

4th Civil No. _____

**IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FOURTH APPELLATE DISTRICT, DIVISION THREE
DIVISION THREE**

HOAG MEMORIAL HOSPITAL
PRESBYTERIAN,

Petitioner,

v.

SUPERIOR COURT OF ORANGE COUNTY,

Respondent.

CERTAIN JOHN DOE PLAINTIFFS (details
on next page),

Real Parties in Interest.

Orange Superior Court
Case No. 30-2023-01370866-
CU-PO-NJC

Hon. Melissa R. McCormick
Department: CX105
Telephone: (657) 622-5305

**PETITION FOR WRIT OF MANDATE, PROHIBITION
OR OTHER APPROPRIATE RELIEF;
MEMORANDUM OF POINTS AND AUTHORITIES**

[Exhibits Filed Under Separate Cover]

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The real parties in interest are those John Doe plaintiffs in the Master Complaint associated with these Unique Identification Numbers: 2, 4, 5, 6, 8, 9, 10, 11, 13, 14, 16, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 32, 33, 34, 35, 37, 39, 41, 43, 44, 46, 50, 51, 57, 59, 62, 64, 65, 66, 67, 68, 69, 71, 72, 76, 77, 78, 79, 80, 81, 86, 87, 88, 90, 91, 92, 93, 94, 97, 98, 99, 100, 101, 104, 105, 107, 109, 111, 112, 113, 116, 117, 118, 119, 121, 122, 123, 124, 125, 127, 129, 130, 133, 134, 135, 136, 137, 138, 140, 141, 144, 148, 152, 153, 156, 157, 158, 159, 160, 164, 165, 167, 168, 169, 171, 173, 174, 176

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**Court of Appeal
State of California
Fourth Appellate District**

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Court of Appeal Case Number: _____

Case Name: Hoag Memorial Hospital Presbyterian v. Superior Court of Orange County (Certain John Doe Plaintiffs)

Please check the applicable box:

- There are no interested entities or parties to list in this Certificate per California Rules of Court, Rule 8.208.
- Interested entities or parties are listed below:

| <u>Name of Interested Entity or Person</u> | <u>Nature of Interest</u> |
|--|---------------------------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

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ISSUE PRESENTED

Does a hospital have a duty to protect victims of misconduct by a physician who is a member of the hospital's medical staff, when the misconduct occurs solely in the physician's private office or home?

INTRODUCTION

“The law never requires impossibilities.” (Civ. Code, § 3531.) But that is what the trial court has done.

For over 40 years the law has been clear that a hospital owes duties only to its patients. (*Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332 (*Elam*)). Although the trial court correctly applied that law when sustaining petitioner Hoag Memorial Hospital Presbyterian’s first demurrer, in its second demurrer ruling it did not. Instead, it imposed an unprecedented duty on hospitals to protect *non-patients* from physician misconduct occurring *outside the hospital*.

The ruling upends long-established rules governing hospitals’ duties to patients. Worse, it is impossibly vague. It offers no guidance as to what hospitals can do—if indeed they can do anything—to discharge the supposed duty. And its potential scope is breathtaking, reaching not only sexual abuse like that alleged here, but also virtually every case of a physician’s medical malpractice while treating his own private patients.

The ruling isn’t just the simple extension of an existing duty. It runs contrary to deeply rooted public policies dating back over a century that *prohibit* hospitals from controlling or disciplining physicians outside the hospital. It also distorts the complex web of regulations to which hospitals are already subject and contravenes a direct expression of legislative intent that limits hospitals’ responsibilities in cases of sexual abuse.

The trial court grounded its ruling in the belief that a hospital can control a physician member of its medical staff because, the court said, the hospital could revoke the physician's medical staff privileges. But as a matter of law a hospital has no power to monitor and control medical care outside of its facilities. It would be contrary to California's long-standing prohibition against the corporate practice of medicine, under which a hospital *cannot* control physicians.

Hospitals provide a facility for the delivery of medical care by physicians who have clinical privileges to treat patients *at the hospital*. The independent medical staff of a hospital evaluates clinical competency and, if satisfied, confers clinical privileges only *at the hospital*. To the extent a hospital has any power to monitor and control medical care, that power is limited to what happens at that facility and the provisions of the medical staff bylaws. Off premises, the hospital has no power at all.

At bottom, the trial court's ruling demands that hospitals exercise supervisory power and control that as a matter of law they do not have. It thus demands the impossible.

But without this Court's intervention, this demand could well spread throughout California, confronting the medical community with years of uncertainty as they struggle to figure out how—if at all—they can adopt procedures that will comply with the demand.

Whether a duty exists is a question of law that the Court can address now. It should grant this petition and direct the trial court to sustain Hoag's demurrer.

PETITION

A. The parties.

1. Petitioner Hoag Memorial Hospital Presbyterian is a nonprofit, general acute-care hospital in Newport Beach, California, which has been serving the Orange County community since 1944. (1-Petitioner's Exhibits (PE)-758.)¹ Hoag is widely recognized for the quality of its services and its commitment to patient safety. The Centers for Medicare and Medicaid Services has awarded Hoag a perfect five-out-of-five-star quality rating every year since 2021.²

2. Real parties in interest are 110 of the plaintiffs in a coordinated proceeding involving 27 related civil lawsuits pending in Orange County Superior Court (the Actions).³ All of

¹ The exhibits in the accompanying appendix are accurate copies of documents filed in the underlying action except for the reporter's transcript, which accurately reports the proceedings it describes. All exhibits are incorporated herein by reference.

² U.S. Centers for Medicare and Medicaid Services, Hospital: Hoag Memorial Presbyterian Hospital, available at <<https://tinyurl.com/yeyj78j4>> (as of Mar. 25, 2026); Hoag, *Hoag Again Named 5-Star Quality Hospital by CMS* (Aug. 18, 2025), available at <<https://tinyurl.com/28u9ucl5>> (as of Mar. 25, 2026).

³ *John Does 1-13 v. Dr. William Moore Thompson, IV, et al.*, No. 30-2023-01370866-CU-PO-CXC; *John Does 74-106 v. Thompson et al.*, Case No. 30-2024-01385792-CU-PO-CXC; *John Does 107-135 v. Thompson et al.*, Case No. 30-2024-01409756; *John Does 136-139 v. Thompson et al.*, Case No. 30-2024-01416159; *John Does 140-144 v. Thompson, et al.*, Case No. 30-2024-01440412; *John Does 1-4 v. Thompson et al.*, Case No. 30-2024-01385767-CU-PO-CXC; *John Doe v. Thompson et al.*,

[Footnote Continues on Next Page]

the Actions arise from the plaintiffs' claims that they were sexually abused by defendant William Moore Thompson, IV, a former member of the medical staff at Hoag.⁴

3. Thompson was a physician specializing in infectious disease and practicing in Orange County. He was well known, especially in the LGBTQ+ community, for his treatment and

Case No. 30-2024-01376857-CU-PN-CJC; *John Doe A.A. v. Thompson et al.*, Case No, 30-2024-01378171-CU-PO-CXC; *John Doe C.M. v. Thompson et al.*, Case No. 30-2024-01396628-CU-PO-CJC; *John Doe S.G. v. Thompson et al.*, Case No. 30-2024-01396654-CU-PO-NJC; *John Doe J.S. v. Thompson et al.*, Case No, 30-2023-01368669 -CU-PO-CJC; *Tinsley v. Thompson et al.*, Case No, 30-2024- 01390386-CU-PO-CXC; *John Doe K.S. v. Thompson et al.*, Case No, 30-2024-01395290-CU-PO-CJC; *John Doe CLF 1 v. Thompson et al.*, Case No, 30-2024-01396653-CU-PO-CJC; *John Doe G.F. v. Thompson et al.*, Case No, 30-2024-01424123-CU-PO-CJC; *John Doe 7125 v. Thompson et al.*, Case No, 30-2024-01430121 -CU-PO-CJC; *John Doe S.W. v. Thompson et al.*, Case No, 30-2024- 01443579-CU-PO-NJC; *John Doe 7131 v. Thompson et al.*, Case No, 30-2024-01446875-CU-PO-NJC; *John Doe A.U. v. Thompson et al.*, Case No, 30-2024-01450837-CU-PO-CJC; *John Doe (F.O.) v. Thompson et al.*, Case No, 30-2025-01456377-CU-PN-CJC; *John Doe (D.H.) v. Thompson, et al.*, Case No, 30-2025-01459516-CU-PO-CJC; *John Doe D.R. v. Thompson et al.*, Case No, 30-2025-01472233-CU-PO-CXC; *J.A. v. Thompson et al.*, Case No, 30-2025-01479176-CU-PO-NJC; *John Doe C.S. v. Thompson et al.*, Case No, 30-2025-01483383-CU-PO-CJC; *John Doe C.Z. v. Thompson et al.*, Case No, 30-2025-01501870-CU-PO-CJC; *John Doe J.A. v. Thompson et al.*, Case No, 30-2025-01510207-CU-PO-CXC; *John Doe J.H. v. Thompson et al.*, Case No, 30-2025-01511285-CU-PO-CXC .

⁴ William Moore Thompson, IV, M.D., Inc., and William Moore Thompson, IV, M.D., Infusion Services, Inc. are also defendants in the Actions. The plaintiffs' direct claims against Thompson are not at issue in this petition.

prevention of HIV. (1-PE-749.) According to the complaint, Thompson “was one of very few Infectious Disease Specialists in the Orange County area.” (*Ibid.*)

4. All of the plaintiffs in the Actions are former patients of Thompson who allege that he sexually abused them under the guise of delivering medical treatment. (1-PE-766-767.) They allege that Thompson engaged in medically unnecessary examinations, unnecessary physical contact with genital areas, and unusual forms of doctor-patient interaction—including unnecessary medical appointments at Thompson’s personal home. (*Ibid.*)⁵

5. One critical fact distinguishes the real parties in interest from the other plaintiffs: They do not allege any nexus between them and Hoag that relates in any way to Thompson’s abuse. They do not allege that they were abused at Hoag, or even that Hoag referred them to Thompson. All of Thompson’s abuse against them occurred at Thompson’s private office or his home. We refer to them as the Non-Hospital Plaintiffs.⁶

⁵ Because this petition arises from the respondent court’s decision to overrule Hoag’s demurrer, Hoag recognizes that the Court must accept all of plaintiffs’ factual allegations as true for purposes of evaluating this petition. (*Hightower v. Farmers Ins. Exchange* (1995) 38 Cal.App.4th 853, 858.) Hoag does not concede the truth of any allegations.

⁶ The allegations specific to each of the Non-Hospital Plaintiffs are set forth in their individual notices of adoption. None of these allegations suggest that the Non-Hospital Plaintiffs were treated by Thompson at Hoag or that they were referred to Thompson by Hoag.

6. The vast majority of the plaintiffs are Non-Hospital Plaintiffs. Even among the remaining 70 plaintiffs that are not the subject of this petition, most do not allege that Thompson abused them at Hoag, but rather that someone at Hoag referred them to Thompson and they were later abused at his office.

7. Respondent Orange County Superior Court is the court exercising jurisdiction over the Actions.

B. Thompson’s medical staff privileges.

8. Hoag is required by law to affiliate with an independent, self-governing medical staff. (*Natarajan v. Dignity Health* (2021) 11 Cal.5th 1095, 1114 (*Natarajan*); Bus. & Prof. Code, § 2282.5.) A medical staff is responsible for credentialing staff physicians and, through peer-review proceedings, recommending when staff credentials should be withheld, suspended, or revoked. (Bus. & Prof. Code, § 805; Cal. Code Regs., tit. 22, § 70703; 42 C.F.R. § 482.22; Bus. & Prof. Code § 809.1-809.4.) Hoag’s Medical Staff has some 1,800 member physicians. (1-PE-75.)

9. Thompson became a member of the medical staff at Hoag (Medical Staff) and received clinical privileges in 2007. (1-PE-755.) These allowed him to treat patients in Hoag’s facilities. (See Bus. & Prof. Code, § 805, subd. (a)(4) [“Staff privileges’ means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility”].)

10. Thompson was not a Hoag employee. (6-PE-2756.) Indeed, under state law, Thompson *could not* be a Hoag employee. Private hospitals are prohibited from employing or otherwise controlling physicians under the corporate-practice-of-medicine doctrine—it would be a crime for Hoag to do so. (See Bus. & Prof. Code, §§ 2052, 2400; *Wicks v. Antelope Valley Healthcare Dist.* (2020) 49 Cal.App.5th 866, 884 (*Wicks*) [“a hospital may not control, direct or supervise physicians on its staff”]; *Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1033 (*Markow*) [“In keeping with California’s ban on the corporate practice of medicine (Bus. & Prof. Code, § 2400), [the physician] was not an employee of [the hospital]”].)

11. Hoag’s Medical Staff suspended Thompson’s staff privileges following his arrest by law enforcement in September 2023. (1-PE-757.)

12. The Medical Board of California did not act against Thompson until eight months after his arrest, announcing in May 2024 that it planned to revoke Thompson’s medical license. (1-PE-757.)

C. Thompson allegedly sexually harassed and abused the Non-Hospital Plaintiffs at his private office and home—not on hospital premises.

13. Plaintiffs in the Actions allege that Thompson sexually harassed and/or sexually abused them under the guise of delivering medical treatment. (1-PE-773.) They allege that

Thompson engaged in medically unnecessary examinations, unnecessary physical contact with genital areas, and unusual forms of doctor-patient interaction—including unnecessary medical appointments at Thompson’s personal home. (*Ibid.*)

14. The Non-Hospital Plaintiffs allege that Thompson abused them at his private medical practice and/or at his home, not at the hospital. (6-PE-2588.)

15. Only one of the 110 Non-Hospital Plaintiffs allegedly complained to Hoag. The complaint alleges that in 2016, “non-party witness identified herein as JOHN DA DOE” complained to Hoag as well as to the police and Medical Board. (1-PE-749-751.) This person has since been added to the case under the identifier 171 and is one of the subjects of the demurrer described below.

D. The Non-Hospital Plaintiffs sue Thompson and Hoag for abuse that Thompson committed at his private medical office and home.

16. Plaintiffs sued Thompson and Hoag in Orange County Superior Court in December 2023. (1-PE-11-12.) The complaint alleged negligence, intentional torts and statutory violations against Hoag in addition to Thompson. (1-709-738.) The Non-Hospital Plaintiffs argued that because Hoag allowed Thompson to practice medicine in the hospital, Hoag should be liable for assaults Thompson committed while practicing medicine outside the hospital, in Thompson’s own private practice and home. (1-PE-55-56, 727-735.) The complaint alleged that “HOAG held Defendant THOMPSON out to be a trustworthy and legitimate” physician, and that it breached a duty of care by failing to monitor and somehow prevent Thompson’s off-premises misconduct against them. (1-PE-55, 727-728.)⁷

17. Hoag demurred to that complaint on the ground that a hospital does not owe a duty of care to supervise the conduct of independent staff physicians outside the hospital, and the trial court sustained the demurrer on that ground with leave to amend. (1-PE-741-744.) The court ruled that *Elam v. College Park Hospital, supra*, 132 Cal.App.3d 332 foreclosed the Non-

⁷ The plaintiffs’ direct claims against Thompson (1-PE-791-824) are not at issue in this petition.

Hospital Plaintiffs’ negligence claims because the alleged conduct did not occur on hospital premises. (1-PE-742.)

18. Citing *Elam, supra*, 132 Cal.App.3d 332, the trial court recognized that a hospital owes a direct duty to its patients to supervise the medical care rendered by independent physicians on its premises. (1-PE-742.) And as the court correctly reasoned, the inverse is true—Hoag has *no* duty to ensure the adequacy of medical care *outside* the hospital. (*Ibid.*)

19. As the court observed, the Non-Hospital Plaintiffs have never refuted this blackletter law: “The Non-Hospital Plaintiffs do not address Hoag’s direct liability argument, and thus appear to concede it. They also do not address, and thus appear to concede, Hoag’s contention that a hospital’s grant of medical staff privileges to a doctor does not extend the hospital’s duty of care beyond patients treated at the hospital.” (1-PE-742.)

20. The trial court also sustained demurrers to the claims of ostensible agency, intentional misconduct and statutory violations. (1-PE-743-744.)

21. After several interim amendments, plaintiffs filed the operative master complaint on June 26, 2025, alleging 13 causes of action against Hoag. (1-PE-791-824.) 180 plaintiffs filed notices adopting the master complaint, including the 110 Non-Hospital Plaintiffs—the real parties in interest here—who had no nexus to Hoag. (See ¶¶ 2, 4-6, *ante.*) As to Hoag, the Non-Hospital Plaintiffs’ allegations were similar to before—i.e., that Hoag negligently held Thompson out to be trustworthy and

breached a duty of care to the Non-Hospital Plaintiffs by failing to monitor Thompson, report or warn of his misconduct, or fire him. (1-PE-758-772, 810-819.) The Non-Hospital Plaintiffs also reasserted their claims of ostensible agency, intentional misconduct and statutory violations.

E. Hoag demurs to the Non-Hospital Plaintiffs' claims in the master complaint.

22. Hoag demurred to the Non-Hospital Plaintiffs' claims in the master complaint on essentially the same grounds as its prior demurrer: Hoag was not liable under a theory of direct negligence because Hoag had no duty to supervise or control Thompson's treatment of patients in his private practice. Hoag again argued that the complaint did not allege ostensible agency for treatment that did not occur at the hospital; it did not allege actual agency because Thompson was not a Hoag employee; and it did not properly plead claims of intentional misconduct or violations of statute. (6-PE-2588-2607.)

23. Hoag emphasized that the Non-Hospital Plaintiffs still had not alleged any nexus to Hoag that could give rise to negligence (or any) liability. (6-PE-2588-2589.) As a matter of law under *Elam, supra*, 132 Cal.App.3d 332 and cases like it, a hospital—which is a highly regulated facility for medical care performed by independent physicians—owes a duty *only* to hospital patients. (6-PE-2593-2594, citing, e.g., *Leung v. Verdugo Hills Hospital* (2012) 55 Cal.4th 291, 310 [hospitals “provide facilities and services in connection with the practice of medicine, and if they are negligent in doing so they can be held liable”];

Walker v. Sonora Regional Medical Center (2012) 202 Cal.App.4th 948, 959, fn. 8 (*Walker*) [“The professional duty of a hospital is primarily to provide a safe environment within which diagnosis, treatment, and recovery can be carried out. Patients in a hospital are owed the duty of reasonable care”]; *Pedroza v. Bryant* (1984) 101 Wash.2d 226, 237 (*Pedroza*) [“a hospital’s duty of care under the doctrine of corporate negligence extends only to those who are patients within the hospital”].)

24. Hoag showed that medical staff privileges do not extend a hospital’s duty of care to patients that a physician treats outside of the hospital because such privileges are specific to care at the hospital. (6-PE-2595-2596, citing *Hay v. Scripps Memorial Hospital* (1986) 183 Cal.App.3d 753, 762 (*Hay*) [“clinical privileges are hospital specific”].) Hoag did not owe a duty to non-patients, so it could not be negligent for breaching a duty to those non-patients. (6-PE-2592-2598.)

25. Hoag also demonstrated that, contrary to the complaint, Hoag could not be indirectly liable. Thompson was not a Hoag employee. (6-PE-2599.) And he was not Hoag’s ostensible agent. Hoag cited a wealth of caselaw holding that, where a patient selects his own physician, there is no claim against a hospital under a theory of ostensible agency, even where—unlike here—the physician treated the patient in the hospital. (6-PE-2599-2562.)

26. In opposition, the Non-Hospital Plaintiffs argued that Hoag had breached a duty it owed them both under the general

duty of care to act reasonably and under a special duty of care owed because of Hoag's alleged special relationship with Thompson. (6-PE-2632-2641.) According to the Non-Hospital Plaintiffs, Hoag acted negligently by not terminating Thompson's medical staff privileges or somehow otherwise preventing his misconduct. (6-PE-2637.)

F. The trial court sustains Hoag's demurrer as to all but the negligence claims, concluding that the Non-Hospital Plaintiffs stated a claim that Hoag breached a duty to protect non-patients from Thompson's off-premises misconduct.

27. Unlike its prior ruling, this time the trial court overruled Hoag's demurrer to the Non-Hospital Plaintiffs' negligence claims. (6-PE-2759.)

28. The court noted that the Non-Hospital Plaintiffs still failed to adequately address *Elam, supra*, 132 Cal.App.3d 332, on which the court based its prior ruling sustaining Hoag's demurrer to the Non-Hospital Plaintiffs negligence claims. (6-PE-2755.) Once again, "Non-Hospital Plaintiffs do not appear to dispute that Hoag did not employ Thompson. They also do not appear to dispute Hoag's general contention that a hospital grant of medical staff privileges to a doctor does not extend the hospital's duty of care beyond patients treated at the hospital." (6-PE-2756.)

29. But the court nevertheless ruled that Hoag owed the Non-Hospital Plaintiffs a duty of care because Hoag allegedly had received a complaint about Thompson’s conduct and it could have “control[led]” Thompson. (6-PE-2756.) The court analogized to *Brown v. USA Taekwondo* (2019) 40 Cal.App.5th 1077, affirmed in *Brown v. USA Taekwondo* (2021) 11 Cal.5th 204 (together *Brown*), where the Court of Appeal held that USA Taekwondo (the national governing body for taekwondo competitions) had a duty to protect athletes from abuse by USA Taekwondo-approved coaches. (6-PE-2756, discussing *Brown*, 40 Cal.App.5th at pp. 1092-1094.) In doing so, the court—like the Non-Hospital Plaintiffs—disregarded *Elam*’s limitation of hospital liability to hospital grounds.

30. The court reasoned that Hoag had a special relationship with Thompson because Hoag allegedly could have controlled him—even outside of the hospital— by “removing Thompson from his position as a physician at” Hoag. (6-PE-2756.) The court’s ruling that Hoag owed a duty to the Non-Hospital Plaintiffs to “remov[e]” Thompson was the only stated basis for the court’s belief that Hoag had some ability to “control” Thompson. The trial court did not define “removal,” but for reasons explained below, it could only mean terminating Thompson’s medical staff privileges, because that was Thompson’s only connection with Hoag.

31. The trial court otherwise sustained Hoag’s demurrers as to all of the Non-Hospital Plaintiffs’ other causes of action. (6-PE-2756-2759.) Although the court granted the Non-Hospital

Plaintiffs leave until January 29, 2026 to amend the claims as to which it sustained demurrers, the plaintiffs elected to proceed on only the negligence claims. (6-PE-2759.)

32. Accordingly, the viability of the Non-Hospital Plaintiffs' case now depends entirely on the trial court's finding that Hoag owed the Non-Hospital Plaintiffs a duty of care to exercise supervisory and disciplinary powers that Hoag did not have. Neither the plaintiffs nor the court explained how Hoag is supposed to do the impossible.

G. Writ review is necessary for multiple compelling reasons.

1. The trial court's ruling directly conflicts with long-settled law on an issue of state-wide importance that affects the entire healthcare system.

33. Appellate courts grant writ relief to resolve before trial pure legal questions with broad public impact. (E.g., *Los Angeles City Ethics Commission v. Superior Court* (1992) 8 Cal.App.4th 1287, 1299 ["Where the issues raised are substantial, the matter is one of widespread interest, and the issue is one which should speedily be resolved, appellate courts have discretion to review the issue immediately on petition for extraordinary writ".]) This is such a case, as it represents a sharp departure from existing law and affects hospitals throughout California.

34. Courts have repeatedly recognized that a hospital's duty is limited to *on-premises* care. As noted above, the leading California case is *Elam, supra*, 132 Cal.App.3d 332, which held that a hospital's duty of care is to “screen[] the competency of its medical staff to insure the adequacy of medical care rendered *to patients at its facility*.” (*Id.* at p. 346, italics added; see ¶¶ 17-18, 23, *ante*; *Fisher v. San Pedro Peninsula Hospital* (1989) 214 Cal.App.3d 590, 616 (*Fisher*) [declining to extend *Elam* to reach torts committed against a non-patient, even at the hospital].)

35. Numerous cases reiterate *Elam*'s rule, similarly observing that a hospital's duty of care is tied to the hospital's provision of services *on its premises*, to its ability and responsibility to monitor and control what happens *on its premises*, and to its “ultimate[] responsib[ility] for the health and safety of the patients it serves.” (*El-Attar v. Hollywood Presbyterian Medical Center* (2013) 56 Cal.4th 976, 993 (*El-Attar*), italics added; *Walker, supra*, 202 Cal.App.4th at p. 959, fn. 8 [“The professional duty of a hospital is primarily *to provide a safe environment* within which diagnosis, treatment, and recovery can be carried out,” italics added]; *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center* (1998) 62 Cal.App.4th 1123, 1143 (*Hongsathavij*) [a hospital has a duty to “to ensure the competency of its medical staff and the adequacy of medical care *rendered to patients at its facility*,” italics added].)

36. This blackletter rule is enshrined in the CACI instructions. (See CACI No. 514 [“A hospital is negligent if it

does not use reasonable care *toward its patients*. A hospital must provide procedures, policies, facilities, supplies, and qualified personnel reasonably necessary for the treatment *of its patients*,” italics added]; CACI No. 516 [“A hospital is negligent if it does not use reasonable care to select and periodically evaluate its medical staff *so that its patients* are provided adequate medical care,” italics added].)

37. Other states similarly follow the rule that “the hospital’s liability extends only to physicians’ conduct while rendering treatment to the patients in the hospital and does not extend to his conduct beyond the hospital premises.” (*Insinga v. LaBella* (Fla. 1989) 543 So.2d 209, 214 (*Insinga*); *Pedroza, supra*, 101 Wash.2d at p. 237 [“a hospital’s duty of care under the doctrine of corporate negligence extends only to those who are patients within the hospital”].)

38. The widely followed *Elam* rule makes sense because a hospital is only able to observe physicians while they are in the hospital. Hospitals have cameras, medical records, and the eyes of trained personnel to monitor potential misconduct at the hospital. No such capability exists outside the hospital’s walls—much less inside a physician’s private office or even, as here, his home. Indeed, among other practical barriers, medical privacy statutes would prohibit hospitals or medical staffs from even attempting to surveil non-patients’ medical records.

39. Beyond being contrary to caselaw, the trial court’s ruling foists upon Hoag and every other hospital a duty to do the impossible. That cannot be right. (See *Barenborg v. Sigma*

Alpha Epsilon Fraternity (2019) 33 Cal.App.5th 70, 79-80 (*Barenborg*) [a defendant does not have a duty to prevent harm caused by a third party whose behavior they cannot monitor]; *Sproul v. Vallee* (2025) 116 Cal.App.5th 285, 296 [affirming a demurrer dismissal, holding that a wife did not have a duty to protect third parties from harm caused by her husband because she could not have controlled it].) A duty of care is necessarily a duty *to do something*, and a hospital *cannot* do what the trial court's ruling *requires* it to do.

40. Without this Court's immediate review, hospitals face at least several years of fundamental uncertainty and risk. Hospitals that comply with the law that prohibits their supervision and control of physicians outside the hospitals' walls will be vulnerable to lawsuits claiming that they should instead have violated that law in order to—somehow—protect non-patients from non-hospital conduct.

2. The broad new duty of care adopted below would undermine a carefully balanced regulatory framework.

41. The legal duty that the trial court invented is not only wrong as a matter of law. It is also contrary to public policy, threatening to disrupt the careful balance drawn by a statutory and regulatory scheme that comprehensively dictates hospitals' operations—and does not impose a duty here. The Legislature, like the courts, has limited a hospital's duty to hospital grounds. It has never created anything like the duty invented by the trial court. By going so far beyond the bounds the Legislature chose,

the trial court rejected fundamental and long-settled policies regarding hospitals' duties of care.

- a. **Hoag's legal duties have been clearly and comprehensively defined—and do not extend beyond the hospital grounds.**

42. ***The medical staff is, and by law must be, independent and self-governing.*** Hoag is required by law to have an independent medical staff that is a separate legal entity from the hospital itself. (*Natarajan, supra*, 11 Cal.5th at p. 1114; see also Bus. & Prof. Code, § 2282.5 [medical staffs are self-governing bodies responsible for setting their own professional practice standards and can bring suit against a hospital if the hospital intrudes on the medical staff's governance rights]; Cal. Code Regs., tit. 22, §§ 70701, 70703; 42 C.F.R. § 482.22.)

43. The Legislature's regulation of medical staff privileges is not only comprehensive, it is exhaustive. The statutes regarding medical staff privileges "methodically delineate[] specific and detailed procedural requirements for each step of a peer review proceeding" that must be completed by the medical staff before a hospital can act against staff privileges. (*Asiryian v. Medical Staff of Glendale Adventist Medical Center* (2024) 100 Cal.App.5th 947, 968 (*Asiryian*); *Natarajan, supra*, 42 Cal.App.5th at p. 386, fn. 3 [hospital "cannot act with respect to staff privileges without a recommendation from the peer review panel"].) Indeed, the Legislature's regulation of peer review and physician reporting is so "general and comprehensive" that it indicates ""a legislative intent that the statute should totally

supersede and replace the common law.”” (*Asiryana*, at pp. 956-957, 966-969.)

44. Medical staff privileges are hospital-specific—the only thing staff privileges do is permit a physician to practice within a particular hospital. (*Hay, supra*, 183 Cal.App.3d at p. 762.) So, by granting staff privileges, the Medical Staff does nothing more than determine who can treat patients at Hoag. “The hospital holds itself out to the community as a competent provider of medical care. The hospital does *not* hold itself out as an inspector or insurer of the private office practices of its staff members. The delineation of staff privileges by the hospital can only affect the procedures used by staff members *while they are inside hospital walls*. The public cannot reasonably expect anything more.” (*Pedroza, supra*, 101 Wash.2d at p. 236, italics added.)

45. ***A hospital’s mandatory reporting obligations do not extend beyond patients at the hospital.*** The Legislature has carefully defined a hospital’s obligation to report complaints about the alleged misconduct of a medical staff member—and it has limited that obligation to written complaints submitted by hospital patients or their representatives or regarding abuse *on the hospital’s premises*. State law requires a hospital to report to the Medical Board of California “any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient . . . or the patient’s representative . . . in

writing” (Bus. & Prof. Code, § 805.8, subd. (b).)⁸ The California Department of Public Health separately imposes a duty to report any of an enumerated list of “adverse event[s],” including “sexual assault on a patient *within or on the grounds of a health facility.*” (Health & Saf. Code, § 1279.1, subd. (b)(6)(C), italics added.)

46. In addition to its duty to report written allegations of sexual misconduct made by a hospital patient, Hoag has several other mandatory reporting obligations relating to sexual misconduct. For example, Hoag must report any time it conducts a sexual assault examination or treats a patient who has suffered certain assaultive injuries, including sexual assault. (Pen. Code, §§ 11160, 13823.11, subd. (a).) And Hoag must report certain public health events (e.g., Health & Saf. Code, § 120130; Cal. Code Regs., tit. 17, § 2500) and workplace violence (Lab. Code, § 6401.9; see Cal. Code Regs., tit. 8, § 3342 [violence prevention in health care]). Here, too, the Legislature has declined to extend the hospital’s duties beyond the hospital facility.

47. By imposing a duty to monitor, investigate, and “remove” physicians in cases where the Legislature did not even impose a duty to report an allegation, the trial court stepped far outside of the legislative scheme.

⁸ The required disclosure is made only to the regulatory agency and is confidential unless and until the agency initiates administrative proceedings against the licensee. (Bus. & Prof. Code, § 805.8, subd. (c).)

48. *The hospital is subject to countless other regulatory requirements within the walls of its facility.*

In addition to the requirements just mentioned, Hoag must adhere to an enormous number of other regulatory strictures. (See, e.g., Cal. Code Regs., tit. 22, § 70707 [patients' bill of rights]; Health & Saf. Code, § 123222.1, subd. (b)(5) [regarding provision of printed materials to patients]; Health & Saf. Code, §§ 129675-129998 [Alfred E. Alquist Hospital Facilities Seismic Safety Act]; Civ. Code, § 56 et seq. [Confidentiality of Medical Information Act]; 42 U.S.C. § 1320d et seq. [Health Insurance Portability and Accountability Act]; Cal. Code Regs., tit. 22, §§ 70103, 70351 [licensure and special permitting]; 42 C.F.R. Part 482 [Conditions of Participation hospitals must follow to treat Medicare and Medicaid patients]; 42 C.F.R. § 482.12(d) [hospital institutional plan and budget requirement]; 42 C.F.R. § 482.13(h) [patient visitation rights]; 42 C.F.R. § 482.15 [emergency preparedness]; 42 C.F.R. § 482.21 [quality assessment and performance improvement program]; 42 C.F.R. § 482.24(b) [medical record requirements]; Cal. Code Regs., tit. 22, § 71517 [admission, transfer, and discharge policy requirement]; Cal. Code Regs., tit. 22, §§ 70801-70865 [hospital physical plant regulations]; Cal. Code Regs., tit. 22, §§ 70053.2, 70217 [patient classification requirement]; Cal. Code Regs., tit. 22, § 70217, subd. (a) [variable nurse-to-patient ratio requirement].)

49. This vast array of legal duties dictates much of Hoag's operations down to the last detail. Each of these duties represents a careful balancing of public policy factors regarding

healthcare. And all share one key feature: *They are limited to the bounds of the hospital.*

50. In sum, every aspect of hospital care—from medical staff privileges to patient care to building safety and more—has been carefully and exhaustively regulated. In promulgating this web of regulation, the legislative and regulatory bodies have opted for bright-line rules that give hospitals certain knowledge that they comply with the law. All of these regulations relate to in-hospital care of patients. Not a single one required Hoag to take action based on the facts alleged by the Non-Hospital Plaintiffs.

b. The comprehensive regulatory scheme counsels against judicial creation of a vague new duty of care.

51. The intricacy of this regulatory scheme—which minutely governs an industry that has as much impact on the public health as any—strongly counsels against imposing a broad new duty of care on hospitals in favor of persons who, like the Non-Hospital Plaintiffs, have no connection to the hospital.

52. Courts are generally “hesitant to ‘impose [new tort duties] when to do so would involve complex policy decisions’ [Citation], especially when such decisions are more appropriately the subject of legislative deliberation and resolution.” (*Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 136, first brackets in original (*Moore*)). Our Supreme Court has repeatedly, and recently, emphasized the

importance of deferring to the Legislature. (*Capito v. San Jose Healthcare System, LP* (2024) 17 Cal.5th 273, 278, 283 (*Capito*) [refusing to impose a duty on hospitals to make non-statutory disclosures because the “California Legislature, United States Congress, and numerous rulemaking bodies have already decided what pricing information to make available in a hospital’s emergency room. Just as importantly, they have decided what *not* to include in those requirements”]; *Sheen v. Wells Fargo Bank, N.A.* (2022) 12 Cal.5th 905, 916, 921 (*Sheen*) [emphasizing the “role of the Legislature, which is better positioned to act in [an] extensively regulated area”; declining to recognize a lender duty of care because, despite the extensive regulation of lenders, no “state or federal statute or regulation applies here to impose a duty along the lines sketched by plaintiff”].)

53. Here, the trial court did what the Supreme Court has instructed courts not to do. Moreover, in contrast to detailed and specific legislative and regulatory requirements governing hospitals, the court-imposed duty here is “ill defined and amorphous,” with “a yet-to-be articulated standard of care.” (*Sheen, supra*, 12 Cal.5th at p. 945.) It creates mystifying uncertainty regarding how the new legal framework “will function in practice, much less that they might operate together to better serve the interests of [the industry and affected participants], or the public at large.” (*Ibid.*) As our Supreme Court has emphasized, such a remedy should not “be created by judicial fiat.” (*Id.* at p. 944.)

3. The trial court’s ruling threatens irreparable harm: The uncertainty it creates will impact hospital administration—and jeopardize public health—throughout the state before an ordinary appeal can be heard.

54. Writ relief is warranted because the trial court’s ruling drastically alters the responsibilities and liabilities that all hospitals face. That the ruling has no binding precedential value does not lessen its practical impact. It poses an immediate threat to hospital administration across the state.

55. Under *Elam*, as well as under the extensive state and federal regulation of hospitals more generally, hospitals were entitled to believe—and to base their planning on the belief—that their liability for medical staff members’ misconduct ended at their facilities’ walls. The trial court’s ruling bursts those walls open, imposing a duty of care to *everyone* to prevent torts by *any* staff physician *anywhere*, without even a hint about how hospitals can possibly discharge such a vast responsibility. (See *Regents of University of California v. Superior Court* (2018) 4 Cal.5th 607, 621 (*Regents*) [“Special relationships also have defined boundaries. They create a duty of care owed to a limited community, not the public at large”].)

56. No hospital can know how to even begin attempting to mitigate this risk until this Court weighs in. If writ relief is not granted, that resolution would be years away in the best-case scenario.

57. Much hangs in the balance. Hospitals can have no way to know how to restructure operations to accommodate the looming prospect that every physician member of their medical staffs—which for Hoag numbers in the thousands—can become the source of massive liability. Neither the plaintiffs nor the trial court have explained how any hospital could manage this uncontrollable duty.

58. Nor is the concern only about liability for sexual misconduct. Since sexual misconduct like that alleged here occurs during the course of medical treatment, under well settled law there is no meaningful distinction between the facts alleged here and cases of medical malpractice. (*Waters v. Bourhis* (1985) 40 Cal.3d 424, 436 [psychiatrist’s sexual misconduct toward patient was a claim of professional negligence]; 6-PE-2757 [“The Non-Hospital Plaintiffs assert that ‘[t]his is not a medical malpractice case.’ [Citation.] The Non-Hospital Plaintiffs’ allegations against Hoag, however, rest on their contention that Hoag did not provide them with proper medical care”].) Hospitals’ potential liability is therefore not just unprecedented but also unlimited.

59. Hospitals like Hoag have to do *something*, but it’s impossible to tell what that might be. Any choice would be a gamble because the ruling below takes long-settled law off the table. It is untenable to require hospitals to operate in the shadow of this threat. Indeed, that is why courts must evaluate *specific* duties and not *abstract* ones. (See *Vasquez v. Residential Investments, Inc.* (2004) 118 Cal.App.4th 269, 280 [“Only after

the scope of the duty under consideration is defined may a court meaningfully undertake the balancing analysis of the risks and burdens present in a given case to determine whether the specific obligations should or should not be imposed on the [defendant]”.)

60. The absence of legal duty is a question of law that the Court can decide now. And it should do so to allow Hoag—and hospitals watching this litigation across the state—to be sure of what their duties are. Anything less would inject much uncertainty into hospital administration, which would inevitably have ramifications on public health. (See *Interinsurance Exchange of Automobile Club v. Superior Court* (2007) 148 Cal.App.4th 1218, 1225 [“writ review may be appropriate to ‘prevent a needless and expensive trial and reversal’” or “where it is necessary to resolve an issue of first impression promptly and to set guidelines for bench and bar”].)

4. Without writ review, the important issue this petition presents may evade appellate review, rendering Hoag’s remedy at law inadequate.

61. Immediate review is also warranted because the risk of runaway damages—not just in this case, but in the tidal wave of cases that will surely follow—means that the trial court’s ruling could easily evade appellate review.

62. As this Court has written, collective litigation that threatens mammoth potential damages “is a paradigmatic example of when writ relief may be necessary.” (*Starbucks Corp.*

v. Superior Court (2008) 168 Cal.App.4th 1436, 1453 [granting petition challenging denial of summary judgment in a class action with a potential \$26 million recovery].) In such situations, waiting to appeal from a judgment is an inadequate remedy because “the potential exposure is so large that the pressure to settle may become irresistible.” (*Ibid.*)

63. Granting writ relief will ensure that the potential exposure will not prevent the resolution of the important issue this petition presents. Otherwise, the issue could evade appellate review for the foreseeable future—leaving hospitals to wonder if issuing staff privileges will result in an unpreventable liability down the road.

H. This petition is timely.

64. The trial court entered the challenged order on January 20, 2026. (6-PE-2759.) It overruled Hoag’s demurrer to the plaintiffs’ general negligence causes of action, but sustained Hoag’s demurrer as to all other causes of action. (*Ibid.*) The court gave plaintiffs until January 29, 2026 to file an amended complaint as to those other causes of action. (*Ibid.*) Thus, as of January 20, 2026, the issues presented in this petition would not have provided a basis to dismiss the Non-Hospital Plaintiffs’ claims in their entirety.

65. On January 29, Plaintiffs elected not to file an amended complaint. This made clear that the viability of the Non-Hospital Plaintiffs’ claims rests entirely on the trial court’s

finding that the master complaint adequately pleads a duty owed by Hoag to the Non-Hospital Plaintiffs.

66. Until the time for plaintiffs to amend their complaint had lapsed without any amendment, i.e., January 30, 2026, the complaint potentially could have contained additional causes of action for the Non-Hospital Plaintiffs, with Hoag's demurrer overruled only as to negligence. Had the Non-Hospital Plaintiffs amended, a writ petition would have been inappropriate, because the Court would not have the power to dispose of the entire action as to the Non-Hospital Plaintiffs by granting relief.

67. As of January 30, however, the complaint asserted only negligence on behalf of the Non-Hospital Plaintiffs. This makes the case suitable for writ relief, because granting that relief will dispose of the entire action as to each of the individual Non-Hospital Plaintiffs. The Court should therefore deem the petition timely.

68. Although 60 days from notice of a challenged order is the informal, equitable period for filing a common-law writ petition (Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs (The Rutter Group 2025) ¶ 15:144 et seq.), the Court has ample discretion, if needed, to consider a later petition when there is a good reason, as there is here.

PRAYER

Petitioner prays that this Court:

1. Issue a peremptory writ of mandate or other appropriate writ in the first instance, directing the Respondent

Court to vacate its order overruling Hoag's demurrer to the Non-Hospital Plaintiffs' negligence claims and to issue an order sustaining the demurrer without leave to amend; or

2. Issue an alternative writ of mandate or other appropriate writ ordering the Respondent Court to appear and show cause why it should not be directed to vacate its order overruling Hoag's demurrer to the Non-Hospital Plaintiffs' negligence claims and to issue an order sustaining the demurrer without leave to amend; and

3. Award Hoag any other appropriate relief.

DATED: March 27, 2026

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By: /s/ Steven A. Velkei

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VERIFICATION

Steven A. Velkei declares:

I am licensed to practice law in California. I am a principal of Velkei Law, counsel of record for petitioner Hoag Memorial Hospital Presbyterian. I have reviewed and am familiar with the records and files that are the basis of this petition. I make this declaration because I am more familiar with the particular facts, *i.e.*, the state of the record and the litigation, than is my client. I certify that the petition's allegations are true and correct.

I declare under penalty of perjury that the foregoing is true and correct and that this verification is executed on March 27, 2026, at Los Angeles, California.



Steven A. Velkei

MEMORANDUM OF POINTS AND AUTHORITIES

Under a body of law going back more than a century, hospitals do not and must not control physicians.

Rather, hospitals control hospital facilities, and the courts have confirmed that their responsibility for physicians' misconduct toward patients stops at the hospitals' walls.

While the trial court acknowledged these principles, it nevertheless expanded liability beyond the hospital's walls despite the complete absence of on-point authority. The trial court's sole authority—*Brown, supra*, 40 Cal.App.5th 1077 and 11 Cal.5th 204—arose in a context entirely unrelated to healthcare and is readily distinguishable. Although the trial court criticized the Non-Hospital Plaintiffs for failing to “wrestle” with the holding in *Elam, supra*, 132 Cal.App.3d 332 (6-PE-2755), the court itself fell prey to the same criticism: It never explained how its ruling could possibly comport with *Elam*.

Nor did the court acknowledge the comprehensive scheme of legislation and regulations that govern every detail of hospital operations. These impose specific and limited obligations with respect to sexual misconduct—and the obligations do not include anything like what the trial court's ruling suggests.

The stakes are enormous—and immediate for hospitals, which must plan their operations to account for this potential new liability. The trial court's ruling provides no guidance at all. But even if it did, the uncertainty that will necessarily prevail until an appellate court addresses the issue casts all California

hospitals onto an uncharted sea with no compass—particularly given a century of jurisprudence that prohibits a hospital from controlling physicians in their private medical practices.

The Court should grant the petition.

ARGUMENT

I. The Trial Court’s Ruling Is Clearly Wrong.

A. Settled law establishes that Hoag’s duty of care is limited to the hospital grounds.

Well-established caselaw holds that a hospital’s duty of care is limited to the hospital’s grounds. A hospital does not have a duty of care to *non-hospital* patients whose physician happens to have medical staff privileges at the hospital.

This rule has deep roots. For more than a century, California has prohibited corporations from practicing medicine or employing physicians who do. (See ¶¶ 10, 28, *ante*; *People ex rel. State Bd. of Medical Examiners v. Pacific Health Corp.* (1938) 12 Cal.2d 156, 160-161 [reaffirming “the long settled policy against corporate medical practice”].) This long-standing policy is intended to benefit patients by ensuring that medical care decisions were made in the best interests of patients and not for financial reasons. (*Id.* at pp. 158-159.) Indeed, it is a crime for a hospital to “control, direct or supervise” a physician. (See *Wicks, supra*, 49 Cal.App.5th at p. 884; Bus. & Prof. Code, §§ 2052, 2400.) Historically, this meant that hospitals could not be liable for physicians’ negligence in the delivery of medical care

in the absence of an employment or agency relationship. (*Elam, supra*, 132 Cal.App.3d at p. 337.)

For many decades, though, California has allowed claims for hospital negligence in a strictly limited situation: A hospital has a duty of care “to ensure the competency of its medical staff and the adequacy of medical care rendered to *patients at its facility*.” (*Hongsathavij, supra*, 62 Cal.App.4th at p. 1143, italics added.) A hospital still cannot control physicians. (*Wicks, supra*, 49 Cal.App.5th at p. 884 [“a hospital may not control, direct or supervise physicians on its staff”].) But it can discharge the duty to its patients by controlling the hospital grounds and who practices medicine there.

This duty is necessarily limited to hospital grounds—the only place where hospitals can exercise that control. The caselaw is uniform in stressing that this is a duty as to *hospital premises*. Until now, courts have never suggested that a hospital has any kind of off-premises duty of care to non-patients.

The leading case in California, *Elam, supra*, 132 Cal.App.3d 332, held that a hospital has a duty of care to “screen[] the competency of its medical staff to insure the adequacy of medical care rendered to *patients at its facility*.” (*Id.* at p. 346, italics added; see also *id.* at p. 345 [this duty “suppl[ies] the hospital with a greater incentive to assure the competence of its medical staff and the quality of medical care rendered within its walls,” italics added.]

This rule is now blackletter law that has been enshrined in CACI jury instructions: “A hospital is negligent if it does not use reasonable care *toward its patients*. A hospital must provide procedures, policies, facilities, supplies, and qualified personnel reasonably necessary for the treatment *of its patients*.” (CACI No. 514, italics added; see also CACI No. 516 [“A hospital is negligent if it does not use reasonable care to select and periodically evaluate its medical staff *so that its patients* are provided adequate medical care,” italics added].)

Plus, *Elam*’s analysis was expressly grounded in and fully consistent with the basic legal framework of duty, including Civil Code section 1714. (*Elam, supra*, 132 Cal.App.3d at p. 339 [“Our analysis of whether Hospital owed the disputed duty to Elam commences with the fundamental policy embodied in Civil Code section 1714, providing liability for injuries to another caused by one’s failure to exercise ordinary care under the circumstances”].) The court reviewed multiple cases that applied general duty principles to hold that a “hospital owes *its patients* the duty of protection, and must exercise such reasonable care toward *a patient* as his known condition may require” and that “a hospital is ‘under a duty to observe and know the condition of *a patient*. Its business is caring for ill persons, and its conduct must be in accordance with that of a person of ordinary prudence under the circumstances, a vital part of those circumstances being the illness of *the patient* and incidents thereof.” (*Id.* at p. 340, italics added.)

Numerous other cases similarly observe that a hospital's duty of care is tied to the hospital's provision of services *on its premises*, to its ability and responsibility to monitor and control what happens *on its premises*, and to its "ultimate[] responsib[ility] for the health and safety of *the patients it serves*." (*El-Attar, supra*, 56 Cal.4th at p. 993, italics added; *Walker, supra*, 202 Cal.App.4th at p. 959, fn. 8 ["The professional duty of a hospital is primarily *to provide a safe environment* within which diagnosis, treatment, and recovery can be carried out," italics added]; *Hongsathavij, supra*, 62 Cal.App.4th at p. 1143 [a hospital has a duty "to ensure the competency of its medical staff and the adequacy of medical care *rendered to patients at its facility*," italics added]; see *Fisher, supra*, 214 Cal.App.3d at p. 616 [declining to extend *Elam* to reach torts committed against a non-patient].)

Other states follow the same rule. For example, the Washington Supreme Court's en banc decision in *Pedroza, supra*, 101 Wash.2d 226 is directly on point. A patient died in the hospital due to malpractice committed by a staff physician at the physician's private office. (*Id.* at pp. 227-228.) The patient's husband sued both the doctor and the hospital, arguing that the hospital was negligent because the patient had been a foreseeable plaintiff that the hospital failed to protect. (*Id.* at pp. 228, 236.) The Washington Supreme Court rejected that argument, holding that "a hospital's duty of care under the doctrine of corporate negligence extends only to those who are patients within the hospital. Defendant Skagit Valley Hospital owed no duty to [the

plaintiff] under the doctrine because she was not a hospital patient when the harm occurred.” (*Id.* at p. 237.) As the court observed: “every jurisdiction that has adopted corporate negligence has based the hospital’s liability on the duty owed by the hospital *to its patients.*” (*Ibid.*, original italics.)

The Florida Supreme Court, relying on *Elam* and *Pedroza*, has also recognized that while a hospital can be liable for negligent care delivered on its premises, its liability “extends only to the physician’s conduct while rendering treatment to patients in the hospital and *does not extend to his conduct beyond the hospital premises.*” (*Insinga, supra*, 543 So.2d at pp. 213-214, italics added.)

The only case we have found that even suggests otherwise is *Copithorne v. Framingham Union Hospital* (1988) 401 Mass. 860. There, over two strong dissents, the court reversed summary judgment for a hospital where a hospital employee sought to impose liability for an off-premises rape. However, that decision explicitly relied on the plaintiff’s status as a hospital *employee* and her personal knowledge of the physician’s good reputation within the hospital. (*Id.* at p. 866.) The court presciently cautioned that a “different question would be presented if a member of the general public claimed that the hospital was liable for similar harm simply because [the physician-abuser] was a staff member”—rather than an employee. (*Ibid.*) In other words, the court would *not* have found liability under our facts. Moreover, the two dissents in *Copithorne* observed that even the majority’s narrow holding was

inconsistent with the nationwide rule that limits hospital liability to its premises.⁹

As we have explained, California’s *Elam* rule makes sense because a hospital is only able to supervise physicians while they are in the hospital. (See ¶ 38, *ante*.) But when, as with the Non-Hospital Plaintiffs, a hospital is *not* in a position to “observe and know the condition of a patient” (*Elam, supra*, 132 Cal.App.3d at p. 340), the control needed to establish a duty of care is absent.

B. Hoag cannot owe a duty to prevent harms it cannot control.

Even setting aside this wealth of controlling law, the ruling below would still be wrong because Hoag could not do what the ruling demands. The trial court found a duty because it believed that Hoag could have controlled Thompson.

It isn’t so—and the reasons are legal, not factual.

⁹ See 401 Mass. at p. 867 (dis. opn. of Lynch, J.) (“It cannot be said, however, that existing values and customs establish a duty of the hospital to protect its patients from the criminal acts of independent physicians occurring off the hospital premises and arising from a private and independent doctor-patient relationship. . . . Where the doctrine of corporate liability has been applied to impose liability on a hospital for the negligence of staff physicians who are independent contractors, it has been done because of the duty of care that the hospital owes to *its* patients,” original italics); *id.* at p. 869 (dis. opn. of O’Connor, J.) (“the imposition on a hospital of a duty of care to nonhospital patients off the hospital premises has no source in existing social values and customs and, particularly because of its likely adverse effect on the cost of hospital care, is unsound public policy. I am aware of no case in which such a duty has been imposed”).

1. As a matter of law, Hoag did not have a duty to prevent harm from conduct it could not control.

As a general rule, there is no duty to protect others from the conduct of third parties. (*Regents, supra*, 4 Cal.5th at p. 627; *Davidson v. City of Westminster* (1982) 32 Cal.3d 197, 203.) Here, the trial court relied on a limited exception to this rule articulated in the Court of Appeal opinion in *Brown, supra*, 40 Cal.App.5th 1077, which applies where “the defendant has a special relationship with the foreseeably dangerous person that entails an ability to control that person’s conduct.” (*Id.* at p. 1091; 6-PE-2755-2756.) But that exception is narrow, and *Brown*’s facts bear no resemblance to ours.

Limited plaintiffs. First, our Supreme Court has explained that “[s]pecial relationships also have defined boundaries. They create a duty of care owed to a limited community, not the public at large.” (*Regents, supra*, 4 Cal.5th at p. 621; see *Hooks v. Southern Cal. Permanente Medical Group* (1980) 107 Cal.App.3d 435, 445 [rejecting argument that hospital owed a duty to “all pregnant women anywhere who were acquainted with [hospital employee] in any way during the period of her employment at the Hospital”].) The narrowness is crucial to the special-relationship doctrine: “Because a special relationship is limited to specific individuals, the defendant’s duty is less burdensome and more justifiable than a broad-ranging duty would be.” (*Regents*, at p. 621.) Thus, the special-relationship doctrine cannot create a hospital duty to protect the

general public—every person who happens to be treated outside the hospital by a physician who happens to have staff privileges.

Control of tortfeasor. Second, the caselaw regarding special relationships emphasizes that no such relationship exists unless the defendant can actually control the tortfeasor’s conduct. (*Hansra v. Superior Court* (1992) 7 Cal.App.4th 630, 645 (*Hansra*)). The key is that the defendant’s control places it in the ““best position to protect against the risk of harm.”” (*Brown, supra*, 40 Cal.App.5th at p. 1092.)

The corollary of this, of course, is that if a defendant cannot control a tortfeasor’s conduct or is not in the best position to do so, the defendant bears no special-relationship duty. As the court recognized in *Barenborg, supra*, 33 Cal.App.5th 70, if a defendant “cannot monitor the day-to-day activities of [the wrongdoer] contemporaneously,” it has no duty to control those activities. (*Id.* at pp. 79-80.) “Absent an ability to monitor the day-to-day operations of [the wrongdoer], the authority to discipline generally will not afford a [defendant] sufficient ability to prevent the harm and thus will not place it in a unique position to protect against the risk of harm.” (*Id.* at p. 80.)

2. Hoag could not monitor or control Thompson’s private medical practice.

Here, the trial court concluded that Hoag owed a duty of care to the Non-Hospital Plaintiffs because it could have controlled Thompson’s private practice “by removing Thompson from his position as a physician at” Hoag. (6-PE-2756.) Not so.

As we have demonstrated, Hoag had no ability to supervise Thompson’s off-premises medical practice. (See ¶ 38, *ante*.) While a physician with staff privileges has the right to use hospital facilities, the hospital has no eyes on any component of the physician’s *private* practice at his or her private office—much less at the physician’s home. The hospital could not oversee Thompson’s medical practice, review his records, or control how he treated those who were his patients *but not Hoag’s patients*. The hospital certainly had no ability to raid Thompson’s private office or home for random inspections. It therefore was not in the ““best position to protect against the risk of harm.”” (*Brown, supra*, 40 Cal.App.5th at p. 1092.) Rather, it was the police, the prosecutor, and the California Medical Board that were in the best position to protect the public against Thompson’s criminal conduct at his home and private offices.

Here, as in *Barenborg, supra*, 33 Cal.App.5th 70, the fact that Hoag could not have “monitor[ed] the day-to-day activities of [Thompson] contemporaneously” bars imposing a duty to do so. (*Id.* at pp. 79-80.) Hoag simply could not have panoptically surveilled the entire private practice—and homes—of the thousands of independent physicians who have staff privileges at its facilities. That task would be administratively impossible, extraordinarily intrusive, and wildly illegal under medical privacy laws. Because Hoag could not monitor Thompson away from the hospital, it did not have a duty to control him there. (*Id.* at p. 80.) As Justice Sills once observed in a different context, “Hospitals exist to help the sick and injured; they are not

detective agencies.” (*Oskooi v. Fountain Valley Regional Hospital* (1996) 42 Cal.App.4th 233, 248 (conc. opn. of Sills, P.J.))

Indeed, this explains why so many cases, including *Elam*, have been careful to note that a hospital’s duties are limited to the hospital: On hospital grounds, the hospital can monitor physicians and, subject to procedural requirements and the medical staff’s input, terminate their staff privileges. But that supervisory authority doesn’t exist outside of the hospital. So the hospital can’t have a duty to discharge it.

There *are* entities with authority to oversee and control criminal conduct like that alleged: the police and the Medical Board of California. Plaintiffs recognize this. They allege that they made multiple complaints about Thompson to the police and the Medical Board. (1-PE-750-753.)

3. *Brown* does not support a different result.

The solitary case the trial court relied on, *Brown, supra*, 11 Cal.5th 204 and 40 Cal.App.5th 1077, bears no factual resemblance to this case, particularly because it involves nothing like the complex regulatory scheme that governs healthcare and strictly limits hospitals’ ability to control physicians and staff privileges.

- a. ***Brown* does not apply at all, because hospitals’ duty has already been defined in *Elam*—and it terminates at the hospital’s walls.**

Brown addresses situations in which—unlike here—the law’s reach has not already been defined. But even in that situation, a special relationship “does not create the duty.” (*Hansra, supra*, 7 Cal.App.4th at p. 646.) Rather, the special-relationship analysis requires “consideration of the same factors underlying any duty of care analysis”; the term “special relationship” is “simply a label expressing the conclusion that the facts, considered in light of the pertinent legal considerations, support the existence of a duty of care.” (*Ibid.*; *Brown, supra*, 11 Cal.5th at p. 227 [“‘Special relationship’ is merely a label for those policy considerations that our shared experience has taught us to treat as especially relevant in such contexts. As the Restatement Third explains, ‘The term “special relationship” has no independent significance. . . . Whether a relationship is deemed special is a conclusion based on reasons of principle or policy’” (conc. opn. of Cuellar, J.), original ellipsis].)

A separate special-relationship duty is not warranted here because all of the relevant policy considerations are already embodied in the *Elam* rule, which focuses the hospital’s attention on care delivered *at the hospital* and *to hospital patients*.

Brown does not support the trial court’s decision to infer a new duty of care where, as here, existing law exhaustively defines the duty. Indeed, the effect of the ruling would be to

eviscerate the *Elam* rule and render meaningless long-standing jury instructions on a hospital’s potential liability. *Elam* thoroughly analyzed the law and policy surrounding hospitals to explain where a hospital has a duty—and, crucially, where it does not. (*Elam, supra*, 132 Cal.App.3d at pp. 337-347.)

b. To the extent *Brown* is relevant, it supports Hoag, not plaintiffs.

Even if it were appropriate to ignore *Elam* and instead apply a special-relationship analysis of duty, *Brown* actually *supports* the conclusion that a special-relationship duty is limited to the particular environment in which the defendant exerts control over the wrongdoer.

In *Brown*, the court held that USA Taekwondo (USAT), a national governing body “responsible for the conduct and administration of taekwondo in the United States,” owed a duty to protect young athletes from abuse by their coach. (*Brown, supra*, 40 Cal.App.5th at p. 1094.) The court emphasized that USAT controlled the entire environment in taekwondo coaching— “[the coach] was required to register with USAT to coach taekwondo *at USAT-sponsored competitions*, athletes could only compete in *USAT-sponsored competitions* with registered coaches, USAT could (and later did) implement policies and procedures to protect athletes from sexual abuse by their coaches, and USAT could (and later did) bar [the coach] from coaching athletes *at taekwondo competitions* for his violations of USAT’s policies and procedures.” (*Id.* at p. 1083, italics added.) Thus, “USAT was in a *unique position* to protect youth athletes against

the risk of sexual abuse by their coaches” at or in connection with USAT-sanctioned events. (*Id.* at p. 1095, italics added.)

On the other hand, a hospital is not in a “unique position” to protect a staff physician’s private patients, and its relationship with staff physicians off premises is nothing like the relationship in *Brown*. *Brown* was completely focused on what USAT could do to protect *USAT* athletes from *USAT*-mandated coaches hired to prepare the athletes for *USAT* events. (*Brown, supra*, 40 Cal.App.5th at pp. 1094-1096.) USAT was necessarily the entity in control. There was no set of athletes analogous to the Non-Hospital Plaintiffs: All athletes who wanted to participate in taekwondo had to do so through USAT’s system. (*Id.* at pp. 1083, 1094.) In marked contrast, nothing constrained the Non-Hospital Plaintiffs’ choice of physician or where they could see the physician—and, unlike the taekwondo coaches in *Brown*, nothing prevented Thompspon from practicing medicine elsewhere.

Moreover, there is no indication that USAT’s control of coaches in *Brown* was subject to any external regulation—much less regulation that reflects the legislative weighing of competing public policies, which characterizes the regulation of medical staff privileges. Here, the trial court applied *Brown* to extend Hoag’s duty of care to Thompson’s treatment of *Non-Hospital Plaintiffs* on *non-hospital premises* even though Hoag had no control over those premises.

Thus, even setting aside that the trial court's reasoning conflicts with the comprehensive hospital regulatory structure (see ¶¶ 42-50, *ante*), *Brown* does not support the trial court's conclusion.

II. The Legislature Has Already Comprehensively Regulated Hospital Conduct And Has Chosen Not To Impose Off-Premises Duties.

The trial court broadly expanded the scope of hospital liability far beyond the hospital's walls to cover conduct of a physician in his private medical office or home involving patients having no connection with the hospital. The court did so based on tort cases that have nothing to do with the hospital-physician context and that therefore did not consider the unique web of public policies that apply.

The competing public policy considerations include the nature of a hospital as a center for delivering healthcare; the feasibility of expanding liability beyond the facility; the impact of such an expansion on hospital peer review systems; and its impact on the affordability of healthcare given that it subjects hospitals to huge liability for conduct that is beyond the hospitals' control. Those are classic legislative concerns. But the Legislature conspicuously has not adopted anything like the expansive duty urged by the Non-Hospital Patients. If anything, the Legislature has affirmatively rejected such a duty.

A. The Legislature has comprehensively defined the parameters of the relationship between medical staff and the hospital.

The Legislature and regulators have precisely dictated hospitals' responsibilities—or lack thereof—in nearly every aspect of hospital administration. This includes comprehensive definition of and limits to hospitals' powers and duties with respect to staff privileges and to sexual assault allegations.

As we have explained, hospitals cannot practice medicine, nor employ, control, direct, or supervise a physician who does. (Bus. & Prof. Code, §§ 2052, 2400; see *Wicks, supra*, 49 Cal.App.5th at p. 884 [“a hospital may not control, direct or supervise physicians on its staff”]; *Markow, supra*, 3 Cal.App.5th at p. 1033 [“In keeping with California’s ban on the corporate practice of medicine,” physician was not a hospital employee].)

Instead, private hospitals are required to have medical staffs. A medical staff is a legally distinct, independent, and self-governing body not controlled by the hospital because of the ban on the corporate practice of medicine. (*Natarajan, supra*, 11 Cal.5th 1095, 1114; *El-Attar, supra*, 56 Cal.4th at p. 983; *Bichai v. Dignity Health* (2021) 61 Cal.App.5th 869, 878-881 [hospital not liable for acts of medical staff]; Bus. & Prof. Code, § 2282.5; Cal. Code Regs., tit. 22, §§ 70701, 70703; 42 C.F.R. § 482.22.) The medical staff credentials physicians and recommends which physicians are granted or denied membership (and thus privileges) and whether to suspend or recommend revocation of those privileges. (Bus. & Prof. Code,

§ 805; Cal. Code Regs., tit. 22, § 70703, subd. (b).) A hospital generally “cannot act with respect to staff privileges without a recommendation” from the medical staff, which requires waiting for the medical staff’s peer review body to complete a detailed set of procedures dictated by statute and bylaws. (*Natarajan, supra*, 42 Cal.App.5th at p. 386, fn. 3; Bus. & Prof. Code, §§ 809.1-809.4; see ¶¶ 42-43, *ante*.)

Rather than working directly for the hospital, physicians typically work for their own, physician-controlled independent medical companies, often with their own medical offices. A physician who wants to use hospital facilities must apply for the staff privilege to do so. For instance, when a woman is pregnant she will visit her OBGYN’s private medical office for checkups. When she needs a hospital delivery room, she travels to a hospital where the OBGYN has staff privileges. Only then does she become a patient of both the OBGYN and the hospital.

In the state-mandated separation of physicians and hospitals, the grant of medical staff privileges to a physician to treat patients at a hospital is necessarily “hospital specific”—it merely determines who can treat patients *at a specific facility*. (*Hay, supra*, 183 Cal.App.3d at p. 762; Bus. & Prof. Code, § 805, subd. (a)(4) [“Staff privileges’ means any arrangement under which a licentiate is allowed to practice in or provide care for patients *in a health facility*,” italics added]; American Medical Association Code of Medical Ethics, Opinion No. 9.5.2 Staff Privileges <<https://tinyurl.com/2ceeb5ha>> (as of Mar. 25, 2026) [“The purpose of medical staff privileging is to improve the

quality and efficiency of patient care *in the hospital*,” italics added].) Each hospital is responsible for the care that occurs *at its facility*. Hospitals are able to discharge that duty by closely supervising their facilities and acting on the recommendations of the medical staff’s peer review body as to staff privileges.

Hospitals have no choice about any of this. It is the “comprehensive” system designed by our Legislature to balance an array of competing public policy factors. (*Asiryan, supra*, 100 Cal.App.5th at pp. 966, 969.)

B. The Legislature has confined a hospital’s duty to report sexual assault only to allegations made by patients within the hospital.

The Legislature requires hospitals to report certain matters concerning sexual assault. Again, the extent of those reporting requirements is the result of legislative balancing to address the host of competing public policies in the healthcare industry. And none of those statutory reporting requirements required Hoag to make a report under the facts alleged in the complaint.

For example, by statute, hospitals must report to the Medical Board of California “any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient, if the patient or the patient’s representative makes the allegation, in writing” (Bus. & Prof. Code, § 805.8, subd. (b).) The Legislature was careful to ensure that hospitals do not have to report every allegation of sexual abuse—only those by a patient or their representative, and only when made “in

writing.” (*Ibid.*) Plaintiffs do not allege any facts (as opposed to conclusions) that Hoag ever received any notice that would have triggered a reporting obligation under section 805.8.

The Legislature has also separately mandated reporting to the Department of Public Health of any “sexual assault *on a patient within or on the grounds* of a health facility” (Health & Saf. Code, § 1279.1, subds. (a), (b)(6)(C), italics added), of a disciplinary action by the peer review board (Bus. & Prof. Code, § 805), of workplace violence (Lab. Code, § 6401.9), and of treatment of a sexual-assault victim (Pen. Code, § 11160). Again, these represent legislative determinations that a hospital must report violence *on the hospital’s premises*—not that it must police allegations of off-premises conduct merely because the allegations happen to involve a member of the medical staff. None of those obligations applied to the Non-Hospital Patients.

This means that although the Legislature has dictated a variety of situations in which Hoag is required by law to make a report, *none of those situations existed here*. Plaintiffs want to go far above and beyond the Legislature, imposing a greater duty where the Legislature expressly imposed a lesser one. By declining to impose that greater burden, the Legislature has implicitly rejected the duty plaintiffs assert.

In sum, the Legislature controls the operations of licensed hospitals via a legion of straightforward bright-line rules. The broad new duty adopted by the trial court is nothing of the sort.

C. Exhaustive regulation by the Legislature counsels against creation of a broad new duty of care by judicial fiat.

The Legislature’s careful regulation of every facet of hospital administration counsels against the creation by a court of a broad new hospital duty to control the conduct of medical staff physicians treating non-hospital patients outside of a hospital facility. That duty would represent a vast and unlimited expansion of hospitals’ tort liability. Given the complexity of the hospital-regulatory scheme and the important public policy balances it seeks to maintain, such a significant expansion of tort principles should be addressed, if at all, by the Legislature.

Courts are generally “hesitant to ‘impose [new tort duties] when to do so would involve complex policy decisions’ [citation], especially when such decisions are more appropriately the subject of legislative deliberation and resolution.” (*Moore, supra*, 51 Cal.3d at p. 136.) “The question of what type or level of regulation is adequate or appropriate is uniquely a question for executive or legislative policy choice.” (*Crusader Ins. Co. v. Scottsdale Ins. Co.* (1997) 54 Cal.App.4th 121, 138 [noting that the private right of action the plaintiff sought to create involved “issues uniquely within the policy-investigating and policy-setting powers of the executive and legislative branches”].) This is especially true where, as here, a court is asked to interpose a common law duty into an already closely regulated field like healthcare. (See *Jabo v. YMCA of San Diego County* (2018)

27 Cal.App.5th 853, 862, 882-886 [court was unwilling to create a common law duty of care in an area that had been “closely regulated” by the Legislature].)

Our Supreme Court underscored this point in two recent decisions in which it declined to impose new tort duties in industries subject to extensive regulation. In fact, one of those cases involved the health care industry.

In *Sheen, supra*, 12 Cal.5th 905, our Supreme Court unanimously rejected a negligence claim against a lender based on its alleged duty of care to process, review, and respond carefully to a loan modification application. (*Id.* at p. 915.) The court noted that extensive statutory and regulatory requirements applied to lenders and that no “state or federal statute or regulation applies here to impose a duty along the lines sketched by plaintiff.” (*Id.* at p. 921.) In the face of that omission, the court declined to create a remedy “by judicial fiat” (*id.* at p. 944), and it emphasized the “role of the Legislature, which is better positioned to act in this extensively regulated area” and to consider the complex interplay of factors that might counsel for or against the creation of a new, broader duty (*id.* at p. 916). “Such a balancing of interests, and more generally of the ‘social costs and benefits’ [citation] implicated by plaintiff’s contentions, is best performed by the Legislature.” (*Ibid.*)

Even more recently, in *Capito, supra*, Cal.5th 273, the Court rejected the plaintiff’s contention that hospitals have a legal duty to make specific disclosures of certain emergency room charges to patients in the emergency room “beyond their

obligations under the relevant statutory and regulatory scheme.” (*Id.* at p. 278.) The court explained that imposition of additional legal duties on a hospital “would alter the careful balance of competing interests, including price transparency and provision of emergency care without regard to cost, reflected in the multifaceted scheme developed by state and federal authorities.” (*Ibid.*) “The ‘California Legislature, the United States Congress, and numerous rulemaking bodies have already decided what pricing information to make available in a hospital's emergency room. Just as importantly, they have decided what *not* to include in those requirements. The reason for this extensive statutory and regulatory scheme is to strike a balance between price transparency and dissuading patients from avoiding potentially life-saving care due to cost.” (*Id.* at p. 283.)

Consistent with these rulings, in *Asiryian, supra*, 100 Cal.App.5th 947, the Court of Appeal held that California’s statutory peer review scheme was so “general and comprehensive” that it indicated ““a legislative intent that the statute should totally supersede and replace the common law.”” (*Id.* at pp. 956-957, 966-969.) By creating so comprehensive a system, the Legislature has signaled its intent to ““occupy the field”” in this area. (*Id.* at pp. 967-969.) There was no room for the former common-law rule the appellant sought to apply.

The ruling below not only interjects new judicial rules into an already completely occupied legislative field; it also does so by exposing hospitals to exactly the sort of uncertainty the Supreme Court warned against. In contrast to the detailed and specific

legislative and regulatory requirements governing hospitals, a court-imposed overarching common law duty to non-hospital patients necessarily would be “ill defined and amorphous,” with “a yet-to-be articulated standard of care.” (*Sheen, supra*, 12 Cal.5th at p. 945.)

Hospitals across the state, including Hoag, need certainty. They need to know how to organize their operations to keep risk-based expenses down. The open-ended duty adopted by the trial court threatens to make that impossible by rendering the hospital potentially liable for any treatment of any patient anywhere by any physician with staff privileges, even if the hospital has nothing to do with it.

When the Legislature has considered a situation and imposed specific legal requirements with specific parameters on affected parties, courts should not question the wisdom of the Legislature’s policy choices by expanding the requirements or creating new tort duties that go far beyond what the Legislature decided to require, essentially overriding any legislative balancing of competing policies and interests. And courts should certainly not do so in a broad, ill-defined way that creates uncertainty.

III. This Petition Presents An Urgent Issue Of Statewide Importance That Merits Immediate Relief.

This case has immediate implications not only for Hoag, but for hospitals across the state. The ruling below threatens to impose expansive liability on a hospital for the misconduct of an independent physician against non-patients who were never at the hospital. Although this case arises from a crime—Thompson’s sexual abuse while treating his patients—the trial court’s ruling logically reaches any claim of medical malpractice. The risk of runaway liability is enormous.

Worse, the trial court’s ruling does not suggest how the duty it has created can realistically be discharged. Large and sophisticated hospitals like Hoag often affiliate with *thousands* of staff physicians. Every one of them now poses a separate risk. Hospitals have no way to know how to structure their operations to manage that new risk. And because the vague, abstract duty the trial court created imposes “a yet-to-be articulated standard of care” (*Sheen, supra*, 12 Cal.5th at p. 945), every hospital faces the same uncertainty.

As a critical industry that constantly deals with lives on the line, hospitals need to know what to do as soon as possible. Allowing the trial court’s erroneous reasoning to hang over the head of every hospital during the years this case could take to proceed to judgment and resolution on appeal would disrupt hospital administration across the state. The resulting uncertainty will inevitably drive up healthcare costs, impair

physician-hospital relationships, and potentially even jeopardize the public health.

CONCLUSION

As a matter of law and sound policy, Hoag did not owe the Non-Hospital Plaintiffs a duty of care. The trial court's ruling is therefore wrong as a matter of law.

But the ruling is also wrong and widely problematic because it upsets an intricate, carefully balanced regulatory structure by imposing a duty that the Legislature did not anticipate. If hospitals are to be liable for misconduct committed by any medical staff member against anyone anywhere, that decision must emerge from the complex balancing of competing interests that is the essence of legislation—not “by judicial fiat.” (*Sheen, supra*, 12 Cal.5th at p. 944.)

This Court should grant this petition and direct the trial court to sustain Hoag's demurrer to the Non-Hospital Plaintiffs' negligence claims.

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CERTIFICATION

Pursuant to California Rules of Court, rule 8.204(c)(1) & 8.486(a)(6), I certify that this **PETITION FOR WRIT OF MANDATE, PROHIBITION OR OTHER APPROPRIATE RELIEF; MEMORANDUM OF POINTS AND AUTHORITIES** contains 12,754 words, not including the tables of contents and authorities, the caption page, signature blocks, the Verification page, or this Certification page.

DATED: March 27, 2026

/s/ Robin Meadow

Robin Meadow