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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

COUNTY OF LOS ANGELES, DEPARTMENT OF HEALTH SERVICES,
Petitioner and Appellant,
v.
CIVIL SERVICE COMMISSION OF THE COUNTY OF LOS ANGELES,
Respondent.
ZVI OSTERWEIL, M.D.,
Real Party in Interest.

B163879

(Los Angeles County Super. Ct. No. BS073295 Consolidated with Los Angeles County Super. Ct. No. BS073313)

ZVI OSTERWEIL, M.D.,
Petitioner and Appellant,
v.
CIVIL SERVICE COMMISSION OF THE COUNTY OF LOS ANGELES,
Respondent.

COUNTY OF LOS ANGELES, DEPARTMENT OF HEALTH SERVICES,
Real Party in Interest.

B165174

APPEAL from judgments of the Superior Court of Los Angeles County. Dzintra Janavs, Judge. Affirmed.

Hausman & Sosa, Jeffrey M. Hausman, Larry D. Stratton and Vincent C. McGowan for Petitioner and Appellant, County of Los Angeles, Department of Health Services.

Whitwell Jacoby Emhoff, Ben D. Whitwell and Brian M. Colligan for Petitioner and Appellant, Zvi Osterweil, M.D.

No appearance by the Los Angeles County Civil Service Commission.

A public medical center discharged a doctor less than a month before he would have otherwise completed his five-year residency. The doctor sought review of the discharge decision. The hearing officer issued his report at the conclusion of a lengthy evidentiary hearing. The hearing officer found the medical center had failed to prove the allegations of misconduct and concluded discipline was therefore inappropriate. The medical center filed objections to the hearing officer's report with the Los Angeles County Civil Service Commission (Commission). The medical center claimed the hearing officer's findings of fact and conclusions of law were fatally flawed because they ignored all evidence supporting the discharge in this case. The medical center also claimed the hearing officer was biased in favor of the doctor as evidenced by his comments during the hearing. At the medical center's urging, the Commission agreed to review the entire record before issuing its final ruling. After reviewing the record, the Commission upheld the hearing officer's findings of fact. However, it disagreed with the hearing officer's recommendation of no discipline and imposed a 15-day suspension instead.

The medical center filed a petition for writ of mandate in the trial court to vacate the Commission's decision and to enter a new and different order directing the doctor be discharged. In urging reversal, the medical center argued the evidence did not support the hearing officer's findings of fact. In addition, the medical center asserted it had just discovered the hearing officer was a founding partner in the law firm whose long-term client was the union which represented the doctor at the evidentiary hearing, and whose firm now represented the doctor in the trial court. The medical center argued this new evidence cast further doubt on the hearing officer's impartiality and constituted sufficient evidence of bias to at least warrant a new hearing before a different hearing officer.

The doctor also filed a petition for writ of mandate seeking to overturn the 15-day suspension.

The trial court denied both petitions for writ of mandate. We affirm.

FACTS AND PROCEEDINGS BELOW

Appellant Zvi Osterweil was a physician in the Los Angeles County/University of Southern California Medical Center (LAC+USC) department of otolaryngology residency training program. Otolaryngology involves treatment and surgery of the head and neck region, particularly involving the ear, nose and throat. For this reason the medical specialty is often referred to as ENT (for ear, nose and throat). Residency programs provide medical school graduates with hands-on training in medical and surgical management of patients. Residents in the department of otolaryngology obtain this training by treating patients in a medical clinic, and when appropriate, by performing surgery. Otolaryngology residents are required to perform a minimum number of surgical procedures as a prerequisite to becoming board certified. Residents generally satisfy these minimum requirements in their fourth year and are then encouraged to pursue surgeries in their desired medical specialty during their fifth year of the residency program.

Dr. Osterweil began the five-year otolaryngology residency program at LAC+USC in 1995 after completing medical school at Cornell University.

Dr. Dale S. Rice was the chair of the department of otolaryngology at LAC+USC and the residency training director for 17 years. He was responsible for supervising all residents in the department.

Dr. Rice placed Dr. Osterweil on probation for eight months in the third year of his residency. Dr. Rice took this action because he had “significant” concerns about Dr. Osterweil’s “thoroughness in evaluating patients” and his “appropriateness in seeking consultation from more senior residents or faculty.” Thereafter, Dr. Osterweil received quarterly performance evaluations which ranged from “good” to “excellent.” By the fourth year of his residency Dr. Osterweil had satisfied all surgical requirements and in fact had performed more surgical procedures than any other resident, and considerably more rhinoplasties than any other resident. In his final evaluation, Dr. Rice rated Dr. Osterweil’s performance “excellent.”

LAC+USC is a public hospital owned and operated by Los Angeles County. It is located in the City of Los Angeles and primarily serves the East Los Angeles, San Gabriel Valley and surrounding areas. Almost half of LAC+USC's patients are indigent and/or without medical insurance. Thus, LAC+USC's primary mission is to provide accessible and affordable health care to those in need.

In April 2000, two incidents occurred which alerted officials at LAC+USC to irregularities in the way in which Dr. Osterweil handled the scheduling and characterization of surgeries he was performing at the hospital.

<u>PATIENT 7</u>:

According to Dr. Osterweil, patient 7 called him in September 1999 and expressed interest in having nasal reconstruction and a face-lift. He gave the patient a clinic appointment for February 2000, and logged the patient's name, telephone number, and requested procedures in his personal palm pilot. Dr. Osterweil examined patient 7 at the clinic in February 2000. Accompanying patient 7 was her husband, her sister and daughter. Dr. Osterweil wrote in his examination notes patient 7 had a traumatic nasal deformity and mild signs of an aging face. Patient 7's husband objected to the idea of his wife having a face-lift. Accordingly, Dr. Osterweil only reviewed, and patient 7 only signed, a consent form for a septorhinoplasty and not for a rhytidectomy, or face-lift.

Dr. Osterweil prepared the outpatient nonadmission request form in preparation for the proposed surgery. This form required Dr. Osterweil to list and classify proposed procedures. The form provided him with three options to describe the proposed surgery: (1) cosmetic; (2) non-cosmetic; or (3) cosmetic with a medical problem. Dr. Osterweil wrote on the form the procedure he intended to perform on patient 7 was "non-cosmetic."

This notation was significant because it informed personnel in LAC+USC's financial office whom to bill for the procedure. If a patient has insurance coverage for a particular procedure the financial office bills the insurer. If the patient lacks private health insurance and is MediCal qualified, the financial office bills MediCal as the third-party payor. If the procedure is designated as purely cosmetic, and thus one which is

generally not covered by either insurance or MediCal, then the patient must pay in full before the surgery.

In late March Dr. Osterweil learned a proposed surgery had been cancelled for April 3, 2000. He scanned his palm pilot for a case which could utilize the reserved operating room time. He found patient 7 which listed her initially requested procedures for nasal surgery and a face-lift. He telephoned patient 7 at home. Patient 7 did not speak English very well. Using her 12 or 13 year-old daughter to interpret, Dr. Osterweil inquired whether patient 7 was still interested in a face-lift.

Dr. Osterweil listed both procedures in the surgery schedule for the day and listed the various instruments he needed to perform both the septorhinoplasty and rhytidectomy, or face-lift. However, the doctor apparently did not make his plans clear with the circulating nurse and did not prepare new paperwork to include the face-lift procedure. The consent form the nurse reviewed with patient 7 before the surgery only addressed the nasal surgery. The nurse was thus very surprised when she saw Dr. Osterweil make an incision in patient 7's cheek.

Patient 7's family members were at LAC+USC during the surgery. When several hours had elapsed without news of patient 7's condition they demanded to see her and/or speak to the doctor. A nurse informed them the doctor would speak to them after the surgery. When several more hours elapsed without response, patient 7's sister became very upset and threatened to contact the state medical board. Patient 7's sister then called the operating room. The nurse who answered the phone indicated the sister was very upset. Dr. Osterweil stopped the surgery to talk to the sister. The sister insisted he stop the surgery because patient 7 had never consented to a face-lift. Dr. Osterweil told the sister she was incorrect and patient 7 had in fact consented to a face-lift. Dr. Osterweil stated he needed to complete the procedure and promised to speak with her personally when he finished the surgery.

When Dr. Osterweil finally completed both procedures he reviewed patient 7's chart and saw patient 7 had not signed a consent for the face-lift. He saw patient 7 in the recovery room and asked her whether she really wanted the face-lift. He saw her again several minutes later after the effects of some of the anesthesia had worn off and again inquired whether she really wanted the face-lift. According to Dr. Osterweil, patient 7 confirmed she wanted the face-lift all along.

The next morning Dr. Osterweil called his supervisor, Dr. Rice, and explained how he had failed to secure written consent for the face-lift procedure on patient 7. Although Dr. Rice acknowledged the lack of written consent was a mistake, Dr. Rice was empathetic and apparently told Dr. Osterweil even experienced surgeons sometimes made the same mistake. He did not discipline Dr. Osterweil.

Meanwhile a nurse wrote up an incident report and the director of nursing contacted Dr. Stephanie Qualls, the associate executive medical director for quality management and risk assessment, to inform her about the incident with patient 7. Dr. Qualls spoke to Dr. Osterweil. Dr. Osterweil explained the circumstances surrounding the face-lift and admitted it was in fact an elective cosmetic procedure. He expressed great remorse about his mistake in failing to ensure the patient had signed a consent form before the surgery.

During their conversation, Dr. Qualls explained to Dr. Osterweil it was inappropriate to use a minor child to interpret a discussion about a proposed surgical procedure. Dr. Qualls told Dr. Osterweil his failure to document an informed consent discussion with patient 7 was substandard, as was his failure to update the consent form when he modified the proposed procedures. Dr. Qualls counseled the doctor and advised him to be extremely cautious in documenting patient consents to surgery, explaining it was an ethical responsibility as well as a legal requirement. Dr. Qualls explained he could be charged with battery, he could be sued for malpractice, and risked being reported to the medical board. She explained the failure to document a patient's informed consent also exposed LAC+USC as well as the county to liability as his

employer.[1] Dr. Qualls informed Dr. Osterweil the matter was so serious she was referring the incident to peer review.

Another incident involving informed consent occurred approximately three weeks later on April 26, 2000.

PATIENT 8:

Patient 8 was then 17 and thus a minor. She had sinus problems which had been unsuccessfully treated with various medications. She had a scheduled septorhinoplasty with Dr. Osterweil. She came to the clinic for pre-op work involving the drawing of blood, an EKG and other tests. She arrived alone at the clinic and the pre-op staff refused to proceed in the absence of a parent and without a current written consent from her parent. Patient 8 found Dr. Osterweil and informed him the pre-op staff would not conduct the tests because her mother was not present to sign a consent form. Patient 8 explained her mother had to work and could not come with her. Dr. Osterweil wrote a note on a prescription pad stating he would assume full responsibility. A nurse called Bonnie Bilitch, administrator of the outpatient department at LAC+USC.

Ms. Bilitch spoke to Dr. Osterweil and explained he could not assume responsibility for the patient nor consent for the patient because he was neither her parent nor legal guardian. In response, Dr. Osterweil stated the patient's mother signed a consent for the surgery and had also signed a general consent for routine matters, such as drawing blood. Ms. Bilitch secured the patient's file. It contained a general consent signed by patient 8's mother several months earlier. However, LAC+USC apparently has an unwritten policy requiring consents be signed at each visit. Thus, the earlier general consent was insufficient to permit patient 8 to proceed with the pre-op work. The patient's chart did not contain the more recently signed consent for surgery because Dr.

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[1] Patient 7 and her husband in fact filed suit against Dr. Osterweil, LAC+USC and the County of Los Angeles for medical malpractice, battery and other claims. The suit was later dismissed on procedural grounds.

Osterweil kept patient 8's chart, and other current patient charts, at home or in his car as a matter of course, despite LAC+USC's written policy prohibiting the removal of confidential patient charts from the medical center.

Ms. Bilitch immediately contacted Dr. Mary Stimmler, deputy executive director and the medical director for primary care services at LAC+USC. Ms. Bilitch presented Dr. Stimmler with patient 8's paperwork, including the note Dr. Osterweil wrote on the prescription pad. She also presented Dr. Stimmler with 22 outpatient nonadmission request forms the patient financial services department had given her. Each of the forms was from the otolaryngology department. Each was coded as non-cosmetic. Most of the forms concerned Dr. Osterweil's patients and most of them were for patients with Armenian surnames. Later in the day Ms. Bilitch retrieved 41 more outpatient nonadmission request forms from the pre-op clinic which had been submitted by Dr. Osterweil. Again, the majority of the patients had Armenian surnames and all of the forms coded proposed surgeries as non-cosmetic. Most of the procedures were for nasal surgery, eyelid surgery, or for face-lifts.

In reviewing this paperwork, Dr. Stimmler learned Dr. Osterweil had had LAC+USC business cards printed with his private cell phone number which described him as a facial reconstructive surgeon. She also learned doctors in the otolaryngology department had devised their own admissions system to bypass LAC+USC's general computerized admissions system. Patients were provided with a form letter granting them permission to bypass the regular appointment system and to come directly to the otolaryngology department to register and have an appointment on the same day. As she reviewed this paperwork Dr. Stimmler was informed two more patients had presented at the otolaryngology clinic for same day appointments.

Dr. Stimmler contacted Dr. Wong, chief medical officer of LAC+USC. They cancelled all of the otolaryngology department's scheduled surgeries for the next day and met with Dr. Rice.

The next day, April 27, 2000, Dr. Stimmler, chief medical officer, Dr. Wong, and quality/risk manager, Dr. Qualls, met with Dr. Rice, chief of the otolaryngology department. They complained to Dr. Rice residents in his department had performed numerous cosmetic procedures which had been improperly coded as non-cosmetic. They pointed out because of this improper coding the financial office had not been able to ensure individual patients paid for elective cosmetic procedures in advance. Moreover, because procedures had been coded as non-cosmetic MediCal had likely been wrongly billed, which put LAC+USC at risk of being charged with MediCal fraud.

They told Dr. Rice they believed Dr. Osterweil's handling of informed consent issues with patients 7 and 8 was inappropriate, as was his apparent preferential treatment of patients from the Armenian community in a facility charged with the duty of providing nondiscriminatory medical services. They also told Dr. Rice Dr. Osterweil exercised poor judgment in using a minor child as an interpreter to discuss consent to a proposed surgery.

They complained about the system the otolaryngology department had devised to bypass LAC+USC's general admissions and screening systems. They also complained about inadequate supervision of the residents in his department.

After this discussion, Dr. Stimmler asked Dr. Osterweil to explain his personal system for scheduling appointments and surgeries. He prepared a memo explaining his usual method of operation: patients learned of him through word-of-mouth; they called his cell phone number and left a message; he returned the call and asked which procedure or procedures the patient was contemplating; he placed the relevant information about the patient in his palm pilot; he set up appointments at the clinic to take the patient's history, conduct a physical examination and discuss options; and when operating room time became available he called them and scheduled the surgery. Dr. Osterweil also explained how he had kept patient charts at his home throughout his residency until LAC+USC changed its policy in December 1999 to require doctors to keep original patient charts at the medical center.

Dr. Stimmler expressed shock at Dr. Osterweil's candor in describing his parallel scheduling system. She explained LAC+USC has such a large load of emergency and other high priority surgeries the medical center cannot block out the operating rooms with elective surgeries. To help residents satisfy the residency requirements of performing a minimum amount of cosmetic surgeries, LAC+USC had established an off-site facility known as Hudson Clinic for this purpose. While elective cosmetic surgeries are not prohibited at LAC+USC, they are only permitted in the event they do not displace more critical surgeries, and provided the patient has paid in advance for the elective procedure.

Dr. Stimmler reviewed all of Dr. Osterweil's surgeries during his residency. She discovered of the 193 surgeries he had performed at LAC+USC (more than any other resident), 137 of the surgeries were potentially cosmetic. Each, however, had been coded as non-cosmetic. Thus, there was nothing on the outpatient nonadmission request form to alert the financial office to request payment in advance from patients who had had cosmetic surgeries.

On May 2, 2000, Dr. Stimmler went to the otolaryngology department and spoke with the residents. She explained the department had not been adhering to LAC+USC's written policies and procedures and stated she was very upset at the department's numerous shortcomings. She discussed with the residents the importance of using LAC+USC's computerized appointment process, the importance of financial screening, LAC+USC's potential exposure to MediCal fraud charges from improper coding, and she demanded an immediate halt to same day appointments at the clinic in the absence of an emergency. Much of the information Dr. Stimmler relayed was news to even the senior residents.

In May 2000, officials at LAC+USC learned an investigator from the inspection and audit division of the Department of Health Services had been conducting a confidential investigation into Dr. Osterweil's practices at LAC+USC. In September 1999, someone had called the employee fraud hotline. The caller stated Dr. Osterweil was falsifying medical records and provided a list of six patient numbers and record numbers which the caller claimed had been falsified.

For some unexplained reason the investigation did not begin until February 2000. In her initial assessment the investigator found the surgeries on so-called patients 1 through 6 were largely cosmetic but had been coded as non-cosmetic, and were in several cases billed to MediCal. The investigator sent patient records for review by otolaryngology or cosmetic specialists at Harbor/UCLA Medical Center in order to maintain confidentiality and objectivity in the investigation. The investigator also attempted to interview the six patients. Only patient 2 agreed to speak with the investigator. Patient 2 stated she had had nasal surgery because her nose was too big and too crooked for her face. She wanted the surgery to make her nose smaller. Contrary to Dr. Osterweil's diagnosis justifying the nasal surgery as a functional, rather than a cosmetic procedure, patient 2 denied she had ever had difficulty breathing before the surgery. As part of the investigation, county counsel reviewed the potential legal ramifications of having billed MediCal for these procedures.

The findings of the investigation were not presented to LAC+USC officials until May 8, 2000.

Dr. Osterweil received a letter of intent to discharge on May 17, 2000. The letter explained his conduct violated numerous written policies of LAC+USC: (1) the policy of not scheduling cosmetic procedures unless sure they did not displace higher priority surgeries, and provided the full cost was paid before the surgery was performed; the policy of coding cosmetic procedures as cosmetic; the policy of obtaining signed patient consents for surgery; and the policy of maintaining confidential patient files at LAC+USC. The letter also alleged he had admitted circumventing LAC+USC's surgery scheduling system by personally scheduling the patients prior to completion of the required registration and financial screening processes. In addition, the letter alleged in essence he had falsified the medical records of patients 1 through 6 by claiming the procedures he performed were non-cosmetic although some included cosmetic procedures. Finally, the letter outlined his deficiencies in failing to secure the required signed consents with regard to patients 7 and 8.

In lieu of a *Skelly*[2] hearing Dr. Osterweil submitted a lengthy written response denying all allegations of wrongdoing, except the allegation relating to his failure to obtain written surgical consent for the face-lift procedure on patient 7.

LAC+USC discharged Dr. Osterweil effective June 5, 2000, 25 days before he was scheduled to complete the five-year otolaryngology residency program.

Dr. Osterweil filed an appeal and a request for a hearing with the Commission. The hearing before hearing officer Kenneth M. Schwartz lasted several days, involved dozens of witnesses and well over a hundred exhibits. An attorney from his union, the Committee of Interns and Residents, SEIU, AFL-CIO, represented Dr. Osterweil at the hearing.

In addition to the foregoing evidence, the hearing officer heard testimony from the medical experts who had reviewed the charts for patients 1 through 6. LAC+USC presented this expert testimony to establish Dr. Osterweil had improperly coded these patients' surgeries as non-cosmetic. The doctors' testimony, however, did not entirely support LAC+USC's position or the charges against Dr. Osterweil.

Dr. Rinaldo Canalis is the chief of head and neck surgery at Harbor UCLA Medical Center. According to his testimony, if an operation is done in order to improve the patient's appearance, the procedure is cosmetic. However, if the main goal of the operation is to produce a functional improvement, then the surgery is classified as reconstructive, and is therefore not cosmetic. He reviewed the case files on patients 2 through 6. In his opinion the procedures performed on patients 2 and 4 were cosmetic; the procedures performed on patient 5 had elements of cosmetic surgery and the procedures performed on patients 3 and 6 appeared to be reconstructive.

Dr. James P. Watson is a plastic and reconstructive surgeon at Harbor UCLA Medical Center. He reviewed the case files on patients 1 and 2 and determined they were

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[2] *Skelly v. State Personnel Bd.* (1975) 15 Cal.3d 194.

both cosmetic.[3] Dr. Watson also reviewed another 60 case files of Dr. Osterweil's patients as part of the investigation.

PATIENT 1:

Dr. Watson stated he was 100 percent certain the procedure performed on patient 1 was cosmetic. Dr. Watson observed patient 1 had flat cheeks. He noted patient 1's problem was drooping skin and fat because of normal aging. She did not appear to him to have a congenital defect at all. Dr. Osterweil had diagnosed patient 1 as having a congenital midfacial deformity and thus indicated the procedure he intended to perform was non-cosmetic. According to Dr. Watson, Dr. Osterweil's operative report, however, clearly described a standard cosmetic face-lift.

Dr. Watson explained Dr. Osterweil used terminology in describing the procedure to make it appear to be reconstructive rather than cosmetic. Dr. Watson believed these terms were likely to mislead not only the personnel at LAC+USC's whose job it is to code procedures for insurance purposes but was also likely to mislead knowledgeable insurance claims adjustors. Dr. Watson detected similar misleading terminology in almost all of the 60 case files he reviewed.

Dr. Watson believed Dr. Osterweil's intent to deceive was apparent from the way he had handled this case. Dr. Osterweil had secured authorization from MediCal to perform upper lid reconstruction claiming patient 1's drooping upper eyelids were

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[3] He described how he usually handled cosmetic surgeries, or surgeries which involved elements of both reconstructive and cosmetic surgeries. To secure preauthorization from an insurer for reconstructive procedures, he would send photographs and a copy of the patient's history to the insurer and explain in a letter why a particular procedure should be considered reconstructive and thus medically necessary. For the cosmetic aspect of the surgery, he would inform the patient of the costs for the surgery, the anesthesiologist and the operating room and explain this portion of the bill would have to be paid before surgery could be performed. He explained documenting reconstructive surgeries was critically important to ensure an insurer would authorize payment for the procedure.

impairing her vision. However, the face-lift procedure Dr. Osterweil performed did not involve patient 1's eyelids at all.

Dr. Rice reviewed patient 1's record and concluded she did not have a face-lift but instead had reconstructive surgery to correct a congenital facial deformity of the mid-facial area.

Dr. Osterweil gave his version of what occurred with patient 1. Moments before the surgery patient 1 asked to speak with him. Patient 1 asked whether Dr. Osterweil could fix her facial deformity at the same time he operated on her eyelids. Dr. Osterweil replied he only had enough operating time for one procedure. They decided on the facial surgery and Dr. Osterweil told her they could do the upper lid reconstruction at a later time. Dr. Osterweil did not modify the outpatient nonadmission request form either to clarify the surgery actually performed or to reclassify it. He stated he did not know it was required once a patient was already scheduled for surgery.

PATIENT 2:

Dr. Osterweil diagnosed patient 2 with nasal valve impairment. Medical history taken on the patient indicated no history of trauma but indicated the patient had a history of nasal obstruction and difficulty breathing while asleep. Dr. Osterweil marked the outpatient nonadmission request form for the proposed surgery as non-cosmetic. In reviewing Dr. Osterweil's notes of the operation, Dr. Canalis noted a mention of Alloderm which is sometimes used in corrective procedures for the nasal valve. However, Dr. Canalis noted the Alloderm was not actually used during the procedure, indicating any nasal valve issue was not addressed. Instead, Dr. Osterweil performed procedures to improve the patient's appearance by cutting and trimming nasal bones to improve the shape of patient 2's nose.

Dr. Watson stated there was a 90 percent probability the procedure performed on patient 2 was a cosmetic rhinoplasty. Although Dr. Osterweil's diagnosis was nasal valve collapse, according to Dr. Osterweil's operative notes the procedure he performed was to narrow, rather than to spread, patient 2's nose.

Dr. Gill of LAC+USC provided written notes after reviewing the case files as part of the investigation. He wrote of Dr. Osterweil's procedure on patient 2, "Review of the surgical details of the procedure appears to indicate appropriate surgical management."

When later interviewed by the investigator, patient 2 explained her nose was too big and too crooked for her face and she wanted a smaller nose. She denied having difficulty breathing before the surgery.

PATIENT 3:

Dr. Osterweil diagnosed patient 3's problem as ectropion of the lower eyelids. This means the lower lid is inverted or drooping outward. This condition is a functional problem because it interferes with eye moisture and increases the possibility of infections. If patient 3 suffered from this condition then Dr. Canalis opined Dr. Osterweil properly classified the procedure he performed as a non-cosmetic, reconstructive surgery.

However, patient 3's file did not provide a full description of the condition of the lower eyelids, nor document whether nerve damage typically associated with this condition existed. Moreover, the file contained no photos to document patient 3's problem.

PATIENT 4:

Dr. Canalis opined patient 4 underwent a primarily cosmetic procedure. According to Dr. Canalis, Dr. Osterweil diagnosed patient 4 as having a traumatic nasal deformity because of blunt trauma "at age three." Dr. Osterweil coded the surgical procedures performed on patient 4 as non-cosmetic. According to his operative notes, Dr. Osterweil took measures to reduce the patient's nasal obstruction, a procedure usually designed to improve a patient's breathing. Dr. Osterweil also cut bones and performed procedures to reduce patient 4's prominent nose. Dr. Canalis found it inconsistent for the patient to have a large, prominent nose after suffering blunt trauma to the nose at age three. He believed an injury at this young age would likely have interfered with the patient's developmental progress and would have resulted in a flat, rather than a

prominent, nose. For this reason, Dr. Canalis opined the procedures Dr. Osterweil performed on patient 4 were largely cosmetic.

Dr. Osterweil testified Dr. Canalis had simply misread his clinic notes. He had written patient 4 suffered "blunt trauma to nose three years ago" not at "age three."

Dr. Rice testified the surgery performed was a functional, non-cosmetic procedure.

PATIENT 5:

Dr. Osterweil diagnosed patient 5 with nasal deformity and nasal obstruction due to trauma. Dr. Osterweil performed two separate procedures on patient 5: a rhinoplasty to correct the nasal deformity and a jaw implant to give patient 5's face a more balanced appearance. According to Dr. Canalis, the nasal surgery was reconstructive, but the jaw implant had strictly a cosmetic purpose. Counsel asked whether Dr. Osterweil had an ethical responsibility to make the distinction between the two procedures clear in the patient's medical records. Dr. Canalis replied, "Well, it's a sticky point mostly because ethics is a very complex issue. In general terms I would say that if one does what is right and it is the right one for the most part is obliging or is paying attention to the ethics of the issue. So failure to state that something is cosmetic is wrong information. It is not an overt lie, but perhaps that—it's a good example of an ethical issue that maybe was bridged."

Dr. Gill wrote in his review of patient 5's case file, "Review of the surgical details contained in the dictated operative note appears to indicate appropriate surgical management."

Dr. Rice testified he probably would have checked cosmetic but with a medical problem for the dual procedures. He explained cases of this sort often involve judgment calls. Dr. Rice stated there were many "gray" areas in reconstructive type surgeries because they invariably improve a patient's appearance.

Dr. Osterweil explained what occurred with patient 5. His clinical notes missed his additional diagnosis of retrognathia, or a receded, unaligned jaw. To correct this deformity he also performed a mandibular implant as stated in his operative notes. He

admitted he did not modify the outpatient nonadmission request form to reflect the fact he had also performed this second procedure.

PATIENT 6:

By the time of the hearing it was undisputed patient 6's history showed a traumatic nasal deformity. Dr. Osterweil performed a nasal reconstruction which was a functional, and properly coded non-cosmetic, procedure.

In his testimony, Dr. Watson expressed the view Dr. Osterweil was being singled out for discipline when the problems at LAC+USC were systemic. He explained he went to LAC+USC several times to pick up the files he was supposed to be reviewing. Sometimes it was not clear which charts LAC+USC wanted him to review. Other times charts were incomplete. On other occasions, he was given charts he had already reviewed. As his investigation proceeded Dr. Watson arrived at the conclusion the real problem was a lack of supervision and accountability. He noticed operative notes rarely if ever stated whether an attending physician was present in the operating room during any portion of the surgeries. He wondered how such irregularities could occur, to say nothing of continue, if faculty and attending physicians were actually taking responsibility for overseeing residents' work. Had there been adequate supervision Dr. Watson believed someone would have questioned who had authorized the surgeries, and/or would have requested better documentation when they noticed questionable practices occurring repeatedly.

Counsel for LAC+USC inquired whether in his view the system-wide problems he identified changed his opinion whether Dr. Osterweil's behavior was unethical or fell beneath the standard of care. Dr. Watson replied, "No. It's sort of one of those issues that two wrongs don't mak[e] a right, and just because your supervisor isn't there, you don't have the right to do anything you want. [¶] But I just felt that looking at Dr. Osterweil alone was missing the big picture, and that was what I was very concerned about that the big picture of looking at the entire system and how did all of these patients get through the system with getting cosmetic procedures done for free, and you can't put

all the blame on Dr. Osterweil, and it doesn't justify his part, but you can't put all the blame on him." Dr. Watson primarily blamed the lack of supervision on the department chair, Dr. Rice.

Dr. Osterweil presented several witnesses to refute LAC+USC's charges of misconduct.

Dr. Jason Zommick was a chief resident in the urology department at LAC+USC. He testified it was a routine matter to use minors as translators and interpreters at LAC+USC. He pointed out the volunteer Candy Stripers usually assisted in interpreting and each was of high school age.

Dr. Zommick stated he had then been at LAC+USC for six years and during those six years had received no training of any kind regarding billing, the computerized admissions system, or regarding MediCal fraud.

Dr. Zommick explained record keeping of patient charts at LAC+USC was notoriously poor. Before the policy change to prohibit the removal of patient files from the premises, doctors routinely took responsibility for his or her own patient charts. The doctors kept patient charts in the on "call" room, at home, in their cars, or kept patient histories on their home computers. After the policy change in December 1999 doctors in the urology department made duplicates of patient charts which they kept in the urology department as a back-up measure.

Dr. Edward Lee was a resident in the otolaryngology department at LAC+USC with Dr. Osterweil. He was then working at LAC+USC as an attending physician. Dr. Lee explained whatever residents learned about LAC+USC's policies and practices came through instructions from senior residents. Dr. Lee was unaware of any requirement for attending physicians to sign operative reports, even when an attending surgeon had been present for all or a part of a surgery.

Dr. Lee testified he had not received any specific training on how to designate whether a surgery was cosmetic, non-cosmetic or cosmetic with a medical problem. He had never seen LAC+USC's written policies regarding cosmetic procedures or those regarding a patient's financial responsibility for cosmetic procedures. Dr. Lee was still

uncertain what type of procedure should be categorized as "cosmetic with a medical problem." Dr. Lee explained the way he personally approached the problem: "Well, I think that in general every surgery that you do for a non-cosmetic reason, . . . , if you are trying to correct a functional medical problem, you oftentimes have a cosmetic component attached to it, and because of the way—when we were residents, the way we suspected the financial screening to be performed, if you were trying to correct a medical problem that had a cosmetic result. [¶] I think that you would try to select the non-cosmetic one so that your patient could complete the financial screening and still get the surgery for their medical problem."

Dr. Lee agreed he and other residents in the otolaryngology department routinely kept current patient charts in their homes, in their cars, or in any other convenient location. The residents started taking responsibility for patient charts after too many patient charts, or items from patient charts, had been lost. Missing items resulted in delays or cancelled surgeries if, for example, an EKG result was missing or if a consent form could not be found.

Dr. Glenn Waldman had been a resident with Dr. Osterweil in the otolaryngology department at LAC+USC. At the time of the hearing he was spending 80 percent of his time as the director of ENT at Ventura County Medical Center and spent the balance of his time in private practice. He explained whatever he knew about policy and practices at LAC+USC he learned through example from senior residents. Dr. Waldman explained attending physicians were almost never in the clinic but usually made themselves available for consultations. He estimated he had performed 60 to 70 percent of his surgeries without an attending physician present.

He had received no formal training on how to properly check the boxes on the outpatient nonadmission request forms. Dr. Waldman explained, "I don't think it was ever really clear. I think we—from the beginning, just like I said, by example, learned—okay, this is the way you do it, and it was like a routine thing. And we didn't think about it. Everyone said you check it off this way, and you didn't think about it." Dr. Waldman clarified, "we were under the impression—I was definitely under the impression by

watching all the residents before me do that any surgery that had any functional element to it at all we would check non-cosmetic."

After LAC+USC discharged Dr. Osterweil Dr. Waldman thought about how to check the form for the first time. On one occasion, he checked the box stating the procedure he was about to perform was "cosmetic with a medical problem." One of the financial screeners called him a few hours later in a quandary on how to treat the case. Dr. Waldman was referred to numerous personnel throughout LAC+USC and finally spoke to Barbara Oliver, the administrator for surgery. Ms. Oliver told him to check the non-cosmetic box if the case involved any functional aspect or any deformity at all.

Dr. Waldman testified he had received no formal training on how the financial office handled billing for different procedures. In addition, he had never heard of LAC+USC's computerized admissions system until Dr. Stimmler came into the otolaryngology department to complain about the private scheduling system she discovered Dr. Osterweil had been using. Prior to Dr. Stimmler's visit, residents kept their own scheduling systems and made their own appointments.

Dr. Waldman testified he knew nothing about MediCal billing or MediCal fraud until he joined the Ventura County Medical Center. There he and everyone else on staff had undergone mandatory and comprehensive compliance training. He had never seen LAC+USC's written policy on cosmetic surgery until after Dr. Osterweil was discharged. He admitted residents tended to avoid using the Hudson Center for cosmetic surgeries because, in his view, the facilities were inadequate, as was available operating room time.

Dr. Rice testified on Dr. Osterweil's behalf. Dr. Rice completely disagreed with the decision to terminate Dr. Osterweil. He believed the punishment was disproportionate and inappropriate.

Dr. Rice agreed Dr. Osterweil's failure to document informed consent before performing the face-lift on patient 7 fell beneath the standard of care. However, Dr. Rice believed the best way to address this mistake was the way he had handled it, namely by talking to Dr. Osterweil. Regarding patient 8, Dr. Rice believed Dr. Osterweil did the right thing by trying to convince the pre-op department patient 8's mother had in fact

given her general written consent as well as written consent to the proposed surgical procedure.

Dr. Rice stated it was a common practice for residents to take responsibility for patient charts to ensure they would not be lost or misplaced in the internal records department. He stated too often missing documents or charts caused surgeries to be delayed or cancelled. Dr. Rice also saw nothing wrong with using family members, even minors as young as 12 or 13, as interpreters.

Dr. Rice acknowledged in September 1999 he had received a memo from Dr. Mildred Milgrom, the medical director of the outpatient center. In her memo, Dr. Milgrom complained three of Dr. Osterweil's MediCal patients had been scheduled for pre-op and surgery but their charts contained no diagnosis. She expressed concern about two other of his patients, a mother and a daughter, who were scheduled to have surgery at LAC+USC although the surgeries appeared to be elective cosmetic procedures and not emergencies. She warned Dr. Rice the penalties for misrepresentation could be great. Dr. Milgrom also questioned why so many of Dr. Osterweil's patients for nasal reconstruction were self-referred and living in the same Glendale area. Dr. Milgrom also questioned the preferential treatment Dr. Osterweil's patients received in terms of scheduling same day clinic appointments and scheduling surgeries. Dr. Milgrom asked Dr. Rice to speak with his residents and set guidelines and procedures to address these concerns.

Dr. Rice spoke to Dr. Osterweil after he received this memo in September 1999, but did not punish him. Dr. Rice then devised the form granting permission for patients of the otolaryngology department to bypass general admissions and to be seen directly in the otolaryngology clinic. He heard nothing further from Dr. Milgrom and thus assumed her concerns were adequately addressed by these measures.[4]

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[4] By the time of the hearing, Dr. Rice had been reassigned and was the subject of a separate disciplinary proceeding. At its conclusion, Dr. Rice similarly received a 15-day suspension.

Dr. Osterweil testified at the hearing. He stated he had not received any training regarding financial screening while at LAC+USC. The initial orientation he received as a first year resident only concerned fire safety, hazardous waste disposal and employee benefits. Dr. Osterweil explained what he learned about LAC+USC's practices and policies he learned through example from senior residents. For example, he learned if any part of a surgery was functional he should classify it as non-cosmetic. In his view what can be considered "functional" falls into two basic categories in the otolaryngology field. If a condition impairs a person's sight, smell, breathing ability or interferes with the mouth's normal functions of tasting, speaking or eating, then the person has a functional deformity. A person may also have asymmetrical facial features, and in his view, these types of problems are classified as congenital deformities when not otherwise caused by trauma. However, he never received any specific training regarding how, or whether, to draw a distinction between what could be considered a normal, and what could be considered a congenitally deformed, face.

Dr. Osterweil testified if he was doing something wrong, or violating some LAC+USC policy, he would have expected someone to say so. However, Dr. Osterweil testified he was never told to stop any particular practice and was never punished for having done anything wrong. If he was inappropriately marking cosmetic surgeries as non-cosmetic he did so because he was following the example of the senior residents. No one directed him to mark the forms otherwise and no one from the financial office ever alerted him to any problem. For example, no one informed him it was part of his responsibilities to ensure a particular patient or any particular third party payor paid for the surgeries he performed. Indeed, residents were unaware who paid LAC+USC for their services. Dr. Osterweil stated he never tried to disguise any of his actions because his operating notes revealed the details of every procedure he performed in any event.

More often than not, there were no attending physicians available in the clinic to consult during his residency. In the later years of his residency, attending physicians did not even review patient examinations or histories to confirm diagnoses. Similarly, attending physicians did not usually review or countersign operative notes.

When LAC+USC officials suspended his operating room privileges he was very upset and spoke with Dr. Rice. Dr. Rice was surprised and told Dr. Osterweil he did not understand why his privileges had been suspended. Dr. Rice attempted to intercede on his behalf. He contacted the chief of surgery and the chief medical officer to request an explanation. Dr. Rice told them Dr. Osterweil had done nothing wrong.

Again at the hearing, Dr. Osterweil conceded he had made a serious mistake in failing to document informed consent before performing the cosmetic face-lift procedure on patient 7.

At the conclusion of the hearing, the hearing officer issued his findings of fact and conclusions of law. He sustained none of the allegations of misconduct, except the allegation Dr. Osterweil failed to obtain written consent for one of the two procedures he performed on patient 7.[5] The hearing officer thus concluded the "department did not meet its burden of proof [Dr. Osterweil's] conduct constituted such serious conduct as to

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[5] The hearing officer's findings of fact are as follows:

"1. There is no policy that requires an attending physician's signature on the report of operation nor is the resident responsible for obtaining such signature.

"2. Appellant [Dr. Osterweil] did not circumvent the surgery scheduling system.

"3. Appellant did not <u>falsely</u> book cosmetic surgeries as non-cosmetic.

"4. LAC+USC and the County were aware that Appellant booked surgeries but never gave Appellant notice that Appellant's conduct in following the practice was incorrect.

"5. Appellant booked Patients One through Six correctly in conforming with LAC+USC practice.

"6. The justification for surgery for Patients One through Six was properly documented in the progress notes.

"7. The Department failed to substantiate that Dr. Osterweil performed additional reconstructive procedures.

"8. Appellant did not routinely bypass the patient financial screening and scheduling process.

"9. Residents routinely maintained medical records outside the hospital and hospital administration was aware of and condoned the practice of which Department was cognizant.

"10. Appellant did violate the practice and did not obtain written consent for one of two (2) procedures performed on Patient Seven.

"11. Appellant's conduct with respect to Patient Eight was appropriate."

warrant discharge from his position of Physician, M.D., Post-Graduate, Department of Health Services, LAC+USC Medical Center."

LAC+USC filed objections with the Commission. LAC+USC complained the hearing officer had ignored virtually all its evidence and the testimony of all its witnesses. In addition, LAC+USC argued the hearing officer's comments during the hearing revealed his bias against LAC+USC. LAC+USC urged the Commission to reject the hearing officer's report and to read the entire record before making any decision.

The members of the Commission read the entire record of the hearings and a month and a half later issued its final order. The Commission sustained LAC+USC's objections in part and adopted, as constituting its final decision, the findings of the hearing officer. However, the Commission did not adopt the hearing officer's recommendation of no punishment. The Commission reduced Dr. Osterweil's punishment from discharge to a 15-day suspension, and granted him the right to complete his residency, if he wished.

LAC+USC filed a petition for writ of mandate to overturn the Commission's decision. Dr. Osterweil filed a separate petition for writ of mandate to reverse the 15-day suspension.

The law firm of Schwartz, Steinsapir, Dohrmann & Sommers substituted in to represent Dr. Osterweil in the trial court. When LAC+USC saw the firm's letterhead LAC+USC realized for the first time the hearing officer, Kenneth M. Schwartz, was a founding partner in the law firm now representing Dr. Osterweil. LAC+USC also discovered the Schwartz law firm had provided legal advice to the union attorney who represented Dr. Osterweil at the hearing. LAC+USC filed a first amended petition for writ of mandate alleging the hearing officer's failure to disclose his connections to the firm, and his failure to recuse himself, created an appearance of bias sufficient to warrant reversal and a new hearing before an impartial decision maker. The trial court granted LAC+USC a continuance to take depositions and conduct discovery to develop an evidentiary record to support its claim of bias.

At the continued hearing, the trial court expressed the view the overall circumstances of the case did create *an appearance* of bias. However, the trial court found no proof of actual bias or prejudice, and thus concluded reversal was not warranted. The court found the hearing officer's findings of fact supported by substantial evidence and denied LAC+USC's petition for writ of mandate. The trial court also denied Dr. Osterweil's petition for writ of mandate. After reviewing the record, the court opined Dr. Osterweil was very fortunate to have received only a 15-day suspension. In the court's view, the evidence would have easily justified a much greater penalty.

LAC+USC and Dr. Osterweil separately appeal from the adverse judgments.

DISCUSSION

I. THE LACK OF EVIDENTIARY SUPPORT FOR SOME OF THE HEARING OFFICER'S FACTUAL FINDINGS ADOPTED BY THE TRIAL COURT DOES NOT WARRANT REVERSAL.

As noted, both the Commission and the trial court adopted the hearing officer's findings of fact. LAC+USC challenges many of those findings as unsupported.

A. Standard of Review of an Administrative Decision.

"In exercising its independent judgment, a trial court must afford a strong presumption of correctness concerning the administrative findings, and the party challenging the administrative decision bears the burden of convincing the court that the administrative findings are contrary to the weight of the evidence."[6] On appeal, we

[6] *Fukuda v. City of Angels* (1999) 20 Cal.4th 805, 817.

review the trial court's determination for substantial evidence.[7] However, the trial court's legal conclusions are subject to this court's independent review for error.[8]

B. The Evidence Established Dr. Osterweil Circumvented LAC+USC's Scheduling Procedures, But Did So in Accordance With Custom and Practice in the Otolaryngology Department Apparently Unaware Of The Alternative System.

In both a memo to Dr. Stimmler and in his testimony Dr. Osterweil candidly described the private system he devised for scheduling examinations and surgeries for his patients. He explained nurses complained about the numerous patient telephone calls to the otolaryngology clinic. In response, he arranged to have potential patients call him instead on his cell phone and leave a voice mail. He described how he then called patients back, asked them what surgeries they were interested in, and then set up clinic appointments to see these patients. When a patient's condition warranted surgery, Dr. Osterweil would then consult his palm pilot to match proposed surgery for a given patient with available operating room time.

This evidence was undisputed. Thus, the hearing officer's finding, adopted by both the Commission and the trial court, namely that Dr. Osterweil *did not* circumvent the scheduling system, is not supported by any evidence.

However, given the other factual circumstances of the case there is no reasonable possibility the punishment Dr. Osterweil received would have been any different.

Dr. Waldman testified many residents of the otolaryngology department handled doctor and self-referrals in the same manner. He testified he was not even aware of LAC+USC's centralized computer system for scheduling patients and surgeries until Dr. Stimmler told the residents about it the month before LAC+USC discharged Dr. Osterweil.

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[7] *Fukuda v. City of Angels, supra,* 20 Cal.4th 805, 825.

[8] *Gai v. City of Selma* (1998) 68 Cal.App.4th 213, 219.

The evidence was also undisputed it was a department policy to bypass the centralized scheduling process. Patients with appointments at the otolaryngology department routinely bypassed the general admissions by appearing for same day registration and appointments directly at the otolaryngology clinic. This treatment of patients at the otolaryngology department had become so ingrained, Dr. Rice himself prepared a special form expressly granting patients permission to bypass general admissions.

The residents were quite surprised when Dr. Stimmler visited the otolaryngology department to complain about their patients being handled outside the main system. Apparently, most, if not all, the residents had never heard of the computerized admissions system and were unaware of either the telephone numbers to access the system, or of any requirement of using LAC+USC's general admissions and scheduling system.

This evidence of the department chair's actions in condoning if not encouraging the practice, and the absence of evidence Dr. Osterweil or the other residents were informed of LAC+USC's proper procedures, compel the conclusion increased punishment for Dr. Osterweil would not be warranted for following department custom and practice in circumventing LAC+USC's scheduling process.

C. The Evidence Established Dr. Osterweil Maintained Numerous Confidential Patient Records At His Residence But Did So In an Attempt to Ensure the Integrity of the Patient's File Prior to Surgery Consistent With the Custom and Practice of Doctors at LAC+USC.

Again, Dr. Osterweil candidly admitted he kept current patient charts at his home. He explained he did not want to risk losing these charts, or items from these charts, which might delay or cause the cancellation of a scheduled surgery.

This undisputed evidence established a violation of LAC+USC's written policy against removing patient charts from the premises. Accordingly, the hearing officer's, the Commission's and the trial court's findings to the contrary are not supported by the record evidence.

However, the evidence was also undisputed residents routinely maintained patient records outside LAC+USC's general records department as a means of ensuring the integrity of a patient's chart before surgery. Department chair, Dr. Rice, testified it was a common practice for residents to take responsibility for patient charts to make sure they would not get lost or misplaced in LAC+USC's internal records system. He explained missing or lost records had often caused surgeries to be delayed or canceled. Fellow resident, Dr. Lee, concurred. He testified so many patient charts were either misplaced or had missing items residents as a matter of course took responsibility for patient charts by keeping them in their homes, cars, in the "call" room, or other convenient location. Dr. Zommick testified residents in the urology department also chose to maintain parallel charts because needed records were so frequently missing from the hospital files.

To recall, Dr. Watson testified as an expert for LAC+USC regarding patients 1 and 2. He reviewed 60 patient charts in preparation for the hearing. He testified to the problems he encountered when he went to the internal records department at LAC+USC. Sometimes they delivered charts he had already reviewed. Sometimes personnel did not know which charts he was to review. Sometimes he received incomplete charts. Dr. Watson's own experience and objective assessment of the situation tended to justify the residents' actions in maintaining patient charts off-premises, despite being in literal violation of LAC+USC's written policy.

Given these overall circumstances, Dr. Osterweil's participation in what was apparently a system-wide practice to ensure the integrity of patient charts does not justify the imposition of additional punishment. Accordingly, this particular violation of LAC+USC policy does not warrant a different outcome.

D. Because The Evidence Established the Custom and Practice of the Otolaryngology Department Was to Classify Surgeries on Outpatient Nonadmission Forms as Non-Cosmetic if Some Aspect of the Surgery was Reconstructive or Functional, Substantial Evidence Supports the Findings Dr. Osterweil Properly Marked the Forms, or Marked the Forms Consistent with this Policy, for Patients 1 Through 6.

LAC+USC contends the evidence involving patients 1 through 6 established Dr. Osterweil repeatedly violated its policies by scheduling low-priority cosmetic procedures without regard to whether such surgeries displaced higher priority surgeries, and without regard to whether these patients had paid in advance for elective procedures. LAC+USC contends this same evidence showed Dr. Osterweil committed MediCal fraud and violated LAC+USC's written policies by categorizing some elective cosmetic procedures as non-cosmetic.

To recall, residents who had worked in the otolaryngology department at LAC+USC testified they learned from senior residents to mark all outpatient nonadmission request forms as non-cosmetic any time any part of a proposed surgery involved reconstruction or had a functional element. Drs. Waldman, Lee and Osterweil testified this was the approach they took by following senior residents' examples. In his testimony, Dr. Rice, their supervisor, did not dispute these residents' understanding. Instead, he testified because so many reconstructive surgeries after traumatic events, or because surgeries to correct congenital deformities, improved a person's appearance, the difference between cosmetic and non-cosmetic surgery was a very large "gray" area. He generally trusted the residents to use their judgment in deciding these questions.

Evidence regarding the specific surgeries alleged as improperly coded in this case, was sometimes conflicting. This was especially true with regard to patients 1 and 2. However, we are mindful of the standards of review in this court. An appellate court does not evaluate the credibility of the witnesses, but must defer to the trier of fact.[9] In

[9] *Lenk v. Total-Western, Inc*. (2001) 89 Cal.App.4th 959, 968.

addition, an appellate court is not free to reweigh the evidence. A judgment will be upheld if it is supported by substantial evidence, even though substantial evidence to the contrary also exists and the trial court might have reached a different result had it believed other evidence.[10] Thus, the testimony of even a single witness may provide the requisite evidence to uphold the judgment.[11] We review the allegations of improper coding with these standards in mind.

Dr. Rice reviewed patient 1's record and concluded she did not have a face-lift but instead reconstructive surgery to correct a congenital facial deformity of the mid-facial area.

Patient 2 had nasal surgery. Dr. Gill of LAC+USC reviewed patient 2's file as part of the investigation into Dr. Osterweil's behavior at LAC+USC. Dr. Gill stated in his notes, "[r]eview of the surgical details of the procedure indicate appropriate surgical management."

Patient 3 had eyelid surgery. LAC+USC's expert, Dr. Canalis of Harbor UCLA Medical Center, opined, the procedure Dr. Osterweil performed was not cosmetic but to reconstruct drooping eyelids, assuming the diagnosis of ectropion was correct.

Crediting Dr. Osterweil's reading of his own operative notes as more accurate than Dr. Canalis's, patient 4 had suffered blunt trauma to his nose three years before, and not at age three, as Dr. Canalis had interpreted patient 4's record. Assuming this was the case, then the nasal surgery Dr. Osterweil performed was properly classified as reconstructive. After reviewing patient 4's chart, Dr. Rice testified the surgery Dr. Osterweil performed was a functional, non-cosmetic, procedure.

Dr. Osterweil performed two procedures on patient 5. According to Dr. Canalis, the nasal surgery was reconstructive but in his view the chin implant was cosmetic. Marking the form non-cosmetic where one of the procedures performed was undisputedly functional was in keeping with the training he received as a resident in the

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[10] *Howard v. Owens Corning* (1999) 72 Cal.App.4th 621, 631.

[11] See, e.g., *In re Marriage of Mix* (1975) 14 Cal.3d 604, 614.

otolaryngology department at LAC+USC, however inappropriate. Moreover, there was evidence to establish both procedures performed were reconstructive. Dr. Osterweil explained he had simply omitted the additional diagnosis of retrognathia, or an abnormally receded, misaligned, jaw line.

LAC+USC no longer disputes patient 6 underwent a non-cosmetic procedure to correct a nasal deformity caused by a recent traumatic event.

In short, substantial evidence in the form of expert medical testimony supports the finding most of these cases were reconstructive and thus properly categorized as non-cosmetic. Substantial evidence also supports the finding that when one of dual procedures in a single surgery was reconstructive Dr. Osterweil categorized the surgery as non-cosmetic in keeping with the custom and practice of, and the training of residents in, the otolaryngology department at LAC+USC.

E. Substantial Evidence Supports the Finding Dr. Osterweil Violated LAC+USC's Policies and Medical Ethics in Failing to Obtain Written Consent for One of Two Procedures Performed on Patient 7.

The evidence was undisputed Dr. Osterweil violated LAC+USC policy as well as medical ethics in failing to document patient 7's informed consent to the face-lift in addition to the nasal reconstruction procedure he performed on her. Dr. Osterweil admitted his mistake and lapse in judgment to officials at LAC+USC the day after the surgery. Dr. Osterweil also admitted his mistake in his testimony at the hearing.

Accordingly, there is no dispute regarding the accuracy of this particular finding.

II. LAC+USC HAS FAILED TO DEMONSTRATE A NEW HEARING IS REQUIRED ON THE GROUNDS THE HEARING OFFICER HAD A PROHIBITED FINANCIAL INTEREST IN THE OUTCOME AND WAS ACTUALLY BIASED AGAINST IT.

LAC+USC contends it is entitled to a new hearing because of the appearance of bias created by the hearing officer's connections to the firm which advised Dr. Osterweil's attorney during the hearing and which later represented him in the trial court.

After the hearing, LAC+USC filed a more than 100-page brief with the Commission, urging its members to independently read the record because LAC+USC claimed it had received an unfair trial because of the hearing officer's bias.

As proof of the hearing officer's bias LAC+USC pointed out the hearing officer did not bother to discuss the testimony of any of its 17 witnesses in his 27-page report. LAC+USC also pointed to comments the hearing officer made during the hearing which in its view indicated an obvious bias in favor of Dr. Osterweil.

LAC+USC pointed out several examples of allegedly biased comments the hearing officer made during the hearing. For example, the hearing officer asked Dr. Stimmler, "how many doctors in private practice, who have done a rhinoplasty or done some other procedure, have checked that, the insurance company then refuses it because it wasn't covered, and they say it was cosmetic as opposed to non-cosmetic. The doctor says, 'Okay, if that's the case, that's what we have to live with.' They don't charge them with fraud, do they? . . . Because I know that doctors do that, and you know doctors do that when there's insurance involved."

The hearing officer had a similar discussion with LAC+USC's chief medical officer, Dr. Wong.

"HEARING OFFICER SCHWARTZ: I'm asking you this just as a general question. Because other than that, it really has no significance. Haven't you heard of instances where doctors will put in their reports information that will make it appear that the particular procedure that they are performing on that patient is covered under a policy when, in fact, it is excluded in the policy?

“THE WITNESS: Well, I am aware of the fact of an article published in the ‘Journal of the American Medical Association,’ very recently surveyed physicians, and it does happen. Yes, it does.

“HEARING OFFICER SCHWARTZ: And what I mean is, it isn’t quote, ‘fraud’ in the sense of [what] we normally think of fraud because if the policy—if the insurance company doesn’t pay it or what have you based upon the fact it was excluded, no other procedure is taken by the Medical Association and so forth as far as the doctor wrote that report that constitutes fraud.

“THE WITNESS: Well, that’s true.

“HEARING OFFICER SCHWARTZ: And what I am saying is that while it’s true, it’s not a true statement. It’s a matter of bending the rules in order to help patients out, but I think—

“THE WITNESS: I think that’s the way most physicians would justify that.”

Hearing officer Schwartz then told Dr. Wong, “You and I and anybody in this room knows that these things are not that unusual.”

Later in the hearing, the hearing officer commented on the often widely divergent views of the medical experts regarding when and whether to characterize a procedure as cosmetic. The hearing officer expressed the view the situation revealed individual experts could each validly have different opinions. The hearing officer did not consider the issue as whether the expert was credible, or whether the foundation for his or her opinion was valid. The hearing officer explained, “just seems to me that’s his opinion. [¶] But the fact that some other doctor has a contrary opinion doesn’t mean he’s lying, and that’s what you were talking about.”

In light of LAC+USC’s objections the Commission read the entire record. The Commission nevertheless sustained the hearing officer’s findings of fact but modified the punishment from discharge to a 15-day suspension.

LAC+USC repeated its objections to the trial court in its petition for writ of mandate. During the course of the proceedings in the trial court, LAC+USC discovered hearing officer Schwartz had a relationship with Dr. Osterweil. The law firm of

Schwartz, Steinsapir, Dohrmann & Sommers substituted in to represent Dr. Osterweil in the trial court. When LAC+USC saw the firm's letterhead LAC+USC realized for the first time the hearing officer, Kenneth M. Schwartz, was a founding partner in the law firm now representing Dr. Osterweil. LAC+USC also discovered the Schwartz firm represented Dr. Osterweil's union, the Committee of Interns and Residents SEIU, AFL-CIO. An attorney employed by this union represented Dr. Osterweil at the hearing, and the attorney periodically consulted during the hearing with Margo A. Feinberg, a partner of the Schwartz firm located in Northern California.

LAC+USC filed a first amended petition for writ of mandate alleging the hearing officer's failure to disclose his connections to the firm and his failure to recuse himself created an appearance of bias sufficient to warrant reversal and a new hearing before an impartial decision maker. The trial court granted LAC+USC a continuance to take depositions and conduct discovery to develop an evidentiary record to support its claim of bias. Discovery revealed the following facts and chronology:

1959 to 1983—Schwartz was a name partner in the Schwartz firm until he retired in 1983.

1983-1984—Schwartz acted as a consultant to the Schwartz firm.

1990—Schwartz received his last payment from the firm.

1993—The union of interns and residents became a client of the Schwartz firm.

Early 2001—Union represented Dr. Osterweil before hearing officer Schwartz and consulted periodically with Ms. Feinberg of the Northern California area Schwartz firm. During the hearing, hearing officer Schwartz visited the Los Angeles office of the Schwartz firm two or three times a month.

June 2001—Union represented Dr. Osterweil before the Commission.

2002—Schwartz firm substituted in and filed a petition for writ of mandate on Dr. Osterweil's behalf and represented him in the trial court until the firm substituted out in November 2002.

The hearing on the petitions occurred in November 2002. The court expressed the view Schwartz should have disclosed his prior relationship with the Schwartz firm, given his ongoing social contacts with the firm.

The court also noted certain aspects of the hearing it found troublesome. The court realized Dr. Rice testified in support of Dr. Osterweil's actions and against the decision to discharge him because as head of the department he was charged with supervising his residents' actions. The court noted, "given the facts of this case, he [Dr. Rice] would be cutting his own throat if he was testifying unfavorably to Dr. Osterweil." However, because Dr. Rice was such a crucial witness the court was disturbed by the way hearing officer Schwartz limited LAC+USC's ability to cross-examine Dr. Rice when his testimony became somewhat evasive. The court was also troubled by the impression the hearing officer gave that virtually all decisions in medicine were judgment calls. The court took some comfort in the fact the Commission read the entire record and nevertheless adopted the hearing officer's findings of fact, despite being alerted to the possibility of the hearing officer's bias.

At the conclusion of the hearing, the court ruled LAC+USC had presented insufficient evidence of bias or prejudice to warrant reversal of the judgment. Although the court found Schwartz should have disclosed his connection to the firm, the court concluded the totality of the circumstances still did not amount to a showing of actual bias or prejudice as is required in the administrative proceeding context.

A. The Evidence Does Not Support LAC+USC's Claim the Hearing Officer Had A Financial Interest In the Outcome.

LAC+USC argues the hearing officer's financial interest in the proceedings created a presumption of bias and thus it is entitled to a new hearing before an impartial hearing officer.

Decisionmakers challenged for reasons other than financial interest are presumed to be impartial. However, the opposite is true of decisionmakers with a financial stake in

the matter being adjudicated.[12] This rule applies to administrative proceedings as well.[13] "Certainly due process allows more flexibility in administrative process than judicial process, even in the matter of selecting hearing officers. But the rule disqualifying adjudicators with pecuniary interests applies with full force. The high court has taken pains to make this clear, even while holding that due process permits, for example, the combination of investigative and adjudicative functions in administrative proceedings. (*Withrow v. Larkin, supra*, 421 U.S. 35.) An assertion of bias based on that combination of functions, as the *Withrow* court explained, needs to 'overcome a presumption of honesty and integrity in those serving as adjudicators.' (*Id*. at p. 47.) In contrast, the adjudicator's financial interest in the outcome presents a 'situation[] . . . in which experience teaches that the probability of actual bias on the part of the judge or decisionmaker is too high to be constitutionally tolerable.' (*Ibid*.) On this point, the court has applied the same rules to administrative hearing officer and judges alike. (See, e.g., *id*. at pp. 46-47; *Gibson v. Berryhill* [(1973)] 411 U.S. [564] at p. 579.)"[14]

Thus, while a pecuniary interest would have disqualified the hearing officer, we conclude LAC+USC has failed to demonstrate the hearing officer had a financial interest in the outcome of this case. Schwartz had retired from the law firm nearly 20 years before the hearing. More significantly, the parties agreed by the time of hearing it had been more than 10 years since the hearing officer had received any type of payment from the Schwartz firm. In these circumstances, his historical financial interest is too remote to create a presumption of bias, or to have had any effect in this hearing.[15]

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[12] *Withrow v. Larkin* (1975) 421 U.S. 35, 47.

[13] *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1026.

[14] *Haas v. County of San Bernardino, supra*, 27 Cal.4th 1017, 1027.

[15] We note Code of Civil Procedure section 170.1 only requires a two-year disqualification period in circumstances where a judge has previously represented a party, or when a judge is about to become a neutral in a dispute resolution program and a matter or party is connected in some fashion.

Accordingly, we find LAC+USC's argument of a prohibited financial interest is not well taken.

B. LAC+USC Has Failed to Establish Actual Bias in the Hearing Officer To Warrant Reversal of the Judgment.

LAC+USC claims the trial court employed the wrong standard in analyzing its claim of bias involving matters other than the hearing officer's alleged financial interest in the proceedings. LAC+USC contends it was only required to demonstrate *an appearance of bias* to justify relief. Specifically, LAC+USC argues the court should have used the objective standard expressed in Code of Civil Procedure section 170.1, subdivision (a)(6)(C). This section directs a *judge* shall be disqualified if "a person aware of the facts might reasonably entertain a doubt that the judge would be able to be impartial." In light of Schwartz's comments at the hearing, his ruling imposing no punishment, and his connection to the law firm whose client was the union which represented Dr. Osterweil at the hearing, LAC+USC argues any person aware of these facts would reasonably entertain a doubt about Schwartz's impartiality.

LAC+USC cites several decisions in support of its argument the correct standard in this context is the objective "appearance of impropriety" standard of review. The decisions, however, do not support its assertion.

Michael v. Aetna Life & Casualty Insurance Company[16] did not involve an administrative proceeding. Accordingly, the decision is inapposite. *Michael* instead concerned the alleged impartiality of an appraiser selected by an insurer. The *Michael* court noted appraisers and arbitrators are required by statute to disclose potential grounds for disqualification, including those for disqualifying a judge found in Code of Civil

[16] *Michael v. Aetna Life & Cas. Ins. Co*. (2001) 88 Cal.App.4th 925.

Procedure section 170.1, subdivision (a).[17] Thus, as dictated by statute, appraisers and arbitrators are required to disclose facts which may cause a person reasonably to entertain a doubt about the appraiser's or arbitrator's impartiality.[18]

The decision in *Kaiser Foundation Hospitals, Inc. v. Superior Court*[19] also concerned arbitration, and not administrative proceedings. The *Kaiser* court noted the grounds for disqualifying a judge expressed in Code of Civil Procedure section 170.1 expressly applied to arbitrators as well. Thus under this statutory standard an allegedly neutral arbitrator had a duty to disclose all matters which might have reasonably raised a doubt about his impartiality.[20]

The decisions in *United Farmworkers of America v. Superior Court*[21] and *Catchpole v. Brannon*[22] are similarly not on point. These decisions instead concern the appearance of bias by trial judges and thus do not apply in the administrative hearing context.

The decisions in *Linney v. Turpen*[23] and *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board*[24] did involve administrative proceedings. However, and contrary to LAC+USC's argument, in neither case did the Court of Appeal employ an "appearance of bias" standard in reviewing challenges to the partiality of the hearing officers.

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[17] See, Code of Civil Procedure section 1281.9, subdivision (e). This code section is functionally identical to Code of Civil Procedure section 170.1 regarding disqualification of judicial officers.

[18] *Michael v. Aetna Life & Cas. Ins. Co., supra*, 88 Cal.App.4th 925, 933-937.

[19] *Kaiser Foundation Hospitals, Inc. v. Superior Court* (1993) 19 Cal.App.4th 513.

[20] *Kaiser Foundation Hospitals, Inc. v. Superior Court, supra*, 19 Cal.App.4th 513, 516-517.

[21] *United Farm Workers of America v. Superior Court* (1985) 170 Cal.App.3d 97.

[22] *Catchpole v. Brannon* (1995) 36 Cal.App.4th 237.

[23] *Linney v. Turpen* (1996) 42 Cal.App.4th 763.

[24] *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board* (2002) 99 Cal.App.4th 880.

In *Linney* an airport police officer was suspended without pay for six months. A civil service hearing officer affirmed the decision. The police officer filed a petition for writ of mandate in the trial court. He claimed the hearing officer had a prohibited financial interest in the proceeding because he was selected and paid by the agency which appointed him. Accordingly, the officer argued he had not received a fair and impartial hearing.[25] The *Linney* court stated in the administrative context due process "requires only a 'reasonably impartial noninvolved reviewer.'"[26] A showing of actual personal or financial interest in the outcome of a case would be sufficient to demonstrate partiality.[27] However, in the absence of these types of facts, "'"[b]ias and prejudice are not implied and must be clearly established. A party's unilateral perception of bias cannot alone serve as a basis for disqualification. Prejudice must be shown against a particular party and it must be significant enough to impair the adjudicator's impartiality. The challenge to the fairness of the adjudicator must set forth concrete facts demonstrating bias or prejudice."'"[28]

The court found the record absolutely devoid of any evidence of bias.[29] To emphasize its point, the *Linney* court stated the record would not even sustain a finding of an "appearance of bias" if that standard applied instead.[30]

In *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board*, the ABC suspended the liquor license of a topless bar because dancers had exposed and touched their bare breasts within six feet of patrons. The owner of the bar claimed the administrative law judge necessarily had a bias in favor of the ABC. He

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25 *Linney v. Turpen, supra*, 42 Cal.App.4th 763, 769-770.

26 *Linney v. Turpen, supra*, 42 Cal.App.4th 763, 771, quoting *Williams v. County of Los Angeles* (1978) 22 Cal.3d 731, 737.

27 *Linney v. Turpen, supra*, 42 Cal.App.4th 763, 772.

28 *Linney v. Turpen, supra*, 42 Cal.App.4th 763, 773, quoting *Binkley v. City of Long Beach* (1993) 16 Cal.App.4th 1795, 1810.

29 *Linney v. Turpen, supra*, 42 Cal.App.4th 763, 776.

30 *Linney v. Turpen, supra*, 42 Cal.App.4th 763, 776.

pointed out the ALJ was employed by and paid by the ABC and thus had a strong, direct financial interest in the outcome.

The court found the ALJ's financial interest in the result too attenuated to require disqualification without a showing of actual bias.[31] It noted ALJ's are protected by civil service laws against arbitrary or retaliatory dismissal and thus could not feel pressured to decide matters in favor of the ABC. Citing *Linney,* the ABC court stated in passing current law also authorized disqualification if the circumstances would lead a reasonable person to suspect bias. However, the court found the bar owner's "other speculative and factually bare concerns about the ALJ's presumed 'coziness' with the Department insufficient to raise a suspicion of bias."[32]

The appellate court in *Gai v. City of Selma*[33] specifically rejected the notion the "appearance of bias" standard applicable to judges applied in administrative proceedings. The *Gai* court characterized the *Linney* court's discussion of this standard as "dicta."[34] The *Gai* court also noted applying an "appearance of bias" standard in the administrative setting was inconsistent with the Supreme Court's then latest pronouncement of the appropriate standard which instead required a showing of actual bias. "In *Andrews* the Supreme Court considered a challenge to an administrative law officer. The court refused to apply an 'appearance of bias' standard. The court noted that under the then governing statutes the appearance of bias standard applied to judicial officers only in cases in which the officer 'either has a personal or financial interest, has a familial relation to a party or attorney, or has been counsel to a party.' (*Andrews v. Agricultural Labor Relations Bd*. [(1981)] 28 Cal.3d [781] at p. 793, fn. 5.) The court went on to

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[31] *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board, supra*, 99 Cal.App.4th 880, 886.

[32] *Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board, supra*, 99 Cal.App.4th 880, 886.

[33] *Gai v. City of Selma, supra,* 68 Cal.App.4th 213, 219.

[34] *Gai v. City of Selma, supra,* 68 Cal.App.4th 213, 232.

reject the adoption of a general appearance of bias standard, noting that it 'may be particularly untenable in certain administrative settings.' (*Id*. at p. 794.)"[35]

A few years later the Supreme Court in *Haas* made clear the presumption of impartiality can only be overcome in the administrative setting, and a hearing officer may only be disqualified, on a showing of actual bias or prejudice—absent evidence of a financial interest in the outcome of the proceeding.[36]

In sum, in order to disqualify the hearing officer in the present case LAC+USC was required to demonstrate not only that the hearing officer's comments and actions created an appearance of bias, but that he harbored actual bias or prejudice against it and/or in favor of Dr. Osterweil.

As the Commission and trial court before us, we have read and analyzed the entire evidentiary record. After such review we are unpersuaded the record demonstrates either a close and ongoing relationship to the Schwartz firm or actual bias in the hearing officer. Schwartz's relationship to the Schwartz firm was limited to "visits" two or three times a month to the Los Angeles office. There was no direct evidence concerning the purpose of each of these visits. However, the record suggests, and the trial court found, the visits were social rather than business-related.

Schwartz had retired years before the union of interns and residents even became a client of the Schwartz firm. He retired in 1983, the year the firm hired Ms. Feinberg as

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[35] *Gai v. City of Selma, supra,* 68 Cal.App.4th 213, 231; compare, *Nightlife Partners, Ltd. v. City of Beverly Hills* (2003) 108 Cal.App.4th 81 [appearance of bias standard applied in situation where an administrative officer performed dual roles: the assistant city attorney advised against issuing a permit to the cabaret and then advised the decisionmaker during the cabaret's appeal of his decision]; *Quintero v. City of Santa Ana* (2003) 114 Cal.App.4th 810 [city attorney's dual roles as prosecutor and as advisor to the city personnel board created such an appearance of impropriety the administrative employment decision was invalid].

[36] *Haas v. County of San Bernardino, supra,* 27 Cal.4th 1017, 1032 ["The County also contends we have not required the disqualification of administrative hearing officers *absent a showing of actual bias*. Although the *contention is accurate with respect to claims of bias arising from a hearing officer's personal or political views*, it is erroneous as to claims of bias arising from financial interest." Italics added.].

an associate. The union became a client ten years later in 1993. In 2001 Feinberg was the union of interns and residents' main contact at the Schwartz firm. She lived and worked in Northern California and thus never saw Schwartz when he visited the Los Angeles office.

Ms. Feinberg periodically advised the union during its representation of Dr. Osterweil before hearing officer Schwartz. However, Ms. Feinberg testified she never spoke to Schwartz at any time during the administrative proceedings.

While we agree with the trial court Schwartz should have disclosed his past relationship to the firm, we do not agree with LAC+USC these same facts establish Schwartz's bias based on his alleged ongoing relationship to the firm. His then connection to the firm was too attenuated, sporadic and likely social, to suggest the possibility of bias against LAC+USC.

In its backup argument, LAC+USC claims the best evidence of bias was the hearing officer's "skewed" and "biased" result. No doubt, this is the subjective belief of the officials and representatives of LAC+USC. The hearing officer did make comments during the hearing which tended to undercut LAC+USC's theory of the case. Also as noted, the hearing officer made some findings which were not supported by the evidence. The hearing officer also recommended no punishment at all. These actions may reflect the hearing officer's personal or political views, or the bizarre factual circumstances of the case, plus the informality of the administrative hearing process. However, in our view, they do not, even in combination, satisfy the requisite showing of *actual* bias or prejudice. Accordingly, we find no basis to reverse the judgment in this case.

III. THE 15-DAY SUSPENSION IMPOSED AGAINST DR. OSTERWEIL WAS JUSTIFIED.

Dr. Osterweil separately appealed from the judgment to challenge the propriety of the punishment imposed against him. He contends no punishment was justified at all. We do not agree.

Dr. Osterweil's admitted failure to document patient 7's consent to a face-lift was a sufficiently egregious breach of good medical practice and medical ethics to justify the punishment. His argument LAC+USC waived its right to punish him for this misconduct is disingenuous at best, given the overall circumstances of the case. Suffice it to say, Dr. Qualls thought Dr. Osterweil's misconduct in failing to document patient 7's consent to the face-lift procedure so serious she referred the case for peer review.

Moreover, the record contains substantial evidence Dr. Osterweil engaged in other questionable practices which might have warranted even more serious discipline. By way of example only, Dr. Watson testified Dr. Osterweil deliberately marked cosmetic procedures as non-cosmetic in order to evade the financial screening process. In addition, Dr. Watson testified Dr. Osterweil described his surgeries in such a way in his operative notes so as to deceive both hospital coders and insurers alike. Had the Commission chosen to, it would have been well within its discretion to have imposed punishment far greater than the 15-day suspension it decided to impose in this case.

We find no abuse of the Commission's discretion.[37]

DISPOSITION

The judgments are affirmed. Each side to bear its own costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

JOHNSON, Acting P.J.

We concur:

WOODS, J.

ZELON, J.

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[37] *Skelly v. State Personnel Bd., supra,* 15 Cal.3d 194, 217-219.