing against insufficiently informed plaintiffs or courts.

That being said, all hope is not lost. There are numerous ways to attack section 1157 and to get the desired discovery.

Fighting back: Understanding the limitations of section 1157 protection

To successfully defend against and attack section 1157, one must start with the mindset that, under the law, section 1157 suppression rights are nowhere near as broad as claimed by the defense. A fuller understanding of the contours of section 1157 protection will significantly assist in these battles.

First, section 1157 is not an evidentiary privilege. That is, it provides immunity from discovery but not from admissibility. If the information comes from another properly obtained source, you are free to use it. (See *Matchett, supra*, at 629; *Alexander v. Superior Court* (1993) 5 Cal.4th 1218, 1223.) Thus, if you can get anyone to talk or to show you the documents, you can use the information.

Next, the section 1157 protection is in part premised on a presumption, in weighing the competing interests, that plaintiff had other sources with which to support his or her cause of action. Therefore, courts should not allow disingenuous broadening of the privilege to prevent these alternate sources, including discovery of post- and pending malpractice claims and hospital incident reports. It is also premised on the notion that plaintiffs would have their medical records, which in turn necessarily assumes the obvious inference that the medical records would not be intentionally incomplete per hospital policy, as now they almost always are.

Further, the *Elam* court stated numerous issues that it expected to be decided at trial. These included whether the hospital should have conducted peer review investigation upon notice of the incident; and whether they had conducted periodic reviews in a non-negligent manner. (*Elam, supra*, at 347-348.) This raises the baseline question about what reviews and interviews are discoverable.

Probably the single most important principle restricting the breadth of section 1157 protection is that "administrators cannot abdicate their concomitant responsibilities" by claiming section 1157 protection. That is, sharing of responsibilities does not bring hospital administrators within the protections of section 1157. (See *Santa Rosa, supra*, at 726.) Specifically, section 1157 "does not shield from discovery administrative activities which, while related to, are independent of the investigative and evaluative activities of medical staff committees . . . 1157 … does not embrace the files of the hospital administration (as distinguished from the staff)." (*Ibid*.)

Accordingly, "[i]nformation developed or obtained by hospital administrators or others which does not derive from an investigation into the quality of care or the evaluation thereof by a medical staff

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committee, and which does not disclose the investigative and evaluative activities of such committee is not rendered immune from discovery under section 1157 merely because it is later placed in the possession of a medical staff committee or made known to committee members." (*Id.* at 724.) That is, the information protected under section 1157 should be limited to documents originally generated by, not merely used by, peer-review committees. This is very important because the defendants constantly try to give protection to documents that are not generated by the committees, but just ends up in their hands, which is disallowed under *Santa Rosa*.

If defendants' argument were accepted, absurd results would occur. For example, the patient's medical records, which are always reviewed by the committee, would become protected by section 1157, thus negating any attempt at medical-malpractice litigation other than by testimony of the wrongdoers. In addition, such attempts directly violate the long-standing law regarding the use of privileges. For example, with the attorney-client privilege, "that which was not privileged in the first instance may not be made so merely by subsequent delivery to the attorney." (See *D.I. Chadbourne, Inc. v. Superior Court* (1964) 60 Cal.2d 723, 732.) Per *Santa Rosa*, the same applies with the delivery of information or documents to peer review.

Another important general principle in limiting the scope of section 1157 is that, notwithstanding the defense's screams of the importance of the legislative goals underlying section 1157, the more general principle is that courts favor liberality in discovery to assist the parties in ascertaining truth. The burden is on the party claiming immunity/resisting discovery to establish the entitlement to non-disclosure under Section 1157. (*Santa Rosa, supra*, at 727; see also *Brown v. Superior Court* (1985) 168 Cal.App.3d 489, 500-01; *Willits v. Superior Court* (1993) 20 Cal.App.4th 90, 104.) Therefore defendants should be required, in all instances, to do more than declare section 1157, but also to show: (1) the protected item is in fact within the purview of section 1157 protection; and (2) in close calls, their need trumps the general principle of liberal discovery.

A related point is that evidence is not protected under section 1157 simply because a person serves part time on a protected committee, because of the defendant hospital's interest in frustrating the plaintiff's discovery, or for any other reason other than an obvious fit within the privilege. Also, *very importantly*, any time the claim of section 1157 privilege is not obvious, it can only be sustained upon particularized judicial inquiry, specifically an in camera hearing. (*Santa Rosa, supra*, at 727.) Thus, upon plaintiff's request in non-obvious situations, the correct judicial response is that, in the absence of hearing and *in camera* review, there can be no immunity under the statute.

Discovery – superior evidence

Whether you prevail on your corporate negligence claims ultimately will rest on whether you can provide evidence superior to that of the defense. But with section 1157, the defense will attempt to withhold from the plaintiffs *all* evidence that might be favorable to plaintiffs. Thus, plaintiffs should make all efforts to maximize their information while minimizing the information defendants will be able to use. That approach will win the day in nearly all cases.

Given the law and contours of section 1157 and *Elam*, there are numerous tactics plaintiffs' counsel can use to enhance their position. These include various types of informal and formal discovery. In general, keep in mind that one of the main purposes of all of the discovery will be to get evidence of wrongdoing on the part of the hospital. Assume that the hospital will make section 1157 objections to almost anything you seek. There is going to be an opportunity to hoist the hospital on its own petard by, as set forth below, making a "sword and shield" motion and preventing the defendant from putting on a defense if they played "hide the ball" in discovery. If the defense continues to play games, as they almost inevitably will, you may be able to prevail with less evidence than you think.

Of course, the more evidence you can amass, the more the defense will be in the posture of needing to counter that evidence. And the more that the defense does so, the more they will need to use at least some information from their own peer review investigation.

That is, the defense almost inevitably will lower its section 1157 shield to parse out exculpatory information. Invariably, defendants will cherry-pick the favorable information amassed from its investigation.

This defense tactic should be followed with a motion to disallow the defense evidence or require the hospital to hand over the entire peer-review file, not merely the exculpatory evidence. With proper discovery efforts, you often will be able to show that most, if not all, of the favorable evidence the defendant uses was initially from the peer-review investigation process, and that, simultaneously, the defendant is suppressing the unfavorable evidence similarly obtained by claiming peer-review privilege.

Informal discovery

Informal discovery often will get information to guide and focus the formal discovery. Are there instances of conduct by the challenged physicians that should have required scrutiny by the hospital? Does there seem to be collusion by the hospital or protection of the doctor by the hospital rather than protection for your plaintiff or future patients? Are there numerous prior instances of misconduct by the doctor that put the hospital on notice?

The informal discovery also will help you learn the parameters and dictates of the hospital's duties. What types of oversights are required? What do other hospitals do in this regard?

Here are some of the things to start out your informal discovery:

• If you've not done this kind of case before, get an expert. There are numerous persons (from former hospital administrators, to leaders of peer review committees) that might be able to lend the expertise necessary in your case.

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It will help you construct the necessary requests, and in all likelihood will be necessary for trial.

• Public records requests: Make California records requests through the Public Records Act and federal request through the Freedom of Information Act. There are numerous publically available documents of interest in this context. These include: (a) section 1279.1 (adverse event) reports. Such reports must be made in many instances, including almost all deaths and serious disability cases. (b) California Department of Public Health ("CDPH") investigation files against the hospital/physicians at issue. Often, the complaints contain a lot of information. Even better, the hospital's required response, its "plan of correction," often contains gold nuggets; (c) CMS reports. These often go hand in hand with the CDPH investigations, because there's the almost universal federal funding of these hospitals; and (d) medical board investigations, including any "Accusations" levied against the doctor, much of which can be found online.

• Determining the areas or "buckets" of wrongdoing that require peer-review investigations. You can get a lot of such information from your expert. You also can get much from the Joint Commission on Accreditation of Hospital Organizations (JCAHO). This organization releases yearly manuals. Health and Safety Code section 32128 dictates that peer review committees review physician care in accordance with minimum standards promulgated by JCAHO. This includes both established criteria for reviewing the cases and the methodologies for peer review. For example, it requires committees to be established (including medical records committees and peer review committees), and for them to meet at least every three months or whenever incidents occur. It further requires that the hospital "demonstrate the quality of care provided to all patients is consistently optimal by continually evaluating it." And section 32128 specifically requires that the procedures for appointment and reappointment of medical staff should be as provided by JCAHO.

• Find witnesses willing to talk. Your best source often is ex-employees, including nurses who worked with the doctor and, even better, former hospital administrators and persons on the peer review committee. These are available more often than one might think because improperly powerful doctors at hospitals often have rid themselves of persons trying to maintain decorum and procedure at the hospital. The ways to find such ex-hospital employee witnesses are numerous and include looking for employment lawsuits, inspecting the nursing boards, and using the "Wayback Machine" online.

• Obtain all outside litigation brought by and against the physicians in question. Particularly useful are divorce proceedings and credentialing and often litigation with the hospital. Once again, these are available more often than you might think. They often come about because eventually there are attempts by the hospital to get rid of the problematic doctor quietly, but that seldom works because the conceited physician often fights back. Furthermore, such physicians often bring lawsuits for intimidation or monopolistic purposes.

• Look for all other cases brought against the doctors in question and the hospital defendant on oversight issues. Try to determine cases which would have required a peer review investigation and 1279.1 adverse event reports. If possible, check these against potential CDPH and CMS reports.

• Promote your own CDPH investigation. Consider having your plaintiffs or others that they have uncovered (often the ones who told your client to get an attorney) to complain to the CDPH. The CDPH is pretty good about protecting the identity of the whistleblowers. However, sometimes their identity can be found in the file.

• Find writings from the hospital. Surprisingly, there is often information from the medical staff, medical executive committee, board and other hospital personnel setting forth policy in their newsletters, advertisements, websites, etc. Seek informal sources setting forth the duties of the administration, including all the American Hospital Association guidelines as well as the JCAHO manual set forth above. Recall that administrative files are not privileged, and this will help you towards formal discovery.

Formal discovery

Expect that every time you submit any formal discovery seeking anything to do with any quality of care functions, the request, initially will be met with blanket section1157 objections. However, as you follow the roadmap set forth in this paper, and compile your informal discovery, you will be able to more and more force their hands to provide responses to a significant portion of the following: Interrogatories for all administrative files relating to the incident in question, the doctor in question, and the overall peer review process. An RFP for all such administrative files should follow.

• Demand policies and procedures/rules and regulations/bylaws of the hospital. This should include policies on credentialing, privileges, proctoring (including the commonly found intranet availability on person's current privileges), incident reports, chain of command, peer review (including all of the criteria for performing peer review after a particular incident and procedures for peer review), and informing patients regarding mistakes and medical errors and for apologies to victims. Remember, most of the desired policies and procedures are statutorily mandated.

• Demand all contracts between the hospital and the doctors in question. Demand they not be redacted. Amounts paid and other "proprietary" details are entirely relevant to most improper reasons for failure to properly investigate. You also should seek contracts preceding and following the contract in question, as well as contracts with other doctors for comparable positions. You should also get all fair market evaluations and all criteria/reasons for which a lot of these positions were awarded to the physician in question to scope out issues about the commercial reasonableness of the contracts.

• Demand all hospital-staff studies for purposes of reducing morbidity and

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mortality. Evidence Code section 1156 expressly makes these discoverable (although they'll eventually be excluded from evidence). They will usually lead to some future discovery or evidence of the hospital's non-compliance.

• Inquire into the fact of peer-review investigations undertaken on this doctor, for your case or other incidents. This can be obtained in a variety of ways, including through the deposition of the defendant doctor. Not only is there nothing in the statute that makes the occurrence of the investigation beyond discovery, *Elam* itself strongly suggest it is a contemplated discovery item. The defense position could be akin to claiming that the fact of a communication with an attorney, rather than the content, is privileged.

• Promulgate contention interrogatories with associated RFPs seeking all evidence that supports that the hospital/doctor acted properly for all things of which you are accusing the doctor of doing improperly. All such responses will greater enhance your ability to uncover all the bad (for them) evidence that they refuse to give over (as explained in the sword and shield motions, below). It is even better if they put forth absolutely no substantive evidence or claim privilege.

• Have the defense set forth everything they did to fulfill their responsibilities under the various statutes and regulations set forth above, including all of the state and federal anti-kickback statutes, such as 42 C.F.R. § 411.353; 42 U.S.C. § 1320a-7b(b); Bus. & Prof. Code § 650; Bus. & Prof. Code § 2273(a); Welf. & Inst. Code § 14107.2; Ins. Code § 1871.7(a); and Health & Saf. Code § 445. These should be set forth as interrogatories, or perhaps RFAs that they did nothing with associated interrogatories for all denials, followed by appropriate document requests.

• Propound requests for admissions and interrogatories eliciting all reasons why doctor X was able to/allowed to do all the challenged conduct despite alleged controls by defendants.

• Obtain testimony of charge nurses and board of director personnel charged with promulgating the policies and procedures in question. Elicit how the tasks in question are to be done when done properly. Then request all evidence showing that these tasks were done properly and, if not, why. This boxes the defense in reasonably well. A refusal to provide evidence leaves them defenseless. All responses will reasonably obviously involve cherry-picking from their peer review investigation files and make it difficult for them not to give you other information. For each piece of evidence of what they say shows things were properly done, inquire how this information was initially uncovered. They cannot both claim the benefit of section 1157 and try to use that evidence without giving you the associated inculpatory evidence.

• Request documents from the hospital that might lead to other cases and incidents against this doctor. Formally request all deaths and serious disabilities caused by the doctor. That cannot be subject to section 1157, given there is required public disclosure for this under Health & Safety Code section 1279.1. In addition, seek OR logs, perfusion logs and other things that will indicate that problems occurred during an operation or procedure.

• Ask for all prior malpractice claims against the doctor, or involving the doctor's care (even if not named), of which the hospital is aware.

• Request all CDPH reports, including but not limited to 1279.1 reports, submitted to the CDPH as a result of this doctor's conduct or any deaths, serious disabilities, or other adverse events caused by this doctor. Then, have the hospital set forth all reasons/evidence for not submitting a section1279.1 report on the doctor for each incident seemingly requiring such. The absence of such reports looks like collusion, and the presence rings alarm bells for the need of a thorough peer review investigation.

Elicit admissions that defendants did not provide information regarding the doctor's past misconduct when obtaining consent. If they claim they did, inquire specifically as to what information was provided.

• Seek records granting or curtailing the doctor's privileges. Although this would usually elicit a proper section 1157 objection, you can circumvent many such objections by doing an RFA that the doctor was not privileged, qualified, or properly credentialed to perform the procedure. Although they will want to object under section 1157, the defense lawyers often will understand the danger of so doing.

Seek hospital information regarding the doctor's privileges (or others whose privileges are relevant) before, during, and after the incident. These often are immediately available at all times to all staff and obviously are peer review committee documents.

• Depose thoroughly the Chief Nursing Officer on chain of command protocols, asking what requires initiating chain of command, whether they did so, and how all such incidents are reviewed.

• Ask whether any oversight, credentialing, or meaningful re-credentialing occurred. Then ask for all evidence supporting that the oversight, credentialing, or re-credentialing were not done negligently. This can also be done in the form of RFAs with associated interrogatories. If the defense refuses to answer, it's dead; if it does, it breaks privilege and makes subsequent section 1157 objections harder.

• Serve RFAs that the hospital did not inform the patient regarding the mistakes that were made. Regardless of the privilege regarding the review itself, they're required to inform the plaintiffs of the mistakes. If the jury decides that the doctor is negligent for anything, thereafter in a jury's mind the hospital becomes negligent for not having found that out, regardless of the information they have withheld from you.

• Consider naming the medical staff as a defendant. This may help make them willing to testify (which they always may do, even though they're not compelled to do so). Recall, often, the wrongdoing doctor is considered overly powerful, anti-competitive or just a really bad egg by persons on the committee. The defense invariably will scream that the medical staff is an incorporeal entity that can't be a defendant. If that's true, then there's no such thing as private files of

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this committee; they're all admitted or they're all administrative files that are available in discovery. Further, the medical staff will never be individually represented by separate counsel and will show to the jury that they are one and the same as the hospital, despite the constant protest of the defense to the contrary. (One example of the actual non-separation between hospital and medical staff is that the president of the medical staff is often appointed for that term to the hospital board.)

• Send interrogatories for each incident to elicit everything that occurred during that incident that falls within the baskets of criteria requiring a review investigation under hospital policy, JCAHO guidelines, or regulations. This will reveal to the jury that peer review investigation should have been done. When there is no adverse event report sent, the house of cards of the hospital may begin to fall. Consider an RFA that there was no peer review investigation.

• Discover everything that occurred and was known prior to the file being handed over to peer review. That is, try to obtain all "original documents" that were generated and later incidentally handed over to peer review. This should include all things told to anyone prior to it being handed over to legal counsel or the peer review committee. The requests can be combined with chain of command interrogatories and/or deposition testimony on what each of the nurses and physicians involved did to let others know what was going on and the need to intervene under the circumstances.

• Specifically demand that all incident reports be produced. Although the defense invariably will object on section 1157 and attorney-client privilege grounds, almost always their policies and procedures will say to fill out incident reports prior to handing the information over to legal or to peer review. Moreover, these attempts by defense should be obviated by the original documents on limitation of *Santa Rosa* and under the initial balancing act justifications of the legislature's enacting section 1157, as set forth in subsequent cases such as *Matchett* (permitting these limitations on discovery because of specific, otherwise-available avenues of discovery). Furthermore, the logic that they try to use to exclude such information would apply specifically to medical records. Most hospitals have policies and procedures effectively telling the staff to make intentionally inaccurate medical records by leaving out all untoward events, and placing them in these incident reports, thereby depriving plaintiffs even of complete and meaningful medical records unless these incident reports are compelled.

• On a related note, do discovery of all past and pending malpractice claims against the doctor or against the hospital relating to the doctor. The hospital will usually use typical HIPAA and other such nonsense defenses. However, this again was part of the balancing act in the legislature allowing section 1157 privileging. Of course, you will need to take extensive depositions. Take those of the ex-hospital personnel you have located and from whom you have obtained favorable declarations. During the deposition be prepared to get in the face of defense counsel when they inevitably threaten (or have threatened) sanctions or imply wrongdoing under section 1157 if the witness chooses to reveal such information. When possible, explain to the witnesses ahead of time their rights to testify, and the games the defense often will play.

• As to the defendant doctor, by definition and rule, he is not protected by section 1157. He cannot be testifying about anything related to section 1157 from personal knowledge because his being there, as above, in and of itself breaks the privilege. Therefore, any defense claims that any such meetings when the defendant doctor is present are protected by section 1157 should go nowhere. Furthermore, section 1157 does not prevent a plaintiff from otherwise discovering relevant info by, inter alia, deposing a physician and asking whether he or she was previously denied staff privileges." (See *Alexander, supra*, at 1221, FN 2.) So always ask such questions.

Motions to bring

To get the necessary evidence and prevail in *Elam* cases, there inevitably is going to be a significant amount of motion work. Initially, you will be provided with minimal information, and that almost exclusively will be what is favorable to the defense. Of course, there will need to be numerous motions to compel, based on the above. In addition, to get the best information and put the defense in awkward positions in which they will need to settle, some or all of the following motions may be useful:

• Early in the case, consider general briefing about the legislative and case history of *Elam* versus section 1157, and the intended contours and limitations of section 1157.

• Later, you will need a "sword and shield" motion. It is going to be a matter of strategy as to whether this should be done early to provoke discovery or as a motion in limine. That will depend primarily on how much information and evidence you are able to obtain informally and to compel formally. The thrust of the motion is going to be that all their non-testimonial information, by necessity and by reasonable inference, was obtained during the peer review investigation; that they cannot use the good stuff unless they show the bad stuff; and such evidence must exist (unless they concede that they spoliated it). In a recent case, we had the defense using swipe cards trying to show where the doctor in question was at the times at issue; however video footage from numerous cameras in the area (of which the hospital was admittedly aware and would have been during the peer review investigation) mysteriously disappeared. This should result in exclusion of the swipe card and similarly supportive evidence.

Similarly, every time that you are given a writing by the defense (an email, almost any correspondence to anyone in the peer review chain) demand the rest of the associated correspondence (the rest of the email string; all other relevant peer review correspondence).

The theme over and over and over again for the plaintiffs has to be that the defense cannot cherry-pick. Once you have found through your discovery that there were peer-review

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investigations going on, it is not believable that they did not come up with the majority of the available evidence during that investigation. The necessary inference is that whatever they are trying to provide for litigation purposes was no less discovered and utilized during the peer-review process than is the disfavorable evidence. Argue that they cannot give you one and not the other.

Related to this is to disallow all positive things about this doctor. All honors, kudos, anything he did well, or claims of knowing anything should be excluded.

That is because this too would have been part of the credentialing process, the review process, the re-credentialing process, or the peer-review investigation process.

Again, try to figure out ways that all that favorable evidence was necessarily within the purview of the same section 1157 objections the defense is making to the evidence you are seeking, so to best argue that the bad evidence must be given to you if the good is going to be admitted.

You may need to do a motion to get all prior medical-malpractice lawsuits. These are generally kept out as prior bad acts. In this context, however, they are extremely relevant to notice and is one of the sources that were allowed to be made available to plaintiffs as a presumption when the section 1157 balancing act was promulgated.

Make a motion to obtain all original documents and all administrative files, as permitted per above. This includes, specifically, all incident reports and complete medical records, including what was intentionally kept out and placed instead in the incident report. (This is most compelling when the records fail to mention the challenged incident you know to have occurred.) The motion also should encompass reports made to people in risk management prior to risk management handing anything over to peer review. (In self-insured hospitals, the defendants might be able to argue successfully that reports given to risk management invokes the attorney-client privilege. See *Scripps v. Superior Court* (2003) 109 Cal.App.4th 529.)

In response to the vast section 1157 protection claims, you likely will need to insist that the defense make a privilege log and provide the documents for in camera review. Clarify that the *Santa Rosa* court was firm that this was to be part of the process. Also, the *Brown* court stated clearly it was not enough merely to assert "that the report may include materials generated by hospital committees" but instead required in camera review. (*Brown*, supra, at 501.) Inform the court that such a privilege log is necessary to establish the proper balance between competing interests in discovery and the assertion of the privilege. (See e.g., *Kaiser Foundation Hospitals v. Superior Court* (1988) 66 Cal.App.4th 1217, 1228.)

Make a motion to exclude any mention or inference that the hospital did anything positive, provided any oversight, or in any way complied with their duties under *Elam* absent providing you evidence that they did so.

You may need a motion to teach the court what it is unknowingly supporting. Consider a motion for the likely (or necessarily, depending on what you found out) bad conduct on the part of the defendant and the defense counsel. In such instances the court may well intervene.

For example, the court may not be willing to uphold section 1157 immunity if it is in furtherance of either a crime or fraud. More immediately germane is that, wherever there is a contrary finding by the peer review committees or other relevant committees in your case (however you find out), the defense lawyers are de facto acting abhorrently. That is, they in all likelihood are getting witnesses knowingly to suborn perjury, given the findings by the hospital committees (or at least going beyond the bounds of zealous advocacy under the California Rules of Professional Responsibility).

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