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NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION TWO

CHRISTOPHER LYNN JOHNSON, Plaintiff and Appellant, v. RIVERSIDE HEALTHCARE SYSTEM, L.P., Defendant and Respondent.	E038410 (Super.Ct.No. RIC420191) O P I N I O N

APPEAL from the Superior Court of Riverside County. Gary B. Tranbarger, Judge. Affirmed.

Christopher Lynn Johnson, in pro. per.; and Fenton & Nelson, Henry R. Fenton and Benjamin J. Fenton, for Plaintiff and Appellant.

Theodora Oringher Miller & Richman, Robert M. Dato and Efrat M. Cogan for Defendant and Respondent.

I. INTRODUCTION

Christopher Lynn Johnson, M.D. appeals from a judgment entered in favor of Riverside Healthcare System, L.P., a private hospital (RHS or hospital), after the trial court denied his petition for a writ of administrative mandate. (Code Civ. Proc., § 1094.5.) In his petition, Dr. Johnson sought to set aside a final decision of the RHS governing board denying his application for readmission to the medical staff. He applied for readmission after he was automatically terminated for failing to timely pay his annual dues. Before his automatic termination, he had been a member of the medical staff for over three years.

The medical staff executive committee (MEC) initially reviewed Dr. Johnson's application and recommended that it be denied. Dr. Johnson requested a hearing, and a hearing was conducted before a judicial review committee (JRC). The JRC made factual findings and issued a decision (the JRC decision), concluding the evidence supported the MEC's recommendation. The JRC concluded that Dr. Johnson's behavior toward nurses and staff at the hospital was so disruptive that it posed a significant risk to patient care. (*Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614 (*Miller*).) But the JRC also concluded that there was insufficient evidence to deny Dr. Johnson's application based on his clinical competence. The JRC noted that even the witnesses who were critical of Dr. Johnson's behavior "uniformly opined that Dr. Johnson was at least 'adequate' clinically and technically."

Dr. Johnson appealed the JRC decision to an appellate committee (the appeal board) of the governing board. The appeal board upheld the JRC decision, but found, contrary to the JRC, that the evidence showed "Dr. Johnson should not be admitted to the [RHS] Medical Staff for clinical as well as behavioral reasons." The governing board of the hospital adopted the appeal board decision as its final decision, and denied the application.

Dr. Johnson raises numerous claims of error. He initially claims he was denied a fair hearing before the JRC in accordance with the medical staff bylaws (bylaws) and Business and Professions Code section 809 et seq.[1] He also claims the medical staff, the JRC, and the hospital committed numerous errors, and that the hospital's final decision denying his application is not based on substantial evidence. He further contends that the appeal board exceeded its authority in concluding, contrary to the JRC, that his application should be denied on both clinical and behavioral grounds. Finally, he claims the JRC erroneously treated him as an initial applicant, and accordingly imposed upon him the burden of proving he was currently qualified to serve on the medical staff.

For the reasons that follow, we conclude that Dr. Johnson's petition was properly denied. Accordingly, we affirm the judgment.[2]

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[1] All further statutory references are to the Business and Professions Code unless otherwise indicated.

[2] Dr. Johnson has requested that this court take judicial notice of reference materials that were not made part of the administrative record or the trial court record. The request is denied, because the materials are not matters of which judicial notice must or may be taken. (Evid. Code, §§ 450-452, 459.)

[footnote continued on next page]

II. OVERVIEW OF FAIR HEARING PROCEDURES (§ 809 ET SEQ.)

In 1989, the Legislature enacted section 809 et seq. "for the purpose of opting out of the federal Health Care Quality Improvement Act of 1986 (42 U.S.C. § 11101 et seq.), which was passed to encourage physicians to engage in effective peer review. California chose to design a peer review system of its own, and did so with the enactment of [sections 809 through 809.8]. (Stats. 1989, ch. 336, § 1, pp. 1444-1445.)" (*Unnamed Physician v. Board of Trustees* (2001) 93 Cal.App.4th 607, 616 (*Unnamed Physician*).)

"Section 809 provides generally that peer review, fairly conducted, is essential to preserving the highest standards of medical practice and that peer review which is not conducted fairly results in harm both to patients and healing arts practitioners by limiting access to care. (§ 809, subd. (a)(3), (4).) The statute thus recognizes not only the balance between the rights of the physician to practice his or her profession and the duty of the hospital to ensure quality care, but also the importance of a fair procedure, free of arbitrary and discriminatory acts. [Citation.]" (*Unnamed Physician, supra,* 93 Cal.App.4th at pp. 616-617.)

Sections 809 through 809.8 delegate "to the private sector the responsibility to provide fairly conducted peer review in accordance with due process, including notice,

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[footnote continued from previous page]

The materials are: (1) Hanson, Catherine J. et al., editors, *California Physician's Legal Handbook* (California Medical Association 2005) ch. 24 at pp. 24:20, 24:32; (2) Mehrabian & Weiner, *Decoding of Inconsistent Communications* (1967) vol. 6, No. 1, Journal of Personality and Social Psychology, pp. 109-114; and (3) Mehrabian & Ferris, *Inference of Attitudes from Nonverbal Communication in Two Channels* (1967) vol. 31, No. 3, Journal of Consulting Psychology, pp. 248-252.

discovery and hearing rights, all specified in the statute. [Citation.] A hospital is required to establish high professional and ethical standards and to maintain those standards through careful selection and review of its staff. [Citation.]" (*Unnamed Physician, supra,* 93 Cal.App.4th at p. 617.)[3]

Section 809 et seq. codifies prior case law requirements governing a physician's right to a fair hearing. (*Sahlolbei v. Providence Healthcare, Inc.* (2003) 112 Cal.App.4th 1137, 1147.) The procedures are mandatory for acute care hospitals and must be incorporated into their bylaws. (§ 809, subd. (a)(8); *Unnamed Physician, supra,* 93 Cal.App.4th at p. 622.)[4]

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[3] In accordance with the statutes, state regulations provide that a licensed hospital facility must have "an organized medical staff 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).) The medical staff, with the approval of the governing body, "shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments . . . and such other subjects or conditions which the medical staff and governing body deem appropriate." (*Id*., subd. (b).)

The medical staff acts primarily through peer review committees, which assess the performance of physicians currently on staff, review the need for and results of each surgery performed in the hospital, and perform other functions. (Cal. Code Regs., tit. 22, § 70703, subds. (b) & (d); *Unnamed Physician, supra,* 93 Cal.App.4th at p. 617.) The peer review committees must report their activities and recommendations to the executive committee of the medical staff and the governing body of the hospital. (Cal. Code Regs., tit. 22, § 70703, subd. (d).)

[4] "To comply with the statute's mandate, the hospital's medical staff must adopt bylaws that include formal procedures for '"the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate." [Citation.]' [Citation.] It is these bylaws that govern the parties' administrative rights. [Citation.]" (*Unnamed Physician, supra,* 93 Cal.App.4th at p. 617.)

III. FACTS AND PROCEDURAL HISTORY

A. *Background*

Dr. Johnson is a general surgeon and board-certified plastic surgeon with experience in plastic, reconstructive, and trauma surgery. He received a master's degree in biochemistry from Oxford University in 1985 and his medical degree from Harvard Medical School in 1989. He was an associate member in good standing of the medical staff of RHS from February 1999 to February 2002.

B. *Dr. Johnson is Terminated From the Medical Staff for Failing to Pay His Dues*

Effective February 12, 2002, Dr. Johnson was "automatically dropped" from the RHS medical staff because he failed to pay his $200 in annual dues by February 11, 2002, as required by rule 25 of the medical staff rules and regulations.[5] At the JRC hearing, Dr. Johnson conceded that he failed to pay his dues by February 11, 2002. He traveled to Ecuador in late January 2002 to perform cleft palate surgeries, and did not return to Riverside until February 18. Moreover, on January 9, he accepted a position

[5] Rule 25 of the rules and regulations of the medical staff states that annual dues are billed on November 1, are payable on or before January 1, and are delinquent if not paid by February 1. Rule 25 further states, "[s]taff members whose dues are not paid by February 1st shall automatically be dropped from the Medical Staff. Reapplication shall require completion of all necessary forms for the application process to the Medical Staff and payment of the application fee." As a member of the medical staff, Dr. Johnson agreed to be bound by the rules and regulations.

In 2002, the medical staff extended the February 1 deadline to February 11 for all physicians. Only two physicians, Dr. Johnson and one other physician, failed to pay their dues before the extended February 11 deadline. Both Dr. Johnson and the other physician were automatically dropped from the medical staff.

with a microsurgery group in Virginia and, in Dr. Johnson's words, "it was known that [he] was leaving."

C. *Dr. Johnson Reapplies for Medical Staff Membership*

As a result of his failure to timely pay his dues by February 11, 2002, Dr. Johnson was required to reapply for medical staff membership if he wanted to continue practicing at RHS.[6] Dr. Johnson wanted to be readmitted "for a short time" to complete surgeries and follow-up on "a small number of patients" still in his care. Thus, following his return from Ecuador on February 20 he paid his outstanding dues of $200, together with a reapplication fee of $750, and submitted a new application for medical staff membership. He was told he was to speak with Dr. Duncanson concerning his reapplication. Dr. Duncanson was the chief of staff and a member of the medical staff credentials committee and the MEC.

At the JRC hearing, Dr. Johnson testified that Dr. Duncanson told him that, under the circumstances, his readmission to the medical staff was not going to be "a problem." Dr. Duncanson disputed this account. According to Dr. Duncanson, he met Dr. Johnson for the first time on February 20 to discuss his options. Dr. Duncanson told Dr. Johnson he was currently not a member of the medical staff and, should he reapply, his "guess was that he was not going to have an easy time" because there had been "multiple . . . complaints about his behavior." Dr. Duncanson also advised Dr. Johnson that if he reapplied and was rejected, "it would generate an 805 [report]."

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[6] See footnote 5, *ante*.

An "805 report" is a report of an adverse disciplinary action, pursuant to section 805, that must be filed with the Medical Board of California (MBC). The 805 report is also filed with the National Practitioner's Data Bank, a federal agency responsible for retaining and sharing physician disciplinary information with other hospitals and health plans. (42 U.S.C. § 11101 et seq.; §§ 805, 809.)

D. *The Reapplication Process*

On April 2, 2002, Dr. Johnson met with the credentials committee to discuss his application. During this meeting, Dr. Johnson learned that the hospital had received 14 written complaints about him. The credentials committee recommended that the MEC deny Dr. Johnson's application because of his inability to "provide adequate information to resolve the committee members' concerns during the interview process. . . ."

The MEC met to review Dr. Johnson's application on April 16. Dr. Johnson was not present at this meeting. The MEC found that Dr. Johnson "was unable to provide adequate information to resolve the committee members' concerns regarding the documented complaints" and on this basis recommended that the governing board deny the application.

E. *The Premature 805 Report*

On April 22, 2002, before Dr. Johnson requested a hearing and before the JRC hearing was conducted, the medical staff filed an 805 report (§ 805) with the MBC and National Practitioner's Data Bank. The 805 report stated that a final decision rejecting the application had been made (the 805 report). The 805 report also stated, "Following

an automatic termination of his Medical staff membership for failure to pay mandatory annual Medical Staff dues, Dr. Christopher Johnson reapplied for membership on the [RHS] Medical Staff on February 20, 2002. Incidents of questionable professional care and numerous instances of rude and disruptive behavior while he was previously on staff were considered. Also considered was his history of failing and refusing to cooperate in the peer review process, specifically, he did not attend meetings when requested for discussion of patient care concerns. Dr. Johnson failed to provide sufficient information to explain or justify these concerns or his conduct, which led to a conclusion that he failed to adequately demonstrate his qualifications for Medical staff membership."

F. *The MEC Notifies Dr. Johnson of Its Recommendation and His Hearing Rights*

On May 22, 2002, the MEC notified Dr. Johnson that it had recommended that the governing board deny his application for staff membership and privileges, and that he had a right to appeal the recommendation within 30 days, that is, by June 22. On July 8, Dr. Johnson requested a hearing on the final proposed action. (§ 809.1, subd. (b).) After Dr. Johnson requested a hearing, the medical staff sent him a letter titled "Notice of Hearing/Notice of Charges" setting forth 19 charges, consisting of the original 14 complaints mentioned at the credentials committee meeting and five additional charges. Most of the charges were based on written complaints called risk identification reports (RIRs) made while Dr. Johnson was a member of the medical staff.

G. *The JRC Hearing and Decision*

The hearings before the JRC began on September 6, 2002, and continued over four additional sessions on September 7, September 18, November 6, 2002, and January 22, 2003. The JRC consisted of five panel members, including John D. Harwell, who was appointed the hearing officer and presided at the hearing. Neither Dr. Johnson nor the MEC were represented by counsel at the hearing. Dr. Johnson represented himself and Dr. Duncanson represented the MEC.

Regarding the burden of proof at the hearing, the JRC found that, under article III, section 4. I. of the bylaws, the MEC had the burden of producing evidence to support its recommendation to deny Dr. Johnson's application. The JRC also found that, as an initial applicant, Dr. Johnson had the burden of proving by a preponderance of the evidence that he was qualified to serve on the medical staff. He was to meet this burden "by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning current qualifications." (Bylaws, art. VIII, § 4. I.; accord, § 809.3, subd. (b)(2).)

The JRC found that the evidence supported 14 of the 19 charges. Dr. Johnson's principal defense was that the charges were motivated by racial or homophobic bias. Dr. Johnson is Black and, in his words, "openly gay." In its decision, the JRC noted it heard "significant evidence on that issue and concluded that the charges brought were true and that the charging individuals had not displayed any personal bias."

The JRC concluded that Dr. Johnson should be denied admission because he had "failed to meet his burden to produce information which allows for adequate evaluation and resolution of reasonable doubts concerning current qualifications for privileges or membership as to the behavioral issues raised in this charge." The JRC concluded that "the charges relating to Dr. Johnson's clinical competence did not support" the denial of the application. A minority believed that Dr. Johnson should be granted membership and privileges on the "condition that he modify his behavior and participate in peer review appropriately."

H. *The Appeal Board's Decision and the Governing Board's Final Decision*

Dr. Johnson appealed the JRC decision to the appeal board, which was appointed by the governing board. The appeal board adopted the JRC's factual findings, but unlike the JRC, recommended that the governing board reject Dr. Johnson's application on both behavioral and clinical grounds. The governing board adopted the appeal board recommendation as its final decision.

I. *The Writ Petition*

In October 2004, Dr. Johnson filed a petition for a writ of administrative mandate, requesting that the superior court set aside the governing board's final decision and order a new hearing. The superior court denied the petition and entered judgment in favor of the hospital. This appeal followed.

III. DISCUSSION

A. *Standard of Review*

"In an administrative mandamus action, the superior court is to decide on the basis of the administrative record '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 . . . or the findings are not supported by the evidence.'" (*Rhee v. El Camino Hospital Dist.* (1988) 201 Cal.App.3d 477, 488; Code Civ. Proc., § 1094.5, subds. (b) & (d).)

Our reviewing function is the same as the trial court. We review the proceedings de novo to determine whether Dr. Johnson received a fair hearing, and whether substantial evidence supports the final decision denying his application for readmission to the medical staff. (See *Hongsathavij v. Queen of Angels etc. Medical Center* (1998) 62 Cal.App.4th 1123, 1136-1137.) We presume the correctness of the findings of fact, and resolve all reasonable doubts in favor of them. (*Ryan v. California Interscholastic Federation-San Diego Section* (2001) 94 Cal.App.4th 1048, 1077-1078.) However, we are not bound by determinations of law, whether made by the JRC, the appeal board, the governing board, or the trial court. (See *Hongsathavij v. Queen of Angels etc. Medical Center, supra,* at pp. 1136-1137.)

B. *Claims of Error*

Dr. Johnson claims that, for numerous reasons, the MEC and JRC "failed to comply with the minimum procedures required by . . . section[] 809 et seq." in processing

his application for readmission and in conducting the JRC hearing. He also claims that the JRC, the appeal board, and the governing board made numerous additional errors, and that insufficient evidence supports the JRC's findings and the governing board's final decision. We address Dr. Johnson's specific claims below.

1. Dr. Johnson Was Not Entitled to Notice of His Automatic Termination

Dr. Johnson first claims he was entitled to *written notice* of his *automatic termination* from the medical staff for failing to pay his dues by the extended due date of February 11, 2002. We disagree.

As a member of the medical staff, Dr. Johnson agreed to be bound by its rules and regulations. Rule 25 provided that members who failed to timely pay their dues "shall automatically be dropped from the Medical Staff. Reapplication shall require completion of all necessary forms for the application process to the Medical Staff and payment of the application fee." This rule put Dr. Johnson on notice that he would be automatically terminated if he failed to pay his annual dues, and that no further notice of the termination would be given.

Furthermore, nothing in section 809 et seq. required that Dr. Johnson be given additional notice of his automatic termination. For these purposes, it is also important to distinguish Dr. Johnson's automatic termination for failing to pay his annual dues from the MEC's recommendation that the governing board deny his application for readmission. Section 809 et seq. requires that notice be given of the latter, but not the former.

Specifically, section 809.1 provides that a physician shall be given notice of "a final proposed action of a peer review body for which a report is required to be filed under Section 805 . . . ." (§ 809.1, subd. (a).) A "final proposed action" is "the final decision or recommendation of the peer review body . . . ." (§ 809.1, subd. (a).) As relevant here, the "peer review body" is the medical staff, acting through its designee, the MEC (§§ 805, subd. (a)(1), 809, subd. (b)), and the MEC's "final proposed action" was its recommendation that the governing board deny Dr. Johnson's application for readmission.

2. Dr. Johnson Was Given Adequate Notice of the MEC's Recommendation

On May 22, 2002, the president of the medical staff, Dr. Duncanson, sent a letter to Dr. Johnson notifying him of the MEC's recommendation that the governing board deny his application for readmission. (§ 809.1.) Dr. Johnson claims the May 22 notice was deficient for several reasons.

First, Dr. Johnson complains that, during his discussions with the medical staff credentials committee on April 2, 2002, he was not given copies of the complaints or medical charts underlying the committee's concerns. Thus, he argues, he was not given "adequate time or information" to respond to the credentials committee's concerns. He also complains he was not given notice of the "specific charges against him" until *after* the credentials committee *and* the MEC recommended that his application for readmission be denied. "Even then," he says, "the MEC did not identify the

complainants or the names of individuals who witnessed the incidents that were the basis for the charges . . . ."

These complaints are without merit. First, Dr. Johnson was not entitled to copies of any complaints or medical charts at any time *before* the MEC recommended that his application be denied. (See § 809.1; Bylaws, art. VIII, § 2.) Instead, once the MEC made its recommendation, he was entitled to "written notice" of the following under section 809.1: (1) the MEC was proposing an action against him which, if adopted, would be taken and reported pursuant to section 805; (2) the final proposed action, namely, that his application be denied; (3) his right to request a hearing on the recommendation; and (4) the time limit for requesting a hearing. (§ 809.1, subd. (b).)

Under the bylaws, he was also entitled to a description of the "acts or omissions with which [he was] charged, a list of charts under question by chart number, or the reasons for the denial [of his application for readmission]." (Bylaws, art. VIII, § 2.) Thus, under the bylaws, he was entitled to receive this information *before* he requested a hearing. (Cf. § 809.1, subd. (c) [notice of reasons for final proposed action including acts or omissions charged required to be given only after licentiate timely requests hearing].)

The May 22 letter to Dr. Johnson complied with the requirements of section 809.1 and the bylaws. In accordance with the statute, the letter advised Dr. Johnson of the MEC's adverse recommendation and that he had a right to request a hearing on recommendation within 30 days, and provided him with a summary of his rights in the event he requested a hearing. (§ 809.1, subd. (b); Bylaws, art. VIII, § 2.) In accordance

with the bylaws, the letter described the "acts or omissions with which [Dr. Johnson was] charged" and the "reasons for the denial" of his application. (Bylaws, art. VIII, § 2.)

As reasons for the denial of the application, the letter cited "[n]umerous reports of inappropriate professional conduct and behavior . . . from late 2000 through early 2002, including, for example, incidents where you made rude and inappropriate remarks and conduct towards [*sic*] staff members, a patient, and a physician, often in a raised voice or in a demeaning, insulting, or offensive tone. Additionally, you made unreasonable demands on staff members, demonstrated a lack of cooperation, interrupted a procedure for a non-urgent phone call, violated sterile procedures despite appropriate requests for caution, failed to follow usual and customary practices with respect to surgical scheduling, equipment requests, orders, and informed consent, demonstrated a cavalier and inappropriate attitude towards [*sic*] cases, unduly delayed seeing a trauma patient, failed to timely follow-up on patient care requests, and provided questionable care and management in a microplate placement case. Finally, the [MEC] considered your history of failing to promptly respond and cooperate in the peer review process - specifically, your failure to attend requests to meet with the Surgical Quality Review Committee to discuss existing concerns about your delivery of patient care and professional conduct."

In conclusion, the letter stated: "Based upon this history, and based upon the view that these concerns were not adequately explained by you in your recent meeting with the Credentials Committee, the [MEC] believes significant and unresolved doubts exist about your professional care and about your conduct and behavior which impacts upon patient

care . . . . Accordingly, the [MEC] has recommended that your application for membership be denied."

Although, as Dr. Johnson complains, the letter did not provide the names of the individuals who witnessed the incidents, neither section 809.1 nor the bylaws required such a list of names at this point in the process. And, although the letter also did not list each and all of the "charts under question by chart number" (Bylaws, art. VIII, § 2. A. 1.), the letter listed several chart numbers that the staff "currently" knew were involved and stated that, in some instances, "the underlying chart numbers are not evident or currently identified."

In any event, under the bylaws, Dr. Johnson was entitled to *either* "a list of charts under question by chart number, *or* the reasons for the denial" or recommended denial of his application. (Bylaws, art. VIII, § 2. A. 1., italics added.) He was clearly given an adequate explanation of the reasons the MEC was recommending the denial of his application. Thus, Dr. Johnson was given adequate notice of the MEC's recommendation and the charges against him.

3. Dr. Johnson Was Given Adequate Information Concerning the Charges

Dr. Johnson further claims the medical staff failed to provide him with "full and complete documentation" of the charges against him "in a timely manner" and he was therefore unable to properly prepare for the hearing.

Several provisions govern the parties' access to and exchange of information in connection with a peer review proceeding. First, both sides were entitled to inspect and

copy "documentary information relevant to the charges" under each other's control, "as soon as practicable after the receipt of the licentiate's request for a hearing." (§ 809.2, subd. (d).) The failure of either party to provide access to this information at least 30 days before the hearing constitutes good cause for a continuance of the hearing. (*Ibid*.)

Furthermore, at least 10 days before the hearing and at the request of either side, both parties are required to exchange witness lists and copies of all documents they expect to introduce at the hearing. Either party's failure to comply with this rule *also* constitutes good cause for continuing the hearing. (§ 809.2, subd. (f).) Finally, both parties have a "right" to be provided with all information made available to the trier of fact at the hearing. (§ 809.3, subd. (a)(1).)

Dr. Johnson requested a hearing on July 8, 2002, and the MEC received his request on the same day. Thereafter, the hearing was scheduled to begin and did begin on September 6, 2002. Initially, the medical staff provided Dr. Johnson with *redacted* copies of RIRs or written complaints underlying some the charges against him. These RIRs were redacted to exclude the names of the persons who made the reports or witnessed the incidents described in the reports. Dr. Johnson complains he was not given *unredacted* copies of the RIRs until the time of the hearing, "and even then, some of the RIRs were incomplete." He argues that, "[w]ithout the names of the complainants and without complete, un-redacted copies of the RIRs, [he] could not properly prepare himself for the JRC hearing."

The record belies Dr. Johnson's claim. Although he was initially given redacted copies of the RIRs, he received *unredacted* copies of the RIRs on August 28, 2002, *nine days* before the September 6 hearing. This one-day delay occurred because Dr. Johnson was not available to receive the documents when they were delivered to his office on August 27. In any event, Dr. Johnson did not request a continuance based on this delay. (§ 809.2, subd. (f).)

Moreover, the hearing began on September 6 and continued over five sessions, with the last session taking place on January 22, 2003. The interim sessions were held on September 7, 18, and November 6. The record indicates that Dr. Johnson ultimately received copies of all documents that were provided to the trier of fact at the hearing, and there is no indication that any documents, including RIRs, were not provided to him in sufficient time to allow him to prepare for and examine witnesses at the hearing.

Furthermore, in a July 23, 2002, letter titled "Notice of Hearing/Notice of Charges," the MEC gave Dr. Johnson detailed explanations of the 19 charges against him. The explanations included dates and chart numbers of the incidents, where appropriate, and dates and detailed explanations where there were no chart numbers involved. The July 23 letter gave Dr. Johnson sufficient information to investigate the charges against him.

Dr. Johnson complains that the July 23 letter included an erroneous chart number for charge 6, and that he was not provided with the correct chart number until the time of

the hearing. He also complains he was not given the "trauma activation sheet" for charge 6 until it was faxed to him on September 30, 2002.

Charge 6 alleged that Dr. Johnson delayed treating a trauma patient who arrived in the emergency department with a liver laceration. An emergency room shift coordinator, Christine Sullivan, wrote an RIR alleging that Dr. Johnson, who was the trauma surgeon on call, failed to respond to her repeated attempts to page him, and he had not seen the patient until three hours after he was initially paged. The response time for trauma surgeons is no more than 20 minutes. Ms. Sullivan testified to these events at the September 6 hearing. She also testified that she talked to Dr. Johnson a number of times, he repeatedly said he was coming, and to her knowledge he was not in another surgery at the time.

At the September 18 hearing, Dr. Johnson requested the "trauma activation sheet" for the patient. He indicated he believed that the document would show he was present and treated the patient much earlier than Ms. Sullivan testified. The medical staff located the document and faxed it to Dr. Johnson and the hearing officer on September 30. However, the document contained no information relevant to Ms. Sullivan's accusation, or when Dr. Johnson first saw the patient.

In any event, the medical staff produced the document very soon after Dr. Johnson requested it. Dr. Johnson did not request it until after the hearing began, and there is no indication that the MEC intended to introduce it at the hearing. In any event, the delay in producing the document could not have affected the JRC's findings on charge 6, because

it did not include any information relevant to the charge. (See *Gill v. Mercy Hospital* (1988) 199 Cal.App.3d 889, 908 [failure to provide document which does not address primary concern in the case, or which does not affect the outcome, is not a denial of a fair hearing].)

4. Dr. Johnson Had a Fair Opportunity to Examine Witnesses and Present a Defense

Dr. Johnson next claims that, for several reasons, he was "denied the opportunity to present and recall witnesses" and "test the reliability of the evidence introduced by the MEC" at the hearing. Again, we find these claims without merit.

First, Dr. Johnson complains that the staff failed to provide him with a list of its witnesses until September 6, the first session of the hearing. He claims this was too late for him "to conduct witness interviews and prepare his case properly." This claim is unsupported by the record. Dr. Johnson did not request a continuance of any of the hearing sessions based on the medical staff's failure to provide its witness list until September 6. (§ 809.2, subd. (f).) Nor is there any indication that the delay deprived Dr. Johnson of any opportunities he otherwise would have had to conduct witness interviews or prepare his case.

Second, Dr. Johnson argues it was improper for the JRC to allow Dr. Duncanson and other nonpercipient witnesses to testify concerning some of the RIRs underlying the charges. Not so. Section 809 et seq. does not preclude the admission of hearsay evidence. Furthermore, the bylaws provide that "[a]ny relevant evidence shall be

admitted by the hearing officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs . . . ." (Bylaws, art. VIII, § 4. F.) Dr. Johnson has not shown that the RIRs or any hearsay testimony concerning them was unreliable.

Third, Dr. Johnson claims the medical staff interfered with his ability to present a defense by "engag[ing] in a systematic effort to threaten and bully [him] and block [his] ability to prepare a defense." He specifically complains that the medical staff refused to facilitate his attempts to contact hospital employees and staff to request that they testify at the hearing and that Dr. Duncanson insisted he make an offer of proof before two nonstaff member physicians testified. There is no merit to either of these claims. The hospital was not required to order any of its employees or staff to testify at the hearing, and the hearing officer had no authority to order any witnesses to testify. (See § 809 et seq.) Nor was it improper for Dr. Duncanson to insist on an offer of proof concerning witnesses who had no apparent knowledge or information concerning any of the 19 charges against Dr. Johnson. In any event, neither the JRC hearing officer or the medical staff precluded Dr. Johnson from contacting or calling any witnesses to testify.

5. Dr. Johnson's Confidentiality and Retaliation Claims Are Without Merit

Dr. Johnson next claims "medical staff representatives did not maintain confidentiality about the proceedings, [and his] witnesses were subject to retaliation while a biased MEC witness was excused from testifying."

On August 30, 2002, Dr. Johnson wrote a letter to Dr. Duncanson complaining that Dr. Duncanson's clerical assistant, Sandy Brassard, had spoken to one of Dr. Johnson's witnesses, Dr. Virginia Garret, concerning the content of her testimony. The letter requested that Dr. Duncanson admonish members of his staff not to speak with Dr. Johnson's witnesses about the proceedings, and expressed concern that the "anonymity and confidentiality" of Dr. Johnson's witnesses "may not be protected by certain members of your staff."

Then, at the hearing on September 6, Dr. Johnson told the hearing officer he was concerned about his witnesses' confidentiality and that they would suffer retaliation for testifying for him. On September 7, Corey Bryant, an operating room nursing assistant, testified for Dr. Johnson that he heard nurses discussing the JRC hearing in the operating room. He said "confidentiality was definitely lost." Mr. Bryant also said he believed the operating room nurses knew he would be testifying; however, he said he was not concerned about that at all.

Despite Dr. Johnson's concerns about confidentiality breaches and retaliation against his witnesses, there is no indication that Dr. Duncanson or his clerical assistant, Sandy Brassard, acted improperly in speaking to Virginia Garrett about her testimony. Each party was free to speak to witnesses and potential witnesses about the proceedings. Nor is there any indication that Dr. Duncanson or any other member of the medical staff was responsible for the operating room nurses' discussion about the hearing, or whether

any of Dr. Johnson's witnesses were threatened with or subjected to retaliation for testifying.

Dr. Johnson also complains that Dr. Duncanson prejudiced him by claiming, at the hearing, that Libby Martin, a nurse whom Dr. Johnson claimed had made numerous, anti-gay remarks about him, refused to testify because she feared Dr. Johnson would subject her to "snide and demeaning remarks." He claims Dr. Duncanson's statements "were extremely damaging" to him and should have been stricken. Dr. Johnson did not object to the remarks, however. Nor is there any evidence that the remarks affected any of the JRC's findings.

Finally, Dr. Johnson claims the "nature of the MEC's presentation made it difficult for [him] to refute the charges" and "the JRC hearing officer and the MEC repeatedly impeded [his] efforts to demonstrate bias." Neither of these claims has any merit. There is no indication that the MEC, the JRC, or the hearing officer prevented Dr. Johnson from presenting any evidence, including evidence that hospital employees or staff members were biased against him.

To the contrary, Dr. Johnson presented evidence that he may have been disliked at least in part because of his sexual orientation. Corey Bryant testified that some of the nurses engaged in "little negative backstabbing-type talk" about Dr. Johnson and "weren't too thrilled to do his cases," "maybe because of his personality" or "sexual orientation." Mr. Bryant said he had heard some of the nurses discuss Dr. Johnson's sexual orientation "[i]n a derogatory way." For example, they said Dr. Johnson was

"flamboyant, a flamer" and "[v]ery colorful." The nurses also argued about who had to work with him on his cases.

Dr. Johnson complains that Dr. Duncanson "made repeated efforts to block Mr. Bryant's testimony." Dr. Duncanson's efforts were obviously unsuccessful, however, in view of Mr. Bryant's testimony. Nor does the record indicate that Dr. Duncanson successfully "blocked" any other witnesses from testifying that hospital employees or staff members harbored biases against Dr. Johnson. Finally, the record does not support Dr. Johnson's claim that the hearing officer "thwarted" Dr. Johnson's efforts to discredit the charges against him as being motivated by racial or homophobic bias.

6. The Medical Staff Was Not Required to Take Informal Corrective Action

Dr. Johnson claims that, instead of terminating him for failing to pay his dues and requiring him to reapply for staff membership, the medical staff should have allowed him "to cure by paying his dues and should have addressed the complaints against [him] and RIRs through the Corrective Action and Peer Review process," in accordance with the Bylaws, at article VII, sections 1 through 4, rules 39 and 43 of the rules and regulations, and the medical staff's "Unprofessional Behavior Policy." We disagree.

Collectively, the bylaws, rules and regulations, and Unprofessional Behavior Policy contemplate taking informal "corrective action" against a physician who engages in disruptive behavior through the peer review process. But the medical staff was not *required* to initiate any informal corrective action against Dr. Johnson *before* he was automatically terminated from the medical staff and reapplied for admission.

Furthermore, the record indicates that the medical staff did attempt to counsel Dr. Johnson about his behavioral problems. Dr. Baxter, the director of trauma services at the hospital, testified that he told Dr. Johnson that "his attitude [was] kind of bothering people" and "a lot of people" "considered him as being disruptive." One of Dr. Johnson's own witnesses, Dr. Rogers, also testified that he had tried to tell Dr. Johnson that his behavior was causing him problems, and that he had brought many of the complaints about his behavior upon himself. Finally, Dr. Duncanson testified that he and Drs. Zekos and Baxter considered referring Dr. Johnson to counseling, but they felt it was "extremely unlikely" he would "cooperate with the very, very loosy-goosey kind of physician aid component," because he did not seem to recognize he had interpersonal problems, and he had ignored their letters urging him to engage in peer review.

7. The 805 Report Was Prematurely Filed

Dr. Johnson claims the medical staff "acted precipitously" in filing the 805 report with the MBC and National Practitioner's Data Bank on or about April 22, 2002, before the JRC hearing was conducted, before his appellate rights were exhausted, and before the governing board issued its final decision denying his application. We agree. The 805 report was prematurely filed; however, there is no indication that this error affected the JRC hearing, the appeals process, or the governing board's final decision.

Under section 805, the medical staff and RHS had an obligation to file an 805 report with the MBC within 15 days after the "effective date" Dr. Johnson's application for staff privileges was denied—that is, 15 days after the governing board issued its final

decision denying the application. (§ 805, subd. (b) [805 report to be filed where application for staff privileges denied as a result of a "disciplinary cause or reason"].) The governing board did not issue its final decision until September 22, 2004. But the reports were prepared and filed on or about May 22, 2002, after the credentials committee recommended, on April 16, 2002, that Dr. Johnson's application be denied.

Dr. Johnson complains that the premature filing of the 805 report—before he was even notified, on May 22, 2002, of the MEC's adverse recommendation prejudiced the subsequent JRC hearing, the appeals process, and the governing board's final decision. He notes that, in *Sahlolbei v. Providence Healthcare, Inc., supra*, 112 Cal.App.4th at page 1150, this court criticized the hospital for treating the medical staff's "final proposed action" (§ 809.1) as the hospital's final decision. But he cites no evidence to support his claim that the premature filing of the 805 report prejudiced the JRC hearing, the appeals process, or the governing board's final decision. His claim of prejudice must therefore be rejected.

Dr. Johnson also complains that the medical staff failed to comply with section 805, subdivision (f), which requires that "[a] copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the [medical staff] to the licentiate named in the report." Section 800 allows a physician, against whom an 805 report has been filed, to "submit any additional exculpatory or explanatory statement or other information" concerning the 805 report with the medical board.

It is unclear from the record exactly when the medical staff sent a copy of the 805 report to Dr. Johnson. Dr. Duncanson's May 22, 2002, letter to Dr. Johnson stated that "this proposed action warrants the submission of a report to the [MBC] under the provisions of Section 805," but the letter did not state that a copy of the 805 report, which had already been prepared and filed, was enclosed with the letter.

It is clear, however, that Dr. Johnson was aware that an 805 report had been filed with the MBC and the National Practitioner's Data Bank at the time of the initial JRC hearing on September 6, 2002. The 805 report was discussed during Dr. Johnson's and Dr. Duncanson's examination of Dr. Julia Terzis, the Virginia doctor who offered Dr. Johnson a position with her reconstructive microsurgery practice in late February or March 2002. Thus, Dr. Johnson must have had a copy of the report by the time of the hearing. Furthermore, there is no indication he was prevented from submitting any additional information concerning the contents of the report to the medical board under section 800, at any time.

8. Dr. Johnson's "Speaking Aid" Was Properly Excluded From the JRC Record

Dr. Johnson claims the appeal board erroneously "excluded relevant evidence" by excluding from the record and refusing to consider a document he used as a "speaking aid" at the JRC hearing. We disagree.

The document consists of a one-page chart listing eight of the charges against Dr. Johnson, and including Dr. Johnson's "comments" concerning each listed charge. For example, regarding charge 2, the document includes Dr. Johnson's comment that the

complainant, Gay Dickinson, "made numerous homophobic remarks about me and acted particularly hostile and obstructive in the setting of my cases."

At the JRC hearing, Dr. Johnson tried to introduce the document into evidence, but the hearing officer refused to admit it on the ground it was "in essence a speaking aid prepared by Dr. Johnson for his own purposes." Still, two copies of the document were included in the JRC record before the appeal board.

In proceedings before the appeal board, the MEC objected to the inclusion of the document in the JRC record and to the appeal board's consideration of it for any purpose, on the grounds it was not admitted into evidence at the JRC hearing and was potentially misleading. The presiding officer of the appeal board ruled that Dr. Johnson could not cite to the document or make any argument based upon it, and that the appeal board could not consider the document for any purpose. This ruling was proper. As the JRC hearing officer recognized, the document had no evidentiary value. It was therefore properly excluded from evidence at the JRC hearing and from the JRC record before the appeal board.

9. The Bylaws Did Not Misstate the Appeal Board Standard of Review

Dr. Johnson claims the medical staff bylaws were "defective" because they did not set forth a clear standard of review to be used by the appeal board in reviewing the JRC decision. He claims the bylaws did not "alert" him to the standard of review to be used by the appeal board, and "vested more discretion in the Appeal Board than is permitted by law." This claim is wholly unsupported.

Dr. Johnson bases his claim on article VIII, section 5. B. of the bylaws, which did not address the appeal board standard of review. The bylaw provision was titled "Grounds for Appeal," and stated: "The grounds for appeal from the hearing shall be: (a) substantial failure of the Judicial Review Committee, Executive Committee or Board of Directors [i.e., the JRC, MEC, or governing board] to comply with the procedures required by this Code or by the Hospital Medical Staff Bylaws in the conduct of hearing and decisions upon hearings so as to deny due process and a fair hearing; (b) action taken arbitrarily, capriciously or with prejudice."[7]

Dr. Johnson disregards article VIII Section 5. D. of the bylaws, which did address the standard of review by providing that the review by the appeal board shall "be in the nature of an appellate hearing." Thus, the appeal board standard of review was the same as that of the trial court and this court. It was to review the proceedings to determine whether there was a fair hearing and any prejudicial abuse of discretion, and whether substantial evidence supported the JRC's findings and recommendation to deny the application. (Code Civ. Proc., § 1094.5, subds. (b) & (d).)

[7] As used in article VIII of the bylaws, the phrase "this Code" referred to article VIII in its entirety, which was titled "Uniform Code of Hearing and Appeal Procedures." The Code set forth numerous provisions governing the JRC hearing and JRC decision, including the right to receive information on charges, the right to exchange witness lists and documents, the rights of both sides at the hearing, the admissibility of evidence, and the burdens of production and proof. Many of these bylaw provisions are based on section 809 et seq.

We also note that Dr. Johnson was represented by counsel before the appeal board, and it does not appear that his counsel was, or reasonably could have been, misled by any of the bylaws in pursuing the appeal.

10. Dr. Johnson Has Not Shown That the JRC's Findings are Based on Unreliable Evidence

Dr. Johnson claims the appeal board made a "significant error . . . in determining that the JRC could rely on uncorroborated hearsay in the form of RIRs prepared by nurses and staff who did not testify at the JRC Hearing." The finding is of no consequence, however, because the JRC did not rely solely on uncorroborated RIRs or on any unreliable evidence to support its factual findings.

In the proceedings before the appeal board, the parties disputed the admissibility of the RIRs and other hearsay evidence. The appeal board found that, as a matter of law, "uncorroborated hearsay can support findings of fact by the JRC." The appeal board based this finding on (1) section 809 et seq., which does not prohibit the admission of hearsay in peer review proceedings; (2) article VIII, section 4. F., of the bylaws, which provided, in pertinent part, that "[a]ny relevant evidence shall be admitted by the hearing officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law"; and (3) case law indicating that the hearsay nature of evidence does not render the evidence insufficient in peer review proceedings. (See, e.g., *Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 556, fn. 14.)

Dr. Johnson maintains that "unsubstantiated hearsay or evidence obtained from unreliable sources is not reliable evidence and cannot by itself be the basis for a finding." We agree. Although hearsay evidence is admissible in peer review proceedings, article VIII, section 4. F. of the bylaws required that all evidence, in order to be admissible, had to be reliable. Thus, admissible hearsay evidence must have some indicia of reliability; however, it does not necessarily have to be corroborated.

Dr. Johnson claims that the JRC relied "entirely on hearsay evidence" in making its findings on charges 1, 2, 3, 7, 8, 10, 11, 12, 14, and 17. It should be noted, however, that the JRC found in favor of Dr. Johnson on charges 5, 7, 9, 10, 16, and 18. Thus, there were no findings adverse to Dr. Johnson on charges 7 and 10.

In any event, Dr. Johnson has not shown that the evidence underlying any of the JRC's adverse findings was unreliable. To the contrary, the record shows that, to the extent the JRC relied on hearsay evidence—including RIRs and nonpercipient testimony concerning them—the evidence was reliable.

For example, it was alleged in charge 1 that Dr. Johnson failed to timely respond to numerous calls from a nurse regarding the postoperative care of a trauma patient who had suffered injuries to his hand. The patient was facing the "prospect of serious vascular compromise" to his hand.

Charge 1 further alleged that, when Dr. Johnson finally responded to the nurse's calls the following day, he "derided the concerns expressed by the day shift nurse with a comment along the lines of 'worry about saving his life, don't worry about his fingers.'"

It was also alleged that Dr. Johnson berated the day shift nurse for giving his telephone number to the patient's mother, was "abrupt" in communicating with the patient and his family, and failed to attend the surgical quality review committee (QRC) meeting to discuss the case.

Dr. Baxter testified concerning charge 1. He was the chairman of the surgical QRC committee at the time of the incident, and wrote a letter to Dr. Johnson about his care and management of the patient. He asked Dr. Johnson to attend that month's meeting of the surgical QRC to discuss the case, but Dr. Johnson did not attend. The nurse called Dr. Baxter the same the night she was trying to call Dr. Johnson regarding the patient. Dr. Baxter tried to counsel Dr. Johnson concerning his rude and unprofessional behavior toward nurses and staff, but Dr. Johnson just looked at him and said nothing.

Dr. Johnson also testified concerning charge 1. He admitted he "might have been unpleasant to the nurse on the phone or when [he] arrived because they gave [his] cellular phone number" to the patient's mother. Regarding his alleged failure to timely respond to the nurse's calls, he explained he was the only physician who did respond to the calls. He was operating in another hospital when he was first called. He immediately called Dr. Baxter after the nurse told him the patient's hand was "cold and blue," but Dr. Baxter did not return his calls. He ordered an angiogram for the patient.

When Dr. Johnson later arrived at the hospital to attend to the patient, he "watched [Dr. Baxter] call one after another of the vascular surgeons to come in and take care of

this patient," and none of them would do so. He said "[t]he system failed this patient," but he was blamed for the failure because he was a "target" and disliked. He claims he never received Dr. Baxter's letter to come to the surgical QRC meeting. Then he said that when he did get the letter or notice, Dr. Baxter told him to just write a letter and the QRC would be happy. At the time, Dr. Baxter did not tell him he was chairman of the QRC.

Regarding charge 1, the JRC found there was considerable confusion concerning whether Dr. Johnson should have been called concerning the postoperative care of the patient, because he was a consultant on the case and not the trauma surgeon or attending physician. Still, the JRC noted that Dr. Johnson might have instructed the nurse to call the attending physician or make the call himself, and his failure to do so "exacerbated the nurse's confusion." The JRC found that Dr. Johnson "assumed a role in the care" of the patient by talking to the attending physician and ordering an angiogram, then failed to respond to follow-up calls from the nurse.

Thus, the RIR underlying charge 1 was not the only evidence admitted or relied upon by the JRC in sustaining charge 1. To the contrary, the essential allegations of the charge were supported by Dr. Johnson's admissions and the testimony of Dr. Baxter. To the extent Dr. Baxter's testimony was hearsay, it was sufficiently reliable in view of his personal knowledge of many of the events surrounding the incident.[8]

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[8] The appeal board also found that the RIRs prepared by nurses and other staff who did not testify at the JRC hearing satisfied the business records exception to the

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11. Substantial Evidence Supports the JRC's Findings and the Governing Board's Final Decision Denying the Application

Dr. Johnson further claims that, to the extent the JRC's findings were not based on hearsay, they were based on insufficient evidence. Specifically, he claims the findings on charges 4, 6, 13, 15, and 19 are based on insufficient evidence.

The proper question, however, is whether the final decision denying Dr. Johnson's application is based on substantial evidence. In this context, substantial evidence includes hearsay, provided the hearsay is reliable. (Bylaws, art. VIII, § 4. I.) And as discussed, Dr. Johnson has not shown that the JRC relied upon unreliable evidence in making its findings and recommendation.

Substantively, the evidence must demonstrate that Dr. Johnson's behavior posed "a realistic and specific threat to the quality of medical care" at the facility. (*Miller, supra,* 27 Cal.3d at p. 632; see also *Pick v. Santa Ana-Tustin Community Hospital* (1982) 130 Cal.App.3d 970, 976-977.) A private hospital may not permanently revoke or terminate a physician's staff privileges based solely on the physician's abrasive personality or inability to work with others. (*Miller, supra,* at p. 626.) Instead, the physician's behavior must be "such as to present a real and substantial danger that patients treated by him might receive other than a 'high quality of medical care' at the facility . . . ." (*Id.* at p. 629.)

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hearsay rule. (Evid. Code, § 1271.) Because this finding was unnecessary to the JRC's findings or the governing board's final decision, we need not address it.

This standard was met here. The evidence as a whole showed that Dr. Johnson was abrasive and disrespectful to nurses and other staff to such an extent they were unwilling to work with him. Indeed, in the words of the JRC, Dr. Johnson's behavior "complicat[ed] scheduling; delayed patient surgeries; and . . . put patient lives at risk."

For example, on charge 4, the evidence showed that Dr. Johnson "behaved inappropriately and unprofessionally by yelling at a nurse" about the number of times he had been called about a patient. Kimmie Harden, a nurse, testified that she submitted the RIR underlying charge 4, the only RIR she had ever made against a doctor in her 16 years of working at the hospital. She made the report in part because Dr. Johnson was "ranting and raving" at the nurse's station because the nurses had been calling him for orders regarding one of his patients, a 24 year old with uncomplicated appendicitis, who was outside smoking. Ms. Harden said she had "never seen that kind of behavior at the nurses' station by a doctor."

Ms. Harden also testified that Dr. Johnson discharged the patient without seeing him, and without asking the nurses any questions about him. It was not usual or customary for a doctor to discharge a postoperative patient without examining him. Dr. Johnson said he had seen the patient smoking and if he was well enough to smoke, he was well enough to go home. He also admitted he was "probably upset," and that his behavior toward the nurses was "probably inappropriate."

The evidence also showed that Johnson "stormed" into the billing/admitting office and degraded the staff regarding a patient's bill (charge 12); called a hospital staff

member a "stupid woman" in the operating room and asked "[h]ow could any woman be so dumb?" when the staff member did not understand how to help Dr. Johnson return a page on his cell phone (charge 14); and was rude to a staff member who did not immediately open the locked ICU unit for him when he knocked on the door (charge 15). Patient family members witnessed the incident in charge 15, and commented on how rude Dr. Johnson's behavior was.

The evidence showed that Dr. Johnson's behavioral problems were longstanding. Dr. Hardesty, one of Dr. Johnson's witnesses with whom Dr. Johnson had previously worked at Loma Linda Hospital, testified that Dr. Johnson had "more than the average" number of interpersonal problems at Loma Linda. When one of the panel members asked whether he would rehire Dr. Johnson at Loma Linda if a position were available, Dr. Hardesty said his answer was "leaning towards [*sic*] no, but not a complete no." He explained that, "based on some of the interactions that he's had at . . . Loma Linda, it may be a difficult situation."

The evidence also showed that Dr. Johnson was unlikely to change his behavior, because he consistently failed to participate in peer review to address his problems. As noted, Dr. Duncanson testified that he and Drs. Zekos and Baxter considered referring Dr. Johnson to counseling, but they felt it was "extremely unlikely" he would "cooperate with the very, very loosy-goosey kind of physician aid component," because he did not seem to recognize he had interpersonal problems, and he had ignored their letters urging him to engage in peer review.

As also discussed, Dr. Baxter, the director of trauma services at the hospital, testified that he told Dr. Johnson that "his attitude [was] kind of bothering people" and "a lot of people" "considered him as being disruptive." One of Dr. Johnson's own witnesses, Dr. Rogers, also testified that he had tried to tell Dr. Johnson that his behavior was causing him problems, and that he had brought many of the complaints about his behavior upon himself.

In sum, substantial evidence showed that Dr. Johnson engaged in persistent and disruptive behavior toward hospital nurses and staff at RHS, to such an extent that staff members were unwilling to work with him. As such, Dr. Johnson's behavior presented "a real and substantial danger that patients treated by him might receive other than a 'high quality of medical care'" at RHS. (*Miller, supra*, 27 Cal.3d at p. 629.)

12. The Appeal Board Did Not Exceed Its Authority in Opining That Dr. Johnson's Application Should Be Denied on Clinical and Behavioral Grounds

Dr. Johnson claims the appeal board exceeded its authority in concluding that his application should be denied on clinical as well as behavioral grounds, in view of the JRC's conclusion that Dr. Johnson was clinically competent.

As discussed, the JRC recommended that Dr. Johnson should be denied admission based on his behavior, which the JRC concluded affected the nursing staff's ability to work with him, and presented "a real and substantial danger that patients treated by him might receive other than a 'high quality of medical care'" at the hospital. (*Miller, supra*, 27 Cal.3d at p. 629.) The JRC also concluded that Dr. Johnson "met his burden in the

area of clinical competence," because even the witnesses who were critical of Dr. Johnson's behavior "uniformly opined that [he] was at least 'adequate' clinically and technically."

The appeal board concluded that Dr. Johnson's problems were "as much 'clinical' as 'behavioral.'" It based this conclusion on the JRC's findings that Dr. Johnson "failed to timely respond to pages and to calls," "discharged a patient without examining him," "refused to wear a surgical mask in sterile portions of the Hospital," "misused a microscope and failed to arrange for post-surgical follow-up care," and "failed to return calls from nursing staff." The governing board adopted the appeal board's decision as its final decision.

We disagree that the appeal board exceed its authority. The board's function was "in the nature of an appellate hearing." (Bylaws, art. VIII, § 5. D.) That is, the board was to determine whether substantial evidence supported the JRC's conclusion that Dr. Johnson's application should be denied. (*Huang v. Board of Directors* (1990) 220 Cal.App.3d 1286, 1294 (*Huang*).)

In *Huang*, the appeal board exceeded its authority by reweighing the evidence presented to the judicial review committee. The appeal board found, contrary to the judicial review committee, that the doctor verbally abused and threatened a nurse. The appeal board rejected the doctor's denials as not credible. (*Huang, supra,* 220 Cal.App.3d at p. 1294.)

But here, the appeal board did not reweigh the evidence. *The appeal board did not conclude that Dr. Johnson was clinically incompetent*. Instead, it merely interpreted several of the JRC's findings as meaning that Dr. Johnson's problems were clinical as well as behavioral. This was not a reweighing of the evidence; it was a fair interpretation of the evidence.

Indeed, the evidence discussed above in connection with charges 1, 4, and 6 showed Dr. Johnson's problems were clinical as well as behavioral. In the words of the appeal board, the evidence presented on charges 1, 4, and 6 showed that Dr. Johnson "failed to timely respond to pages and to calls," "discharged a patient without examining him," and "failed to return calls from nursing staff." We therefore find it unnecessary to discuss the evidence that Dr. Johnson "refused to wear a surgical mask in sterile portions of the Hospital [charge 17]" and "misused a microscope and failed to arrange for post-surgical follow-up care [charge 2]."

In any event, the appeal board concluded that substantial evidence supported the JRC's recommendation to deny Dr. Johnson's application on the ground his inappropriate behavior toward nurses and staff threatened patient care. (*Miller, supra*, 27 Cal.3d at p. 632.) Its comment that Dr. Johnson's problems were clinical as well as behavioral was unnecessary to support its recommendation to the governing board. It was also unnecessary to support the governing board's final decision denying Dr. Johnson's application.

13. The JRC's Ruling on the Burden of Proof Did Not Affect the Outcome

Finally, Dr. Johnson claims that the JRC erroneously determined he was an initial applicant, and that he therefore had the burden of proving he was qualified to serve on the medical staff. He claims he should have been treated as an existing member of the medical staff, and that the MEC should have therefore had the burden of proving that the denial of his application was reasonable and warranted. (Bylaws, art. VIII, § 4. I.; accord, § 809.3, subd. (b).)

Regarding the burden of proof at the JRC hearing, the bylaws stated: "In all cases, it shall be incumbent on the body or committee whose recommendation prompted the hearing to come forward initially with evidence in support of its action or decision. Thereafter, the person who requested the hearing shall come forward with evidence in his support. The body or committee whose recommendation prompted the hearing shall have the burden of persuading the [JRC] by a preponderance of the evidence that the action or recommendation is reasonable and warranted, except when the hearing is on an initial application for membership or special clinical privileges. Initial applicants shall bear the burden of establishing by a preponderance of the evidence their qualifications, by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning current qualifications for privileges or membership. . . ." (Bylaws, art. VIII, § 4. I.; accord, § 809.3, subd. (b).)[9]

[9] The bylaw provision is based on section 809.3, subdivision (b), which provides: "(1) The peer review body shall have the initial duty to present evidence which supports the charge or recommended action. [¶] (2) Initial applicants shall bear the burden of

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It is indisputable that Dr. Johnson was not a member of the medical staff at the time of the JRC hearing. He was reapplying for admission, and was an *applicant* at the time of the hearing. He argues, however, that he was not an "initial applicant," as that term is used in the bylaws and in section 809.3, subdivision (b). We find it unnecessary to decide this question, because it is not reasonably probable that the JRC's ruling on the burden of proof affected its factual findings or, ultimately, the governing board's final decision. (Cal. Const., art. VI, § 13; *People v. Watson* (1956) 46 Cal.2d 818, 836.)

Although the JRC treated Dr. Johnson as having the burden of proving he was "appropriately qualified, both clinically, and behaviorally, to be appointed as a member of the Medical Staff," there is no indication the burden of proof had any effect on the JRC's findings. The evidence supporting the JRC's findings was clear and not closely contested at the hearing. Indeed, as the JRC noted, Dr. Johnson admitted "several of the charges of inappropriate behavior."

IV. DISPOSITION

The judgment is affirmed. Respondent shall recover its costs on appeal.

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persuading the trier of fact by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for staff privileges . . . . [¶] (3) *Except as provided above for initial applicants*, the peer review body shall bear the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable and warranted." (§ 809.3, subd. (b), italics added.)

/s/ King
J.

We concur:

/s/ Ramirez
P.J.

/s/ Miller
J.