STATE OF CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

UNION OF AMERICAN PHYSICIANS & DENTISTS, Charging Party, v. STATE OF CALIFORNIA (DEPARTMENT OF CORRECTIONS), Respondent.	Case No. SF-CE-228-S PERB Decision No. 1967-S June 27, 2008

Appearances: Davis, Cowell & Bowe by Paul L. More, Attorney, for Union of American Physicians & Dentists; State of California (Department of Personnel Administration) by Edmund K. Brehl, Labor Relations Counsel, for State of California (Department of Corrections).

Before Neuwald, Chair; McKeag and Wesley, Members.

DECISION

NEUWALD, Chair: This case is before the Public Employment Relations Board (Board) on appeal by the Union of American Physicians and Dentists of an administrative law judge's (ALJ) proposed decision (attached). The amended unfair practice charge alleged that the State of California (Department of Corrections) violated the Ralph C. Dills Act (Dills Act)[1] by changing the performance appraisal provision of a memorandum of understanding without negotiating the decision in violation of the Dills Act section 3159(c), and derivatively, section 3519(a) and (b).

The Board reviewed the entire record in this matter. In light of our review, the Board adopts the ALJ's proposed decision as a decision of the Board itself.

[1]The Dills Act is codified at Government Code section 3512 et seq.

ORDER

The complaint and underlying unfair practice charge in Case No. SF-CE-228-S are hereby DISMISSED WITHOUT LEAVE TO AMEND.

Members McKeag and Wesley joined in this Decision.

STATE OF CALIFORNIA
PUBLIC EMPLOYMENT RELATIONS BOARD

UNION OF AMERICAN PHYSICIANS & DENTISTS, Charging Party, v. STATE OF CALIFORNIA (DEPT. OF CORRECTIONS), Respondent.	UNFAIR PRACTICE CASE NO. SF-CE-228-S PROPOSED DECISION (9/1/06)

Appearances: Davis, Cowell and Bowe, by Andrew J. Kahn and Paul L. More, for Union of American Physicians and Dentists; K. William Curtis, Warren C. Stracener, Edmund K. Brehl and Jennifer M. Garten, for State of California (Department of Corrections and Rehabilitation).

Before Fred D'Orazio, Administrative Law Judge.

PROCEDURAL HISTORY

The Union of American Physicians and Dentists (UAPD) initiated this action on October 15, 2004, by filing an unfair practice charge against the State of California (Department of Corrections and Rehabilitation) (State or CDCR).[1] The General Counsel of the Public Employment Relations Board (PERB or Board) issued a complaint on March 10, 2005. The complaint, as amended, alleges the CDCR changed the performance appraisal provision in a memorandum of understanding (MOU) with UAPD without negotiating about the decision and/or the effects of the decision, in violation of the Ralph C. Dills Act (Dills Act) section 3519(c), and, derivatively, sections 3519(a) and (b).[2] By letter dated the same day, UAPD withdrew its allegation that the State failed to bargain about the effects of the decision.

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[1] CDCR was formerly known as the California Department of Corrections. (CDC) CDCR and CDC are used interchangeably below.

[2] The Dills Act is codified at Government Code section 3512 et seq. Unless otherwise indicated, all statutory references refer to the Government Code. Section 3519 states in relevant part that it shall be unlawful for the state to do any of the following:

The State answered the complaint on April 1, 2005, generally denying all allegations and setting forth various affirmative defenses. Denials and defenses will be addressed below, as necessary. A settlement conference was conducted by a Board agent on May 25, 2005, but the matter was not resolved.

The undersigned conducted a formal hearing in Oakland on September 27, 2005, and in Sacramento on September 29, 2005. After submission of post-hearing briefs, the parties requested the undersigned take judicial notice of certain documents in related federal court litigation. On March 16, 2006, the receipt of the final argument related to these requests was received and the case was submitted for proposed decision.

FINDINGS OF FACT

Jurisdiction

UAPD is an exclusive representative of an appropriate unit of physicians, dentists and podiatrists (Unit 16) within the meaning of section 3513(b). The State and CDCR are employers within the meaning of section 3513(j). At all relevant times, UAPD and CDCR were parties to an MOU ending in binding arbitration.

> (a) Impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights guaranteed by this chapter. For purposes of this subdivision, "employee" includes an applicant for employment or reemployment.
>
> (b) Deny to employee organizations rights guaranteed to them by this chapter.
>
> (c) Refuse or fail to meet and confer in good faith with a recognized employee organization.

Background

UAPD represents some 650 medical practitioners who work for CDCR in Unit 16. About 272 of these are classified as Physicians and Surgeons, Correctional Facility. The minimum qualification for the class, as determined by the California State Personnel Board, is that the physician hold a valid medical license. To obtain a medical license in California, the practitioner must have had one year of post-medical school training. Although much of the work performed by physicians and surgeons involves primary care, the CDCR employs specialists in a number of fields whose only responsibility is work within their field of expertise. For example, a surgeon may perform only minor surgery or other procedures. CDCR also employs specialists whose primary responsibility is to provide care in their area of specialty, but who also provide some primary care to inmates. For example, a neurologist may perform 80 percent of his work in neurology and 20 percent in primary care.

Although the minimum qualification for CDCR physicians and surgeons is that they have a valid medical license, most physicians and surgeons possess greater qualifications, such as eligibility or certification by certain boards. In the field of Internal Medicine, for example, board-eligibility requires completion of three years of medical school and a residency. Board-certification by the American Board of Internal Medicine requires completion of a proctored two-day examination. Similar eligibility and certification exists in other fields, such as neurology. An alternative route to eligibility and certification is through the American Osteopathic Association. For example, a practitioner can become board-eligible in Family Practice through the American Osteopathic Board of Family Practice by completing the required years of practice, acquiring medical education credits, and holding membership in certain societies. The American Osteopathic Board of Family Practice then determines whether the practitioner is qualified to sit for the exam that leads to certification.

The MOU and Physician Evaluations

Section 12.5 (Performance Appraisal) of the MOU provides:

> A. The performance appraisal system of each department shall include annual written performance appraisals for permanent employees. Such appraisals shall be completed at least once each 12 calendar months after an employee completes the probationary period for the class in which he/she is serving.
>
> B. A performance appraisal of a bargaining unit employee shall not be based solely on a numerical rating, statistical analysis, or percentage rating of the employee's professional work.
>
> C. The State and UAPD encourage periodic informal performance evaluations and conferences between Unit 16 employees and their supervisors to discuss work performance, job satisfaction, and work-related problems. Such conferences shall be held in a private setting.
>
> D. When a Performance Appraisal Summary results in any "improvement needed" rating, the employee may grieve the evaluation up to and including the third step of the grievance procedure.
>
> E. A management peer of the employee's profession shall countersign any Unit 16 employee's rating which indicates "I" or improvement needed and which involves the employee's licensed professional competency.

Section 16.2 (Peer Review) provides:

> Peer review shall be a committee of the organized medical staff and its makeup is a prerogative of the medical staff to be determined in the Medical Staff by-laws.
>
> In facilities with medical staffs all questions of professional competence may be referred to peer review for review and recommendation. Based on the peer review a recommendation for disciplinary action may be made.

UAPD Executive Director Gary Robinson testified that section 12.5 has been in the MOU since the first round of negotiations in 1982. Section 12.5.B was added in 2003 to make sure unit members were not evaluated by the Quality Medical Assessment Team (QMAT) strictly on statistics or the number of forms submitted; instead, evaluations would take into

account the "totality of their practice."[3] If the "[QMAT] rating was going to be included, it would have to be put in context," Robinson said. Peer review was made part of the MOU in the early 1980s to prevent non-physicians from exceeding their authority in evaluating physicians.

Prior to September 2004, CDCR physicians were evaluated in three ways. First, they were given annual performance appraisals under section 12.5 by the Chief Medical Officer or the Chief Physician and Surgeon at the facility. The standard evaluation form includes nine categories in which physicians were rated "I" for improvement needed, "M" for fully meets expected standards, or "E" for consistently exceeds expected standards.[4] The form also contains a section for comments about performance in the listed categories, as well as other categories.

Second, CDCR physicians were evaluated under a peer review process. Under section 16.2 of the MOU, peer review is conducted by a committee of the "organized medical staff." Dr. Scott Anderson, chief physician and surgeon at Napa State Hospital, described the peer review process:

> Well, Peer Review involves a number of different activities, one of which, for example, was a Morbidity and Mortality Conference. And in that conference, every death was carefully reviewed by a team of physicians in an effort to improve medical care. And if the care was felt to be lacking in any respect, that could be referred on for more detailed Peer Review of the doctor who cared for the patient. That would be one example.
>
> . . . . It was both directed and non-directed Peer Review. Directed Peer Review is Peer Review in response to a specific allegation or complaint about the care of the doctor. So if anyone

[3] QMAT site evaluations were being conducted in connection with related litigation. The purpose of the QMAT audits was to determine under various indicators if a facility was providing adequate health care.

[4] The categories are quality of work, quantity of work, work habits, relationships with other people, taking action independently, meeting work commitments, analyzing situations and materials, supervising the work of others, and personnel management practices.

> complained about the care of a doctor, that the care, the quality of care rendered by a doctor for any particular patient, that triggered Peer Review automatically.
>
> And the allegation did not need to come only from another doctor. It could come from anyone, including relatives of patients, nurses, other medical personnel, technicians, anyone.
>
> . . . . Then there was what was called non-directed Peer Review. That took the form of the doctors coming together in a room about this size and reviewing charts. And we would each be assigned to review a certain number of charts, perhaps half a dozen, and we would look for specific aspects of whether or not the patient care was documented, it was thorough and was carefully, both performed and written down on the chart.

Dr. Nicholas Capozzoli works in the psychiatric program at the California Medical Facility in Vacaville. He described directed peer review as "focused Peer Review" that is requested by someone, while non-directed peer review is "routine Peer Review."

Section 16.1.A of the MOU permits an organized medical staff to be formed for the purpose of peer review at any hospital where there are more than ten Unit 16 employees providing direct patient care. Anderson testified that the organized medical staff

> . . . . exists under the medical staff bylaws and it represents the medical staff in its interactions with administration and contains various officers in various roles who are elected, including Chief of Staff, Vice Chief of Staff, Secretary and so forth.
>
> The medical staff would meet and discuss issues, past [sic] resolutions, and make recommendations to various other bodies within the hospital.

The peer review process could result in specific recommendations to higher levels -- such as the Department of Medicine, Medical Executive Committee, the governing body, or the administration -- to improve quality of care.

Acting Director of the CDCR's Division of Correctional Health Care Services, Dr. Renee Kanan, testified that the peer review process was not standard throughout the department. She said institutions with a licensed facility were required to conduct peer

reviews, and they did so based on local policies and bylaws. The requirement did not extend to all institutions. Kanan said she has reviewed peer review findings related to deaths of inmate patients and found the process "inadequate."

Third, CDCR investigated physicians' performance on an ad hoc basis, according to Anderson and Capozolli. For example, CDCR referred individual cases or physicians to the peer review process; CDCR has the option of investigating physicians and patient care issues using their administrative protocols; and CDRC has referred physicians suspected of incompetence to the California Medical Board for chart review and investigation. Inmates sometimes initiate such referrals. Investigations have led to remedial training, continuing medical education, and psychological testing.

The Plata Case

On April 2001, a class of California state prisoners sued the Governor and other state officials in the Federal District Court for the Northern District of California, alleging that plaintiffs were not receiving constitutionally adequate medical care as required by the Eighth Amendment to the U.S. Constitution.[5] The parties had conducted informal negotiations since July 1999 in an effort to resolve plaintiffs' demand that medical services be improved, but they reached no resolution.

In June 2002, the parties agreed to settle the suit through a Stipulation for Injunctive Relief, which was entered by Judge Thelton Henderson. The 2002 Consent Decree stated that "a dispute exists between the parties as to the extent to which [CDCR's] provision of inmate-medical care meets constitutionally-mandated minimum standards" and required that the CDCR implement the Health Care Services Division Policies and Procedures that had been filed with the court. The parties stipulated that implementation of the Policies and Procedures

[5] Marciano Plata et al. v. Arnold Schwarzenegger et al. No. C-01-1351. (Plata)

would ensure constitutionally adequate medical service. The CDCR was to implement the Policies and Procedures on a staggered basis.

The 2002 Stipulation for Injunctive Relief also created the QMAT audit program referred to earlier. According to testimony by a court expert in a later evidentiary hearing, QMAT was intended to be "the link between the Central Office and the institutions for the implementation of the medical policies required by the injunction" and to "assist the institutions with implementing the medical policies with doctors, nurses and custody staff from Central Office." Dennis Beaty is assistant general counsel for CDCR's health care team. He described QMAT as a group of medical practitioners who go into the field and audit facilities against the Policies and Procedures, a "quality assurance group."

QMAT teams would audit each facility and assign a numerical rating based on the degree to which the facility had adopted the Policies and Procedures in the Stipulation for Injunctive Relief. For example, an 85 percent compliance rating would signify the facility was in substantial compliance with the Policies and Procedures and auditing requirements. Court appointed experts had the discretion to find prisons in compliance if they fell within the 75-85 percent range.

As part of the 2002 Stipulation for Injunctive Relief, the parties agreed to the court's appointment of Dr. Joe Goldenson, Dr. Michael Puisis, and Nurse Practitioner Madde LaMarre as experts under Federal Rule of Evidence 706. At the request of any party, the experts were authorized to visit facilities and evaluate, among other things, implementation of the Policies and Procedures, the QMAT audit procedure, and overall compliance.

Adoption of Program to Evaluate Competency of Physicians

Early in 2004, CDCR began discussions with the Physician Assessment and Clinical Education (PACE) program at the University of California, San Diego, (UCSD) to develop a

program to evaluate physicians.[6] In brief, PACE is a physician evaluation and remedial education program at UCSD. The California Medical Board refers physicians determined to have competency problems to PACE for evaluation and remediation. Kanan testified that the discussions with UCSD began in May 2004, including the services provided by PACE and development of training programs for the CDCR. CDCR also discussed training and evaluation options with the California Medical Association, Institute of Medical Quality, at around the same time.

On July 16, 2004, after the Plata court experts visited three facilities, they produced a report concluding, among other things, that "there appears to be an emerging pattern of inadequate and seriously deficient physician quality in [CDCR] facilities." The report was highly critical of CDCR's credentialing and physician qualifications. For example, the report stated that "credentialing considers not only licensure but other qualitative factors such as moral character, whether a physician is impaired physically or mentally, and the training that a physician has. However, the current CDC credentialing rules are not selective and it is extremely difficult to weed out poor quality physicians." In addition, the report stated that CDCR had no job description requirements other than licensure, and physicians see patients for conditions that they have never been trained to treat. In one chart review, for example,

> . . . . at one of the CDC acute care hospitals a patient who was breathing fast because of bilateral pneumonia was seen by a retired neurosurgeon who thought the patient was having an anxiety attack and prescribed anti-anxiety medication and medication for psychosis when instead he needed intravenous antibiotics and oxygen. This was a potentially life threatening mistake that was remedied when the patient was seen by a different physician the next day and admitted to a community hospital.

[6] The PACE Program as applied to CDCR was later renamed Quality Improvement in Correctional Medicine (QICM).

"Physicians without training are approving physicians for practice in which they are not trained," the report stated. Also, the report noted that of the 20 credentialed physicians at one facility, seven "have problems, including mental health disorders, prior alcoholism, or loss of privileges or license because of substance abuse or incompetence or both."

The report was critical of the peer review process, noting a lack of qualified physicians in the managerial ranks. "Thus, when mistakes are made by staff physicians there is no supervisory physician with experience who can correct or amend mistakes," the report stated. The report recommended establishment of an effective system of peer review.

According to Goldenson's testimony in this proceeding, the experts "found a medical system that was totally broken in almost every aspect." He said there were "numerous episodes" where the medical care was "substandard;" there were physicians in the peer review process "who weren't competent" reviewing the work of other physicians; and deaths occurred as a result of substandard care. The report recommended a new peer review policy using physicians trained in primary care internal medicine with supervisory authority.

Goldenson also testified about so-called "death reviews" where cases are reviewed to determine quality of care and emergency responses by physicians. The experts found about 300 cases of inmates who had died during the last few years where CDCR had not performed death reviews. He testified that "in a significant number, there were . . . . pretty egregious mistakes made on the part of medical staff. And that a significant number of the deaths from the information we had would have been preventable." Goldenson said after it became clear that the health care situation was worse than initially thought, "the court asked us to become more involved in both assessing the situation of the different facilities and working with the state to come up with ways to address those problems."

The idea to use the PACE program to evaluate the competency of physicians did not originate with the court experts. Kanan discussed the program with PACE before raising it with the experts. According to Goldenson, "none of us had a real clear idea of exactly what PACE was or what they did or how they did it. Which was why we decided to go down to San Diego and actually meet with the people from the program so that they could tell us what to do."

In August 2004, the experts visited UCSD to evaluate the PACE program. Goldenson testified that "we were all extremely impressed with the program and thought it would be an excellent evaluation tool." He said the experts formed the opinion that "PACE was the only program of its sort that evaluated the competency of physicians in California. And that it was the most comprehensive program of its type in the country." Asked if PACE was the only way to deal with the problem, Goldenson testified:

> I don't remember specifically talking about whether it was the only way, but, you know, there are other ways it could have been done in other settings. The feeling was that in CDC, because of the scale of the problem and the lack of supervisory staff as we talked about, in terms of the Chief Medical Officers and the Chief Physicians, that ways that it would work in other systems where you had that kind of supervision above the physicians wouldn't work here.
>
> So that things like Peer Review and depending on someone's supervisor to make sure that they do a good job, you know, which could work somewhere else and works, for example, in my system, wouldn't work in CDC.[7]

Goldenson said "preventing as many of the further deaths that are preventable as possible, that PACE is the quickest way to do it." Goldenson also testified that the performance appraisal system in the MOU had not identified significant problems in health care and CDCR lacked

[7] Goldenson is the medical director for jail health services in San Francisco. He is responsible for providing all medical and mental health services to prisoners in the San Francisco county jail.

competent people to perform the appraisal. "Physicians who really shouldn't be practicing were still practicing," he said.[8]

The experts reported their findings to the Plata court. Goldenson testified Judge Henderson "thought it was an excellent idea and wanted them to move forward as quickly as possible with it." By August 30, 2004, Beaty testified, the PACE program had been discussed along with other options during status conferences with the Plata court and was "probably the choice." In fact, the Joint Status Conference Statement of August 30, 2004, states that the parties were working on a proposed order that will provide for, among other things, "evaluation and training of primary care providers and supervisors by a non-CDC entity approved by the experts and plaintiffs' counsel."

September 17, 2004, Stipulated Order Re Quality of Patient Care

On September 10, 2004, CDCR and the plaintiffs in Plata entered into a stipulated agreement to engage an independent entity to test physicians for competency. Judge Henderson signed the agreement one week later, on September 17.

The Patient Care Order required CDCR to engage an independent entity within 60 days "to evaluate and train [CDCR] physicians." It set a timeline for the completion of evaluations, requiring that physicians at the 2003-2005 so-called "roll-out institutions" be evaluated prior to December 31, 2005, and physicians at the other institutions by December 31, 2006. The Patient Care Order also required evaluation and, if appropriate, training of "all other CDC

[8] Goldenson testified along similar lines at a hearing in the Plata case on June 2, 2005. Asked why he approved of QICM, he said it was "basically sort of an admission on the part of the Department that they were unable to really evaluate the physicians who work for them, and wanted to find some other mechanism for doing that." He said QICM would be a good "first cut in the sense that I don't believe that if someone passes QICM that necessarily means that they are going to be a qualified physician, but if they don't pass QICM, then they shouldn't be practicing."

physicians with clinical responsibilities, including but not limited to the Chief Deputy of Clinical Services, and any Assistant Deputy Director with a medical degree by June 30, 2005."

Pursuant to the Patient Care Order, the independent entity was to classify each examined physician in one of three categories. Category one physicians were defined as "competent to provide care to class members without remedial training." Category two physicians were defined as "competent to provide care to class members pending successful completion of remedial training by the independent entity." Category three physicians were defined as "not competent to provide care to class members, or failed to successfully complete remedial training required by the independent entity."

The Patient Care Order also provided that "upon notification by the independent entity, physicians in Category 3 shall not engage in direct patient care, direct the activities of persons engaged in patient care, prepare or supervise the preparation of case histories, supervise persons engaged in patient care, or participate in any oversight or management of patient care." Lastly, the Patient Care Order stated that "this order is necessary to correct a current and ongoing violation of the federal right, and is narrowly drawn and the least intrusive means to correct the violation."

Bargaining During Fall 2004

CDCR notified UAPD of the pending Patient Care Order on September 16, 2004, when Kanan told Robinson that Judge Henderson was considering signing an order requiring all physicians to be evaluated for competency by an independent entity. He told Kanan the doctors are going to be "furious," and that it would be a "big, big problem." Kanan and Robinson discussed the reasons for the Patient Care Order and the competency evaluation.

In a September 24, 2004, letter, CDCR formally informed Robinson that it intended to implement the Patient Care Order, and that it "anticipated" the implementation would occur in

30 days. The letter also stated that the Department of Personnel Administration (DPA) had delegated authority to CDCR to meet and confer "over the impact of this decision."

A negotiations meeting was held on October 7, 2004. Asked by Robinson why UAPD received no advance notice, Beaty responded that the experts were interviewed, PACE was selected, and it would be hard to change the court order at this point. Beaty said the parties at the October 7 meeting also discussed the experts' reports and the standard of care required to satisfy the Eighth Amendment claims in the litigation. Beaty testified that he discussed the newly evolved "separate QICM program," but he didn't know much about it at the time.[9] He told Robinson "we didn't unilaterally pick this group. We had to get court expert approval. We had several discussions with the court and this is where we finally ended up, after this long process."

According to Robinson, the CDCR representatives at the October 7 meeting were unable to answer basic questions about the examination, such as whether physicians who failed it would be fired. The meeting ended with CDCR Labor Relations Representative Sandra Samaniego asking Robinson for written proposals. He agreed to provide them and the parties set another date to meet.

UAPD submitted a written proposal on October 13, 2004. UAPD proposed that CDCR not use the PACE program because UCSD had a conflict of interest in conducting the program. UAPD proposed Goldenson be appointed as the evaluator and additional independent entities engaged, as necessary. UAPD also submitted the following set of proposals.

> [T]he independent entity agreed upon by the CDC and the UAPD to do the evaluations will go into the CDC facilities, review patient charts, interview patients and CDC doctors, and use whatever other techniques are appropriate to evaluate the work of the physicians and nurse practitioners. The physician or nurse practitioner who is found to be below standard as the result of the

[9] PACE was renamed QICM around this time.

> evaluation will be informed of the reasons for the poor evaluation and be given an opportunity to appeal the evaluation to a neutral primary care physician agreed upon by the CDC and the UAPD.
>
> Physicians and nurse practitioners who, as a result of the evaluations, are considered to be below standard will have their assignments limited to those areas in which they are fully competent, will be given training in the areas of their deficiencies, will be allowed to take additional continuing education in the areas of deficiency, and their practices will be monitored in those areas in which they are deficient until they reach acceptable standard of practice.

UAPD also submitted proposals in the event an outside entity was selected.

> [A] syllabus for the evaluation and/or training programs must be supplied to all Physicians and Surgeons in the CDC at least 90 days before the doctors are to be evaluated.
>
> Physicians must have 10 CME days to study for the evaluation and/or education process. These days are in addition to the CME days currently available in the MOU.
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> Physicians must have actual costs of tuition, travel to CME courses, materials, hotels, meals, and related costs reimbursed when taking CME to study for this program.
>
> Physicians must be able to choose the time when they are to attend the evaluation if they are to take an off site evaluation and/or training.
>
> When attending any evaluation and/or training, physicians must be on full pay status.
>
> If there is off site evaluation and/or training, physicians must receive paid travel time and payment for full costs of transportation, material, hotels, and meals while they are attending evaluations and/or training.
>
> When off work for CME or for evaluation and/or training in connection with this program, all bargaining unit physicians must be replaced on an hour for hour basis by qualified physicians.
>
> The UAPD reserves the right to make additional proposals concerning matters contained in the Plata stipulation signed by CDC and the [plaintiffs] on September 10, 2004.

UAPD received no response to these proposals. Two negotiation meetings were set for October and November, but CDCR cancelled both, according to Robinson.

UAPD Intervention in Plata

On October 15, 2004, as negotiations continued, UAPD moved to intervene in the Plata case and modify the Patient Care Order to clarify its bargaining rights under the Dills Act. On December 8, 2004, the court permitted a limited intervention, ruling as follows: "UAPD reasonably argues that it should not have anticipated earlier that the CDC would enter into a stipulation which (in the UAPD's view) violates the UAPD's state law bargaining rights. This is particularly so given that the CDC previously met and conferred to the UAPD's satisfaction in advance of entering into an earlier stipulation with the plaintiffs in this case." Accordingly, the court found UAPD did not unreasonably delay in bringing its motion.

Regarding UAPD's request to modify the Patient Care Order, the court wrote:

> As the UAPD emphasizes, state officials cannot enter into stipulations or agreements with third parties that violate state law. *See, e.g., S. Ca. Edison Co. v. Lynch* 307 F.3d 794, 809 (9th Cir. 2002). In this case, the UAPD argues that the CDC improperly agreed to a stipulation that violates the UAPD's state law bargaining rights, as set forth in California Government Code sections 3517 and 3516.5, and the Stipulated Order should therefore by modified to avoid this conflict.

The court concluded, however, that modification of the Patient Care Order to guarantee UAPD's Dills Act bargaining rights was unnecessary.

> First, there is nothing on the face of the Stipulated Order that expressly abrogates any bargaining rights provided by state law. Rather, the Stipulated Order is silent with respect to such rights and obligations. Second, the UAPD has failed to show that any express terms of the Stipulated Order violated state law bargaining rights. The objected to portions of the Stipulated Order essentially require that the CDC (1) develop proposals on various subjects, and (2) engage an independent entity to evaluate the competency level of CDC physicians and provide remedial training where appropriate. The substance of the agreement with the independent entity is not addressed. The UAPD has not

> persuasively demonstrated that these provisions - which on their face do not preclude the CDC from meeting and conferring or negotiating with the UAPD regarding any proposal that may be developed or any other subject that is addressed in the Stipulated Order – create any direct or irreconcilable conflict with the UAPD's state law bargaining rights. Third, the CDC asserts that it did not intend the Stipulated Order to discharge or release it from any of its state law bargaining obligations. [Citation omitted.] The plaintiffs concur in this interpretation.
>
> Consistent with the parties' expressed intent, the Court construes the Stipulated Order to not release or discharge the CDC from any of its state law bargaining obligations. [Citation omitted.] In light of this interpretation, and the fact that the UAPD has not satisfactorily shown that any express provision of the Stipulated Order necessarily violates the UAPD's state law bargaining rights, the Court concludes that the Stipulated Order itself does not violate state law. Accordingly, a modification on this ground is not warranted.

The court also addressed UAPD's argument that CDCR had violated its Dills Act bargaining rights by failing to negotiate about the Patient Care order.

> While it is proper for this Court to address the UAPD's contention that that Stipulated Order itself violates state law, the UAPD's claim that the CDC is committing an unfair labor practice by failing to satisfy its negotiation or meet and confer obligations with respect to the Stipulated Order – under either state labor laws governing California public employees or its contract with UAPD – must be raised before the California Public Employees [sic] Relation Board ("PERB") – *not* this court. Indeed, the UAPD could point to no case, and the Court could find none, in which a federal court had resolved a claim that a California state employer had engaged in an unfair labor practice. Notably, the UAPD has filed an unfair labor practice claim before PERB, and that is the proper forum for resolution of this issue. Accordingly, the Court declines to be drawn into any disputes between the UAPD and the CDC concerning whether the CDC has violated any state laws governing public employee bargaining (or its contract with the UAPD) in the course of implementing the Stipulated Order. Modification of the Stipulated Order is simply not an appropriate vehicle for addressing such issues. [Italics in original.]

A status conference report dated December 1, 2004, indicates that the court experts agreed that the PACE program was by far the most appropriate entity to evaluate and train

physicians, some of UAPD's concerns about PACE had been addressed, and CDCR had set a meeting for December 9, 2004, to finalize the agreement with UCSD. The conference report also confirmed that UCSD had developed the QICM program for CDCR and PACE had been renamed QICM.

The December 9, 2004, Meeting

An information session with UAPD and physicians was conducted on December 9, 2004. QICM representative Dr. Joseph Scherger made a presentation about the program, which CDCR announced had been officially renamed QICM. Kanan testified the CDCR staff explained that it was important to evaluate the core knowledge and skills of primary care physicians based upon the Plata case, expert reports, and analysis of peer reviews and death reviews. Robinson testified that Scherger conceded that neither he nor his staff had experience dealing with correctional institutions. According to Robinson, Scherger also said there would be no exemptions for board-certified physicians, and physicians who failed the test would be referred to the California Medical Board.

At the December 9, 2004, informational meeting, DPA representative Diane Navarro announced that DPA would be reassuming responsibility for the negotiations about matters addressed in the Patient Care Order. Navarro said there was a concern about how the negotiations were conducted on October 7, and CDCR asked DPA for assistance. Robinson testified he "felt a little sorry" for Navarro because she walked into the December 9 meeting "a little blind." Although UAPD had submitted proposals on October 13, Navarro apparently had not seen them. She asked Robinson for a copy of the proposals.

On December 10, 2004, Robinson sent Navarro a copy of UAPD's proposals and related documents. He asked her to provide dates when DPA was available to resume negotiations. In a lengthy follow-up letter to Navarro on February 8, 2005, Robinson stated

that "it is very important that we expedite our next meeting" because CDCR was unilaterally setting an early date for testing UAPD members. Robinson reiterated requests for information, argued that an adverse evaluation by QICM need not be reported to the California Medical Board, and requested assurances from CDCR that adverse evaluations will not be reported.

Navarro did not immediately respond to Robinson. Instead, she said she encouraged CDCR to get its policies and procedures in place because of the responsibility "to negotiate the impact of those policies and procedures with UAPD. And before we sent any physicians to undergo a QICM evaluation, we needed to conclude the negotiations on impact bargaining."

As Robinson was communicating with Navarro, CDCR and UCSD were negotiating to implement QICM. Kanan testified that an agreement was reached on or about January 31, 2005. During a teleconference on February 1, 2005, Scherger officially announced that board-certified physicians in primary care specialties such as Family Practice and Internal Medicine would be exempt from QICM. In late February 2005, Navarro sent Robinson QICM's actual policies and procedures, and a meeting was scheduled for March 4, 2005.

March and April 2005 Negotiations

A few days before the March 4, 2005, negotiating session, DPA sent UAPD a copy of QICM's program and the Due Process Policy designed to implement the Patient Care Order.[10] Robinson testified that Navarro started the meeting "by saying that the decision to have the QICM exam was not negotiable. The decision to have the . . . . two policies, the QICM Evaluation policy and the . . . . Due Process Policy was not negotiable. But they would negotiate on the impact effects." Navarro agreed. She testified that she stated at the outset of the meeting that "it was not the state's position that we were going to negotiate who the Department identified as the entity to evaluate or train the doctors. That had already been done

[10] The QICM program and Due Process Policy are more fully discussed below.

. . . . as a management decision." She testified that she agreed to "negotiate impact, but not the decision. And I made that very clear." She also testified "we would agree to disagree" on the obligation to negotiate the decision, and that issue would be resolved in another forum. There was a sense of urgency and the State had to move forward, according to Navarro. Robinson responded that the QICM program was contrary to the MOU, but Navarro reiterated the position that the MOU doesn't take into account the Plata order.

Robinson next raised a series of questions, including whether doctors who failed QICM would be fired. He pointed out that QICM had three categories – pass, need more training, and fail – and asked what standards would be used under QICM to make the decision. Robinson objected to the QICM management committee that would conduct peer review, arguing that the committee was not truly a committee of peers. He raised questions about definitions, such as "community standards," used in the Due Process Policy. Would QICM use the CDCR standard or the UCSD standard? Robinson questioned the validation of the test itself.

Robinson testified that DPA "definitely" did negotiate about effects of the policy. For example, the time to appeal a decision of the peer review committee was discussed along with issues such as study time and paid time off to take the test. He said these issues were "really negotiated." However, Robinson said DPA took the position that "not a single word [of QICM] can be changed. This is the way the test is. Nothing will be changed." He said DPA would negotiate "around the fringes" of the Due Process Policy, but topics such as "who the evaluator would be and what the evaluation would be was not negotiated." Nothing was resolved at the March 4 meeting.

After the meeting, Navarro testified, she became "concerned that the Union was stalling negotiations or going to draw out negotiations." She explained that "we had to go through two policies and one was actually pretty thick. And as I recall, it took two hours to go through, I

think the first page or the second page. I mean, it was extremely slow and some of the questions, with all due respect were, they seemed like forgone conclusions." Another meeting was held on March 8, but the parties' positions remained unchanged.

In a March 10, 2005, letter to Robinson, Navarro announced that CDCR planned to implement the QICM program on May 2. In an attempt to move the negotiations forward in a more expeditious manner to meet the time frames mandated by the court, Navarro asked that UAPD provide a list of questions concerning the procedures and specific "impact issues" for discussion at the next session on March 18.

Robinson responded by letter on March 11, noting that PERB had issued the instant complaint the previous day. He asked Navarro to expand the negotiations to include "the decision to implement the change in policy." He noted that he and the UAPD negotiating team had other commitments and Navarro's requests left little time to respond by March 18. He recognized the need to rapidly conclude negotiations, but asserted that CDCR created the deadline by starting to work on the evaluation process in early 2004 without informing UAPD of the plan until September 2004. Lastly, Robinson said the May 2 deadline surprised him and he asked Navarro for the reasons DPA selected that particular date.

On March 16, 2005, Navarro responded that the PERB complaint had not changed DPA's position. She reiterated that DPA would negotiate only the effects of the court order, and CDCR planned to implement the plan on May 2.

Another meeting was held on March 18, 2005, but the parties' respective positions remained essentially unchanged. Navarro reiterated the May 2 deadline to reach agreement. According to Robinson, Navarro stated two reasons for the deadline: it permitted sufficient time to negotiate an agreement and the evaluations could be completed by December 31 if implementation started May 2.

The last negotiations session was on April 29, 2005, and soon thereafter PERB declared an impasse at Navarro's request. A mediation session was held in early June, and the parties eventually reached agreement on effects. CDCR began to send out notices to physicians on or about June 5.

The agreement on effects was memorialized in an addendum to the MOU dated June 9, 2005. Among other things, the agreement provides that the information provided by CDCR to UCSD would be limited to the physician's name and scope of practice, physicians selected to attend the QICM evaluation would be notified of the reasons for selection in accord with QICM policy, and the physician's referral letter would not be placed in his or her personnel file. Other areas covered by the agreement include scheduling, travel reimbursement, release time, study time, and reimbursement costs.

QICM and Due Process Policy

QICM covers the evaluation of physicians and the Due Process Policy covers the rights of physicians who are being tested. Physicians with board-certification in Internal Medicine or Family Practice were exempted from examination, unless an individualized suspicion of clinical practice problems emerged through peer review, death review or other significant clinical outcomes.

The QICM evaluation consists of two phases and a chart review. Phase 1A is "a two day assessment utilizing a variety of methods, including written, oral, and standardized computer based examinations to provide an overall picture of a physician's medical and communications skills, knowledge, and professionalism." Dr. Ben Chapnick, Chief Medical Officer of QMAT, testified that this component of the test includes "some pencil and paper, multiple choice type tests, which include some basic science, aspects of medicine, pharmacology, ethics." Kanan testified before the Plata court that the exam includes a

computer simulation in which physicians must demonstrate their clinical decision-making and patient management skills, examine a mock patient, and review charts. At the conclusion of Phase 1A, the physician is assigned to one of the three categories set out in the Patient Care Order. If a physician is determined to have failed Phase 1A, he or she could be categorized as "not competent to provide care to patients," according to the agreement between CDCR and UCSD.

Phase 1B is "a one-day assessment whereby QICM staff observes scripted physician diagnosing and managing simulated patients with carefully scripted conditions relevant to the physician's normal scope of practice." The standardized assessments are conducted in a laboratory and videotaped. At the end of Phase 1B, physicians are again placed in one of the three categories in the Patient Care Order. Physicians who are placed in category three in the Patient Care Order are subject to "intensive chart review" for 25 inmate-patients over a 12 month period and given the opportunity to attend a five day remedial training program at UCSD.

Chart Review includes assessment of selected inmate-patient charts. Charts are assessed for overall quality, organization, legibility, and proper documentation.

The Due Process Policy established the Professional Practices Executive Committee (PPEC) in the central office of CDCR. The PPEC is made up of three physicians, one dentist, one psychiatrist, one psychologist, and a physician-chairperson. All members are managers. The policy states that the PPEC "shall be the peer review body for the Department of Corrections . . . . and shall be responsible for managing the peer review process for both routine peer reviews and for those required for a medical disciplinary cause or reason . . . . " The policy sets out the responsibilities of the PPEC. For example, it describes the circumstances under which the "routine" and "for cause" peer review procedures may be

initiated and the principles the PPEC must follow. It permits the PPEC to make findings and recommendations to CDCR, including revocation of privileges, further monitoring and evaluation, or suspension/limitation of clinical privileges. The policy also permits the PPEC to recommend revocation or denial of clinical privileges as a result of the QICM peer review process. The ultimate authority to take action based on recommendations is vested in CDCR.

Order to Show Cause and Hearings

On May 10, 2005, the Plata court issued an Order to Show Cause Re Civil Contempt and Appointment of Interim Receiver. In the introduction to the Order, Judge Henderson wrote:

> In the four years since this case was filed, which includes the year and a half that this Court has been meeting with the parties on a regular basis, two things have become ever increasingly clear: (1) the Governor has appointed, and the State has hired, a number of dedicated individuals to tackle the difficult task of addressing this crisis in the delivery of health care in the California Department of Corrections ("CDC"), and, (2) despite the best efforts of these individuals, little real progress is being made. The problem of a highly dysfunctional, largely decrepit, overly bureaucratic, and politically driven prison system, which these defendants have inherited from past administrations, is too far gone to be corrected by conventional methods.
>
> The prison medical delivery system is in such a blatant state of crisis that in recent days defendants have publicly conceded their inability to find and implement on their own solutions that will meet constitutional standards. The State's failure has created a vacuum of leadership, and utter disarray in the management, supervision, and delivery of care in the Department of Corrections' medical system.
>
> Defendants have devised a long-term strategy to contract out health care management and much of the delivery of care. However, full implementation of that plan is, by defendants' own estimates, years away. In the meantime, roughly 162,000 prisoners are being subjected to an unconstitutional system fraught with medical neglect and malfeasance. Defendants themselves have conceded that a significant number of prisoners have died as a direct result of this lack of care, and it is clear to

> the Court that more are sure to suffer and die if the system is not immediately overhauled.
>
> In light of this crisis and defendants' concession that the constitutional violations will not be corrected for a long time to come, the Court is compelled to take it upon itself to construct a remedy that will cure the violations as soon as possible. Having considered the range of options available, the Court believes that the appointment of an interim receiver to manage the CDC's delivery of health care services may be necessary. Therefore, the Court issues this Order requiring defendants to show cause why a receiver is not the appropriate remedy and, if not, why not. Defendants also shall address the issue of contempt, which may be procedurally necessary as a predicate to the appointment of a receiver.

Six days of evidentiary hearings were held between May 31 and June 30, 2005. Puisis testified that, in his opinion, the QICM program was necessary because CDCR could not otherwise fire or discipline incompetent physicians.

> As I said in my testimony, would one normally construct a process like QICM if you had a reasonable management staff, and the answer is no, or a reasonable personnel policy, and the answer is no, because you would be able to discipline people with the staff you had. Because you don't, and because you have a union that opposes the firing of physicians, QICM seemed like a reasonable step to take.

Puisis continued:

> . . . . I have managed for years, when you have a disciplinary problem such as the doctors were finding, it would take a day, you would sit down, counsel them and give them due process, and if you needed to, you would fire them.
>
> The CDC has to use QICM because they can't do that, . . . Because their – perhaps because their managerial staff is nonexistent. They can't supervise their physicians, so they have to invent a mechanism whereby everyone, is quote, "treated fairly." So everyone is tested.
>
> Well, not everyone needs to be tested. Some of the doctors are competent. They have board certification, yet they are required to go to QICM. The reason why they do that is because of the union and personnel rules.

> They have to reinvent and reconstruct ways of doing things to satisfy this bureaucracy that is so cumbersome and complex, but the solution is really just do it. Just fire someone. Just hire someone.

Goldenson testified at the same hearing:

> I'm extremely concerned that in a number of the cases that I have looked at that people have been dying unnecessarily, that their deaths could have been prevented. So that the question here is a lot bigger than just saying whether it's a constitutional system in terms of providing constitutional health care, because I've seen systems where constitutional health care is the issue, but people aren't dying in the numbers they are dying in the [California] system in terms of preventable deaths.

Goldenson went on during the hearing to describe in detail specific cases where he discovered substandard health care.

During the hearing, UAPD submitted a letter to the court asking to participate. In an exchange with defendants' counsel about UAPD's collective bargaining rights under the Dills Act in the event a receiver was appointed, Judge Henderson stated: "No, I understand that, and I will take that into account. And I will not empower the receiver to interfere with those rights." Judge Henderson allowed UAPD to file an *amicus curiae* brief.

Appointment of Receiver

On October 3, 2005, the court issued its Findings of Fact and Conclusions of Law Re Appointment of Receiver. Judge Henderson wrote:

> By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action. The Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system.

After reviewing testimony provided during the evidentiary hearings between May and June, the judge concluded that appointment of a receiver was necessary. The judge did not name a receiver at that time. Instead, he stated that a search was underway and that the receiver would be appointed in the future. The judge did issue an Order Appointing Court Expert "to assist the Court in identifying discrete, urgently needed, remedial measures that can be undertaken immediately without interfering with the comprehensive and systemic reform that the Receiver will necessarily undertake." Among other things, the expert was authorized by the court to meet and confer with the parties to the Plata case and the Coalition of CDCR Health Care Unions concerning concrete measures that can be undertaken to address issues such as staffing, adequate peer review and investigations following serious injury or death of an inmate.

On November 14, 2005, Correctional Expert John Hagar issued a Report Regarding Clinical Staffing. He found that, in terms of staffing, the CDCR's health care system was in worse shape than the conditions existing at the time of the evidentiary hearings in May and June, and the vacancy rate had climbed from 15 percent to 30 percent. Hagar set out several reasons the health care system had deteriorated. The report also stated that the failure to manage the QICM program had actually increased the physician shortage in CDCR. While raising the bar to require board certification or eligibility, CDCR failed to implement improvements in its hiring and recruitment process and failed to communicate the new standard to companies that traditionally provide contract physicians to CDCR. Hagar wrote:

> Likewise, for a variety of reasons, including the need to bargain with the UAPD concerning QICM (a dispute which led to litigation between the union and the State), this quality related program was not implemented in a timely manner. Unfortunately, QICM also appears to have limited impact in identifying substandard physicians.[11]

[11] Hagar noted that only two CDCR physicians had been found unsuitable for practicing medicine in the correctional environment.

> Moreover, as a direct consequence of QICM, according to CDCR officials and affirmed by UAPD, almost 60 physicians have quit their jobs. While CDCR and the UAPD disagree concerning why certain of these doctors terminated their employment, there is consensus that some left because they believed they may fail the QICM examination while others quit out of frustration because of bad working conditions and a lack of leadership at Health Services Headquarters. To some CDCR doctors, QICM was "the last straw."

Hagar recommended a series of reforms in CDCR's hiring and employment policies.

CDCR raised numerous objections to Hagar's report. With respect to QICM, CDCR asserted that

> . . . . it is simply too early in QICM implementation to draw this conclusion. QICM has had a dramatic impact as about twenty percent of the total physician workforce left CDCR between July 2004 and July 2005. Of those 52 physicians who left CDCR, the vast majority lacked board certification or admissibility in Family Practice or Internal Medicine or left under adverse circumstances. Furthermore, these physicians have been replaced by better credentialed and better qualified physicians. Finally, it is important to recall that QICM was developed in conjunction with Court experts, Plaintiffs, and Defendants. Following such development, the Court ordered its implementation.

On December 1, 2005, Judge Henderson issued an Order Re Interim Remedies Relating to Clinical Staffing adopting Hagar's recommendations.

Appointment of Receiver

On February 14, 2006, Judge Henderson issued an Order Appointing Receiver. The Receiver was given the authority to "negotiate new contracts and to renegotiate existing contracts, including contracts with labor unions, in the event that such action is necessary for the Receiver to fulfill his duties under this Order. The Receiver was also given authority with respect to "Governing State Laws, Regulations, and Contracts."

> The Receiver shall make all reasonable efforts to exercise his powers, as described in this Order, in a manner consistent with California state laws, regulations, and contracts, including labor contracts. In the event, however, that the Receiver finds that a

> state law, regulation, contract, or other state action or inaction is clearly preventing the Receiver from developing or implementing a constitutionally adequate medical health care system, or otherwise clearly preventing the Receiver from carrying out his duties as set forth in this Order, and that other alternatives are inadequate, the Receiver shall request the Court to waive the state or contractual requirement that is causing the impediment. Upon receipt of any such request, the Court shall determine the appropriate procedures for addressing such request on a case-by-case basis.

Robert Sillen was appointed to serve as Receiver. In a separate order, Correctional Expert Hagar was appointed to assist the Receiver.[12]

ISSUE

(1) Should this dispute be deferred to arbitration?

(2) If not, did the State refuse to negotiate about the decision to implement the QICM program, in violation of its duty to bargain under the Dills Act?

CONCLUSIONS OF LAW

The State argues as a threshold matter that the complaint should be deferred to arbitration under section 3514.5(a)(2). That section provides in relevant part that PERB shall not

> . . . . issue a complaint against conduct also prohibited by the provisions of the agreement between the parties until the grievance machinery of the agreement, if it exists and covers the matter at issue, has been exhausted, either by settlement or binding arbitration. However, when the charging party demonstrates that resort to contract grievance procedure would be futile, exhaustion shall not be necessary.

[12] On October 31, 2005, CDCR requested judicial notice of the Findings of Fact and Conclusions of Law Re Appointment of Receiver. On November 30, 2005, UAPD requested judicial notice of the Correctional Expert's Report Re Clinical Staffing. On December 8, 2005, UAPD requested judicial notice of the Order Re Interim Remedies Relating to Clinical Staffing and Associated Briefing. On March 9, 2006, CDCR requested judicial notice of the Order Appointing Receiver and the Class Action Order appointing the Correctional Expert to assist the Receiver. These requests are hereby granted.

The State argues that the MOU covers the matter at issue here and section 3514.5(a)(2) creates a jurisdictional bar that precludes PERB from adjudicating the issue raised by the complaint.

The State also argues under section 3514.5(b) that PERB has no jurisdiction over this matter. That section provides in relevant part:

> The board shall not have authority to enforce agreements between the parties, and shall not issue a complaint on any charge based on alleged violation of such an agreement that would not also constitute an unfair practice under this chapter.

The State claims this provision similarly constitutes a jurisdictional bar to PERB adjudicating this matter.

In response, UAPD argues that deferral is an affirmative defense that is waived if not timely asserted, and the State has not raised the defense in a timely manner. UAPD argues, moreover, that the issue raised by the complaint is not a mere contract violation but rather a complete abrogation of the MOU.

The State's argument rests on a rationale reflected in Lake Elsinore School District (1987) PERB Decision No. 646. (Lake Elsinore) In that case, the Board held that section 3541.5(a)(2) of the Educational Employment Relations Act (EERA),[13] which contains language identical to Dills Act section 3514.5(a)(2), established a jurisdictional rule that a charge must be dismissed and deferred arbitration if: (1) the grievance machinery of the agreement covers the matter at issue and culminates in binding arbitration; and (2) the conduct complained of in the charge is prohibited by the provisions of the agreement between the parties. However, Lake Elsinore is no longer controlling in deferral cases. In State of California (Department of Food and Agriculture) (2002) PERB Decision No. 1473-S (Department of Food and Agriculture), the Board reversed Lake Elsinore and held that section 3514.5(a)(2) requires deferral to arbitration only when doing so results in a decision on the

[13] EERA is codified at Government Code section 3540 et seq.

merits. When deferral to arbitration does not result in a decision on the merits because the employer asserts a procedural defense as justification for refusing to participate in an arbitration, deferral is inappropriate because it would be futile. (Id., at pp. 7-8.) Thus, the Board held in Department of Food and Agriculture that it will not defer to arbitration unless the employer agrees to waive procedural defenses.

In East Side Union High School District (2004) PERB Decision No. 1713 (East Side), the Board further clarified its post-Lake Elsinore deferral doctrine, holding that it would no longer treat deferral as a jurisdictional bar. In East Side the Board declared it will treat deferral as an affirmative defense that must be raised in a timely manner, or waived. (East Side, at p. 4.)

The State has not raised the affirmative defense of deferral in a timely manner. The State raised deferral for the first time at the outset of the hearing. Therefore, it is untimely and deemed waived. (East Side, at p. 4.)

Nevertheless, the State insists that it raised the deferral defense in its answer, which asserts that "the complaint does not state facts sufficient to constitute a cause of action under the Ralph C. Dills Act." According to the State, this defense is derived from Code of Civil Procedure section 430.10, which provides that a party may demurrer or answer on the ground that the pleading does not state facts sufficient to constitute a cause of action. Code of Civil Procedure section 480.30(a) provides that "[i]f the party against whom a complaint or cross-complaint has been filed fails to object to the pleading, either by demurrer or answer, that party is deemed to have waived the objection unless it is an objection that the court has no jurisdiction of the subject matter of the cause of action alleged in the pleading or an objection that the pleading does not state facts sufficient to constitute a cause of action." The State

argues that "this broad affirmative defense is asserted when a party is testing the power or jurisdiction of the court."

As UAPD argues, the State's argument is yet another untimely challenge to the Board's jurisdiction. The purpose of requiring that an affirmative defense be raised in a timely manner is to provide the agency and opposing counsel with notice so that a claim can be addressed and disposed of in advance of hearing to prevent prejudice to opposing counsel, insure a fair litigation process, and avoid unnecessary expenditure of resources in preparation for hearing if the claim is meritorious. (See e.g., Beverly Hills Unified School District (1990) PERB Decision No. 789, pp. 13-14.) The State's assertion in its answer that the complaint "does not state facts sufficient to constitute a cause of action" is overly broad and did not reasonably put either the Board or opposing counsel on notice of the deferral claim. It does not qualify as an explicit, timely assertion of a deferral defense. And, it bears repeating that deferral is an affirmative defense under current Board precedent, not a jurisdictional doctrine. Where, as here, the defense is not clearly raised in a timely manner, it is considered waived. (East Side, p. 4.)

The State also has failed to meet the requirements for deferral set out in Dry Creek Joint Elementary School District (1980) PERB Order No. Ad-81a. (Dry Creek.) Under Dry Creek, the requirements for deferral are that (1) the dispute must arise within a stable bargaining relationship; (2) the employer must be willing to proceed to arbitration and waive procedural defenses; and (3) the contract and its meaning must lie at the center of the dispute. The State has not indicated that it is willing to arbitrate and will waive procedural defenses; and, as noted above, the meaning of the contract does not lie at the center of the complaint. Therefore, even assuming the dispute is subject to deferral, the State has not raised the defense

in a timely manner, nor has it satisfied the Dry Creek requirements. The deferral claim is rejected. (Id.; Department of Food and Agriculture, at p. 13.)

It is unnecessary to address the State's argument that various sections of the MOU cover the issue raised by the complaint. These claims have already been rejected on the record at the outset of the hearing. Suffice it to say that the allegation in the complaint is not that the State merely defaulted on a contractual obligation that may be resolved by interpretation of the performance evaluations provisions in sections 12.5, 16.2, or the various Government Code sections covering performance evaluations incorporated by reference in section 17.2 of the MOU. Nor does the allegation involve interpretation of the duty to engage in "impact" bargaining under sections 17.1 of the MOU. Rather, the allegation in the complaint is that the State unilaterally implemented an entirely new policy to evaluate the competency of physicians. As such, it is not subject to deferral. (Grant Joint Union School District (1982) PERB Decision No. 196, p. 9 (Grant)

The Plata Case Defense

The State argues that neither the Dills Act nor the MOU create barriers that prevent CDCR from addressing "life and death" matters in the prison system, and it had no obligation to bargain with UAPD before entering into a stipulation or consent decree in the context of the Plata case. UAPD was permitted to intervene in Plata on a limited basis, but the court refused to modify the Patent Care Order. According to the State, the court "balanced the life and death interests of the inmates against the collective bargaining interests of the physicians and concluded the health and safety issues had to prevail."

Even assuming it had a duty to bargain before entering into the stipulated order, the State continues, it had no duty to bargain in this instance because applicable case law holds that "[e]xcept as part of court-ordered relief after a judicial determination of liability, an

employer cannot unilaterally change a collective bargaining agreement as a means of settling a dispute over whether the employer has engaged in constitutional violations." The State asserts that the June 2002 Stipulation for Injunctive Relief was prepared to avoid a lengthy trial that all parties to the Plata case acknowledged would result in a finding that CDCR was not providing constitutionally adequate health case to inmates. The Stipulation was adopted by Judge Henderson shortly thereafter. It provides that "the court shall find that this stipulation satisfies the requirements of 18 U.S.C. section 3626(a)(1)(A) and shall retain jurisdiction to enforce its terms."[14] According to the State, this aspect of the Stipulation constitutes a specific finding of liability concerning the Eighth Amendment violations, and it permitted the court to assert continuing jurisdiction over the dispute. Thus, the September 17, 2004, Patient Care Order constitutes court-ordered relief after a determination of liability.

UAPD cites two main reasons to reject the claim that the Patient Care Order required CDCR to conduct independent competency testing. First, the Plata court made it clear that the Patient Care Order did not absolve CDCR of its state bargaining obligations. Second, even had the court not made this point explicit, the case law is clear that an employer may not avoid its bargaining obligations through a consent decree with a third-party.

UAPD argues that the State has misinterpreted the PLRA, which was designed to limit incursions by federal courts adjudicating prison reform cases into state law and state authority. Thus, UAPD contends, the PLRA provides that "the court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates state law" unless certain stringent standards are met, including a requirement that "no other relief will correct the violation of the federal right." (18 U.S.C. section 3626(a)(1)(B).) According to UAPD, the Plata court did not make such a finding, and

[14] This section is part of the Prison Litigation Reform Act (PLRA).

therefore the prospective relief contained in the Patient Care Order does not authorize the CDCR to override state law bargaining rights.

It is unnecessary to address the various arguments advanced by the State in asserting this defense. Judge Henderson refused to set the Patient Care Order as a bar to Dills Act claims, and the State acknowledged in the Plata litigation that it did not intend the Stipulated Order to release it from its bargaining obligation. Responding to UAPD's motion to modify the Patient Care Order, Judge Henderson wrote:

> First, there is nothing on the face of the Stipulated Order that expressly abrogates any bargaining rights provided by state law. Rather, the Stipulated Order is silent with respect to such rights and obligations. Second, the UAPD has failed to show that any express terms of the Stipulated Order violated state law bargaining rights. The objected to portions of the Stipulated Order essentially require that the CDC (1) develop proposals on various subjects, and (2) engage an independent entity to evaluate the competency level of CDC physicians and provide remedial training where appropriate. The substance of the agreement with the independent entity is not addressed. The UAPD has not persuasively demonstrated that these provisions - which on their face do not preclude the CDC from meeting and conferring or negotiating with the UAPD regarding any proposal that may be developed or any other subject that is addressed in the Stipulated Order – create any direct or irreconcilable conflict with the UAPD's state law bargaining rights. Third, the CDC asserts that it did not intend the Stipulated Order to discharge or release it from any of its state law bargaining obligations. [Citation omitted.] The plaintiffs concur in this interpretation.

In addition, Judge Henderson expressly noted that Dills Act claims are appropriately resolved by PERB:

> While it is proper for this Court to address the UAPD's contention that that Stipulated Order itself violates state law, the UAPD's claim that the CDC is committing an unfair labor practice by failing to satisfy its negotiation or meet and confer obligations with respect to the Stipulated Order – under either state labor laws governing California public employees or its contract with UAPD – must be raised before the California Public Employees [sic] Relations Board ("PERB") – *not* this court.
> . . . . . .

> Notably, the UAPD has filed an unfair labor practice claim before PERB, and that is the proper forum for resolution of this issue. Accordingly, the Court declines to be drawn into any disputes between the UAPD and the CDC concerning whether the CDC has violated any state laws governing public employee bargaining (or its contract with the UAPD) in the course of implementing the Stipulated Order. Modification of the Stipulated Order is simply not an appropriate vehicle for addressing such issues.

Based on Judge Henderson's rulings, I conclude that the Plata case presents no bar to PERB adjudicating the Dills Act claims advanced here by UAPD.

The Unilateral Change

It is well established that a pre-impasse unilateral change in a matter within the scope of representation violates the duty to meet and negotiate in good faith. (San Mateo County Community College District (1979) PERB Decision No. 94 (San Mateo); NLRB v. Katz (1962) 369 U.S. 736 [50 LRRM 2177].) Unilateral changes are inherently destructive of employee rights and are a per se failure of the duty to negotiate in good faith. (San Mateo; Davis Unified School District, et al. (1980) PERB Decision No. 116.)

To prevail on a complaint of unilateral change, UAPD must establish by a preponderance of the evidence that (1) CDCR implemented a change in practice, policy or terms of an agreement; (2) the action was taken without giving UAPD notice or an opportunity to bargain; (3) the action was not merely an isolated incident, but amounted to a change that had a generalized effect or continuing impact on terms and conditions of employment; and (4) the change concerned a matter within the scope of representation. (Grant, at pp. 9-10.)

It is clear that CDCR added a new component to the existing performance appraisal system under the MOU and established practice. Prior to September 2004, physicians were evaluated in three ways. First, they received annual performance appraisals under section 12.5 of the MOU in quality of work, analyzing situations, meeting work commitments, and other related areas. Second, physicians were evaluated by the organized medical staff under a

"directed" or "non-directed" peer review process under section 16.2 of the MOU. Third, CDCR investigated the performance of physicians on an ad hoc basis, using peer review, administrative protocols, and referrals to the California Medical Board. While these provisions remained in effect as part of the MOU and practice, CDCR added an entirely new aspect to the process when it implemented QICM.

QICM was a departure from the MOU and the established practice. QICM is an independent entity which has authority to evaluate physicians for competency. Unlike the MOU, the QICM evaluation consists of two phases and a chart review. Phase 1A is a two-day assessment using a variety of methods, including written, oral, and standardized computer based examinations. It provides an overall picture of medical and communications skills, knowledge, and professionalism. At the conclusion of Phase 1A, the physician is assigned to one of the three categories set out in the Patient Care Order. A physician who fails Phase 1A may be categorized as not competent to provide care to patients.

Phase 1B is a one-day assessment whereby QICM staff observes physicians diagnosing and managing simulated patients with scripted conditions relevant to the physician's normal scope of practice. At the end of Phase 1B, physicians are again placed in one of the three categories in the Patient Care Order. Physicians who are placed in category three are subject to "intensive chart review" for 25 inmate-patients over a 12 month period and given the opportunity to attend a five day remedial training program at UCSD.

The Due Process Policy established the PPEC, a peer review body made up of three physicians, a dentist, a psychiatrist, a psychologist, and a physician-chairperson. The PPEC is responsible for managing the peer review process for routine reviews and for those required for discipline. The PPEC makes findings and recommendations to CDCR, including revocation of privileges, further monitoring and evaluation, or suspension/limitation of clinical privileges.

The policy also provides that the PPEC "shall recommend the revocation or denial of clinical privileges of a practitioner identified as Category 3 as a result of the QICM peer review process.

QICM had a generalized effect and a continuing impact on terms and conditions of employment. QICM has wide application in that it impacts a large number of bargaining unit employees because it requires them to undergo a competency evaluation unlike the system in the MOU or practice. A physician who fails the QICM test may face revocation of clinical privileges and be reported to the California Medical Board.

It is not disputed that the State refused to negotiate about the decision to implement QICM. On September 10, 2004, CDCR and plaintiffs in the Plata case entered into a stipulated agreement to engage an independent entity to evaluate physicians for competency, and Judge Henderson signed the agreement one week later. Kanan gave Robinson notice of the agreement in general and PACE in particular on September 16. On September 17, 2004, CDCR informed Robinson that it anticipated implementing the Patient Care Order in about 30 days.

The parties began negotiations on October 7, 2004. Several sessions were held between October and April 29, 2005. While the parties were negotiating, CDCR and UCSD were deciding to implement QICM. They reached an agreement on January 31, 2005, and in late February Navarro sent Robinson the actual policies and procedures.

At a March 4, 2005, negotiating session, Navarro made it clear that CDCR did not intend to negotiate about the decision to select the independent entity: "it was not the state's position that we were going to negotiate who the Department identified as the entity to evaluate or train the doctors. That had already been done . . . . as a management decision." Navarro said the State would negotiate only the effects of the decision.

Despite Robinson's objection to QICM and questions about the program, he said DPA took the position that "not a single word [of QICM] can be changed. This is the way the test is. Nothing will be changed." He said DPA would negotiate only "around the fringes" of the policy, but topics such as "who the evaluator would be and what the evaluation would be was not negotiated." After several meetings, the positions of the parties remained unchanged.

Bargaining over effects ended in late April or May, and PERB declared an impasse at Navarro's request. An unsuccessful mediation session was held in early June and CDCR began to send out evaluation notices to doctors on or about June 5. The parties' agreement on effects was memorialized in an addendum to the MOU dated June 9, 2005, but no decision-bargaining took place.

The main issue here is whether the decision to adopt QICM is a negotiable matter or a fundamental management right. UAPD argues that the decision falls within the scope of representation, and the MOU is evidence that CDCR has already negotiated with UAPD about evaluations in general, the criteria for evaluations, and the persons who perform the evaluation. CDCR's unilateral adoption of the QICM policy to evaluate the competence of physicians was a departure from the MOU and established an entirely new system to accomplish this task.

In response, CDCR argues that the decision to adopt the QICM program does not fall under the scope of representation. The State argues that the steps CDCR takes to provide health care for inmates may involve wages, hours or other terms of employment, but nevertheless implicate fundamental managerial prerogatives and thus are outside the scope of representation. The State asserts that California courts have for decades recognized that some decisions are so fundamental to the government's role in providing services to the public that the decision should not be placed on the bargaining table.

Section 3516 provides:

> The scope of representation shall be limited to wages, hours, and other terms and conditions of employment, except, however, that the scope of representation shall not include consideration of the merits, necessity, or organization of any service or activity provided by law or executive order.

At the outset, it is instructive to review the cases relied on by the parties in support of their respective positions.

The phrase "wages, hours, and other terms and conditions of employment," construed broadly, "could encompass practically any conceivable bargaining proposal;" and the phrase "merits, necessity, or organization of any service or activity provided by law or executive order," broadly construed, "could swallow the whole provision for collective negotiations and relegate determination of all labor issues to the city's discretion." (Firefighters Union v. City of Vallejo (1974) 12 Cal.3d 608, 615 [116 Cal.Rptr. 507] (City of Vallejo).) In applying these overlapping phrases, the court observed that "apparently the Legislature included the limiting language not to restrict bargaining on matters directly affecting employees' legitimate interests in wages, hours and working conditions but rather to forestall any expansion of the language of 'wages, hours and working conditions' to include the more general managerial policy decisions." (Id., at p. 616.)

In City of Vallejo, a union of firefighters proposed negotiations about a manning procedure. The union claimed that its manpower proposal was not directed at general fire prevention policy; rather, the union claimed it involved a matter of workload and safety of employees, both negotiable subjects. The city claimed that the proposal involved a matter of fire prevention policy, and, as such, was a managerial prerogative. The court observed that if the relevant evidence demonstrated the union's manpower proposal was directed at maintaining a particular standard of fire prevention, as opposed to workload and employee safety, the city's position would be well taken. (Id., at p. 619.) However, the court did not

resolve the question. The court remanded the matter to arbitration to establish a factual record on which to base a decision. "The nature of the evidence presented to the arbitrators should largely disclose whether the manpower issue primarily involves the workload and safety of the men ('wages, hours and working conditions') or the policy of fire prevention of the city ('merits, necessity or organization of any government service'). On the basis of such a record, the arbitrators can properly determine in the first instance whether or not, and to what extent, the present manpower proposal is arbitrable." (Id., at pp. 620-621)

In Building Material and Construction Teamsters Union, Local 216 v. Farrell (1986) 41 Cal.3d 651 [224 Cal.Rptr. 688] (Building Material), the issue was whether elimination of two positions and creation of new positions in a separate bargaining unit involved negotiable topics, or a managerial prerogative. The court observed that "even when the action of an employer has a significant and adverse effect on the wages, hours, or working conditions of the bargaining unit employees, the employer may yet be excepted from the duty to bargain under the 'merits, necessity, or organization'" limitation. "If the action is taken pursuant to a fundamental managerial or policy decision, it is within the scope of representation only if the employer's need for unencumbered decisionmaking in managing its operations is outweighed by the benefit to employer-employee relations of bargaining about the action in question." (Id., at p. 660) When decisions directly affect the "quality and nature of public services" the "burden of requiring an employer to meet and confer about such fundamental decisions clearly outweighs the benefits to employer-employee relations that bargaining would provide." (Id., at p. 664) Finding the decision "to reorganize certain work hours" negotiable, the court concluded it was hardly "fundamental" and had "little, if any, effect on public services." Rather, "it primarily impacted the wages, hours, and working conditions of the employees in question and thus was a proper subject for mandatory collective bargaining." (Id.)

Courts of appeal have taken a similar approach. In Berkeley Peace Officers Assn. v. City of Berkeley (1977) 76 Cal.App.3d 931 [143 Cal.Rptr. 255] (City of Berkeley), the proposal involved a city's decision to (1) allow a member of the police commission to attend hearings conducted by the police department to investigate complaints of officer misconduct, and (2) send a representative to commission trial board meetings to answer questions of commission members concerning the department's position on individual complaints. The decision was consistent with an existing regulation and therefore did not constitute a change in working conditions. Applying City of Vallejo, the court found the decision not negotiable because it involved "a matter of police-community relations" and a "fundamental policy decision." (City of Berkeley, at p. 937)

In San Jose Peace Officers Assn. v. City of San Jose (1978) 78 Cal.App.3d 935 [144 Cal.Rptr. 638] (City of San Jose) a union of police officers attempted to negotiate about the city's use of force policy governing when a peace officer may discharge his firearm. In concluding the decision to implement the policy was not within the scope of representation, the court recognized that the safety of police officers is clearly a negotiable term or condition of employment, but the danger posed to a police officer by a suspected criminal must be balanced against difficult considerations of when an escaping criminal should pay the price of death for ignoring a peace officer's command to stop. Viewed in this context, the court concluded, "the safety of the policeman, as important as it is, is so inextricably interwoven with important policy considerations relating to the basic concept of the entire system of criminal justice that we cannot say that the use of force policy concerns 'primarily' a matter of wages, hours or working conditions." (City of San Jose, at p. 946.)

In Holliday v. City of Modesto (1991) 229 Cal.App.3d 528 [280 Cal.Rptr. 206] (City of Modesto), the court determined a decision to implement a drug testing policy fell within the

scope of representation. The appellate court found significant the lack of evidence at the trial court level concerning the purpose the city sought to accomplish by ordering the drug testing. Although public safety was one of the concerns in ordering the drug test, the city offered no evidence that public safety was its primary consideration. "Because of the fundamental differences between the use of force policy reviewed in [City of San Jose] and the drug-test order involved here, and because of the absence of evidence showing that respondents' primary purpose was protection of public safety, we cannot apply [City of San Jose] in this case." (City of Modesto, at p. 539.) Accordingly, the court found the drug testing policy negotiable.

The most recent California Supreme Court case to address the scope of representation in the public sector is Claremont Police Officers Association v. City of Claremont et al. (2006) ___ Cal.4th ___ [47 Cal.Rptr.3d 69] (Claremont).) A lower appellate court held that a city's decision to take measures to combat the practice of racial profiling was a fundamental policy decision that directly affects the police department's mission to protect and serve the public and thus was not negotiable. However, the lower court held that implementation of the policy was not itself a fundamental policy decision and thus was negotiable. The issue before the Supreme Court was whether the effects of the decision to implement a racial profiling policy were negotiable. Reversing the appellate court, the Supreme Court applied a three-part test to determine if the effects of the racial profiling policy was a matter within the scope of representation or a managerial prerogative.

> First, we ask whether the management action has "a significant and adverse effect on the wages, hours, or working conditions of the bargaining-unit employees." [Citation omitted.] If not, there is no duty to meet and confer. [Citation omitted.] Second, we ask whether the significant and adverse effect arises from the implementation of a fundamental managerial or policy decision. If not, then as in Building Material, the meet-and-confer requirement applies. [Citation omitted.] Third, if both factors are present – if an action taken to implement a fundamental managerial or policy decision has a significant and adverse effect

> on the wages, hours, or working conditions of the employees – we apply a balancing test. The action "is within the scope of representation only if the employer's need for unencumbered decision-making in managing its operations is outweighed by the benefit to employer-employee relations of bargaining about the action in question." (Building Materials, supra, 41 Cal.3d at p. 660.) In balancing the interests to determine whether parties must meet and confer over a certain matter [Citation omitted.], a court may also consider whether the "transactional cost of the bargaining process outweighs its value." [Citation omitted.] (Claremont, 47 Cal.Rptr.3d at p. 80.)

The court concluded that the city had no duty to negotiate before implementing the policy because the evidence did not establish that employees suffered any significant or adverse effect. Thus, the court found no need to balance the city's need for unencumbered decision-making against the benefit to be derived from collective bargaining.

In deciding whether a subject is negotiable or a management prerogative, PERB has adopted an approach similar to that in Claremont and the cases cited above. In Anaheim Union High School District (1981) PERB Decision No. 177 (Anaheim), the Board held that a subject not expressly stated as within the scope of representation is negotiable if (1) it is logically and reasonably related to wages, hours, or employment conditions; (2) the subject is of such concern to both management and employees that conflict is likely to occur and the mediatory influence of collective bargaining is an appropriate means of resolving the conflict; and (3) the employer's obligation to negotiate would not significantly abridge its freedom to exercise those managerial prerogatives essential to the achievement of its mission. (Id., at pp. 4-5.) .

Applying Anaheim, PERB has on two occasions held that the criteria and procedures for evaluating competency of employees, under normal circumstances, is a negotiable topic. In Holtville Unified School District (1982) PERB Decision No. 250 (Holtville), a teachers' union requested negotiations about a mandatory retirement policy that involved evaluating the competency of teachers over the age of 70. Under the policy, three district-appointed

educators would conduct the evaluations. The Board held that the subject was of concern to both management and employees and likely to create conflict "because of its profound effect on a most fundamental aspect of employer-employee relations – termination of employment," and the process of collective bargaining is a viable means of resolving such disputes since it "furthers the statutory objective of bringing a matter of mutual vital concern within the framework of peaceful, private resolution and provides employees with the opportunity to dissuade the employer or offer alternatives to the employer's chosen course of action." (Id., at p. 7)

> Because of the pervasive impact of compelled retirement on the subjects enumerated in section 3543.2 [of the Educational Employment Relations Act], we cannot limit negotiation of such a policy to the procedures to be employed in determining whether aged employees are to be retained or terminated.[15] To so limit bargaining is to give management virtually unlimited and total control over this fundamental employment relationship which the Legislature intended to be subject to the collective negotiation scheme. Without the opportunity to negotiate the standards for compelled retirement, the employee would be limited to little more than deciding through which door he or she must exit. (Id., at p. 9.)

Thus, the Board found that negotiations would not interfere with a management prerogative and the achievement of its mission. (Id., at pp. 8-9.)

In Walnut Valley Unified School District (1983) PERB Decision No. 289 (Walnut Valley), a school district unilaterally adopted an evaluation policy governing the issuance of certificates of competence to certificated employees over the age of 65. The policy included

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[15] Section 3543.2(a) of the Educational Employment Relations Act (EERA) provides:

> The scope of representation shall be limited to matters relating to wages, hours of employment, and other terms and conditions of employment. "Terms and conditions of employment" mean health and welfare benefits as defined by Section 53200, leave, transfer and reassignment policies, safety conditions of employment, class size, *procedures* to be used for the evaluation of employees . . . .

six criteria for determining competency: capabilities; effectiveness; classroom management and control; professionalism; planning and preparation; and mental and physical health. The policy also included the procedure to be followed, including a requirement that an employee request continued employment, a physical and/or psychological examination, final determination by the superintendent and the school board, and timelines to complete the procedure. (Id., at pp. 5-6.) Following its reasoning in Holtville, the Board held negotiable the

> . . . . criteria for determining competency to continue employment because they establish the areas the District will evaluate. As such they are negotiable because they relate to wages, hours and terms and conditions of employment. This matter is of such concern to both the employees and the employer that conflict is likely to occur for it touches the most fundamental aspect of the employment relationship, its continuity. The mediatory influence of collective negotiations would help to assure that all concerned have the opportunity to discuss a matter of mutual interest within the framework of peaceful, private resolution. Finally, the evidence does not indicate that these [criteria] are issues of fundamental policy which would significantly abridge the employer's freedom to manage the enterprise or achieve its mission. We conclude, therefore, that Policy No. 6460 in its entirety, including both the procedure and the criteria to be employed in evaluating the competency of employees over 65 to continue employment was negotiable. (Id., at p. 9.).

UAPD argues that Holtville and Walnut Valley squarely hold that competency evaluations are negotiable and thus are controlling here. The State would distinguish these cases. It argues that the school district in Holtville presented no business reasons to establish that teachers aged 70 or older, as a class, were incompetent or otherwise unfit for continued employment. (Holtville, at pp. 8-9.) Hence, the district faced no immediate threat to its right to manage its operation. The same was true in Walnut Valley. There was no evidence that the criteria to evaluate competency of teachers interfered with the district's right to manage its operation or achieve its mission. (Walnut Valley, at p. 9.) Therefore, the State argues, these cases stand only for the proposition that, under normal circumstances, the decision to

implement procedures and criteria to evaluate the competency of employees are negotiable. The difference between the evidence in this case and the evidence in those cases, the State reasons, distinguishes them from this case and should lead to a different conclusion. I agree.

As the cases drawing the line between the scope of representation and managerial prerogative make clear, courts and the Board balance the benefit of negotiations against an employer's right to make fundamental policy decisions on a case-by-case basis, considering the precise factual context in which a union proposal or a management decision is made. Following the same approach, I find that the evidence plays a key role here, for the context in which this dispute arose is extraordinary.

A summary of the conditions identified by the experts is necessary to balance the competing rights recognized in section 3516. The experts' July 16, 2004, report indicated there was an "emerging pattern of inadequate and seriously deficient physician quality in [CDCR] facilities." The report severely criticized CDCR's credentialing process and the basic qualifications of its physicians. The report said it was "extremely difficult" under the existing structure to "weed out poor quality physicians." Physicians were treating patients outside their field of training, and potentially life threatening mistakes were being made. At one facility, the experts found some physicians had problems such as mental health disorders, and some physicians lost privileges due to substance abuse or incompetence. The criticism was not limited to Unit 16 employees. Because of a serious lack of qualified supervisory physicians, the peer review process was not working and mistakes in patient care were not corrected.

Goldenson corroborated these findings in his testimony. He credibly testified that the experts "found a system that was totally broken in almost every aspect," "numerous episodes" where medical care was "substandard," physicians in the peer process "who weren't competent," and deaths had occurred as a result of the substandard care. The experts also

found 300 cases where death reviews were not performed, a significant number reflected "pretty egregious" mistakes, and "a significant number of the deaths from the information we had received would have been preventable," Goldenson said. He testified the situation was worse than the experts initially thought.

CDCR's selection of QICM to address the problem was dictated by the extraordinary circumstances presented here. Granted, the experts did not select QICM as the independent entity, and they were not familiar with the program initially. After a visit to UCSD in August 2004, however, they were "extremely impressed," and thought it would be an "excellent evaluation tool," Goldenson testified. According to Goldenson, the experts formed the opinion that "PACE was the only program of its sort that evaluated the competency of physicians in California. And that it was the most comprehensive program of its type in the country."

Goldenson could not recall any discussion about whether it was the only alternative, and he said there are ways such an evaluation could have been done "in other settings." However, the

> . . . . feeling was that in CDC, because of the scale of the problem and the lack of supervisory staff as we talked about, in terms of the chief Medical Officers and the Chief Physicians, that ways that it would work in other systems where you had that kind of supervision above the physicians wouldn't work here.
> So that things like Peer Review and depending on someone's supervisor to make sure that they do a good job, you know, which could work somewhere else and works, for example, in my system, wouldn't work here.

Goldenson credibly testified the current system of evaluation had failed, it lacked competent people to perform appraisals, "physicians who really shouldn't be practicing were still practicing," and "PACE was the quickest way" to prevent "as many of the further deaths that are preventable as possible." Because of the magnitude of the problem, approaches that may

have worked in other settings simply would not work in CDCR. During his testimony during the Order to Show Cause hearing in June 2005, Goldenson reiterated his opinion.

> I'm extremely concerned that in a number of the cases that I have looked at that people have been dying unnecessarily, that their deaths could have been prevented. So that the question here is a lot bigger than just saying whether it's a constitutional system in terms of providing constitutional health care, because I've seen systems where constitutional health care is the issue, but people aren't dying in the numbers they are dying in the [California] system in terms of preventable deaths.

Judge Henderson shared a similar view. In his May 10, 2005, Order to Show Cause, he pointed out that "defendants themselves have conceded that a significant number of prisoners have died as a direct result of this lack of care, and it is clear to the Court that more are sure to suffer and die if the system is not immediately overhauled." In his order appointing a receiver after the hearings, Judge Henderson concluded that the situation had not changed.

> By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action. The Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system.

It is against this background that the parties' rights must be weighed.

As the court observed in Building Trades, "even when the action of an employer has a significant and adverse effect on the wages, hours, or working conditions of the bargaining unit employees, the employer may yet be excepted from the duty to bargain under the 'merits, necessity, or organization'" limitation. "If the action is taken pursuant to a fundamental managerial or policy decision, it is within the scope of representation only if the employer's need for unencumbered decision-making in managing its operations is outweighed by the

benefit to employer-employee relations of bargaining about the action in question." (Building Trades, at p. 660) When decisions directly affect the "quality and nature of public services" the "burden of requiring an employer to meet and confer about such fundamental decisions clearly outweighs the benefits to employer-employee relations that bargaining would provide." (Building Trades, at p. 664)

Although the decision to implement QICM impacted wages, hours and employment conditions of Unit 16 physicians, the decision was not made primarily to alter these matters. Unlike the decision to eliminate positions in a bargaining unit and create new positions an a separate bargaining unit in Building Trades, the primary purpose of the decision to implement QICM involved a fundamental policy matter related to "the quality and nature of public service." (Building Trades, at p. 664.) The primary purpose of the decision was to weed out incompetent physicians and bring health care in the prisons to a constitutionally acceptable level. As in City of San Jose, negotiable terms and conditions of employment may have been "inextricably interwoven" with the decision to implement QICM, but the decision was made primarily to address the substandard health care delivered to inmates. Nor is this case like City of Modesto, where a court found the decision to implement a drug testing policy negotiable because the record lacked evidence that the purpose of the testing was primarily to protect public safety. The evidence in this matter clearly shows that the primary purpose of the decision to implement QICM was to establish constitutionally acceptable health care in the prisons.

In addition, the record in this case stands in stark contrast to the records in Holtville and Walnut Valley. In Holtville, the Board recognized that there was no evidence that teachers over the age of 70, as a class, were incompetent or otherwise unfit for duty, and in Walnut Valley the Board pointed out that there was no evidence that the criteria to evaluate involved a

fundamental policy which would significantly abridge the district's freedom to manage the enterprise or achieve its mission. In applying the Anaheim balancing test in those cases, the Board was not faced with evidence that incompetent teachers actually had undermined the educational process on a large scale, or that even a single student had suffered in any way. In contrast, the overwhelming evidence here is that the level of health care for inmates had fallen below constitutionally acceptable standards, and inmate deaths had occurred as a result. Moreover, unlike Holtville and Walnut Valley, this case does not involve a single institution; rather, it involves an attempt to remedy a deficiency in a public service throughout a huge statewide correctional health care system. The marked difference between the record evidence here and the records in Holtville and Walnut Valley distinguishes this case from those cases and leads to a different conclusion under the Anaheim balancing test.

Lastly, it is noteworthy that the serious lack of qualified supervisory physicians in CDCR rendered existing rating systems such as the performance appraisal and peer review processes inadequate to realistically address a crisis of this magnitude in the conventional way. Goldenson confirmed in his testimony that an evaluation of physician competency could have been made "in other settings," but because the "scale of the problem and the lack of supervisory staff . . . . in terms of the chief Medical Officers and the Chief Physicians, that ways that it would work in other systems where you had that kind of supervision above the physicians wouldn't work here." In terms of alternatives, Goldenson, the other experts, and Judge Henderson thought QICM was an excellent idea. And the experts formed the opinion that QICM was the only program of its kind in California and the country to evaluate physicians on the scale needed in CDCR. Plainly, the options available to address the health care crisis in a meaningful fashion were limited.

Therefore, I conclude the decision to implement the QICM program primarily involved the need to provide constitutionally acceptable health care and prevent inmate deaths. The decision may impact wages, hours and other terms and conditions of employment, but the decision was made primarily to implement a fundamental policy decision related to the quality and nature of essential public services. Under the tests articulated by the Board in Anaheim and by the courts in a line of cases beginning with City of Vallejo, when the right of CDCR to manage its operations and achieve its mission by providing constitutionally required health care for inmates in the California prison system is balanced against the benefits to be achieved under the duty to bargain the decision with UAPD, the balance tips in favor of CDCR.[16] Accordingly, I find CDCR had no duty to negotiate about the decision to implement QICM.

PROPOSED ORDER

Based on the foregoing findings of fact, conclusions of law and the entire record in this case, the complaint and underlying unfair practice charge in Case No. SF-CE-228-S, Union of American Physicians and Dentists v. State of California (Department of Corrections and Rehabilitation) are hereby dismissed.

Pursuant to California Code of Regulations, title 8, section 32305, this Proposed Decision and Order shall become final unless a party files a statement of exceptions with the Public Employment Relations Board (PERB or Board) itself within 20 days of service of this Decision. The Board's address is:

Public Employment Relations Board
Attention: Appeals Assistant
1031 18th Street
Sacramento, CA 95814-4174
(916) 322-8231
FAX: (916) 327-7960

[16] Given these conclusions, it is unnecessary to address CDCR's waiver and business necessity defenses.

In accordance with PERB regulations, the statement of exceptions should identify by page citation or exhibit number the portions of the record, if any, relied upon for such exceptions. (Cal. Code Regs., tit. 8, sec. 32300.)

A document is considered "filed" when actually received during a regular PERB business day. (Cal. Code Regs., tit. 8, secs. 32135(a) and 32130; Gov. Code sec. 11020(a).) A document is also considered "filed" when received by facsimile transmission before the close of business together with a Facsimile Transmission Cover Sheet which meets the requirements of California Code of Regulations, title 8, section 32135(d), provided the filing party also places the original, together with the required number of copies and proof of service, in the U.S. mail. (Cal. Code Regs., tit. 8, sec. 32135(b), (c) and (d); see also Cal. Code Regs., tit. 8, secs. 32090 and 32130.)

Any statement of exceptions and supporting brief must be served concurrently with its filing upon each party to this proceeding. Proof of service shall accompany each copy served on a party or filed with the Board itself. (See Cal. Code Regs., tit. 8, secs. 32300, 32305, 32140, and 32135(c).)

Fred D'Orazio
Administrative Law Judge