SUPREME COURT, STATE OF COLORADO
Court Address: 2 E. 14th Avenue
Denver, Colorado 80203

Original Proceeding Pursuant to C.A.R. 21
District Court, County of El Paso, Colorado
Case No. 06CV1649, Hon. Thomas Kelley Kane

In Re:

PLAINTIFF:

JIMMIE R. CROW, M.D. Case Number: **06 SA 323**

DEFENDANT:

THE PENROSE-ST. FRANCIS HEALTHCARE SYSTEM, D/B/A PENROSE ST. FRANCIS HEALTH SERVICES

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BRIEF *AMICUS CURIAE* OF AMERICAN MEDICAL ASSOCIATION, COLORADO MEDICAL SOCIETY, and AMERICAN COLLEGE OF SURGEONS

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DESCRIPTIONS OF *AMICI CURIAE*

The American Medical Association (AMA), an Illinois not-for-profit corporation with approximately 240,000 members, is the largest organization of physicians, residents, and medical students in the United States. Its objectives, as set forth in its articles of incorporation, are "to promote the science and art of medicine and the betterment of public health." As additional goals, it strives to be the unified voice of the medical profession, speaking for all physicians, as well as the most authoritative voice and influential advocate in the United States for patients and physicians. Its members practice in all areas of medical specialization and in every state, including Colorado.

The AMA sets policy through its House of Delegates, whose members represent the medical societies of every state, the District of Columbia, several territories of the United States, the principal medical specialty societies, and the United States Armed Forces. Even if they are not themselves AMA members directly, the overwhelming majority of America's physicians are represented at least indirectly in the House of Delegates. In addition, the AMA publishes the Principles of Medical Ethics and interpretative ethical opinions, which serve as guidance for responsible medical behavior. These Principles and ethical opinions are found in *The Code of Medical Ethics*, the primary compendium of medical professional value statements in the United States.

The AMA has considered, debated, and adopted numerous policies on many of the principal issues raised in this dispute, including questions concerning due process in physician disciplinary proceedings, peer review and its proper relationship to the legal system, and the relationship between the organized hospital medical staff and the hospital administration. In fact, AMA polices and ethical opinions have been critical to the

evolution of the various laws that govern these subjects. AMA policies and ethical opinions are posted at http://www.ama-assn.org/apps/pf_new/pf_online.[1]

The American College of Surgeons (ACS) is a scientific and educational association of surgeons. Its objective is to improve the quality of care for surgical patients by setting high standards for surgical education and practice. ACS currently has over 70,000 members, making it the largest organization of surgeons in the world.

Both the AMA and the ACS are founding members of the Joint Commission (formerly known as the Joint Commission on Accreditation of Hospitals) and have permanent seats on its Board of Commissioners, its governing body. The Joint Commission accredits the vast majority of hospitals in the United States for safety and quality of care standards. Joint Commission accreditation qualifies hospitals for Medicare and Medicaid reimbursements under 42 U.S.C. § 1395bb.

The Colorado Medical Society (CMS) is the largest organization of physicians, residents, and medical students in Colorado. Its mission is to promote the science and art of medicine, the betterment of public health, and the welfare of the medical profession and the patients it serves. With more than 5,000 members, its objective is to champion issues of importance to Colorado physicians and to the patients they serve.[2]

Jimmie R. Crow, M.D., the plaintiff in the suit below, is a member of all three *amicus* medical societies.

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[1] In this brief, AMA House of Delegates policies are referenced as "H-___," and AMA ethical opinions are referenced as "E-____."

[2] The AMA and CMS appear herein in their own persons and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition of the AMA and the medical societies of every state and the District of Columbia. Its purpose is to represent the general interests of the medical profession in the courts, according to AMA policies.

ISSUES TO BE ADDRESSED IN *AMICUS* BRIEF

Amici appear herein pursuant to this Court's invitation of January 23, 2007. Although the invitation did not specify any particular issues to address, the *amici* believe that the following issues are of interest:

1. What is "Peer Review," and why does it receive special legislative protection against interference from legal processes?

2. How should this Court balance the protection of Dr. Crow's procedural rights against the public health interest in successful peer review?

This brief will address both of these issues.

STATEMENT OF THE CASE

I. Nature of the Case, Course of Proceedings, and Disposition Below.

This is an "original action" pursuant to C.A.R. 21, concerning hospital "peer review" of physician conduct. The peer review action was initiated on November 17, 2004 by Penrose-St. Francis Healthcare System ("the hospital") against Dr. Jimmie R. Crow, a surgeon on the hospital's medical staff.[3] The hospital summarily suspended Dr. Crow's medical staff privileges. It seeks, through the peer review process, to terminate those privileges permanently.[4]

Complaining of the procedures utilized in the peer review action, Dr. Crow sued the hospital in the District Court for El Paso County, Colorado, seeking declaratory relief, monetary damages, and an injunction to prohibit the hospital "from revoking, suspending, reducing, limiting, conditioning or otherwise adversely affecting Dr. Crow's Medical Staff privileges for any past matters relating to [certain patients]."

[3]The "medical staff" refers to those physicians and possibly other health care professionals who are allowed by a health care facility (typically a hospital) to admit and/or treat patients at that facility.
[4] "Privileges," in this context, means a medical professional's right to admit and/or treat patients at a health care facility.

II. Statement of Facts.

The following facts are taken from the pleadings.

A. Pre-Litigation Events: Breach of Care, Suspension, Investigation, Recommendation, and Hearing.

On October 1, 2004, while "on call,"[5] Dr. Crow allegedly failed to timely respond to a patient who had been injured in an automobile accident. Petition pp. 3-4; Response p. 3.[6] Eventually, Dr. Crow saw and operated on the patient, but the patient died after a period of apparent improvement. Response p. 6.

On October 8, 2004, the hospital summarily suspended Dr. Crow's hospital medical staff privileges, pursuant to a recommendation from the Surgical Peer Review Committee and the Medical Executive Committee ("MEC").[7] Petition p. 5. Dr. Crow did not contest the summary suspension, and he remains suspended. Petition p. 6.

The hospital reported the incident to the Colorado Board of Medical Examiners ("CBME"). The CBME determined that Dr. Crow's care had fallen "below the generally accepted standards of medical practice for a surgeon practicing in the state of Colorado." It admonished Dr. Crow, but it did not restrict his license to practice medicine. Petition pp. 4-5.

After further investigation, the MEC recommended permanent termination of Dr. Crow's hospital staff privileges and notified him of this recommendation on November 17, 2004. Petition p. 6. On December 10, 2004, Dr. Crow requested a full peer review hearing regarding the proposed termination of privileges. Response p. 12.

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[5] "On call" means available, through telephone notification, to provide emergency medical services.
[6] The hospital's Petition for Rule to Show Cause is referenced as "Petition p. __." Dr. Crow's Response to Order and Rule to Show Cause is referenced as "Response p. __."
[7] A "Medical Executive Committee" is a committee chosen from among the members of a medical staff, which is charged with overseeing the administration of the medical staff as a whole.

Following invocation of the peer review process, the proceedings became inordinately delayed, due to uncooperativeness and intransigence. Petition pp. 8-12; Response pp. 11-19. Eventually, a hearing was scheduled for October 18, 2006. Appendix pp. 127, 131, 134.[8]

B. Trial Court Pleadings and Proceedings.

On April 20, 2006, Dr. Crow sued the hospital in the District Court for El Paso County. Appendix p.1. His complaint alleges various irregularities both in the peer review action that led to the summary suspension of his staff privileges and in the ongoing peer review proceedings. It asserts the following procedural deficiencies:

1. The case that caused Dr. Crow's summary suspension should have been reviewed by an outside physician, because the members of the Surgical Peer Review Committee lacked experience in his specific specialty; Appendix p. 4.

2. Members of the Surgical Review Committee and the MEC were his competitors and thus had a conflict of interest; Appendix p. 4.

3. Dr. Crow was not given a hearing of the summary suspension before it was imposed, even though there was no emergency in deciding on the suspension; Appendix p. 4.

4. The notice of the summary suspension was defective; Appendix p. 10.

5. At the MEC meeting of November 16, 2004, which considered whether to institute a disciplinary action in order to revoke his privileges permanently, Dr. Crow was not given prior notice and was not allowed to have counsel present; Appendix p. 5.

6. The hospital imposed the summary suspension without complying with internal review procedures under its Fair Hearing Manual and the Medical Staff Bylaws;[9] Appendix pp. 9-11.

[8] Appendix to Petition for Rule to Show Cause is referenced as "Appendix p.__."

[9] "Medical Staff Bylaws" are a written protocol between the medical staff and the hospital concerning mutual rights and obligations, as well as various administrative procedures applicable to the medical staff. Such procedures include processes involved in credentialing as well as peer review. AMA Policy H-235.989. *See also* 6 CCR 1011-1 (Part A) Standards for Hospitals and Health Facilities, at 3.1-3.2.

7. The hospital delayed in implementing the peer review proceedings, notwithstanding Dr. Crow's summary suspension of privileges, in violation of the Medical Staff Bylaws; Appendix pp. 10, 13.

8. A physician involved in the peer review process breached the confidentiality provisions of the Fair Hearing Manual and the Medical Staff Bylaws by discussing the peer review proceedings against Dr. Crow with physicians outside the peer review process and by describing Dr. Crow as "a bad physician;" Appendix p. 17.

9. The initial notice of the peer review hearing did not include all the information required under the Medical Staff Bylaws; Appendix p. 6.

10. The hospital failed to provide Dr. Crow with information necessary for his defense and was dilatory in responding to his discovery requests; Appendix pp. 6-8.

11. The hospital unduly delayed the peer review hearing, in violation of a requirement in the Medical Staff Bylaws that it begin "as soon as practicable." Appendix p. 8.

Dr. Crow claims that the hospital has breached various explicit and implicit contractual obligations and that it tortiously interfered with his professional and business relationships. Appendix. pp. 9-19. He seeks declaratory relief of wrongdoing, monetary damages, and an injunction to prohibit the hospital "from revoking, suspending, reducing, limiting, conditioning or otherwise adversely affecting [his] Medical Staff privileges for any past matters relating to [certain patients]." Appendix. p. 20.

The hospital moved to dismiss on June 7, 2006, claiming that the civil action was "not ripe" because a hearing had not yet been held. Appendix. p. 21. The motion was denied. The hospital's motion to reconsider was also denied, on September 21, 2006. Petition p. 2. On October 17, 2006, the day before the scheduled peer review hearing, the hospital filed this C.A.R. 21 action. Petition p. 1.

C. Original Action in the Supreme Court.

The hospital seeks from this Court an order requiring the trial court to dismiss Dr. Crow's civil suit. Petition p. 2. It predicts dire consequences if this Court fails to do so, asserting:

> **"REASONS WHY NO OTHER REMEDY IS ADEQUATE**
>
> The relief requested [to dismiss Dr. Crow's suit] is crucial to the current and future success of the peer review process. The Complaint is a collateral attack on peer review proceedings, threatening to disrupt the peer review process and impose liability for peer review activities. If this type of claim is allowed to proceed, the peer review immunities, privileges and procedural protections set in place to encourage willing participation in peer review activities will be destroyed. If common law tort claims can be asserted against peer review participants prior to completion of the process, physicians and others will refuse to participate in the process. Petition p. 2.

Dr. Crow responded that he is not launching a general attack against the peer review process but merely wants to preserve due process. Response p. 2. According to Dr. Crow, he is seeking a peer review that will be procedurally fair. Response p. 40.

ARGUMENT

I. Peer Review is an Important Mechanism for Maintaining and Enhancing Quality Patient Care in Hospitals, and it Receives Special Legal Protections at the Federal and State Levels.

A. Peer Review is a Form of Professional Self-Regulation, Commonly Used Within Hospital Medical Staffs to Improve Patient Care and to Discipline Physicians Whose Practices Fall Below Accepted Professional Standards.

Due to the complex, technical nature of medicine, it is extremely difficult for lay persons to oversee the quality of a physician's medical practices. As a practical matter, that oversight must be provided by another physician. Accordingly, peer review, a process by which physicians evaluate the quality of work performed by their colleagues, has been developed as a mechanism for determining compliance with appropriate

standards of health care. George Newton, Comment, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 Ala. L. Rev. 723 (2001). As such, it operates as "a self-regulatory tool of quality assurance" for the medical profession, and it is one of the principal tools for monitoring and maintaining the quality of physicians' work. *Id.*

Since the mid-twentieth century, the Joint Commission on Accreditation of Healthcare Organizations has required hospitals to utilize peer review to qualify for accreditation.[10] *See* Jeanne Darricades, Comment, *Medical Peer Review: How is it Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. Contemp. L. 263, 269 (1992).

Hospital peer review committees are comprised of members of the hospital's medical staff. To enhance the fairness and impartiality of the peer review process, reviewers are generally prohibited from evaluating a direct economic competitor. *See* 42 U.S.C. 11112(b)(3)(A)(iii). While it is the hospital governing body that ultimately determines whether to grant, suspend, or revoke a physician's staff privileges, the recommendations of the peer review committee strongly influence the governing body's decision. *See* AMA Policy H-225.997.

The federal Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §§ 11101, *et seq.*, governs physician peer review actions. The HCQIA was passed to encourage peer review, in order to improve the quality of medical care and reduce the incidence of medical malpractice. 42 U.S.C. § 11101. The HCQIA facilitates both identification of, as well as actions against, incompetent physicians who engage in

[10] Hospitals obtain Joint Commission accreditation in order to qualify for payment under certain federally funded programs, including Medicare and Medicaid. 42 U.S.C. § 1395bb.

unprofessional conduct. *See* David Burlage, *Representing Physicians in Hospital-Based Professional Review Actions,* 25 Colo. Lawyer 57 (Mar. 1996). The HCQIA created the National Practitioner Data Bank ("NPDB"), a nationwide reporting system, for the reporting of decisions of peer review bodies. 42 U.S.C. at §§ 11131-34. The HCQIA requires hospitals to notify the NPDB of peer review decisions that adversely affect a physician's privileges for more than thirty days. 42 U.S.C. §11133.

In Colorado, the Colorado Professional Review Act ("CPRA"), acknowledges that "a review of care provided in a hospital is ineffective without concomitantly reviewing the overall quality and appropriateness of care rendered by physicians and other licensed health care professionals." C.R.S. § 12-36.5-104.4(1). The CPRA requires professional review committee to be: (1) composed primarily of physicians in active practice within the state; (2) established by the medical staff of the hospital or "a hospital related corporation;" and (3) operated pursuant to written bylaws, policies, or procedures approved by the hospital's governing board in compliance with CPRA. C.R.S. § 12-36.5-104. Professional review committees assist the CBME in meeting its responsibilities of reviewing and disciplining physicians. C.R.S. § 12-36.5-103.

Peer review maintains practice standards and helps prevent medical errors through two functions. First, it educates physicians by suggesting improvements in their practices or in the caretaking systems used within the hospital generally. Second, it allows the hospital to modify, suspend, or revoke the medical staff privileges of physicians who fall below accepted professional standards. The CPRA instructs that a professional review committee is obligated "to review and evaluate the quality and appropriateness of patient

care by, and the professional conduct of, any physician licensed to practice medicine in the state of Colorado." C.R.S. § 12-36.5-104(1).

B. Federal and State Laws Recognize the Importance of Peer Review by Prohibiting Discovery of Information Utilized in the Reviewing Process and by Insulating Peer Review from Litigation Brought by Adversely Affected Physicians.

Successful peer review depends on the cooperation of the medical profession. The CPRA states: "All physicians are encouraged to serve upon … professional review committees when called upon to do so and to study and review in good faith the professional conduct of physicians, including the quality and appropriateness of patient care." C.R.S. § 12-36.5-103(2).

Physicians serve on peer review panels because it is a professional obligation and because it is required under the medical staff bylaws. Such service is generally without pay. Rarely, if ever, do physicians relish the prospect of sitting in judgment over their colleagues. The *amici* are also committed to peer review and encourage their members to support it.[11]

Peer review is ineffective if concerns are not brought to the committee's attention. Often, physicians initiate review. However, physicians may decline to participate if they fear the loss of referrals or general ill will from their colleagues. Susan Scheutzow, *State Medical Peer Review: High Cost but no Benefit—Is it Time for a Change?*, 25 Am. J. L. and Med. 7, 16 & 19 (1999).

More importantly, physicians are very aware that a doctor who has suffered an adverse peer review outcome may have the motivation and sometimes the financial resources to challenge the action in litigation. The threat of even an unsubstantiated

[11] AMA Policies H-375.990; H-375.996.

lawsuit can chill participation in the process. Thus, successful peer review depends on minimizing litigation over hospital peer review decisions. AMA Policy H-375.979.

Because of these concerns, the HCQIA and the CPRA have safeguards to lessen the burden on those who participate in peer review. One such safeguard is a requirement that peer review information be kept confidential. The CPRA thus provides that "all records and proceedings related to [professional review committees] shall remain confidential." C.R.S. § 12-36.5-104.4(2)(b). *Amici* likewise believe that if peer review is to be effective, peer review data must be kept confidential. AMA Policies H-375.972; H-375.989; H-375.992.

A second safeguard is immunity from legal liability. The preface to the HCQIA finds that the threat of private money damage liability under federal laws, including treble damage liability under the antitrust laws, is an impediment that "unreasonably discourages physicians from participating in effective professional peer review." 42 U.S.C. § 11101(4). The HCQIA provides immunity from damages under state or federal laws to professional review bodies and those who act as a member of or assist the professional review bodies. Such immunity, however, is conditioned on the peer review body's meeting basic standards of procedural and substantive fairness. 42 U.S.C. § 11112.[12] Also, the HCQIA guarantees unconditional immunity to any person who provides information to a professional review body. 42 U.S.C. § 11111(a).

The CPRA provides immunity to professional review committee members, witnesses, complainants, and other participants from civil suit brought by a physician who is the subject of the review of the committee. C.R.S.. § 12-36.5-105. This immunity

[12] A further limitation on HCQIA immunity applies in Civil Rights actions. 42 U.S.C. § 11111(a).

exists for committee members as long as they acted reasonably and in good faith in the performance of their duties. *See Berg v. Shapiro*, 36 P.3d 109, 112 (Colo. App. 2001). As a separate source of immunity, the CPRA protects peer review bodies and participants from monetary damages if the peer review process conforms to the HCQIA procedural standards. C.R.S. § 12-36.5-203.

A third legislative protection is the HCQIA's provision allowing attorneys fees against a physician who unsuccessfully sues to contest a peer review action. This provision states that

> [T]he court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. 42 U.S.C. § 11113.

Finally, to protect against peer review's being used to stifle competition, the CPRA has created a separate committee of the CBME, known as the Committee on Anticompetitive Conduct. This committee is authorized to assess whether a final action results from unreasonable anticompetitive conduct, and it has the authority to set aside such actions or to require the governing entity to review the matter further. C.R.S. § 12-36.5-106. The key provisions are as follows:

> (7) Any physician who is the subject of a final action by a governing board, which action results in the denial, termination, or restriction of privileges at or membership in or participation in an organization, and who believes that such action resulted from unreasonable anticompetitive conduct shall have, as his sole and exclusive remedy, direct review of the record by the committee. Such review shall be limited to the sole issue of whether such final board action resulted from unreasonable anticompetitive conduct. Failure to exhaust this administrative remedy before the committee shall preclude the right of de novo review on the merits of the issue of unreasonable anticompetitive conduct.
>
> (8) Nothing in this article shall preclude a physician or health care provider otherwise aggrieved by the final action of a governing board from seeking other

> remedies available to them by law, except as provided in subsection (7) of this section.

As recognized by this Court: "Both the United States Congress and the Colorado General Assembly have demonstrated a clear intent to encourage professional peer review in the medical field, and to immunize participants in the peer review process from subsequent liability and/or suit when the process satisfies appropriate standards." *North Colorado Medical Center, Inc. v. Nicholas*, 27 P.3d 828, 848 (2001). *See also*, Kathleen Blaner, Comment, *Physician, Heal Thyself, Because the Cure, The Health Care Quality Improvement Act, may be Worse than the Disease*, 37 Cath. U.L. Rev. 1073, 1075-1076 (1988). *Amici* support these safeguards.

II. Although Courts Should not Determine Physicians' Substantive Medical Competence, They Should Protect Due Process Rights in Peer Review.

The question remains as to how Dr. Crow's lawsuit, if allowed to continue, will affect the willingness of hospitals and physicians to continue with the peer review process. *Amici* believe that, although Dr. Crow's suit has the potential to interfere with the substantive work of peer review, that potential can be minimized or eliminated by limiting any judicial action to the protection of his procedural rights.

Notwithstanding the general desirability of insulating peer review proceedings from judicial interference, that objective is not absolute. There are also countervailing considerations.

First, Dr. Crow's lawsuit, as presently constituted, is brought only against a hospital and not against individuals. Penrose-St. Francis, by virtue of its legal licensure and accreditation requirements, C.R.S. §§ 12-36.5-104.4 & 25-1.5-103, its medical staff bylaws, and its concern for quality patient care, will persevere with its peer review

obligations no matter how this Court rules. So will every other hospital in the State of Colorado.

The hospital suggests that Dr. Crow has threatened to join individual physicians to his lawsuit, Petition pp. 13-14, a charge that Dr. Crow denies. Response pp. 1-2. Should such joinder occur, then the public interest calculations may shift, but it has not yet happened and it may never happen. The physicians and other medical professionals engaged in the peer review process are aware of the possibility of a lawsuit from Dr. Crow or others who may follow in his footsteps, but that possibility is necessarily more remote than a present lawsuit against a large business entity. It does not justify the calamitous predictions in the hospital's petition.

Second, the hospital has ably presented its case to the trial court, and there is every reason to believe that the court will be adequately sensitized to the dangers of judicial intervention in the peer review process. The trial court has a panoply of mechanisms to avoid or at least mitigate such intervention, under the appropriate circumstances. These include a stay order as to all or part of the proceedings, a refusal to allow joinder of additional defendants if Dr. Crow (or the hospital) should request it, a summary judgment, orders limiting or supervising discovery, establishment of a high burden of persuasion, or a requirement that any equitable relief granted be narrowly tailored. Should the trial court abuse its discretion, appeal can be had to a higher court.[13] Physicians appreciate the difference between the filing of a lawsuit and the granting of substantive relief.

[13] In this regard, *see Vranos v. Franklin Medical Center*, 448 Mass. 425 (2007), a suit by a physician against a hospital premised upon a "bad faith" peer review. The Supreme Judicial Court of Massachusetts vacated a trial court order that would have allowed the physician to obtain discovery of the hospital's peer review records. The Supreme Court noted that actual evidence would be needed to demonstrate that the peer review privilege should not apply, and "mere inference" from statements made in the physician's affidavit would be insufficient.

The hospital is probably right that injunctive relief, if it is to be granted at all, should await completion of the peer review process. Respect for the expertise of the peer review committee in determining Dr. Crow's medical competence and for the public health concerns at issue should require a high threshold of certainty before an injunction is entered against a peer review hearing.[14] *City of Golden v. Simpson*, 83 P.3d 87, 96 (Colo. 2004)(observing that a preliminary injunction should not disserve the public interest); *see also, Dominion Video Satellite v. Echostar Satellite,* 269 F.3d 1149, 1154 (10th Cir. 2001)(noting that a preliminary injunction should issue only when the basis for granting it is "clear and unequivocal"). However, this does not necessarily mean that all discovery should be precluded (although it should be within the trial court's discretion to make this determination).[15] Being "probably" right does not mean being "definitely" right, and "a high threshold of certainty" does not mean "absolute certainty."

Moreover, if Dr. Crow's pleadings are borne out factually, perhaps some level of injunctive relief might be appropriate to modify the current peer review process. Conceivably, the persons involved in the peer review process should be replaced, or perhaps closer judicial oversight might be required. *Amici* do not advance these scenarios as either desirable or probable. They are simply possibilities, and if justified by a strong factual basis they are unlikely to engender catastrophic consequences within the medical community.

Third, although physicians value the public health benefits of peer review, they fervently espouse that peer reviews comport with fundamental fairness and due process.

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[14] The HCQIA, at 42 U.S.C. § 11112, provides that peer review actions are presumed to have been conducted in good faith and according to accepted standards of procedural fairness, "unless the presumption is rebutted by a preponderance of the evidence."

[15] *Vranos v. Franklin Medical Center*, n. 13, *supra.*

AMA Policies H-375.973; H-375.983. Thus, AMA Ethical Opinion E-9.10 deems it ethical for physicians to participate in the peer review process "as long as principles of due process … are observed." Similarly, Ethical Opinion E-9.05 urges physicians to observe "the basic principles of a fair and objective hearing" when a physician's professional conduct is reviewed. A fair hearing requires, at a minimum, "a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense." *Id.* Dr. Crow alleges that some of these fundamental rights may have been violated in this instance.

To some extent, judicial oversight can encourage physician involvement in the peer review process, by buttressing its integrity. Physicians claim neither infallibility nor superiority to the law. Mistakes can and do happen, and so physicians may be more willing to participate in the process if a mechanism exists to rectify such mistakes. While *amici* are sensitive to the dangers that litigation can pose to the peer review process (*see* AMA Policy H-375.979), they also appreciate the need to keep the courtroom doors open to the physician who is genuinely deprived of due process rights.[16] *See* Colo. Const. Art. II, Section 6 ("Courts of justice shall be open to every person, and a speedy remedy afforded for every injury to person, property or character; and right and justice should be administered without … delay").

Furthermore, fundamental fairness in this case means compliance with the procedural protections set forth in medical staff bylaws. Physicians, as represented by *amici*, believe that members of hospital medical staffs should be able to rely upon and

[16] If it turns out that Dr. Crow was not so genuinely oppressed as he now claims to have been, then, as discussed *supra*, he may be required to pay the hospital's attorneys fees in this action. 42 U.S.C. § 11113.

legally enforce their rights established in the medical staff bylaws. AMA Policies H-230.969; H-235.991.

Dr. Crow's privileges have been summarily suspended. Following that suspension, there has been no hearing, for well over two years. Neither party has suggested that the peer review proceedings are close to completion.[17] If the trial court accepted Dr. Crow's pleadings at face value, as it was obliged to do, *Public Service Co. of Colorado v. Van Wyk*, 27 P.3d 377 (Colo. 2001), it was required to presume that, because of the suspension, he has been suffering ongoing and irreparable injury to his practice and to his reputation. That injury may be aggravated by a continuing wrongful peer review. Dr. Crow has alleged sufficient irregularities to raise a legitimate concern about the integrity of the peer review action, and the trial court is best situated to strike the proper balance between the need to protect his due process rights and the public health imperatives fostered by peer review.

Fourth**,** this case does not present a strict dichotomy between the present lawsuit and no lawsuit at all. The hospital does not suggest – nor could it fairly suggest – that Dr. Crow should be absolutely precluded from invoking any legal rights, regardless of the course of the peer review. Rather, the issue is whether Dr. Crow should be temporarily barred from bringing a lawsuit, until the peer review process runs its course. Certainly, there is a chance that if this case is dismissed on ripeness grounds, Dr. Crow may choose not to refile his case.[18] In these circumstances, though, the consequences of allowing a current lawsuit to continue are sufficiently close to the consequences of insisting that any lawsuit be filed *in futuro* as to blunt the supposedly dire need for this Court's action.

[17]The record does not indicate whether the hearing set for October 18, 2006 actually took place.
[18] Among other possibilities, Dr. Crow may prevail in the peer review action.

Physician participation in the peer review process probably *is somewhat* diminished by the threat of suits such as this, but the additional litigation that would ensue if Dr. Crow's case is allowed to stand is likely to be of only minor concern.[19]

The hospital overstates its position when it posits that cases challenging the peer review process, brought prior to the final peer review determination, such as in this case, if allowed to proceed, could "destroy statutory privileges and immunities guaranteed by both federal and state law." Petition p. 3. In contrast to this assertion, the HCQIA, at 42 U.S.C. § 11111, protects peer reviewers against monetary damages (but not against injunctive relief) *if* the peer review process meets prescribed standards of procedural fairness, as set forth in 42 U.S.C. § 11112.[20] Section 11112(c)(B) allows a relaxation of these procedural requirements "in the case of a suspension or restriction of clinical privileges for a period of not longer than 14 days." 42 U.S.C. § 11112(c)(B). Dr. Crow's privileges have been suspended for far more than 14 days, and his complaint alleges numerous transgressions of the HCQIA fairness standards.

The CPRA similarly requires that peer review satisfy basic criteria of fairness, C.R.S. § 12-36.5-104, and while it provides immunity from liability for damages, that immunity is conditioned on conformity with the HCQIA standards. C.R.S. § 12-36.5-203. As with the federal law, the CPRA does not immunize against injunctive relief, and

[19] *Amici* emphasize that, although some measure of judicial oversight is consistent with the peer review process, abrogation of the legislatively guaranteed confidentiality associated with that process, C.R.S. § 12-36.5-104, is likely to prove fatal. While it may prove difficult to develop the facts under this statutory constraint, *see Vranos v. Franklin Medical Center*, at n. 13, *supra*, that will be a problem primarily for Dr. Crow, who bears the burden of proving his case.

[20] Those standards include an adequate notice and adequate hearing procedures. 42 U.S.C. § 11112(b) provides detailed guidelines for determining when those standards are meet.

it does not excuse peer review that violates procedural rights, as alleged in Dr. Crow's complaint.[21]

The hospital's Petition for Rule to Show Cause relies heavily on *North Colorado Medical Center v. Nicholas*, 27 P.3d 828 (Colo. 2001). That case, however, in no way requires that this Court assume Rule 21 jurisdiction. For one thing, *Nicholas* did not consider whether a suit brought prior to the completion of a peer review, seeking to prevent an ongoing tort, would be inherently premature or whether a trial court would necessarily abuse its discretion if it failed to dismiss such a suit before the filing of a responsive pleading. To the contrary, that suit was filed after the peer review had been concluded, and the appeal was taken after the entry of summary judgment. The decision noted that "[i]mmunity under the HCQIA … may be resolved whenever the record has been adequately developed." 27 P.3d at 838. Further, this Court specifically found that Dr. Nicholas had been afforded "adequate notice and hearing procedures," as required under HCQIA and CPRA. Here, by contrast, the record has been essentially undeveloped, and Dr. Crow's suit alleges inadequate notice and numerous violations of the HCQIA and the CPRA hearing requirements. The trial court is best positioned to develop the record and apply the law, subject to an appeal if necessary.

CONCLUSION

Amici stand strong in their support for the participation of the organized medical staff in peer review. They also stand strong in maintaining the due process rights of

[21] C.R.S. § 12-36.5-105(2) also provides immunity for an "individual [who] was acting in good faith" in the peer review process. It is unclear whether the hospital here would be considered an "individual" for purposes of this statute and whether that immunity was intended to apply to injunctive as well as monetary relief. At any rate, the trial court could have reasonably inferred that, should the facts bear out Dr. Crow's pleadings, the hospital has not been acting in good faith.

physicians under the HCQIA and the CPRA. They believe that the district court, as aided by this Court, is the appropriate forum where the parties' rights and obligations can best be sorted out.

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