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No. S259364

**IN THE SUPREME COURT OF THE
STATE OF CALIFORNIA**

SUNDAR NATARAJAN, M.D.,

Petitioner and Appellant,

v.

DIGNITY HEALTH

Respondent.

After a Decision by the Court of Appeal
Third Appellate District
Case No. C085906

On Appeal from the Superior Court for the State of California,
County of San Joaquin,
The Honorable Barbara A. Kronlund
Superior Court Case No. STK-CV-UWM-2016-4821

APPLICATION OF ADVENTIST HEALTH; KAISER FOUNDATION HOSPITALS; MEMORIALCARE HEALTH SYSTEM; PROVIDENCE ST. JOSEPH HEALTH; SHARP HEALTHCARE; AND SUTTER HEALTH FOR LEAVE TO FILE AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT DIGNITY HEALTH

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APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT DIGNITY HEALTH

Adventist Health, Kaiser Foundation Hospitals, MemorialCare Health System,[1] Providence St. Joseph Health, Sharp HealthCare, and Sutter Health ("amici") are California healthcare organizations that provide hospital care to hundreds of thousands of California citizens each year, in dozens of hospital facilities, through the services of the hospitals' physician medical staff members. Amici respectfully apply for leave to file the accompanying proposed amici curiae brief in support of Respondent Dignity Health, in accordance with Rule 8.200(c) of the California Rules of Court. Amici are familiar with the content of the parties' briefs and the issues presented by this case, which are of vital importance to amici—and ultimately to the patients amici serve.

Adventist Health is a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and in Hawaii. Founded on Seventh-day Adventist heritage and values, Adventist Health provides care in 19 California hospitals, as well as clinics, home care agencies, hospice agencies, and joint-venture retirement centers in both rural and urban communities. Adventist Health's compassionate and talented team of 37,000 includes associates, medical staff

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[1] MemorialCare Health System is a dba for Memorial Health Services.

physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness, and hope.

Kaiser Foundation Hospitals is a nonprofit, public benefit corporation that owns and operates dozens of community hospitals in California (where Kaiser has 36 hospitals), Hawaii, and Oregon. Kaiser Foundation Hospitals is one of the separate legal entities that collectively comprise Kaiser Permanente in each operating region. Kaiser Permanente is dedicated to providing high-quality, affordable health care, and to improving the health of its members and the communities it serves. Kaiser Permanente also is committed to helping shape the future of health care, and is recognized as one of America's leading health systems. Care at Kaiser Permanente is focused on total health. The Kaiser Permanente system provides industry-leading and world-class health care to *over 8 million California residents*. Kaiser Permanente has over 16,000 California physicians within its two California Permanente Medical Groups, whose members form the self-governing medical staffs of the Kaiser Permanente hospitals.

MemorialCare Health System is a nonprofit health system that includes four hospitals, two medical groups, outpatient health centers, urgent care centers, imaging centers, breast centers, surgical centers, and dialysis centers throughout Orange County and Los Angeles County. MemorialCare's mission is to improve the health and well-being of individuals, families, and the system's communities.

Providence St. Joseph Health ("Providence") is a system of passionate providers focused on partnering with patients to simplify health care. With dozens of hospitals across seven states, Providence is continuing a more than 100-year tradition of improving the health of the communities it serves, especially the poor and vulnerable. As one of the largest health care organizations in California, Providence is a significant provider of care, including charity care to Medi-Cal and other underserved patients. Providence's core values are respect, compassion, justice, excellence, and stewardship.

Sharp HealthCare ("Sharp") is a not-for-profit integrated regional healthcare-delivery system based in San Diego. The system includes four acute-care hospitals, three specialty hospitals, three affiliated medical groups, outpatient and urgent care centers, and a full spectrum of other facilities and services. Sharp has approximately 2,700 affiliated physicians. Sharp's purpose is to provide exceptional care with excellence, commitment, and compassion.

Sutter Health's 24 California hospitals partner with more than 12,000 physicians to deliver top-rated, affordable healthcare to more than three million Californians. Sutter hospitals compassionately care for more low-income Medi-Cal patients in Northern California than any other health system, and some Sutter facilities have been providing care in their communities for more than 100 years. Sutter Health supports community programs to help ensure those in need have access to care and social services. Sutter Health also strives to be an industry

innovator, including by integrating physical and mental health to provide care for the whole person.

The missions of amici all include improving the health of their communities by providing quality care. Amici's hospitals operate 24 hours a day, seven days a week, 365 days a year, providing vital healthcare services to citizens of this state in times of acute illness and emergency. Thus, amici are essential healthcare resources for the citizens of California, and amici have a compelling interest in judicial decisions that affect the ability of their hospitals to maintain qualified medical staffs—by conducting effective, timely, efficient peer review.

This case is important to every organization, public and private, that routinely conducts administrative hearings—particularly in a specialized area. Amici seek to file the accompanying brief due to their concern that—unless this Court upholds the Court of Appeal's correct, informative, and highly significant decision—amicis' ability to engage knowledgeable, experienced hearing officers for peer review hearings will be severely undermined. That result will diminish—not enhance—the ability of hospitals and their medical staffs to conduct fair peer review hearings and to protect patients by properly excluding or restricting physicians who provide substandard care or engage in unprofessional conduct.

Amici believe the information and perspective provided in the accompanying proposed brief will assist the Court in resolving this case, by helping the Court to understand the

critical importance of having knowledgeable, experienced hearing officers conduct peer review hearings.

No party or counsel for any party authored any part of the proposed brief. No person or entity other than amici made a contribution intended to fund the preparation or submission of the proposed amici curiae brief.

Dated: October 28, 2020

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PROPOSED AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT DIGNITY HEALTH

I. INTRODUCTION

In the midst of the COVID-19 pandemic, Californians are acutely aware of how essential hospitals are to public health and safety. Peer review of hospital physicians is critical to protecting the public, as California's Legislature and courts have recognized repeatedly—but peer review is demanding and difficult. Physicians often hesitate to be involved, as this Court noted in *Kibler v. Northern Inyo County Local Hospital District* (2006) 39 Cal.4th 192, 201: "many physicians are reluctant to join peer review committees so as to avoid sitting in judgment of their peers." Working through all phases of the peer review process is incredibly challenging, despite the participants' best efforts. Any additional obstacles to medical staffs' ability to conduct effective peer review is detrimental to patients, physicians, and the hospitals themselves—but reversal of the Court of Appeal's correct, valuable decision would have exactly that harmful effect. This Court should affirm the decision below because a hospital's medical staff must have—and does have, under the governing statute—the ability to engage knowledgeable, experienced hearing officers, whose expertise promotes fairness, and benefits all participants involved—including the physician who is the subject of the hearing.

II. HOW PEER REVIEW WORKS IN CALIFORNIA HOSPITALS

A. Peer Review at Hospitals is Mandatory and Ongoing.

A hospital is an incredibly complex institution. Hundreds of people work there in dozens of roles—administrators; physicians in a multitude of specialties and subspecialties; physician assistants; nurse practitioners; nurses and nurse aides; technicians; social workers; dieticians; cooks; maintenance, housekeeping, and sanitary workers; and numerous others. All of them must engage in elaborately coordinated teamwork, in an effort to ensure that every hospital patient receives appropriate, high-quality medical services in a sanitary, safe environment—safe for patients and workers alike—24 hours a day, seven days a week, 365 days a year. Hospitals constantly face a daunting array of operational challenges involving, for example, managing armies of employees, disposing of hazardous waste properly, maintaining myriad pieces of equipment ranging from the mundane to the miraculous, and many more.

Then there are the hospital's relations with its physicians. Hospitals cannot provide patient care without physicians, but California law does not allow hospitals to employ physicians to provide medical care (California Business and Professions ("Bus. & Prof.") Code Section 2400)—so the relationship is more complicated than that of employer-employee. The Medical Board of California licenses physicians to practice in our state, but the Medical Board cannot possibly monitor what its thousands of licensees do in hospitals daily. Thus, federal Medicare law and

state hospital licensing law require every hospital medical staff to conduct peer review. (*See* 42 Code of Federal Regulations Sections 482.12 and 482.22; Title 22 California Code of Regulations Sections 70701 and 70703.) The Joint Commission is a national organization that accredits acute-care hospitals, which qualifies hospitals for all-essential participation in the federal Medicare program. The Joint Commission mandates that our medical staffs conduct peer review on an *ongoing* basis—and they do.[2] (*See* The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, MS.08.01.03 (2018).)

Amici know from their own ongoing experience that, contrary to the contention of Petitioner Sundar Natarajan, MD (Dr. Natarajan), peer review hearings at hospitals are not rare—even though the majority of physicians practice good medicine and behave professionally. At a large hospital with hundreds of physicians on its medical staff, it is inevitable that some of them will experience problems necessitating corrective action. (Not all peer review hearings involve proposed revocation of medical staff membership.) Sometimes a hospital may even have multiple peer review hearings going on simultaneously. Importantly, the trigger for a peer review hearing in California is a disciplinary recommendation made by a committee of the physician's medical

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[2] Compliance with The Joint Commission's hospital accreditation standards is one way for a hospital to fulfill the Medicare Conditions of Participation for hospitals (42 C.F.R. § 488.5(a)). Medicare pays the largest share of reimbursement for hospital services nationally, by far.

staff colleagues. Hospital administrators ordinarily do not initiate or participate in peer review proceedings, other than by paying expenses (which may include hearing officer fees).

B. Peer Review Hearings at Hospitals Differ from Other Types of Administrative Proceedings.

California peer review hearings differ from other types of administrative proceedings, and are particularly challenging in several important ways. Peer review hearings typically are conducted before volunteer panels of practicing physicians,[3] so hearing sessions are held at night, but still are extremely difficult to schedule because they include numerous busy professionals. A peer review hearing may go on for years if it concerns complex clinical issues in multiple patient cases, at tremendous expense to the hospital and the participants. Amici cannot emphasize enough that physicians involved in peer review hearings almost always are doing double duty— as clinicians serving their patients during the day, and as hearing panel members at night.

Additionally, unlike the adjudicatory hearings in *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, a medical staff peer review proceeding can have a direct impact on public safety. Often a hearing concerns whether a physician who is incompetent or persistently behaves unprofessionally may continue practicing medicine in the hospital, or must practice with restrictions. In

[3] California Bus. & Prof. Code § 809.2(a) allows a peer review hearing to be held before either a hearing panel or an arbitrator; in amicis' experience, proceedings with hearing panels are much more common.

establishing the standards for fair hearings in Bus. & Prof. Code Section 809 et seq., the Legislature struck a balance between competing priorities: the paramount need to protect patients by preserving high medical practice standards, and the rights and economic interests of physicians. (*See* Bus. & Prof. Code Section, 809(a).) As Respondent explains (Answer Brief at pp. 30-37), in enacting Section 809 et seq., the Legislature determined what constitutes fair procedure in this context.

California has a substantial body of statutory and case law governing peer review, which a hearing officer conducting a medical staff hearing must know, understand, and interpret. A peer review hearing officer also must understand how hospitals and their medical staffs function in accordance with medical staff bylaws and policies—which must comply with various statutory, regulatory, and accreditation requirements, but nevertheless may vary significantly from one hospital to another. A peer review hearing officer also must know the standards for physicians to provide appropriate patient care and conduct themselves professionally, and know how to work effectively with physician hearing panel members. When a medical staff has determined it must take disciplinary action against a physician that will result in a hearing, California hospital leaders (including medical staff officers as well as hospital administrators) know that a knowledgeable, experienced hearing officer is indispensable to conducting an effective, reasonably efficient peer review proceeding. Retired judges and neutrals affiliated with organizations such as AAA and JAMS do not possess these

essential qualifications, unless specially trained. For example, former jurists and other professional neutrals may reflexively apply the rules of evidence, even though typically the medical staff bylaws specify that those rules do *not* apply. Rather, any relevant evidence, including hearsay, is admissible 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.[4] The leaders of hospitals' self-governing medical staffs choose hearing officers accordingly, consistent with the law.

C. Peer Review Participants Do Their Best to Conduct Proceedings Fairly While Protecting Patients.

Dr. Natarajan asks this Court to believe corrective action against hospital physicians routinely is maliciously motivated, substantively wrong, and procedurally unfair. He also insists hospitals and hospital systems are corrupt, and always pressuring their medical staffs to engage hearing officers who will ensure the upholding of improper actions. That contention

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[4] *Oliver v. Board of Trustees of Eisenhower Medical Center* (1986) 181 Cal.App.3d 824, 834 (quoting the defendant hospital's medical staff bylaws provision). The Bylaws of the St. Joseph's Medical Staff are included in the record of this case and cited in the Answer Brief at pp. 19-20, 51. The admissibility of evidence provision is in Bylaws Section 9.10; it includes language similar to that in *Oliver,* and specifically mentions the admissibility of hearsay. This lenient evidentiary standard is akin to the rule applicable in agency administrative proceedings, Gov't Code § 11513(c), but the medical staff bylaws are even more lax, because unlike the Gov't Code, the bylaws expressly allow admissibility of hearsay.

defies logic and common sense. No hospital (or system), and no medical staff, wants to take the risk that the result of an expensive, stressful, years-long peer review proceeding will be overturned because the hearing officer purposely issued erroneous rulings against the physician, or drafted a termination decision for the physician panel that is unsupported by the administrative record and cannot withstand a court challenge. Physician peer reviewers who determine they must initiate discipline against a colleague typically do so reluctantly. They do not undertake corrective action lightly, and medical staff leaders endeavor to conduct hearings fairly.

Courts may hesitate to second-guess hospitals on clinical issues (so peer review decisions are not often overturned on substantial-evidence grounds), but jurists do not balk at exercising their authority and ability to determine whether a peer review hearing was fair. Medical staffs need and seek hearing officers with the expertise, experience, and integrity to do the job right—***which necessarily includes doing it fairly***. Amicis' experience shows that despite the hardships of the hearing process, people who agree to participate in peer review hearings—including hearing officers, panel members, witnesses, and advocates—commit themselves to persevering, performing their respective roles to the best of their abilities, and treating the subject physician fairly.

When our Legislature enacted Bus. & Prof. Code Section 809 et seq., the Legislature stated its intent to protect patients

primarily, and the rights and economic interests of physicians secondarily:

> *To protect the health and welfare of the people of California*, it is the policy of the State of California to exclude, through the peer review mechanism as provided for by California law, those healing arts practitioners who provide substandard care or who engage in professional misconduct, regardless of the effect of that exclusion on competition.

(Bus. & Prof. Code Section 809(a)(6) [emphasis added]; *see also Medical Staff of Sharp Memorial Hospital v. Superior Court (Pancoast)* (2004) 121 Cal.App.4th 173, 181-182 ["the overriding goal of the state-mandated peer review process is protection of the public and that while important, physicians' due process rights are subordinate to the needs of public safety"]; *Rhee v. El Camino Hospital District* (1988) 201 Cal.App.3d 477, 489 ["[a] physician's right to pursue his livelihood free from arbitrary exclusionary practices must be balanced against other competing interests: the interest of the members of the public in receiving quality medical care, and the duty of the hospital to its patients to provide competent staff physicians"].[5])

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[5] As Respondent correctly notes (Answer Brief at pp. 45-50), a private hospital that proposes to restrict or terminate a physician's clinical privileges is required to provide the physician with "fair procedure," *i.e.,* notice and an opportunity to be heard. This procedural standard is not as stringent as the constitutional "due process" standard applicable in some other contexts. (*See Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 555; *Ezekial v. Winkley* (1977) 20 Cal.3d 267, 278 ["recogniz[ing] the practical limitations on the ability of private institutions to provide for the full airing of disputed factual issues"]; *Kaiser Found. Hosps.*

The best interests of California hospital patients, as well as the best interests of the physicians who selflessly conduct peer review—and even the physicians who are the subjects of peer review hearings—will *not* be well-served by a new rule of law that broadly prohibits hospitals from using well-qualified hearing officers, precisely because they are seasoned. This cannot possibly be what the Legislature intended when stating in Section 809.2(b) that a peer review hearing officer can gain no *direct* financial benefit from the *outcome*. ***Haas* and *Yaqub*[6] do not apply here, but regardless, neither can be read to compel automatic disqualification of peer review hearing officers with valuable experience for purported universal financial bias**. Amici urge this Court not to adopt a nonsensical, misguided rule that will benefit no one.

III. ARGUMENT

A. Using a Knowledgeable, Experienced Hearing Officer in a Peer Review Hearing Is Beneficial to All Participants—Not Unfair.

1. Hospitals want and need to do peer review right. Courts cannot presume hospitals will act improperly, or that knowledgeable hearing officers who regularly preside over peer review hearings harbor financial bias.

Dr. Natarajan contends that any hearing officer who has

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v. Super. Ct. (2005) 128 Cal.App.4th 85, 102.) Although courts sometimes use the terms "fair procedure" and "due process" interchangeably, the court in *Kaiser* recognized that the standards are *not* identical.

[6] *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474.

presided over a hospital peer hearing has an impermissible, *direct* financial interest in the outcome of every subsequent hearing, *i.e.*, the desire for future hearing officer work. That contention depends upon Dr. Natarajan's purely speculative assertion that hospitals and hospital systems hire and reward hearing officers who favor hospitals—contrary to the merits of the disputes—by hiring them repeatedly to conduct biased medical staff peer review hearings. Not only is that assertion unsupported, but the law requires courts to presume hospitals and their medical staffs will act properly, not improperly.

Under existing law, disqualification for bias in a medical staff peer review hearing requires a showing of at least a "practical probability of unfairness," even when the physician asserts the hearing officer has a financial interest in the outcome. (*See, e.g., Hongsathavij v. Queen of Angels Hollywood Presbyterian Medical Center* (1998) 62 Cal.App.4th 1123, 1142 [hospital's board of directors was not precluded from making a peer review decision based on its purported financial incentive to exclude the physician, under the actual bias or "practical probability of unfairness" standard]; *Gill v. Mercy Hospital* (1988) 199 Cal.App.3d 889, 911 [the prejudice must be "sufficient to impair the judge's impartiality so that it appears *probable* that a fair trial cannot be held"] [citation omitted; emphasis added]; *Rhee v. El Camino Hospital District* (1988) 201 Cal.App.3d 477, 494 ["bias cannot be presumed in the absence of facts establishing the probability of unfairness as a practical matter"].)

Dr. Natarajan also wants this Court to believe hospitals routinely use peer review as a weapon to exclude physicians the hospitals view as business competitors, but this notion makes no sense either. Hospitals do face fiscal challenges, but their revenues derive from caring for patients, not from excluding doctors. *A hospital wants to attract and retain as many well-qualified doctors to serve on its medical staff as its patient care facilities can accommodate.* As a result, hospitals sometimes confront "turf" battles and other conflicts between competing individual physicians, practitioners in specialties whose areas of expertise overlap, or medical groups. (*See, e.g., Major v. Memorial Hospitals Ass'n* (1999) 71 Cal.App.4th 1380, 1400-1402 [competition between two large anesthesiology groups had led to a dysfunctional department, prompting the appellate court to wonder why it took the hospital so long to remedy the situation via an exclusive contract that excluded some physicians].)

However, a hospital has *no* incentive to exclude doctors who provide good patient care, and who behave professionally and cooperatively. Every hospital wants to work in tandem with its medical staff physicians so the hospital can meet the healthcare needs of its community, and consistently provide high-quality care to patients.

This Court expressly recognized that courts cannot presume hospitals will act badly (*El-Attar v. Hollywood Presbyterian Medical Center* (2013) 56 Cal.4th 976, 995-996)—and that principle endures today:

> There is certainly the *potential* for a hospital's governing body to abuse the

> power of appointment in a way that would deprive a physician of a fair hearing. A hospital's governing body could undoubtedly seek to select hearing officers and panel members biased against the physician. It might even do so because it wishes 'to remove a physician from a hospital staff for reasons having no bearing on quality of care.' [Citation omitted.] But where, as here, the medical staff has left to the hospital's governing body the task of selecting the participants in the judicial review hearing, we are not persuaded that we must presume *any* hearing officer or panel member appointed by the governing body is likely to be biased. (*See Rhee*, *supra*, 201 Cal.App.3d at p. 494 ["bias cannot be presumed in the absence of facts establishing the probability of unfairness as a practical matter"].)… ***Simply because the governing body of a hospital may be in a position to deprive a physician of a fair hearing does not mean that it is likely to do so***.[7]

In addition to the case law, several California statutes that apply to hospitals and their medical staffs (as well as generally) presume good-faith action. Specifically:

- Evidence Code Section 664 establishes that "[i]t is presumed that official duty has been regularly

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[7] First and last emphasis added; "any" italicized in original. Notably, amicus curiae American Academy of Emergency Medicine quotes only the first two sentences of this passage, and omits even to mention this Court's conclusion that a "potential" for unfairness is *not* a disqualifying "probability." (Amicus Curiae Brief of the American Academy of Emergency Medicine, at p. 15.)

performed."[8] This presumption applies to administrative activities, which include peer review investigations and actions. (*Bowles v. Glick Brothers Lumber Company* (9th Cir. 1945) 146 F.2d 566, 571 ["There is a presumption of regularity in respect to the proceedings of administrative bodies. Hence it is to be presumed that the Administrator has not acted oppressively or undertaken to pursue investigation where no need therefor is apparent"]; *Inyo Citizens for Better Planning v. Board of Supervisors* (2009) 180 Cal.App.4th 1 [no evidence was presented that the involved agencies' calculation method was improper, so plaintiff had failed to meet its burden of establishing the calculation was untrustworthy].)

- Civil Code Section 3545 declares that "[p]rivate transactions are fair and regular." As the court explained in *California Shoppers, Inc. v. Royal Globe Insurance Company* (1985) 175 Cal. App. 3d 1, 47, "section 3545 clearly imports the proposition that the law does not condone inferences of improper purpose in the absence of direct evidence to support such inferences";

[8] The statute goes on to state that the presumption "does not apply on an issue as to the lawfulness of an arrest if it is found or otherwise established that the arrest was made without a warrant."

- Civil Code Section 3548 codifies the presumption that "[t]he law has been obeyed." In *County of San Diego v. Mason* (2012) 209 Cal.App.4th 376, 383, the court relied upon Civil Code Section 3548 to presume that the county and its laboratory contractor would comply with federal and state privacy laws, despite the petitioner's speculative assertion that his privacy rights would not be protected sufficiently.

As explained above, due to the distinct, specialized nature of peer review hearings—which of course the *Haas* Court had no occasion to consider—a hospital's medical staff has an enormous *disincentive* to rehire a hearing officer who previously made biased rulings, drafted an indefensible decision, or otherwise favored the hospital unfairly. No hearing officer could rationally expect to get repeat work that way, absent highly unusual circumstances—which arguably distinguish *Yaqub* from most situations. For example, the hearing officer in *Yaqub* had other prior connections with the hospital in addition to his past hearing officer work, and he also had presided over an earlier hearing involving Dr. Yaqub (so the hearing officer might have preconceived notions). *Yaqub*'s facts are anomalous.

A typical peer review hearing officer has no direct financial interest in the outcome of the hearing—only an interest in gaining or enhancing a reputation in the healthcare community for presiding over fair, efficient peer review hearings that withstand judicial scrutiny. Doing the job right is the best way for an experienced hearing officer to secure future work. It

makes no sense to disfavor expertise, so repeat service cannot be a disqualifying factor.[9] This principle applies regardless of who sends the engagement letter to the hearing officer or cuts the hearing officer's check—particularly since the hospital is legally required to pay the hearing officer. (*See California Teachers Association v. State of California* (1999) 20 Cal.4th 327, 342-357 [a professional who is entitled to a hearing cannot be required to pay the adjudicator's fees because that would chill the hearing right].)

A rational decision-maker would not select a biased, pro-hospital hearing officer. Similarly, a hospital and its medical staff would not continue to rely on an attorney who recommended biased hearing officers to the medical staff—because a process or decision tainted by bias portends years of costly legal proceedings, and (contrary to Natarajan's arguments, POB at pp. 82-85) hospitals are not insulated from liability for unfair peer review. (*See*, *e.g.*, *Rosenblit v. Superior Court* (1991) 231 Cal.App.3d 1434, 1445 [overturning hospital's decision against a physician where the peer review hearing had "a notable stench of unfairness"].) A lawyer who advises using a biased hearing officer is not fulfilling the attorney's ethical obligation to protect his or her client. Rather, the opposite is true. The hospital and medical staff serve their own

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[9] The governor vetoed the Legislature's 2009 attempt to impose conflict-of-interest disclosure requirements on peer-review hearing officers (along with other proposed amendments to the law), so "direct financial interest in the outcome" remains the sole financial disqualifier. *See* http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=200920100AB120.

best interests—and the subject physician's best interest, too—when the medical staff selects a well-qualified hearing officer who knows and follows the law.[10]

2. A pool of knowledgeable, experienced hearing officers is good for all participants.

Amici do not suggest (nor has Dignity Health argued) that *only* hearing officers trained by the California Society for Healthcare Attorneys ("CSHA") can be good hearing officers. However, in this esoteric, highly regulated area, the pool of well-qualified hearing officers *is* limited. CSHA established its hearing officer training program to help expand the pool. The CSHA-trained hearing officer pool comprises both attorneys who focus their advocacy and litigation practices on representing *individual physicians*, as well as attorneys who represent medical staffs and hospitals. Medical staffs regularly engage physician-focused attorneys as hearing officers to preside over peer review hearings. Often the parties can agree on a hearing officer both sides know and trust, sometimes without *voir dire*.

As noted above, serving as a hearing officer in a peer review hearing at a hospital simply is not a function that virtually any attorney, or even any retired jurist, can perform well without specialized training, regardless of the training

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[10] The statement in *Haas* that a hiring entity "must, therefore, be presumed to favor its own rational self-interest by preferring those who tend to issue favorable rulings" (*Haas*, 27 Cal.4th at 1029)—even if such favorable rulings are unsupported—is inconsistent with the statutes and cases cited here, including *El-Attar*, and their underlying principles.

venue. The procedural rules governed by medical staff bylaws and the medical context are unique to this setting, but the need for expert hearing officers also exists in other highly specialized areas that the decision in this case could affect.

Attorneys with no background in an arcane area are considerably more likely to make procedural errors than those who are well-versed in the applicable rules and standards. For example, a hearing officer with no experience, much less expertise, in physician peer review may be unable to draft a decision that passes muster under *Topanga Association for a Scenic Community v. County of Los Angles* (1974) 11 Cal.3d 506. A hearing officer who doesn't know the law well enough may fail to connect the hearing panel's factual findings sufficiently with the panel's conclusions about whether the particular corrective action was reasonable and warranted, as required for the medical staff to meet its burden of proof under Bus. & Prof. Code § 809.3. Dr. Natarajan's proposed alternative selection processes do nothing to ensure expertise, so they are no solution to the shortage of knowledgeable, experienced hearing officers. Sometimes the parties can agree on a hearing officer, but not always, and medical staffs need to engage well-qualified hearing officers even when agreement is not possible.

Notably, the Legislature requires physician hearing panel members—who, unlike hearing officers, act as the factfinders—to be selected via a process mutually acceptable to the physician who is the subject of the hearing and the peer review body; or that the panel consist of "unbiased" individuals "who shall gain

no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the same matter.....” (Bus. & Prof. Code § 809.2, subdivision (a).) By contrast, the statute does *not* require a mutually acceptable selection process or the appointment of “unbiased” presiding officers. This shows the Legislature intended to treat presiding officers differently, probably because a presiding officer—unlike a fact-finding, decision-making panel member—does not determine the hearing’s outcome. Thus, a medical staff’s unilateral selection of a hearing officer is fair if it meets the statutory criteria for that selection process.

3. Peer review hearing officers can’t decide hearings—and physician hearing panel members are highly unlikely to defer to an attorney on the merits of an action.

Dr. Natarajan argues peer review hearing officers are decision-makers in peer review hearings, even though the Legislature has stated in Bus. & Prof. Code Section 809.2(b) that they are not—as this Court has reaffirmed. (*Mileikowsky v. West Hills Hospital & Medical Center* (2009) 45 Cal.4th 1259, 1271.) According to Natarajan, the hearing officer’s authority to rule on admissibility of evidence, attend deliberation sessions, and draft the physician hearing panel members’ decision means the hearing officer can dictate the outcome. This contention is surprising coming from a physician. In the experience of amici and their counsel, physicians are very serious about the fairness of a peer review proceeding that could remove a fellow physician from the medical staff or significantly restrict the physician’s

practice, and oftentimes imagine themselves in the physician's shoes. Thus, any attempt by a hearing officer to influence or usurp a hearing panel's decision is unwelcome.

Additionally, clinical privileges are hospital-specific (*Bonner v. Sisters of Providence* (1987) 194 Cal.App.3d 437, 445-447), and like any organization, each hospital's medical staff has its own culture. Physician members of a hearing panel are unlikely to go along with anything a hearing officer says that the physicians perceive as a dictate from the hospital or system.

B. Dr. Natarajan is wrong that only actual patient harm warrants adverse peer review action, and that despite the unchallenged substantial evidence against him, he should get to sue the hospital now.

Dr. Natarajan chose not to challenge the hearing panel's determination that substantial evidence supported his physician peers' recommendation. He also did not seek review of either the hospital board's similar determination that substantial evidence supported the physician peer reviewers' recommendation, or the merits of the hospital's final decision to terminate him for engaging in misconduct that posed a danger to patients. Nevertheless, Dr. Natarajan argues the facts at length, contending he never actually endangered any patients, and therefore the hospital could not legitimately terminate him.

Imagine the effect on patient safety if no medical staff ever could take corrective action against a physician until one or more patients already had suffered harm. Fortunately, that is not the standard. The Legislature expressly recognized that such a scheme is exactly the opposite of how peer review should work.

Instead, peer reviewers are supposed to get ahead of problems and address them *before* patients suffer harm:

> It is the intent of the Legislature that peer review of professional health care services be done efficiently, on an ongoing basis, and *with an emphasis on early detection of potential quality problems* and resolutions through informal educational interventions.

(Bus. & Prof. Code § 809(a)(7) [emphasis added].)

When attempts at early intervention in significant problems fail, formal corrective action becomes necessary, and need not wait until patients are harmed (*Marmion v. Mercy Hospital & Medical Center* (1983) 145 Cal.App.3d 72, 88), or even until the medical staff identifies specific patients who *may* be in harm's way. (*Pancoast*, *supra*, 121 Cal.App.4th 173, 182.)

Dr. Natarajan also argues the substantial evidence adduced against him doesn't matter if the hearing officer was biased by the circumstances of his appointment. As explained above, rehiring a hearing officer based on his or her valuable expertise and long experience does not create financial bias. Equally mistaken is the assertion that if the hearing officer is found to have been financially biased, Dr. Natarajan can avoid the legislatively and judicially established processes for challenging the merits of final hospital peer review decisions, and immediately pursue a damages action before a jury. No doubt Dr. Natarajan would prefer that people with no expertise hear his case, lest the result in a new peer review hearing be the same no matter who presides over it. Dr. Natarajan's hearing officer

bias theory is faulty (so he is not entitled to any relief at all)—but even if it were not, nothing in California law or policy supports the notion that hearing officer bias would entitle him to any remedy at this stage other than a new peer review hearing.

IV. CONCLUSION

The carefully considered decision in this case is consistent with California law on fair procedure in general and hearing officer bias in particular. The fact that an experienced, knowledgeable attorney works regularly as a hearing officer at hospitals throughout the state cannot possibly be a legitimate basis for invalidating the result of a 19-session peer review hearing, with a record of more than 10,000 pages, over which the hearing officer presided. Disqualifying expert hearing officers across the board, based on a presumption that they are all impermissibly biased by the prospect of future work, has no legitimate basis in law or fact—and would be a terrible result for all California hospitals, the millions of patients they serve, and the many hospital physicians who are involved in peer review.

Dated: October 28, 2020

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TERRI D. KEVILLE

By *__/s/ Terri D. Keville__*
Terri D. Keville

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ADVENTIST HEALTH; KAISER FOUNDATION HOSPITALS; MEMORIALCARE HEALTH SYSTEM; PROVIDENCE ST. JOSEPH HEALTH; SHARP HEALTHCARE; AND SUTTER HEALTH

CERTIFICATE OF WORD COUNT

The undersigned certifies that the text of this Application to Submit Amici Curiae Brief and Proposed Amici Curiae Brief, including footnotes, table of contents, table of authorities, and this Certificate of Word Count, consists of 7,188 words in 13-point Century Schoolbook type as counted by the Microsoft Word program used to generate the text.

Dated: October 28, 2020

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PROOF OF SERVICE

I, Vicky Isensee, hereby declare:

I am employed in the City and County of Los Angeles, State of California. I am over the age of eighteen years and am not a party to the within action. My business address is 865 S. Figueroa Street, Suite 2400, Los Angeles, California 90017.

On October 28, 2020, I hereby certify that I served the within **APPLICATION OF ADVENTIST HEALTH; KAISER FOUNDATION HOSPITALS; MEMORIALCARE HEALTH SYSTEM; PROVIDENCE ST. JOSEPH HEALTH; SHARP HEALTHCARE; AND SUTTER HEALTH FOR LEAVE TO FILE AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENT DIGNITY HEALTH** on the interested parties in this action as addressed below.

Based on a court order or an agreement of the parties to accept service by e-mail or electronic transmission via the Court's Electronic Filing System (EFS) operated by TrueFiling. I certify that participants in the case who are registered TrueFiling users will be served via the electronic filing system pursuant to California Rules of Court, Rule 8.70, also listed below. I further certify that participants, indicated below, in the case who are not registered TrueFiling users are served by mailing the within document by First-Class Mail, postage prepaid.

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Hon. Barbara A. Kronlund
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(via U.S. Mail)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on October 28, 2020, at Los Angeles, California.

Vicky Isensee	*/s/ Vicky Isensee*
Print Name	Signature

Supreme Court of California
Jorge E. Navarrete, Clerk and Executive Officer of the Court
Electronically FILED on 10/28/2020 by Florentino Jimenez, Deputy Clerk

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

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Case Number: **S259364**
Lower Court Case Number: **C085906**

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