IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

FILED WITH PERMISSION

No. S259364

SUNDAR NATARAJAN, M.D., Petitioner and Appellant, v. DIGNITY HEALTH, Respondent.	Court of Appeal Case No. C085906 County of San Joaquin Superior Court No. STK-CV-UWM-20164821

PETITIONER SUNDAR NATARAJAN, M.D.'S ANSWER TO AMICUS CURIAE BRIEFS OF THE (1) CALIFORNIA HOSPITAL ASSOCIATION; (2) ADVENTIST HEALTH, KAISER FOUNDATION HOSPITALS, MEMORIALCARE HEALTH SYSTEM, PROVIDENCE ST. JOSEPH HEALTH, SHARP HEALTHCARE, AND SUTTER HEALTH; (3) SCRIPPS HEALTH AND THE REGENTS OF THE UNIVERSITY OF CALIFORNIA; AND (4) PATRICK K. MOORE, GLENDA ZARBOCK, CARLO COPPO, JOHN HARWELL AND JAMES R. LAHANA

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. **PETITIONER'S ANSWER TO AMICUS BRIEFS**

I. INTRODUCTION

Petitioner and Appellant Sundar Natarajan, M.D. submits this Consolidated Answer to the amicus curiae briefs filed in support of Respondent Dignity Health by (1) the California Hospital Association ("CHA"); (2) Adventist Health, Kaiser Foundation Hospitals, Memorialcare Health System, Providence St. Joseph Health, Sharp Healthcare, and Sutter Health ("Adventist Health et al."); (3) Scripps Health and the Regents of the University of California ("Scripps and UC"), and (4) Patrick K. Moore, Glenda Zarbock, Carlo Coppo, John Harwell and James R. Lahana ("Moore et al.") These amici are hereafter collectively referred to as "Dignity Amici."[1]

Dignity Amici primarily rely on a policy argument that permitting physicians to disqualify hearing officers with an appearance of bias will impair hospital peer review and therefore endanger the public. They claim that only experienced "qualified" attorneys can competently preside over hospital hearings; that if physicians are permitted to disqualify hearing officers with an appearance of bias, it will be difficult for hospitals to find a

[1] On December 28, 2020, Dr. Natarajan filed a Motion to Strike four of the arguments of Moore et al. on the ground that they were an attempt to augment the factual record with facts outside the record. Since the Motion has not been granted at the time of this writing, Dr. Natarajan will address those arguments of Moore et al. in this Answer.

"qualified" hearing officer; choosing neutral hearing officers and requiring due process will cause delay in hearings; and hospitals cannot afford to use neutral hearing officers.[2] This brief will primarily address Dignity Amici's policy arguments, since they constitute the bulk of their briefs.

However, the most important aspect of Dignity Amici's policy arguments is their irrelevance. They are based on a claim that the financial and administrative burdens of using neutral hearing officers outweighs the benefit of doing so. As discussed in Dr. Natarajan's Opening Brief (AOB), p. 78, under *Haas v. County of San Bernandino* (2002) 27 Cal.4th 1017, 1035-1036, the due process cost-benefit analysis of *Mathews v. Eldridge* (1976) 424 U.S. 319, 335, does not apply to the selection of impartial hearing officers. The policy arguments therefore should have no weight in this Court's decision. The integrity of official quasi-judicial hearings is the paramount consideration.

Dignity Amici's policy arguments fail as a matter of fact as well as a matter of law because they are unsupported by evidence and contradicted by the facts in the record. Their primary argument, that requiring neutral hearing officers will cause a peer review catastrophe, is contradicted by the fact that California's public hospitals have been functioning for more than

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[2] For the sake of brevity, Dr. Natarajan will refer to hearing officers who do not have a financial incentive to favor the prosecuting entity, or other appearance of bias, as neutral hearing officers.

40 years under the constraints of constitutional due process, without a shred of evidence that their peer review has been impaired. Likewise, the argument that hospitals cannot afford to provide neutral hearing officers is untrue, given the small cost of doing so and the immense wealth of California hospitals.

The legal arguments of Dignity Amici have been mostly addressed in Dr. Natarajan's prior briefs, so this Answer will primarily focus on their factual claims. Dignity Amici's most significant new legal argument is contained in the Adventist Health et al. brief, p, 27, n. 10: the presumption that hiring entities will act in their own self-interest does not apply to hospitals. This footnote is the heart of the Dignity Amici's arguments. They assert that unlike all other litigants in quasi-judicial and judicial proceedings, they should be trusted to *always* act in the best interest of the public health and with complete fairness toward the physicians they are attempting to remove from their hospitals. There is no basis in the law or reality for believing that hospitals do not sometimes act in their own self-interest, and so their arguments must fail.

Contrary to Dignity Amici's arguments, requiring hospitals to provide due process to physicians will not endanger patients. Neutral hearing officers are not only consistent with patient safety, they enhance it.

Dignity Amici make it clear that they want to have the power to deny physicians due process, and only be bound by some ephemeral "fair procedure" that does not include the right to a neutral hearing officer. The Dignity Amici briefs only reinforce the need for this Court to make it clear that physicians are entitled to due process, including hearing officers without an appearance of bias.

II. THE POLICY ARGUMENT OF DIGNITY AMICI IS IRRELEVANT TO THIS COURT'S DECISION.

As discussed in both Dr. Natarajan's Opening Brief (AOB), pp. 77-78, and his Reply Brief (RB), p. 38, any alleged administrative or financial burden of providing impartial adjudicators is not part of a due process analysis, because of the fundamental importance of neutral adjudicators. (*Haas,* at 1035-1036.) Despite Dr. Natarajan's emphasis on this point, both Dignity and Dignity Amici have failed to address it, apparently in the hopes that this Court will disregard that part of the law governing due process.

Nonetheless, because Dignity Amici claim that granting Dr. Natarajan's Petition will damage patient safety, he will address the merits of Dignity's policy arguments to allay any concerns that somehow this Court might harm patients by requiring due process for physicians in hospital hearings.

III. CASES MUST BE DECIDED BASED ON FACTS IN THE RECORD.

A. The Dignity Amici Rely on "Facts" Outside the Record.

Dignity Amici rely on unsupported and contradictory factual claims, including but not limited to the following:

1. Hospital hearings are informal collegial proceedings with no motions. Hearing officers only arrange logistics and promote decorum and do not rule on disputed factual and legal matters. (CHA brief, pp. 12, 16-17, 22, 41; Scripps and UC brief, pp. 12-13, 18.)

2. Hospital hearings are highly litigious and similar to complex civil trials. Because of the complexity and importance of the hearing officer, and the specialized knowledge required to perform in that role, only experienced "qualified" attorneys with decades of experience have the capacity to serve as hearing officers. (Moore et al. bried, pp. 12-18, CHA brief, pp. 13, 26-27, 30-31; Adventist Health et al. brief, pp. 15-17.)

3. Medical Staffs operate independently from hospitals. (CHA brief, pp. 45-46.)

4. Using the appearance of bias standard would require the automatic disqualification of all experienced hearing officers. (Adventist Health et al. brief, p. 20; CHA brief, p. 23; see also, Moore et al. brief, p. 9; and Scripps and UC brief, p. 8.)

5. The number of hearing officers with the experience necessary to serve as a hearing officer is "exceedingly small." (Scripps and UC brief, p. 10; see also, Moore et al. brief, pp. 19-22, 26.)

6. Hospitals cannot afford to provide neutral hearing officers. (CHA brief, pp. 29-30.)

7. Hospitals never want to eliminate competitors. (Adventist Health et al. brief, p. 22,)

8. Hearing officers "typically" only participate in deliberations if invited to do so by the hearing panel. (Scripps and UC brief, p. 12, n. 1.)

9. Hearing officers only have an interest in gaining a reputation as being fair. (Adventist Health et al. brief, p. 25; Moore et al. brief, pp. 10, 26-27.)

10. The "overriding interest" of all peer review bodies, practitioners, hearing panels, hearing officers, hospitals and medical staff is to have fair procedures overseen by impartial hearing officers. (Moore et al. brief, p. 27.)

There are only two problems with these and other facts asserted by Dignity Amici, one procedural and one substantive. Their purported facts are nowhere in the appellate record, and they are unauthenticated, unverified and unsupported by any actual evidence in (or outside) the record, contrary to the rules of appellate practice and the Evidence Code. For example, the CHA purports to rely on an obviously unscientific survey

of its members it conducted "in connection with this brief," which was apparently a "survey" designed to obtain unverifiable "facts" that would help the CHA defeat Dr. Natarajan's Petition. (CHA brief, p. 28.) This kind of evidence would not pass muster in any trial court, much less when offered for the first time in a brief to the California Supreme Court.

To ensure that cases are decided on facts, California law requires parties to argue cases based only on the appellate record. (*Kendall v. Barker* (1988) 197 Cal.App.3d 619, 625.) The only facts that can be relied upon are those in the record, because there are well-developed methods of vetting evidence when it is presented. (Evidence Code §§ 310 through 1605.) That is why statements of alleged facts in briefs which are not in the record are not evidence and are disregarded by appellate courts. (*Knapp v. City of Newport Beach* (1960) 186 Cal.App.2d 669, 679; *Kendall v. Barker, supra,* 197 Cal.App.3d at 625.) "It is axiomatic that the unsworn statements of counsel are not evidence." (*In re Zeth S.* (2003) 31 Cal.4th 396, 413, n. 11.) Petitions for writ of mandate are decided on the facts in the administrative record or admitted into evidence through a motion to augment pursuant to Code of Civil Procedure § 1094.5, subd. (e). (*Pomona Valley Hospital Medical Center v. Superior Court* (1997) 55 Cal.App.4th 93, 101.)

The facts alleged by Dignity Amici were not introduced at Dr. Natarajan's hearing or in any subsequent judicial proceeding through a

motion to augment, a motion for judicial notice or a motion to consider additional evidence pursuant to Code of Civil Procedure § 909. They should therefore be disregarded by this Court.

The other problem with Dignity Amici's purported facts is that they are not true.

The best evidence as to what actually happens in peer review is contained in the appellate record. As Dignity noted, the administrative record is nearly 10,000 pages and Dr. Natarajan's hearing included 19 evidentiary sessions. (Dignity Answer, p. 14.) There is no way of knowing how typical Dr. Natarajan's hearing was, but there is no reason to believe that his experience was unique. Cases are decided on the facts presented in the record, not on some hypothetical other cases that may be conjured up by counsel. (*Haas,* 27 Cal.4th at 1036.) Here, the factual foundations of Dignity Amici's arguments are not only unsupported by evidence, they are proven false by the facts of this case and other reported cases.

IV. DIGNITY AMICI'S PORTRAYAL OF HOSPITAL CONDUCT IS UNTRUE.

A. Hospital Hearings Are Adversarial in Nature, Not Collegial.

1. Business and Professions Code § 809, Subd. (a)(7) Does Not Make Hospital Hearings Collegial or Non-adversarial.

Dignity Amici seize upon the language of Business and Professions Code § 809, subd. (a)(7) to argue that the Legislature intended peer review to be "collegial" and that hospital hearings are therefore different from other types of quasi-judicial and judicial proceedings.[3] (CHA brief, pp. 15-16.) As a consequence, it is argued, a neutral hearing officer is unnecessary, because these hearings are only collegial efforts to protect patient care. (*Id.* at pp. 15-21.) Like Dignity, Dignity Amici conflate the general concept of "peer review" with "hospital hearings." They do so in order to argue that hospital hearings have the primary purpose of protecting patient care, and to portray hospitals as disinterested parties overseeing hearings that are non-adversarial in nature, thus diminishing the importance of physicians' right to due process and a neutral hearing officer. (See, e.g., Moore et al. brief, pp. 27-30.)

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

The phrase in Section 809, subd. (a)(7) relied upon by Dignity Amici, that peer review should be done "efficiently" and "ongoing" and "with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions," is clearly intended to apply to pre-hearing peer review proceedings, not hospital hearings. Furthermore, subdivision (a)(7) is aspirational in nature. It is the Legislature's recommendation, without any enforcement mechanism, for how peer review *should* be done. The legislative language does not prove how peer review is actually done either generally or in any specific case. As will be demonstrated below, starting in August, 2013, the pre-hearing peer review proceedings that Dr. Natarajan faced were inconsistent with the legislative language and not the least bit collegial.

2. Hospital Hearings Are Very Much like Trials.

The CHA asserts that a hospital hearing is not a "miniature trial" because "[t]here are no motions, no jury, no judge" and there are no formal discovery requests. (CHA brief, pp. 12, 17.) This claim is false. As will be discussed below, a hospital hearing officer functions just like a judge. The hearing panel functions like a jury, considering evidence from witnesses and documents and then rendering a verdict which is subject to an appeal.

It is true there is nothing "miniature" about hospital hearings. The 19 evidentiary sessions in this case included more testimony than many jury trials. Moore et al. state that the hearing in *Sadeghi v. Sharp Memorial Medical Center of Chula Vista* (2013) 221 Cal.App.4th 598 took 43 sessions. (Moore et al. brief, p. 19, n. 11.)

The CHA's claim that there are no motions or formal discovery requests is a blatant misrepresentation of how hospital hearings are conducted, as demonstrated not only by the record in this case, but by an article written by its own attorney cited in its own brief.[4]

On page 31 of its brief, the CHA quotes an article written by Lowell Brown, one of the attorneys on the brief, that "[T]he hearings tend to have all of the trappings of []formal proceedings . . . 'law and motion' type proceedings before the hearing officer between hearing sessions and so forth." The CHA does not explain how hearings can be both informal without motions on page 12 and formal hearings similar to a trial on page 31.

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[4] On the issue of whether hearings have motions, the CHA is intentionally misrepresenting the facts. In the Court of Appeal, the CHA's amicus brief made the same claim, and Dr. Natarajan refuted that claim with the same evidence presented in this section. (See CHA amicus brief in the Court of Appeal, p. 12, and Dr. Natarajan's Answer to that brief, pp. 38-39.) Nonetheless, the CHA repeats it false claim, with no explanation of why it is contradicted by the record.

The accepted use of motions in hospital hearings is proven by the record in this case. The bylaws of the St. Joseph Medical Center (SJMC), § 9.6 (7 PAR 1619) stated:

> The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full Hearing Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the hearing officer.

Counsel for the hospital and medical staff made a motion to exclude evidence of Dr. Natarajan's conduct after March 10, 2014, to prohibit Dr. Natarajan from showing that he was performing well after the recommendation of the Medical Executive Committee (MEC) for his termination. (20 PAR 5030-5031.) Dr. Natarajan made a formal discovery request for document production followed by a motion to compel documents. (21 PAR 5259-5277.) Dr. Natarajan made other pre-evidentiary hearing motions: (1) to disqualify Robert Singer as hearing officer (1 PAR 277-286); (2) to disqualify Harry Shulman because he had a conflict of interest in simultaneously representing both the Hospital and the Medical Staff (20 PAR 4839-4843); (3) to have a hospitalist on the hearing panel pursuant to Section 809.2 subd. (a) (20 PAR 4933-4936); (4) for a statement of the standards that would be applied at the hearing (21 PAR 5192-5196); (5) for an order prohibiting witness or evidence suppression

(25 PAR 6362-6369); and (6) filed a formal objection to Singer's ex parte unrecorded communications with the hearing panel. (22 PAR 5489-5490.) After the evidentiary part of the hearing began, Dr. Natarajan made a request for written jury instructions. (34 PAR 9181-9183.)

Singer granted St. Joseph's motion to exclude evidence. (3 PAR 735-740.) He denied all of Dr. Natarajan's motions listed above, other than granting a small portion of Dr. Natarajan's motion to compel documents. (1 PAR 290; 3 PAR 557-559; 20 PAR 4998-5001; 21 PAR 5319-5324; 21 PAR 5349-5370; 22 PAR 5538-5542; 25 PAR 6387-6388; 35 PAR 9400.) Although the record reflects that Singer was a very experienced hearing officer, he never suggested that motions were inappropriate or unusual in a hospital hearing, contrary to the CHA's brief. These rulings also demonstrate a hearing officer's influence on the outcome of a hearing through decisions on motions.

Likewise, in *Sadeghi v. Sharp Memorial Medical Center of Chula Vista, supra,* Dignity amicus Carlo Coppo denied a motion by Dr. Sadeghi to permit the panel to consider an additional issue in the hearing. (*Id.,* 221 Cal.App.4th at 611.)

Dignity Amici portray hospital hearings as informal and collegial to conceal the fact they are just as adversarial as civil and criminal litigation. In those hearings, physicians' careers are at stake. There is nothing "collegial" about facing hospital discipline that will be reported to the

California Medical Board and National Practitioner Data Bank and that can destroy a career that took a decade or more of extremely hard work and long hours to achieve. (*Mileikowsky v. West Hills Hospital & Medical Center* (2009) 45 Cal.4th 1259, 1267-68.) Likewise, as discussed in the AOB, p. 80, hospitals always have a significant financial stake in winning hospital hearings to protect themselves from liability for bad faith peer review or related causes of actions. They sometimes have additional financial incentives such as eliminating an economic competitor like Dr. Natarajan or a physician whistleblower who is drawing attention to hospital deficiencies. The record in this case demonstrates that Dr. Natarajan's hearing was just as adversarial as a civil or criminal trial.

B. Hospitals Have a Long History of Attempting to Exclude Physicians For Reasons Other Than Patient Safety.

The contention of Dignity Amici that all hospital administrators, managers and attorneys are exclusively interested in patient safety and fairness to physicians is inconsistent with the history of hospitals and the importance of financial considerations for current hospital corporations.

Hospital privileging has been used for a century as a tool to exclude physicians for reasons other than patient safety. Paul Starr's Pulitzer Prize-winning book "The Social Transformation of American Medicine" (1982, Basic Books) describes how in 1919 the American College of Surgeons initiated hospital peer review to implement minimum hospital standards.

(*Id.,* at 167.) The granting and termination of physician hospital privileges were a part of that system. (*Ibid.*) Although the theory of peer review was to improve patient care, hospital administrators and physician insiders used privileging as a means of excluding black, Jewish and foreign-born doctors. (*Id.,* at 167-168.)[5]

California courts began to require hospital hearings because they recognized that hospitals are essential to physicians' practice of medicine, and that hospitals are capable of arbitrarily denying or terminating hospital privileges to physicians disliked for reasons other than patient safety. In *Wyatt v. Tahoe Forest Hospital* (1959) 174 Cal.App.2d 709, 711-712, the first case to require a hospital hearing, Dr. Wyatt had a history of providing abortions to women before they were legal. In *Rosner v. Eden Township Hospital District* (1962) 58 Cal.2d 592, 594-596, Eden Hospital terminated Dr. Rosner's privileges following his complaints about patient safety issues. In *Ascherman v. San Francisco Medical Society* (1974) 39 Cal.App.3d 623, 635-636, Dr. Ascherman was a vocal proponent for the adoption of Medicare and criticized a medical organization that was opposing it. Within five months of his criticism, four Bay Area hospitals terminated or refused to renew his privileges. In *Anton v. San Antonio Community Hospital* (1977) 19 Cal.3d 802, this Court cited each of these cases, and

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[5] This paragraph adapts a portion of the amicus brief that the California Medical Association submitted to the Court of Appeal below.

especially relied on *Ascherman,* when it recognized physicians' fundamental vested property right in their hospital privileges. (*Anton,* at 19 Cal.3d at 815, 817, 825, 827.) It was hospitals' abuse of their power to privilege that led California courts to recognize physicians' right to due process before privileges can be terminated.

C. The Hospital Industry Is Big Business.

There is no evidence to support a contention that hospitals no longer pose a risk of abusing their power to terminate physician privileges. To the contrary, the risk is now greater than ever due to increased consolidation and integration of hospitals in large chains. Paul Starr described the early years of hospital consolidation:

> [In the early 1970's] the medical system was still made up almost entirely of independent practitioners and local, non-profit institutions. . . . [P]rofit-making hospital and nursing home chains were visibly on the rise but still marginal to the health care system as a whole. Ten years later, this is no longer the case. Large health care corporations are becoming a central element in the system. . . .
> But the change goes beyond the increased penetration of profit-making firms directly into the medical services. By the growth of corporate medicine, I refer also to changes in the organization and behavior of nonprofit hospitals and a general movement throughout the health care industry toward higher levels of integrated control.

Starr, *supra,* at p. 429.

As described by the California Medical Association (CMA) in its amicus brief in this Court, pp. 36-37, since 1995, the consolidation of the hospital system has proceeded rapidly, so that by 2018 59% of the State's

hospitals were part of hospital systems, and by 2015 the eight largest hospital systems owned 40% of the hospital beds in California. Hospital systems are thus large corporate enterprises engaged in constant competition for market share and revenue.

California has 147 for-profit hospitals whose executives are charged with a primary responsibility of generating profit for their shareholders. (Dr. Natarajan's Fourth Motion for Judicial Notice ("MJN"), Exhibit 10, pp.17-26.) The idea that all of those executives would ignore any financial considerations when deciding on hearing officers for hospital hearings is not credible and no evidence supports that concept.

There is no evidence or reason to believe that non-profit hospital systems are immune from financial considerations, either. Executives in charge of non-profit hospitals must try to ensure that their hospitals generate more revenues than expenses, not only to keep their jobs, but also to justify their generous compensation packages.[6]

Adventist Health et al. argue, without citation to any fact in or outside of the record, that a hospital never has a financial incentive to eliminate a business competitor, because maximum hospital revenues are generated by having as many physicians on staff as possible. (Adventist

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[6] Donald Wiley, the President of St. Joseph's Medical Center, made $1,218,608 in 2018. Lloyd Dean, Chief Executive Officer of Dignity, made $11,433,166, including $6,578,474 in "bonus and incentive compensation" in 2018. (Dr. Natarajan's Fourth MJN, Exhibit 14, pp. 52, 48.)

Health et al. brief, p. 22.) While that is likely true as a general rule, it does not in any way eliminate the financial incentive to eliminate particular physicians who are competing with a hospital or hospital system.

The only authority Adventist Health et al. cite in support of this argument is the Court's criticism of Memorial Hospital in *Major v. Memorial Hospitals Ass'n* (1999) 71 Cal.App.4th 1380, 1400-1402. However, *Major's* criticism was directed at the hospital's failure to address long-standing problems in its anesthesiology department. The hospital itself did not provide anesthesiology services, so the Court's criticism and the *Major* case had nothing whatsoever to do with a hospital's relationship to a competitor.

On the other hand, Adventist Health et al. do not address a far more pertinent case Dr. Natarajan cited in the AOB, p. 79, on the competition issue, *Smith v. Selma Community Hospital* (2008) 164 Cal.App.4th 1478. The numerous *Smith* appellate opinions describe how the Adventist system relentlessly attempted to eliminate Dr. Smith, a competitor, from their hospitals in the Central Valley, using tactics such as making false allegations of professional misconduct, threatening to report him to the Medical Board of California, summarily suspending him, overriding a hearing panel decision, filing false statements in court, and refusing to process his application to renew his privileges. (*Id.,* at 1489-1490, 1497-1498; *Smith v. Selma Community Hospital* (2010) 188 Cal.App.4th 1, 8-20;

Smith v. Adventist Health System/West (2010) 190 Cal.App.4th 40, 44-47.)

In one of the cases, the Court described the start of Dr. Smith's problems with the Adventist health system:

> Smith's conflicts with the parent and affiliates of SCH appear to have begun in October 1999 when Smith planned to open a birthing center in Hanford, California, that would have competed directly with the Hanford hospitals. Around that time, Darwin Remboldt (who Smith believed was the chief executive officer of Central Valley General Hospital and an attorney) summoned Smith to a meeting at Remboldt's offices. At that meeting, according to Smith, Remboldt was blunt: "Mr. Remboldt informed me that he was not going to allow me to build the birthing center. Mr. Remboldt said to me: `Either you become a physician in Kings Health [a Medical Group run by one of (the Hanford) hospitals] or we are going to run you out of town.'

(*Smith v. Selma Community Hospital, supra,* 188 Cal.App.4th at 8.)

The idea that private entities in a highly competitive industry like healthcare would never have a desire to eliminate a competitor is on its face absurd. The claim of Adventist Health, et al. that hospital systems would never use peer review mechanisms to eliminate competitors bears no relation to reality or their own history.

As will be discussed further below, Section 809 et seq. was adopted after the CMA urged it was necessary to prevent hospitals from using their privileging power to eliminate competitors. (Dr. Natarajan's Response to Dignity's MJN, Legislative History of SB 1211, Exhibit A, p. 70.) It should be interpreted consistent with that purpose.

D. Dignity Amici Seek to Maintain Corporate Control of Hearing Officer Selections.

The CHA admits that the engagement of attorneys as hospital hearing officers "is usually centrally managed at the health system level" as a "matter of routine financial discipline." (CHA brief, p. 47.) This central management of hearing officer hiring explains why the same attorneys are repeatedly hired – they are favored by corporate counsel.

The integrated corporate control of hospital hearings was manifested in this case by Dignity's selection of Robert Singer as hearing officer for eleven different hearings. As described in Dr. Natarajan's Reply Brief, p. 44, n. 6, the odds of Singer being hired "independently" 10 different times are considerably less than infinitesimal. The fact that Dignity's corporate counsel controlled his repeated selection is an inescapable conclusion.

Dignity Amici's briefs are also consistent with corporate control of the selection of hearing officers. The CHA asserts that "[p]eer review hearings are relatively rare," consistent with the 2008 State study of peer review. (CHA brief, p. 29, 6 CT 1701.) Moore et al. disagree because the five of them were appointed as hearing officers 17 times in 2020. (Moore et al. brief, p. 7.) The logical reconciliation of these assertions is that hearings are relatively rare, and California hospitals repeatedly chose Moore et al. as hearing officers, exercising their corporate control over their selections.

Scripps and UC claim that hospital bylaws typically allow the medical executive committee (MEC) to appoint a hearing officer, citing the CMA's model bylaws. (Scripps and UC brief, p. 12.) There is no evidence in the record to suggest that any hospitals have adopted this provision of the CMA's model bylaws.[7] In this case, the Dignity bylaws conferred the power to appoint hearing officers on the President of the hospital, as discussed in Dr. Natarajan's Reply, pp. 43-46. Again, it is the facts of this case that govern this appeal, not hypothetical other situations. (*Haas, supra,* 27 Cal.4th at 1036.)

Adventist Health et al. falsely claim, without citing any brief, that Dr. Natarajan insists that hospitals and hospital systems are "always pressuring their medical staffs" to appoint hearing officers who will guarantee that the hospital will win. (Adventist Health et al. brief, p. 17.) Dr. Natarajan made no such assertion. However, it is true that hospitals have the ability to influence the appointment of hearing officers with a financial incentive to favor them.

Applying the reasoning of *Haas*, for purposes of a due process analysis, the question is not only who officially appoints hearing officers, but also who selects them, because those will be the persons whom the

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[7] Dr. Natarajan objected to Dignity's Motion for Judicial Notice of the CMA's model bylaws on the ground of irrelevance. (Dr. Natarajan's Response to Dignity's Motion for Judicial Notice, p. 6.)

hearing officer has a financial incentive to please. (*Haas*, at 1029.) There is no reason to believe that physicians serving as Chiefs of Staff or on MEC's have any pre-existing knowledge of who to appoint as a hearing officer. When medical staff leaders are asked to do so, it can reasonably be inferred that they will always, or virtually always, turn to medical staff or hospital attorneys for advice, who then in effect make the selection. The bylaws of the University of California San Francisco (UCSF) Medical Staff explicitly express this reality, by stating that the hearing officer shall be appointed by "[t]he President of the Medical Staff in conjunction with the Office of Legal Affairs." (Natarajan Fourth MJN, Exhibit 15, p. 57.)

Based on the facts of this case and the representations of Dignity Amici, it can be expected that in the vast majority of hearings, hospital or medical staff attorneys will recommend a health law attorney they know to serve as the hearing officer and their recommendation will be followed. Scripps and UC state that they "rely on the same pool of qualified hearing officers to preside over peer review hearings." (Scripps and UC brief, p. 6.) Hospital and medical staff attorneys repeatedly selecting or recommending the same attorneys is the only rational explanation for Dignity's selection of Robert Singer eleven times; the selection of Carlo Coppo as a hearing officer seventy times (Moore et al. brief, p. 19, n. 11); and the selection of the five attorneys submitting an amicus brief seventeen times in 2020 alone. (Moore et al. brief, p. 7.) It is also the only course of conduct consistent

with Dignity Amici's insistence that only experienced attorneys they know are "qualified" should be appointed as hearing officers. (CHA brief, p. 28; Adventist Health, et al. brief, pp. 27-29; Scripps and UC brief, p. 10; and Moore et al. brief, pp. 11-19.)

Adventist Health et al. and Moore et al. make pro forma statements that hearing officers on the website of the California Society for Healthcare Attorneys (CSHA) are not the only attorneys qualified to serve as hearing officers. (Adventist et al. brief, p. 27, Moore et al. brief, p. 21.) However, the thrust of the Dignity Amici briefs is that only hearing officers approved by the CSHA are sufficiently "qualified" to serve.

In effect, Dignity Amici want a closed shop, similar to the closed shops that were used to exclude racial minorities and women from many professions and trades in the previous century. One of the foundational cases that led to the requirement of hospital hearings was *James v. Marinship Corp.* (1944) 25 Cal.2d 721, which held that a union could not arbitrarily deny membership to African-Americans through a closed shop. (*Potvin v. Metropolitan Life Insurance Company* (2000) 22 Cal.4th 1060, 1062.) Here, Dignity Amici do not want a closed shop in order to discriminate based on race or gender. But like the white union workers in *Marinship*, Moore et al. stand to benefit financially if Dr. Natarajan's Petition is denied, because they will be able to keep their lucrative hearing officer work safe from competition. Other Dignity Amici stand to benefit if

this Petition is denied because, as in *Haas*, they will have the ability to choose hearing officers that they expect to issue favorable rulings, if they wish to do so. (*Haas,* at p. 1029.)

E. Adventist Health Misstates the Problem With Not Requiring Due Process.

Adventist Health, et al. claim that:

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

(Adventist Health et al. brief, pp. 17-18.)

Adventist Health, et al. do not cite to any of Dr. Natarajan's briefs to support this claim, because they misrepresent his position to make it seem unreasonable. Dr. Natarajan never claimed that hospitals and hospital systems routinely conduct malicious and unfair hearings. Because the record of most hearings is confidential, there is no way of knowing how often hospitals and hearing officers unfairly bend hearings for the hospital's advantage. As the 2008 State-commissioned study of peer review concluded:

> [Peer review and 805 reporting in California] allow entities to conduct medical peer review in a clandestine manner, so it is unknown whether the reviews are fair, whether the medical care is judged without bias, or whether or not physician practice is improved.

(6 CT 1715.)

Dr. Natarajan wrote that there was a high probability that "hospitals will on some occasions intentionally choose hearing officers that will not be neutral" because of the financial incentives to do so. (Natarajan AOB, p. 78.) Dr. Natarajan did not claim that all hospital and hospitals systems are corrupt, only that this Court should require due process in hospital hearings to ensure that they are not subject to corruption. (*Ibid.*)

Dr. Natarajan's position on this issue is entirely consistent with this Court's decision in *Haas*, when it held that hiring entities must be presumed to act in their own self-interest by preferring hearing officers who tend to issue favorable rulings. (*Id.,* 27 Cal.4th at 1029.) The position of Dignity Amici, on the other hand, is contrary to *Haas,* which is why they insist that *Haas* does not apply to hospital hearings. (CHA brief, pp. 37-38; Adventist et al. brief, p. 20; Scripps and UC brief, pp. 13-21; Moore et al. brief, pp. 22-26.)

The 2008 State-commissioned study of peer review did not explore the question of biased hearing officers. However, it did interview physicians who had been the subject of hospital hearings and reported the following:

> The 805-subject physicians described a process that was highly "political" and was used to eliminate competitors and eliminate peers, based on gender, ethnicity, language, psychiatric illnesses, "get rid of me," or just failure to fit into the culture of a particular medical staff. These 805-subject

> physicians described not being able to find any position or job after having an 805 report filed and spending three to five years in 809 hearings and other procedures to fight for their reputations, even after the MBC found no wrongdoing on their part. They reported spending thousands of dollars to fight the charges so they could again practice as physicians.

(6 CT 1705.) The State study thus supports Dr. Natarajan's assertion that there is a high probability that on some occasions hospital and medical staffs will attempt to conduct unfair hearings using biased hearing officers, and that requiring due process is therefore essential.

Incompetent or dangerous physicians are actually more likely to receive genuinely fair hearings than competent physicians, for several reasons. Hospitals and medical staff have little reason to be concerned that they will lose a hearing if a physician's negligent care has injured patients, been confirmed by reputable experts from outside the hospital, and/or obviously violated established standards of care. Since there was no evidence that Dr. Natarajan's care had ever harmed a single patient or violated the standard of care, and there were no external reviews, Dignity had good cause to fear that a truly fair hearing would end up exonerating him.

In addition, hospitals bear little or no financial risk if an incompetent physician somehow wins a hearing. If that physician damages a patient in the future, the hospital would not have liability under *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, since it would be entitled to rely on

the hearing decision as evidence it was not negligent. Likewise, an incompetent doctor who manages to win a hearing is much less likely to sue for bad faith peer review, and would have a difficult time winning such litigation, because there would be objective evidence that the charges were reasonable. On the other hand, if a hospital frames an economic competitor or whistleblower, and the physician wins the hearing and sues for damages, a jury is unlikely to be sympathetic to the hospital's conduct. The incentive for hospitals to hold unfair hearings is thus far greater when targeting competitors or whistleblowers.

This Court needs to require due process not because every hospital hearing is corrupt, but to protect the ability of competent physicians to continue to practice. Doing so will not impair patient safety in any respect, as discussed in Section VII, below.

Dignity Amici's arguments are not based on the record, but rather on their own generalizations about their motivations and conduct. Significantly, none of them deny that Singer had a financial incentive to favor Dignity and that Dr. Natarajan's hearing was therefore unfair. Since this case turns on that fact and that issue, Dignity Amici's argument that all hospitals hearings are invariably fair necessarily fails.

F. Medical Staffs Do Not Always Act Independently of the Hospital Administration.

1. The Record Disproves the CHA's Contention That Dignity Was Uninvolved in Dr. Natarajan's Peer Review Before His Internal Appeal.

The CHA asserts that Dignity played no part in the peer review proceedings against Dr. Natarajan until his appeal:

> 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.

(CHA brief, p. 45.)

The only "evidence" cited in support of that alleged fact is a reference to the appeals procedures in the hospital's bylaws. (*Ibid.*) The CHA then argues that hospitals are uninvolved with peer review until appeals to governing bodies, and that "[t]he health system has no role in peer review proceedings." (CHA brief, p. 46.)

A medical staff is, as a matter of law, a self-governing entity charged with conducting peer review. (Business and Professions Code § 2282.) However, a medical staff's legal status does not mean that its hospital administration lacks the ability to use peer review proceedings to terminate disfavored physicians.

The issue of whether Dignity manipulated St. Joseph's pre-hearing peer review of Dr. Natarajan is not directly relevant to the question of whether Dr. Natarajan received a fair hearing. For that reason, Dr. Natarajan's Opening Brief devoted only one paragraph to those proceedings. (AOB, p. 18.)

However, the facts set forth below are relevant to disprove the CHA's contention that medical staffs always conduct peer review proceedings wholly independently from the hospital administration. They are also relevant to disprove the contention of Dignity Amici that due process for physicians is not necessary because hospitals, hospital systems and medical staffs always function as protectors of the public health when conducting peer review. The facts described in this section also show how the theoretical legal separation of a medical staff and hospital administration can become an illusion in practice.

The manner in which Dignity arrived at charges against Dr. Natarajan is also relevant to show that what might appear on the surface to be "substantial evidence," when closely examined, can be either false or completely meaningless, in terms of a physician's ability to practice safely. These events are also relevant to show how any physician can be put on the road to termination by the application of standards that are literally impossible to meet.

2. The Hospital Administration Initiated the Charges Against Dr. Natarajan.

Dr. Susan MacDonald, a Vice-President of St. Joseph's Medical Center, stated to the MEC that she had been the person who initiated the "Focused Professional Practice Evaluation" ("FPPE") of Dr. Natarajan by speaking to Dr. Dighe, then Chief of Staff of the Medical Staff, and Dr. Venkata Emani. (6 PAR 1359.)

Dr. Emani was Chief of the Hospital's Department of Medicine, Dr. Natarajan's department. He was responsible for monitoring and reporting the quality of care and performance of Dr. Natarajan for the medical staff. (7 PAR 1633.) He corroborated that it was the hospital administration, not the medical staff, that initiated an investigation of Dr. Natarajan. Before the hospital initiated the investigation, Dr. Emani did not talk to Dr. Natarajan about any problems except one conversation about medical records. (11 PAR 2609-2611.) He testified that he would have talked with Dr. Natarajan if there had been any significant problems with his performance. (*Ibid.*) He did not observe any problems with Dr. Natarajan's medical practice or his medical record-keeping. (11 PAR 2614-2615.) He never met with Dr. Natarajan about any problems with his medical practice, record-keeping or any of the issues that were cited to justify a peer review evaluation of Dr. Natarajan. (11 PAR 2615-2617.) He never sent Dr. Natarajan a letter of reprimand, or even a single email or

letter notifying him of any problems with his performance before the formal evaluation of Dr. Natarajan's privileges began in August, 2013. (11 PAR 2618.)

Dr. Emani had a contract with Dignity to provide cardiology services and Dignity also paid him for being Chairman of the Hospital's Department of Medicine. (12 PAR 2866-2867.) He therefore had a financial incentive not to oppose the hospital in any significant way, in order to preserve his relationship with the hospital administration.[8] Dr. Emani agreed to order a "Focused Professional Practice Evaluation" (FPPE) of Dr. Natarajan after he attended a meeting which included Dr. McDonald and Dr. Bruce Ermann, who was a corporate medical director for Dignity Health. (1 PAR 188; 11 PAR 2627-2637.) At that meeting, Dr. McDonald presented a power point presentation that was highly critical of Dr. Natarajan, and that concluded with the sentence "And so . . . What Should Be Done?" (11 PAR 2632-2635; 5 PAR 1081.) Dr. McDonald's Power Point presentation contained numerous false allegations against Dr. Natarajan. (17 PAR 4141-4142, 4180-4197.)

[8] At Dr. Natarajan's hearing, Singer sustained objections to Dr. Natarajan's questions about how much Dignity was paying Dr. Emani. (12 PAR 2866-2867.)

3. Dignity Influenced the Results of the FPPE in Many Ways.

Lori Brown, another hospital administrator, suggested to Dr. Emani names of physicians to serve on the FPPE Committee, including Dr. Philip Dodd. (12 PAR 2855-2856.) Dr. Emani appointed Dr. Dodd to be a member of the FPPE Committee, even though he did not know Dr. Dodd, at the suggestion of Brown. (*Ibid.*) Dr. Dodd was hostile to Dr. Natarajan and a strong advocate for his termination. (See, e.g., 6 PAR 1320-1321, 1338-1339.)

According to the CHA, in the informal system of peer review, "lawyers are never required and in some cases expressly prohibited." (CHA brief, p. 16.) Harry Shulman had been an attorney for St. Joseph's for 30 years. (6 PAR 1346.) He appeared at the beginning of the investigation of Dr. Natarajan. His attendance at the first and subsequent FPPE meetings shows that St. Joseph's peer review of Dr. Natarajan was not intended to be a "collegial" process to resolve perceived problems through "informal educational interventions," as intended by the Legislature. (Section 809, subd. (a)(7).) Informal educational interventions or regular peer review proceedings would not have required the presence of a hospital attorney. The most reasonable inferences from Shulman's presence at the FPPE meetings is an intention by the hospital to terminate Dr. Natarajan's privileges before the evaluation of his practice had even

begun; and that Dignity wanted that process to be guided by an experienced and trusted Dignity attorney whose advice would be shielded by the attorney-client privilege. (See 5 PAR 1157, 1177-79; 6 PAR 1207, 1322, 1324-1325 and 1337-1339, all showing Shulman's redacted secret communications with the FPPE Committee.)

Shuman was directly involved with every step of the investigation. He drafted a letter dated August 20, 2013, which Dr. Emani signed, notifying Dr. Natarajan that he was going to be the subject of an FPPE. (11 PAR 2648-2649; 12 PAR 2867-2868.)[9] The letter contained a false statement that the FPPE was being imposed based on "routine monitoring activities," when in fact it was based on Dr. McDonald's intensive review of Dr. Natarajan's practice, not any regular Medical Staff quality review proceedings or findings. (5 PAR 1007; 11 PAR 2652.) Dr. McDonald had even searched the computer records of when Dr. Natarajan had entered the Hospital using his entry card, to support a claim that he had inaccurately stated his time with a patient. (5 PAR 1064.) As Dr. Emani admitted, that was not "routine monitoring activities." (11 PAR 2651-2652.)

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[9] At Dr. Natarajan's hearing, Singer sustained objections to Dr. Natarajan's questions about whether it was Dr. Emani's decision to get Shulman involved, why a lawyer was needed for a departmental peer review evaluation, and when was it decided to get Shulman involved. (12 PAR 2868.) Singer's rulings prevented Dr. Natarajan from developing evidence that the Hospital used Shulman's participation in the peer review investigation to help ensure a recommendation for Dr. Natarajan's termination.

According to Adventist Health et al., "[h]ospital administrators ordinarily do not initiate or participate in peer review proceedings, other than by paying expenses (which may include hearing officer fees)." (Adventist Health et al. brief, p. 15.) The FPPE was supposedly a medical staff departmental evaluation of Dr. Natarajan. However, Shulman, Dr. McDonald, Brown and Dr. Scott Neeley, another hospital vice-president, all attended the FPPE Committee's meetings, even though they were not members of the medical staff. (5 PAR 1013, 1082, 1109, 1114, 1153, 1168, 1207, 1317, 1337; 15 PAR 3548-3549.) The attendance of the hospital administrators, like the attendance of Shulman, proves that Dr. Natarajan was not a subject of "ordinary" peer review.

Dr. Philip Yu, the Chief of the Sutter-Gould hospitalist group that worked at the hospital, was appointed Chair of the FPPE Committee, even though he was Dr. Natarajan's direct economic competitor who would directly benefit if the hospital terminated Dr. Natarajan's privileges. (5 PAR 1013; 6 PAR 1372 .)

Shulman, Dr. McDonald and Brown attended the first meeting of the FPPE Committee. Dr. McDonald decided that she and Brown would participate in the evaluation, before the Committee met. (12 PAR 2888; 5 PAR 1013.) Shulman announced to the Committee he was there to assist them, even though the Committee had not asked for his help. (5 PAR 1013.) Shulman's appearance was followed by Dr. McDonald's highly

critical power point presentation about Dr. Natarajan. (*Ibid.*) Dr. McDonald selected the records of Dr. Natarajan that the committee would review, not the medical staff. (5 PAR 1092.) Dr. McDonald, Donald Wiley and possibly Brown asked Dr. Neeley to also attend the meetings of the FPPE Committee. (15 PAR 3548-3549; 5 PAR 1082.) He was an extremely strong voice damning Dr. Natarajan and advocating the termination of his privileges. (See, e.g., 6 PAR 1318-1324, 1337-1339.)

On or about November 8, 2013, Dr. Natarajan received a 12-page letter describing the FPPE's purported concerns, the precursor of the charges later brought against him. (5 PAR 1180-1191.) Although the letter was signed by Dr. Yu, he testified that his letter had been drafted by Shulman, using information that had been provided by Dr. McDonald and a hospital department. (13 PAR 2991.)

The Hospital's decision to ask Shulman to attend these meetings, and the active role he, Dr. McDonald, Dr. Neeley and Brown played in bringing charges against Dr. Natarajan, demonstrates that the claimed separation between an "independent medical staff" and the hospital was a fiction in this case. Their attendance at meetings was not to assist in Dr. Natarajan's education, but rather to shepherd the investigation to a recommendation for his termination.

At a meeting on December 11, 2013, Dr. Natarajan provided the Committee with survey responses from 18 nurses showing that he was

highly responsive to pages and that the nurses believed that Dr. Natarajan provided excellent and compassionate care to patients. (6 PAR 1221-1238.) He also provided the Committee with evidence that his medical record completion rate was better than other comparable physicians, based on the hospital's own data. (6 PAR 1239-1250; 17 PAR 4151-4152.) He also provided medical records of other physicians that demonstrated that the quality of their medical records was considerably worse than Dr. Natarajan's. (6 PAR 1251-1283.) He later provided 24 nursing surveys attesting to his responsiveness to pages and his availability for care. (6 PAR 1289-1313.)

One of the Committee's major criticisms of Dr. Natarajan was that he did not dictate all of his History and Physical's ("H & P's") within 24 hours. At the December 11, 2013, meeting, he stated that he would work on improving his performance in that regard, with the goal of completing 100% of his H & P's in 24 hours within 6 months, while he worked on reducing his workload. (6 PAR 1212-1213.)

Following the FPPE Committee's meeting with Dr. Natarajan, it met again without Dr. Natarajan present on December 20, 2013. (6 PAR 1317.) At that meeting, Dr. Shiraz Buhari, one of the physicians on the FPPE committee, advocated that Dr. Natarajan should only be subjected to monthly close monitoring by the MEC, observing that "there are no patient harm issues." (6 PAR 1317-1318.) Dr. Neeley and Dr. McDonald, the

hospital Vice-Presidents, both reacted negatively to Dr. Buhari's suggestion, claiming with no factual basis that Dr. Natarajan had been lying and was not sincere about improving his performance. (6 PAR 1318.) Dr. Yu and Dr. Dodd sided with the hospital administration. (6 PAR 1317-1324.) However, Dr. Goswami, another physician on the committee, advocated giving Dr. Natarajan 30 to 60 days to improve his purported poor performance. (6 PAR 1323-1324.) Although Dr. Neeley persistently argued for a recommendation to terminate Dr. Natarajan's privileges, the Committee agreed to reevaluate Dr. Natarajan's privileges in 30 days to see if his performance had improved. (6 PAR 1324.)

On January 15, 2014, Dr. Natarajan emailed Brown to notify the Committee that he had completed all of his H & P's in the past month within 24 hours. (6 PAR 1330-1331.) He stated that he took the issue seriously and was striving for perfection. (*Ibid.*) He also attached a detailed list showing the patients' admission times and when he dictated the H & P for each of his patients. (6 PAR 1332-1333.)

On January 16, 2014, Mary Beth Smith, the Director of the Health Information Management Department at St. Joseph's, reviewed the cases submitted by Dr. Natarajan and produced a chart that claimed that four H & P's that were Dr. Natarajan's responsibility had not been dictated within 24 hours. (6 PAR 1334-1335.)

On January 17, 2014, at 6:59 a.m., Dr. McDonald sent an email to Dr. Yu, Dr. Dodd, Dr. Buhari, Dr. Goswami, Brown, Shulman, Dr. Neeley, Wiley (the President of the hospital) and Smith stating in reference to the H & P's that "[a]ll of the missing ones in yellow do have H & P's dictated by Dr. M. Singh." (6 PAR 1335.) Dr. McDonald must have reviewed the medical records in question, which definitively and indisputably demonstrate that Dr. Singh had completed the H & P in each of those cases within 24 hours, and that Dr. Singh was the responsible physician for those patients, not Dr. Natarajan. (17 PAR 4286-4289; 10 PAR 2418-2428.) Thus, Dr. Natarajan had in fact attained 100% compliance in dictation of H & P's in just one month, and Smith's claim that he had not done so was demonstrably false, easily disproven, and acknowledged as inaccurate by Dr. McDonald. Furthermore, Dr. McDonald's notification that Smith's information was wrong had been communicated to all of the FPPE Committee members, Shulman, Dr. Neeley and Brown before the Committee's meeting that day.

Nonetheless, at the FPPE Committee's meeting later in the morning of January 17, 2014, Dr. Yu claimed that Dr. Natarajan had not achieved 100% compliance in dictating H & P's and that Dr. Natarajan's claim of 100% compliance had not been truthful. (6 PAR 1337.) Dr. Dodd commented that Dr. Natarajan's apparent dishonesties and attempts to sway the committee were very disturbing to him. (6 PAR 1338.) Dr. Yu then

echoed Dr. Dodd's claim that Dr. Natarajan had been dishonest with the committee. (*Ibid.*) Although Dr. McDonald was present at the meeting, she did not contradict Dr. Yu or Dr. Dodd when they claimed Dr. Natarajan had been dishonest with the Committee about his H & P compliance. (6 PAR 1337-1340.) Dr. Yu and Dr. Dodd both asserted that Dr. Natarajan had not changed his practice pattern. (6 PAR 1339.) The Committee then agreed to recommend the termination of Dr. Natarajan's privileges. (*Ibid.*)

Thus, the recommendation for the termination was based on false information provided by the Hospital that all of the Committee members and Hospital administrators knew or absolutely should have known was false. They did so because a false claim of dishonesty against Dr. Natarajan was the only way to avoid a conclusion that he had significantly improved his performance and that termination of his privileges was therefore not required.

The Committee's recommendation for Dr. Natarajan's termination was not only engineered by false accusations, but also by adopting a standard that no physician could possibly have met. At Dr. Natarajan's hearing, Dr. Yu testified that the Committee was holding Dr. Natarajan to a "zero deficiency" rate on medical records. (13 PAR 2947-2949.) That standard was literally impossible to achieve. For example, after a physician dictated an H & P, s/he would be notified that the H & P was ready to be signed the next time s/he signed into that patient's medical record. (13

PAR 3122-3123.) That would be considered a "deficiency" until the record was completed. (*Ibid.*) An Electronic Health Record (EHR) will thus inevitably have "deficiencies", i.e., incompletions, any time a physician dictated anything, such as an H & P, discharge summary or operative report, any time a physician used a verbal order that would need to be signed later, any time he entered a draft progress note, and any time anything needed to be electronically signed or a required box needed to be checked. Smith admitted that these EHR "deficiencies" do not indicate that a physician did anything wrong, was untimely or had a problem. (13 PAR 3123.) Thus, the Committee was not only holding Dr. Natarajan to a standard that was impossible to achieve, it was also a standard that was clinically meaningless, since it had virtually nothing to do with the quality of care a patient received.[10]

Following the Committee's January 17, 2014, meeting, Shulman drafted a committee report highly critical of Dr. Natarajan that Dr. Yu signed. (13 PAR 3038-3039; 5 PAR 917-937.) The methods the Committee used to evaluate Dr. Natarajan's practice did not meet accepted medical, scientific or peer review standards. There was no review of any of Dr. Natarajan's medical charts by one or more expert outside physician

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[10] The hearing panel decision written by Singer also used these kind of record-keeping "deficiencies" as a primary rationale for terminating Dr. Natarajan's privileges. (35 PAR 9448.) Dignity also used them in its Answer Brief, pp. 19-20, 83, as support for its claim that Dr. Natarajan had "endangered" patients, as referenced in Dr. Natarajan's Reply Brief, p. 59.

reviewers, as would normally be expected in these circumstances. (18 PAR 4304.) There was no effort made to avoid selection bias, reviewer bias, interviewer bias or recall bias during the review. (12 PAR 2912-2921.) The charts the FPPE Committee reviewed were not randomly selected. (5 PAR 1013, 5 PAR 1109-1110.) Dr. Emani did not refer the cases in which the Hospital accused Dr. Natarajan of substandard care to the hospital's established quality assurance committees for peer review. (12 PAR 2868-2869.) The FPPE Committee never gave Dr. Natarajan an opportunity to respond to any criticisms arising from cases it reviewed before it issued its recommendation to terminate his privileges. (18 PAR 4268-4273.) Those cases were not discussed with him at the one meeting of the FPPE Committee that he was allowed to attend. (6 PAR 1207-1216.)

One example of how the FPPE relied on false information provided by the Hospital Administration is the case of "MS." In that case, Dr. McDonald claimed that Dr. Natarajan had falsely written that he had spent 35 minutes with a patient. (5 PAR 1066.) Dr. McDonald made that claim based on the fact that the hospital door-entry records showed Dr. Natarajan arriving at 11:17 a.m., that he had made orders for MS at 11:30 and accessed her chart at 11:41 a.m. (*Ibid.*) Using that information, the FPPE claimed that "The maximum time [Dr. Natarajan] could have actually spent on his visit with M.S. AND discharge orders and charting was 11 minutes, based on badge and computer activity- the charted time of >35' was a

falsification." (5 PAR 915.) Dr. McDonald and the Committee effectively accused Dr. Natarajan of fraud based on these facts, since a physician's compensation depends on the amount of time spent with patients. (14 PAR 3353.) Dr. McDonald and the FPPE made the false conclusion that Dr. Natarajan had stopped caring for the patient at 11:38 a.m., simply because he had interrupted his care of MS to check the records of another patient. (5 PAR 915.) The medical records of MS actually showed that Dr. Natarajan had attended the patient from 11:20 or 11:25 a.m. until at least 12:19 p.m., corroborating that he had spent more than 35 minutes with the patient, even if he had taken a few minutes to deal with another patient. (17 PAR 4128-4140; 7 PAR 1566; 9 PAR 2221, 2227, 2228, 2233, 2235.) The extremely serious claim that Dr. Natarajan had fraudulently misrepresented his time was a total fabrication by the hospital administration disproven by the patient's medical records. Nonetheless, the Committee adopted the charge without even asking Dr. Natarajan about it. (17 PAR 4128-4140.)

The other charges based on Dr. Natarajan's treatment of specific patients were likewise without merit. The discussion of the details of each of those cases would be too lengthy to include in this brief. However, the lack of merit in the charges is reflected by the fact that the Hearing Decision written by Singer did not claim that Dr. Natarajan had violated the standard of care in any of those cases. (35 PAR 9426-9461.)

4. The Medical Executive Committee Never Conducted the Independent Investigation Required by the Hospital Bylaws.

The St. Joseph's hospital bylaws required the hospital's Medical Executive Committee (MEC) to conduct its own independent investigation of the charges against Dr. Natarajan. (7 PAR 1608-1609.) The MEC did not do so, despite the fact that Dr. Natarajan requested in writing that it conduct the investigation required by the bylaws. (6 PAR 1371-1379; 18 PAR 4320-4322.) Instead, the MEC recommended the termination of Dr. Natarajan's privileges based on the FPPE report written by Shulman. (5 PAR 910.)

The Hospital was thus able to achieve a recommendation for the termination of Dr. Natarajan through an investigation that was completely outside of the Hospital's established peer review committees. By avoiding the usual quality assurance committees, the Hospital ensured that unbiased physicians serving on those committees would not exonerate Dr. Natarajan. Instead, the investigation was conducted exclusively by physicians suggested to Dr. Emani by the hospital administration, and by hospital administrators serving on the FPPE Committee, which was a committee of the Medical Staff in name only. The Hospital's attorney wrote the Committee's letters and its report and guided the Committee throughout its course.

The facts stated above, all of which are in the record, disprove the factually unsupported assertions of the Dignity Amici that medical staffs operate independently of hospitals and that hospitals can be counted on to always act fairly in the interest of patient care. It may be true that sometimes, or even "ordinarily," medical staffs conduct peer review independently. However, the facts of this case show that hospitals also have the capacity to effectively control the pre-hearing peer review process. In this case, Dignity did so by obtaining the cooperation of a single compliant medical staff leader who was directly paid by the Hospital, and therefore had a financial incentive not to oppose the Hospital's efforts to terminate Dr. Natarajan's privileges.[11]

F. The Ability of Hospitals to Influence Medical Staffs To Bring Charges Against a Physician Is an Additional Reason Why Hospital Hearings Must Be Governed by Due Process.

Dignity's manipulation of peer review to generate disciplinary charges against a physician is not unique. In *Fahlen v. Sutter Central Valley Hospital* (2014) 58 Cal.4th 655, 662-663, a hospital chief operating officer (COO) employed by Dignity amicus Sutter Health first got Dr.

[11] The facts in this section were included in Dr. Natarajan's Answer (pp. 20-31) to the CHA's amicus brief in the Court of Appeal. Despite being aware of these facts, the CHA repeated its false assertion of Dignity's lack of involvement in Dr. Natarajan's peer review in its amicus brief to this Court.

Fahlen's medical group to fire him. Shortly thereafter, the COO told him he should leave Modesto, because if he didn't leave town, the hospital would start an investigation and peer review proceedings that would result in a report to the Medical Board of California. When Dr. Fahlen did not leave town, the hospital convened an ad hoc investigating committee, just as Dignity did in this case. As in this case, the investigating committee made a report to the hospital's MEC which led to a recommendation to terminate Dr. Fahlen's privileges. He prevailed in his hearing due to the weakness in the case against him, but Sutter nonetheless terminated his privileges. (58 Cal.4th at 663-664.)

In Dr. Natarajan's case, after initiating and generating the charges, Dignity had the power to select the hearing officer who would guide the hearing panel to a conclusion, serving, according to the CHA, as the "conductor" of the hearing. (CHA brief, p. 26.) As described in Dr. Natarajan's AOB, p. 19, despite being Dr. Natarajan's economic competitor, Dignity ignored his request for a neutral or mutually-agreed-upon hearing officer. (1 PAR 216-219.) It refused to appoint any of the 13 retired judges suggested by Dr. Natarajan or to even confer with him about a mutually-acceptable appointment. Instead, it unilaterally selected, contracted with, and paid a hearing officer that it had selected nine times previously, who had a financial incentive to favor it. (AOB, pp. 19-24.)

The totality of these facts illustrate why this Court should require hospitals and medical staffs to provide physicians with due process in all hospital hearings, whether public or private. Since California law gives private hospitals the ability to destroy the careers of physicians who are economic competitors, whistleblowers, or otherwise disfavored, the least it can do is require that those hearings be governed by the same due process requirements that protect physicians in public hospitals.

V. HEARING OFFICERS HAVE THE CAPACITY TO INFLUENCE HEARING OUTCOMES.

A. Experienced Hearing Officers Have the Capacity to Influence the Hearing Panel.

Adventist Health et al. assert that hearing panel members "are unlikely to go along with anything a hearing officer says that the physicians perceive as a dictate from a hospital or system." (Adventist Health et al. brief, p. 30.) But there is no reason to believe that any experienced hearing officer would attempt to influence physicians in a way they perceived as dictatorial. Given the experience, intelligence and sophistication of hospital-appointed hearing officers, if they want to influence hearing panels, it would be much more reasonable to expect them to use charm, humor, anecdotes, descriptions of the law, descriptions of dangers to patients or the hospital if the subject physician is not terminated, or other subtle methods of persuasion.

As the CMA points out, hearing officers may not even realize their own unconscious biases favoring the hospitals that appointed them, and scientific research supports the conclusion that hearing officers have the capacity to influence panel members. (CMA amicus brief, pp. 16-21.) It is also common sense. As described by Dignity Amici, most current hearing officers will have years of experience in hearings; the panelists will likely have none, given the relative rarity of hospital hearings. Hearing officers also wear a cloak of authority similar to those who wear black robes in a courtroom. The assertion that they lack the capacity to influence hearing panels is untrue.

B. The Lack of Evidentiary and Substantive Standards Enhance the Ability of Hearing Officers to Influence the Hearing Panel.

Hearing officers also have the capacity to influence the hearing results in important ways other than direct comments to the panel. As Adventist Health et al. state, usually the only limitation on what evidence can be introduced in a hearing is relevance. (Adventist Health et al. brief, p. 17.) The lack of the usual evidentiary standards obviously gives a hearing officer broad discretion to limit what the panel hears, or to allow prejudicial evidence to be introduced.

In this case, the hearing officer *sua sponte* ruled that Dr. Natarajan could only introduce very limited information about Dignity's economic

incentive to terminate his privileges, despite the fact that such information was admissible and probative. (22 PAR 5496-5501, 5694-5696.) He limited Dr. Natarajan to "one or two questions" to witnesses about economic motivations. (22 PAR 5696.) Mr. Singer also excluded eleven nurses' declarations that were highly probative and directly relevant to the charges against Dr. Natarajan, even though they would have only taken a short time for the panel to read. (25 PAR 6339-6344; 31 PAR 8144-8173.) Those declarations were strong evidence that allegations that Dr. Natarajan was not responsive to pages and other charges against him were false. (*Ibid*.) He also prohibited Dr. Natarajan from introducing highly probative evidence that his record of completing medical records was far superior to other physicians in the hospital. While Dr. Natarajan had only one suspension day since September 25, 2012, the excluded documents showed that other physicians in the hospital had 77, 28, 28, 21, 14 and 14 days of suspension, including Dr. Michael Herrera, the Chief of Staff, who had 21 suspension days. (6 PAR 1395; 31 PAR 8174-8175.)

Likewise, under California law as interpreted by hearing officers and the Court of Appeal below, there is no requirement that a physician's clinical performance be governed by the recognized standard of care or other objective standard. (*Natarajan v. Dignity Health* (2019) 42 Cal.5th 383, 392-393; see also *Gaenslen v. Board of Directors* (1985) 185 Cal.App.3d 563, 569.) In the trial court and the Court of Appeal, Dr.

Natarajan argued that the failure to apply objective standards in his case made it unfair. He did not seek review of that contention, so it is not an issue before this Court. However, the failure to use objective standards in hospital hearings remains relevant to the ability of a hearing officer to influence panel members, an issue raised by Dignity Amici.

In this case, the hearing officer denied Dr. Natarajan's motion that his medical care should be evaluated based on the recognized standard of care. (21 PAR 5192-5196, 5319-5324.) That ruling certainly had an impact on the hearing result, given that there was no finding in the hearing decision that Dr. Natarajan ever violated the standard of care. (35 PAR 9426-9461.) The current absence of a clear requirement in the law for objective standards provides opportunities for a hearing officer to influence a hearing panel concerning what kind of conduct warrants a termination of privileges, without being limited by such standards.

C. Hearing Officers' Ability to Have Ex Parte Communications With Panels, Standing Alone, Requires Neutral Hearing Officers.

Hearing officers' ability to engage in ex parte communications with hearing panels gives them an unchecked opportunity to influence the hearing decision. In this case, the hearing officer not only deliberated with the hearing panel, he gave them a private unrecorded "orientation" to the case. Before undertaking the "orientation," he asked if there was any

objection to his doing so. (22 PAR 5410.) Dr. Natarajan submitted a written objection that included the following passage:

> Substantive ex parte communications are prohibited in all parts of our legal system. The Rules of Professional Conduct and the Judicial Code of Ethics prohibit most ex parte contacts. A judicial officer may only initiate ex parte communications, where circumstances require, for scheduling, administrative purposes, or emergencies that do not deal with substantive matters. (Cal. Code Jud. Ethics, canon 3B(7)(d).) (*Alvarez v. Workers' Comp. Appeals Bd.* (2010) 187Cal.App.4th 575, 588.) In this case, the scheduling of the upcoming hearing sessions has already been done by the hospital, there are no administrative needs that require a private, ex parte "orientation" of the panel, and there is no emergency. In the context of an administrative hearing, the decision-maker should not be provided off-the-record information during discussions from which the parties are excluded. *Rondon v. Alcoholic Beverage Control Appeals Bd.* (2007) 151 Cal.App.4th 1274, 1288-1289.)

(22 PAR 5489.) The hearing officer overruled Dr. Natarajan's objection to ex parte contacts and conducted his private "orientation" with the panel, with no court reporter present. His ruling was based on the ground that hospital hearing officers are not constrained by limitations on adjudicators in other quasi-judicial or judicial settings, citing, inter alia, his right to deliberate ex parte with the hearing panel. (22 PAR 5538-5542.) At the conclusion of the hearing, he deliberated with the hearing panel with no court recorder present. (19 PAR 4528.)

In Dr. Natarajan's internal appeal of the termination of his privileges, he pointed out that in deliberations, the hearing officer could have truthfully emphasized to the hearing panel that if they ruled in favor of

Dr. Natarajan, he could sue the MEC for bad faith review, as an example of the potential influence the hearing officer had on the decision. (1 PAR 42.) This is just one of countless examples of how a hearing officer might unduly influence a hearing panel.

Apparently recognizing the due process problems arising from hearing officers with an appearance of bias deliberating with panel members, Scripps and UC claim that "typically a hearing officer would only participate in deliberations if allowed to do so under the bylaws and invited to do so by the panel of medical professionals," citing the CMA's model bylaws. (Scripps and UC's brief, p. 12, n. 1.) However, as stated above, there is no evidence that any hospitals in California have adopted the CMA's model bylaws, in whole or in part. Scripps and UC's claim is contrary to the record in this case. The St. Joseph Medical Center bylaws not only "allowed" the hearing officer to deliberate with the hearing panel, as asserted by Scripps and UC, but affirmatively stated that the hearing officer "should" participate in deliberations. (7 PAR 1617.)

Hospitals have final authority over medical staff bylaws. (Section 809, subd. (a)(8).) Given that medical staffs ordinarily lack financial resources (CHA brief, p. 47), it is likely that hospital attorneys draft those bylaws. They are more likely to use the CHA's model bylaws, which permit the hearing officer to both participate in deliberations and to assist in the preparation of the hearing panel's report and recommendations, than

those of the CMA. (CHA MJN, p. 10.) Amicus UC does not disclose that the bylaws of both the UCSF and UCLA Medical Centers permit the hearing officer to participate in the deliberations of a hearing panel, contrary to its factually unsupported representation of what "typically" happens in hospital hearings. (Dr. Natarajan's Fourth MJN, Exhibit 15, pp. 58, 73.)

None of the Dignity Amici address the holding of *Chevrolet Motor Division v. New Motor Vehicle Bd.* (1983) 146 Cal.App.3d 533, 541, that the participation in hearing deliberations by persons with a financial conflict of interest violates due process, as described in Dr. Natarajan's Reply Brief, p. 21. That case, among others, requires that this Petition be granted. The ability of hearing officers to deliberate with hearing panel members is one of the most important reasons why it is imperative to have neutral hearing officers rather than hearing officers with a financial incentive to favor hospitals.

VI. REQUIRING DUE PROCESS IN HOSPITAL HEARINGS WILL NOT CAUSE CALIFORNIA'S PEER REVIEW TO IMPLODE.

A. Dignity Amici's Theory That Requiring Due Process Will Harm Peer Review Has Been Disproven by Public Hospitals.

Dignity Amici all assert that requiring hearing officers to be neutral or mutually-agreed-upon would damage California's peer review system because hospitals would not be able to engage experienced "qualified" hearing officers. (CHA brief, pp. 26-29; Adventist et al. brief, pp. 20-28; Scripps and UC brief, pp. 21-23; Moore et al. brief pp. 11-19.) Dignity Amici advance this theory as the primary reason why Dr. Natarajan's Petition should be denied. However, as stated above, the fiscal and administrative burdens of providing impartial hearing officers are not considered when evaluating whether due process was violated. (*Haas*, 27 Cal.4th at 1035.)

Their theory is also unsupported by any facts in the record, and it has been effectively disproven by the fact that public hospitals have been providing due process to physicians since *Anton v. San Antonio Community Hospital, supra,* 19 Cal.3d at 823-825, established that physicians have a fundamental vested property interest in their hospital privileges. It is undisputed that "constitutional due process governs peer review

proceedings in government-owned hospitals." (CHA brief, pp. 34-35, citing Section 809.7 and *Kaiser Foundation Hospitals v. Superior Court* (2005) 128 Cal.App.4th 85, 102, n.15.)

In California, based on current data from the State's Office of Statewide Health Planning and Development (OSHPD), there are 81 public hospitals. (Natarajan Fourth MJN, Exhibit 10, pp. 17-26.) Scripps and UC assert that both of them "rely on the same pool of qualified hearing officers to preside over peer review hearings. And despite their differences as private and public hospital systems, amici's hospitals adhere to largely similar peer review procedures." (Scripps and UC's brief, p. 6.) However, despite the fact that public hospitals, including the UC hospitals, must provide constitutional due process, there is no evidence that any public hospital has faced any problem finding "qualified" hearing officers to conduct hospital hearings. Given the 81 public hospitals in the State, if there were any practical problems with providing constitutional due process, including hearing officers without an appearance of bias, they would surely have come to light by now.

Dr. Natarajan's Reply Brief, pp. 39-40, noted the absence of any public hospital problems resulting from the requirement for a neutral hearing officer. Dignity Amici, including UC, completely fail to discuss the ability of public hospitals to provide due process to physicians on their staffs. If public hospitals, with their more limited resources, can provide

due process in hospital hearings, there is no plausible reason why private hospitals cannot do so as well.

B. Dignity Amici's Theory That Retired Judges and Justices Are Not Competent to Preside Over Hospital Hearings Is Untrue.

Dignity Amici's argument that retired judges and justices cannot competently serve as hearing officers is unsupported by anything in the record. It is contradicted by other arguments made by Dignity Amici and lacks any merit.

Moore et al., the CHA and Adventist Health et al. argue that retired judges and justices are incompetent to serve because only attorneys having esoteric knowledge of the intricacies of peer review and the delivery of medical care can function competently. (Moore et al. brief, pp. 12-18, CHA brief, p. 26-27, Adventist Health et al. brief, pp. 15-17.) On the other hand, the CHA, Scripps and UC argue that having a neutral hearing officer is unnecessary because peer review hearings are informal and collegial; hearing officers have no impact on the outcome of a hearing; their role is limited to resolving discovery disputes, assisting with logistical issues and maintaining decorum; and they do not rule on disputed factual and legal questions. (CHA brief, pp. 12, 16-17, 22, 41; Scripps and UC brief, pp. 12-13, 18.)

Dignity Amici's differing characterizations of hearings are obviously analytically opposite. The CHA's simultaneous claims that there are no motions in hearings and that hearings are bogged down by motions, discussed in Section IV(A)(2), above, is another example of Dignity Amici arguing both that hearing officers are in effect only well-paid administrative assistants and that hearing officers require far more knowledge and competence than retired judges and justices.

The truth lies in between those two extremes. The best and only evidence before this Court on the question of how hospital hearings are conducted is the administrative record in this case. The record shows that Dr. Natarajan's hearing was very similar to a superior court trial in most respects. Like a jury trial in superior court, there was a notice of charges that functioned like a complaint, discovery and pre-trial motions, voir dire of the hearing panel jury (albeit with no peremptory challenges), opening statements, witnesses who were subjected to direct and cross-examinations, with the hearing officer ruling on objections, closing statements, deliberations and a decision. (1 PAR 216 - 35 PAR 9461.)

Although Moore et al. contend that presiding over a hospital hearing requires occult knowledge that can only be gained by years of experience with peer review hearings, the record in this case shows no such need. All of the motions and other procedural questions raised by either party were briefed and/or argued by the parties' attorneys and then decided by the

hearing officer based on those arguments, the same as in any litigation.

Because of the relative rarity of hospital hearings, and the fact that such hearings began to take place only after the 1959 decision in *Wyatt v. Tahoe, supra,* the body of case law governing those hearings is not extensive, contrary to the representation of Moore et al. at p. 12 of their brief. There are not a large number of published opinions concerning hospital hearings, and a minority of them concern how a hearing is conducted. There are only eight published opinions that reference Section 809.2, including this one, and four of them are *Mileikowsky* cases involving the same physician.[12] A majority of the hospital hearing cases concern issues such as whether a physician was entitled to a hearing, whether a governing body was entitled to overrule a hearing panel decision or similar issues.

Compared to the caselaw governing legal issues with a longer history and more frequent litigation, such as contracts, torts, real property, insurance, family law or estates and trusts, there are very few cases addressing how a hospital hearing should be conducted. In a footnote, Moore et al. admit there is actually a "paucity of authority" on how a hearing is conducted. (Moore et al. brief, p. 12, n. 5.) As previously noted

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[12] *Mileikowsky v. West Hills Hospital and Medical Center, supra,* 45 Cal.4th 1259; *Mileikowsky v. Tenet Healthsystem* (2005) 128 Cal.App.4th 531; *Mileikowsky v. West Hills* (2007) 154 Cal.App.4th 752; and, *Mileikowsky v. West Hills* (2007) 151 Cal.App.4th 1249.

by Dr. Natarajan (RB, p. 38), there are only six procedural statutes that govern hospital hearings, compared to the hundreds that govern civil and criminal procedure.

In our legal system, judges and justices are considered competent to decide complex factual matters outside their legal expertise, in cases involving, inter alia, intellectual property, construction defects and environmental regulations.

Depending on the charges, a hospital hearing is similar to a medical malpractice and/or employment case in superior court. If the hospital charges problems with the clinical care of patients, the essential question is whether the physician failed to provide quality medical care. The primary difference is that in hospital hearings, the outcome is not necessarily based on whether the physician violated the standard of care or other objective standard, as discussed above. However, the review of medical records, percipient and expert witness testimony are similar to a malpractice action, as the testimony in this record shows. (20 PAR 2443 to 39 PAR 4523.)

Sometimes the hospital charges that the physician is a disruptive physician or otherwise has significant behavior issues that impair patient care. (See, e.g,, *Fahlen v Sutter Cental Valley Hospitals, supra,* 58 Cal.4th at 662-663.) In such cases, the hearing presents issues very similar to a wrongful termination of employment case, i.e., whether the conduct at issue warrants termination of the physician. There is no reason to believe that

retired judges and justices could not be briefed by the parties' attorneys on any legal issue that arises during a hospital hearing and then make intelligent decisions, with or without prior peer review experience.

Dignity's lawyer Shulman was an experienced hearing officer who appears on the CSHA's list of "Completed Hearings", so he could have easily conveyed any necessary esoteric knowledge to a hearing officer with less experience with hospital hearings. Dr. Natarajan proposed thirteen retired judges as neutral hearing officers. (1 PAR 218.) The idea that all of these retired judges were unqualified to serve as a hearing officer because they were not experienced hospital attorneys is untrue.

Dignity has never explained or addressed why it refused Dr. Natarajan's request that one of these retired judges, or another mutually-agreed-upon neutral, be appointed as hearing officer. In the absence of any explanation by Dignity, *Haas* requires this Court to adopt its presumption that Dignity was following its own rational self-interest by choosing someone who would issue rulings in its favor. (*Haas,* at 1029.)

Dignity Amici provide no evidence for the claimed lack of competence and intellectual capacity of retired judges and justices to preside over hospital hearings. Each of the hearing officer responsibilities described by Moore et al. at pp. 12-18 of their brief would be familiar to every judge or justice, because the same responsibilities frequently arise in law and motion practice and bench and jury trials.

The low esteem that Moore et al. have for retired judges and justices is echoed by Adventist Health et al. They suggest, without evidence, that a hearing officer without peer review experience would be unable to write a decision that links facts to conclusions, something judges and justices do as a basic, essential and routine part of their work. (Adventist Health, et al. brief, p. 28.) They also suggest that retired judges and justices would be incapable of applying the relaxed evidentiary standard used in hospital hearings, and that they might "reflexively" apply the rules of evidence. (Adventist Health et al. brief, p. 17.) The theory that retired judges and justices are incapable of writing decisions and that their reflexes are stronger than their intellects is unproven, to say the least.

Dignity Amici's argument that retired judges and justices are incompetent to serve as hospital hearing officers is intended to justify keeping hearing officers within the closed shop controlled by hospitals and hospital systems. The argument that only attorneys approved by the California Society for Healthcare Attorneys are fully "qualified" to serve as hearing officers is another facet of the closed shop. Under the CSHA rules, only attorneys that have been lead counsel or hearing officers in five completed hospital hearings are "qualified" to serve on the "Completed Hearings" list featured on the CSHA's website. (Moore et al. brief, p. 20-21.) Because hospitals systems own the majority of California hospitals (CMA amicus brief, p. 37), they almost certainly also hold the majority of

hospital hearings. By repeatedly using the same attorneys (such as Moore et al.) as lead counsel or hearing officers, those attorneys are able to obtain the requisite experience to be deemed fully "qualified" by the CSHA.

On the other hand, because of the relative rarity of hospital hearings, the many different attorneys who represent physicians, and the length of hospital hearings, it is likely that very few attorneys who do not represent medical staffs or hospitals are ever able to obtain sufficient experience to be deemed "qualified" for the CSHA's "Completed Hearings" list. It is noteworthy that there is not a single retired judge or justice on the "Completed Hearings" list. (https://www.csha.info/csha-hearing-officers.)

This is the same kind of qualification Catch 22 that has historically been used to exclude women and minorities from employment in trades and professions. Because you don't have the experience, you can't have the job, and you can't get the experience because no one will hire you.

More importantly, there is no guarantee that an attorney who does manage to make it onto the CSHA's list will ever be appointed by a hospital to serve as a hearing officer. The briefs of Dignity Amici make it clear that they want permission from this Court to continue to repeatedly appoint their favored attorneys as hearing officers without limitation. If *Natarajan* is affirmed, hospitals will be able to choose without restraint only those attorneys that they consider likely to issue rulings in their favor.

Dignity Amici's argument that neutral hearing officers will cause peer review in California to fail depends entirely on its argument that retired judges and justice are incompetent to serve as hearing officers. Because that contention is unsupported by evidence or reason, the policy argument of Dignity Amici collapses. There are ample numbers of available neutral hearing officers that hospitals can appoint who will not have an appearance of bias.

C. Experienced Hearing Officers With a Reputation for Impartiality Can Continue to Serve If Due Process Is Required in Hospital Hearings.

Dignity Amici assert that granting this Petition will result in the "automatic disqualification" of all experienced hearing officers. (Adventist Health et al. brief, p. 20; CHA brief, p. 23; see also, Moore et al. brief, p. 9 and Scripps and UC brief, p. 8.) That is incorrect. Granting the Petition will only give physicians a right, not a duty, to disqualify hearing officers with a financial incentive to favor hospitals or other appearance of bias. That is, hospitals will not be able to appoint hearing officers with an appearance of bias *without the consent of the physician.* That is an important distinction, because Dignity Amici assume, without evidence or logic, that physicians will disqualify every experienced hearing officer who has the possibility of being rehired in the future. Based on the representations of Moore et al., that will not be the case.

Requiring the use of the appearance of bias standard does not automatically disqualify anyone. Hearing appointments would continue to be considered on a case-by-case basis, with physicians having the right to challenge an appointed hearing officer after voir dire, pursuant to Section 809.2, subds. (b) and (c).

Adventist Health, et al., at p. 27 of their brief, note that "[o]ften the parties can agree on a hearing officer both sides know and trust." Moore et al. stress at pp. 25-27 of their brief that all hearing officers appointed by hospitals want a reputation of impartiality and to act fairly and impartially. They also assert that hospitals and medical staff only appoint hearing officers they believe will be fair and impartial, in order to protect patient safety and to be fair to physicians, and to avoid the risk of having the decision overturned in a writ of mandate proceeding. (Moore et al. brief pp. 27-30.) If those assertions are true, then there is no cause for concern that granting this Petition will cause any adverse impact on the peer review system, because the hearing officers appointed by hospitals and medical staffs will have a reputation of impartiality that will lead physicians to consent to their service.

One of the great advantages of granting this Petition is that all attorneys serving as hearing officers will have a direct financial incentive to conduct the hearing even-handedly, in order to develop a reputation for fairness that will avoid challenges by a physician to any future appointment

by a hospital or medical staff. This Court would thus place the financial incentives where they belong, advancing fairness and integrity, instead of a financial incentive to favor the prosecuting entity.

D. Hospitals Can Afford to Train and Hire Neutral Hearing Officers.

The CHA contends that hospitals cannot afford to provide neutral hearing officers through an "office of the hearing officer" and also argue that "engrafting costly trial procedures onto medical staff peer review" will discourage medical staff from policing their members." (CHA brief, p. 29-30.) The CHA"s argument, aside from being unsupported by any evidence in the record, is false and highly deceptive.

First, there is no evidence or logic supporting the idea that having neutral hearing officers will be significantly more costly than using attorneys with an appearance of bias, who presumably also charge substantial hourly rates. The CHA's brief claims that "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." (CHA brief, p. 30.) Hospital hearings are certainly costly for both sides, but the implication that having neutral hearing officers or due process would result in massive additional costs for medical staffs or hospitals is a fabrication. At most, there might be a

marginal increase in cost if neutrals from ADR agencies are used who have a higher hourly rate than attorneys with an appearance of bias.

Furthermore, as described in Section VI(C) above, if this Court requires neutral hearing officers, hospitals will still often be able to use the same hearing officers as before, if Moore et al.'s representation of the unblemished impartiality of commonly-used current hearing officers is accurate. When physicians agree to a hospital's choice, there will be no additional cost at all.

Second, the CHA is asserting that medical staffs pay for hearing officers and hearing expenses. That is another fabrication. It is contradicted by the record in this case that shows that Dignity, not any medical staff, paid Singer in at least ten of the eleven hearings he was appointed as hearing officer. (AAR 66-312.) It is also contradicted by the CHA's own brief, in which it admits that it is "routine" and "common" "for a hospital or health system to shoulder the costs of a medical staff hearings. (CHA brief, p. 47.) As noted by the CHA in its brief, "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." (*Ibid.*) There is no evidence that a medical staff has ever paid for the cost of a hearing officer rather than the hospital. The financial dependence of medical staffs on hospitals is also contrary to

Dignity Amici's claim that medical staffs are independent from hospitals when conducting peer review hearings.

Third, the argument that medical staffs would permit a dangerous doctor to continue to practice because of the possible incremental increased cost of using a neutral hearing officer is unsupported by the evidence. It is a scare tactic that only demonstrates just how much California hospitals want to be able to appoint their favored attorneys as hearing officers. If it were true, it would contradict the idea that all hospitals, medical staffs and hearing officers are only motivated by a desire to protect patient safety and to be fair, and that financial considerations do not affect their decision-making.

Fourth, the idea that private hospitals cannot afford neutral hearing officers is incorrect. It is contradicted by the fact that public hospitals have been providing neutral hearing officers for 40 years despite their more limited financial resources.

Even if one accepts the wrong-headed premise that retired judges and justices are incompetent to preside over hospital hearings because of their lack of peer review experience, it would be a simple and inexpensive matter for hospitals to train additional "qualified" hearing officers. As described by Moore et al., at pp. 19-22 of their brief, the CSHA has already developed training programs for hearing officers. The CHA or any of the large hospital systems could offer to pay for four, six, eight or twelve-hour

zoom trainings of ADR neutrals to teach them whatever esoteric knowledge the Dignity Amici claim is required to function as a hearing officer.

It's hard to imagine that the cost of such a training would exceed $30,000, including payments to presenters and marketing the program to ADR providers. The cost doing such a training would likely be less than the costs of the briefs the Dignity Amici have submitted. Even if a training cost $100,000, California's private hospitals can afford that amount to train additional hearing officers.

Based on its most recent publicly-available federal income tax filings from 2018, the CHA had annual net income of over $7 million, net worth of nearly $15 million, and spent nearly $1 million on legal fees and over $22 million on lobbying. (Dr. Natarajan's Fourth MJN, Exhibit 13, pp. 43-44.) The CHA could choose to spend less than two-tenths of one per cent of its lobbying expenses on training new hearing officers and almost certainly get the job done.

In their most recent tax filings, Respondent Dignity Health had over $119 million in net annual income, over $5 billion in net assets and paid its CEO over $11 million in salary and other compensation, even though it is a non-profit charitable corporation. (Dr. Natarajan's Fourth MJN, Exhibit 14, pp. 46, 48.) Amicus curiae Kaiser Foundation Health Plan, another non-profit, had over $307 million in net annual income, nearly $3 billion in

net assets and paid its CEO over $16,000,000 in 2018. (Dr. Natarajan's Fourth MJN, Exhibit 12, pp. 33, 35.)

In 2019, California general acute care hospitals, excluding Kaiser, had a net annual income of over $8 billion, over $65 billion in equity (net worth) and over $12 billion in cash. (Dr. Natarajan's Fourth MJN, Exhibit 11, pp. 28, 29.) The CHA's claim that California hospitals cannot afford to train and hire sufficient numbers of neutral hearing officers or to have hearings governed by due process is untrue.

VII. DUE PROCESS WILL IMPROVE, NOT HARM, PATIENT CARE.

A. Selecting a Neutral Hearing Officer Will Not Jeopardize Patient Care.

Dignity Amici strain to find a viable argument that neutral hearing officers and due process will somehow damage patient safety, but fail to do so. The argument that neutral hearing officers will dissuade medical staffs from suspending dangerous physicians is addressed in Section VI(D), above.

The CHA also argues that hearings are long, that "procedural barriers" interfere with their ability to exclude substandard physicians, and that doctors have an incentive to avoid the final outcome by delaying matters, in order to retain their privileges. (CHA Brief, p. 31-32.) The CHA asserts that it is common for hearings to take years. (CHA brief, p.

31.) However, Adventist Health et al. admit that most of the length of hearings is caused by the fact that they usually take place at night, and the necessity of coordinating the schedules of the many busy panel participants, including both physicians and attorneys. (Adventist Health et al. brief, p. 15.) Dignity amici provide no evidence that physician-caused delay is a significant cause of the length of hearings.

Dr. Natarajan agrees that hearings are often extremely lengthy, as demonstrated by the 19 months that passed between the notice of proposed adverse action and the final hospital decision in this case. (6 PAR 1386; 1 PAR 211.) Moreover, five and one-half years passed between the hospital's charges and the Court of Appeals' decision at issue here. (6 PAR 1386; *Natarajan, supra.*) Amply resourced hospitals may prefer longer hearings as part of a battle of attrition with physicians who lack their resources.

More importantly, the fact that many or most hearings go on for well over a year, and sometimes for multiple years, obviously is not a problem caused by any requirement of neutral hearing officers. Moore et al. insist that experienced "qualified" attorneys have the ability to manage the logistical challenges of hospital hearings. (Moore et al., pp. 18-19.) But those attorneys obviously have not been successful in doing so. For example, it was one of the Dignity Amici, Carlo Coppo, who presided over the hearing in *Sadeghi, supra,* that took two and one-half years. (Moore et

al. brief, p. 19, n. 11.) Retired judges and justices working through JAMS or AAA, who have administrative staff to assist with logistics, could hardly do worse and likely would do better.

In order to decide promptly on a neutral hearing officer, a hospital could adopt procedures that would expedite the selection. For example, a hospital could adopt a rule that the prosecuting entity will request five potential hearing officers from an ADR provider such as JAMS or the American Arbitration Association within three days of a physician's request for a hearing. Each side would have seven days to strike up to two persons from the list and rank the others in order of preference. The ADR provider would then designate the hearing officer based on the responses.[13] The entire selection process would take about two weeks, an insignificant amount of additional time given that hearings take many months or years. A physician would retain the right to voir dire the selected hearing officer pursuant to Section 809.2, subd. (c). Hospitals could also expedite the selection by adopting a rule that physicians facing discipline can appoint the hearing officer when they request hearings, subject to voir dire by the medical staff or hospitals, who could challenge the hearing officer for an appearance of bias.

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[13] This procedure is similar to those in JAMS Streamlined Arbitration Rules.
https://www.jamsadr.com/rules-streamlined-arbitration/#Rule12

Other than the slight delay in hearings to select the hearing officer, Dignity Amici have no other plausible or specific arguments supporting their contention that affirming physicians' right to due process will jeopardize patient safety.

The CHA's disdain for due process is exemplified by its comment that an approach to hearings "that does not incorporate all of the trappings of constitutional due process and trial litigation–is a good thing for patients." (CHA brief, p. 29.) However, a neutral hearing officer is not mere "trappings," some unimportant procedural requirement, an ornament that can be discarded without cost to the integrity and reliability of those hearings. The issue here is the impartiality of a hearing officer that will preside over a hearing with extremely high stakes. As Moore et al. recognize, monetary disputes "pale in comparison" to the consequences of hospital hearings for physicians. (Moore et al. brief, p. 18, n. 10.) No one would consider due process a mere "trapping" of civil trials, yet that is the CHA's position concerning hearings with much more significance to physicians, as well as an impact on the public health.

The CHA quotes *Medical Staff of Sharp Memorial Hospital v. Superior Court* (2004) 121 Cal.App.4th 173, 181-182, for the proposition that hospital hearings are not criminal cases, and patient safety must be valued more highly than the due process rights of physicians. Here, however, Dr. Natarajan is not seeking to require the same due process

protections provided to criminal defendants. He is seeking to affirm physicians' right to impartial adjudicators in hospital hearings, rather than ones with a financial incentive to favor hospitals. Other due process protections for hospital hearings are flexible and should reflect an assessment of their value and costs. (*Mathews v. Eldridge, supra,* 424 U.S. at 335.) As discussed in the AOB, pp. 77-78, this Court has recognized that impartial adjudicators are fundamental and essential for all quasi-judicial hearings in this state, not a mere "trapping." (*Haas,* 27 Cal.4th at 1036.)

In *Medical Staff of Sharp Memorial Hospital*, there was a tension between patient safety and due process rights, because the question was a hospital's authority to summarily suspend a physician who had mental health problems. (*Id.,* 121 Cal.App.4th at 175-180.) Here, on the other hand, there is no plausible argument that using hearing officers with an appearance of bias is good for patients. The fact that hospitals do have the power pursuant to Section 809.5 to summarily suspend physicians if they pose an imminent danger to anyone is an important safeguard that helps ensure that physicians' due process rights will not jeopardize patient care. (*Sahlolbei v. Providence Healthcare, Inc.* (2003) 112 Cal.App.4th 1137, 1159*; Hackethal v. Loma Linda Community Hosp. Corp.* (1979) 91 Cal.App.3d 59, 67.)

B. Requiring Due Process Will Benefit Patients and the Healthcare System.

The Legislature recognized that unfair peer review has a detrimental impact on patient care by removing patient access to competent physicians. (Section 809, subd. (a)(4).) This case demonstrates the potential impact of unfair hearings. As described in the AOB, pp. 17, 82, at the time of Dr. Natarajan's hearing, he had treated approximately 10,000 different hospitalized patients in 12 years of practice, with no malpractice cases ever filed against him and no evidence of harm to a single patient through substandard care. If Dignity's termination of his privileges eliminates or substantially impairs Dr. Natarajan's ability to practice medicine, tens of thousands of patients may lose access to a highly competent physician. The United States faces a severe physician shortage this decade. ("The Complexities of Physician Supply and Demand: Projections From 2018 to 2033", June 2020, by IHS Markit Ltd. for the American Association of Medical Colleges.)[14] Limiting or destroying the ability of competent physicians to practice only exacerbates that problem.

There are other less obvious negative impacts of unfair peer review. As discussed in the AOB, p. 40, peer review systems that are distorted by financial or other improper considerations not only create a risk of

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[14] This study can be found at: https://www.aamc.org/media/45976/download

damaging competent physicians. They also create a risk that physicians who are truly dangerous are protected from peer review scrutiny because they are creating revenue for the hospital or are well-connected to the hospital administration.

Requiring due process for physicians protects conscientious physicians who would like to expose improper peer review, but fear the consequences to their own lives and livelihoods if they do so. If physicians can have confidence that hospital hearings will function properly, and that they will receive due process if unfairly charged, they should have less fear of being targeted by hospital administrations or medical staff leadership if they report irregular peer review or other health and safety issues that the hospital management would prefer not be exposed.

Another reason unfair peer review damages the public health is the cost. As stated by the CHA, hearings can cost hospitals hundreds of thousands of dollars in payments to the hearing officer and the medical staff or hospital attorneys. (CHA brief, p. 30.) In this case Dignity paid the hearing officer $99,289.60. It likely paid the hospital and medical staff's attorney a similar amount or more. In addition, given that there were 19 evidentiary sessions, the total hours spent on the hearing by the physician panel, Dr. Natarajan, the physician witnesses and the medical staff representative likely well exceeded 400 hours, valuable time that could

otherwise have been expended on patient care. Dignity's defense of its action in the court probably drove its cost up to over a million dollars.

When hospitals use peer review illegitimately as a tool to target economic competitors or whistleblowers, there is a significant waste of health care resources that would have been much better spent on patient care. A rule that physicians in private hospitals are entitled to the same due process protections as physicians in public hospitals should deter such wasteful expenditures of precious healthcare dollars.

VIII. Dignity Amici's Legal Arguments Are Contrary to California Law.

A. Dignity Amici Do Not Dispute the Applicability of California Law Requiring Due Process for Physicians.

Before addressing Dignity Amici's legal arguments, it is important to note that they do not dispute most of the legal foundations for requiring the same due process for physicians in private and public hospitals.

Like Respondent Dignity (see RB, pp. 19-20), Dignity Amici do not dispute that the appearance of bias standard applies to ad hoc hearing officers in official quasi-judicial hearings, arbitrators, superior court judges and private attorneys serving as temporary judges; that physicians have a fundamental vested property right in their hospital privileges; and that there is no rational basis to give physicians in private hospitals less protection of

their hospital privilege than physicians in public hospitals, as set forth in Dr. Natarajan's AOB, pp. 28-44.

Dignity Amici also do not dispute that Section 809 et seq. did not supplant the common law; that the common law both before and after the enactment of Section 809 et seq. applies to hospital hearings (AOB pp. 52-60); that Section 809.2, subd. (c) is intended to ensure that physicians have an impartial hearing officer and hearing panel (AOB pp. 60-64); that physicians are entitled to hospital hearings meeting the prevailing standard of impartiality (AOB, pp. 76-77); that under *Natarajan*, only direct competitors and hearing officers who admit being promised a bribe or a bonus for a favorable outcome would be disqualified as hearing officers, in the absence of an admission of actual bias by the hearing officer (AOB, p. 67); that under *Natarajan*, even family members of the person appointing hearing officers could serve as hearing officers, unless they admitted actual bias (AOB p. 68); and that judicial review currently provides very limited protection to physicians. (AOB, pp. 82-85.)

Dignity Amici also do not dispute that the Legislature intended to provide due process protections to physicians when it enacted Section 809.1 - 809.4 and 809.6 and that the primary purpose of those laws is to protect physicians. (RB pp. 10-12.)

B. The Presumption That Entities Will Act in Their Own Self-Interest Applies to California Hospitals.

A key element of the legal argument of Dignity Amici is revealed in the footnote in the Adventist Health et al. brief, p. 27, n. 10. According to Adventist Health et al., the presumption of self-interest of hiring entities set forth in *Haas*, 27 Cal.4th at 1029, does not apply to hospitals because it is "inconsistent with the statutes and cases cited here, including *El-Attar*, and their underlying principles."

This footnote correctly recognizes that the arguments of the CHA, Adventist Health and Moore et al. all are inconsistent with the presumption of self-interest in *Haas*. Their arguments rest on the premise that hospitals and their appointed hearing officers can be trusted to be fair, even when their financial interests give them an incentive to provide an unfair hearing. Nothing in the law of California, the history of hospitals in California or the real world supports a theory that unlike government entities, other private corporations and individuals, private hospitals alone are exempt from the presumption that they will act to further their own rational self-interest.

The very reason hospital hearings exist in the law is the realization of California courts and the Legislature that hospitals *cannot* be trusted to invariably be fair, and that their decisions directly affect both physicians' ability to practice their livelihoods and the public health. (*Wyatt v. Tahoe Forest Hospital, supra;* Section 809.) If hospitals were always the perfectly

fair institutions they purport to be, neither the Courts nor the Legislature would have needed to impose hearing requirements on them.

Adventist Health et al.'s assertion that statutes cited in their brief support their exemption from the presumption of self-interest is not supported by the language of those statutes or any case law.

The presumption of regularity of official duties in Evidence Code § 664 has never been interpreted to mean that any official conduct is lawful. Otherwise, government officials could act without restraint. It only creates a rebuttable presumption of the regularity of official actions. (*Inyo Citizens for Better Planning v. Inyo County Board of Supervisors* (2009) 180 Cal.App.4th 1, 13.) Here, Dr. Natarajan has provided ample evidence that Dignity's appointment of the hearing officer violated his statutory and common law right to due process and an impartial hearing officer.

Likewise, the statement that "private transactions are fair and regular" of Civil Code § 3545 is no longer even a presumption, it is only a maxim which has no application when, as here, there is evidence that legal requirements have been violated. (*California Shoppers, Inc. v. Royal Globe Ins. Co.* (1985) 175 Cal.App.3d 1, 47.) Likewise, the maxim of Civil Code § 3548 that the law has been obeyed obviously does not apply when there is evidence that the law has not been followed.

None of these very general presumptions and maxims provide a scintilla of support for the theory that the presumption that hiring entities will act in their own rational self-interest is inapplicable to hospitals.

Adventist Health et al.'s assertion that *El-Attar v. Hollywood Presbyterian Medical Center* (2013) 56 Cal.4th 976 altered *Haas sub silencio* to remove its presumption of self-interest is not supported by the language or the holding of the case. The portion of *El-Attar* quoted by Adventist Health et al. on p. 23 of their brief only holds that there is no presumption of bias of a hearing officer or panel member simply because they were appointed by the governing body. (*Id.,* at 995-996.)

In *El-Attar*, unlike here, there was no evidence that the hearing officer had any financial incentive to favor the hospital, or that the hospital had any financial incentive to want to terminate Dr. El-Attar's privileges. *El-Attar* specifically noted the absence of any evidence of a pecuniary or other conflict-of-interest as a reason for its holding. (*Id.* at 996.) After doing so, it cited *Haas, Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 483–486*,* and *Applebaum v. Bd. of Directors of Barton Memorial Hospital* (1980) 104 Cal.App.3d 648, 659–660 as cases where there were conflicts-of-interest that rendered hearings unfair. (*Id.,* at 996-997.) The idea that *El-Attar* somehow implicitly overruled the presumption that entities will act in their own self-interest is completely unwarranted.

To the contrary, as discussed in Dr. Natarajan's AOB, p. 44, *El-Attar's* reference to *Haas, Yaqub* and *Applebaum* in a case involving a private hospital makes it clear that this Court considered that those cases apply to private hospital hearings. Respondent Dignity and the Dignity Amici effectively agree that if *Haas* and *Yaqub* apply to this case, this Petition should be granted, given their arguments that *Haas* and *Yaqub* do not apply and/or that *Yaqub* was wrongly decided. (CHA brief, pp. 37-40; Adventist Health et al. brief, pp. 20, 25; Scripps and UC brief, pp. 8-11; Moore et al. brief, pp. 23-25.)

At p. 21 of its brief, Adventist Health et al. cite *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center* (1998) 62 Cal.App.4th 1123, 1142, *Rhee v. El Camino Hospital District* (1988) 201 Cal.App.3d 477, 494, and *Gill v. Mercy Hospital* (1988) 199 Cal.App.3d 889, 911, for the proposition that disqualification is only required if there is a probability of unfairness. As discussed in Dr. Natarajan's AOB, pp. 31-33, the probability of bias is the same as the appearance of bias, and *Haas* held that there is a probability of bias when a hearing officer has a financial incentive to favor the hiring entity. (*Id.,* 27 Cal.4th at 1027.) None of these cases, all of which preceded *Haas*, hold that the presumption that entities will act in their own self-interest stated in *Haas* is inapplicable to the selection of hospital hearing officers.

The history and conduct of hospitals described above, and the purpose of hospital hearings, makes it obvious that the presumption that they will act in their own rational self-interest should and does apply to them. That is one of the most important reasons why this Court should clearly affirm that physicians working in private hospitals are entitled to the same due process protections as physicians in public hospitals, as held in *Applebaum, supra,* 104 Cal.App.3d at 657.

C. Hearing Officers Are Adjudicators Subject to the *Haas* Doctrine.

The amicus brief of Scripps and UC focuses on the argument that hearing officers are not adjudicators, based on the fact that the hearing officer is not supposed to be the decision-maker in hospital hearings. (Scripps and UC brief, pp. 8-18.)

Generally, adjudication refers to adversarial proceedings in which evidence is presented and there are opportunities for cross-examination and rebuttal. (*Rivera v. Division of Industrial Welfare* (1968) 265 Cal.App.2d 576, 586.) Persons who preside over adversarial hearings, as well as subsequent decision-makers, are adjudicators, because they make decisions that can determine the outcome of a hearing.

The Legislature plainly recognized that hearing officers are adjudicators with the ability to influence the outcome of a hearing when it enacted Section 809.2, because it required hearing officers to be impartial;

gave physicians the right to voir dire them to uncover any bias; and prohibited them from acting as an advocate or having a financial interest in the outcome of the proceedings. These requirements of Section 809.2 are only consistent with a legislative recognition that hearing officers are adjudicators. To Plaintiff's knowledge, the requirements of impartiality and voir dire are not imposed on any non-adjudicators under California law.

Likewise, California courts have recognized that hearing officers are adjudicators. *Yaqub, supra,* clearly considered the hearing officer an adjudicator subject to the *Haas* doctrine. It expressly rejected the hospital's contention that the hearing officer was not an adjudicator because he did not make a final decision on the physician's termination. (*Yaqub,* 122 Cal.App.4th at 484-485.) Even though *Yaqub* is obviously one of the two cases most central to this appeal, Scripps and UC make no attempt to distinguish its holding on this point, not even mentioning *Yaqub* in their brief.

Although Dignity argued below that hearing officers are not adjudicators (Dignity Court of Appeal Answer, pp. 36-37), the Court of Appeal clearly did not accept that argument. It repeatedly used the term "adjudicator" to refer to hospital hearing officers. (*Natarajan*, 35 Cal.App. 5th at 389-391.

Scripps and UC claim that hospital hearing officers are not judges, and that *Haas* only applies to judges. They assert that the hearing officer in

Haas decided the merits and therefore was not a hearing officer but rather a judge. (Scripps and UC brief, pp. 8-10.) Their argument is incorrect both as a matter of law and as a matter of fact. In *Haas*, the hearing officer was not a judge, she was expressly denominated a hearing officer under the applicable statutes. (Government Code § 27720 et seq.) The hearing officer in *Haas* only made a recommendation to the government agency, not the final decision. (*Haas*, 27 Cal.4th at 1023.) Scripps and UC call the hearing officer an "administrative judge" (p. 9), but that language was never used by this Court. Justice Werdeger's opinion invariably referred to the adjudicator at issue as a hearing officer, not as a judge. (*Id.,* at 1020-1024.) The Court also consistently used the term "adjudicator" to refer to administrative hearing officers. (*Id.* at 1024-1036.) Scripps and UC's implicit contention that this Court was careless in its language is unwarranted.

Scripps and UC are attempting to create a technical distinction between a hearing officer and a judge that has no basis in fact or in the law. As described above, hospital hearing officers and judges perform essentially the same functions when presiding over a hearing, and hearing officers, like judges, have the ability to influence the outcome of a hearing with their rulings. Scripps and UC's theory was expressly rejected by *Haas:* "While the rules governing the disqualification of administrative hearing officers

are in some respects more flexible than those governing judges, the rules are not more flexible on the subject of financial interest." (*Id,* at 1024.)

Scripps and UC also argue that *Haas* should not apply because hospitals adopt safeguards in their bylaws to reduce the risk of hearing officer bias. (Scripps and UC brief, pp. 19-20.) The "safeguards" referenced by Scripps and UC are simply the statutory requirements required by Section 809 et seq. (*Ibid.*) There is no evidence in the record that any hospitals have adopted "safeguards" more stringent than what they are required to do under Section 809 et seq. As this case demonstrates, the opportunity to voir dire hearing officers provides no real protection because hearing officers are entitled to decide whether they are biased. And the prohibition on a hearing officer having a financial interest in the outcome provides no protection if that rule only prohibits bribes and bonuses for a favorable outcome, and not a financial incentive to favor the hospital.

Scripps and UC cite *County of Santa Clara v. Superior Court* (2010) 50 Cal.4th 35, 51, on the theory that hospital hearing officers are more like prosecutors than judges. Based on that theory, they contend that a hearing officer with a financial interest in the outcome under *Haas* is permitted. (Scripps and UC brief, p. 10.) While it may be true that some hearing officers act more like prosecutors than judges, Section 809.2, subd. (b) prohibits hospital hearing officers serving as prosecuting officers or advocates, consistent with *County of Santa Clara*: "It is well established

that the disqualification rules applicable to adjudicators are more stringent than those that govern the conduct of prosecutors and other government attorneys." (*Id.,* 50 Cal.4th at 57, n.12.)

Likewise, Scripps and UC's argument reliance on *Marshall v. Jerrico, Inc.* (1980) 446 U.S. 238, 248, fails for the same reason. In *Marshall,* the Court found that a federal administrator was not a judge, and therefore not subject to the law governing judicial qualifications, because he performed no judicial or quasi-judicial functions, and did not rule on any disputed factual or legal questions, unlike hospital hearing officers. (*Id.,* at 247.)

D. *Natarajan* Would Render Section 809.2 Toothless.

As described in Dr. Natarajan's AOB, pp. 67-69, because actual bias is effectively impossible to prove absent an admission from the hearing officer, under *Natarajan* hearing officers could only be disqualified when physician could somehow prove that they had taken bribes or bonuses for a favorable outcome. In response, the CHA argues that *Natarajan* would not render Section 809.2 toothless, because it "could be interpreted to prevent the appointment of a competing physician as the hearing officer." (CHA amicus brief, p. 25.) This sentence demonstrates precisely how toothless Section 809.2 subds. (b) and (c) would be under *Natarajan.* The CHA model bylaws *require* that the hearing officer be an attorney. (CHA MJN, p. 9.) Dignity Amici have insisted throughout their briefs that only very

experienced "qualified" attorneys should be appointed as hearing officers, so they obviously would never appoint a physician as a hearing officer. They collectively constitute a huge swath of the hospital industry, with Kaiser alone serving over eight million California residents. (Adventist et al. brief, p. 3.) The idea that Section 809.2 subd. (b) would be enforced only when a physician competitor is appointed as hearing officer would mean that it would be enforced about as often as the proverbial cow jumps over the moon. The CHA's argument confirms that *Natarajan* would render Section 809.2, subd. (b) nugatory.

E. The Appearance of Bias Standard Applies to Hospital Hearings.

1. The Legislature Had to Act Quickly When It Adopted Section 809 Et Seq.

The CHA argues that the appearance of bias standard does not apply to hospital hearings because Section 809 et seq. does not provide the same comprehensive language that the Legislature used when it enacted statutes governing arbitrators and judges, and it did not expressly state that it was adopting the appearance of bias standard. (CHA brief, pp. 23-24.)

The CHA's argument does not take into account the purpose and the circumstances of the adoption of Section 809 et seq. The brevity and gaps in Section 809 et seq. were likely the result of the short timeline the Legislature had to enact the law, combined with conflict between the CMA

and the CHA over whether SB 1211 should be passed. Based on the legislative history, it can be said with certainty that the Legislature did not intend to change the law to limit the due process rights provided by the common law.

As stated in Section 809, subd. (a)(1) and (2), and subd. (a)(9)(A), the primary reason the Legislature enacted Section 809 et seq. was to opt-out of the federal Health Care Quality Improvement Act (HCQIA), because of deficiencies in HCQIA. The Legislature faced a short timeline to do so. HCQIA only permitted states to opt-out before October 14, 1989. (Dr. Natarajan's Response to Dignity's MJN, Exhibit A, p. 43.) Sen. Barry Keene introduced SB 1211 on March 8, 1989. (Exhibit A, p. 5.) Because of the short time available to enact the legislation, it was soon thereafter declared an urgency bill to take effect immediately. (Exhibit A, pp. 13, 46.) It was amended on April 12, May 2, July 7 and July 20, 1989. (Exhibit A, p. 32.)

The Legislature thus had little time to pass the bill as amended before the State's opportunity to opt-out expired. It also faced conflict over the bill between the CMA, the bill's chief proponent, and the CHA (then the California Association of Hospitals and Health Systems, or CAHHS). The CHA strongly opposed SB 1211, making the same argument it now uses to oppose due process rights for physicians before this Court. It claimed that SB 1211 would make it more difficult to discipline physicians

and therefore threaten patient care because it would be harder to dismiss "marginal" physicians. (Exhibit A, pp. 70-71.)

"The Legislature, of course, is deemed to be aware of statutes and judicial decisions already in existence, and to have enacted or amended a statute in light thereof." (*People v. Yartz* (2005) 37 Cal.4th 529, 538.) The most reasonable conclusion from the legislative history is that the Legislature was only able to agree on the basic structure of hospital hearings due to the lack of time and the lack of agreement between the CMA and the CHA, and therefore relied on the courts to interpret those laws in light of the common law. That explains why there are gaps in the legislation, including the failure to state who has the authority to choose the hearing officer and the failure to state what standard of bias should be used to evaluate impartiality. (Section 809.2.)

2. The Legislature Did Not Adopt an Actual Bias Standard.

As described in Dr. Natarajan's Reply Brief, pp. 12-16, Dignity and Dr. Natarajan agree that the "direct financial benefit from the outcome" language in Section 809.2, subd. (b) was derived from the common law. In 1989, the common law applied the "probability of bias" standard which is the same as the "appearance of bias" standard, as discussed above and in the AOB, at pp. 31-33. The common law in 1989 also included the holdings in *Applebaum v. Bd. of Directors of Barton Memorial Hospital,*

supra, that fair procedure and constitutional due process provide the same extent of protection and that physicians are entitled to hearings meeting "at least currently prevailing standards of impartiality." (*Id.,* 104 Cal.App.3d at 657-658.) The legislative history strongly supports a conclusion that the Legislature was effectively adopting the appearance of bias standard when it passed SB 1211. (RB, 12-16.) The CHA's argument does not dispute or even address the legislative history described in the Reply Brief.

As described in Dr. Natarajan's Reply Brief, pp. 10-11, the legislative history is clear that a primary purpose of the bill was to protect physician's due process rights. (See, e.g., Exhibit A, p. 68.) The right to challenge the impartiality of the hearing officer was one of the due process rights provided to physicians. (*Ibid.*)

According to the legislative history, the Legislature intended to strengthen, not weaken, existing common law protections for physicians. A legislative analysis states that "SB 1211 requires adoption of procedures which may not be required as a matter of the common law doctrine of fair procedure." (Exhibit A, p. 70.) The CHA's own contemporaneous analysis that SB 1211 would make it more difficult to discipline physicians is inconsistent with its current argument that the Legislature intended to adopt a more restrictive actual bias standard through SB 1211.

The CMA, the primary advocate for SB 1211, argued for the adopting of those protections specifically to protect physicians from

hospitals using peer review to eliminate competitors or other physicians who were hurting the hospital's bottom line. The record of the hearing of the Assembly Subcommittee on Justice of July 11, 1989, states:

> CMA argues strongly that these procedures will prevent abuse of the peer review process, such as that witnessed in the Patrick case when the peer review process was wielded as an economic club against a competitor and not on the basis of patient care. For example, CMA argues that licentiates who admit "too many" Medi-Cal patients or refuse to quickly discharge elderly patients will, under SB 1211, be safe from the abusive use of the peer review process.

(Exhibit A, p. 70.)[15]

The legislature history of this bill is entirely inconsistent with the CHA's argument that the legislature intended to change the existing common law probability of bias standard to one of actual bias. There is not one word in the legislature history that evinces any intent to require an actual bias standard, or to limit the grounds of disqualification of hearing

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[15] It is noteworthy that Dignity refused to renew Dr. Natarajan's contract as chief of its hospitalist group after he repeatedly refused its requests that he see less ill patients before critically ill patients, which would have jeopardized the safety of the critically ill patients. Dignity had a financial incentive to discharge Medicare patients quickly because they received a set amount for those patients and their additional time in the hospital had the effect of reducing Dignity's revenues. It was Dignity's refusal to renew Dr. Natarajan's contract as Chief of its hospitalist group that led him to form his own hospitalist group, a competitor to Dignity. Dignity then became hostile to Dr. Natarajan and attempted to damage his group by recruiting its physicians and calling primary care physicians to dissuade them from using Dr. Natarajan's group. After those efforts failed, it moved to terminate his hospital privileges as described above. (16 PAR 3752-3753; 6 PAR 1375-1376.)

officers to direct competitors, or those receiving bribes or bonuses based on the outcome of hearings.

F. Due Process Standards Are the Same for Public and Private Hospitals.

None of the Dignity Amici address the fundamental irrationality of having different due process standards for physicians depending on whether they work in public or private hospitals. The Dignity Amici do not dispute that they are quasi-public institutions and that their control over hospital privileges is a fiduciary power to be exercised reasonably and for the public good. (*Ascherman v. San Francisco Medical Society, supra,* 39 Cal.App.3d at 631, 664.) They do not dispute that they have been given the power to take the fundamental vested power property rights of physicians through hospital hearings. (*Anton v. San Antonio Community Hospital,* supra, 19 Cal.3d 802 at 823-825.) They do not deny that hospital hearings are official proceedings under California law, comparable to quasi-judicial public agencies, and that those hearings are an essential element of California's system of safeguarding the public health through identifying and disciplining substandard physicians. (*Kibler v. Northern Inyo County Local Hospital Dist.* (2006) 39 Cal.4th 192, 199-201.)

Dignity Amici also fail to provide any policy reason why private hospitals in California should be entitled to terminate the privileges of physicians using hearing officers with an appearance of bias when public

hospitals cannot. Although private hospitals are owned and governed by private corporations, public funding provided 71 per cent of their gross revenue and 58 percent of their net revenue in 2019. (Dr. Natarajan's Fourth MJN, Exhibit 11, p 31.) Hospitals serve a vital public purpose, as the pandemic has emphatically proven.

Dignity Amici also fail to address the long-standing California law that physicians in public and private hospitals have the same due process rights, including not only *Applebaum, supra,* but also this Court's decisions in *Anton, supra,* 19 Cal.3d at 815, and *El-Attar, supra,* 56 Cal.4th at 987. The CHA only asserts, without authority, that "[t]he law generally expects more of the government than of private actors." (CHA brief, p. 37.) While that may "generally" be true, in the case of hospital hearings, it is not, for good reason.

Hospital hearings are the only official quasi-judicial hearings that the State has placed in the hands of private entities.[16] Private hospital hearings are conducted by private corporations subject to financial imperatives that are always important and sometimes paramount. Private hospital executives, managers and attorneys are thus subject to the temptation to hold unfair hospital hearings to a far, far greater extent than the public officials and judges, salaried government employees, who are responsible

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[16] Private arbitrations are not official proceedings under California law. (*Zhang v. Jenevein* (2019) 31 Cal.App.5th 585, 596.)

for public quasi-judicial and judicial proceedings. The due process safeguards applicable to private hospitals need to be at least as great as those applicable to public entities, if not greater.

Dignity Amici fail to address the irrationality of treating doctors in private and public hospitals differently in hospital hearings because they cannot deny it.

G. *Yaqub* States the Correct Standard Applicable to Hospital Hearing Officers.

In its amicus brief, the CMA correctly asserts that *Yaqub* is the governing precedent on the issue presented here, and that it is necessary to use its broad impartiality standard: "The question is not whether the [hearing officer] is actually biased, but whether a person aware of the facts might reasonably entertain a doubt that the [hearing officer] would be able to act with integrity, impartiality, and competence." (*Id.,* 122 Cal.App.4th at 486.) A decision limited to a holding that *Haas* applies here, prohibiting hearing officers with a financial incentive to favor the appointing entity, would not address issues such as the personal relationships between hearing officers and the attorneys that select them or other potential conflicts of interest. This Court should therefore affirm that the same appearance of bias standard that applies to superior court judges, temporary judges, administrative law judges, arbitrators and public hospital hearing officers also applies to private hospital hearing officers.

It should also affirm the holding in *Applebaum, supra,* that the extent of due process protection for physicians is the same whether they work in public or private hospitals. Doing so will clarify the law, help ensure fair hearings in private hospitals, provide clear guidance for hospital hearing officers and lower courts evaluating the fairness of hearings, and avoid any question about whether California's system of peer review violates the due process requirements of the state or federal constitutions.

H. The Correct Remedy Is to Overturn the Hearing Decision, Permitting Dr. Natarajan to Proceed in Superior Court.

Adventist Health et al. argue that Dr. Natarajan's only remedy if his Petition for a Writ of Mandate is granted would be another hearing controlled by Dignity Health. (Adventist Health et al. brief, p. 31-32.) In doing so, they do not mention or attempt to distinguish *Westlake Community Hospital v. Superior Court* (1976) 17 Cal.3d 465, 469, 484, the leading case on this question. (AOB p. 86.) Nor do they address the practical reasons why it would make no sense to require physicians to endlessly go through hospital hearings. (AOB, p. 86.)

Given that both Dignity and Adventist Health et al. have called into question Dr. Natarajan's right to proceed with an action in superior court if his Petition is granted, this Court should affirm the *Westlake* holding that physicians who are subjected to hearings that courts find unfair have a right to file civil court actions for equitable relief, including reinstatement, and

damages. Doing so will provide needed guidance for lower courts on this issue.

IX. CONCLUSION

Adventist Health et al. argue that courts cannot presume that hospitals will act badly, citing *El-Attar, supra,* 56 Cal.4th at 995-996.) (Adventist Health et al. brief, p. 22.) That is true. It is also true that this Court cannot presume that all hospitals will always act fairly, either. In the same passage quoted by Adventist Health et al., this Court recognized the potential for abuse of peer review hearings.

Requiring due process for physicians will only help ensure that hospitals act fairly and deter private hospitals from using peer review as a tool to terminate economic competitors, whistleblowers or other disfavored physicians. All physicians have spent a decade or more of their lives studying and working to have careers in medicine. They all deserve the same due process to prevent their careers from being devastated or destroyed, whether they work in public or private hospitals.

Dated: January 14, 2021

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

Pursuant to Rule 8.360, subd. (b)(1), I certify that the attached brief uses the 13 point Times New Roman font and contains 22,022 words.

Dated: January 14, 2020

By Stephen D. Schear
Stephen D. Schear
Attorney for Petitioner and Appellant
Sundar Natarajan, M.D.

PROOF OF SERVICE

Re: Natarajan v. Dignity Health, Supreme Court Case No. S259364

I, the undersigned, hereby declare:

I am a citizen of the United States of America over the age of eighteen years. My business address is 2831 Telegraph Avenue, Oakland, CA 94609. I am not a party to this action.

On January 14, 2021, I served this Petitioner's Consolidated Answer to Amicus Briefs on the following persons/parties by electronically mailing a true and correct copy through the True Filing filing and service electronic mail system to the e-mail addresses, as stated below, and the transmission was reported as complete and no error was reported.

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I declare under penalty of perjury the foregoing is true and correct.

Date: January 14, 2021 Stephen D. Schear

Oakland, California Stephen D. Schear

STATE OF CALIFORNIA
Supreme Court of California

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STATE OF CALIFORNIA
Supreme Court of California

Case Name: **NATARAJAN v. DIGNITY HEALTH**
Case Number: **S259364**
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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

1/14/2021

Date

/s/Stephen Schear

Signature

Schear, Stephen (83806)

Last Name, First Name (PNum)

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