2d Civil No. B167180

COURT OF APPEAL

FOR THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT, DIVISION FOUR

ASSA WEINBERG, M.D.,

Petitioner and Appellant,

vs.

CEDARS-SINAI MEDICAL CENTER,

Respondent.

Appeal from a Judgment of the Los Angeles Superior Court
Los Angeles Superior Court Case No. BS080287
Honorable Dzintra Janavs

RESPONDENT'S BRIEF

BINGHAM McCUTCHEN LLP
Susan L. Hoffman (SBN 90496)
Elizabeth Van Horn (SBN 212592)
Hwannie Lee (SBN 222342)
355 South Grand Avenue, Suite 4400
Los Angeles, California 90071-3106
(213) 680-6400

GREINES, MARTIN, STEIN & RICHLAND LLP
Robin Meadow (SBN 51126)
Michael D. Fitts (SBN 145114)
5700 Wilshire Boulevard, Suite 375
Los Angeles, California 90036
(310) 859-7811

Attorneys for Respondent
CEDARS-SINAI MEDICAL CENTER

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INTRODUCTION

Physician peers at Cedars-Sinai Medical Center found that their colleague, appellant Dr. Assa Weinberg, committed numerous serious medical and patient care errors—in one case contributing to a patient's death. The findings of a *majority* of the peer review hearing committee were so negative that they prompted the trial court to remark that it "ha[d] seen licenses revoked for less." (RT 20.)

Despite their general agreement about the substandard quality of his work, Dr. Weinberg's peers thoroughly disagreed about how to respond. A 4-to-2 majority of the hearing committee, expressing "hope" that Dr. Weinberg might improve, recommended to Cedars-Sinai's Board of Directors (Board) that it conditionally reinstate his staff privileges. (Appellant's Appendix ("AA") 43.) The minority was "more pessimistic," finding no reason to believe "that Dr. Weinberg's behavior would be any different in the future" (AA 46) and that he "represent[ed] a continuing imminent danger to his patients" (AA 44).

Cedars-Sinai's peer-based Medical Executive Committee (MEC) approved the majority's conditional reinstatement recommendation (AA 54), but the Board remanded the matter to the MEC for reconsideration (AA 55-58). Although a majority of the MEC reaffirmed its recommendation, fully one-third of its 27 physician members refused to agree that Dr. Weinberg "does not pose a risk to patents in his care at Cedars-Sinai Medical Center." (AA 210-211.) Citing the risk to patients, the Board agreed with the minority and voted unanimously to revoke Dr. Weinberg's staff privileges. (AA 62-65.)

Even though Dr. Weinberg does not challenge the findings of substandard care, he nonetheless claims that this Court must force the Board

to put him back on staff because a divided peer review panel so recommended. He has no such right.

Dr. Weinberg relies on Business and Professions Code section 809.05, subdivision (a), which requires hospital governing bodies to give "great weight" to peer review recommendations. But the statute does not even permit, much less require, rubber-stamp acceptance. To the contrary, the Legislature has made clear that governing bodies retain broad authority over critical staffing matters. The only limitations are that they must not act arbitrarily or capriciously, must give serious consideration to the peer review bodies' report and recommendations and—most important of all—must act "*exclusively* in the interest of maintaining and enhancing quality patient care" in peer review matters. (Bus. & Prof. Code, § 809.05, subd. (d), emphasis added.)

The Board met all of those requirements. Upon receiving the divided recommendation, it remanded the matter to the peer review body for reconsideration in light of specifically articulated concerns. (AA 55-57.) In ultimately deciding to reject the majority's reinstatement recommendation, the Board explained why: Dr. Weinberg's repeated serious medical errors put patients at unacceptable risk, and no substantial evidence supported the majority's speculative hope that he would improve. (AA 214-216.)

Tacitly recognizing that he cannot establish that the Board failed to follow the law, Dr. Weinberg devotes most of his brief to trying to show that the Board had no power to act, either because of an impermissible conflict of interest or because it lacked statutory authorization. The first argument founders on the rule of necessity—the Board was empowered to act because it was the only body legally authorized to make the final

decision. This is what Division Two of this Court squarely held on indistinguishable facts in *Hongsathavij v. Queen of Angels etc. Medical Center* (1998) 62 Cal.App.4th 1123. And Dr. Weinberg's argument that the Board lacked statutory authority contradicts numerous express statutory provisions that grant the Board final authority over staff privileges issues.

That leaves only a one-page argument that the Board improperly received evidence outside the record, to which the complete answer is that the record provides no basis for the claim.

The Board's decision was fully authorized and amply justified. This Court should affirm.

STATEMENT OF THE CASE

A. The Parties.

Plaintiff and appellant Assa Weinberg, M.D., is a California licensed physician who has practiced medicine since 1980. (AA 1.)

Defendant and respondent Cedars-Sinai Medical Center is a nonprofit public benefit corporation and an accredited general acute care hospital and health facility under California law. (AA 129, 156; Health & Saf. Code, § 1250, subd. (a).) Cedars-Sinai is also a participating hospital in the federal Medicare and California Medi-Cal programs. (AA 156.)

B. Dr. Weinberg's Summary Suspension.

Dr. Weinberg was a member of Cedars-Sinai's Medical Staff.[1] (AA 1.) On November 5, 1999, Cedars-Sinai's Senior Vice President for Medical Affairs and Chief Medical Officer ("Chief Medical Officer") summarily suspended Dr. Weinberg from the Medical Staff, having determined that Dr. Weinberg's substandard care "causes a potential or imminent danger of harm to Medical Center patients." (AA 10; Bus. & Prof. Code, § 809.5.)

Dr. Weinberg's suspension followed a detailed review of 32 of Dr. Weinberg's patient admissions by the Cedars-Sinai Department of Medicine Performance Improvement Committee ("Committee"). The Committee concluded that Dr. Weinberg had endangered his patients' lives by committing "serious quality of medical care errors" involving "egregious" patient care. (AA 10.) On the basis of this review, the

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[1] A physician's "staff privileges" at a hospital "means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility." (Bus. & Prof. Code, § 805, subd. (a)(4).)

Committee recommended termination of Dr. Weinberg's staff privileges. (AA11.)

C. Dr. Weinberg Receives A Medical Staff Evidentiary Hearing.

Dr. Weinberg requested a medical staff hearing. (AA 16.) In accordance with the Cedars-Sinai Medical Staff Constitution ("Constitution"), the Chief Medical Officer notified Dr. Weinberg that a hearing would be scheduled for the next month and sent him a detailed Notice of Charges. (AA 26, 19-25.)

There was a hearing before a panel of six physician peers and a hearing officer ("Hearing Committee"). (AA 28.) During 23 sessions that consumed over 100 hours, both Dr. Weinberg and the hospital examined numerous witnesses and medical charts under the detailed procedural rules set forth in the Constitution. (AA 28-29, 233-241.)

D. The Hearing Committee Members Generally Concur On The Substandard Quality Of Dr. Weinberg's Care, But Divide On Whether To Terminate His Privileges.

1. The majority view: serious problems, but hope that Dr. Weinberg can be rehabilitated.

The 4-to-2 majority submitted detailed findings and conclusions concerning the quality of Dr. Weinberg's patient care. (AA 28-44.) These included:

- Dr. Weinberg mis-prescribed Methotrexate and neglected to review the order during administration of the drug; "this

inappropriate dose was a contributing factor to the patient's death." (AA 30 [Case No. 1, Findings 6, 9].)[2]

- Dr. Weinberg failed to obtain a timely cardiology consultation on a muscular dystrophy patient who "suffered cardiac arrest with subsequent anoxic encephalopathy and death" and he practiced "sub-optimal" record keeping, although these failures "did not contribute to the patient's death." (AA 31-32 [Case No. 2, Conclusion 2].)

- A dosage of the drug Gentamicin to one of Dr. Weinberg's patients "was in error," although responsibility for the error was unclear—"[t]he cause involved the 'system' as well as Dr. Weinberg, the individual." (AA 42 [Finding No. 6].)[3]

- Dr. Weinberg would wait until a patient was discharged to dictate the patient's history and physical information as of admission, but would use the present tense—creating the impression that the dictation was contemporaneous with admission. (AA 31 [Case No. 2, Finding 9]; 34 [Case No. 4, Finding 3]; 36 [Case No. 5, Finding 12].)

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[2] According to the 2003 Physician's Desk Reference (PDR), methotrexate "has the potential for serious toxicity" and that "[t]here have been reports of death following overdose." (Physician's Desk Reference (Thomson PDR 57th ed. 2003), pp. 3415-3417.)

Courts of Appeal regularly rely on this and similar common medical reference texts. (See *Manriquez v. Gourley* (2003) 105 Cal.App.4th 1227, 1236, fn. 2; *Conservatorship of Valerie N.* (1985) 40 Cal.3d 143, 169, fn. 28.)

[3] According to the U.S. National Institutes of Health (NIH), Gentamicin is an antibiotic whose potential side effects include deafness, kidney damage, and loss of balance. (See NIH website at http://www.nlm.nih.gov/medlineplus/druginfo/uspdi/202027.html#SXX14.)

- Dr. Weinberg failed to record a two-month-old skin rash when a patient was admitted. (AA 34 [Case No. 4, Findings 1-2].)
- Dr. Weinberg advocated the experimental use of Thalidomide without adequate evidentiary support and with potentially adverse side effects on a terminal patient, although the evidence was "inconclusive" as to whether Dr. Weinberg acted against the patient's wishes as articulated by family and clergy. (AA 35, 36 [Case No. 5, Findings 7-11, Conclusions 1-4].)
- In response to the wishes of a patient's wife concerning an end-of-life extubation and hospice request, Dr. Weinberg told her that "she would be killing her husband by having the tube removed and by placing him in the hospice service," an incident the majority felt demonstrated "some insensitivity." (AA 37 [Case No. 6, Finding 6, Conclusion 1].)
- Dr. Weinberg "failed to delineate [patient] goals and therapy and associated values." (AA 40 [Case No. 8, Conclusion 2].)

These and other findings led the majority to conclude that Dr. Weinberg had committed "serious errors of judgment and action that have been documented and presented" in caring for his patients (AA 43), but that no individual error was sufficiently egregious to justify termination or summary suspension (see AA 30, 32, 34, 36, 38, 39 [conclusion for each case stating that permanent suspension not warranted]). The majority also found that Dr. Weinberg's "behavior and attitudes represent a problem in the hospital setting" and that he "conveys an attitude of arrogance and impatience with others" that is "counterproductive to effective collegial interaction and, more importantly, patient care." (AA 43.)

Despite Dr. Weinberg's serious medical errors, his "flawed behaviors and attitudes," and his "confrontational and obstinate" manner, the majority expressed "hope" that Dr. Weinberg would "resolve those issues that impede his taking care of patients." (AA 43.) Citing "an obligation to offer him the opportunity to receive the help that he needs to remediate his shortcomings," the majority opined that "under the proper conditions, [Dr. Weinberg] could be capable of providing a high level of care for his patients." (AA 43.) The majority findings did not articulate those "proper conditions" or address how to avoid risk to patients during the rehabilitation efforts or if the efforts failed.

Because "the majority conclusion is simply that he deserves a chance" (AA 43), the majority recommended that Dr. Weinberg "should be permitted to be reinstated" on condition that he accept referral to the Impaired Physicians Committee and that he abide by its recommendations (AA 43-44).

2. The minority view: serious problems, and equally serious doubts about rehabilitation.

The two dissenting panel members "generally accept[ed]" the majority's findings, "but not some of the conclusions and not the final recommendation" of conditional reinstatement. (AA 44.)

As to Dr. Weinberg's medical errors, the minority disagreed on several points. These included:

- Dr. Weinberg's Methotrexate error "contributed significantly to the death of the patient" and "his performance was egregious." (AA 44.) (The majority found the dosage mistake was a "contributing factor." (AA 30 [Case No. 1, Finding 6].).)

- Dr. Weinberg's administration of Gentamicin "was at odds with hospital protocol." (AA 44.) (The majority found the evidence "inconclusive" on this point. (AA 33-34.))
- Dr. Weinberg has a "longstanding problem with record keeping," showing "obstinacy" in the face of "repeated warnings" from Medical Staff. (AA 44-45.)
- Dr. Weinberg showed an inability to "deal appropriately with families and patients at the end of their lives." (AA 45.) He engaged in conduct that caused "emotional harm to patients' families." (AA 45.)

The real disagreement between the majority and minority, however, centered on the implications of Dr. Weinberg's established patterns of sub-par conduct—whether he would be willing, or even able, to change. The dissent's detailed conclusions in this regard were:

- "The claims against Dr. Weinberg consist of more than his simply making admitted medical errors in prescribing Methotrexate or Gentamicin. It is the totality of many cases that leads us to conclude that Dr. Weinberg represents a continuing imminent danger to his patients." (AA 44.)
- Dr. Weinberg's obstinate failure to amend his record-keeping despite repeated warnings is "a manifestation of his arrogance." (AA 45.)
- Dr. Weinberg "is frequently unable to acknowledge his errors"; instead, he behaves "arrogantly" toward Medical Staff and other hospital professionals and responds to allegations of substandard

care by alleging that a "conspiracy exists which is 'out to get him.'" (AA 45.)

- Dr. Weinberg "has been unable to limit or control his contentiousness on the wards with patients, their families and the Medical Staff" (AA 45), and "some physicians and staff of CMSC [Cedars-Sinai] find Dr. Weinberg difficult or impossible to work with" (AA 44).
- "Some physicians with difficult personalities are able to function and practice without their problems interfering with their decision-making capabilities. Dr. Weinberg's personality and character traits, however, have not only interfered with his effective performance, but also have threatened and harmed patients." (AA 45-46.)

"The principal way in which we differ from the majority of the Hearing Committee," the minority summarized, "is that we are more pessimistic, given Dr. Weinberg's intractable personality and character traits, about his willingness or capacity to change." (AA 46.) "We have not seen any believable evidence, or remorse, contrition or efforts to change," continued the minority, "that would indicate that Dr. Weinberg's behavior would be any different in the future." (AA 46.)

Instead of relying on an "obligation" to a fellow physician, as the majority did (AA 43), the minority emphasized the medical staff's obligations to patients: "We believe that if and when the Medical Staff leadership perceives a direct threat to patients, it must act promptly for the safety of those patients, according to the Bylaws of the Medical Staff." (AA 46.)

Because of the risk to patients, the minority concluded that "[t]he Medical Staff and the Medical Center cannot afford to take the chance of allowing [Dr. Weinberg to] return to practice here" and recommended permanent suspension of Dr. Weinberg's staff privileges. (AA 47.)

E. The Medical Executive Committee's Review And Recommendation.

The Cedars-Sinai Medical Executive Committee (MEC), a body composed of attending and faculty physicians entrusted with reviewing the conclusions of the Hearing Committee and making recommendations to the Board (AA 242-244), reviewed the Report of the Hearing Committee and adopted the majority's conditional reinstatement recommendation (AA 54, 158). Three days later, Cedars-Sinai's Chief Medical Officer notified Dr. Weinberg of the result and forwarded the MEC's "Report and Recommendation of the Medical Executive Committee to the Board of Directors in the Matter of Assa Weinberg, M.D." (AA 203.)

As required by Cedars-Sinai's internal procedures, the letter notified Dr. Weinberg of his right to further proceedings—a review of the "total record" and of the MEC's recommendations by the Appeal Committee of Cedars-Sinai's Board of Directors in an additional hearing. (AA 203-204.) Dr. Weinberg declined to appeal. (AA 205.) Accordingly, the matter automatically went to the Board for final action. (AA 244.)[4]

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[4] The relevant procedures appear in the "Cedars-Sinai Medical Center Manual of Procedure For Hearings Under Article XIII Of The Constitution Of The Medical Staff And Consisting Of Article XVII Of The Medical Staff Rules And Regulations." (AA 233 ["Hearing Manual"].) On this point, the Hearing Manual provides that in the absence of an appeal request, "the MEC's recommendation shall be submitted to the [Cedars-Sinai] Board of Directors for final action." (AA 244.)

F. The Board Remands The Matter To The MEC For Reconsideration; The MEC Reaffirms Its Conditional Reinstatement Recommendation By A Divided Vote.

A special subcommittee of the Board reviewed the MEC's report and recommendations. (AA 206.) It advised the Board to "take notice of the substantial divergence" between the majority and minority views of the Hearing Committee. (AA 206.) It further recommended that the Board find that:

> "without substituting its medical judgment for that of the members of the Hearing Committee and MEC, and paying deference to the tenor of the findings of the Hearing Committee, the Board expresses to the MEC a substantial concern as to the justifications for the Hearing Committee's [*sic*] Majority's conclusions and recommendations, especially in light of the Hearing Committee's Minority position which the Board subcommittee found to be persuasive and compelling." (AA 207.)

The subcommittee recommended that the Board acknowledge its obligation to "assure" that all patients receive medical care that "meets the professional standards of the Medical Center's Medical Staff, as recommended by the MEC and approved by the Board of Directors." (AA 207; see also AA 221 [Art III, § 3(d) of the Constitution reserves Cedars-Sinai's authority to set professional standards higher than licensure requirements and higher than those in force in other institutions].)

These concerns prompted the subcommittee to advise the Board to remand the matter to the MEC for reconsideration of its report and to determine whether, given the cumulative results of the nine cases that

resulted in findings adverse to Dr. Weinberg, he: (1) met Cedars-Sinai's standard of professional medical care; (2) did not pose a risk to patients; (3) was capable of following hospital prescription protocols; (4) could modify his behavior and attitude so that he would not threaten the well-being of patients, their families and others in the hospital; (5) complied with minimal documentation and record-keeping standards; and (6) could comply with documented end-of-life desires of patients as Cedars-Sinai policy requires. (AA 207-208.) The Board adopted the subcommittee's recommendations. (AA 214.)

Although on remand the MEC reaffirmed its earlier conditional reinstatement recommendation by a vote of 22 to 5, substantial minorities of MEC peer physicians, and in one case a majority of them, answered "no" to each of the six questions. (AA 211- 212 [vote tally].)

G. The Board Revokes Dr. Weinberg's Staff Privileges.

The full Board then considered the matter as required by Article XIII, Section 7, of the Constitution. (AA 228.) Its final report concluded:

- Dr. Weinberg received a fair hearing. (AA 214.)
- Legal requirements and hospital accreditation standards compelled the Board to reserve to itself final decision-making authority over medical staff, and "in doing so the Board must act to assure the safety of patients and the quality of patient care provided at the Medical Center." (AA 214.)
- Dissension in the Hearing Committee and in the MEC, as well as the substance of the Hearing Committee minority report, "heightened the Board's concern." (AA 214.)

- Without substituting its judgment for the medical judgment of the majority members of the Hearing Committee and the MEC, and "even giving great weight to the findings of the Hearing Committee majority," the majority's recommendations were not supported "by substantial evidence contained in the record." (AA 214-215.)
- The nine cases should have been considered cumulatively, and the Hearing Committee majority erred in not doing so. (AA 215.)
- Dr. Weinberg's medical care posed a risk to patients; medication errors contributed to one patient's death, and he expressed a willingness to experiment in another terminal patient case. (AA 215.)
- Dr. Weinberg's substandard documentation placed patients in jeopardy, and his behavior persisted despite notice and opportunities to correct it. (AA 215.)
- The record did not support the conclusion that the remedial actions contemplated as a condition of reinstatement would be effective. (AA 214-216.)

The Board further recited that it had access to the entire record of proceedings and that it considered reports by the Chief of Staff and Cedars-Sinai's General Counsel. (AA 213-214, 217.) "Based on the entire record before it, the reports and the ensuing discussion" (AA 214), the Board revoked Dr. Weinberg's staff privileges and membership (AA 216).

H. Trial Court Proceedings.

Dr. Weinberg filed his verified petition for writ of mandate under Code of Civil Procedure section 1094.5 in December 2002. (AA 1-18.) He

made essentially the same arguments in support of his petition that he now makes on appeal. (AA 77-81.)

At the hearing, the trial court remarked that it "ha[d] seen licenses revoked for less than what [Dr. Weinberg] was found to be guilty of by the majority all along. I mean, there's some very, very severe findings against him that were made by the [peer review] majority at all levels." (RT 20:6-9.) Dr. Weinberg's counsel acknowledged that "the majority and the minority seem to agree in terms of Dr. Weinberg's performance as a physician." (RT 24:12-14.)

The trial court rejected all of Dr. Weinberg's arguments (RT 2-3) and entered judgment for Cedars-Sinai on May 2, 2003 (AA 261-262). Dr. Weinberg filed a timely notice of appeal on May 12, 2003. (AA 268.)

STANDARD OF REVIEW

In administrative mandamus cases, "[t]he appellate court . . . does not review the actions or reasoning of the superior court, but rather conducts its own review of the administrative proceedings to determine whether the superior court ruled correctly as a matter of law." (*Hongsathavij v. Queen of Angels etc. Medical Center, supra*, 62 Cal.App.4th 1123, 1137 ("*Hongsathavij*") [applying this standard to affirm a hospital governing body decision to reject the recommendation of peer-based hospital judicial review committee].) Accordingly, vis-à-vis the trial court, this Court's review is de novo.

In this de novo review, the primary question is "whether there was any prejudicial abuse of discretion" by the Board. (Code Civ. Proc., § 1094.5, subd. (b).) Ordinarily, answering this question involves a

substantial evidence review under Code of Civil Procedure section 1094.5, subdivision (d), which states that "in cases arising from private hospital boards . . . 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." A hospital's findings "must be affirmed unless they are 'so lacking in evidentiary support as to render them unreasonable.'" (*Oskooi v. Fountain Valley Regional Hospital* (1996) 42 Cal.App.4th 233, 243.)

In the present case, Business and Professions Code section 809.05, subdivision (a) ("section 809.05(a)") also imposes the following standard on decision-making by hospital governing bodies: "In all peer review matters, the governing body shall give great weight to the actions of peer review bodies and, in no event, shall act in an arbitrary or capricious manner."[5]

The following standards of review govern the specific issues Dr. Weinberg has raised:

The nature of the Board's power under section 809.05. Both Dr. Weinberg's first and third arguments (AOB Legal Discussion §§ A, C) address the nature and extent of the Board's power under section 809.05(a). These are questions of statutory interpretation that this Court reviews de novo. (See *R & P Capital Resources, Inc. v. California State Lottery* (1995) 31 Cal.App.4th 1033, 1036.)

Whether the Board's substantive decision complied with section 809.05. Once the Court has interpreted section 809.05, it will apply its interpretation to the Board's decision to revoke Dr. Weinberg's staff privileges. In addition to applying the statute's "great weight" standard, this

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[5] All undesignated citations are to the Business and Professions Code.

exercise will require a determination of whether the Board's action was "arbitrary or capricious" within the meaning of section 809.05(a). While it appears that this standard has not been judicially defined in the context of quasi-adjudicative peer review proceedings, virtually identical language in the quasi-legislative arena provides ample guidance. A typical formulation is that the standard requires a determination of whether the administrative body "has adequately considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." (*Carrancho v. California Air Resources Bd.* (2003) 111 Cal.App.4th 1255, 1265.)[6]

More generally, "[n]either an appellate court nor a trial court is free to substitute its discretion for that of the administrative agency concerning the degree of punishment imposed." (*Alford v. Department of Motor Vehicles* (2000) 79 Cal.App.4th 560, 563 [upholding agency decision to reject recommendation of license suspension in favor of revocation]; see also *Barber v. State Personnel Bd.* (1976) 18 Cal.3d 395, 404 [agency decision about appropriate sanction subject to abuse of discretion standard of review]; *Landau v. Superior Court* (1998) 81 Cal.App.4th 191, 218 [manifest abuse of discretion standard applies to degree of medical discipline imposed.)

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[6] *Carrancho* involved judicial review of informal agency action under traditional mandamus. The term "arbitrary and capricious" also has been defined in the federal Administrative Procedure Act, 5 U.S.C. § 706, under which agency action must be upheld unless the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." (*Confederated Tribes of Umatilla Indian Reservation v. Bonneville Power Admin.* (9th Cir. 2003) 342 F.3d 924, 928.)

Conflict of interest and ex parte communication. These issues (AOB Legal Discussion §§ B, D) require a determination of "whether there was a fair trial." (Code Civ. Proc., § 1094.5, subd. (b).) This question "is one of law, which [a court] review[s] de novo." (*Clark v. City of Hermosa Beach* (1996) 48 Cal.App.4th 1152, 1169.)

ARGUMENT

I.

THE BOARD ACTED WITHIN ITS STATUTORY AUTHORITY IN REVOKING DR. WEINBERG'S STAFF PRIVILEGES.

Dr. Weinberg does not clearly articulate the basis of his claim that the Board failed to give "great weight" to the peer review bodies' recommendations. In part, he seems to raise relatively narrow procedural claims, such as that the Board did not "provid[e] any rationale or supporting evidence" for rejecting the peer review recommendations. (AOB 10.) More fundamentally, however, Dr. Weinberg questions the *power* of a hospital governing body. He appears to claim that once a peer review body makes a recommendation on a staff privileges issue, the "great weight" standard *requires* the governing body to adopt it. The governing body's role, according to Dr. Weinberg, is limited to insuring the peer reviewers' impartiality and absence of improper motive (AOB 8), and "the Board *is bound by* the substantial evidence as found by the majority report . . ." (AOB 12, fn. 3, emphasis added).

Dr. Weinberg provides neither authority nor analysis to support this view; rather, he almost seems to take it as a given. (See AOB 9-13.)

Accordingly, before we can discuss his more limited claims, we must first show why the laws that govern peer review proceedings cannot work as Dr. Weinberg seems to claim they do—and why a governing body like the Board not only does, but *must*, retain ultimate decision-making power, including the power to reject peer review recommendations.

A. A Hospital's Governing Body Has Ultimate Decision-Making Authority In Peer Review Matters.

1. Section 809.05(a)'s express language compels the conclusion that the governing body retains ultimate decision-making authority in peer review matters.

"To determine [statutory] intent, the court turns first to the words themselves for the answer. If the language is clear and unambiguous there is no need for construction, nor is it necessary to resort to indicia of the intent of the Legislature . . . ." (*Los Angeles County Dept. Of Children & Family Services v. Superior Court* (2003) 112 Cal.App.4th 509, 516, internal quotation marks and citations omitted.)

Section 809.05(a)'s express language unambiguously reserves final decision-making power concerning staff privileges issues to a hospital's governing body. Section 809.05(a) requires two things of a hospital's governing body when it decides a peer review matter: (1) that it give "*great weight*" to the actions of peer review bodies; and (2) that "in no event, shall [it] act *in an arbitrary or capricious manner*." (Emphasis added.) These commands can only mean that the governing body retains broad discretion to disagree with peer review body recommendations.

a. The words "great weight" represent a distinct and significant legislative choice. The Legislature could have, but did not, require

governing bodies to give "conclusive weight" to peer review recommendations. It could have, but did not, say that governing bodies "shall adopt" those recommendations. Just the opposite: The Legislature's careful choice of words gives the governing body discretion to accord *even greater weight* to *other* considerations. It confers on the governing body both the power and the duty to strike the final balance among competing policy options.

The Legislature was likely aware of how the term "great weight" is used in a closely analogous context: legal disciplinary proceedings before the Supreme Court after State Bar Court and Review Department proceedings. The Supreme Court accords "great weight" to the recommendations of the State Bar, but it still retains the right to exercise its "independent judgment" in selecting what it believes is the appropriate sanction. (See *In re Nadrich* (1988) 44 Cal.3d 271, 275.)[7]

These same words should mean the same thing in the similar circumstances presented here. The governing body should retain final say in determining the appropriate sanction, even after giving great weight to the recommendations of peer review bodies. (Cf. *Kuntz v. Kern County Employees' Retirement Assn.* (1976) 64 Cal.App.3d 414, 422 ["when words used in a statute have acquired a settled meaning through judicial interpretation, the words should be given the same meaning when used in another statute dealing with an analogous subject matter"].)

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[7] Cedars-Sinai's internal procedures use a formulation similar to the Supreme Court's construction of the "great weight" standard: "The MEC should give great weight to the actions of the Hearing Committee, *but shall not be bound by the Hearing Committee Report or recommendation.*" (AA 244 [Cedars-Sinai Manual of Procedure for Hearings, § 17.4.8], emphasis added.)

b. Section 809.05(a) enjoins the *governing* body, not the peer review body, from acting in an "arbitrary or capricious manner." The Legislature's choice of such a deferential standard *directed solely to the governing body* necessarily implies that that body retains broad discretionary decision-making authority.

This construction is consistent with settled law holding that the only final agency decision subject to judicial review is that of the governing body, not the peer review body. (See *Kumar v. National Medical Enterprises, Inc.* (1990) 218 Cal.App.3d 1050, 1055 [only the governing body decision was reviewable where the peer review committee was only authorized to make "written report and recommendation" for governing body review].)

2. The statutory context also illustrates that the Legislature intended governing bodies to retain ultimate decision-making authority.

Even if there were some ambiguity in the text of section 809.05(a) about the relative responsibilities of governing boards and peer review bodies, analysis of the statutory context resolves it. (See *Medical Board of California v. Superior Court* (2003) 111 Cal.App.4th 163, 175 ["A statute must be construed in the context of the entire statutory system of which it is a part, in order to achieve harmony among the parts"]; *Lakin v. Watkins Associated Industries* (1993) 6 Cal.4th 644, 659 ["The meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible"].)

As of 1989, when the Legislature enacted the peer review scheme that includes section 809.05(a), both state and federal law recognized the

paramount authority of governing bodies in medical staffing matters. The statutory scheme explicitly preserves this distribution of authority.

Under state law, final decision-making authority and discretion in administrative matters, including in medical staff decisions, has long been vested exclusively in a hospital's governing body. A licensed and accredited "general acute health care hospital" like Cedars-Sinai must, by definition, be "a health facility having a duly constituted *governing body with overall administrative and professional responsibility*." (Health & Saf. Code, § 1250, subd. (a), emphasis added [Stats.1973, ch. 1202, p. 2564 § 2]; see also Cal. Code Regs., tit. 22, § 70035 [same]; § 70701, subd. (a)(1)(B) [governing body responsible for reappointment of medical staff].) Conversely, a hospital's medical staff is "responsible *to the governing body* for the adequacy and quality of the medical care rendered to patients in the hospital." (Cal. Code Regs., tit. 22, § 70703, subd. (a), emphasis added.) Consistent with these mandates, Cedars-Sinai's bylaws establish the Board as the exclusive final decision-maker concerning the rights of medical staff. (See AA 225, 244 [Constitution Art. XII, § 7; Hearing Manual, Art. XIII, § 17.4.9].)

Federal law also imposes final responsibility on the governing body. As a condition of participating in the federal Medicare program—a *sine qua non* of any operating hospital—a hospital "must have an effective governing body legally responsible for the conduct of the hospital as an institution." (42 C.F.R. § 482.12.) Moreover, the governing body must "[e]nsure that the medical staff *is accountable to the governing body* for the quality of care provided to patients." (42 C.F.R. § 482.12(a)(5), emphasis added; see also 42 C.F.R. § 482.12(a)(2) [reserving power of appointment of staff in governing body]; 42 C.F.R. § 482.12(a)(7) [requiring governing body to maintain its own professional standards].)

Courts have long recognized that these state and federal laws require the governing body to retain ultimate responsibility for patient care through oversight of the quality of its Medical Staff. (See *Rhee v. El Camino Hospital Dist.* (1988) 201 Cal.App.3d 477, 489 [state and federal law requires hospitals to maintain high professional standards through "careful selection and review of staff"]; *Hay v. Scripps Memorial Hospital* (1986) 183 Cal.App.3d 753, 756 ["responsibility for operation of a general acute care hospital rests in the hospital's governing body"].)

In creating the statutory peer review process, the Legislature explicitly preserved the governing body's broad oversight authority: "Sections 809 to 809.8, inclusive, *shall not affect the respective responsibilities* of the organized medical staff or the governing body of an acute care hospital with respect to peer review in the acute care hospital setting." (§ 809, subd. (a)(8), emphasis added).)

These "respective responsibilities" would be profoundly "affected"—in violation of this statutory mandate—if the "great weight" language in section 809.05(a) meant what Dr. Weinberg suggests. If all a governing body could do was "assure the impartiality of the peer review process" while final discretionary authority vested in the peer review body (AOB 8), the governing body would effectively cede what is probably its most important administrative responsibility: assuring the quality of patient care. Section 809, subdivision (a)(8) prohibits such a result, and this Court must interpret the "great weight" standard consistently with that prohibition.

Finally, section 809.4 contemplates that a hospital may provide an appellate mechanism for medical staff members who disagree with peer

review findings.[8] Such an appellate mechanism "need not provide for de novo review" by the governing body. (§ 809.4, subd. (b).) The Legislature's decision to offer governing bodies the option of an appellate standard more deferential than de novo review would be meaningless if governing bodies did not possess plenary decision-making power in the first place.

3. Public policy supports a construction that aligns decision-making authority with ultimate responsibility for the consequences of the decision.

In delineating the relationship between peer review and governing bodies, the law favors a policy that apportions decision-making authority according to each body's responsibility for the decision's outcome.

That is what Division Two of this Court did in *Hongsathavij*, *supra*, 62 Cal.App.4th 1123. There, the plaintiff urged that hospital governing bodies must defer to peer review bodies in matters involving physician discipline because governing bodies are subject to a conflict of interest. (*Id*. at p. 1143.) The court rejected this argument.[9] Its conclusion stemmed, in part, from its recognition that the hospital, and potentially its individual directors, could be held liable for "failing to ensure the competency of its medical staff and the adequacy of medical care rendered to patients at its

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[8] Cedars-Sinai provides such a procedure for its staff physicians. (See AA 228, 244.) Dr. Weinberg elected not to use it. (AA 205.) The need for Board review and action, however, does not depend on the existence of an appeal. (See AA 244 ["If the Medical Staff Member elects not to request an appeal within the thirty (30) calendar day period, the MEC's recommendation shall be submitted to the Board of Directors for final action"].)

[9] Dr. Weinberg makes the same conflict-of-interest argument that the court rejected in *Hongsathavij*. We address it in Section II, *post*.

facility." (*Ibid*.; see also *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 346 [hospital liable for inadequate oversight of medical staff].) Because "[h]ospital assets are on the line," the court concluded that "[a] hospital's governing body must be permitted to align its authority with its responsibility and to render the final decision in the administrative context." (*Hongsathavij, supra*, 62 Cal.App.4th at p. 1143.)

Under Dr. Weinberg's suggested construction of section 809.05(a), there would be no such alignment. A hospital could be saddled with liability for the malpractice of physicians whose privileges it had no power to terminate. Nothing in section 809.05(a) or any other statute suggests that the Legislature intended such impotence.

These potentially negative consequences militate strongly against Dr. Weinberg's interpretation and dictate that any uncertainty be resolved against it. (See *Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1387 ["Where uncertainty exists consideration should be given to the consequences that will flow from a particular interpretation"].)

4. Section 809.05(a)'s "great weight" language cannot require more than that the governing body give careful and serious consideration to the peer review body's recommendations.

"Great weight," then, cannot require the rubber-stamp deference Dr. Weinberg claims. At the same time, a governing body cannot just ignore the peer review body's recommendation. So what should it do?

Dr. Weinberg's case both answers this question and demonstrates compliance with the standard. What the governing body should do—as the

Supreme Court does in lawyer disciplinary cases when it gives "great weight" to recommendations but declines to follow them (see *In re Nadrich, supra,* 44 Cal.3d at pp. 275-276)—is to give careful and serious consideration to the reasoning and recommendation of the peer review body. But in the end, the governing body retains the power to conduct its own analysis, provided it does not do so arbitrarily or capriciously.

The Board fully complied with these requirements.

B. The Board Gave Great Weight To The Peer Review Majority Recommendations, Adequately Explained Why It Sided With The Peer Review Minorities, And Revoked Dr. Weinberg's Staff Privileges On The Basis Of Substantial Evidence.

1. Substantial evidence and adequate findings supported the Board's revocation decision. In any event, Dr. Weinberg never properly challenged the sufficiency of the evidence.

Dr. Weinberg claims that the Board's conclusions lacked "supporting evidence." (AOB 10.) To the extent this argument concerns the presence of substantial evidence in the administrative record, Dr. Weinberg waived the claim when he stipulated that the voluminous record of the Hearing Committee's proceedings need not be made a part of the administrative record. (RT 4.) As this Court has written, "[w]hen an appellant challenges an administrative decision as unsupported by substantial evidence in light of the record as a whole, it is appellant's burden to demonstrate that the administrative record does not contain sufficient evidence to support the agency's decision." (*International*

Brotherhood of Electrical Workers v. Aubry (1996) 42 Cal.App.4th 861, 870.) To satisfy this burden, "it is the responsibility of the petitioner to make available to the trial court an adequate record of the administrative proceeding." (*Foster v. Civil Service Com.* (1983) 142 Cal.App.3d 444, 453.) "In the absence of an evidentiary record, sufficiency of the evidence is not an issue open to question. Rather, we must presume that the findings were supported by substantial evidence." (*Ibid.*)

That leaves only the claim that the Board's conclusion is not supported by the Hearing Committee's and MEC's *findings*. There is no basis for such a claim.

The Hearing Committee's findings present an essentially undisputed history of dangerously substandard medical care. Even Dr. Weinberg's counsel conceded that "the majority and the minority seem to agree in terms of Dr. Weinberg's performance as a physician." (RT 24:12-14.) The majority's findings by themselves were extremely serious and highly adverse to Dr. Weinberg. They included contributing to the death of a patient, disregard of patients' end-of-life wishes, and persistent record-keeping and documentation errors (see pp. 5-7, *ante*; AA 45); the trial court noted that it had seen *licenses* revoked for less (RT 20). The majority also acknowledged Dr. Weinberg's "confrontational and obstinate" behavior and his "arrogance and impatience with others." (AA 43.) The majority findings alone compellingly support the Board's stated reasons for revoking Dr. Weinberg's privileges. Coupled with the concern of the substantial minorities in both the Hearing Committee and the MEC that "Dr. Weinberg represents a continuing imminent danger to his patients" (AA 44 [Hearing Committee]) and that he "pose[s] a risk to patients in his care at

Cedars-Sinai Medical Center" (AA 210-211 [MEC]), the Board's reasons are unassailable.[10]

2. The Board rationally rejected the peer review majority's reinstatement recommendation and was wholly justified in revoking Dr. Weinberg's privileges.

The Board articulated a specific and dispositive reason for adopting the minority's reasoning: The undisputed findings established that Dr. Weinberg posed an unacceptable risk to patients, in contrast to the majority's speculative "hope" that he would improve. (AA 214-216.)

In peer review proceedings, both the peer review and governing bodies "shall act *exclusively* in the interest of maintaining and enhancing quality patient care." (§ 809.05, subd. (d), emphasis added.) As one court observed:

> "*Here the rights of the patients to rely upon competent medical treatment* are directly affected, and must always be kept in mind. An analogy between a surgeon and an airline pilot is not inapt: a hospital which closes its eyes to

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[10] Dr. Weinberg claims that criticism of his personality by the Hearing Committee minority would be an "uncharged 'offense'" that could not be a proper basis of termination. (AOB 11, fn. 2.) He misses the point of the minority's concerns. The majority was just as critical of Dr. Weinberg's behavior. Where the minority departed from the majority was not on the impact of his personality on patient care, but rather its impact on his chances for rehabilitation—rehabilitation that *the majority* believed was necessary. As the dissent put it, "we are more pessimistic, given Dr. Weinberg's intractable personality and character traits, about *his willingness or capacity to change*." (AA 46, emphasis added.) Just like the determination of a sentence following a criminal conviction, this concern involves issues that are distinct from the offenses charged.

questionable competence and resolves all doubts in favor of the doctor does so *at the peril of the public*." (*Rhee v. El Camino Hospital Dist.*, *supra*, 201 Cal.App.3d at p. 489, emphasis added.)

In light of these policies, it was entirely rational for the Board to reject the majority's reasoning, to refuse to speculate on the majority's "hope" that Dr. Weinberg would change, and to revoke Dr. Weinberg's staff privileges in the interest of ensuring of patient safety.

3. The Board demonstrated that it gave great weight to peer review body recommendations.

Dr. Weinberg maintains that at a minimum the "great weight" standard required the Board to "establish a foundation" for its departure from the recommendations of the peer review body. (AOB 9-10.) He also claims that instead of "providing any rationale or supporting evidence" for its conclusions, the Board "merely stated its disagreement" with the peer review majority. (AOB 10.)

Not so. The Board's premises and reasoning are abundantly clear from its decision.

a. The Board gave serious consideration to the majority's recommendation.

The dispute among Dr. Weinberg's peers focused not so much on the quality of his work as on the broader policy question of whether the prospects for his rehabilitation justified the risk to patients of allowing him to retain his staff privileges. (See Statement of Facts, § D.) This was a policy call that laypersons are as well equipped to make as physician experts. More importantly, it was a policy call that the Board was *required*

to make as the "final authority" over the "conduct of the hospital" (Cal. Code Regs., tit. 22, § 70035) in order to meet its statutory obligation to "act exclusively in the interest of maintaining and enhancing quality patient care." (§ 809.05, subd. (d); see also *Landau v. Superior Court*, *supra*, 81 Cal.App.4th at p. 218 ["In medical discipline cases 'the highest priority' is protection of the public"].)

And even on this policy question, the Board seriously considered the MEC's views. After reviewing the MEC's initial recommendation, it remanded the matter for consideration of the cumulative effect of Dr. Weinberg's multiple cases of substandard medical care, seeking the MEC's advice on six specific questions. (AA 207-208, 215.) This effort belies any notion that the Board was acting arbitrarily or capriciously. That the Board ultimately reached a different conclusion than the MEC does not undercut the careful, deliberative evaluation—the great weight—that the Board accorded to the MEC's conclusion. (See *In re Nadrich*, *supra,* 44 Cal.3d at pp. 275-276 [decision-maker may reject recommendation on "the appropriate discipline" consistent with giving it great weight].)

b. The deep divisions among Dr. Weinberg's peers independently justified the Board's rejection of the majority recommendation.

A significant minority of Dr. Weinberg's physician peers on both the Hearing Committee and the MEC disagreed with the conditional reinstatement recommendation. In the analogous attorney disciplinary context, the Supreme Court has repeatedly emphasized that it is "particularly appropriate" for the decision-maker to exercise its independent judgment when the recommending bodies disagreed and "the review board itself was closely divided." (*In re Nadrich*, *supra*, 44 Cal.3d at pp. 275-

276; see also *In re Leardo* (1991) 53 Cal.3d 1, 10 [same]; *In re Scott* (1991) 52 Cal.3d 968, 977-978 [same].)

Just as in that context, the Hearing Committee here was closely divided, only one vote away from a 3-3 deadlock on whether to recommend revocation. (AA 29 [4-2 Hearing Committee vote].) And the MEC's divisions were no less deep—in fact, on one of the questions a majority found *against* Dr. Weinberg, and a substantial minority found against him on the rest. (AA 211-212 [vote tally].) Moreover, the Hearing Committee minority's detailed and well-reasoned criticisms significantly devalued the reliability of the majority's recommendation. (AA 44-46.)

With such deep division among physician peers on the fundamental question of whether Dr. Weinberg could be rehabilitated sufficiently to deliver acceptable patient care, arguably it would have been improper for the Board to give *any* greater weight to the majority's conclusions than to the minority's. Dr. Weinberg does not suggest, nor does anything in the record suggest, that the peer reviewers in the majority were better qualified or possessed more discerning judgment than those in the minority. The Board could not responsibly allow its final decision to be based on a simple head count. Its reasoned rejection of the majority recommendation and adoption of the minority view was entirely consistent with the "great weight" standard.

4. The "three flaws" Dr. Weinberg identifies are non-existent.

The record contradicts Dr. Weinberg's claim of "three flaws" in the Board's decision. (AOB 11.)

1. Dr. Weinberg claims that no evidence supports the Board's conclusion that the Hearing Committee did not consider his conduct "cumulatively." (AOB 11, referring to AA 28-53.) However, the majority did in fact state separate conclusions as to whether each instance of misconduct justified permanent suspension. (AA 30, 32, 34, 36, 38, 39, 40.) The Board could therefore rationally conclude that the Hearing Committee considered each instance in isolation and failed to consider their cumulative effect.

2. His second assertion—that the minority opinion does not support the Board's action (AOB 11)—disregards three detailed pages of minority findings and conclusions (AA 44-47). The minority paid particular attention to reasons why Dr. Weinberg was unlikely to change his ways and the concomitant risk to patients. The majority, in contrast, premised its reinstatement recommendation on an "obligation" to "remediate [Dr. Weinberg's] shortcomings"—without ever addressing whether this meant putting patients at risk. (AA 43.)

While an opportunity for self-correction is an element of peer review (see § 809, subd. (a)(7)), it is necessarily subject to the physician's willingness to cooperate and, most importantly, to the protection of patients. Indeed, there is a *mandatory* duty to act "*exclusively* in the interest of maintaining and enhancing quality patient care." (§ 809.05, subd. (d), emphasis added.) The majority did not acknowledge this controlling obligation, which is central to the minority's view "that Dr. Weinberg

represents a continuing imminent danger to his patients" (AA 44) and that it saw nothing "that would indicate that Dr. Weinberg's behavior would be any different in the future" (AA 46).

3. The record contradicts Dr. Weinberg's third claim that the Board merely substituted "its own lay judgment for that of the experts on the medical staff." (AOB 12.) The majority and minority findings concerning the particulars of Dr. Weinberg's sub-par performance differed little, as even Dr. Weinberg's counsel acknowledged. (RT 24:13-14.) The Board therefore did not have to second-guess the peer review bodies' technical determinations of medical error, which were the type of factual determinations that arguably most deserve deference. To the contrary, the Board *relied* on them.

II.

THE BOARD WAS NOT SUBJECT TO ANY DISQUALIFYING CONFLICT OF INTEREST.

Dr. Weinberg argues that the Board cannot independently take action against a physician because it has an impermissible conflict of interest. (AOB 13-24.) He bases this claim on the rule that a physician cannot seek damages until he has succeeded in setting aside a termination decision in a mandamus action. (See *Westlake Community Hosp. v. Superior Court* (1976) 17 Cal.3d 465 [writ of mandamus setting aside staff privileges decision adverse to physician essential precondition to suit against hospital for damages].) Once a hospital takes action against a physician, Dr. Weinberg maintains, it has an impermissible incentive to avail itself of this temporary immunity by ruling against the physician. (AOB 6-7, 15.) His rationale is that if the Board were to set aside Dr. Weinberg's temporary

suspension, it would immediately be open to a claim for damages accruing during the suspension period, whereas upholding the suspension would require the physician to surmount difficult hurdles before he could recover anything. (AOB 14.)

This administrative exhaustion doctrine, however, does not suffice to create evidence of actual bias supporting a conflict. Even if it did, the fact that the Board is legally required to act precludes assertion of a conflict under the doctrine of administrative necessity.

A. The Board Had No Impermissible Conflict.

It is true, as Dr. Weinberg claims, that a governing body that wrongfully revokes a physician's staff privileges may be liable to the physician in tort. (See *O'Byrne v. Santa Monica-UCLA Medical Center* (2001) 94 Cal.App.4th 797, 812 [cause of action in damages stated for intentional interference with the practice of a profession].) But it is just as true that if a governing body negligently fails to take action against a physician whose malpractice then injures a hospital patient, hospital assets will be "on the line." (*Hongsathavij, supra,* 62 Cal.App.4th at p. 1143 [hospital has legal duty to ensure competence of staff by overseeing peer review process, citing *Elam v. College Park Hospital, supra*, 132 Cal.App.3d at p. 346].)

The net result of these competing exposures is that they cancel each other out. To the extent that avoiding potential liability motivates a governing body's behavior, the governing body has an incentive to avoid it as to both physicians *and* patients. This means that its primary motive will be to make the right decision, leaving in place the single most important incentive it has: to act "*exclusively* in the interest of maintaining and enhancing quality patient care." (§ 809.05, subd. (d), emphasis added.)

Nor does the fact that a hospital has overall responsibility for the prosecutorial and adjudicative functions create an inherent and impermissible conflict. Courts have recognized that this circumstance is common, unavoidable and perfectly acceptable in many administrative settings, including in private hospital administration. (See *Hongsathavji*, *supra*, 62 Cal.App.4th at p. 1142 ["Overlapping investigatory, prosecutorial functions do not necessarily deny a fair hearing and are common before most administrative boards"].)

None of the authorities Dr. Weinberg cites even remotely supports finding an impermissible conflict here. In *Ward v. Village of Monroeville* (1972) 409 U.S. 57 [93 S.Ct. 80, 34 L.Ed.2d 267], an impermissible conflict arose when the individual mayor/judge had plenary authority over village finances, which depended heavily on revenue from traffic fines, and also personally adjudicated contested traffic citations that could generate revenue from fines. (*Id.* at p. 60 [93 S.Ct. at p. 83].) Similarly, in *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, the County hearing officer had an impermissible direct pecuniary incentive to rule in a particular way because she was personally selected at the discretion of the County prosecuting attorney on a case-by-case basis and was paid by the County. (*Id.* at pp. 1023-1024.)

Here, by contrast, neither the Board members nor the institution derive any pecuniary advantage from a revocation, as opposed to a reinstatement, decision. And, unlike the mayor/judge in *Ward* and the hearing officer in *Haas*, the Board faces liability for a wrong decision whichever way it rules.

Neither *Mennig v. City Council* (1978) 86 Cal.App.3d 341, nor *Applebaum v. Board of Directors* (1980) 104 Cal.App.3d 648, support

Dr. Weinberg. In these cases, the administrative proceedings were found unfair because the specific individuals involved in bringing the charges also had undue influence over or actually participated in the bodies adjudicating those charges. (*Mennig*, *supra*, 86 Cal.App.3d at p. 351; *Applebaum*, *supra*, 104 Cal.App.3d at pp. 659-660.) Here, Dr. Weinberg has never suggested—nor was it the case—that any Board member was personally involved in the decision to charge Dr. Weinberg or that the charging officials had any influence over the Board. (Compare (AA 13-14 [charging letter from Michael Langberg, M.D.] with AA 216 [Board decision].)

A claim of bias requires concrete evidence. (*Gill v. Mercy Hospital* (1988) 199 Cal.App.3d 889, 911 ["concrete" evidence of bias required].) There is none here and thus no cognizable conflict.

B. Even If A Conflict Existed, Administrative Necessity Would Permit The Board To Decide Medical Staff Matters.

Under the doctrine of administrative necessity, where "an administrative body has a duty to act, and is the only entity capable of acting, the fact that the body may have an interest in the result does not disqualify it from acting." (*Hongsathavij*, *supra*, 62 Cal.App.4th at pp. 1142-1143; see also *Gonsalves v. City of Dairy Valley* (1968) 265 Cal.App.2d 400, 404 [same].) According to Cedars-Sinai's Bylaws, the Board is unquestionably the exclusive final decision-maker concerning the rights of Medical Staff. (See AA 225, 244 [Constitution Art. XII, § 7; Hearing Manual, Art. XIII, § 17.4.9.)

Dr. Weinberg nevertheless asserts that "[n]o statute grants the hospital boards the exclusive jurisdiction to make [medical staff] decisions." (AOB 20, emphasis omitted.) This argument ignores the fact

that both state and federal law *compel* the Board to assume this responsibility. (See p. 22, *ante*.) It follows that peer review bodies *cannot* carry out these functions independently. (AOB 24.)

Nor does Dr. Weinberg reveal any error in *Hongsathavij*'s extension of the doctrine of administrative necessity to publicly-licensed private institutions. (See AOB 18.) The Board's retention of exclusive authority to make the final decision on medical staff matters is essential to Cedars-Sinai's existence as a licensed and accredited acute care hospital in this state, and critical to its Medicare eligibility. (§ I.A.2., *ante*.) There is no functional difference in the degree of necessity between public entities and publicly-licensed private entities.

Dr. Weinberg urges the Court not to follow *Hongsathavij*, arguing that the rule of necessity should extend only to democratically elected public decision-making bodies because only they are accountable, as opposed to "self-serving" private corporate boards. (AOB 19.). The argument rests on a false premise. The governing body of a licensed and accredited acute care hospital is, in fact, accountable—to its patient constituency as well as to multiple governmental entities. (§ I.A.2., *ante*.) Indeed, this very accountability underlies *Hongsathavij*'s rationale—"to align [a hospital's governing body's] authority *with its responsibility* and to render the final decision in the hospital administrative context." (*Hongsathavij, supra*, 62 Cal.App.4th at p. 1143, emphasis added.)

III.

THE BOARD HAD THE STATUTORY POWER TO TERMINATE DR. WEINBERG'S STAFF PRIVILEGES.

Dr. Weinberg briefly argues that, under subdivision (c) of section 809.05 ("section 809.05(c)"), a governing body has no power to take action against a physician unless a peer review body "fails to initiate" action after a request to do so. (AOB 25.) This argument misconstrues the statute's *grant* of power as a *limitation.*

Section 809.05(c) provides that "[i]n the event the peer review body *fails to take action* in response to a direction from the governing body, the governing body shall have the authority to take action against a licentiate." (Emphasis added.) By its terms, section 809.05(c) *augments* the governing body's existing powers: It ensures that the governing body can act on its own when necessary to fill a void in peer review action. Nothing in the section suggests any *limitation* on the governing body's powers; it does not even address situations like the one here, where a peer review body has *already* acted.

The statutory scheme further undermines Dr. Weinberg's claim that the governing body can only act in the absence of peer review action. Most notably, the "great weight" language of section 809.05(a), which is at the core of Dr. Weinberg's lead argument, only makes sense where a peer review body *has* acted and the governing body is reviewing its actions.

Other sections in the scheme bolster this conclusion. Section 809.1, dealing with notice requirements, speaks of a "final *proposed* action of a peer review body" "which, *if adopted*, shall be taken and reported . . . ." (Emphasis added.) Section 809.4, describing the rights of the parties after a hearing, contemplates an "appellate mechanism" that "need not provide for

de novo review." And the Health & Safety Code defines general acute health care hospitals like Cedars-Sinai as "a health facility having a duly constituted governing body with *overall administrative and professional responsibility*." (Health & Saf. Code, § 1250, subd. (a), emphasis added.) None of these sections would make sense if the governing body did not have authority to make the final call following peer review action.

IV.

THE BOARD RECEIVED NO IMPROPER EX PARTE COMMUNICATIONS.

Dr. Weinberg devotes twelve lines at the end of his brief to a claim that the Board received unspecified "oral and written reports from the chief of staff" that somehow deprived him of a fair hearing. (AOB 26-27, referring to AA 63.)

Nothing in the record suggests that the report Dr. Weinberg describes was anything but routine and irrelevant to the merits of his claim. Article VI, § 1(a) of the Constitution requires the Chief of Staff, as the elected head of the medical staff, to attend all Board meetings and to report to the Board on the actions of the medical staff committees, including the MEC. (AA 224.) The Chief of Staff is a non-voting member of the MEC whose function is to serve as liaison with the Board consistent with state regulations. (AA 224; Cal. Code Regs., tit. 22, § 70703, subd. (d) [requiring reports to governing body of medical staff committee activities].) Dr. Weinberg offers no evidence that the Chief of Staff at the time, Dr. Michael Shabot, did anything beyond performing that ministerial function, or that he was in any way connected with those at Cedars-Sinai who initiated charges against Dr. Weinberg. (AA 202.)

Dr. Weinberg accuses Cedars-Sinai of "refus[ing] to disclose what the Chief of Staff said" to the Board. (AOB 27.) But there is no evidence in the record that Dr. Weinberg ever requested that information from Cedars-Sinai.

Aside from the fact that nothing in the record shows that Dr. Shabot's report was in any way improper, Dr. Weinberg cannot show that he suffered any prejudice from it. (See *Samaan v. Trustees of Cal. State University & Colleges* (1983) 150 Cal.App.3d 646, 660 [fact of ex parte communication insufficient to show lack of fairness where substance of case not discussed].) Nothing in the Board's final decision suggests reliance on anything but the record developed by the peer review bodies.

CONCLUSION

The deep division among Dr. Weinberg's physician peers underscores the importance of the need for governing bodies to make the final decision on staff privileges:

- One-third of the Hearing Committee physicians concluded that "Dr. Weinberg represents a continuing imminent danger to his patients." (AA 44.)

- One-third of the MEC physicians refused to agree that Dr. Weinberg "does not pose a risk to patients in his care at Cedars-Sinai Medical Center." (AA 210-211.)

How many patients would be willing to assume the risk that these minority views portend? And what responsible hospital could countenance such a risk to patient safety?

The Board's decision to avoid this risk to patients was a lawful exercise of its discretion and entirely consistent with its statutory responsibilities. The Court should affirm.

March 1, 2004

Respectfully submitted,

BINGHAM McCUTCHEN LLP
Susan Hoffman
Elizabeth Van Horn
Hwannie Lee

GREINES, MARTIN, STEIN & RICHLAND LLP
Robin Meadow
Michael D. Fitts

By _____
Michael D. Fitts
Attorneys for Respondent Cedars-Sinai Medical Center

CERTIFICATION

Pursuant to California Rules of Court, Rule 14(c), I certify that this **RESPONDENT'S BRIEF** contains **9,972** words, not including the tables of contents and authorities, the caption page, signature blocks, or this Certification page.

Dated: March 24, 2004

_____
Michael D. Fitts