No. S259364

IN THE SUPREME COURT

OF THE STATE OF CALIFORNIA

SUNDAR NATARAJAN, M.D.,

Petitioner and Appellant,

vs.

DIGNITY HEALTH,

Respondent.

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

San Joaquin County Superior Court
No. STK-CV-UWM-2-16-4821

RESPONDENT'S CONSOLIDATED ANSWER TO BRIEFS OF AMICI CURIAE CALIFORNIA MEDICAL ASSOCIATION AND AMERICAN ACADEMY OF EMERGENCY MEDICINE

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I. INTRODUCTION

Dignity Health hereby responds to the two amicus briefs filed "in support of neither party."[1] Neither brief demonstrates a reason for the Court to deviate from or alter the statutory standard applicable to the financial bias of a hearing officer in a physician peer review proceeding.

Amicus curiae California Medical Association (CMA) says it wants to "help the Court establish the most appropriate standard for hearing officer impartiality . . . ." (Amicus Curiae Brief of the California Medical Association (CMA Br.) 11.) But the "appropriate standard" is already established. CMA wrote it, and it is set forth in Business and Professions Code section 809.2, subdivision (b) (section 809.2(b)), the statute that CMA sponsored in 1989, urging that it would ensure fairness to physicians subject to peer review. Contrary to CMA's characterization, the Court of Appeal here did not "craft[]" an unduly "narrow" standard (CMA Br. at 10); the Opinion applied the plain terms of the statute and held that a hearing officer's possibility of future work for an affiliated hospital is not a "direct financial benefit from the outcome" of a peer review proceeding. (Bus. & Prof. Code, § 809.2, subd. (b).)

Notably, CMA does not even support the disqualification rule that Natarajan urges in this case. Instead, CMA wants to conflate the controlling statute (section 809.2(b)) with section 809.2, subdivision (c), arguing that subdivision (c) permits a

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[1] Four amicus briefs were filed in support of Dignity Health. No amicus briefs were filed in support of Appellant Dr. Sundar

physician to challenge a hearing officer's "impartiality" based on common-law principles. However, the broad disqualification standard that CMA asks this Court to adopt is plainly something different from what the statute requires for hearing officer *financial* bias. CMA has no explanation for why the Legislature added the "no direct financial benefit from the outcome" language to subdivision (b) and it concedes the legislative history is silent on the subject. There would have been no reason for the addition if CMA were correct that subdivision (c) broadly encompasses challenges for financial bias. And CMA takes no position on whether the facts here would fall even within the standard CMA urges—presumably because it disagrees with Natarajan and is simply taking the opportunity to argue for a standard far broader than the one in the statute that CMA itself wrote. The standard for hearing officer financial bias cannot enlarge or deviate from the express language that the Legislature chose as the standard for a hearing officer's financial bias at a private hospital and set forth in section 809.2(b).

American Academy of Emergency Medicine (AAEM) does not express a position on any relevant issue before this Court. AAEM merely generically asserts that peer review hearings should be fair. That is not in dispute. As such, AAEM's brief does not attempt to shed light on how this case should be resolved.

Natarajan.

II. RESPONSE TO AMICUS CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION

A. The governing statute requires disqualification of a hearing officer who may gain a direct financial benefit from the outcome of the proceeding.

1. The statutory standard.

Business & Professions Code section 809 et seq., effective January 1, 1990, codified the common-law principles applicable to certain physician peer review fair hearings. (*El-Attar v. Hollywood Presbyterian Med. Ctr.* (2013) 56 Cal.4th 976, 988 [noting that certain principles regarding fair hearings for physicians had been addressed in the case law and that "[t]he Legislature subsequently codified the common law fair procedure doctrine in the hospital peer review context by enacting Business and Professions Code sections 809 to 809.8 in 1989"]; *Mileikowsky v. West Hills Hosp. & Med. Ctr.* (2009) 45 Cal.4th 1259, 1267 ["In 1989, California codified the peer review process at Business and Professions Code section 809 et seq., making it part of a comprehensive statutory scheme for the licensure of California physicians . . . ."].)

The disqualifying financial bias of a hearing officer is explicitly defined in section 809.2(b): a hearing officer may serve if he or she "gain[s] no direct financial benefit from the outcome" of the proceeding. CMA argues that this is not the *sole* basis on which a hearing officer could be disqualified for bias, and that other types of bias can be disqualifying under section 809.2, subdivision (c) and the common law.

But this case is about *financial* bias. In section 809.2(b), the Legislature articulated the limited scenario in which the mere risk (or "appearance") of *financial* bias, which is what Natarajan claims existed here, can suffice to disqualify a hearing officer without proof of actual bias. (See *Andrews v. Agricultural Labor Rel. Board* (1981) 28 Cal.3d 781, 793, fn. 5; see also Dignity Health's Answer Brief pp. 32-35.) A physician may claim that a hearing officer should be disqualified for personal or other types of bias, but he must raise the challenge under subdivision (c) and prove facts demonstrating actual bias. (*Andrews*, 28 Cal.3d at 792 ["the threshold determination [whether facts demonstrate bias] . . . has never been satisfied by an allegation of the mere appearance of bias"].) Natarajan himself never contended that the hearing officer in his case had disqualifying financial bias under subdivision (c).[2]

This interpretation of the statute is fully consistent with the common law that preceded section 809.2, which the statute codified. CMA agrees with Dignity Health that the Legislature intended to impose a bias standard derived from the common law existing at the time. The common law was that an *adjudicator*[3]

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[2] Natarajan did contend that the hearing officer was additionally biased because of a "friendship" with the medical staff's attorney. This type of bias must be "actual" in order to be disqualifying. (*Andrews*, 28 Cal.3d at 793; *Tumey v. Ohio* (1927) 273 U.S. 510, 523 ["matters of kinship [and] personal bias . . . would seem generally to be matters merely of legislative discretion"].) Dignity Health explained why the facts of this supposed friendship did not support a claim of bias here. (Answer Br. at 24, 79-80.)

[3] As discussed in Dignity Health's Answer Brief, and in several amicus briefs supporting Dignity Health, a hospital peer review

should be disqualified only for actual bias, except for certain specific situations where the *probability* of actual bias was too high. (Answer Brief at 32-35; see also *Rhee v. El Camino Hosp. Dist.* (1988) 201 Cal.App.3d 477, 492; *Andrews*, 28 Cal.3d at 793, fn. 5.) The case law at the time of S.B. No. 1211 had acknowledged four such situations. (See *Hackethal v. California Medical Ass'n* (1982) 138 Cal.App.3d 435, 443 ["Disqualification should occur if there is actual bias. Disqualification may also be necessary if a situation exists under which human experience teaches that the probability of actual bias is too high to be constitutionally tolerable. [¶] Categories have been identified where the probability of actual bias by a panel member is too high."]; see also *Applebaum v. Board of Directors of Barton Memorial Hospital* (1980) 104 Cal.App.3d 648, 657.) "Those categories include: (1) a member has a direct pecuniary interest in the outcome; (2) a member has been the target of personal abuse or criticism from the person before him; (3) a member is enmeshed in other matters involving the person whose rights he is determining; (4) a member may have prejudged the case because of a prior participation as an accuser, investigator, fact finder or initial decisionmaker." (*Hackethal*, 138 Cal.App.3d at 443.)

The Legislature (and CMA, which wrote the bill) chose to incorporate only *one* of those "appearance of bias" scenarios into the statutory provision governing hearing officers, and it was the

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hearing officer is not an "adjudicator." (See Answer Br. at 5-54; see also Amicus Brief of Scripps Health et al. at 13-21.)

Legislature's prerogative to make that choice. (*Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1033 [where the Constitution is not implicated, it is "appropriate[]" to determine adjudicator bias "by reference to state statutes and regulations"].) By contrast, in subdivision (a), which applies to the adjudicatory hearing panel, the Legislature chose to incorporate the "no direct financial benefit from the outcome" standard as well as one other common law standard (prohibiting hearing panel members who had acted as an accuser, investigator, fact finder or initial decisionmaker).

CMA suggests—based on pure speculation—that subdivision (b) does not address bias at all, but merely enumerates certain prohibited scenarios that would place a hearing officer in a position to exercise too much control over a peer review hearing and thus are always prohibited—such as voting on the matter or acting as an advocate or prosecuting officer, both of which are enumerated in subdivision (b). However, a restriction on gaining a direct financial benefit from the outcome is qualitatively different from voting or advocating, which pertain to adjudicative-like conduct during the peer review hearing. All of these distinct subjects are addressed in subdivision (b) as separate restrictions. A hearing officer who would gain a direct financial benefit from the outcome would not be in a *position* to exert influence; rather, he might have a *motivation* to exert influence—in other words, he might be biased. Thus, CMA's reinterpretation of subdivision (b) makes no sense. As the sponsor of S.B. No. 1211, CMA should be able to

cite some support for its interpretation if it exists. It cites nothing and relies throughout its brief on sheer speculation.

Finally, there is nothing inherently inadequate or overly narrow about limiting disqualifying hearing officer financial bias to those cases where the hearing officer will gain a direct financial benefit from the outcome. CMA's own Model Bylaws' provision on hearing officer conflicts sets forth the identical standard as in subdivision (b), as well as an additional requirement that attorneys at law firms that do work for the hospital or the physician not be permitted to serve as hearing officers. (See Dignity Health's Motion for Judicial Notice (MJN) pp. 166-167 [CMA Model Bylaw 7.4-3].) CMA should not be trying in this Court to alter its prior positions before the Legislature or in its Model Bylaws.

And the Health Care Quality Improvement Act (HCQIA), the federal peer review law, sets forth minimum procedural standards that the federal law "deem[s]" sufficient to ensure fairness in peer review hearings. (42 U.S.C. § 11112, subd. (b).) Under HCQIA, a hearing officer—even one who is an adjudicator, as permitted under federal law—may serve unless he or she "is in direct economic competition with the physician involved." (*Id.*, subd. (b)(3).) The section 809.2(b) standard would disqualify those same potential hearing officers who are in direct economic competition with the physician, but also would more broadly disqualify others who would gain "direct financial benefit from the outcome" in other ways, and so the state statute conforms with HCQIA's minimum requirements as relate to hearing officer

financial bias.[4]

2. The legislative history does not support CMA's interpretation of section 809.2.

CMA is hard-pressed to contend that the financial bias standard that it wrote into the bill is unfair to physicians. CMA sponsored the peer review reform legislation in part because it believed that legislation was needed to ensure that peer review hearings were fair to physicians and that the common law was insufficient to protect physicians because it was not specific and was inconsistently applied. A legislative report on S.B. No. 1211 noted that "CMA argues strongly that these procedures [in the statute] will prevent abuse of the peer review process . . . . " (MJN, p. 53.) CMA urged the Governor to sign S.B. No. 1211, arguing that "SB 1211 would establish minimum guidelines which would make for a *more certain, defined process* of peer review, encouraging information to be fully and fairly aired. *Setting forth clear procedures* and eliminating peer review abuse will reduce litigation . . . ," and "Senate Bill 1211 will clearly enhance and tighten the disciplinary process . . . ." (MJN, pp. 57, 60 [underlining in original; italics added].) Thus, CMA requested, and got, the "direct financial benefit from the

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[4] In *Fahlen v. Sutter Central Valley Hospitals* (2014) 58 Cal.4th 655, 684-686, this Court explored HCQIA's application to California peer review proceedings, although it declined to address the question of whether another state peer review-related law at issue in *Fahlen* was preempted by HCQIA. The Court identified HCQIA preemption, an issue raised by amici in *Fahlen* but not by the hospital itself, as an issue for further legal development. (*Ibid.*)

outcome" standard to address and respond to its concerns that the peer review process be fair to physicians. CMA's effort now to impose only the vaguest possible "impartiality" standard[5] is inconsistent with its own legislative efforts and its own interpretation of the statute when it was enacted.

Nonetheless, CMA now attempts to use the legislative history of the statute to support its argument that a direct financial benefit from the outcome is *not* the governing standard for financial bias. CMA says that, as the sponsor of S.B. No. 1211, CMA has "valuable insight" into the Legislature's intent.[6] (CMA Br. at 10.) CMA's brief, however, does not provide any of its own insight, instead relying only on legislative material from the generally available legislative history file—material that CMA admits does not contain any information indicating that the Legislature intended anything other than what it said in the plain language of section 809.2(b). (CMA Br. at 26.)

At any rate, CMA's legislative history argument is contrary to basic principles of statutory interpretation. As CMA notes, S.B. No. 1211 as initially proposed included the provision in subdivision (c) permitting a physician to challenge the "impartiality" of a hearing officer. The original bill said nothing about "financial benefit" to hearing officers. CMA added the "no direct financial benefit from the outcome" restriction in

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[5] For example, Merriam-Webster defines "impartial" as "not partial or biased: treating or affecting all equally." <https://www.merriam-webster.com/dictionary/impartial>

[6] In the Court of Appeal, CMA filed an amicus brief that did not mention the legislative history of S.B. No. 1211.

subdivision (b) in an amendment to the bill prior to passage. According to CMA, this sequence demonstrates that hearing officer bias is governed by the broad "impartiality" standard in subdivision (c). (See CMA Br. at 25-27.) CMA offers *no reason* for the addition of the language in subdivision (b) and admits that the Legislature itself offered no reason to suggest that the statute be interpreted other than in accordance with its plain language. (CMA Br. at 26.)

But this sequence clearly supports the *opposite* point: the Legislature's addition of an express and specific provision addressing hearing officer financial bias in subdivision (b) signals a legislative intent that only a direct financial benefit from the outcome would support disqualification for financial bias. The rule is that "[i]f conflicting statutes cannot be reconciled, . . . more specific provisions take precedence over more general ones." (*Lopez v. Sony Elecs., Inc.* (2018) 5 Cal.5th 627, 634 [citation omitted]; see also *People v. Prothero* (1997) 57 Cal.App.4th 126, 133-134 [interpreting statute based on language added in most recent amendment to the bill].) Subdivisions (b) and (c) are easily reconciled by interpreting (b) to state the limited basis for disqualification for appearance of bias and (c) to state a more general standard for disqualification upon proof of actual bias. But to the extent they cannot be reconciled, the more specific standard in (b) must take precedence. (*Id.*)

CMA's interpretation also would render subdivision (b)'s provision superfluous. (See *Wang v. Nibbelink* (2016) 4 Cal.App.5th 1, 15 [rejecting broad interpretation of one statutory

provision where a broad construction would render superfluous a more specific provision].) If the broad "impartiality" standard in subdivision (c) governs all allegations of bias, then there would have been no need or reason for the Legislature to amend the bill to create the narrower "no direct financial benefit from the outcome" standard for hearing officer financial bias. The addition of that language would have been a meaningless and idle act. But "the Legislature does not engage in idle acts, and no part of its enactments should be rendered surplusage if a construction is available that avoids doing so." (*Mendoza v. Nordstrom, Inc.* (2017) 2 Cal.5th 1074, 1087.)

It is significant that subdivision (a), addressing the adjudicatory hearing panel, included from the outset a prohibition on panel members gaining a direct financial benefit from the outcome. This supports an inference that CMA and the Legislature were initially focused on the more direct problem of adjudicator bias, the subject addressed in the case law.

During the enactment process, the Legislature saw fit to extend this prohibition to non-decision-maker hearing officers. While the legislative history does not discuss the purpose of the addition, it does contain a hint. HCQIA, the federal peer review statute from which the Legislature was attempting by S.B. No. 1211 to opt out,[7] permits hearing officers to serve (including as

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[7] CMA argues that one purpose of S.B. No. 1211 was to opt out of the federal HCQIA statute to ensure that California peer reviewers got certain protections under state law that HCQIA would have preempted. (CMA Br. at 23-24.) It is true that this was one stated purpose of S.B. No. 1211. (Bus. & Prof. Code,

adjudicators) unless they are "in direct economic competition with the physician involved." (42 U.S.C. § 11112, subd. (b)(3).) The legislative history of S.B. No. 1211 contains a letter dated April 13, 1989—prior to the addition of the "no direct financial benefit from the outcome language" to subdivision (b)—criticizing S.B. No. 1211 for not explicitly prohibiting a hearing officer who is a direct economic competitor of the physician, as in HCQIA. (MJN, Ex. 1, pp. 260-261 of .pdf file.) On May 2, 1989, less than three weeks later, the Legislature amended the bill to add the "no direct financial benefit" provision restriction to section 809.2(b). (MJN, p. 43.)

CMA does not even mention that in 2009, it again sponsored legislation on the subject of fair procedure requirements for peer review hearings, Assembly Bill No. 120. That bill, which did not become law, included a number of provisions relating to the specific subject of hearing officers.[8] CMA explained to the bill's author that "[t]he bill . . . guarantees

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§ 809, subd. (a)(9)(A).) However, Congress expressly forbade states from opting out of HCQIA in December 1989, and so the attempted opt-out was invalid from the start and the federal statute applies squarely to peer review in California. (See *Smith v. Selma Commun. Hosp.* (2010) 188 Cal.App.4th 1, 27, fn. 22; see also *Fahlen*, 58 Cal.4th at 685-686.) Indeed, on precisely this basis, this Court in *Mileikowsky* modified its Opinion to delete a passage that had suggested California opted out of HCQIA. <https://appellatecases.courtinfo.ca.gov/search/case/dockets.cfm?dist=0&doc_id=1888664&doc_no=S156986&request_token=NiIwLSEmXkg9W1BZSCNdUEhJUEg0UDxfJiM%2BIzJSUCAgCg%3D%3D> The Court did so at the request of the California Hospital Association. (*Id.*)

[8] The bill was vetoed by Governor Schwarzenegger. (MJN, p. 64.)

fairness in panel hearings by specifying the qualifications and powers of hearing officers" and by "*requir[ing] that hearing officers be free from conflicts of interest* and sufficiently qualified to lead these quasi-judicial hearings." (MJN, p. 122 [emphasis added].)

CMA's proposed 2009 legislation offered no change to the statute's existing language. Instead, it would have broadened section 809.2(b) by adding a requirement that a hearing officer "shall disclose all actual and potential conflicts of interest." (MJN, p. 75.) This provision was subsequently modified to require disclosure only of those "actual and potential conflicts of interest within the last five years reasonably known to the hearing officer." (MJN, p. 92.) As the bill did not become law, the statute on hearing officer conflicts remains the same as it was in S.B. No. 1211, focusing only on a "direct financial benefit from the outcome" of a peer review hearing.[9]

B. Common-law standards for financial bias, to the extent they differ from the statutory standard, do not override or supplement section 809.2(b).

CMA wants to shift the focus away from the express statutory standard for financial bias and to substitute general

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[9] At one point during the legislative process, the 2009 bill was amended to set forth a detailed procedure for the parties to attempt to mutually agree on a hearing officer. (MJN, pp. 92-93.) That provision was deleted from a later version of the bill. (MJN, pp. 104-105.) As Dignity Health has explained (Answer Brief at 53), mutual selection is reserved only for peer review hearings in which an arbitrator is selected to preside and decide the matter. (Bus. & Prof. Code, § 809.2, subd. (a).)

common-law principles regarding appearance of bias. (CMA Br. at 10, 22-27.) As explained, the statutory standard in section 809.2(b) codified the common law and applies now. (See, e.g., *El-Attar*, 56 Cal.4th at 988.) There is no basis, 30 years later, to rewrite the statutory procedure that the Legislature, at CMA's urging, found necessary and sufficient to protect physicians.

Seeking to rely on common law rather than the directly applicable statute, CMA argues that *Haas*, 27 Cal.4th 1017 and *Yaqub v. Salinas Valley Mem. Healthcare System* (2004) 122 Cal.App.4th 474 set the "governing" standard for impartiality of hearing officers in physician peer review. (CMA Br. at 32.) CMA goes so far as to assert that *Yaqub* "established" the standard for hearing officer bias as "whether a person aware of the facts might reasonably entertain a doubt that the judge would be able to act with integrity, impartiality, and competence." (CMA Br. at 11.) CMA asserts that "*Yaqub*'s approach to analyzing hearing officer bias is the proper interpretation and application of a legal standard for hearing officer impartiality." (*Ibid.*) There are many problems with this assertion.

First, it ignores the statute. The standard articulated in *Yaqub* is entirely different from the "direct financial benefit from the outcome" standard stated in section 809.2(b). That statute inexplicably was not mentioned in *Yaqub* and was irrelevant in *Haas*.

CMA tries to neutralize *Yaqub*'s fatal omission, surmising that "*Yaqub* was aware of section 809.2 but did not rely on the statutory language, *opting instead* to rely on common law case

precedents and due process principles foundational to the statutory language to discern the scope of a hearing officer impartiality standard."[10] (CMA Br. at 34 [emphasis added].) This is highly dubious speculation. A court is not free to "opt" to ignore an on-point statute and apply different law "instead." The *Yaqub* court clearly erred in disregarding the statute, and that disregard of binding authority makes the *Yaqub* decision not the "governing standard," but rather "a deviation from the strong current of precedent and therefore 'a derelict on the waters of the law,'" as the Court of Appeal put it. (*Natarajan*, 42 Cal.App.5th at 391 [citation and some internal quotation marks omitted].) In the context of physician peer review reportable to the Medical Board, it is section 809.2(b) that sets the "governing" standard.

CMA also tries to get around *Yaqub*'s failure to mention 809.2(b) by speculating that *Yaqub*'s application of common-law, non-statutory principles was in effect nothing more than a correct application of the "impartiality" requirement of subdivision (c). *Yaqub* did not mention subdivision (c), just as it did not mention subdivision (b). At any rate, applying the general concepts of "impartiality" under the common law would not validate *Yaqub*'s

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[10] CMA's assertion that the *Yaqub* court was "aware" of section 809.2(b)'s standard is inconsistent with Natarajan's own assertion that the *Yaqub* court did not discuss section 809.2(b) because the parties did not argue about the statute. (See Petitioner's Opening Brief on the Merits p. 62.) Again, speculation regarding why *Yaqub* neglected to address the applicable statute is unimportant because *Yaqub* is wrongly decided. Further, *Yaqub* does cite section 809.2(a), thus undermining CMA's factual assumption that the court chose to avoid the statute. (*Yaqub*, 122 Cal.App.4th at 487.)

analysis. The court was not permitted to ignore the statutory subdivision directly on point (subdivision (b)).

Second, Dignity Health's brief explained at length why *Haas* is inapplicable in the physician peer review context, including that the "hearing officer" in *Haas* was an adjudicator with responsibility for deciding the petitioner's case on the merits. (Answer Brief, pp. 57-62.) *Yaqub* simply assumed without discussion that *Haas* applied. CMA's own discussion of *Haas* is replete with specific references to "adjudicators," which is understandable as *Haas* refers to adjudicators 53 times. (CMA Br. at 32-33.)[11]

Third, even if *Haas* were applicable to private hospital peer review, *Haas* explained that any implication of bias due to possible future work may be avoided by restricting future work with the entity for a certain period. The *Haas* Court said that such a restriction would "eliminate the risk of bias" that might arise from the prospect of future work. (*Haas*, 27 Cal.4th at 1037, fn. 22.) St. Joseph's did that here, agreeing with the hearing officer that he would be ineligible to work as a hearing officer at St. Joseph's' medical staff peer review hearings for three years. CMA does not mention this key fact nor does it discuss *Haas* in this respect. But CMA cannot have it both ways. If, as CMA assumes, *Haas* applies to medical staff peer review proceedings, then CMA must acknowledge that hospitals comply

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[11] CMA's speculation about the outsized influence of hearing officers on peer review decisions, despite the fact that hearing officers "have no part in the decisionmaking process" (*Mileikowsky*, 45 Cal.4th at 1271), is discussed *infra* Part II.E.

with *Haas* when they impose the temporal restriction that existed here.

Fourth, CMA argues that *Haas*'s and *Yaqub*'s reliance on common law shows that "[s]ection 809.2 . . . cannot be read in isolation based exclusively on the language contained in a single subdivision. The legislative genesis of the section and the case law applicable to hearing officer bias does [sic] not support such a narrow interpretation." (CMA Br. at 35.) But section 809.2(b) is the subdivision in which the Legislature expressly addressed the grounds for disqualifying a peer review hearing officer for financial bias. And neither *Haas* nor *Yaqub* has any relevance to how to interpret subdivision (b), which neither mentioned. *Haas* did not involve subdivision (b) because it was not a medical staff peer review case, but rather involved an administrative law judge who adjudicated a license revocation proceeding. That judge had no choice but to rely on common law because there were no statutory standards applicable to those administrative proceedings. (See *Haas*, 27 Cal.4th at 1036 [observing that "[t]he problem" of impermissible financial bias in that case "arises from the lack of specific statutory standards governing temporary hearing officers appointed by counties under Government Code section 27724"].) *Yaqub* was a hospital peer review case but the decision inexplicably ignored the statute. So neither of these cases supports the notion that common-law principles impact how section 809.2(b) should be interpreted or requires the use of a different standard from the one in the statute.

C. CMA erroneously equates the fair procedure required by the statute with due process.

Dignity Health's Answer Brief explains in detail how and why physician peer review at private hospitals is governed by "fair procedure," not "due process." (Answer Br. at 45-50.) This Court has explained that "rudimentary procedural and substantive fairness," not due process, is required for private hospitals' peer review hearings. (*Ezekial v. Winkley* (1977) 20 Cal.3d 267, 278; see also *Anton v. San Antonio Commun. Hosp.* (1982) 132 Cal.App.3d 638, 653-654 ["our high court has been meticulously consistent in pointing out that the requirement does not derive from the constitutional guarantees of due process of law but, rather, from established common law principles of fairness"] [citations and internal quotation marks omitted]; *Pinsker v. Pacific Coast Soc'y of Orthodontists* (1974) 12 Cal.3d 541, 550, fn. 7 [noting that constitutional due process does not apply to private peer review proceedings].) Nonetheless, CMA argues that the two concepts are substantively identical and used interchangeably in the legislative history of S.B. No. 1211 and case law.[12] CMA accuses the Court of Appeal of "drawing a chasmic distinction" between fair procedure and due process.

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[12] If the "fair procedure" applicable to physician peer review at private hospitals were just another, interchangeable name for "due process," it is difficult to understand why the alternative term even exists. "Due process" is a well-established concept, and using another term to describe the same thing would only create confusion. For instance, CMA says it uses the terms due process and fair procedure interchangeably; but it also asserts that sometimes "they might have distinct meanings." (CMA Br. at 29.)

(CMA Br. at 29.) However, this Court has made clear that the distinction between the two concepts is "important." (*Pinsker*, 12 Cal.3d at 550, fn. 7; see also *Anton*, 132 Cal.App.3d at 653-654.)

Moreover, "due process" applies to state actors (*Garfinkle v. Superior Court* (1978) 21 Cal.3d 268, 276-277, 281-282), and there is no basis to deem private hospitals subject to due process without the Legislature actually saying so.[13]

Not only did the Legislature not say so, but the express language of the peer review statute reflects that the Legislature was well aware of the distinction between the fair procedure applicable to private hospitals and the due process applicable to state hospitals. Thus, the Legislature *exempted* "peer review proceedings conducted in state or county hospitals" from the procedural requirements of all of section 809 et seq. (including section 809.2) and confirmed that the exemption "shall not affect the obligation to afford due process of law to licentiates involved in peer review proceedings in these hospitals." (Bus. & Prof. Code, § 809.7.) In other words, the statutory procedures do not apply to public hospitals, but the Legislature acknowledged and confirmed that due process requirements *do* apply. If statutory procedures were the same as due process, there would have been no reason for the Legislature to exempt state hospitals from the statute—that would have been another idle, superfluous act.

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[13] CMA does not acknowledge the fact that private hospitals are not state actors and therefore are not subject to due process, despite Dignity Health's citation to multiple decisions holding that private hospitals and other health care providers are not state actors. (See Answer Br. at 47-48.)

CMA cites section 809.7, but it does so as purported *support* for its argument that due process and fair procedure are interchangeable. Its argument does not support its conclusion. CMA says: "The separate origins of both standards [due process and fair procedure] were well [e]stablished long before S.B. 1211 was introduced to the Legislature, and it must be presumed that the Legislature was acutely aware of such a fundamental distinction in the law." (CMA Br. at 31-32.) However, the "presum[ption] that the Legislature is aware of laws in existence when it enacts a statute" (*Meza v. Portfolio Recovery Assocs., LLC* (2019) 6 Cal.5th 844, 862-863) confirms that CMA's argument is wrong. The Legislature's recognition that state hospitals are exempt from the statutory requirements, yet still subject to due process, means that private hospitals are, conversely, subject to the statute and not to due process.[14]

D. CMA agrees with Dignity Health that qualified hearing officers are necessary to effective peer review.

A major theme of Natarajan's argument is that hearing officers should not be selected from the small pool of experienced

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[14] Natarajan has argued that the Legislature enacted section 809.7 because it did not want to apply "additional due process protections to public hospitals that were already governed by constitutional due process principles." (Petitioner's Reply Brief at 17.) But "constitutional due process principles" are presumably the gold standard for procedural protections; Natarajan does not identify what "additional due process protections" are required for private and not public hospitals. And he also contradicts himself by arguing that the statutory fair procedure protections are coextensive with constitutional due process.

health care attorneys who generally perform such work. He has repeatedly contended that no expertise is necessary or desirable for peer review hearing officers, and that hearing officers should be retired judges and other neutrals working through JAMS or similar organizations. According to Natarajan, this is the solution to the financial and other bias that he believes arises from medical staffs' and hospitals' reliance on a pool of hearing officers with expertise in physician peer review. Dignity Health and its amici have explained why the use of novice hearing officers is not practicable. (See Answer Br. at 55-57; Amicus Curiae Brief of California Hospital Association (CHA Br.) at 26-32; Amicus Brief of Hearing Officers Carlo Coppo et al. (Hearing Officer Br.) at 11-19.)

CMA agrees with Dignity Health. (See CMA Br. at 16 ["attorney hearing officers [are] best equipped—with their legal training, experience, and background—to serve fairness and efficiency in peer review proceedings"]; *ibid.* ["it has become the industry standard for skilled healthcare attorneys to fill the [hearing officer] role"]; *id.* at 17 ["The experience and knowledge required of [California Society of Healthcare Attorneys'] attorney hearing officers is [sic] necessary to navigate the myriad procedural and evidentiary issues that often arise during peer review proceedings"].) In fact, CMA's brief goes to great lengths to ensure that this Court is fully educated regarding the value—and necessity—of the use of experienced health care attorneys as hearing officers for medical staff peer review hearings.

CMA's strong endorsement of Dignity Health's position in

this respect further shows the inherently unworkable effect of the rule that Natarajan urges, whereby a hearing officer would have to be disqualified from virtually every assignment because he or she could always be hired again to preside over another peer review hearing at another hospital. Natarajan has never addressed this flaw in his argument or that the small pool of qualified hearing officers would quickly be depleted.[15]

E. CMA overstates and misrepresents the purported influence of hearing officers on the outcome of peer review hearings.

CMA speculates that physician peer review hearing officers have a highly influential role in the outcome of peer review proceedings, which justifies the need for a broad disqualification rule.[16] According to CMA, the various functions with which a hearing officer is tasked by statute, bylaws, and case law, and the supposed "deference" afforded to a hearing officer by the decision-making JRC panel because of his "expertise," make the potential impact of a hearing officer's bias particularly acute. (CMA Br. at 16 ["the expansive role of hearing officers undoubtedly allows them, wittingly or not, to tip the balance of the proceedings"].) CMA's speculative concerns are overstated as to the first point

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[15] CMA argues that experienced hearing officers are necessary because of their expertise in peer review hearing matters, but at the same time argues that this very expertise causes them to have undue influence on the decision-making panel. (See *infra* Part II.E.2.)

[16] CMA compares hearing officers to "Charon, the Greek mythological ferryman guiding souls across the river Styx to their final destiny." (CMA Br. at 13.) But Charon was not said to have had any particular influence in what that final destiny was.

and misrepresented as to the second.

1. The hearing officer's role is limited.

The statute grants hearing officers certain authority, but also limits their authority. Section 809.2 provides, but does not require, that a hearing officer may be appointed to preside at a peer review hearing.[17] (Bus. & Prof. Code, § 809.2, subd. (b) ["*If* a hearing officer is selected to preside at a hearing held before a panel . . ."] [emphasis added].) When a hearing officer is selected to preside, the statute "carefully limit[s] the authority of the [hearing] officer." (*Mileikowsky*, 45 Cal.4th at 1269.) The statute requires that the hearing officer shall not act as a prosecutor or advocate and may not vote. (Bus. & Prof. Code, § 809.2, subd. (b); *Mileikowsky*, 45 Cal.4th at 1271 ["the [hearing] officer, who 'shall not be entitled to vote[,]' has no part in the decisionmaking process and no authority to prevent the reviewing panel from reviewing the recommendation"] [citation omitted].)

Medical staff hearings in which a hearing officer presides always involve a separate JRC-decisionmaker in addition to the hearing officer. (Bus. & Prof. Code, § 809.2, subds. (a), (b).) The ultimate decision following the hearing will be "[a] written decision *of the trier of fact* . . . ." (Bus. & Prof. Code, § 809.4, subd. (a)(1) [emphasis added]; see also *Mileikowsky*, 45 Cal.4th at 1234 ["The merits are determined by the trier of fact, often a panel drawn from other of the physician's peers."]; Bus. & Prof. Code, § 809.05, subd. (a) ["In all peer review matters, the

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CMA's analogy does not support its argument.

[17] Under CMA's Model Bylaws, the appointment of a hearing

governing body shall give great weight to the actions of *peer review bodies* . . ."] [emphasis added]; *id.*, § 805, subd. (a)(1)(B) [defining "peer review body" to include a medical staff].) The hearing officer has no medical expertise (as CMA itself explains) and thus is not in a position to weigh in on the ultimate facts that will be dispositive of the case. If his actions effectively decide the merits, the decision will be invalidated. (See *Mileikowsky*, 45 Cal.4th at 1273 [a hearing officer's "order dismissing the proceedings is a far cry from a ruling on a procedural or evidentiary issue . . ."].)

Hearing officers' duties include ruling on challenges to the impartiality of the panel and the hearing officer (Bus. & Prof. Code, § 809.3, subd. (c)); and making rulings on the relevance of evidence (Bus. & Prof. Code, § 809.3, subd. (a)(4)), discovery (*id.*, § 809.2, subd. (d)), and requests for continuances. (*Id.*, § 809.2, subds. (d), (g).) A hearing officer may "impose any safeguards the protection of the peer review process and justice requires." (Bus. & Prof. Code, § 809.2, subd. (d).)[18]

In fact, in section 809, the Legislature minimized the role of the hearing officer as compared to HCQIA, the federal peer review law. HCQIA provides that a presumptively fair hearing

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officer is mandatory. (CMA Model Bylaws § 7.4-3, MJN p. 166.)

[18] CMA does not object to hearing officers having a broad range of duties. In 2009, CMA sought to *require* hearing officers to have "the authority and discretion to make all rulings on questions pertaining to matters of law, procedure, or the admissibility of evidence." (MJN, p. 75.) This same provision is in CMA's Model Bylaws. (MJN, p. 167.)

may be held "before an arbitrator who is mutually acceptable to the physician and the health care entity, *or before a hearing officer,*" or before a panel of individuals who are not in direct economic competition with the physician. (42 U.S.C. § 11112, subd. (b)(3) [emphasis added].) Section 809 does not include the option to use a hearing officer as adjudicator. Only a JRC panel or an arbitrator can perform that role. (Bus. & Prof. Code, § 809.2, subd. (a); *Mileikowsky*, 45 Cal.4th at 1234.)

Medical staff bylaws and case law may set forth additional tasks and roles. (Bus. & Prof. Code, § 809.6, subd. (a).) If a particular medical staff's bylaws grant a hearing officer additional powers, that means the medical staff—of which the subject doctor is a member—voted for that provision.

CMA speculates that these ordinary functions of hearing officers give hearing officers such undue influence over peer review proceedings that a stringent disqualification requirement is called for. But the degree of a hearing officer's potential to influence the outcome of the proceedings, if it exists, is built into the statute and is therefore accommodated by existing protections, including the requirement that a hearing officer "shall gain no direct financial benefit from the outcome."

CMA also speculates, with no factual support, that a hearing officer would use his or her "influence" only in a way that favors the medical staff and hospital as opposed to the physician. CMA did not believe that its speculative concerns about a hearing officer's purported outsized influence on peer review proceedings required any different law from the one it sponsored when the

Legislature enacted section 809. Nothing CMA says decades later provides a basis to override the standard the Legislature enacted as part of the same bill that granted the authority and tasks to hearing officers in the first place. And nothing CMA says provides a basis to presume, without particular evidence and proof in the record of a particular case, that a hearing officer carrying out his or her ordinary duties will have any undue or improper influence on the outcome of the proceeding. To the extent a hearing officer's legal, procedural, and evidentiary rulings may trickle down to have an effect on the way the case is ultimately decided, that is no different from a jury trial where the judge makes such rulings but does not decide the case or a case where a discovery referee makes a recommendation to a judge.

CMA argues that hearing officers have discretion to take various actions, but the cases it cites do not speak to a hearing officer's ability to adjudicate a matter or influence the outcome. (See *Unnamed Physician v. Board of Trustees of Saint Agnes Med. Ctr.* (2001) 93 Cal.App.4th 607, 620 [hearing officer's statutory responsibility to make evidentiary and discovery rulings included the power to change his mind and reverse those rulings]; *Sadeghi v. Sharp Mem. Med. Ctr. Chula Vista* (2013) 221 Cal.App.4th 598, 619 [hearing officer's statutory responsibility to "impose any safeguards the protection of the peer review process and justice requires" includes the right to restrict ex parte communications].) The tasks the Legislature assigned to hearing officers are by their nature discretionary (*e.g.,* ruling on evidentiary and scheduling issues), yet the

Legislature imposed only the "no direct financial benefit from the outcome" standard.

The undue influence of a hearing officer posited by CMA would exist in every case that has a hearing officer, and would be just as likely to favor the physician as the hospital. Yet this Court has not indicated concern for undue bias in the ordinary course of the proceedings, even when it scrutinized the hearing officer's role. (See *Mileikowsky*, 45 Cal.4th at 1269-1272.)

2. CMA misrepresents the "deference" afforded hearing officers.

CMA speculates that "[p]recisely because of a hearing officer's legal expertise, deference is often given to them by the peer review panel." (CMA Br. at 17.) While CMA advocates for the use of experienced health care attorneys as hearing officers—and CMA's proposed 2009 legislation would have *required* that every hearing officer be "an attorney licensed to practice law in the State of California" (MJN, p. 75)—its brief raises a nefarious specter of some inherently improper influence over the proceedings when hearing officers are attorneys.[19]

CMA's discussion of the "influence" of hearing officers is misleading speculation because it relies on sources that have nothing to do with peer review proceedings or hearing officers and it assumes, based on no facts, that any influence would be

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[19] CMA says (without citation) that in this case "[t]here is little doubt that the physician members of the peer review panel worked closely with the hearing officer during the proceedings and relied upon the hearing officer's expertise to address the legal matters that arose throughout the process." (CMA Br. at 17.)

prejudicial to the physician. CMA asserts that "this dynamic between the hearing officer and the panel members can result in the hearing officer having tremendous influence over the proceedings" and that this is "well supported by empirical research." (CMA Br. at 17.) However, the studies and research it cites (CMA Br. at 19-21) do not address attorneys who serve as non-adjudicator hearing officers in physician peer review matters. CMA even concedes that "direct research on the impact of legal experts on peer review panels are [sic] lacking." (CMA Br. at 19.)

CMA tries to extrapolate to the peer review JRC/hearing officer relationship from research in the inapposite contexts of attorneys serving as expert witnesses or advisors to adjudicators and of judges' instructions and commentary to juries. (CMA Br. at 19-20.)[20] The final paragraph of CMA's discussion, which purports to tie in the social research to the specific context of physician peer review, contains no citations to authority whatsoever and is nothing more than irrelevant speculation. (CMA Br. at 21.)

CMA's comparisons are baseless. For instance, CMA's premise that a hearing officer's legal expertise necessarily makes him or her equivalent to an expert witness/advocate with a point of view on the merits of how a JRC should decide the matter and an intent to "influence" the JRC's decision is false. (CMA Br. at 19.) It is directly contrary to the statutory prohibition on hearing

[20] The entire topic of empirical research about how juries are influenced is far afield of CMA's supposed expertise and

officers acting as "advocate[s]" and thus is contrary to the presumptions that "[t]he law has been obeyed" (Civ. Code, § 3548) and "official duty has been regularly performed." (Evid. Code, § 664.) CMA presumes that the law is not being obeyed when hearing officers perform their functions.

CMA's analogy to expert witnesses also is flawed. The very purpose of an expert witness is to influence the outcome by giving testimony (in exchange for payment) intended to "assist the trier of fact" in deciding the merits. (Evid. Code § 801.) Physician peer review hearing officers are very different. They have a specific role, defined by the statute and bylaws, and have been granted—also by statute and bylaws—authority to make certain peripheral or procedural decisions. By accepting those decisions made by a hearing officer, a panel is not giving "deference" to the hearing officer; it is simply allowing the hearing officer to perform his or her function.

CMA also analogizes to the deference that lay juries may give judges who instruct the jury and make remarks about the case. The sources it cites in support are confusing and it is not clear how CMA thinks they apply here. In any event, there is nothing analogous in the relationship between an experienced judicial officer and a jury empaneled under the direction and supervision of the judge, made up of laypersons with no prior exposure to legal proceedings or to the cases they are asked to decide. JRC panel members may not be experienced in law and procedure, but they are very experienced in the subject matter

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perspective on medical staff matters.

before them, are themselves members of medical staffs and familiar with their standards of practice, and have voluntarily taken on the role of hearing panel member. Physician peer reviewers also are fiercely independent and take no pleasure in committing to the thankless task of sitting in judgment of their peer physicians. (See *Kibler v. Northern Inyo County Local Hosp. Dist.* (2006) 39 Cal.4th 192, 201 [noting that participation in peer review "is voluntary and unpaid, and many physicians are reluctant to join peer review committees so as to avoid sitting in judgment of their peers"]; *Westlake Community Hospital v. Superior Court* (1976) 17 Cal.3d 465, 484 [noting that peer reviewers "take on, often without remuneration, the difficult, time-consuming and socially important task of policing medical personnel"].)

The sole peer-review-related source cited by CMA is a study by Lumetra. CMA says peer review participants who responded to the study "highly rated the effectiveness of a peer review hearing to ensure both individual rights and proper process." (CMA Br. at 18.) CMA suggests that "deference is strongly linked to the perception of procedural justice," without explaining what that means. (*Ibid.*) Because hearing officers are in charge of the "process," CMA assumes from the study's statement that JRCs defer to hearing officers. But the table CMA cites for this point does not support any inference that JRC panels are affording undue deference to hearing officers. At most, it suggests that hearing officers are doing a capable job at

overseeing the process.[21]

F. CMA's suggestion that corporate ownership of one or more hospitals may lead to hearing officer bias is unsupported and speculative.

Another central premise of Natarajan's argument is that Dignity Health, the corporate owner of St. Joseph's and other hospitals, influenced the selection of the hearing officer in this case and may do so again in other cases at other Dignity Health hospitals. According to Natarajan, this common ownership and asserted influence over hiring decisions means that hearing officers believe that if they can make sure the JRC rules in favor of the medical staff of a Dignity Health hospital in a peer review proceeding, they will be retained for future hearing officer engagements at other Dignity Health hospitals and must be presumed to be inherently biased in favor of any and all Dignity Health medical staffs and hospitals. Dignity Health and its amici have explained why that is wrong. (See, e.g., Answer Br. at 70-78; Hearing Officer Br. at 22-26; Amicus Brief of Adventist Health et al. (Adventist Br.) at 20-27.)

CMA picks up on Natarajan's theme, offering vague innuendo suggesting that hospital corporations may nefariously direct medical staff proceedings at individual hospitals, which CMA speculates would cause hearing officers to favor the

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[21] Further, CMA itself has thoroughly discredited the study. (See http://www.allianceforpatientsafety.org/ca-senate-report.pdf p. 14 [describing CMA's published criticisms of the Lumetra study's "methodology, conclusions, and recommendations," including "that the surveys used by Lumetra were poorly designed and the hospitals did not respond or completely respond to the surveys"].)

hospitals in order to enhance the prospect of future work. CMA argues that courts should pay "careful attention" and apply "[c]areful scrutiny" to a physician's claim that a hearing officer is biased due to alleged corporate influence, particularly where a hospital's owner owns other hospitals as well. (CMA Br. at 13, 40.) CMA speculates that "[t]he decisions made in particular peer review cases at a particular local facility could be colored by the hearing officers [sic] desire to cultivate such relationships with corporate headquarters." (CMA Br. at 39.)

But as CMA acknowledges, a hospital's medical staff is an independent and self-governing body that exercises control over its own peer review. (CMA Br. at 38 [citing Bus. & Prof. Code, § 2282; Cal. Code Regs., tit. 22].) Thus, the default presumption is that it is the individual medical staff of an individual hospital that selects hearing officers for peer review proceedings in that hospital. Business and Professions Code section 2282.5 (which CMA sponsored but does not cite) specifies particular rights and responsibilities of the *independent* medical staff, including "[e]stablishing, in medical staff bylaws, rules, or regulations, criteria and standards . . . for medical staff membership and privileges, and enforcing those criteria and standards," and "[e]stablishing, in medical staff bylaws, rules, or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities." (Bus. & Prof. Code, § 2282.5, subds. (a)(1), (2).)

CMA also acknowledges that a medical staff may lawfully delegate particular peer review functions to a hospital. (CMA Br.

at 38; see also *El-Attar*, 56 Cal.4th at 989 [confirming that a medical staff may delegate certain duties to a hospital].) The trial court here found in an unchallenged finding that the medical staff permissibly authorized hospital representatives to contact and contract with the hearing officer. Necessarily, such a delegation of duties says nothing about corporate influence over hearing officer selection at any hospital and does not give rise to any inference of bias or improper influence. As CMA itself explains, "[t]he peer review laws do not contemplate a strict separation between the medical staff and the hospital governing body as a prerequisite for fairness." (CMA Br. at 41.) CMA also explains that "it is important also to observe that bias cannot be presumed out of structural arrangements alone." (CMA Br. at 41.)

CMA speculates that hospital mergers create enhanced danger of corporate influence on hearing officers' motivations, because mergers mean that one entity controls a greater number of hospitals (although CMA appears to approve of the efficiencies achieved by such mergers). (CMA Br. at 36-38.) But CMA's pure speculation that ownership of more hospitals means the corporate owner will interfere in or influence more hospitals' medical staff peer review proceedings is unsupported by any citation to evidence or any authority and is plainly counterintuitive. The more logical assumption is that as a hospital system increases in size, the corporate parent entity will have less ability and time to devote individualized attention to what is going on with the medical staff peer review proceedings

at each (or any) hospital—to the extent it does so at all. The real significance of hospital mergers to this case is that they exacerbate the problem posed by Natarajan's proposed standard: that the pool of qualified hearing officers would quickly dwindle if each is disqualified from work at every hospital within a hospital system simply by performing work at one hospital.

CMA's argument is wholly speculative and supported by no evidentiary citations. (CMA Br. at 39 ["Although each facility within the [hospital] system may retain some local control (including having local advisory boards), hospital systems use a large degree of central control. This reality cannot be ignored in evaluating hearing officer impartiality."]; *ibid.* ["Hearing officers *could*, for instance, have relationships with system corporate offices that have control over local facility decision-making. The decisions made in particular peer review cases at a particular local facility *could* be colored by the hearing officers [sic] desire to cultivate such relationships with corporate headquarters."] [emphasis added].)

CMA says that "[a]n approach that focuses only on the hearing officer's relationship with an individual medical staff at an individual hospital in the larger system would fail to take account of the realities of how large hospital systems function." (CMA Br. at 40.) But CMA's approach ignores the realities (which it elsewhere concedes exist, see CMA Br. at 38) that a medical staff is, by law, independent and that a medical staff's delegation of a function to a hospital administrator is not in itself a cause for any concern.

Finally, CMA discusses the recent ministry affiliation between Dignity Health and another faith-based hospital system, Catholic Health Initiatives. (CMA Br. at 37-38.) That affiliation is patently irrelevant to this case, in which the peer review hearing took place years ago. Moreover, there is nothing about the affiliation that even arguably would impact the ability of the corporate owner to interfere in or influence peer review proceedings at individual California hospitals. Peer review is a state-controlled matter (subject to federal requirements imposed by HCQIA), and the affiliation does not change anything in California, where only Dignity Health (not its affiliation partner) operates hospitals.

G. CMA's "guiding principles" do not support applying an appearance of bias standard broader than the statute requires.

CMA concludes its brief by suggesting three "guiding principles" for evaluating hearing officer impartiality. (CMA Br. at 40-42.) CMA ignores the fact that the Court is not writing on a blank slate and that an on-point statute governs the subject matter. To the extent guiding principles have any role to play in this statutory interpretation case, CMA's approach fails.

CMA's first guiding principle is that a court should scrutinize a hearing officer's "prior work with the hospital system and any one or more local hospitals within the system to uncover *potential patterns of bias*." (CMA Br. at 40 [emphasis added].) CMA's speculative and vague construct of "potential patterns of bias" is not the law as written and cannot be reconciled with the concrete statutory standard of "direct financial benefit from the

outcome." CMA also presumes that hearing officers' potential bias would only operate one way, to the detriment of the physician.

CMA's focus on a hearing officer's "prior work" is similarly misplaced. *Past* employment is irrelevant to bias where there is no evidence of potential *future* employment of a hearing officer. (*Thornbrough v. Western Placer Unified Sch. Dist.* (2013) 223 Cal.App.4th 169, 188 [no financial bias shown where decision-maker/hearing officer was asked about past and present employment but not "about *future* employment prospects with the District"] [emphasis in original].) In fact, CMA proposed in 2009 to add a provision to the statute that would have disqualified only those hearing officers with certain *specific* and past financial relationships to the hospital: "Except as otherwise agreed by the parties, an attorney from a firm utilized by the hospital, the medical staff, or the involved licentiate within the preceding two years shall not be eligible to serve as a hearing officer." (MJN, p. 117.) That provision did not become law. (MJN, p. 64.) Even if a hearing officer's past relationship with a hospital might provide some evidence of a supposed tendency to take actions that favor the hospital, a contractual restriction on future work as contemplated by *Haas* (assuming *Haas* has any application) negates that inference. (*Haas*, 27 Cal.4th at 1037, fn. 22.)

CMA's second "guiding principle" is that "courts should not rely too heavily on corporate formalities and subsidiary relationships that may not reflect the true influence that corporate headquarters exercise over local facilities" because

hearing officers purportedly are subject to "temptations" that "are not limited to such legal distinctions." (CMA Br. at 41.) The applicable statutory standard, however, is not a "temptation" to favor the corporate owner of a hospital, but a "direct financial benefit from the outcome." And whatever the corporate formalities of a particular set of entities, that does not change the fact that the statutorily independent and self-governing medical staff is presumed to have made its own decision regarding selection of a hearing officer or has delegated the decision to its own hospital, as happened in this case. Absent actual evidence of a direct influence in a particular case of a corporate parent over a subsidiary hospital and that hospital's independent medical staff to select particular hearing officers who may favor the hospital, the corporate structure is unlikely to create a direct financial benefit from the outcome. "[B]ias cannot be presumed out of structural arrangements alone," as CMA properly acknowledges. (CMA Br. at 41.)

Finally, CMA's third "guiding principle" is that "it is more likely that hearing officer bias will be rooted in temptations to please hospitals and hospital systems [as opposed to medical staffs]. Hospitals (not medical staffs) are the ones paying hearing officers. And most importantly, hospitals (not medical staffs) exercise final authority over the peer review matter." (CMA Br. at 41.)

CMA asks courts to assume that hearing officer bias inherently arises from the hospital's role as payor and as ultimate decisionmaker regarding physician privileging and

membership. The law is clear, however, that payment of a hearing officer does not give rise to an inference of bias. (*El-Attar*, 56 Cal.4th at 996; *Thornbrough*, 223 Cal.App.4th at 189.)

And a hospital board's final say over the ultimate outcome of a physician's disciplinary proceeding likewise does not give rise to any inference of bias. It could not do so, because the hospital necessarily has the last word in every case, regardless of the identity of the hearing officer and regardless of what disqualification rules were applied. Because a hospital may be sued for "negligently failing to ensure the competency of its medical staff and the adequacy of medical care rendered to patients at its facility," and "[h]ospital assets are on the line," "[a] hospital's governing body must be permitted to align its authority with its responsibility and to render the final decision in the hospital administrative context." (*Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center* (1998) 62 Cal.App.4th 1123, 1143 [citing *Elam v. College Park Hosp.* (1982) 132 Cal.App.3d 332].) This responsibility and authority cannot give rise to any inference of bias on the part of a hearing officer who knows that the hospital entity will make the final decision in every case.

CMA's speculative suggestion that there is a "greater pay off for hearing officers to appease hospitals" (CMA Br. at 41) does not create a "direct financial benefit from the outcome." It is just rank speculation, at odds with the statutory and case law limitations on what hearing officers can and cannot do, and it defies common sense. (See Adventist Br. 20-27 [negating the

suggestion that hospitals want to hire hearing officers who orchestrate rulings in the hospitals' favor].)

III. RESPONSE TO AMICUS CURIAE BRIEF OF AMERICAN ACADEMY OF EMERGENCY MEDICINE

AAEM's brief provides no assistance to the Court in deciding the issues presented in this case. The brief argues only that it is important that physician peer review be conducted fairly. That is not in dispute. The brief does not provide any argument or authority about the appropriate analysis of the financial bias of a hearing officer—the issue presented in this case. Ultimately, the brief serves no purpose other than to reinforce that multiple associations that advocate for physicians do *not* support the disqualification rule for which Natarajan argues in this case.

IV. CONCLUSION

The Legislature has stated the applicable rule for hearing officer bias, and it was not met here. Neither amicus presents any basis for expanding the disqualification standard the Legislature chose to impose based on an intolerable risk of bias. The Opinion should be affirmed.

Dated: January 14, 2021 MANATT, PHELPS & PHILLIPS, LLP

By: /s/ Barry S. Landsberg
Attorneys for Respondent
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CERTIFICATE OF WORD COUNT

Pursuant to California Rules of Court, rule 8.520(c), I certify that this Answer to Briefs of Amici Curiae contains 10,137 words, not including table of contents, table of authorities, the caption page, or this Certification page.

Dated: January 14, 2021 MANATT, PHELPS & PHILLIPS, LLP

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PROOF OF SERVICE

I, Brigette Scoggins, declare as follows:

I am employed in Los Angeles County, Los Angeles, California. I am over the age of eighteen years and not a party to this action. My business address is Manatt, Phelps & Phillips, LLP, 2049 Century Park East, 17th Floor, Los Angeles, California 90067. On **January 14, 2021**, I served the within: **RESPONDENT'S CONSOLIDATED ANSWER TO BRIEFS OF AMICI CURIAE CALIFORNIA MEDICAL ASSOCIATION AND AMERICAN ACADEMY OF EMERGENCY MEDICINE** on the interested parties in this action addressed as follows:

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Brigette Scoggins

STATE OF CALIFORNIA
Supreme Court of California

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Date

/s/Joanna McCallum

Signature

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