No. B316601

In the

Court of Appeal

of the

State of California

SECOND APPELLATE DISTRICT
DIVISION 7

MEDICAL STAFF OF ST. MARY MEDICAL CENTER
Plaintiff and Appellant

vs.

ST. MARY MEDICAL CENTER
Defendant and Respondent.

APPEAL FROM LOS ANGELES SUPERIOR COURT
THE HONORABLE MITCHELL L. BECKLOFF
CASE NO. 20STCP01915

AMICUS CURIAE BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF RESPONDENT ST. MARY MEDICAL CENTER

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Medical Staff of St. Mary Medical Center vs. St. Mary Medical Center

Appeal No. B316601

There are no interested entities or parties that must be listed in this certificate under California Rules of Court, rule 8.208(d)(3).

Dated: August 29, 2022

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AMICUS CURIAE BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION

I. INTRODUCTION

On behalf of over 400 hospitals and hospital systems throughout California, the California Hospital Association ("CHA") urges the Court to affirm in full the Superior Court's well-reasoned decision. To do otherwise and accept Appellant Medical Staff of St. Mary Medical Center's ("Appellant" or "Medical Staff") arguments would be to turn California hospital governance on its head.

The Superior Court's decision accurately reflects the longstanding interdependent relationship between California hospitals and their medical staffs. Simply put, the medical staffs' main function is to oversee the professional work done in the hospital and make recommendations accordingly to the hospital board, thus helping to protect patients and provide high-quality care. Hospitals have a more comprehensive role: ultimate responsibility for the hospital's mission and all of its activities, from parking lot operations to patient care to fulfilling the hospital's overall mission. In this case, the actions of Respondent St. Mary Medical Center's ("Respondent" or "St. Mary") were completely consistent with its lawful authority to make business decisions in the hospital's best interests. Such decisions include approving and entering into exclusive contracts and exercising the board's statutory approval rights over proposed amendments to the Medical Staff Bylaws.

Appellant continually insists that its right to self-governance entitles it to be completely independent from any decisions made by St. Mary. (See Appellant's Opening Brief ("AOB"), p. 8.) This fundamentally mischaracterizes the unique interdependent relationship between California hospitals' medical staffs and their governing bodies. The medical staff's self-governance is subject to the authority of the hospital governing body, which, again, is ultimately

responsible for every facet of the hospital. The two entities are practically and legally interdependent, not independent, and must cooperate to provide high-quality patient care to the public.

Appellant also claims that St. Mary's "entire course of conduct" in governing the hospital violated California's prohibition against the corporate practice of medicine ("CPOM"). (Appellant's Reply Brief ("ARB"), p. 5; see AOB, p. 8.) Specifically, Appellant challenges three of St. Mary's acts: (1) allowing past exclusive contracts with certain physician groups to expire and then entering into new ones; (2) withholding approval of Appellant's proposed amendments to the Medical Staff Bylaws ("Bylaws"); and (3) forming an advisory committee of physicians to serve as a sounding board for the hospitals administration regarding existing exclusive contracts with Medical Staff members. As the Superior Court recognized in its decision, Appellant's challenges are groundless. California law clearly provides that St. Mary, as the entity ultimately responsible for governing the hospital, had full authority to take all of those actions. None of these actions violated CPOM or Appellant's right to self-governance. The authority that St. Mary's hospital board exercised in this case is essential to allowing California hospitals to fulfil their responsibilities to the citizens of California.

II. INTERESTS OF AMICUS CURIAE

CHA is a non-profit association dedicated to representing the interests of California's hospitals. CHA is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the patient beds in California. CHA's members include general acute care hospitals, acute psychiatric hospitals, academic medical centers, county hospitals, and multi-hospital health systems. Its members furnish vital health care services to millions of our state's residents every year. CHA is the largest hospital advocacy organization in California. CHA provides its members with

state and federal representation in the legislative, judicial, and regulatory arenas in its continuing efforts to improve healthcare quality, access, and coverage.

CHA's efforts include educating members of the legislature, judiciary, and others about the complex laws and regulations governing healthcare operations and their impact, as well as pertinent facts regarding California's healthcare industry. As part of these efforts, CHA often participates as an amicus curiae in appeals that have a substantial impact on hospitals and health systems. (See, e.g., *Gerard v. Orange Coast Mem'l Med. Ctr.* (2018) 6 Cal.5th 443; *Rashidi v. Moser* (2014) 60 Cal.4th 718; *Fahlen v. Sutter Cent. Valley Hosps.* (2014) 58 Cal.4th 655; *UFCW & Emp'rs Benefit Tr. v. Sutter Health* (2015) 241 Cal.App.4th 909; *Sutter Health v. Superior Court* (2014) 227 Cal.App.4th 1546.) CHA also has been amicus in federal cases, including *California v. Texas* (2021) 141 S.Ct. 2104, *American Hospital Association v. Becerra* (2021) 141 S.Ct. 2853 and *American Hospital Association v. Becerra* (2022) 142 S.Ct. 1896. Additionally, CHA participates directly in the development of health care policy and related legislation.

CHA members have an ongoing interest in the sensible and accurate application of the laws concerning hospital governance, which is critical to ensuring health care quality. CHA is gravely concerned that if adopted, Appellant's misinterpretations of the law will undermine hospitals' ability to fulfill its duty to protect patients. Appellant mischaracterizes its right to self-governance and completely ignores the reality that medical staffs and hospitals are interdependent. Appellant's misguided views would usurp hospitals' ultimate authority over hospital affairs, leaving no room for hospitals to take actions necessary for quality patient care. CHA therefore wishes to submit an amicus curiae brief to assist the Court in its analysis of these critical issues.

III. STATEMENT OF THE CASE

Amicus Curiae CHA adopts by reference St. Mary's Statement of the

Case.

IV. HOSPITALS AND MEDICAL STAFFS ARE PRACTICALLY AND LEGALLY INTERDEPENDENT

Appellant claims that "chief amongst the 'to do' items" of a medical staff is "the obligation to maintain" its "independence" from the hospital. (AOB, p. 13.) This statement, however, reflects a grievous misunderstanding of the uniquely balanced relationship between a California hospital and its medical staff. Neither is independent from the other; instead, they are interdependent. In response to Appellant's claim of independence, St. Mary correctly notes that a medical staff is "self-governing," but "its role is limited, with the hospital having ultimate authority as to which physicians may practice at its facility." (Respondent's Brief ("RB"), p. 9.)

A. The Hospital's Governing Body is Ultimately Responsible for Hospital Governance

California law is unambiguous: hospital governing bodies are ultimately responsible for everything at the hospital, including managing hospital affairs. This principle is enshrined in the very definition of a hospital in the California licensing statutes: "'General acute care hospital' means a health facility having a duly constituted governing body *with overall administrative and professional responsibility* and an organized medical staff that provides 24-hour inpatient care…." (Health & Saf. Code, § 1250(a), emphasis added; see also Cal. Code Regs., tit. 22, § 70035 ["Governing body means the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital"].) As the Supreme Court of California has noted, hospitals in this state have a "dual structure" that leaves final authority in the governing body's hands:

> First, an administrative governing body (often comprised of persons other than health care professionals) takes ultimate responsibility for the quality and performance of the hospital. Second, an "organized medical staff" entity (composed of health care professionals) has responsibility for providing medical services, and is "responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital." (Cal. Code Regs., tit. 22, § 70703, subd. (a); see also *id.*, § 70701, subd. (a)(1)(F); Bus. & Prof. Code, § 805.5.)

(*Alexander v. Superior Court* (1993) 5 Cal. 4th 1218, 1224.)

Each of these interdependent parts of a hospital has its own responsibilities. The governing body focuses on the hospital's overall mission, business and operation, while the medical staff focuses on patient safety. But it is the medical staff that is "responsible *to the governing body* for the adequacy and quality of the medical care rendered to patients in the hospital" – not the other way around. (Cal. Code Regs., tit. 22, § 70703, subd. (a), emphasis added.)

B. Medical Staffs Are Responsible for Their Own Self-Governance

While the governing body governs the hospital as a whole, the medical staff is responsible for its own self-governance "with respect to the professional work performed in the hospital." (Cal. Code Regs. Tit. 22 § 70701, subd. (a)(1)(F).) The medical staff is an unincorporated association, a separate legal

entity from the hospital, and within its sphere of professional work enjoys certain statutory independent rights as provided in Business & Professions Code Section 2282.5 ("Section 2282.5"). (*Bichai v. Dignity Health* (2021) 61 Cal.App.5th 869, 872, review denied (June 9, 2021); Bus. & Prof. Code, § 2282.5.)

But this right to self-governance is subject to the governing body's ultimate authority over the hospital. This is abundantly clear from the Legislature's findings and declarations regarding Section 2282.5 itself. In the acts adding Section 2282.5 to the law, the Legislature found and declared:

> … the governing board of a hospital must act to protect the quality of medical care provided and the competency of its medical staff, and to ensure the responsible governance of the hospital in the event that the medical staff fails in any of its substantive duties or responsibilities. *Nothing in this act shall be construed to undermine this authority*. The final authority of the hospital governing board may be exercised for the responsible governance of the hospital or for the conduct of the business affairs of the hospital …

(Stats.2004, c. 699 (S.B.1325), § 1, emphasis added; Stats.2004, c. 848 (S.B.1456), § 1.)

Although Section 2282.5 provides certain self-governing rights to the medical staff, such rights are subject to the "final authority" of the governing body "for the responsible governance" or the "conduct of business affairs" of the hospital. (*Id.*)

C. The Hospital and its Medical Staff Have a Uniquely Interdependent Relationship

Although the governing body and the medical staff have different responsibilities, their relationship is symbiotic, with each entity playing an essential and lawful role. From both a practical and legal standpoint, they are interdependent. There is a healthy push and pull relationship between these two entities; in the end, however, the hospital is the entity to which the law gives ultimate authority and which the courts and society hold accountable.

Practically, the governing body and medical staff have a clear and undeniable common interest in the hospital's success. Both entities benefit from the hospital's service success, patient loyalty, and market reputation. To pursue this common interest, the governing body and medical staff must engage in day-to-day cooperation and develop a strong, trusting partnership.

Legally, certain realities make it clear that California medical staffs are not entirely independent of their hospitals, but must interact cooperatively in several respects. Although the medical staff is self-governing, it cannot unilaterally amend its own medical staff bylaws. (Bus. & Prof. Code, § 2282.5, subd. (a)(6).) Nor can it appoint or terminate its own members – it can only recommend appointment and termination to the hospital board, which makes the final decision. (See Cal. Code Regs., tit. 22, § 70703.) The medical staff's peer review must be overseen by the governing body, which has a legal duty to ensure the medical staff's competence. (See *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 341-42, 347; *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center* (1998) 62 Cal.App.4th 1123, 1143.) Moreover, the medical staff relies on the governing body to indemnify the medical staff and its individual members from losses and expenses arising from litigation related to

peer review activities. This is a practically universal requirement in medical staff bylaws throughout California. (See, e.g., California Hospital Association Model Medical Staff Bylaws, § 9.5.1; California Medical Association Model Medical Staff Bylaws, § 13.6.)

At the same time, the governing body must also cooperate with the medical staff. The governing body has ultimate authority over the hospital, but it may not unilaterally amend medical staff bylaws. (See Bus. & Prof. Code, § 2282.5, subd. (a)(6); Cal. Code Regs., tit. 22, § 70701.) Additionally, when withholding its approval of bylaws amendments, the board may not do so unreasonably. (*Id*.) The governing body also has final approval authority over a medical staff member's appeal of an adverse peer review decision, but it still must give great weight to the medical staff's recommendations and decisions. (See Bus. & Prof. Code, § 809.05, subd. (a).)

The Legislature has recognized this interdependent relationship. In the acts establishing the medical staff's right to self-governance as statutory law, the Legislature found and declared: "providing quality medical care in hospitals depends on the mutual accountability, interdependence, and responsibility of the medical staff and the hospital governing board." (Stats.2004, c. 699 (S.B.1325), § 1; Stats.2004, c. 848 (S.B.1456), § 1.)

This careful and logical relationship between the two entities is critical to this Court's analysis of Appellant's repeated overstated claims of independence from the Respondent hospital.

V. HOSPITALS – NOT MEDICAL STAFFS – HAVE ULTIMATE AUTHORITY OVER CONTRACTING FOR PROFESSIONAL SERVICES

Appellant implies that St. Mary violated the Corporate Bar by allowing

the previous exclusive contracts to expire and entering into new ones. (See ARB, p. 5; AOB, p. 8.) In response, St. Mary correctly refutes that implication: "[D]ecisions regarding contracting and management of the operation of departments within a hospital are within the discretionary expertise of the hospital and its board." (RB, p. 33.) Specifically, California courts have consistently and repeatedly upheld hospital decisions to enter into, renew or terminate exclusive contracts when the decision is based on rational business management objectives. These include enhancing the quality of patient care, reducing costs, and facilitating efficient operation and utilization of hospital resources.

A. California Courts Have Repeatedly Confirmed Hospitals' Authority to Enter into Contracts with Entities of its Own Choosing

Appellant's outrage over St. Mary's decision to end certain exclusive contracts, including one that had a 60-year history with St. Mary, and to enter into exclusive contracts with other entities is misdirected and unreasonable. A hospital should never be or feel forced to enter into a contract with any particular provider or group of providers—even if there has been a longstanding contractual relationship in the past. This is because a hospital must make decisions in real time and in the best interests of its community and the patients it serves there without fear of intimidation or harassment.

California's courts have repeatedly recognized the hospital governing body's scope of authority in "oversee[ing] the operations of the hospital." (*El-Attar v. Hollywood Presbyterian Medical Center* (2013) 56 Cal.4th 976, 983.) It has the "ability to make managerial and policy determinations and to retain control over the general management of the hospital's business" because it is

obligated to "remedy any situation which threatens or jeopardizes patient care." (*Mateo-Woodburn v. Fresno Community Hospital & Medical Center* (1990) 221 Cal.App.3d 1169, 1184–1185; see *Redding v. St. Francis Medical Center* (1989) 208 Cal.App.3d 98, 106 [upholding a hospital's "ability to change its procedures" and "power to manage and control its legitimate business"].) The governing body is ultimately responsible for patient care and thus has the authority "to render the final decision in the hospital administrative context." (*Hongsathavij, supra*, 62 Cal.App.4th at p. 1143.)

Without a doubt, such authority includes contracting with providers to improve hospital operations and patient care. In a line of cases going back almost sixty years, California courts have repeatedly upheld a hospital's governing body's decision to enter into contracts with a physician or medical group of its own choosing to provide certain medical services. (See, e.g., *Major v. Memorial Hospitals Assn.* (1999) 71 Cal.App.4th 1380 [contract with anesthesiology group]; *Mateo-Woodburn, supra*, 221 Cal.App.3d 1169 [contract with anesthesiology group]; *Redding, supra*, 208 Cal.App.3d 98 [exclusive contract with a cardiothoracic surgeon]; *Centeno v. Roseville Community Hospital* (1979) 107 Cal.App.3d 62 [contract with radiology group]; *Lewin v. St. Joseph Hospital of Orange* (1978) 82 Cal.App.3d 368 [contract with nephrology group]; *Letsch v. Northern San Diego County Hospital Dist.* (1966) 246 Cal.App.2d 673 [contract with radiology group]; *Blank v. Palo Alto-Stanford Hospital Center* (1965) 234 Cal.App.2d 377 [contract with radiology group].)

B. Hospitals Are Exercising Quasi-Legislative Authority When They Enter Into Exclusive Contracts to Service Duly Closed Departments

In this case, not only was St. Mary's board exercising its authority to

enter into contracts for professional services pursuant to well-established California law, but St. Mary was also acting pursuant to quasi-legislative authority. Closed arrangements in hospital departments are common in California and legally viable. A hospital's decision to close a service is within its "quasi-legislative" authority. (*Lewin, supra*, 82 Cal.App.3d at p. 389.)[1] A quasi-legislative decision is a managerial decision to adopt a rule of general application governing operation of the hospital; in contrast, a "quasi-judicial" decision affects an individual practitioner for reasons relating only to that practitioner. (*Id*. at pp. 383, 385; see *Mateo-Woodburn, supra*, 221 Cal.App.3d at pp. 1182-1183; *Alborzi v. University of Southern California* (2020) 55 Cal.App.5th 155, 169.) Because "the process of moving from an open to a closed system cannot be segmented but are to be considered as an integrated whole," contracting procedures are an "integral part" of the hospital's quasi-legislative decision to close a department. (*Mateo-Woodburn*, at p. 1187 [finding that the hospital's decision to contract with anesthesiology group and to reserve authority to review and approve subcontracts were part of the quasi-legislative decision to close anesthesiology department].)

Courts defer substantially to a hospital's quasi-legislative decision to enter into an exclusive contract. Such decisions "will not be set aside by a court unless it is substantively irrational, unlawful, contrary to established public policy, or procedurally unfair." (*Centeno, supra*, 107 Cal.App.3d at p. 73.) Therefore, St. Mary's decisions regarding the exclusive contracts in this case constitute the implementation of quasi-legislative decisions and are entitled to *Lewin* deference.

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[1] *Lewin* is the leading decision in the area of exclusive hospital contracting. There, the Court of Appeal established the standards for deferential judicial review of quasi-legislative decisions like the ones the Respondent hospital made in this case. (*Lewin*, at pp. 384-385.)

C. Although the Hospital Makes the Final Contracting Decisions, Medical Staffs Should be Included in the Process

As explained in Section IV(A), decisions regarding exclusive contracts are the province of the hospital governing body, but this does not mean that the medical staff should be excluded from the process.

Once the decision is made to close a department, the next step in the process is for the hospital to select the entity it will enter into a professional services contract with to service the closed department. This is typically done by issuing a Request for Proposal ("RFP"), which opens a solicitation process to any qualified group. It is during this RFP process that hospitals typically solicit the medical staff's input.

In this case, St. Mary did consider Appellant's input before making the contracting decisions at issue. The trial court made a factual finding that before St. Mary even initiated an RFP process, Appellant pre-emptively declared that it did not support any changes to the existing exclusive contracts. (See RB, pp. 34-35.) Despite Appellant's apparent unwillingness to participate in the process, St. Mary notified Appellant when it initiated the RFP, invited Appellant's MEC members to participate in panel hearings to interview the groups that responded, and kept Appellant informed of the process. (See RB, pp. 19-22, 24-25, 27-28.) Thus, Appellant has no grounds to claim that it was excluded from the contracting process.

VI. A HOSPITAL'S CONTRACTING DECISION THAT INDIRECTLY RESULTS IN AUTOMATIC TERMINATION OF CERTAIN MEDICAL STAFF OFFICERS DOES NOT VIOLATE SECTION 2282.5

Appellant makes the startling claim that St. Mary, by allowing exclusive

contracts to expire, interfered with the Medical Staff's right under Section 2282.5(a)(3) to select or remove its officers. (AOB, p. 25.) That is not what the record says happened in this case. Instead, as an automatic result of the hospital's exclusive contracting decisions, several physicians lost their membership and privileges because they chose not to join the incoming medical groups who had succeeded in the RFP process. Being outside the exclusive contract, they became ineligible to serve as officers. (RB, p. 10.) Appellant's argument is thus misdirected.

A. Bylaws Requiring Automatic Termination for Non-Group Physicians are Common and Sensible

Among CHA member hospitals, it is common for medical staff bylaws or exclusive contracts to include a provision that automatically terminates the membership or privileges of a physician when his or her exclusive contract with the hospital ends. This sensible provision helps medical staffs avoid the situation in which a physician has membership and privileges with the medical staff but is not permitted to exercise those privileges at the hospital because the hospital holds an exclusive contract with a group to which the physician does not belong. Furthermore, physicians who are no longer members of the medical staff cannot logically be allowed to hold medical staff leadership positions. They no longer have an investment in the medical staff and can act without consequence. For this reason, CHA member hospitals' medical staff bylaws often state that to be eligible for medical staff officer positions, a physician must have "active staff" membership at the hospital. Officers, it is thought, should provide reasonably frequent patient care at the hospital in order to have the necessary familiarity with the facility and its medical staff members.

California courts have repeatedly considered such provisions, never

finding them to be in violation of state or federal law. (See, e.g., *Major, supra*, 71 Cal.App.4th at p. 1387 [medical staff bylaws providing that no hearing is required for "termination of privileges following the decision … to close a department/service pursuant to an exclusive contract …"]; *Abrams v. St. John's Hospital & Health Center* (1994) 25 Cal.App.4th 628, 633 ["under an 'automatic termination of medical staff membership and privileges' provision [of the exclusive contract], the medical staff membership and privileges of plaintiff doctor and the staff pathologists terminate automatically upon the expiration or other termination of the contract"]; *Mateo-Woodburn, supra*, 221 Cal.App.3d at p. 1181 [discussing a contract provision that automatically terminates the physician's privileges to practice anesthesiology at hospital if contract terminates].) When physicians lose their privileges or membership because of an administrative decision regarding exclusive contracting, the Court of Appeal has considered the termination an "indirect result" that does not entitle the physicians to a hearing. (*Abrams*, at p. 637.)

B. The Indirect Results of a Hospital's Contracting Decision Do Not Constitute an Action Taken by the Hospital

With no supporting authority whatsoever, Appellant interprets Section 2282.5(a)(3) as prohibiting hospital governing bodies from taking any action that would result, directly or indirectly, in the termination of a medical staff officer's membership or privileges. Section 2282.5(a)(3) does grant medical staffs the independent right to select or remove their officers, but the section does not guarantee officers an immunity from the effects of any and all actions taken by the hospital. Courts have upheld a hospital's "right" to "take quasi-legislative action," such as a decision about exclusive contracts, "regardless of the negative impact it may have on the staff privileges of a physician or group of physicians."

(*Major, supra*, 71 Cal.App.4th at p. 1401; see *Redding, supra*, 208 Cal.App.3d at p. 106 [upholding "the right of hospitals to make rational management decisions, even when exercise of that right might prove adverse to the interests of specific individual practitioners"].)

If Appellant's interpretation of Section 2282.5(a)(3) were upheld, it would be extremely burdensome and difficult for a hospital to fulfill its managerial responsibilities. Any time a hospital needed to make a decision within its legal authority, it would first have to contemplate how its decision might directly or indirectly affect a medical staff officer's privileges or membership. If the hospital did discover a potential direct or indirect impact, then under Appellant's interpretation, that would violate Section 2282.5(a)(3) and the hospital would be unable to take that action notwithstanding that it was in the best interests of the hospital and its patients. For example, hospitals occasionally decide, for various reasons, to stop offering a particular service. When CHA member hospitals decide to take such a step, it is common and sensible that the physicians with privileges to provide that service would lose their privileges and membership, as there would be no clinical work for them to do there. Under Appellant's interpretation, hospitals would be prohibited from taking this action if it adversely affected the privileges or membership of any medical staff officer.

Here, St. Mary provided a fair remedy to avoid automatic termination of the affected medical staff leaders: physicians in the outgoing service groups were given the opportunity to join the incoming service groups. (RB, pp. 22, 50.) Those who accepted this offer maintained their memberships and privileges with the St. Mary, thus minimizing the impact on the medical staff and the quality of patient care. (*Id*.) That others did not take this opportunity is their own responsibility.

C. A Hospital's Decisions to Enter into Exclusive Contracts for Certain Hospital Services Do Not Violate the Prohibition Against the Corporate Practice of Medicine

Appellant claims that St. Mary's conduct, including its decisions regarding exclusive contracts, violated California's CPOM. (AOB, p. 8; ARB, pp. 8-9.) Again, Appellant's argument is misplaced because California courts have repeatedly approved exclusive contracts as being outside CPOM.

CPOM is established in the Business and Professions Code. "[A]ny person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing … [medicine] without having at the time of so doing a valid, unrevoked, or unsuspended certificate … is guilty of a public offense." (Bus. & Prof. Code, § 2052.) "Corporations and other artificial legal entities shall have no professional rights, privileges, or powers." (*Id*. at § 2400.) "The restriction is meant to protect the professional independence of physicians and to avoid the divided loyalty inherent in the relationship of a physician employee to a lay employer." (*California Physicians' Service v. Aoki Diabetes Research Institute* (2008) 163 Cal.App.4th 1506, 1514 [quotation marks omitted].)

Case law discussing CPOM has created "chinks in the armor of the corporate practice doctrine." (*Conrad v. Medical Bd. of California* (1996) 48 Cal.App.4th 1038, 1044.) Specifically, an exclusive contract between a hospital and a physician's group is "approved as outside the ban on corporate medical practice" so long as the physicians "retained their freedom of action in conducting their practice." (*Id*.) This is the Court of Appeal's holding in *Blank v. Palo Alto-Stanford Hospital Center*, where the court distinguished such exclusive contracts from the financial arrangement in *People ex rel. State Board of Medical Examiners v. Pacific Health Corp.* (1938) 12 Cal.2d 156. (*Blank,*

supra, 234 Cal.App.2d at p. 390 [finding no violation of CPOM where contract provided "the hospital gets 66 2/3 per cent and the physician 33 1/3 per cent of the gross income from the fees for the diagnostic service which is set by the hospital"].) In the present case, Appellant has provided no evidence that St. Mary's exclusive contracts imposed any kind of restrictions on the group physicians' freedom of action. Under established case law, St. Mary's decisions regarding exclusive contracting do not impinge on CPOM.

VII. HOSPITALS HAVE ULTIMATE AUTHORITY TO WITHHOLD APPROVAL OF RECOMMENDED BYLAW AMENDMENTS

Appellant also challenges the decision by St. Mary's governing body to withhold its approval of Appellant's proposed amendments to the Medical Staff Bylaws. (AOB, pp. 32-34.) But California law is clear: all amendments to medical staff bylaws must be approved by the governing body. (Bus. & Prof. Code, § 2282.5, subd. (a)(6); see Cal. Code Regs., tit. 22, § 70703, subd. (a)(8).) The governing body may withhold its approval of any bylaw amendment recommended by the medical staff, so long as the governing body does not do so "unreasonably." (Bus. & Prof. Code, § 2282.5, subd. (a)(6).)

Appellant argues that St. Mary's act of withholding approval was improper because it was done so by Dignity Health Board rather than the Hospital Community Board ("HCB"). (AOB, pp. 31-32.) Appellant implies that St. Mary's governing body somehow usurped the authority of the HCB. Appellant, however, fails to understand the factual and legal reality: The governing body of St. Mary is the Dignity Health Board. St. Mary Medical Center-Long Beach is one of 18 California hospitals owned and operated by Dignity Health. (RB, pp. 13-14.) Per publicly available information on California Department of Public Health's website, the Hospital's licensee is

Dignity Health and the Hospital's Board Members and Officers are the members of the Dignity Health Board.[2] As is permitted under California law, the Dignity Health Board formed a committee called the Hospital Community Board and delegated certain responsibilities to the HCB. (*Id*. at pp. 14-15.) California corporations, including nonprofit public benefit corporations such as Dignity Health, are permitted to "delegate the management of the activities of the corporation to *any person or persons, management company, or committee* however composed, provided that the activities and affairs of the corporation shall be managed and all corporate powers shall be exercised under the *ultimate direction of the board*." (Corp. Code, § 5210, emphasis added.)

Among CHA member hospitals, it is common for large health systems to have a hierarchy of boards. Because of the practical complexities involved in overseeing many hospitals across the country, large health systems generally have regional boards to oversee a large region, which delegates certain authority to local boards that oversee a few hospitals within a much smaller area. Here, the existing two-level board system is prudent. It would be impossible for the Dignity Health Board to competently fulfill, on its own, all governing body responsibilities for 18 hospitals. It is sensible that Dignity Health Board delegates certain responsibilities to a local board like the HCB. Because local boards are able to provide careful attention to issues that arise at the 18 hospitals, this two-level board system promotes patient safety and high quality of care.

Regional boards retain ultimate authority and can revoke the delegation at any time because local boards exercise their delegated authority "under the ultimate direction" of the regional board. (See Corp. Code, § 5210.) Here, the Dignity Health Board delegated its Medical Staff Bylaws approval function to

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[2] <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Search>

the HCB. (RB, pp. 15-16.) But the HCB's bylaws make clear that Dignity Health Board may de-delegate at any time and "elect to exercise the approval rights of the [HCB]". (*Id*. [quoting HCB Bylaws Sections 1.2, 9.2].) This is exactly what was done here – the Dignity Health Board de-delegated its Medical Staff Bylaws approval function and exercised its statutory right to withhold approval of the Medical Staff's proposed amendments to the Medical Staff Bylaws.

VIII. MEDICAL STAFF BYLAWS ARE NOT A BINDING CONTRACT, UNLESS EXPRESSLY STATED

Appellant claims that that the Medical Staff Bylaws constitute a binding contract on the Medical Staff and the Community Board. St. Mary has responded accurately and comprehensively to this claim. As St. Mary explained, the Court of Appeal has held that "under California contract law, medical staff bylaws adopted pursuant to California Code of Regulations, title 22, section 70703, subdivision (b), do not in and of themselves constitute a contract between a hospital and a physician on its medical staff." (*O'Byrne v. Santa Monica UCLA Med. Ctr.* (2001) 94 Cal.App.4th 797, 810.) CHA agrees with St. Mary that *O'Byrne* is on point. California law is clear—a hospital's medical staff bylaws are not a binding contract unless the bylaws explicitly state that they are. (See *Smith v. Adventist Health System/West* (2010) 182 Cal.App.4th 729.) CHA's Model Bylaws contain a provision clearly stating the non-contractual nature of the medical staff bylaws:

> The Bylaws, Rules and Regulations, and Policies and Procedures and other Governing Documents are not, and shall not be deemed to be, contracts of any kind between the Governing Body, the Hospital, the

> Medical Staff and/or any individual (including any Medical Staff member, applicant, or AHP).

(CHA Model Bylaws, §6.7.1.)

CMA itself has acknowledged that medical staff bylaws do not constitute a binding contract without a provision expressly stating so. (See CMA's Statement on Organized, Self-Governing Medical Staffs, CMA Legal Counsel, January 2004, pp. 10-11 ["the *O'Byrne* ruling settles the question in California whether medical staff bylaws, in and of themselves, constitute a legal contract. The answer is 'no.'"].) The CMA Model Bylaws contain a provision identical to the one found in *Smith v. Adventist Health System/West*, for those situations in which a hospital's medical staff and governing body wish to make the bylaws a binding contract. Section 15.5(a) of the CMA Model Bylaws states:

> Upon adoption and approval as provided in Article XV, in consideration of the mutual promises and agreements contained in these bylaws, the hospital and the medical staff, intending to be legally bound, agree that these bylaws shall constitute part of the contractual relationship existing between the hospital and the medical staff members, both individually and collectively.

(See *Smith, supra*, 182 Cal.App.4th at p. 751.)

In the present matter, because St. Mary Medical Center-Long Beach's Medical Staff Bylaws contain no such provision making the bylaws a binding contract, they are not and cannot be a binding contract.

IX. HOSPITALS MAY FORM ADMINISTRATIVE ADVISORY COMMITTEES, AND SUCH COMMITTEES ARE NOT MEDICAL STAFF COMMITTEES

In December 2018, the Hospital's CEO formed a Physician Advisory Council ("PAC") to obtain input from physicians regarding physician recruitment, physician engagement, quality measures, and performance expectations. (See RB, p. 19.) It is common for CHA member hospitals to form administrative committees that assist administrative leaders fulfill their "ultimate responsibility for the quality and performance of the hospital." (*Alexander, supra*, 5 Cal. 4th at p. 1224.) The committees are an effective way for hospitals to obtain advice and information from physicians before making decisions about quality and the hospital's performance; they are a crucial step to preserving the quality medical care and protecting patient safety.

Appellant is mistaken in asserting that the formation of the PAC required approval from the Medical Staff's Chief of Staff. (See AOB, pp. 14-15, 34-35.) The PAC was a hospital administrative committee, and although it included physicians, it is distinct from a medical staff committee. For example, in *Santa Rosa Memorial Hospital v. Superior Court* (1985) 174 Cal.App.3d 711, the Court considered the question of whether the plaintiff hospital's infection control committee was a "hospital administration committee" or a "medical staff committee." (*Santa Rosa Memorial Hospital*, at p. 718.) The Court noted that under guidelines from the Joint Commission on Accreditation of Hospitals, such a committee should be a hospital committee, but under the facts presented it was a medical staff committee because it was established under the medical staff bylaws. (*Id*. at pp. 718-719.)

Here, the PAC was not formed by any medical staff leaders or established

by the medical staff bylaws. The Hospital's CEO formed the PAC solely for the purpose of providing advice to administrative leaders; the PAC did not have any authority to perform Medical Staff functions. (See RB, p. 19.) It is clear that the PAC was a hospital administrative committee, not a medical staff committee, and thus did not require approval from the Chief of Staff.

X. CONCLUSION

For the foregoing reasons, the trial court correctly denied Appellant's petition for writ of administrative mandamus, and CHA urges the Court to affirm the judgment of the trial court.

Dated: August 29, 2022

ARENTFOX SCHIFF LLP

By: 

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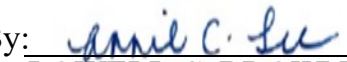
CERTIFICATE OF COMPLIANCE

Counsel of Record hereby certifies that pursuant to Rule 8.204(c)(1) or 8.360(b)(1) of the California Rules of Court, the attached Amicus Curiae Brief is produced using 13-point Roman type including footnotes and contains 5821 words, which is less than the total words permitted by the rules of court, not including the table of contents, table of authorities, the caption page or this certification page. Counsel relies on the word count of the computer program used to prepare this brief.

Dated: August 29, 2022

ARENTFOX SCHIFF LLP

By: 

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PROOF OF SERVICE

I am a citizen of the United States. My business address is ArentFox Schiff LLP, 555 West Fifth Street, 48th Floor, Los Angeles, California 90013. My email address is katryn.smith@afslaw.com. I am employed in the County of Los Angeles where this service occurs. I am over the age of 18 years, and not a party to the within cause.

On the date set forth below, according to ordinary business practice, I served the foregoing document(s) described as on the following parties:

AMICUS CURIAE BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF RESPONDENT ST. MARY MEDICAL CENTER

I certify that, except as noted, and on information and belief, all participants in this action are registered to use TrueFiling and that service will be accomplished by TrueFiling. All other parties will be served as indicated on the service list by either:

x (U.S. Mail) I am readily familiar with my employer's business practice for collection and processing of correspondence for mailing with the U.S. Postal Service, and that practice is that correspondence is deposited with the U.S. Postal Service the same day as the day of collection in the ordinary course of business. On this date, I placed the document(s) in envelopes addressed to the person(s) on the attached service list and sealed and placed the envelopes for collection and mailing following ordinary business practices.

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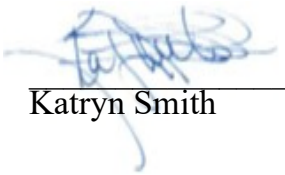

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