Case No. S259364

IN THE SUPREME COURT OF CALIFORNIA

SUNDAR NATARAJAN, M.D.,

Petitioner and Appellant,

v.

DIGNITY HEALTH,

Respondent.

Court of Appeal of the State of California Case No. C085906

Superior Court of the State of California
County of San Joaquin Case No. STK-CV-UWM-20164821

APPLICATION TO FILE AMICUS BRIEF AND PROPOSED AMICUS CURIAE BRIEF OF CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF RESPONDENT DIGNITY HEALTH

LOWELL C. BROWN, Bar No. 108253
SARAH BENATOR, Bar No. 204407
*DIANE ROLDÁN, Bar No. 288224
Arent Fox LLP
55 Second Street, 21st Floor
San Francisco, CA 94105
Telephone: 415.805.7985

Attorneys for Amicus Curiae
California Hospital Association

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APPLICATION TO FILE AMICUS CURIAE BRIEF

California Hospital Association ("CHA") is a nonprofit membership corporation representing the interests of more than 400 hospital and health-system members in California, with 97 percent of the state's patient beds. CHA respectfully applies for leave to file the accompanying proposed amicus curiae brief in support of Respondent Dignity Health, in accordance with Rule 8.200(c) of the California Rules of Court. Amicus curiae is familiar with the content of the parties' briefs and the issues on appeal, which will affect hundreds of hospitals in California and their patients.

I. INTERESTS OF AMICUS CURIAE APPLICANT

CHA advocates for California's hospitals and health systems as they work to care for all Californians. CHA's goal is for every Californian to have equitable access to affordable, safe, high-quality, and medically necessary health care.

CHA hospitals and health systems furnish vital health care services to millions of our state's citizens. CHA supports hospitals in improving health care quality, access, and coverage; promoting health care reform and integration of services; complying with laws and regulations; and maintaining the public trust in healthcare.

CHA members have an ongoing interest in the appropriate, fair, and effective application of the medical staff peer review process, which is critical to insuring health care quality. CHA is gravely concerned that if adopted, Petitioner Dr. Sundar Natarajan's misinterpretations of the law will undermine the

effectiveness of the peer review process. Dr. Natarajan ignores the applicable peer review statute, Business and Professions Code section 809.2, which sets the standard for hearing officer disqualification. Dr. Natarajan's proposed alternative is contrary to the governing statute and would disqualify hearing officers based solely on their peer review experience. Dr. Natarajan also conflates the separate and distinct legal standards of common law *fair procedure*—applicable to private hospitals, including those operated by Respondent Dignity Health—with *constitutional due process*, applicable to state actors. The result would harm peer review and thus increase risks to patients safety. CHA therefore wishes to submit an amicus curiae brief to assist the Court in its analysis of these critical issues.

II. PURPOSE OF THE AMICUS CURIAE BRIEF

CHA's proposed brief will assist the Court in its analysis of the role and development of peer review. Through CHA's unique perspective as the state-wide membership organization for California hospitals and health systems, the amicus brief will explain that: (a) the Legislature intended peer review to be an adaptable system designed and directed by medical professionals; (b) Business and Professions Code section 809 et seq. states the fair procedure applicable to medical staff peer review in private hospitals; (c) experienced hearing officers are critical to the efficient and fair administration of peer review; (d) the legal standards of fair procedure, applicable to private hospitals, are separate and distinct from "constitutional due process," applicable to state actors; and (e) even under constitutional due

process standards the hearing officer's appointment was proper. CHA's analysis of the medical staff peer review process is informed not only by the relevant statutes and case law, but also by the real-world experiences of the governing bodies and medical staffs in CHA's over 400 member hospitals and health systems. CHA believes its unique perspective on these issues will assist the Court in deciding this matter.

No party, counsel for a party, person, or other entity—other than CHA and its counsel in this matter—authored the proposed amicus curiae brief in whole or in part, or made any monetary contribution intended to fund the preparation or submission of the brief.

III. CONCLUSION

For the reasons set forth above, CHA respectfully requests that the Court accept and file the amicus curiae brief filed concurrently herewith.

Respectfully submitted,

Dated: November 30, 2020 ARENT FOX LLP

By: 

Lowell C. Brown
Sarah Benator
Diane Roldán

Attorneys for Amicus Curiae
California Hospital Association

PROPOSED AMICUS CURIAE BRIEF IN SUPPORT OF RESPONDENT DIGNITY HEALTH

I. INTRODUCTION

At its heart, this case asks whether courts should burden medical staff peer review at private hospitals with onerous constitutional due process requirements, contrary to the Legislature's existing statutory scheme, which already ensures a procedurally fair process. Unless the Court's answer is a resounding "no," California's citizens will suffer.

In Section 809.2(b),[1] the Legislature stated the disqualification standard for medical staff peer review hearing officers: "[T]he hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote." Ignoring this facially clear controlling statute, Petitioner Dr. Sundar Natarajan invites the Court to instead engraft constitutional due process standards onto Section 809.2(b) and impose them on private parties. Dr. Natarajan's "appearance of bias" standard is contrary to statute and case law, and would unduly burden an already-strained peer review system.

California peer review law has developed over decades as a physician-driven process focused on patient safety. Rather than punishment or compensation, the underlying concern in every medical staff hearing is protecting patients. In that sense, the

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

stakes could not be higher. But rather than respond to these stakes with ever-more constrictive and byzantine legal requirements, the courts developed common law standards that defer to the expertise of medical professionals. The Legislature eventually codified these "fair procedure" standards in Section 809.

A Section 809 medical staff hearing is not a miniature trial. There are no motions, no jury, no judge. Instead, peer review is a collegial system that places primary responsibility on physicians, operating within a hospital's self-governing medical staff, to evaluate, educate, and discipline their peers in a fair and efficient manner. Section 809 grants medical staffs the flexibility and responsibility necessary to respond to urgent patient risks as they arise.

Dr. Natarajan invites this Court to write additional constitutional requirements, not envisioned by the Legislature, into Section 809's hearing officer standards for private hospitals. Specifically, Dr. Natarajan argues for a sweeping rule that would disqualify hearing officers from any future appointments by the same medical staff or even by different medical staffs within the same health system. Such an onerous disqualification rule would quickly reduce the existing pool of experienced medical staff hearing officers to a tiny puddle.

Dr. Natarajan's proposed requirements will not protect physicians, who already enjoy the multiple safeguards the Legislature included in Section 809, as well as the right to judicial review by petition for writ of mandate. Indeed,

physicians' safeguards will be at risk if medical staffs are forced to use inexperienced hearing officers. Nor will Dr. Natarajan's requirements protect patients or the public, who will be endangered while needlessly protracted hearings and legal battles grind toward conclusion and medical staffs can finally discipline errant physicians. The Court should deny Dr. Natarajan's effort to replace Section 809's highly-developed and long-established fair procedure standards with a muddled interpretation of constitutional case law.

The peer review system is already in jeopardy. Every year, the system becomes more litigious and more like the complex civil trials the Legislature so thoughtfully sought to avoid. Physicians can force medical staffs to endure increasingly long, burdensome, and expensive peer review hearings and related litigation. Now it is not uncommon for peer review hearings to last years, and for physicians to object to every hearing panel member and every hearing officer in hopes of delaying discipline and creating an issue for appellate review. Engulfed in all the procedural rules and maneuvers, the reason for medical staff peer review—patient protection—is losing its place as the top priority.

The Court should not burden the process further, and particularly without a clear legal basis. Needlessly requiring medical staffs and hospitals to select only inexperienced hearing officers, who foreswear all future appointments, would impair medical staffs' ability to safeguard California's citizens. On behalf of over 400 hospitals and hospital systems throughout California, CHA urges the Court to deny Dr. Natarajan's request

to overwrite Section 809 and affirm the Court of Appeal's well-reasoned decision.

II. PEER REVIEW IS A UNIQUE STATUTORY SYSTEM GUIDED BY PHYSICIANS AND DESIGNED TO PROTECT PATIENTS.

A. The Legislature Codified the Fair Procedure-Based Peer Review System as Section 809.

California's peer review system is "essential to preserving the highest standards of medical practice." (§ 809, subd. (a)(3).) Peer review "protect[s] the health and welfare of the people of California" by excluding "those healing arts practitioners who provide substandard care or who engage in professional misconduct." (§ 809, subd. (a)(6); see also *Kibler v. Northern Inyo County Local Hospital Dist.* (2006) 39 Cal.4th 192, 200 ["peer review procedure plays a significant role in protecting the public against incompetent, impaired, or negligent physicians"].)

Medical staff hearing rights for physicians have their genesis in the common law doctrine of fair procedure. (*El-Attar v. Hollywood Presbyterian Medical Center* (2013) 56 Cal.4th 976, 986.) In the peer review context, fair procedure means notice of the charges and a reasonable opportunity to respond. (*Ibid.*) This Court first applied the fair procedure doctrine in 1888, and for decades afterward, courts honed these common law rights into a unique and comprehensive peer review system designed specifically for California. (*Potvin v. Metropolitan Life Ins. Co.* (2000) 22 Cal.4th 1060, 1067.)

In 1989, after nearly a century of development, the Legislature codified this judicially-developed fair procedure

system as Section 809. (*El-Attar*, *supra*, 56 Cal.4th at p. 986.) Since Section 809's enactment, California courts, hospitals, medical staffs, physicians, patients, and the public have relied on Section 809's plain language to guide medical staff hearings, which themselves protect quality of medical care.

Section 809 methodically describes each step of the medical staff hearing process: initial investigations and information sharing (§§ 809.05, 809.08); the notice of action and hearing rights (§ 809.1); voir dire of hearing panel members and officers (§ 809.2, subd. (a)–(c)); discovery rights (§ 809.2, subd. (d)–(f)); the manner in which the hearing shall be conducted, including the burdens of proof (§ 809.3, subd. (a)–(b)); and, finally, the parties' rights upon completion of the hearing (§ 809.4). At every step of this process, patient safety is the overriding interest. (§ 809.05, subd. (d) ["A governing body and the medical staff shall act exclusively in the interest of maintaining and enhancing quality patient care."].)

In the thirty years since Section 809's enactment, the Legislature has continued to refine the peer review process the statute describes, including by amendments in 2006, 2008, 2009, and 2011. The resulting statutory scheme reflects the Legislature's careful design and intent.

B. Peer Review Is an Informal, Collegial Process Focused on Patient Safety.

By design, medical staff hearings are unlike any other process in law, whether civil, criminal, or administrative. The Legislature intended medical staff hearings to be efficient,

informal, and collegial processes, unlike full court trials. (§ 809, subd. (a)(7) ["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."].) In Section 809, the Legislature thus approved a streamlined process, eschewing the typical trappings of litigation.

As an initial matter, peer review is conducted by "peers"—typically other members of the medical staff—rather than by traditional litigants or lawyers. (See § 809.05 [peer review is performed by licentiates]; § 809.2, subd. (a) [encouraging the appointment of "an individual practicing the same specialty as the licentiate" to the hearing panel where feasible].) In this informal system lawyers are never required and, in some cases, are expressly prohibited. (*Gill v. Mercy Hospital* (1988) 199 Cal.App.3d 889, 903 [attorneys are not required]; § 809.3, subd. (c) ["No peer review body shall be represented by an attorney if the licentiate is not so represented …."]; see, e.g., *Cipriotti v. Board of Directors* (1983) 147 Cal.App.3d 144, 156 ["The bylaws, however specifically provide that a lawyer may not appear on behalf of any party in the hearing process."].) Even the hearing officer may be a fellow physician. (§ 809.2, subd. (b).) In all instances, physician peers are encouraged to seek "resolutions through informal educational interventions" rather than resorting to full-blown hearings. (§ 809, subd. (a)(7).)

Section 809's procedural requirements echo this emphasis on informal resolution and patient care, rather than litigation and delay. Unlike litigants in a full civil trial, physicians in medical staff hearings are not entitled to extensive pre-hearing discovery, pre and post-hearing motions, or a myriad of other litigation-based procedures. (See, e.g., § 809.2, subd. (d)–(f).) In medical staff hearings, there are no formal discovery requests or depositions; no motions for summary judgment; no civil jury or judicial appointments. Discovery is limited to one production of "documentary information relevant to the charges." (§ 809.2, subd. (d).) Pre-hearing exchanges are limited to "lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing." (§ 809.2, subd. (f).) A full bells-and-whistles trial this is not.

C. Section 809.2 States the Fair Procedure Standards for Hearing Officer Disqualification.

The Legislature enacted a similarly streamlined procedure for selecting and vetting hearing panel members and the hearing officer. (§ 809.2.) The Legislature's only absolute requirement for hearing officer selection is as follows:

> If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

(§ 809.2, subd. (b).) Although medical staffs are free to add to these requirements in their bylaws on hearing officer qualifications, they are not required to do so.

In 2009, the Legislature considered amending Section 809.2 to impose further, more onerous conditions on hearing officer selection. Assembly Bill 120 proposed the following additional language:

> (1) If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, **shall disclose all actual and potential conflicts of interest within the last five years reasonably known to the hearing officer**, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.
>
> **(2) The hearing officer shall be an attorney licensed to practice law in the State of California.**

(Respondent's Motion for Judicial Notice, Ex. 12, Assem. Bill No. 120 (2009–2010 Reg. Sess.), p. 7, emphasis added.) But this bill was not enacted, and thus the law continues to require only that the hearing officer "gain no direct financial benefit from the outcome."

D. Courts Interpret Section 809 to Preserve Its Adaptable, Patient-Focused Intent.

In considering Section 809's requirements, courts have sought to preserve peer review as a flexible, adaptable system that avoids the burdens of trial. As this Court explained in *Pinsker v. Pacific Coast Society of Orthodontists*, courts should not write new requirements into the law:

> **The common law requirement of a fair procedure does not compel formal proceedings with all the embellishments of a court trial** (*citation*), nor adherence to a single mode of process. It may be satisfied by any one of a variety of procedures which afford a fair opportunity for an applicant to present his position. **As such, this court should not attempt to fix a rigid procedure that must invariably be observed.** Instead, the associations themselves should retain the initial and primary responsibility for devising a method which provides an applicant adequate notice of the "charges" against him and a reasonable opportunity to respond.

(*Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 555, emphasis added.)

This departure from "rigid procedure" results directly from

peer review's patient protection goal. When a medical staff imposes limits or restricts a physician's privileges to practice at a particular hospital, the physician's income may be impacted. But a physician's financial interests cannot outweigh patients' lives. (*Rhee v. El Camino Hospital Dist.* (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 members of the public in receiving quality medical care, and the duty of the hospital to its patients to provide competent staff physicians."].) Dr. Natarajan argues that "the primary purpose of peer review *hearings* is plainly to protect physicians' right to practice their profession." (Opening Brief, pp. 60–61.) But that proposition stands peer review's purpose on its head. As the Court of Appeal recognized in *Ellison v. Sequoia Health Services*, patient safety takes precedence over due process accoutrements:

> "The overriding goal of the state-mandated peer review process is protection of the public and **while important, physicians' due process rights are subordinate to the needs of public safety**." (*Medical Staff of Sharp Memorial Hospital v. Superior Court* (2004) 121 Cal.App.4th 173, 181–182, 16 Cal.Rptr.3d 769.) A physician facing peer review is not entitled to the same due process protections as a

> criminal defendant. (*Ibid.*) The question, rather, is whether the procedure leading to the revocation of privileges was fair.

(*Ellison v. Sequoia Health Services* (2010) 183 Cal.App.4th 1486, 1498, internal editing omitted, emphasis added; see also *Cipriotti*, *supra*, 147 Cal.App.3d at p. 157 ["So long as a fair hearing is provided, in disciplining or suspending those who do not meet its professional standards, the hospital should not be hampered by formalities not required by its bylaws nor by due process considerations."].)

III. SECTION 809 AND FAIR PROCEDURE DO NOT REQUIRE THE DISQUALIFICATION OF EXPERIENCED HEARING OFFICERS.

With *Pinsker's* directive in mind against burdening peer review with unnecessary "rigid procedure" (*Pinsker*, *supra*, 12 Cal.3d at p. 555), the Court's inquiry begins with the controlling statute's plain language, Section 809.2. Nothing in this statute would disqualify a hearing officer merely because the officer has experience from prior hearings within the same health system, or because she may serve again at some time in the future.

A. Section 809 Safeguards Fairness in the Hearing Officer Role.

In Section 809, the Legislature provided at least three means of protecting physicians from bias in the hearing officer, without converting peer review into a full trial. First, the Legislature limited the role of hearing officers in peer review.

Hearing officers are not adjudicators. Consistent with peer review's physician-driven design, hearing officers do not vote on the outcome. (§ 809.2(b).) Rather, they are present to ensure the process runs smoothly and efficiently. (See, e.g., § 809.2(d); CHA Model Bylaws, § 16.5.5, subd. (c) ["The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained."]; CMA Model Bylaws, § 7.4–3 [same].)

Second, the Legislature provided a system for physicians to challenge hearing officers for bias. The physician under review has "the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer." (§ 809.2, subd. (c).) "Challenges to the impartiality of any member or hearing officer shall be ruled on by the presiding officer, who shall be the hearing officer if one has been selected." (*Ibid.*) Physicians may renew their objections on appeal to the hospital's governing board or through a writ of administrative mandate. (§§ 809.4(b), 809.8; Code Civ. Proc., § 1094.5.) This process ensures that, in most cases, bias challenges are decided on a case-by-case basis, rather than through a one-size-fits-all prohibition.

Third, the Legislature provided guidance on certain *per se* minimum requirements. Although the Legislature adopted a flexible approach for hearing officer impartiality challenges, the Legislature imposed three black-and-white rules for hearing

officer neutrality: "If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote." (§ 809.2, subd. (b).)

B. Pursuant to Section 809.2, Hearing Officers Are Not Disqualified Based on the Mere Possibility of Future Work.

The question before this Court is whether to interpret Section 809.2(b)'s "direct financial benefit from the outcome" standard so broadly as to require—as a *per se* rule—the automatic disqualification of all hearing officers with prior experience administering a peer review proceeding within the same health system. It should not impose such a rigid rule. (See *Pinsker*, *supra*, 12 Cal.3d at p. 555).

The Legislature chose its language in Section 809.2(b) carefully. A "direct financial benefit" indicates an immediate pecuniary interest—not a potential, attenuated, or indirect benefit, or the mere appearance of a benefit. Moreover, the financial benefit must be "from the outcome" of the proceedings, not merely compensation for services rendered.

Notably, Section 809's language differs from the more comprehensive language the Legislature used in other statutes. For example, Section 809.2 prohibits the actual receipt of a financial benefit, not merely the possibility of one. (Compare, e.g., § 809.2, subd. (b) ["shall gain no direct financial benefit"]; with Pub. Resources Code, § 36993, subd. (a) ["Any person who

might reasonably be expected at some time to derive a direct financial benefit from the activities of the trust shall be ineligible to serve as a trustee."], emphasis added.) Nor does the mere appearance of a conflict disqualify a peer review hearing officer. (Compare, e.g., § 809.2, subd. (b) ["shall gain no direct financial benefit from the outcome"]; with Code Civ. Proc., § 1281.9 [arbitrators "shall disclose all matters that *could cause* a person aware of the facts *to reasonably entertain a doubt* that the proposed neutral arbitrator would be able to be impartial, including … a current arrangement concerning prospective employment …."], emphasis added.) The standards for California judges regarding prospective employment likewise do not apply. (See Code Civ. Proc., § 170.1, subd. (a) ["A judge shall be disqualified if any one or more of the following are true: … The judge has a current arrangement concerning prospective employment or other compensated service as a dispute resolution neutral or is participating in, or, within the last two years has participated in, discussions regarding prospective employment or service as a dispute resolution neutral …."].) If the Legislature had wanted the same disqualification standards for judges to apply to peer review hearing officers, it would have used the same language. It did not.

Section 809's "direct financial benefit" standard does not describe what occurred in this case—and Dr. Natarajan knows it. That is why his Opening Brief avoids quoting Section 809.2 whenever possible, and instead imports inapplicable constitutional due process law. Boiled down to its essence,

Natarajan argues that his hearing officer received a "*direct* financial benefit" because of the "*potential* for future employment at Dignity hospitals" at an *unknown* time to come—perhaps never. (Opening Brief, p. 76, emphasis added.) Using the example of Dignity Health in this case, according to Dr. Natarajan, serving as hearing officer at one hospital would mean automatic, permanent disqualification from serving at over two dozen other Dignity-affiliated hospitals in California. Nothing in Section 809 suggests the Legislature intended to disqualify experienced hearing officers precisely *because* they are experienced.

This does not mean that the statute is toothless. For example, Section 809's prohibition on a "direct financial benefit" could be interpreted to prevent the appointment of a competing physician as the hearing officer. (See CHA Model Bylaws, § 16.5.5, subd. (a) ["The Hearing Officer … shall not be in direct economic competition with the Practitioner …."].) Moreover, the question Dr. Natarajan presents to this Court is not whether future employment *may ever*, given the facts of a particularly egregious case, constitute bias. Respondent agrees that certain facts may demonstrate an "unacceptable *risk* of bias as the result of a tangible interest" (Answer Brief, p. 34), and the Legislature has already permitted physicians to challenge such bias on a case-by-case basis. (§ 809.2, subd. (c).) Rather, Dr. Natarajan seeks a decision interpreting Section 809 to *require* disqualification in all cases where the hearing officer has an appearance of bias. Dr. Natarajan's "appearance of bias"

standard is not consistent with the plain language of the statute. Section 809 does not state that hearing officers "shall *not appear to* gain [a] direct financial benefit"; it states that they "*shall gain* no direct financial benefit." Dr. Natarajan's standard is not that of the Legislature.

IV. EXPERIENCED HEARING OFFICERS ARE ESSENTIAL TO THE FAIR AND EFFICIENT ADMINISTRATION OF PEER REVIEW HEARINGS.

Section 809's hearing officer standards make sense. The "direct financial benefit" standard both ensures that medical staff hearing officers remain free from actual bias and that medical staffs can rely on experienced professionals. Experienced hearing officers are crucial bulwarks for fairness and against peer review's steady slide towards full-scale civil trials.

A. Peer Review Hearing Officers Require Rare, Specialized Skills.

Like train conductors, hearing officers can keep peer review hearings on track or grind them to a halt. Section 809 affords hearing officers various powers to efficiently manage the proceedings by allowing them to rule on requests for information, schedule hearing sessions, and oversee the presentation of evidence. (See §§ 809.2–809.3.) Most medical staff bylaws also permit the hearing officer to participate in the panel's deliberations, and even to draft the final report. (See, e.g., CHA Model Bylaws, § 16.5.5, subd. (f); CMA Model Bylaws, § 7.4–3.) At the same time, however, the Supreme Court has limited the

authority of hearing officers to sanction parties who refuse to cooperate in the hearing process, even if they repeatedly disobey their written orders. (See, e.g., *Mileikowsky v. West Hills Hospital & Medical Center* (2009) 45 Cal.4th 1259, 1272 [holding that a hearing officer lacked authority to impose terminating sanctions].)

Successful hearing officers must thus be both skillful negotiators and knowledgeable specialists—coaxing passengers back on the train, while also attending to the knobs and dials that keep the engine running. They must be intimately familiar with peer review's ever-growing body of unique case law and the web of regulatory statutes governing reporting requirements and hearing procedure. They must understand health systems, hospital administration, and how medical staff committees function. They must be capable of appreciating complex medical jargon, patient health conditions, and the standard of care in different medical subspecialties. They must also understand case law on the scope of their own powers, as limited by bylaws that differ in every case. These types of skills and reservoirs of knowledge are developed through decades of experience. No one wants a conductor who has never operated a train before.

B. Finding Skilled and Knowledgeable Hearing Officers Is Already Difficult.

Dr. Natarajan's proposal—where experience itself is the disqualifying factor—would quickly deprive peer review proceedings in California of experienced hearing officers. Peer review law is a niche practice area: although lawyers and former

judges may be exposed to it on occasion, few attorneys practice this specialty exclusively or even predominantly. Many otherwise experienced former judges and mediators have never encountered a peer review case.

In connection with this brief, CHA surveyed many of its members, who reported that it is increasingly difficult to find qualified hearing officers willing and able to serve. This difficulty is even greater for remote and rural hospitals. Medical staffs prefer not to use the same hearing officer twice, but they cannot always avoid using a hearing officer who has, at some point, served a different medical staff in the same health system.

Those CHA members who have used inexperienced hearing officers report concerns regarding the viability of hearing panel decisions and over-reliance on the parties' attorneys. If the hearing officer is unfamiliar with peer review, the medical staff cannot proceed without attorneys, as it otherwise might. (See *Gill*, *supra*, 199 Cal.App.3d at p. 903 [attorneys are not required].) In addition, because peer review decisions are reviewable by writ of administrative mandate, the hearing officer must guide the proceedings to avoid legal pitfalls that may result in a reversal many years down the road. An unwarranted reversal, due to a hearing officer's inexperience, represents an enormous loss of resources for the medical staff, and, more importantly, puts patients at risk.

In *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1037, the Court observed that when the government seeks an adjudicator, it has several fairly simple options for finding an

independent, experienced candidate. Most obviously, the government may select an administrative law judge ("ALJ") through the Office of Administrative Hearings. (Gov. Code, § 27727.) ALJs often specialize in their area of focus, for example, in Medical Board proceedings. This specialization is critical, due to the intricate issues of law and medicine presented. But as private entities, medical staffs cannot simply hire an ALJ from the local Office of Administrative Hearings. Nor could any hospital afford to establish an "office of the hearing officer," another option this Court suggested the government could adopt. (See *Haas*, *supra*, 27 Cal.4th at p. 1037.) Peer review hearings are relatively rare; a hospital may hold no hearings for many years, making a dedicated hearing officer unfeasible.

In short, medical staff peer review hearings present logistical challenges and resource burdens on private hospitals that cannot be easily addressed by adopting governmental solutions. Dr. Natarajan's proposed disqualification standard would further burden an already difficult process for private hospital medical staffs.

C. Peer Review Guided by Medical Staffs, Rather Than Courts, Helps Protect Patients.

In general, experienced peer review practitioners and physicians recognize that a more flexible approach to medical staff hearings—that does not incorporate all the trappings of constitutional due process and trial litigation—is a good thing for patients. As the Court in *Medical Staff of Sharp Memorial Hospital v. Superior Court* observed:

> We do not wish to denigrate the importance of due process rights; however, it must be emphasized that this is not a criminal setting, where the confrontation is between the state and the person facing sanctions. Here the rights of the patients to rely upon competent medical treatment are directly affected, and must always be kept in mind. An analogy between a surgeon and an airline pilot is not inapt: a hospital which closes its eyes to questionable competence and resolves all doubts in favor of the doctor does so at the peril of the public.

(*Sharp Memorial*, *supra*, 121 Cal.App.4th at p. 182.)

Engrafting costly trial procedures onto medical staff peer review will serve only to further discourage medical staffs from policing their members. A medical staff staring at the prospect of hundreds of thousands of dollars in attorneys' fees may think twice before suspending a risky physician, even at the potential expense of patient safety. (See, e.g., *Mir v. Charter Suburban Hospital* (1994) 27 Cal.App.4th 1471, 1485 ["Facing the specter of attorney fees, hospitals would have to consider taking the safer course and ignoring all but the most egregious malfeasance."].) The trend towards more litigious peer review has already begun, and the results are not encouraging:

> Attorneys who have been practicing in this area for a number of years have watched the medical staff peer review process become increasingly frustrating…. [T]he hearings tend to have all the trappings of [ ] formal proceedings: delay, procedural jousting among the attorneys, suspension of the hearing while judicial review is sought, "law and motion" type proceedings before the hearing officer between hearing sessions and so forth. Thus, hearings that once were concluded within 60 to 90 days after the initial adverse action against the physician now often last a year or two, and sometimes longer…. Clearly, formalizing and 'lawyering up' the medical staff peer review process has not improved it.

(Brown, *The medical staff peer review system is growing towards a procedural paralysis that will endanger patient safety* (Feb. 23, 2011) Daily Journal ("*Peer Review Paralysis*"), at p. 6.)

Today, it is not uncommon for hearings to last multiple years. (See, e.g., *Armin v. Riverside Community Hospital* (2016) 5 Cal.App.5th 810, 819 [hearing that began in March 2012 had not yet concluded by the time of the Court's decision four years later, in November 2016].) Because medical staffs are required to

report final adverse actions to the Medical Board, it is almost always in the physician's best interest to delay the final outcome of a hearing for as long as possible. (See § 805(b); 42 U.S.C. § 11133; Brown, *Peer Review Paralysis*, at p. 6.) Thus what was once intended to be a collegial process between peers has become a grindingly slow battle of the lawyers.

These delays and burdens are costly to all involved. This includes the medical staffs and hospitals who must pay for the hearing procedures and the physicians whose careers remain uncertain. But no one pays the price more than the patients at risk. Ultimately, such procedural barriers undermine the purpose of peer review, which is to exclude "those healing arts practitioners who provide substandard care or who engage in professional misconduct." (§ 809, subd. (a)(6).)

V. CONSTITUTIONAL DUE PROCESS DOES NOT APPLY TO PRIVATE PEER REVIEW HEARINGS.

Dr. Natarajan's "appearance of bias" standard derives not from the plain language of Section 809, but from a misreading of constitutional due process case law. Constitutional due process standards, however, do not apply to private parties like Respondent. Dr. Natarajan conflates basic *fair procedure* principles—applicable to any administrative remedy—with *constitutional* due process cases that rely on the 14th Amendment and state action for their reasoning. Although the two are similar in many ways, they are manifestly not the same.

A. Fair Procedure—Not Constitutional Due Process—Applies to Private Hospital Peer Review Hearings.

This Court has long recognized that fair procedure standards, as codified in Section 809, apply to medical staff peer review at private hospitals. (*El-Attar*, *supra*, 56 Cal.4th at p. 986.) Because private hospitals are not state actors, constitutional due process does not apply. (See, e.g., *Gill*, *supra*, 199 Cal.App.3d at p. 903 ["[The] actions of a private hospital in medical staff proceedings, like the instant case, are not sufficiently involved with the state or federal governmental authority to qualify as 'state action' that is subject to the procedural due process requirements of the United States Constitution."].)

To be sure, any administrative remedy must provide basic procedural protections, often called "due process." (*Kaiser Foundation Hospitals v. Superior Court* (2005) 128 Cal.App.4th 85, 104 [observing that certain "basic procedural protections [ ] are fundamental to any fair administrative remedy, whether the remedy is governed by principles of 'fair procedure' or 'due process'"].) In his Reply brief, Dr. Natarajan argues at length that the Legislature intended physicians to have some level of "due process" rights. (Reply Brief, pp. 10–11.) But that has never been in dispute. (*Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, 815, abrogated by statute on other grounds ["a physician may neither be refused admission to, nor expelled from, the staff of a hospital, *whether public or private*, in the absence of a procedure comporting with the minimum

common law requirements of procedural due process"], emphasis in original.)

What is in dispute, however, is *how much* due process is owed. Two standards have emerged to describe the degree of due process provided: "fair procedure"—applicable to private actors—and "constitutional due process" —applicable to state actors. At least five different courts, from 1980 until 2018, have made exactly the same holding, nearly word for word, in the peer review context:

> Since the actions of a private institution are not necessarily those of the state, **the controlling concept in such cases is fair procedure and not due process**. Fair procedure rights apply when the organization involved is one affected with a public interest, such as a private hospital.

(*Applebaum v. Board of Directors* (1980) 104 Cal.App.3d 648, 657, emphasis added; accord *Gaenslen v. Board of Directors* (1985) 185 Cal.App.3d 563, 568 [quoting *Applebaum*]; *Goodstein v. Cedars-Sinai Medical Center* (1998) 66 Cal.App.4th 1257, 1265 [quoting *Applebaum*]; *Kaiser*, *supra*, 128 Cal.App.4th at p. 102 [quoting *Goodstein*]; *Powell v. Bear Valley Community Hospital* (2018) 22 Cal.App.5th 263, 274 [quoting *Kaiser*].)

The Legislature itself has recognized this distinction between public and private hospitals and the applicability of Section 809. In Section 809.7, the Legislature carved out "state

or county hospitals"—state actors—from Section 809's requirements. (§ 809.7.) These public hospitals, the Legislature wrote, should continue "to afford due process of law to licentiates involved in peer review proceedings." (*Ibid;* see also *Kaiser*, *supra*, 128 Cal.App.4th at p. 102, fn. 15 [as described in Section 809.7, "constitutional due process governs peer review proceedings in government-owned hospitals"].)

B. Fair Procedure and Constitutional Due Process Are Different Legal Standards.

What does "fair procedure" require? Nothing more or less than the rights provided in Section 809:

> With respect to private hospitals, like Bear Valley, the physician's fair procedure rights "arise from section 809 et seq. and not from the due process clauses of the state and federal Constitutions."

(*Powell*, *supra*, 22 Cal.App.5th at p. 274, quoting *Kaiser*, *supra*, 128 Cal.App.4th at p. 102; see also *El-Attar*, *supra*, 56 Cal.4th at p. 988 [Section 809 "established the minimum procedures that hospitals must employ in certain peer review proceedings."].)

In an ongoing attempt to rewrite Section 809, however, Dr. Natarajan maintains "that common law fair procedure and constitutional due process provide[] the same extent of protection." (Opening Brief, pp. 40–41.) Dr. Natarajan relies on the following dicta from *Applebaum*:

> The distinction between fair procedure

> and due process rights appears to be one of origin and not of the extent of protection afforded an individual; the essence of both rights is fairness. Adequate notice of charges and a reasonable opportunity to respond are basic to both sets of rights.

(*Applebaum*, *supra*, 104 Cal.App.3d at p. 657.)

Here, *Applebaum* describes the floor for fair procedure, not the ceiling. That both fair procedure constitutional due process require the same basic rights does not mean they are identical in every respect. *Applebaum*'s general observation is true: Of course notice and an opportunity to respond are core features of both fair procedure and due process. But nearly forty years of jurisprudence, including *Applebaum*, has emphasized the different contours of fair procedure and constitutional due process. (See, e.g., *Applebaum*, *supra*, 104 Cal.App.3d at p. 657 [decided in 1980]; *Powell*, *supra*, 22 Cal.App.5th at p. 274 [decided in 2018]; see also *Ellison*, *supra*, 183 Cal.App.4th at p. 1498 ["A physician facing peer review is not entitled to the same due process protections as a criminal defendant."].) Contrary to Dr. Natarajan's argument, *Applebaum* was not discussing hearing office bias. Moreover, the *Applebaum* court acknowledged that fair procedure and constitutional due process differ, although describing those differences was beyond the scope of that case. (*Applebaum*, *supra*, 104 Cal.App3d at p. 657 ["the controlling concept in such cases [with private hospitals] is fair

procedure and not due process"].)

Courts distinguish between the two concepts for a reason: the law has long treated public and private actors differently. (See, e.g., *Jackson v. Metropolitan Edison Co.* (1974) 419 U.S. 345, 349 [the "essential dichotomy" between state action and private action has been emphasized since 1883].) In the peer review context, for example, courts review medical staff actions at public hospitals under the independent judgment test. (*Cipriotti*, *supra*, 147 Cal.App.3d at p. 154.) Similar actions at private hospitals, however, are reviewed by the substantial evidence standard. (*Ibid.*) As another example, in *Kaiser*, the Court of Appeal denied a claim that the hospital somehow violated due process by delays in the hearing. (*Kaiser*, *supra*, 128 Cal.App.4th at p. 109.) "Since Kaiser and TPMG are private institutions, whatever fair procedure rights Dr. Dennis has arise from section 809 et seq. and not from the due process clauses of the state and federal Constitutions." (*Id.* at p. 102.) The law generally expects more of the government than of private actors. The Court should not accept Dr. Natarajan's invitation to muddy these precedential waters.

C. *Haas* Does Not Apply and *Yaqub* Should Be Expressly Disapproved.

Fighting on, Dr. Natarajan urges the Court to "harmonize" Section 809 with two constitutional due process cases: *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, and *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474. (Opening Brief, pp. 65–66.) But these cases are

not germane here and cannot be reconciled with Section 809's plain language.

Haas involved the County of San Bernardino—unquestionably a state actor. (*Haas*, *supra*, 27 Cal.4th at p. 1017.) Because constitutional due process requires more of state actors, *Haas* is inapt. Moreover, *Haas* is not a medical staff peer review case. The court undertook no consideration of the unique aims of peer review or Section 809; it did not need to. Nothing in *Haas* applies to this peer review case, which involves: (a) a controlling statute governing hearing officer disqualification standards (Section 809.2(b)); (b) a private actor and thus fair procedure standards; (c) the unique demands of a peer review system focused on patient safety; and (d) a hearing officer that does not adjudicate any claims and may not vote on the outcome.

Yaqub is scarcely more relevant. The *Natarajan* court correctly denigrated *Yaqub* as "a deviation from the strong current of precedent and therefore 'a derelict on the waters of the law' that we have not found to be followed on this point in any published decision." (*Natarajan v. Dignity Health* (2019) 42 Cal.App.5th 383, 391.) Since its publication, *Yaqub* has confused litigants and undermined peer review. On behalf of its members, CHA urges the Court to end the confusion and expressly overrule *Yaqub*.

The Court should reject *Yaqub* for at least three reasons. First, *Yaqub* **not once** cites Section 809.2(b), the controlling statute on hearing officer bias in peer review. This astonishing lacuna is inexcusable. What is more, *Yaqub* not only fails to cite

on-point peer review statutes, it also relies extensively on statutes that have no application to peer review. Instead of examining Section 809.2(b), *Yaqub* quotes extensively from Code of Civil Procedure section 170.1 and the California Code of Judicial Ethics, which apply to civil court judges who *adjudicate cases*, not to peer review hearing officers. (See *Yaqub*, *supra*, 122 Cal.App.4th at p. 486.)

Second, the disqualification standard articulated in *Yaqub* is diametrically at odds with Section 809.2(b). The statute provides that "the hearing officer shall gain **no direct financial benefit from the outcome**" (§ 809.2(b), emphasis added). The *Yaqub* Court, in contrast, expressly acknowledged that "there was **no evidence** of actual prejudice or **of a direct financial interest in the outcome** of the case," and went on to apply a "possible temptation" standard not found anywhere in the statute. (*Yaqub*, *supra*, 122 Cal.App.4th at p. 485, emphasis added.) There is simply no way to pound *Yaqub*'s square peg into 809.2's round hole while staying faithful to the language of either.

Third, *Yaqub* applied constitutional due process cases, including *Haas*, without addressing the fact that (a) Section 809.2 is a fair procedure statute, and (b) *Haas* was not a peer review case. The Court made no attempt to grapple with the differences between civil judges, who decide questions of both fact and law, and peer review hearing officers, who do not. Indeed, the Court made no attempt to grapple with the unique goals and patient-protection urgencies of peer review at all.

CHA encourages this Court to explicitly disapprove of *Yaqub*, which was poorly-reasoned and came to the wrong result.[2]

VI. EVEN UNDER INAPPLICABLE CONSTITUTIONAL DUE PROCESS STANDARDS, A HEARING OFFICER'S EXPERIENCE IS NOT DISQUALIFYING.

As the *Natarajan* court correctly decided, principles of constitutional due process do not apply to private actors, including hospitals. But even assuming constitutional due process applied, the hearing officer's appointment here would meet those stricter standards. Unlike the hearing officers in *Haas*, peer review hearing officers are not government-appointed adjudicators. Moreover, the hearing officer here prudently agreed to a period of repose, in which he would not serve as a hearing officer for the next three years. Both distinctions resolve any due process concerns.

A. Unlike in *Haas*, Peer Review Hearing Officers Are Not Government-Appointed Adjudicators.

Even assuming constitutional due process applied to

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[2] After *Yaqub* was published, CHA led an early effort in the Legislature to mitigate *Yaqub*'s effects, although the bill never progressed out of committee. (See Opening Brief, p. 66.) Dr. Natarajan argues that this effort "demonstrates that the CHA understood that *Yaqub* applied to private hospital hearings" and that the Legislature supported *Haas*'s application to peer review. (*Ibid.*) Not in the least. On the contrary, this history demonstrates that CHA—and hospitals throughout California—immediately understood that the Court of Appeal had made a grave and disruptive error in failing to identify the controlling statute for peer review.

private hospitals, which it does not, *Haas* does not resolve Dr. Natarajan's appeal. *Haas* involved two elements not found in peer review. First, the hearing officer was an adjudicator responsible for deciding the case. In peer review, the hearing officer is expressly prohibited from voting on the outcome. (§ 809.2, subd. (b).) A peer review hearing officer's role is limited to resolving discovery disputes, assisting with scheduling, and otherwise ensuring that "proper decorum is maintained." (See § 809.2(d); CHA Model Bylaws, § 16.5.5, subd. (c); CMA Model Bylaws, § 7.4–3.) Second, in *Haas* the government was "the only player in the hearing officer game." (*Natarajan*, *supra*, 42 Cal.App.5th at p. 392.) In the peer review context, however, a hearing officer may "pursue employment with the *other* hospital networks that have made use of his services." (*Ibid*.) In sum, even applying constitutional due process standards, *Haas* is inapposite.

Even in constitutional due process cases, courts are cautious about assuming bias. The Supreme Court case *Smith v. Phillips* (1982) 455 U.S. 209, is instructive. There, a juror (Smith) applied for employment with the prosecutor's office during a criminal trial. (*Id.* at p. 212.) The trial "court imputed bias to Smith because 'the average man in Smith's position would believe that the verdict of the jury would directly affect the evaluation of his job application,'" and the Second Circuit affirmed. (*Id.* at p. 214.) But the Supreme Court reversed. It held that even in such a situation—where a decision-maker had a pending employment application with one side—the trial court

could not simply impute bias. (*Id.* at p. 215.) Instead, the Supreme Court instructed that the court should have held a hearing, in which the defendant could attempt to elicit facts showing actual bias. (*Ibid.*)

Of course, the circumstances in *Smith* are quite unlike those here. Peer review is not a criminal trial. A peer review hearing officer is not a decision-maker. And there is no evidence that the hearing officer had an already pending application for employment by the hospital or medical staff. But those are all reasons why even greater caution in presuming bias is warranted here.

B. Periods of Repose Eliminate Even the Appearance of Bias.

The hearing officer's appointment in this case also cleared constitutional muster because the period of repose removed any potential appearance of bias. In footnote 22, the *Haas* Court stated:

> [A] county that wished to continue appointing temporary hearing officers on an ad hoc basis might **adopt the rule that no person so appointed will be eligible for a future appointment until after a predetermined period of time** long enough to eliminate any temptation to favor the county. Under such a rule, an attorney might be appointed to hear all cases arising during

the designated period.

(*Haas*, *supra*, 27 Cal.4th at p. 1037, fn. 22, emphasis added.) Such periods of repose are both fair and common. (See, e.g., American Health Lawyers Association, *The Code of Ethics for Hearing Officers in Peer Review Hearings* (Jun. 29, 2013), Canon I.C. ["For a reasonable period of time after the decision of a case, a person who has served as a Hearing Officer should avoid entering into any [business, professional, or personal] relationship, or acquiring any [financial or personal] interest, in circumstances which might reasonably create the appearance that he or she has been influenced in the Fair Hearing by the anticipation or expectation of the relationship or interest."]; see also Advisory Committee on Judicial Conduct of the District of Columbia Courts, *Opinion No. 13* (Jul. 9, 2014) [recommending a one year period of repose for judges to disqualify themselves when former law clerks appear before them].) Indeed, since *Haas*, both private and public hospitals have relied on its language approving of periods of repose to avoid conflicts over hearing officer neutrality.

C. Periods of Repose Provide Reasonable Protection Against Bias Because of the Structure of Medical Staff Hearings.

Dr. Natarajan objects to the three-year period of repose in this case because it applied to the medical staff of St. Joseph's Medical Center but not the 33 other medical staffs in the Dignity Health system. Once again, Dr. Natarajan is attempting to impose rigid, litigation-like restrictions on the peer review

process that have no basis in law. Dr. Natarajan's position also betrays a misunderstanding of the self-governing nature of medical staffs. There is no reason why a hearing officer's work with one medical staff should disqualify her from assisting a completely separate medical staff in the same health system.

1. A Hospital's Medical Staff Is a Self-Governing Entity, Independent of Other Medical Staffs.

In California, each medical staff is self-governing. Each medical staff has its own officers and is entitled to develop its own bylaws and establish its own criteria for quality assurance. (Corp Code, § 2282.5, subd. (a)(1), (2) [listing the medical staff's rights of self-governance]; Cal. Code Regs., tit. 22, §§ 70701, subd. (a)(7), 70703, subd. (b).) Unless multiple hospitals agree otherwise, peer review is conducted independently at each hospital pursuant to bylaws adopted by that hospital's medical staff. (§ 809, subd. (a)(8).) Nothing prevents one medical staff from conducting peer review differently from another, even when it involves the same physician. The period of repose here thus correctly applied to the medical staff conducting the peer review hearings, and not to other medical staffs at other hospitals, which function separately and independently.

2. The Layered Nature of California Hospital Governance Distinguishes the Medical Staff's Role in Peer Review From That of Hospitals and Hospital Systems.

Dr. Natarajan's opposition to the period of repose also

ignores the important differences between the roles of medical staffs, hospitals, and hospital systems. Although each of these entities cooperates to make certain that peer review occurs, they have different roles and interests. Because of this, there is no reason why the hearing officer should have been prevented from accepting future work for other self-governing medical staffs in the Dignity system.

In his briefing, Dr. Natarajan confuses the roles of hospitals and medical staffs by repeatedly and inaccurately referring to medical staff hearings as "hospital hearings." But in California, the medical staff conducts the hearing process, not the hospital. (See § 809, subd. (a)(8); Cal. Code Regs., tit. 22, § 70701, subd. (a)(7).) It is also the medical staff that has the power (which may be delegated) to appoint hearing officers under most bylaws. (See, e.g., CMA Model Bylaws, § 7.4–3; CHA Model Bylaws, § 16.5.5, subd. (b).) In this case, the court's unchallenged statement of decision found that the hearing officer was duly appointed pursuant to the medical staff's authority. (See Answer Brief, p. 26.)

As a hospital, St. Joseph's Medical Center had no direct involvement in the proceedings until the medical staff hearing concluded and the decision came to the Board's attention as an appellate body. The self-governing medical staff acted first to recommend adverse action against Dr. Natarajan to the Board. The medical staff then held an evidentiary hearing before its adverse recommendation reached the Board. (See PAR-1621 ¶ 9.15 [appeals procedure in the bylaws]; *Matchett v. Superior*

Court (1974) 40 Cal.App.3d 623, 628 ["In an accredited hospital, the organized medical staff is responsible to the hospital governing body for the quality of in-hospital medical care …."]; Cal. Code Regs., tit. 22, §§ 70701, 70703.) This is typical of the hospital governing body's role in any medical staff hearing process. (§ 809.05, subd. (a) [the governing body may review the final decision of a peer review body]; § 809.4, subd. (b) [physicians may appeal and receive a written decision from the appellate body].) Although the hospital board has ultimate legal responsibility for the hospital's protection of patients, it must give "great weight" to a medical staff hearing panel's decision. (§ 809.05, subd. (a).) The medical staff investigates the matter, brings charges, prosecutes the case, and appoints a hearing panel that, in turn, considers the subject physician's challenge to the medical staff's proposed action and then renders a written decision. The board's role is to act only as an appellate body, applying a generally deferential standard of review. (See, e.g., *Ellison*, *supra*, 183 Cal.App.4th at p. 1496.)

Hospital members of a health system are independently licensed, each with its own governing board. (Cal. Code Regs., tit. 22, §§ 70701, 70703.) At the next level above an individual hospital's board is the health system—a group of affiliated health care organizations, including one or more hospitals—assuming the hospital is a member of such a system, as is the case here. The health system has no role in peer review proceedings. California law assigns that duty to individual licensed hospitals and their medical staffs, whether or not a hospital belongs to a

larger health system.

Dr. Natarajan makes much of the fact that the Dignity Health System paid the hearing officer's fees. (See, e.g., Opening Brief, p. 22.) But this arrangement is hardly unusual or nefarious. It is simply a matter of routine financial discipline in the engagement of attorneys, which is usually centrally managed at the health system level. It is both common and legally justified for a hospital or health system to shoulder the costs of a medical staff's peer review activities. Pursuant to Section 809, medical staffs, through their peer review bodies, are responsible for conducting peer review in the first instance—regardless of who pays. (§ 809.05 ["It is the policy of this state that peer review be performed by licentiates."], § 805, subd. (a)(1)(B) ["peer review body" includes "a medical or professional staff"].) But few, if any, medical staffs could afford to pay for even a single peer review hearing solely from their dues. Hospitals and hospital systems are thus often called on to bridge the financial gap. These financial arrangements do not mean that medical staffs, hospitals, and hospital systems are interchangeable, or that hospitals or health systems are primarily responsible for medical staff hearings. As explained, medical staffs drive the hearing process itself.

Although the roles of self-governing medical staffs, hospitals, and hospital systems in patient protection are complementary, the Court's decision must not transform the three entities into one single, undifferentiated mass, as Dr. Natarajan proposes. Dr. Natarajan's requirement that serving a

single medical staff within a complex multi-layer organization disqualifies a hearing officer from work with any other medical staff in a hospital system would do just that.

VII. CONCLUSION

The Legislature originally envisioned peer review as an efficient, informal, and collegial process whereby physician peers maintain a high level of patient care by reviewing each other's care. But with time, achieving this goal has become increasingly difficult. Peer review is too often an onerous, long, expensive, and extraordinarily litigious process directed more by attorneys than physicians. That is not in the best interests of patient care.

CHA urges the Court not to add further burdens onto peer review by imposing constitutional due process requirements the Legislature did not include in Section 809. Requiring peer review conducted at private hospitals to comply with constitutional due process standards applicable to state actors is not supported by law and undermines patient safety.

Dated: November 30, 2020 ARENT FOX LLP

By: 

Lowell C. Brown
Sarah Benator
Diane Roldán

Attorneys for Amicus Curiae
California Hospital Association

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Dated: November 30, 2020

By: 

Lowell C. Brown
Sarah Benator
Diane Roldán

Attorneys for Amicus Curiae
California Hospital Association

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Case No. S259364

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Service List

Stephen D. Schear Law Offices of Stephen Schear 2831 Telegraph Avenue Oakland, CA 94609 Phone: (510) 708-9636 **steveschear@gmail.com**	Counsel for Petitioner and Appellant **Sundar Natarajan, M.D.**
Jenny Chi-Chin Huang Justice First 180 Grand Avenue, Suite 1300 Oakland, C 94612 Phone: (510) 628-0695 Fax: (510) 318-7701 **jhuang@justicefirst.com**	Counsel for Petitioner and Appellant **Sundar Natarajan, M.D.**
Tharini Natarajan 8111 Presidio Drive Cupertino, CA 95014-4027 Phone: (408) 250-7269 **tarabadwal@yahoo.com**	Counsel for Petitioner and Appellant Sundar Natarajan, M.D.
Joanna S. McCallum Craig S. Rutenberg Barry S. Landsberg Doreen W. Shenfeld Manatt, Phelps & Phillips, LLP 2049 Century Park East Suite 1700 Los Angeles, CA 90067 Phone: (310) 312-4000 Fax: (310) 312-4224 **jmccallum@manatt.com** **crutenberg@manatt.com** **blandsberg@manatt.com** **dshenfeld@manatt.com**	Counsel for Defendant and Respondent **Dignity Health**

Hon. Barbara A. Kronlund (Case No. STK-C-UMW-20164821) c/o Clerk of the Court San Joaquin County Superior Court 180 E. Weber Avenue, Suite 200 Stockton, CA 95202	Service by US Mail

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Terri Keville Davis Wright Tremaine LLP 162492	terrikeville@dwt.com	e-Serve	11/30/2020 7:30:16 PM
Lowell Brown Arent Fox LLP	brown.lowell@arentfox.com	e-Serve	11/30/2020 7:30:16 PM
Tharini Natarajan Attorney at Law	tarabadwal@yahoo.com	e-Serve	11/30/2020 7:30:16 PM
Patrick Moore Patrick K. Moore Law Corporation	pmoore@moorehealthlaw.com	e-Serve	11/30/2020 7:30:16 PM
Peder Batalden Horvitz & Levy LLP 205054	pbatalden@horvitzlevy.com	e-Serve	11/30/2020 7:30:16 PM
Diane Roldan Arent Fox LLP 288224	Diane.Roldan@arentfox.com	e-Serve	11/30/2020 7:30:16 PM
Joseph Cachuela California Medical Association 285081	jcachuela@cmadocs.org	e-Serve	11/30/2020 7:30:16 PM
H. Thomas Watson Horvitz & Levy 160277	htwatson@horvitzlevy.com	e-Serve	11/30/2020 7:30:16 PM
Marc Shrake Freeman Mathis & Gary, LLP 219331	MShrake@fmglaw.com	e-Serve	11/30/2020 7:30:16 PM

Glenda Zarbock Hanson Bridgett LLP 178890	gzarbock@hansonbridgett.com	e-Serve	11/30/2020 7:30:16 PM
Joshua McDaniel Horvitz & Levy LLP 286348	jmcdaniel@horvitzlevy.com	e-Serve	11/30/2020 7:30:16 PM
Joseph Wood Attorney at Law	woodesqmd@yahoo.com	e-Serve	11/30/2020 7:30:16 PM
Joanna Mccallum Manatt Phelps & Phillips, LLP 187093	jmccallum@manatt.com	e-Serve	11/30/2020 7:30:16 PM
Barry Landsberg Manatt Phelps & Phillips 117284	blandsberg@manatt.com	e-Serve	11/30/2020 7:30:16 PM
Stephen Schear Law Offices of Stephen Schear 83806	steveschear@gmail.com	e-Serve	11/30/2020 7:30:16 PM
Jill Gonzales Horvitz & Levy LLP	jgonzales@horvitzlevy.com	e-Serve	11/30/2020 7:30:16 PM
Jenny Huang Justice First 223596	jhuang@justicefirst.net	e-Serve	11/30/2020 7:30:16 PM
Brigette Scoggins Manatt Phelps & Phillips LLP	bscoggins@manatt.com	e-Serve	11/30/2020 7:30:16 PM

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Last Name, First Name (PNum)

Arent Fox LLP

Law Firm