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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

MICHAEL D. MORAN, Plaintiff and Appellant, v. SOUTH COAST MEDICAL CENTER, Defendant and Respondent.	G045628 (Super. Ct. No. 30-2009-00303136) O P I N I O N

Appeal from a judgment of the Superior Court of Orange County, William M. Monroe, Judge. Affirmed.

Engstrom, Lipscomb & Lack, Walter J. Lack, Robert J. Wolfe and Edward P. Wolfe for Plaintiff and Appellant.

Horvitz & Levy, Jeremy B. Rosen, Andrea A. Ambrose; Patrick K. Moore Law Corporation and Patrick K. Moore for Defendant and Respondent.

* * *

An executive committee of South Coast Medical Center (Hospital) recommended denying the application of Dr. Michael Moran for reappointment to the Hospital's medical staff. Dr. Moran challenged the recommendation through a lengthy, multilevel administrative review process. In the end, the governing board of the Hospital upheld the decision not to reappoint Dr. Moran. The superior court denied Dr. Moran's petition for a writ of mandate to compel the Hospital to vacate its decision denying his reappointment and to withdraw a report sent to the Medical Board of California. Dr. Moran appeals.

We affirm. Substantial evidence supports the findings in support of the recommendation not to reappoint Dr. Moran to the Hospital's medical staff. Furthermore, we reject Dr. Moran's various challenges to the administrative procedures utilized by the Hospital.

I

FACTS

A. Background:

Dr. Moran is a cardiologist who specializes in endovascular interventions. He joined the Hospital medical staff in 1997 and became the director of the Hospital catherization lab (cath lab) in 2002.

One morning in August 2005, Patient No. 1 was brought in by paramedics. Dr. Raymond Chang scheduled an emergency pacemaker implantation at the cath lab for 11:00 a.m., a time slot that was open at the time of scheduling. Dr. Moran's office later sought to schedule an angiogram for the same time slot. At 10:50 that morning, Dr. Chang was informed of the scheduling conflict. He contacted Dr. Moran and asked for his procedure to take priority because his patient was in unstable condition and the pacemaker consultant and the technologist had already been called. Dr. Moran refused to yield to Dr. Chang and a confrontation between the two doctors ensued. Staff had to contact the chair of the department of medicine and the chief of staff to resolve the

dispute. It was determined that because of the unstable condition of Patient No. 1, Dr. Chang's emergency procedure would have priority over Dr. Moran's elective procedure.

A few days later, Dr. Moran performed an extremely difficult pacemaker replacement on an elderly patient (Patient No. 2) with a history of heart disease. The next morning, Patient No. 2 was suffering palpitations and had an abnormal electrocardiogram. The charge nurse contacted Dr. Moran, informed him of the condition of Patient No. 2, and reported a suspected ventricular tachycardia—a potentially life-threatening condition. Dr. Moran was contacted again that afternoon and reminded of the abnormal electrocardiogram of Patient No. 2. Dr. Moran, without reviewing either the electrocardiogram or a chest X-ray that had been taken of Patient No. 2 that morning, and also without examining Patient No. 2, ordered by telephone that Patient No. 2 be discharged. When Dr. Moran went to the Hospital later in the day and was shown the electrocardiogram results, he had Patient No. 2 readmitted immediately.

B. Administrative Proceedings:

The Hospital's Medical Executive Committee became aware of the confrontation between Dr. Moran and Dr. Chang and the incident involving the discharge of Patient No. 2. The Medical Executive Committee recommended that Dr. Moran be removed as director of the cath lab and that the matter of the physician dispute be reviewed by the Physician Aid Committee. However, Dr. Moran refused to meet with the Physician Aid Committee. The Medical Executive Committee, after reviewing a report from the Physician Aid Committee, voted to require Dr. Moran to enroll in an anger management program.

The Medical Review Committee also commenced a corrective action investigation, pursuant to the Hospital bylaws. It appointed an ad hoc committee (Ad Hoc Committee), consisting of four doctors—Drs. Navneet Boddu, Kathleen Farinacci, J.S. Reynard and Frank Rose. The Ad Hoc Committee commenced an investigation in

November 2005 and, in addition to reviewing extensive medical records, it interviewed four doctors, including Dr. Chang and Dr. Moran, four nurses, and two others.

While the investigation was ongoing, two vascular surgeons, Dr. William Wallace and Dr. Marcello Borzatta, each initiated contact with Dr. Michael Coccia, then acting chief of staff, to express their concerns about Dr. Moran's medical practices. Dr. Wallace, who had privileges at both the Hospital and Saddleback Memorial Medical Center, wanted to report that Dr. Moran had placed stents all the way from the groin to the mid-calf of Patient No. 3 and thereby created a situation that was surgically non-reconstructible. Dr. Borzatta, who had privileges at Mission Hospital Regional Medical Center, sought to bring to the attention of the Hospital's review committee what he felt was injurious care rendered by Dr. Moran to four patients. One of those patients was Patient No. 4, upon whom at least 10 procedures had been performed in two years or less, and who ultimately suffered an amputation.

At its February 16, 2006 meeting, the Medical Executive Committee suspended Dr. Moran's privileges to perform peripheral vascular interventions below the groin. It also decided to have an independent interventional cardiologist perform a peer review of the treatment of Patient Nos. 3 and 4. In response to the suspension, Dr. Moran sought and obtained an opportunity to interview with the Medical Executive Committee. After the February 28, 2006 interview, the Medical Executive Committee rescinded the suspension pending a more detailed evaluation of the treatment of the two patients in question.

Dr. Suhail Dohad, an interventional cardiologist, was retained to perform the peer review. Dr. Dohad was the chairman of the Pacific Heart and Vascular Institute at the Brotman Medical Center and the co-director of the Endovascular Committee at Cedars Sinai Medical Center.

Dr. Dohad prepared a report that was critical of Dr. Moran. He stated, inter alia, that the care for Patient Nos. 3 and 4 fell below the standard of care. The last line of

Dr. Dohad's 11-page report states: "All of these issues are egregious and clearly below [the] standard of current endovascular care." After receiving Dr. Dohad's report, the Ad Hoc Committee invited Dr. Moran in for an interview regarding those two patients. In response, Dr. Moran gave the committee a two and one-half hour presentation.

The Ad Hoc Committee issued a report in June 2006 in which it concluded that "(2) Dr. Moran's behavior was inappropriate, unethical and disruptive with regard to the . . . incident [involving Patient No. 1]; (3) Dr. Moran exercised poor judgment with regard to the . . . case [involving Patient No. 2]; and (4) Dr. Moran lacked appropriate judgment in evaluating the risks and benefits of peripheral endovascular interventions and in obtaining valid informed consent for those procedures with regard to [Patient No. 3 and Patient No. 4]."

After reviewing the written report of the Ad Hoc Committee and the report of Dr. Dohad, the Medical Executive Committee voted to recommend that Dr. Moran's application for reappointment be denied. Dr. Moran then sought review before a judicial hearing committee (Judicial Hearing Committee). Dr. Moran was notified of the charges against him. He and the Hospital were each represented by counsel through the proceedings.

Seven doctors, including Dr. Andrew Sassani, were selected to serve on the Judicial Hearing Committee. The Judicial Hearing Committee held 15 hearings over 10 months. Each party made opening statements and called witnesses who were examined under oath. Eight doctors, including Dr. Moran, testified, in addition to other persons. Hospital records and other documents were presented for consideration. Each party presented written briefs and oral argument at the conclusion of the hearing.

The Judicial Hearing Committee ultimately sustained three of the charges brought against Dr. Moran—those pertaining to Patient Nos. 1, 2, 3, and 4. A majority of the Judicial Hearing Committee concluded that the decision of the Medical Executive Committee to deny Dr. Moran's application for reappointment should be affirmed.

Thereafter, Dr. Moran commenced an appeal before the Hospital's governing board (Governing Board), which appointed an appeal board (Appeal Board) consisting of three persons. Attorney Daniel Willick was appointed the hearing officer.

In bifurcated proceedings, the Appeal Board first addressed certain procedural issues Dr. Moran raised, including whether Dr. Sassani was precluded by the Hospital bylaws from either sitting on the Judicial Hearing Committee or participating in its voting. Dr. Sassani had relinquished his active staff position at the Hospital and become an affiliate staff member of the Hospital after the Judicial Hearing Committee proceedings began. Although he had been an active staff member during most of the Judicial Hearing Committee hearings, he had become an affiliate staff member before the final sessions, deliberation and vote. After briefing and a hearing at which counsel for each party presented oral argument, the Appeal Board concluded that the Hospital bylaws did not preclude Dr. Sassani from sitting on the Judicial Hearing Committee, joining in its deliberations, or participating in its voting.

The parties were then given an opportunity to brief the merits and their attorneys again presented oral argument before the Appeal Board. The Appeal Board thereafter found that substantial evidence supported the findings of the Judicial Hearing Committee regarding Patient Nos. 1, 2, 3, and 4, and the confrontation with Dr. Chang. The Appeal Board unanimously affirmed the decision of the Judicial Hearing Committee, except for the denial of Dr. Moran's application for reappointment. By a two-to-one vote, the Appeal Board recommended that Dr. Moran be reappointed, subject to six months of proctoring.

Attorney Jay Christensen was hired as special counsel to advise the Hospital's board of directors concerning Dr. Moran's appeal of the Judicial Hearing Committee decision. He made a presentation to the Governing Board, at its June 25, 2009 meeting. According to the minutes of the meeting: (1) Attorney Christensen addressed the actions of the Medical Executive Committee, the findings and decision of

the Judicial Hearing Committee, the findings and recommendations of the Appeal Board, and applicable legal considerations; and (2) the Governing Board thereafter engaged in extensive discussion and voted to uphold the recommendation of the Medical Executive Committee to deny Dr. Moran reappointment to Hospital medical staff.

The Governing Board issued its final decision five days later. It reiterated certain findings of the Judicial Hearing Committee regarding Patient Nos. 1, 2, 3, and 4. As had the Appeal Board, the Governing Board determined that the findings were supported by substantial evidence. The Governing Board stated that while two members of the Appeal Board had opined that the failure to reappoint Dr. Moran would be disproportionate and drastic, the Governing Board found that the opinion of those two members was not supported by the evidence. It further stated that there was no evidence to support the conclusion that proctoring would have been an appropriate method of protecting patients. The Governing Board concluded that because the recommendation of the Medical Executive Committee was amply supported by the findings of the Judicial Hearing Committee and the Appeal Board, it had to be upheld. The final decision concluded with the attestation of Robert Carmen, the president of the Governing Board. He stated that, pursuant to his delegated authority, he adopted the "statement of the Governing Board's final decision, consistent with its action of June 25, 2009."[1]

C. Judicial Proceedings:

Dr. Moran filed a petition for a writ of administrative mandate. He challenged the decision of the Governing Board on numerous grounds, including: (1) the Governing Board denied him a fair hearing by, inter alia, violating Hospital bylaws and Business and Professions Code sections 809 and 2282.5; (2) Dr. Sassani, as an affiliate staff member, was improperly permitted to vote on the Judicial Hearing Committee, so it

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1 The Hospital ceased operations on July 1, 2009.

reached a decision adopted by less than a majority vote; (3) the Judicial Hearing Committee's findings did not warrant the drastic punishment of nonrenewal of privileges; (4) the findings of the Judicial Hearing Committee were based on conclusory, speculative and inadmissible evidence and were not supported by substantial evidence; and (5) Dr. Moran was prevented from presenting an effective defense because the charges against him were based on multiple layers of hearsay and unreliable documentation.

In his prayer for relief, Dr. Moran asked that the court: (1) issue a peremptory writ of mandate directing the Hospital to vacate the decisions of the Judicial Hearing Committee and the Governing Board denying his application for reappointment; (2) issue a peremptory writ of mandate directing the Hospital to withdraw the Business and Professions Code section 805 report sent to the Medical Board of California and the National Practitioner Data Bank; and (3) award him his costs of action, including reasonable attorney fees, pursuant to Business and Professions Code section 809.9. The court denied the requested relief.

II

DISCUSSION

A. Code of Civil Procedure Section 1094.5:

A party seeking to challenge certain final administrative orders or decisions may file a petition for a writ of mandate. (Code Civ. Proc., §§ 1085, 1094.5.) Code of Civil Procedure section 1094.5, subdivision (b) provides: "The inquiry in such a case shall extend to the questions whether the respondent has proceeded without, or in excess of, jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence."

Code of Civil Procedure Section 1094.5, subdivision (d), provides that, with certain exceptions, in cases arising out of the actions of private hospital boards or

the governing bodies of certain municipal hospitals, "abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record."[2]

B. Substantial Evidence:

Dr. Moran claims the final decision of the Governing Board is not supported by substantial evidence. The Hospital disagrees, asserting there is ample evidence to support the findings regarding Patient Nos. 1, 2, 3, and 4. We agree with the Hospital.

(1) Patient No. 1—

(a) introduction

With regard to Patient No. 1, the Judicial Hearing Committee stated: "The JHC unanimously finds that Dr. Moran behaved in a disruptive manner by inappropriately asserting his leadership position to Dr. Chang and the nursing staff in an attempt to gain priority for his elective procedure. The confrontation . . . caused an approximate one-hour delay in treating Dr. Chang's unstable patient who required urgent intervention. Accordingly, the JHC concludes that Dr. Moran's disruptive behavior deleteriously impacted the delivery of patient care."

Dr. Moran attacks the last sentence of the quoted material. He says, first, that the finding was unsupported by the evidence because the evidence had to do with only a single incident over his career and, second, that there was no evidence the patient was negatively affected by the one-hour delay in any event. However, the findings make clear that the quoted sentence was directed to Dr. Moran's behavior in connection with one incident, not to Dr. Moran's behavior over the course of his entire career. Furthermore, there is no finding that Patient No. 1 in fact suffered harm because of the

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[2] The Hospital represents that it was a nonprofit public benefit corporation that operated a community hospital.

incident. The clear import of the finding is simply that, on the occasion in question, it was dangerous to cause a one-hour delay in treating an unstable patient who required urgent care. Taken in context, Dr. Moran's first two challenges to the findings fall flat.

Dr. Moran challenges the findings on a third point, saying they are unsupported by the evidence. He maintains that only uncorroborated hearsay was offered in support of the charge arising out of the incident. He acknowledges that hearsay evidence is to some extent admissible in administrative proceedings, but states that it cannot be the only evidence in support of the charge. Indeed, it has been held that "[w]hile uncorroborated hearsay alone is insufficient to support an administrative finding, hearsay together with other reliable evidence may support a finding. [Citations.]" (*Cipriotti v. Board of Directors* (1983) 147 Cal.App.3d 144, 155, fn. 2.) Dr. Moran also says that his own testimony was the only live testimony. We shall address the other evidence first.

(b) Melinda Johnson's memorandum

The Ad Hoc Committee interviewed nurse Melinda Johnson and considered her written memorandum describing the events occurring on August 23, 2005. We look now at that memorandum.

Johnson said she was in the cath lab when she got a call from Dr. Chang about a permanent pacemaker for a patient in the intensive care unit. She told Dr. Chang that there were no cases scheduled. Chris from Dr. Moran's office later called about a patient she said was scheduled for a procedure. Johnson then called Dr. Chang and told him there was a case of which they had not been aware. After Drs. Chang and Moran spoke, Dr. Chang told Johnson to take his patient to the cath lab. However, Dr. Moran contacted her immediately thereafter and contradicted Dr. Chang's instructions. Johnson suggested that because Dr. Chang had called first to schedule a patient, he should be allowed to go first. Dr. Moran repeatedly told her that he was the director of the cath lab and that she was to do as she was told.

Johnson called nurse Karolyn Scheneman, vice-president of patient care services.[3] Dr. William Anderson, then chief of staff, and Dr. J.S. Reynard, chairman of medicine,[4] were then contacted and Dr. Reynard said for Dr. Chang's patient to go first. However, Dr. Moran arrived claiming that Dr. Anderson had said he could go first. Scheneman called Dr. Anderson to confirm. Johnson stepped away, and when she came back, Dr. Moran said that Dr. Chang could go first. However, he said that he was the director of the cath lab and was "only going to allow Dr. Chang to perform a temporary pacing lead!"

(c) Dr. Chang's letter

The Ad Hoc Committee also considered a letter dated August 23, 2005 from Dr. Chang to the Hospital's Medical Staff Office. The Ad Hoc Committee reviewed that letter with Dr. Chang when it interviewed him.

In the letter, Dr. Chang said he had been contacted at 9:30 that morning to see the patient. He scheduled the patient for an emergent permanent pacemaker implantation to take place at 11:00 a.m. Dr. Chang had been informed that there were no cases scheduled in the cath lab at that time. He called a radiological technologist and a pacemaker technical consultant and drove to the Hospital to perform the procedure. At 10:50 a.m., he received a call informing him that Dr. Moran had scheduled a case at 11:00 a.m.

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[3] Scheneman is variously described in the record as a registered nurse and the vice-president of patient care services, and as a doctor and the director of cardiac services. The former description appearing in written documents and the latter being found in a reporter's transcript, we use the former for the purposes of this opinion. We intend no disrespect should we have selected the wrong designation.

[4] Dr. Reynard, a cardiologist, is described at different points in the record as either the chief of cardiology or the chairman of medicine. The latter description appearing more frequently, we choose to use that term, unless the other term appears in a quotation.

Dr. Chang said he immediately called Dr. Moran and requested that his procedure go first, because his patient was unstable and he had already called in the radiological technologist and the pacemaker consultant. Dr. Moran refused to yield and said he should place a temporary wire in the patient while in the intensive care unit. Dr. Chang said, "I informed him that . . . the ICU is not the ideal location to place a temporary wire, as it is often difficult to get fluoroscopy at the bedside, and sometimes all the necessary materials have been absent. . . . In addition, I also noted that if I were to place a temporary wire in the patient, there is no guarantee that the wire would stay in place, or that the patient may become asystolic during my placement of the temporary wire, which can happen occasionally. He stated that I should then place the wire in the cath lab, where there are more materials with better fluoroscopy, but I was not allowed to implant the permanent pacemaker until he was finished with his elective case. I again stated to him that placement of a temporary wire, no matter where it is done, is no guarantee that the patient [will] become stable from being unstable. I also stated it would not be in the patient's best interest to take the patient to the cath lab, place a temporary wire, bring him back to the ICU, then perform the permanent pacemaker implantation later after [Dr. Moran] was done with his elective procedure . . . ."

Dr. Chang continued: "[Dr. Moran] then stated that he did not feel that [an] inpatient with asystole should take precedence over an elective outpatient procedure. He also became quite belligerent and stated that he was the director of the cath lab, and I was not, under any circumstances, to perform a permanent pacemaker implantation until he was finished with his case. Of note, his patient had not even arrived to the hospital at 11:30 a.m. I then talked to Dr. Anderson, chief of staff, and Dr. Reynard, chief of the department of cardiology. They both agreed that in this situation, an inpatient with an unstable condition should take precedence over an elective outpatient procedure. I was given permission to perform the procedure. Dr. Moran then appeared visibly upset. He stated that he will go over my credentialing and consider withdrawing my privileges."

(d) Dr. Moran's testimony

Dr. Moran testified before the Judicial Hearing Committee as follows. On the date in question, Dr. Moran apparently had been paged but had not received the page. Eventually, he spoke with Dr. Jamali, who had been trying to reach him. She said "there was a very unstable patient in the ICU who was in complete heart block . . . ." By the time Dr. Moran spoke to Dr. Jamali, however, Dr. Chang already had been summoned to take care of the patient.

Dr. Moran learned that he and Dr. Chang each sought to use the cath lab during the same time slot. The nurses informed Dr. Moran that Dr. Chang's "patient was very unstable and critical . . . ." Dr. Chang told Dr. Moran that he needed to use the cath lab to implant a pacemaker. Dr. Moran suggested that it would be better to stabilize the patient at the bedside using a temporary pacing wire. Dr. Chang responded that he was uncomfortable implanting a temporary pacing wire in that setting given the nursing staff and equipment available in the intensive care unit. So Dr. Moran, understanding that the "patient was critically unstable," offered to put a temporary pacing wire in place himself while at the patient's bedside in the intensive care unit.

Dr. Moran called Scheneman and found out that she was already talking to Dr. Chang. Dr. Moran then went to the cath lab and found Scheneman there talking with Johnson. Scheneman and Johnson were discussing whose patient would go first. Scheneman said that Dr. Chang's patient should go first because it was an emergency. Dr. Moran said that he was better qualified than she was to make the decision.

Scheneman then called Dr. Anderson for a ruling. Dr. Anderson asked Dr. Moran why he didn't just let Dr. Chang's patient go first. Dr. Moran opined that the patient was too unstable to be moved to the cath lab for the procedure. Dr. Anderson overruled Dr. Moran and decided to let Dr. Chang's patient go first because of the emergency situation. Dr. Moran abided by Dr. Anderson's decision as a matter of protocol and, under protest, let Dr. Chang go first.

Dr. Moran nonetheless told Dr. Chang to put in a temporary pacemaker, not a permanent one, but Dr. Chang insisted on a permanent pacemaker. The two of them got into an exchange over whether it was appropriate to put in a permanent pacemaker in an emergency situation. Dr. Moran said he tried to settle the matter in a way "to keep from getting angry and keep it from escalating." He added that, "[u]nfortunately, that was unsuccessful."

Ultimately, Dr. Anderson had to be contacted a second time to resolve the dispute. Dr. Anderson asked Dr. Moran why he didn't just let Dr. Chang do a permanent pacemaker and Dr. Moran replied that it "[was] not the right thing to do . . . ." Dr. Anderson overruled Dr. Moran a second time and told him to let Dr. Chang proceed with the permanent pacemaker.

When Dr. Moran testified before the Judicial Hearing Committee, three doctors, Drs. Acacio, Carlberg, and Cornett, each asked Dr. Moran why, when he realized that Dr. Chang had a different treatment style than he did, he did not simply step aside and let Dr. Chang go forward in the treatment of his very unstable patient, rather than try to control Dr. Chang's method of treatment. Dr. Moran maintained that it was safer to use the temporary pacing wire in the intensive care unit than to move the patient to the cath lab to implant a permanent pacemaker.

(e) substantial evidence re Patient No. 1

As Dr. Moran's own testimony makes clear, there was a scheduling dispute concerning the use of the cath lab. Dr. Chang's patient was critically unstable and Dr. Chang wanted to perform a permanent pacemaker implantation on an emergency basis. Dr. Moran wanted Dr. Chang to place a temporary wire in the unstable cardiac patient, at bedside in the intensive care unit, while he himself performed an elective procedure in the cath lab. The chief of staff and the vice-president of patient care services each had to be called to resolve the dispute.

Even after the chief of staff overruled Dr. Moran and told him to permit Dr. Chang to use the cath lab first, Dr. Moran persisted in furthering the dispute with Dr. Chang by endeavoring to control Dr. Chang's treatment methods. Dr. Moran insisted that even though Dr. Chang was going to be allowed to use the cath lab first, he would only be permitted to place a temporary wire in the patient, not to implant a permanent pacemaker. Because the dispute continued, the chief of staff had to intervene a second time. The chief of staff again overruled Dr. Moran and told him to permit Dr. Chang to implant the permanent pacemaker.

So, Dr. Moran's own testimony, even without the letter from Dr. Chang and the memorandum from Johnson, was sufficient to support the finding that Dr. Moran's disruptive behavior negatively impacted the delivery of patient care. True, there is no evidence to show that the patient suffered harm in the end. However, Dr. Moran himself testified repeatedly as to his understanding of how critically unstable the patient was, and it simply may have been good fortune that no harm befell the patient during the one-hour delay in treatment.

(2) Patient No. 2—

With regard to Patient No. 2, the Judicial Hearing Committee concluded: "The JHC unanimously finds that Dr. Moran was advised on two separate occasions of suspected ventricular tachycardia and failed to review the rhythm strips or examine the patient prior to ordering discharge. The JHC unanimously concludes that, by ignoring a 'red flag' that was potentially lethal to the patient, Dr. Moran violated the standard of care for cardiologist[s] in this community. This conclusion is confirmed by Dr. Dohad's opinion that to discharge a patient under these circumstances, knowing that ventricular tachycardia is potentially lethal, is egregious."

Dr. Moran contends there is no substantial evidence to support this finding. Furthermore, he says the only nonhearsay evidence concerning what information he did or did not have prior to discharging Patient No. 2 was his own testimony in the

administrative proceedings. He testified before the Judicial Hearing Committee as follows.

Dr. Moran had performed a replacement of an atrial pacemaker lead due to pacemaker lead failure. In his own words, "[i]t was a very difficult procedure," because the patient had extensive scar tissue due to prior surgeries. Dr. Moran stated "[i]t took quite some time to find a position where the atrial lead would function . . . ." Ultimately, he placed the lead "low in the atrium."

Nurse Elvia Bender contacted Dr. Moran at home around 8:00 a.m. on August 26, 2005 and told him the night nurses reported that the patient had suffered episodes of ventricular tachycardia. However, she stated that, in the morning, the patient had stable vital signs, was walking around, and said he felt fine. He was asymptomatic except for occasional palpitations.

Because it had been reported to him that there was a possibility of ventricular tachycardia or "wide complex beats," Dr. Moran told Bender to get an electrocardiogram and to let him know if there were any problems with it. He said he spoke to her later in the day and she reported again that "she was being told by the ICU that the monitor was printing out strips that had the V-tach alarm." Bender also told him that the electrocardiogram and a chest X-ray were okay, and "something about the lead being low in the atrium."

Dr. Moran was not concerned about the situation because he had placed the lead low in the atrium, and the patient was walking around, asymptomatic except for occasional palpitations, which he had had in the past with atrial fibrillation. Dr. Moran was at a different hospital that day, but was in contact with staff at the Hospital throughout the day.

At one point, the nurse, in describing the heart rhythm to Dr. Moran, "said that she really couldn't tell if it was irregular or regular, if . . . it was atrial fibrillation versus ventricular tachycardia." So Dr. Moran asked to speak to a nurse in the intensive

care unit, who told him the rhythm "was irregularly irregular." Dr. Moran opined that this was consistent with atrial fibrillation, but not ventricular fibrillation. Dr. Moran explained that he "discounted the computer interpretation, because the computer sees two or three wide beats in a row and it spits out a strip that says V-tach." At some point, Dr. Moran let the patient go home because his vital signs were stable, he was anxious to leave the Hospital, and he lived just around the corner.

Eventually, Dr. Moran got to the Hospital and saw the rhythm strips. He immediately observed that the atrial lead was pacing the ventricle and it was obvious that the pacemaker needed to be fixed. He also looked at the X-ray and observed that the lead was clearly in the ventricle, not "low in the atrium" as he had been told. Ultimately, Dr. Moran had Patient No. 2 come back to the Hospital.

When asked if he could not have requested that another cardiologist on staff check the situation, Dr. Moran said that he didn't think to have another doctor check on the patient because the patient seemed stable.

As we can see, Dr. Moran himself testified that suspected ventricular tachycardia was reported to him at least twice and that he discharged the patient without reviewing the rhythm strips, the electrocardiogram or the X-ray, and without examining the patient. He said he "discounted" the "V-tach alarm" the computer spit out because of the nurse's description of the patient and his belief that the palpitations the patient was suffering were consistent with his history of atrial fibrillation. Dr. Moran's reasoning aside, his testimony supports the factual findings of the Judicial Hearing Committee.

The Judicial Hearing Committee, having made its factual findings, concluded that Dr. Moran ignored a red flag that could have signaled a lethal condition for Patient No. 2. The Judicial Hearing Committee correctly observed that Dr. Dohad, in his peer review report, had opined that to discharge Patient No. 2 under the circumstances was "egregious" and below the standard of care.

This notwithstanding, Dr. Moran notes a portion of Dr. Dohad's testimony before the Judicial Hearing Committee wherein he stated: "[W]hen you're discharging a patient on the phone you have a full conversation with the nurse and you look for red flags. If there are none, then you're okay, you may send the patient home." Based on this testimony, Dr. Moran claims the issue in the case is simply whether he requested information from the nurses. Because he did talk to the nurses and he saw no red flags, he says he was in the clear.

In so arguing, Dr. Moran distorts Dr. Dohad's testimony. Dr. Dohad also said that a doctor cannot rely on a nurse's description of a telemetry strip and cannot ask a nurse a question like whether the rhythm is irregularly irregular. He further stated that when a nurse calls to notify a doctor of a possible ventricular tachycardia, the doctor has to assume the worst possible scenario, whether the patient seems stable or not. Then, the doctor has to make an effort to double check the situation and have the strip faxed to him or have a colleague take a look at it.

Dr. Dohad stated that it is extremely rare to discharge a patient without seeing him or her in person. Moreover, he said that a doctor has to review what needs to be reviewed on remote web access and that the nurse needs to affirm that there are no complications. He also stated, "Here, the nurse is telling you it's not right and you still discharge the patient." Dr. Dohad continued on, asking "Why would you discharge the patient?" He further asked: "With that strip? I'm not sure any cardiologist would discharge that patient." When asked whether he was saying that because Dr. Moran didn't have the strip faxed to him before giving discharge orders his treatment fell below the standard of care, Dr. Dohad replied, "No question."

(3) Patient Nos. 3 and 4—

(a) introduction

Dr. Moran was charged with "perform[ing] peripheral vascular procedures without adequate evaluation of the benefits against the risks in" the treatment of eight

identified patients, including Patient Nos. 3 and 4. In its findings and conclusions, the Judicial Hearing Committee stated: "The JHC recognizes that, in general, the aggressive style of treatment employed by Dr. Moran . . . is an accepted approach practiced by a minority of practitioners. However, a majority of the JHC concludes that these cases, most notably [Patient Nos. 3 and 4], demonstrate an unacceptable pattern of aggressive care with an inadequate regard for an appropriate surgical option. The JHC agrees with the concern that this overly aggressive pattern of treatment created virtually non-reconstructible surgical situations. . . . Dr. Moran's own testimony confirmed the JHC's conclusion that there is virtually no instance in which he would offer surgery as an alternative. . . ."

Dr. Moran attacks these findings as being unsupported by the evidence because: (1) there was no evidence to show that he ever failed to refer a patient to surgery where it would have been better to do so; (2) there was no evidence to show that his treatment actually compromised a surgical option; and (3) the findings were based exclusively on speculative expert witness testimony. His arguments are unpersuasive.

First, the Judicial Hearing Committee found that Dr. Moran exercised "an inadequate regard" for appropriate surgical options. It did not find that he had not ever referred a patient to surgery when it would have been better to do so. Second, the record contains ample evidence to support a finding that Dr. Moran exercised inadequate regard for surgical options and that his treatment compromised the surgical options for Patient Nos. 3 and 4. Third, Dr. Dohad's expert witness testimony was based on a review of medical records, charts and films, and the Judicial Hearing Committee's findings were not based entirely on his testimony in any event.

(b) interviews with Drs. Wallace and Borzatta

As we recall, the Hospital was first alerted to the situation with Patient Nos. 3 and 4 by vascular surgeons Drs. Wallace and Borzatta. Dr. Wallace reported that Dr. Moran had placed stents all the way from the groin to the mid-calf of Patient No. 3 and

thereby created a situation that was surgically non-reconstructible. Dr. Borzatta reported what he felt was injurious care rendered by Dr. Moran to various patients, including both Patient No. 3 and Patient No. 4, who ultimately suffered an amputation. Drs. Wallace and Borzatta each attended the Medical Executive Committee meeting on February 16, 2006.

The minutes of that meeting read in pertinent part: "Dr. Borzatta reviewed 2 patients that he had cared for . . . who were referred by [Dr. Moran]. The patients had claudication[5] and one had undergone 14 peripheral vascular procedures by [Dr. Moran] over 18 months. The other patient had undergone 10 peripheral vascular procedures and he felt that this was excessive and a danger to patients. In both patients he found multiple bare metal jackets. . . . [¶] Dr. Borzatta was questioned by members of [the Medical Executive Committee], and stated that what was at issue was the number of interventions that these patients had undergone as well as the locations of the stents and the types of stents that were used. His assessment was that bare metal stents were not a good choice and the number and location of stents made later intervention by a vascular surgeon extremely difficult. He stated that both patients were claudicators, but were not in a limb threatening situation when these peripheral vascular procedures were done by [Dr. Moran]. Intervention should not upgrade the patient's risk to a potential limb loss situation. He felt that more than 1 intervention was too many for someone with claudication without having a limb in jeopardy."

The minutes continued: "Dr. Wallace agreed that it was not appropriate for distal stents to be placed unless there was disabling claudication. Dr. Wallace shared one of the two patients that Dr. Borzatta had referenced. He stated that he had been asked by [Dr. Moran] to perform peripheral by-bass surgery. He accepted the patient . . . , but then realized that stents had been placed from the groin down through the profunda and

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5 Claudication means "limping; lameness; cramplike pains in the legs." (1 Schmidt's Attorneys' Dict. of Medicine (17th ed. 1992) p. C-239, col. 2.)

femoral arteries. He felt that doing a peripheral by-pass down to the foot was too risky, and refused to operate. . . . [¶] Both vascular surgeons felt that the number of interventions, the number of stents, the choice of stent type and their location represented a variation in the standard of practice in the community and represented a danger to these patients.

(c) Dr. Dohad's report and testimony

With regard to Patient No. 3, Dr. Dohad noted in his report that 14 vascular procedures had been performed over three years. He stated Dr. Moran had utilized a "very aggressive approach to a benign complaint," certain interventions "[did] not appear to be justified," and "there [was] a loss of surgical targets." He also wrote: "Stents crossing joints are at best controversial and clearly alters future surgical technique and options." Dr. Dohad concluded that the treatment fell below the standard of care and stated: "This case itself illustrates disregard for interventional principles, natural history of the disease, . . . and disregard for alternative options from the surgical stand point and eventually horrendous outcome for the patient which may lead to right above knee amputation . . . ."

When he testified before the Judicial Hearing Committee, Dr. Dohad said Dr. Moran had performed "increasingly complicated procedures" using "the same strategy of multi-modality intervention even though repeatedly failing." Dr. Dohad concluded that Patient No. 3 had been converted from a fairly stable patient with claudication to someone who had severe pain at rest and that her surgical options and alternatives had been compromised. In other words, she had gone from someone with a "lifestyle interferon symptom" to someone with a limb-threatening condition. He described the treatment of Patient No. 3 as "egregious."

Turning to Patient No. 4, Dr. Dohad wrote in his report, inter alia, that the patient had undergone multiple vascular procedures in two years and that "[v]ery aggressive interventional strategies" were employed to treat moderate symptoms. He

again wrote: "Stents crossing joints are at best controversial and clearly alters future surgical technique and options." In conclusion, Dr. Dohad said the treatment of the patient was inconsistent with the standard of care and further stated: "Reviewing this case reveals significant compromise of surgical targets, use of extensive aggressive multi modality procedures with limited success, recurrent restenosis and the inability to step back and consider no further intervention. . . . Overall this procedure has significantly jeopardized this patient with increased likelihood for limb loss and poor salvage due to loss of surgical targets."

The evidence before the Judicial Hearing Committee showed that Patient No. 4 did indeed suffer an above-the-knee amputation. When Dr. Dohad was asked whether Dr. Moran's procedures were medically responsible for, and causally related to, the above-knee amputation, Dr. Dohad replied, "I think clearly a contributor, absolutely." He also said that the patient did not start out with a "drastic indication" but ended up with a "drastic outcome."

Dr. Dohad testified: "A loss of limb above the knee carries a very poor prognosis. In general, an above-knee amputation, . . . can have a mortality of about 50 percent over the next two to three years. So I think any time we embark on . . . interventions that are this extensive — there may be a time, even if we have indulged in the first one or second one, there must be a time where we have to step back and say enough is enough and maybe you should make a search for alternative procedures or leave the patient alone, especially if the patient doesn't have limb-threatening ischemia. [¶] I found that fairly evident in this case . . . . At some point we could have stepped back and perhaps offered this patient a surgical vascularization . . . ."

(d) Dr. Moran's testimony

The Judicial Hearing Committee questioned Dr. Moran at length about his treatment of Patient Nos. 3 and 4. Members of the committee expressed great concern about the number of procedures he had performed and questioned whether there was not

a point at which he should have stopped performing additional procedures and told the patients that there was nothing more he could do without risking greater harm. He was asked, for example, whether it wasn't an option to tell the patient that if she wouldn't quit smoking he was not going to perform a risky procedure on her. Dr. Moran responded, "My ethics and morals don't let me do that."

In discussing Patient No. 3, Dr. Moran was asked, "Did you ever have any physician ever come to you and tell you, 'Gee, Dr. Moran, by you placing these stents, we can't perform bypass'?" Dr. Moran replied, "Just Dr. Coccia." Thus, Dr. Moran himself admitted another doctor had informed him that because of his use of stents he had precluded the possibility of a surgical bypass being performed.

(e) substantial evidence

Dr. Moran cites *Hongsathavij v. Queen of Angels Etc. Medical Center* (1998) 62 Cal.App.4th 1123 in support of his position that the foregoing evidence was insufficient to support the findings. As stated in that case: "[A]n appellate court must uphold administrative findings unless the findings are so lacking in evidentiary support as to render them unreasonable. [Citations.] A reviewing court will not uphold a finding based on evidence which is inherently improbable [citation] or a finding based upon evidence which is irrelevant to the issues. [Citations.] . . . Finally, we note that the opinion testimony of expert witnesses does not constitute substantial evidence when it is based upon conclusions or assumptions not supported by evidence in the record. [Citations.]" (*Id.* at p. 1137.)

Dr. Moran hangs his hat on the final sentence of the above-quoted language and complains that the Medical Executive Committee relied on speculative testimony by Dr. Dohad. We observe that before preparing his peer review report, Dr. Dohad went to the Hospital on three occasions and reviewed the patients' charts and films. He then wrote a five-page summary of the treatment of Patient No. 3 a four and one-half page summary of the treatment of Patient No. 4. After Dr. Dohad prepared his report, but

before he testified before the Judicial Hearing Committee, Dr. Dohad had an opportunity to review Dr. Moran's medical records concerning these two patients. During his testimony before the Judicial Hearing Committee, Dr. Dohad was questioned about those records, which were presented as exhibit Nos. 619 and 623 and which form a part of the record on appeal.

Dr. Dohad, who characterized himself as aggressive with respect to interventional cardiology and endovascular procedures, opined that Dr. Moran's treatment of Patient Nos. 3 and 4 was "[v]ery aggressive" and that surgical options had been compromised and alternatives to interventions should have been considered. Dr. Dohad was not the only doctor who expressed an opinion with respect to Patient Nos. 3 and 4, however. Drs. Borzatta and Wallace each opined that Dr. Moran had performed too many interventions. Dr. Borzatta in particular opined, as summarized in the Medical Executive Committee minutes, that Dr. Moran's use of stents "made later intervention by a vascular surgeon extremely difficult." He further indicated that where the "patients . . . were not in a limb threatening situation when these peripheral vascular procedures were done by [Dr. Moran,]" his interventions upgraded their "risk to a potential limb loss situation." Finally, Dr. Moran himself admitted that Dr. Coccia had told him, generally, that by Dr. Moran's "'placing these stents, [they couldn't] perform bypass'[.]"

Given the foregoing, we certainly cannot conclude that the findings are so lacking in evidentiary support as to render them unreasonable.

(4) Denial of Reappointment—

Dr. Moran also maintains that the denial of reappointment was not supported by substantial evidence. He says that even if the evidence supported the charges regarding Patient Nos. 1, 2, 3 and 4, the few sustained charges did not warrant ending his career.

The Supreme Court has "recognized that a 'doctor's license . . . does not determine qualification for hospital privileges or establish competence to engage in

specialties in the hospital . . . .' Indeed, the 'determination of the standards to be applied in granting privileges involves a legislative judgment [citation], and just as courts have largely deferred to administrative expertise in determining whether an applicant is qualified to practice a profession . . . they should defer to administrative expertise in determining whether the professional is qualified to take on the additional responsibilities involved in a grant of hospital privileges.' [Citations.]" (*Gill v. Mercy Hospital* (1988) 199 Cal.App.3d 889, 897.)

In short, it is not our place to substitute our judgment for that of the Governing Board. This would be true even if, in our view, a different decision seemed equally or more reasonable. (Cf. *Cipriotti v. Board of Directors*, *supra,* 147 Cal.App.3d at p. 155.)

C. Motions for Discovery and Augmentation of Administrative Record:

(1) Motion for Discovery—

In the writ proceedings, Dr. Moran filed a motion to compel discovery and to augment the administrative record with the results of the discovery. He asserted that the Governing Board had failed to perform an independent review of any of the Judicial Hearing Committee proceedings or findings and had failed to review or consider the recommendations of the Appeal Board. He further asserted that the final decision of the Governing Board contained findings that were neither discussed nor voted upon by the Governing Board. Dr. Moran maintained that he was, therefore, deprived of "any legitimate appellate procedure" and denied a fair hearing.

Dr. Moran sought discovery of all documents distributed to and produced by the Appeal Board and the Governing Board and, after receipt of the documents, the opportunity to depose one member of the Appeal Board and one member of the Governing Board. He claimed that this would allow him to determine whether the Appeal Board and the Governing Board had complied with Hospital bylaws in their

review and would enable him to prove that he was denied a fair hearing. The court denied the motion.

On appeal, Dr. Moran asserts that the court erred in denying his motion. He maintains that the court had the authority, under Code of Civil Procedure section 1094.5, subdivision (e), to grant the requested relief. That statutory provision states in pertinent part: "Where the court finds that there is relevant evidence that, in the exercise of reasonable diligence, could not have been produced or that was improperly excluded at the hearing before respondent, . . . in cases in which the court is authorized by law to exercise its independent judgment on the evidence, the court may admit the evidence at the hearing on the writ without remanding the case." (Code Civ. Proc., § 1094.5, subd. (e).)

Dr. Moran, citing *Windigo Mills v. Unemployment Ins. Appeals Bd.* (1979) 92 Cal.App.3d 586, 596-597, emphasizes that Code of Civil Procedure section 1094.5, subdivision (e) permits the court to consider evidence that could not have been produced during the administrative proceedings. He says he could not have provided the Governing Board with evidence that it was not affording him a fair hearing, because he could not have known that before the Governing Board took its actions. In other words, he argued that only if he were permitted to do discovery to obtain evidence showing that the Governing Board acted improperly would he then be able to present his argument that the Governing Board denied him a fair hearing.

As stated in *Pomona Valley Hospital Medical Center v. Superior Court* (1997) 55 Cal.App.4th 93, "discovery under section 1094.5, unlike general civil discovery, cannot be used to go on a fishing expedition looking for unknown facts to support speculative theories. The stringent requirements set forth in section 1094.5, subdivision (e) require the moving party to identify what evidence is sought to be discovered for purposes of adding it to the record; to establish the relevancy of the evidence; and to show that either (a) any such relevant, additional evidence was

improperly excluded at the administrative hearing, or (b) it could not have been produced at the hearing with the exercise of reasonable diligence. (§ 1094.5, subd. (e).) If the moving party fails to make the required showing, it is an abuse of the court's discretion to allow posthearing discovery." (*Pomona Valley Hospital Medical Center v. Superior Court*, *supra*, 55 Cal.App.4th at p. 102.)

In his motion, Dr. Moran sought evidence to show that he was denied a fair hearing because the Appeal Board and the Governing Board had failed to comply with the Hospital's bylaws in performing the administrative review. However, he did not cite any of the bylaws in support of his position. He made broad and unsupported claims about what procedures the Appeal Board and the Governing Board were supposed to follow and claimed that he needed evidence to demonstrate the lack of compliance with the purported procedures. He failed to demonstrate that the evidence he sought was relevant to show a breach of the bylaws, inasmuch as he neither quoted nor cited the bylaws on the topic. This being the case, he failed to make the required showing under Code of Civil Procedure section 1094.5, subdivision (e), and the court did not abuse its discretion in declining to grant his request for discovery on this point.

(2) Motion to Augment—

The discovery motion having been denied, Dr. Moran sought to obtain by another avenue information on the manner in which the final meeting of the Governing Board was conducted. He procured the declaration of Carole Bowman, a member of the Governing Board he had known for 10 years.

The declaration was filed under seal. In that declaration, Bowman described the June 25, 2009 meeting of the Governing Board, which she stated was its final meeting before the sale of the Hospital to Mission Hospital on June 30, 2009. She disclosed what the Governing Board was "told" concerning Dr. Moran's appeal, including what information was provided about the administrative proceedings and findings, what instructions were given to the Governing Board on how to process the

appeal, and what effect the Governing Board's decision would have upon Dr. Moran. She stated, inter alia, that the Governing Board was "told" the Judicial Hearing Committee and the Appeal Board each had found that three particular events had occurred. However, she also said that the Governing Board itself did not independently review the evidence. In her declaration, Bowman did not identify the individual who "told" the Governing Board about the information, gave the Governing Board instructions on how to proceed in determining the appeal, or explained the ramifications to Dr. Moran. She declared that there was no vote upon the recommendation to deny Dr. Moran's reappointment.

The Hospital opposed the motion to augment on several grounds: (1) the information in Bowman's declaration concerning what was "told" to the Governing Board was subject to the attorney-client privilege, inasmuch as the information in question was provided by Attorney Christensen to his client, the Governing Board; (2) Hospital bylaws section 10.5-10 specified that peer review matters, including appellate review proceedings, were confidential, and precluded disclosure; (3) the information in the declaration concerning what the Governing Board was "told" was inadmissible hearsay; and (4) the information in the declaration was irrelevant, inasmuch as the Hospital bylaws required the affirmance of the Judicial Hearing Committee decision once the Appeal Board determined that the findings of the Judicial Hearing Committee were supported by substantial evidence.

The Hospital's opposition was supported by several declarations, including the declarations of both Attorney Christensen and Carmen, president of the Governing Board. Attorney Christensen declared that, at the June 25, 2009 meeting, Bowman disclosed that she had a personal, business or professional relationship with Dr. Moran, but she did not recuse herself from participating in the meeting. He further declared that he had hand delivered to each member of the Governing Board, including Bowman, a letter upon which was written "CONFIDENTIAL ATTORNEY/CLIENT

COMMUNICATION." In addition, Attorney Christensen stated that he went through his letter line by line at the meeting and that he advised the members of the Governing Board that the statements at the meeting were confidential and privileged. He further stated that the members of the Governing Board asked him questions about Dr. Moran's appeal and that they "engaged in an extensive discussion." From his point of view, the entire discussion was privileged. Finally, Attorney Christensen declared that he was the source of most of the information Bowman described, but that she had, many times, inaccurately described what the Governing Board was or was not "told."

Carmen declared that he had been in attendance at the June 25, 2009 meeting. Attached to his declaration was a copy of the minutes of the meeting, which Carmen declared had been prepared in the ordinary course of business, at or about the time of the meeting. Carmen further declared that, to the best of his recollection, the minutes accurately described the Governing Board's proceedings with respect to Dr. Moran's appeal. The minutes stated that Attorney Christensen had discussed the actions of the Medical Executive Committee, the findings and decision of the Judicial Hearing Committee, the findings and recommendation of the Appeal Board, and applicable legal considerations. The minutes further stated that extensive discussion had followed and that upon a motion duly made and seconded, the Governing Board, by voice vote, had voted to uphold the recommendation of the Medical Executive Committee to deny Dr. Moran's reappointment. Finally, the minutes stated that the Governing Board had authorized Carmen to work with Attorney Christensen to prepare the final decision of the Governing Board.

In concluding its opposition, the Hospital asked that if the court should decide to permit Bowman's declaration to be added to the record, then it should also allow the Hospital to submit declarations to show the falsity of Bowman's statements.

The court ordered the deposition of Bowman, to address who was in attendance at the June 25, 2009 meeting, whether Attorney Christensen was present,

who presented the information she disclosed in her declaration, and whether she was advised that she had the authority to waive the attorney-client privilege. At her deposition, Bowman explained that she was a branch manager of a bank and that Dr. Moran was a customer of the bank whom she had known for 10 years. Bowman acknowledged that Attorney Christensen was present at the June 25, 2009 meeting. She said that Carmen introduced Attorney Christensen to the Governing Board and said he was going to provide a timeline of events with regard to Dr. Moran and "what the appeal board had gone through the process." Bowman said that Attorney Christensen read a document—a timeline "about the date of the occurrences and what the appeal board found." However, she said they were never told at the meeting that it was attorney-client privileged. Bowman acknowledged that no officer of the Hospital ever told her that she was authorized to waive the attorney-client privilege on the Hospital's behalf.

At her deposition, Bowman stated that it was Carmen who told the Governing Board: (1) the members' function was to decide whether the three events had occurred; (2) that the Judicial Hearing Committee and the Appeal Board had found that the three events had occurred; (3) that their only task was to vote on whether the three events had occurred; and (4) that one patient had suffered a leg amputation because of Dr. Moran's treatment.

After Bowman's deposition was taken, the parties provided supplemental briefs on the motion to augment. In support of its brief, the Hospital provided another declaration of Carmen and a declaration of Don Ammon, also a member of the Governing Board. Ammon declared: (1) Carmen introduced Attorney Christensen as the Hospital's special counsel retained to advise the Governing Board on Dr. Moran's appeal; (2) Attorney Christensen was the one who provided all substantive information regarding the appeal, including a detailed presentation of his privileged and confidential letter to the Governing Board; (3) Attorney Christensen actively participated in the ensuing discussion and answered questions; (4) it was Attorney Christensen, not Carmen,

who provided all the information that Bowman had ascribed to Carmen; (5) no one could reasonably have understood that the meeting was anything other than a privileged discussion with legal counsel; (6) section 10.5-10 of the Hospital's bylaws required the discussion of Dr. Moran's appeal to be kept confidential; and (7) the Hospital did not authorize a waiver of either the attorney-client privilege or the confidentiality of the peer review proceedings. In the first two pages of his declaration, Carmen made the same declaration as Ammon on the first five points. In what would appear to be a copying or compilation error, the remaining pages of Carmen's declaration were not included in the record on appeal.

The court denied the motion to augment the record with the declaration of Bowman, for two reasons. First, the court stated that Bowman's declaration contained "much hearsay." Second, it said the statements in Bowman's declaration seemed to be covered by the attorney-client privilege and so were inadmissible. The court noted the contradictory positions of Bowman, on the one hand, and Ammon and Carmen, on the other, concerning whether the statements described in Bowman's declaration were made by Carmen. The court concluded that the record suggested the statements were made during a confidential legal discussion with Attorney Christensen.

On appeal, Dr. Moran argues the trial court erred in denying the motion to augment based on the attorney-client privilege because: (1) it only found that the matters disclosed in Bowman's declaration "might" have been protected by the attorney-client privilege; (2) there was insufficient evidence to show the matters were protected by the attorney-client privilege; (3) the matters were not protected by the attorney-client privilege because Attorney Christensen was not providing legal advice at the June 25, 2009 meeting; and (4) the Hospital waived the attorney-client privilege by publishing information in its final decision.

First, the Hospital correctly notes that Dr. Moran, in his opening brief, argues that the court erred in excluding Bowman's declaration based on the attorney-

client privilege and does not argue the court erred in excluding the declaration based on hearsay. In his reply brief, Dr. Moran contends that he addressed the issue on page 36 of his opening brief. We don't see the mention of hearsay anywhere on that page and the reference to *Windigo Mills v. Unemployment Ins. Appeals Bd.*, *supra*, 92 Cal.App.3d 586 is insufficient to clue us in to an intent to argue hearsay. Any arguments based on the court's hearsay ruling are waived. (*G.R. v. Intelligator* (2010) 185 Cal.App.4th 606, 610, fn. 1.)

In any event, we observe that the trial court was clearly correct that Bowman's declaration contained "much hearsay." It was up to Dr. Moran to argue whether hearsay portions of the declaration should be redacted and nonhearsay portions permitted to be considered. For example, the portion of the declaration wherein Bowman declared that the Governing Board did not vote upon Dr. Moran's appeal is not hearsay. (Evid. Code, § 1200, subd. (a).) However, we decline any invitation to go line by line through Bowman's declaration to evaluate whether there may be other statements that also might not be hearsay. (*McComber v. Wells* (1999) 72 Cal.App.4th 512, 522-523.)

Dr. Moran, as we have noted, focuses his attentions on the attorney-client privilege. He first attacks the wording of the court's tentative ruling attached to and incorporated by reference into the formal order denying his motion to augment. The tentative ruling stated that the statements "[did] seem to be covered by the attorney-client privilege, and thus seem inadmissible." The tentative ruling went on to address the deposition testimony of Bowman, on the one hand, and the declarations of Ammon and Carmen, on the other hand. It concluded: "The record suggests that these statements *might* have been made during a confidential legal discussion with the Board's special counsel, attorney Jay Christensen, regarding Dr. Moran's appeal." (Italics added.)

Dr. Moran attacks the use of the word "might." He says the court's wording shows that the Hospital did not meet its burden to demonstrate that the challenged communications fell within the attorney-client privilege. "When a party

asserts the attorney-client privilege it is incumbent upon that party to prove the preliminary fact that a privilege exists. [Citation.] Once the foundational facts have been presented, i.e., that a communication has been made 'in confidence in the course of the lawyer-client . . . relationship, the communication is presumed to have been made in confidence and the opponent of the claim of privilege has the burden of proof to establish that the communication was not confidential,' or that an exception exists. [Citations.]" (*State Farm Fire & Casualty Co. v. Superior Court* (1997) 54 Cal.App.4th 625, 639.)

We agree that the wording of the tentative ruling was less than ideal. However, "[w]e imply all findings necessary to support the judgment, and our review is limited to whether there is substantial evidence in the record to support these implied findings. [Citations.]" (*In re Marriage of Cohn* (1998) 65 Cal.App.4th 923, 928.) Here, we imply a finding that the court ultimately found certain statements were subject to the attorney-client privilege. Dr. Moran claims that there is no substantial evidence to support this finding. We disagree.

At her deposition, Bowman said that Carmen had made the statements in question. However, she acknowledged that Carmen introduced Attorney Christensen to the Governing Board for the purpose of providing a timeline of events with regard to Dr. Moran and "what the appeal board had gone through the process." She also acknowledged that Attorney Christensen read a timeline "about the date of the occurrences and what the appeal board found." At the same time, Ammon and Carmen each declared that Attorney Christensen was the one who had provided all the information that Bowman had said was furnished by Carmen. Each of them also declared that Attorney Christensen had been retained to advise the Governing Board on Dr. Moran's appeal and had provided all of the substantive information regarding the appeal. In addition, Attorney Christensen himself declared that he had attended the June 25, 2009 meeting, had presented a letter marked "CONFIDENTIAL ATTORNEY/CLIENT COMMUNICATION," had gone through the letter line by line at the meeting, and had

responded to questions. Finally, he stated that he was the one who provided most of the information Bowman described, even though she had described some of it inaccurately, and that he viewed the entire discussion as being privileged.

The declarations of Ammon, Carmen and Attorney Christensen provided substantial evidence that the source of the statements in question was Attorney Christensen. Consequently, the Hospital met its burden to show that the statements were made in confidence in the course of the attorney-client relationship, and the statements were presumed to have been made in confidence. The burden then shifted to Dr. Moran to show that the statements were not confidential or that an exception existed. (*State Farm Fire & Casualty Co. v. Superior Court, supra,* 54 Cal.App.4th at p. 639.)

Dr. Moran asserted that the statements, even if made by Attorney Christensen, were not subject to the attorney-client privilege because he simply recited factual information but did not provide legal advice. As stated in *State Farm Fire & Casualty Co. v. Superior Court, supra,* 54 Cal.App.4th 625, "the attorney-client privilege only protects disclosure of *communications* between the attorney and the client; it does not protect disclosure of underlying facts which may be referenced within a qualifying communication. [Citation.]" (*Id.* at p. 639.) So, for example, to the extent Attorney Christensen was the one who "told [the Governing Board] that the [Judicial Hearing Committee] and the Appeal Board found all three factual events to have occurred," the disclosure that the Judicial Hearing Committee and the Appeal Board had made those findings was not subject to the attorney-client privilege. That does not mean, however, that all statements contained in the Bowman declaration would fall outside the attorney-client privilege. For example, to the extent Attorney Christensen was the one who told the members of the Governing Board what "[their] sole purpose was," his statement would have been in the nature of legal advice, not in the nature of a recitation of fact.

As is evident, some of the statements in Bowman's declaration would be subject to the attorney-client privilege and some would not, just as some of them would

be hearsay and some of them would not. On appeal, Dr. Moran states broadly that Bowman's declaration addressed the underlying facts of the case, that is, what information was or was not before the Governing Board, and that this information was not privileged. In so doing, he does not cite the portions of the record to show what arguments he made before the trial court—which of Bowman's statements he argued were not subject to the attorney-client privilege because they were purely factual—or even whether he argued that every single one of her statements was factual. To the extent he may have argued that all of Bowman's statements were factual and thus not subject to the attorney-client privilege, he was mistaken. As we have already stated, by way of example, to the extent Bowman's declaration addressed the instructions given concerning the function of the Governing Board with respect to Dr. Moran's appeal, that is legal advice, not factual recitation.

As his final point, Dr. Moran says that the Hospital waived the attorney-client privilege when it published its own version of events in the form of its final decision, which it made available to Dr. Moran as a third party. The final decision of the Governing Board recapitulated the history of the case from the Medical Executive Committee summary suspension through the decision of the Judicial Hearing Committee and the findings and recommendation of the Appeal Board. Dr. Moran argues the Governing Board "cannot make public its own version of what information the [Governing] Board relied on, but then claim that no one can challenge whether the [Governing] Board was actually provided with that information because it was an attorney who provided it." As we have already stated, the recitation of factual information is not privileged, so we do not even need to address the issue of waiver.

Our task is to determine whether the court abused its discretion in denying the motion to augment. (*Pomona Valley Hospital Medical Center v. Superior Court*, *supra*, 55 Cal.App.4th at p. 101; *Pannu v. Land Rover North America, Inc.* (2011) 191 Cal.App.4th 1298, 1317.) We are hampered in making that determination due to Dr.

Moran's limited citations to the record concerning the arguments made to the trial court. "'The reviewing court is not required to make an independent, unassisted study of the record in search of error or grounds to support the judgment. . . .'" (*McComber v. Wells*, *supra*, 72 Cal.App.4th at p. 522.) Without performing an unassisted study of the record we do not know whether Dr. Moran made any effort to separate out statements that were privileged and statements that were not and offer the court anything other than an "all-or-nothing" proposition. Because it is evident that at least some of the statements were privileged and at least some of them were hearsay, we cannot say that the court abused its discretion in denying the motion to augment.

D. Fair Procedure:

(1) Governing Board review—

Dr. Moran insists that he received no meaningful appeal. He says Business and Professions Code section 809.4, subdivision (b)(1) provides that in an administrative appeal before a medical peer review panel, he is entitled to appear and respond. However, because, he asserts, the Governing Board never heard or considered the Appeal Board's recommendation and did not perform any review whatsoever of his case, he was denied his appeal rights. We disagree.

Hospital bylaws section 10.5-1 provides that a doctor receiving a Judicial Hearing Committee decision "may request an appellate review by the Governing Board." According to bylaws section 10.5-4, once "appellate review is requested, the Governing Board may sit as the appeal board or it may appoint an appeal board . . . ." Then, according to bylaws section 10.5-5, the parties have a right to be represented by legal counsel, to present a written statement, and to appear and make oral argument. After these rights have been exercised, the Appeal Board may deliberate and shall present written recommendations to the Governing Board. (Bylaws, § 10.5-5.) Pursuant to section 10.5-6, the Governing Board shall then render a final written decision, giving

"great weight to the recommendation of the Judicial Hearing Committee" and affirming the recommendation of the Judicial Hearing Committee if supported by substantial evidence.

The procedures comply with Business and Professions Code section 809.4, subdivision (b)(1), inasmuch as they offer the doctor a right to appear and respond during the appellate proceedings. Indeed, Dr. Moran acknowledges that he presented "argument and evidence to the Appeal Board over two hearings and through extensive briefing." In essence, he contends that his argument and appearance before the Appeal Board did not count, because it was the Governing Board that issued the final decision, which did not adopt the findings and recommendation of the Appeal Board in full. But neither Business and Professions Code section 809.4, subdivision (b)(1) nor the bylaws require the doctor to have *three* opportunities to appear and respond, first before the Judicial Hearing Committee and then twice during the appellate review process. The bylaws permit an appeal to the Governing Board and permit the Governing Board to appoint an Appeal Board, but require that the Governing Board issue the ultimate decision. This was done.

Furthermore, section 10.5-6 of the bylaws requires the Governing Board to affirm the recommendation of the Judicial Hearing Committee if supported by substantial evidence. The Appeal Board, appointed by the Governing Board to address Dr. Moran's appeal, determined that substantial evidence supported the findings of the Judicial Hearing Committee. Consequently, affirmance of the decision of the Judicial Hearing Committee was appropriate, as the Governing Board acknowledged.

However, notwithstanding the fact that the Appeal Board determined the findings of the Judicial Hearing Committee were supported by substantial evidence, two out of three members of the Appeal Board disagreed with the Judicial Hearing Committee's recommendation to deny Dr. Moran's reappointment. They felt that while substantial evidence supported the findings of the Judicial Hearing Committee, substantial evidence did not support the recommendation, which was too drastic. In other

words, two members of the Governing Board, while sitting on the Appeal Board, voted not to uphold the recommendation of the Judicial Hearing Committee even though its findings were supported by substantial evidence. However, the Governing Board, apprised of both the opinion of the Appeal Board that substantial evidence supported the findings of the Judicial Hearing Committee and the opinion of two members of the Appeal Board that the recommendation of the Judicial Hearing Committee was too drastic, chose to issue a final decision upholding the recommendation of the Judicial Hearing Committee.

Dr. Moran heartily disagrees with this characterization of the events. He maintains that both the minutes of the June 25, 2009 meeting and the final decision of the Governing Board contain false information. He says the Governing Board was not apprised that two members of the Appeal Board did not want to uphold the recommendation of the Judicial Hearing Committee. He also maintains that the Governing Board itself did not review any of the evidence, did not conduct a detailed review of the case as stated in the final decision, and did not even vote on his appeal. Dr. Moran grounds these assertions in the declaration of Bowman, which the court rejected based on hearsay and the attorney-client privilege.

As Dr. Moran observes, we independently review his claim of unfair procedure, as a question of law. (*Rosenblit v. Superior Court* (1991) 231 Cal.App.3d 1434, 1438, 1443.) We conclude that Dr. Moran received a fair hearing.

Dr. Moran does not claim that he was denied notice and an opportunity to be heard at any step of the proceedings except during the administrative appellate review. Even then, he does not challenge the proceedings before the Appeal Board. He only challenges the actions of the Governing Board at its final meeting. Dr. Moran had notice and an opportunity to be heard during the appellate review process inasmuch as he had notice and an opportunity to be heard by the Appeal Board. The Appeal Board was designated by the Governing Body to perform a review of the evidence and the findings

of the Judicial Hearing Committee. The Appeal Board found that there was substantial evidence to support the findings of the Judicial Committee. Although two members of the Appeal Board, essentially a subset of the members of the Governing Board, opined that the recommendation of the Judicial Hearing Committee was too drastic, the Governing Board voted to uphold the recommendation. This is consistent with section 10.5-6 of the Hospital bylaws.

Even taking Bowman's declaration into consideration, what we have is the declaration of one person directly contradicting the declarations of other persons. Bowman says the members of the Governing Board were not informed that the majority of the Appeal Board disfavored the recommendation of the Judicial Hearing Committee as too drastic and "there was absolutely no discussion or vote where the Governing Board concluded that the [Medical Executive Committee's] recommended denial of reappointment was reasonable and warranted."

Carmen, on the other hand, declared that the minutes of the meeting were correct, and the minutes of the meeting reflected both that Attorney Christensen had discussed with the Governing Board the findings and recommendation of the Appeal Board and that the Governing Board had made its decision based on a voice vote. Attorney Christensen declared that he had prepared a written communication to the Governing Board, that he had gone through it with the Governing Board line by line, and that extensive discussion had ensued. Bowman ultimately conceded at deposition that Attorney Christensen had read to the Governing Board a document that was "a timeline . . . about the date of the occurrences and what the appeal board found." This is consistent with the declaration of Ammon, who stated that Attorney Christensen had provided a detailed presentation and that discussion, including questions and answers, had followed.

In short, the declarations of Ammon, Carmen and Attorney Christensen, the minutes of the June 25, 2009 meeting, and the Governing Board's final decision itself, support the conclusion that the findings and recommendation of the Appeal Board were

disclosed to the Governing Board and that a majority of the members of the Governing Board voted to uphold the recommendation of the Judicial Hearing Committee even knowing that two members of the Appeal Board, who were also members of the Governing Board, disagreed.

(2) Disqualified voter—Dr. Sassani—

The selection of the Judicial Hearing Committee members began in August 2007. After the members were selected, 15 evidentiary hearings took place over a period of 10 months, beginning December 20, 2007 and ending October 23, 2008. Meanwhile, Dr. Sassani relinquished his active staff position at the Hospital and became an affiliate staff member in August 2008. The Judicial Hearing Committee began its deliberations on October 23, 2008 and concluded them on November 20, 2008.

As noted previously, Dr. Moran asserted in the writ proceedings that Dr. Sassani was precluded by the Hospital bylaws from either sitting on the Judicial Hearing Committee or participating in its voting. The court concluded that the decision to allow Dr. Sassani to vote was "not such a departure from the Bylaws as to deny Petitioner Moran a fair hearing, in light of the overall record." Dr. Moran challenges this ruling on appeal, renewing the arguments he made previously.

We turn now to the Hospital's bylaws. The Hospital's affiliate staff are "practitioners who practice only in an outpatient department or facility, or affiliate or subsidiary entity of the Hospital, which is not subject to the Hospital's license as a general acute care Hospital." (Bylaws, § 4.6-1.) They are members of the medical staff. (Bylaws, § 4.6-2.) Dr. Moran emphasizes the portion of bylaws section 4.6-2 which provides that affiliate staff "may not vote on any Medical Staff matter . . . ." (Bylaws, § 4.6-2.) This, as far as he is concerned, plainly and simply answers the question here. Not necessarily.

Bylaws section 4.6-2 does not define the term "Medical Staff matter." However, we find two other provisions of the bylaws where the term is defined. Bylaws

sections 4.3-2 and 4.4-2 provide that that provisional staff members and courtesy staff members, respectively, "may not vote on any Medical Staff matters (i.e., Staff Officers, Bylaws, etc)." So, the bylaws preclude affiliate staff members, as well, from voting on matters such as staff officers and bylaws, "etc."

Keeping that in mind, we turn to bylaws section 4.6-3, which requires each affiliate staff member to "meet the basic responsibilities specified in Section 3.6, *excluding paragraphs (i) and (o).*" Section 3.6, paragraph (c) of the bylaws provides that it is an ongoing responsibility of each member of the medical staff to attend meetings and "participat[e] in peer review . . . ." The excluded responsibilities, contained in paragraphs (i) and (o), are the responsibility to participate in emergency service coverage and the responsibility to participate in medical staff proctoring.

So, on the one hand, the bylaws state that an affiliate member may not vote on a "Medical Staff matter," but that, on the other hand, an affiliate member must participate in peer review. Bylaws section 10.3-5 specifies the persons who shall serve on the Judicial Hearing Committee. That section states that the Judicial Hearing Committee shall consist "of at least three (3) members," and at least two alternates. The definitional provisions of the bylaws define the term "member" to mean "any Practitioner who has been appointed to the Medical Staff." Also, section 4.1 of the bylaws provides that a member of the affiliate staff is a member of the medical staff. Thus, section 10.3-5 of the bylaws permits an affiliate staff member, as a member of the medical staff, to serve as a member of the Judicial Hearing Committee.

Here, we have a doctor who was an active staff member at the time of his appointment to the Judicial Hearing Committee, who was clearly entitled to participate thereon and to vote, at the time of his appointment. When after the proceedings were largely complete, he transferred to affiliate member status, he was still entitled to participate as a member of the Judicial Hearing Committee and, indeed, was required to participate in peer review matters. The question is whether bylaws section 4.6-2, which

provides that an affiliate staff member may not vote on medical staff matters (defined elsewhere as such matters as medical staff officers or bylaws), precluded the doctor from concluding his service on the Judicial Hearing Committee by voting.

This was one of the issues determined by the Appeal Board in its bifurcated proceedings. The Appeal Board stated that the Judicial Hearing Committee did not vote on any "Medical Staff" matters and thus an affiliate staff member could vote on a Judicial Hearing Committee peer review matter without violating section 4.6-2 of the bylaws.

Dr. Moran sought reconsideration of that ruling, and presented additional evidence to the Appeal Board on the point. He argued that the Medical Executive Committee had construed the bylaws differently in another matter. Having considered Dr. Moran's additional evidence and argument on the point, the Appeal Board declined to change its ruling.

We agree with the Appeal Board that rules should be harmonized when possible. (Cf. *Pineda v. Williams-Sonoma Stores, Inc.* (2011) 51 Cal.4th 524, 530.) We achieve that goal in this case by construing the bylaws as permitting an affiliate staff member to complete his service on the Judicial Hearing Committee by voting on a peer review matter in which he has participated.

Dr. Moran continues to assert, however, that the Hospital is barred from construing its bylaws in the manner that the Appeal Board did, because it had taken an inconsistent position previously. He cites an April 15, 2009 letter from counsel for the Hospital arising in connection with a hearing concerning another doctor. In that case, it was clear that the Judicial Hearing Committee could not conclude its proceedings before the sale of the Hospital. Counsel was addressing whether it was possible for the Judicial Hearing Committee to complete its work and issue findings and a recommendation after the Hospital closed. Obviously, there would no longer be any active staff members to serve on the Judicial Hearing Committee, since the Hospital would no longer exist. Counsel offered the suggestion that even if doctors could be found who would be willing

to serve on a Judicial Hearing Committee after the Hospital had closed, they would at best be construed as affiliate staff members, precluded from voting by bylaws section 4.6-2.

However, the Appeal Board reviewed Dr. Moran's evidence on this point when it reconsidered the issue at its May 6, 2009 hearing. It rejected the interpretation of the bylaws espoused in the April 15, 2009 letter. So, the final word from the Appeal Board is that a vote on a Judicial Hearing Committee peer review matter is not a vote on a "Medical Staff" matter precluded by section 4.6-2 of the bylaws. We agree that this construction best harmonizes the various provisions of the bylaws. Dr. Sassani was not precluded from participating in the Judicial Hearing Committee proceedings or voting on its findings and recommendation under the circumstances of this case.

III

DISPOSITION

The judgment is affirmed. South Coast Medical Center shall recover its costs on appeal.

MOORE, J.

WE CONCUR:

RYLAARSDAM, ACTING P. J.

THOMPSON, J.