In the

Court of Appeal

of the

State of California

FIRST APPELLATE DISTRICT
DIVISION TWO

Case No, A166748

RYAN KIME,
Plaintiff and Appellant,

v.

DIGNITY HEALTH,
Defendant and Respondent.

FROM SAN FRANCISCO COUNTY, SUPERIOR COURT
CASE NO. CGC-20-586388,
HON. RICHARD ULMER, JR., JUDGE

AMICUS CURIAE BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF DIGNITY HEALTH

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

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: September 11, 2023

ARENTFOX SCHIFF LLP

By: _____

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

AMICUS CURIAE BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION

I. INTRODUCTION

On behalf of over four hundred 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. In challenging that decision, Ryan Kime, M.D. ("Appellant") misapprehends the legal and practical relationships among hospital administrations, medical staffs, and individual physicians in California. Those relationships have developed over many decades into a system that is well-designed to protect patients and has been repeatedly upheld by California courts. The theories advocated by Appellant, if adopted, would fundamentally alter that system by upending established legal and operational norms and weakening existing safeguards for patient safety.

The Superior Court rightly concluded that section 3.13 of Mercy Hospital's Emergency Department Agreement[1] with VEP set forth a quasi-legislative eligibility requirement applicable to all VEP physicians. The contractual term was an integral part of the hospital's quasi-legislative decision to close its Emergency Department. In California, a hospital's decision to "close" a clinical service and enter an exclusive contract with a physician group is within its quasi-legislative authority and is entitled to judicial deference. It is standard practice among California

[1] All capitalized terms not defined herein have the same meaning attributed to them in the Respondent's Brief by Dignity Health.

hospitals for the board to make the initial determination that a department should be closed, and then for the hospital administration to implement that decision by negotiating with physician entities and executing the relevant exclusive contract. This practice is both sensible and lawful. The Court of Appeal has held that a hospital's quasi-legislative decision includes all contractual terms implementing the decision because the various steps of moving from an open to a closed system "cannot be segmented" and must be considered as "an integrated whole." (*Mateo-Woodburn v. Fresno Community Hospital & Medical Center* (1990) 221 Cal.App.3d 1169, 1187.) Contrary to this established norm, Appellant argues that the terms of an exclusive contract are not quasi-legislative and not entitled to judicial deference unless they have been expressly approved by the hospital board. (AOB, p. 39; ARB, p. 37.) His argument threatens to destroy the sensible and lawful division of responsibility between hospital boards and administrations.

Additionally, Appellant makes at least three other assertions in his briefs that ignore legal realities governing hospital operations in California.

First, he claims that it would be arbitrary and discriminatory for a hospital to establish a threshold basic requirement that a physician seeking to join a closed group must have no disciplinary history. (AOB, pp. 48-49.) But California hospitals routinely establish their own minimum requirements for clinical privileges. The law upholds each hospital's right to do so based on the established principle that such privileges are

hospital specific.

Second, Appellant argues that all actions by a hospital that leave an applicant without their requested privileges are legally and practically the same, whether the application is discontinued, withdrawn, or denied outright. (AOB, p. 29.) Appellant's startling view would erase the well-settled distinction between a quasi-*legislative* rule, which is of general application, and a quasi-*judicial* rule, which is directed at an individual. Such an erasure would place a heavy burden on hospitals and medical staffs to provide a formal hearing in any instance where an applicant does not receive his or her requested privileges, even when he or she fails to meet the minimum qualifications.

Third, Appellant argues that Mercy Hospital is a "peer review body" and its Chief Medical Officer ("CMO") acted on behalf of the Medical Staff to deny his application for privileges. (AOB, pp. 26–28.) This argument misapprehends the legal reality that the hospital is a separate legal entity from the medical staff. While medical staffs are defined as "peer review bodies" in the Business and Professions Code, hospitals are not. They are "health facilities" licensed and regulated under the Health and Safety Code. Hospitals and medical staffs throughout California respect this separation in their day-to-day functions. For example, CMOs are generally part of the hospital administration's executive leadership. Serving as liaisons between hospital and medical staff leaderships, they are often given a limited role to assist in medical staff functions. But without an express delegation of authority from the medical staff,

a CMO does not and cannot act on behalf of the medical staff.

For the reasons stated above, CHA urges the Court to affirm the trial court's judgment granting Dignity Health's motion for summary judgment.

II. INTERESTS OF AMICUS CURIAE

CHA is a non-profit association dedicated to representing the interests of California's hospitals. It is the largest hospital advocacy organization in California and one of the largest hospital trade associations in the nation, serving more than four hundred 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 provides its members with state and federal representation in the legislative, judicial, and regulatory arenas in its continuing efforts to improve health care 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 where the potential outcomes have a substantial impact on hospitals, health systems and their employees, physicians, and especially patients. (See, e.g., *Naranjo v. Doctors Medical Center of Modesto* (July 26, 2023, S280374) ___ Cal.5th

___ [310 Cal.Rptr.3d 729]; *Boermeester v. Carry* (July 31, 2023, S263180) __ Cal.5th __ [311 Cal.Rptr.3d 24]; *Natarajan v. Dignity Health* (2021) 11 Cal.5th 1095; *Bonni v. St. Joseph Health System* (2021) 11 Cal.5th 995; *Gerard v. Orange Coast Mem'l Med. Ctr.* (2018) 6 Cal.5th 443; *Shaw v. Superior Court* (2017) 2 Cal.5th 983.) CHA also has been amicus in federal cases, including *California v. Texas* (2021) 593 U.S. ___ [141 S.Ct. 2104], *American Hospital Association v. Becerra* (2021) 141 S.Ct. 2853, and *American Hospital Association v. Becerra* (2022) 596 U.S. ___ [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 promoting efficiency and clarity in matters relating to hospital operations including medical staff peer review. CHA therefore submits this amicus curiae brief to assist the Court in its analysis of these critical issues affecting hospitals, medical staffs, and physician employers.

III. STATEMENT OF THE CASE

CHA adopts by reference Dignity Health's Statement of the Case.

IV. HOSPITAL ADMINISTRATIONS DO AND SHOULD NEGOTIATE AGREEMENT TERMS IMPLEMENTING CLOSED DEPARTMENT DECISIONS WITHOUT REQUIRING BOARD APPROVAL FOR EACH TERM

In his briefs, Appellant argues that if the specific terms of a

hospital's exclusive contract have not been expressly approved by the governing body, those terms do not stem from quasi-legislative authority and are not entitled to judicial deference. He alleges "[t]here is no evidence that Dignity's governing body approved the Disclosure Requirements [section 3.13 of the ED Agreement] as its rule or policy," and "[s]ince they are not policies or rules of Dignity's governing body, they are not quasi-legislative" and deserve no judicial deference. (AOB, p. 39; ARB, p. 37.) Not only is this premise impractical and legally unsupported, adopting Appellant's position would recklessly upend established standard practice among California hospitals.

A. Hospitals Exercise Quasi-Legislative Authority When They Enter Exclusive Contracts to Implement Closed Departments

With rare exceptions, California hospitals "close" a department or clinical service and enter exclusive contracts for certain services when doing so is in the best interests of patient care and advances the hospital's mission. Common examples of closed departments are anesthesiology, radiology, pathology, and—as in the present case—emergency medicine. A hospital's decision to close a service is within its "quasi-legislative" authority. (*Lewin v. St. Joseph Hospital of Orange* (1978) 82 Cal.App.3d 368, 386–387, 389 [upholding a hospital's decision to enter into an exclusive contract with nephrology group].)[2] A

[2] *Lewin* is the leading decision in exclusive hospital contracting. There, the Court of Appeal established the standards for deferential judicial review of quasi-legislative decisions like the

quasi-legislative decision is a 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. 383–384.)

Courts have long deferred to a hospital's quasi-legislative decision to enter an exclusive contract like the one at issue in this case. Such a decision "will not be set aside by a court unless it is substantively irrational, unlawful or contrary to established public policy or procedurally unfair." (*Lewin*, 82 Cal.App.3d at p. 385.) This judicial deference is based on reality: "[J]udges are untrained and courts ill-equipped for hospital administration, and it is neither possible nor desirable for the courts to act as supervening boards of directors for every nonprofit hospital corporation in the state." (*Ibid.*)

B. California Hospital Administrators Routinely Implement Decisions to Close a Department

Among California hospitals, it is standard practice for hospital administration to execute exclusive contracts once the board determines a department should be closed. To implement the board's decision, a hospital administration will often negotiate with physician medical groups formed to provide medical services to the closed department's patients. The administrations are authorized to determine an exclusive contract's terms without seeking further board approval. This practice is eminently sensible, as a hospital board is responsible

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ones Mercy Hospital made and implemented in this case. (*Lewin*, at pp. 384-385.)

for providing strategic direction and oversight, whereas a hospital administration is responsible for managing and implementing the details of day-to-day operations, including entering contracts consistent with the hospital's goals and strategy.

Both common sense and the law support this division of responsibility between the governing body and hospital administrators. So also do myriad analogous practices. For example, in the state education arena, under California statute, the State Board of Education ("State Board") is "the governing and policy determining body of the department," whereas the Superintendent of Public Instruction ("Superintendent") "is vested with all executive and administrative functions." (*State Bd. of Education v. Honig* (1993) 13 Cal.App.4th 720, 729; Ed. Code, §§ 33301, subds. (a), (b).) The State Board is responsible for "establish[ing] goals affecting public education in California, principles to guide the operations of the Department, and approaches for achieving the stated goals." (*State Bd. of Education*, at p. 766.) The State Board's role as governing body "refers to governance in the broad sense by virtue of its policymaking authority." (*Ibid.*) "The Legislature did not intend the Board to involve itself in 'micro-management.'" (*Ibid.*) Instead, the Superintendent, not the Board, is responsible for "'the practical management and direction of the executive department," including the "day-to-day execution of Board policies, supervision of staff, and more detailed aspects of program and budget oversight." (*Ibid.*)

As another example, California corporations' officers routinely negotiate and execute contracts on behalf of the corporation without any involvement by the board of directors. Under state law, a corporate officer can have "authority to enter into an agreement on behalf of the corporation" based on the board's express grant of authority or based on the board's consent and acquiescence to the officer's exercise of the power. (*Snukal v. Flightways Mfg., Inc.* (2000) 23 Cal.4th 754, 779; *Englert v. IVAC Corp.* (1979) 92 Cal.App.3d 178, 190.) "Any contract . . . made in the name of a corporation" which is "done within the scope of the authority" or "agency power of the officer executing it . . . binds the corporation." (Corp. Code, § 208, subd. (b).)

In the same way, hospital boards establish goals, guiding principles, and overarching policies of hospital operations, and hospital administrations implement those goals and principles. Boards generally do not devote time to "micro-management" of the detailed aspects of running a hospital, such as executing exclusive contracts. Hospital administrators and executives have the authority to manage the day-to-day operations without obtaining board approval for every contract-related decision. Hospital administrators can and should fulfill the duties of daily operations management without board involvement.

C. The Law Does and Should Defer to a Hospital Administration's Implementation of Decisions to Close a Department

California law supports this standard practice: A hospital's quasi-legislative decision to close a department encompasses all

contractual terms implementing the decision. In *Mateo-Woodburn v. Fresno Community Hospital & Medical Center* (1990) 221 Cal.App.3d 1169, the hospital board decided to operate its anesthesiology department as a closed department. (*Mateo-Woodburn*, at p. 1175.) To implement this closed system, the hospital administration entered an exclusive contract with an anesthesiologist to serve as the department's director and to deliver all anesthesia services to the hospital through sub-contractual arrangements with other anesthesiologists. (*Ibid.*) The hospital did not participate in the director's negotiation or preparation of the subcontracts. (*Id.* at p. 1180.) The court held that the "contracting procedure," including the subcontract terms, was "an integral part of the quasi-legislative decision to close the department of anesthesiology." (*Id.* at p. 1187.) The court explained:

> The various steps involved in the process of moving from an open to a closed system cannot be segmented but are to be considered as an integrated whole. [¶] As such, **if the hospital's policy decision to make the change is lawful**, and we hold it is, **then the terms of the contracts offered to the doctors was [sic] part of the administrative decision** and will not be interfered with by this court unless those terms bear no rational relationship to the objects to be accomplished . . . .

(*Ibid.* [emphasis added].) The Mateo-Woodburn court rightly concluded that the director's "implementation" of the board's decision to close the anesthesiology department was quasi-legislative and entitled to the same judicial deference as the initial board decision. (See *id.* at pp. 1175, 1187.) In the

present case the negotiation and execution of the Emergency Department must receive the same deference. In CHA's experience, the unsegmented contracting process that *Mateo-Woodburn* approved is uniformly followed among California hospitals.

D. If Appellant's Claims Prevail, Hospitals' Routine and Lawful Standard Processes Will Be Upended.

Appellant overlooks this sensible and lawful division of labor between board and administration and seeks to overturn California hospitals' established practice of implementing periodic, customary decisions to close a department. If Appellant's argument holds, hospital administrators across California would need to seek board approval at every step of the process until the "closure" of a department is final. Hospital boards would be forced to devote their time to micro-managing the contracting process, which often involves painstaking back-and-forth negotiations. Such responsibilities should fall on the shoulders of hospital administrators and officers, not board members. Imposing such a burden on governing bodies would replace oversight with management, which is not in the interest of California hospitals or the public.

V. HOSPITALS HAVE THE RIGHT TO SET THEIR OWN MINIMUM QUALIFICATIONS FOR PROVIDERS OF CLOSED DEPARTMENT SERVICES

Appellant argues that it would be arbitrary and discriminatory for a hospital to establish as a threshold basic

requirement that a physician seeking to join a closed group must have no disciplinary history. (AOB, pp. 48–49.) But as Dignity Health rightly notes, hospitals have every right to set their own standard minimum qualifications for membership and privileges, even if that means shutting their doors to all physicians with a history of disciplinary actions. (RB, p. 48.) Hospitals and medical staffs routinely establish "minimum requirements" rendering a physician eligible to practice at a particular hospital. The law supports their right to do so. Such standard requirements are not directed at individuals, but at everyone seeking practice privileges. The "requirements for clinical privileges at each hospital will not be the same" because "clinical privileges are hospital-specific." (*Hay v. Scripps Memorial Hospital* (1986) 183 Cal.App.3d 753, 762 [upholding hospital's "requirement of the completion of an OB-GYN residency of four years as a minimum requirement of staff privileges to do dilation and curettage procedures"].) "So long as there is a rational basis for the medical staff's requirements for clinical privileges, a hospital may make its requirements as stringent as it deems reasonably necessary to assure adequate patient care." (*Bonner v. Sisters of Providence Corp.* (1987) 194 Cal.App.3d 437, 446.)

VI. SIGNIFICANT LEGAL DIFFERENCES EXIST AMONG DISCONTINUATION, WITHDRAWAL, AND DENIAL OF AN APPLICATION

Appellant argues that "'discontinuing' or 'withdrawing' an application is the equivalent to a 'denial' or 'rejection,'" because whether his "application was withdrawn, not processed, denied,

or rejected, the result was the same: he did not obtain the privileges he applied for." (AOB, p. 29.) In other words, Appellant claims that all actions by a hospital that result in an applicant not receiving his or her requested privileges are practically and legally the same. Dignity Health is correct in stating that this misguided claim is false. (RB, p. 37.) Adopting Appellant's view would effectively nullify the well-established distinction between a quasi-legislative rule of general application and a quasi-judicial rule directed at an individual. Even worse, that nullification would place an extraordinary burden on hospitals and medical staffs in California. Any physician aggrieved by a minimum credentialing standard would be entitled to a formal hearing to challenge that standard. No court decision or legislative enactment has ever endorsed or required such a sweeping burden.

There are significant differences between the three scenarios referenced by Appellant, namely (1) discontinuation, (2) withdrawal, and (3) denial. In the first scenario, discontinuation, the hospital or medical staff begins reviewing the physician's application for privileges, but because the physician fails to meet established minimum qualifications, the review process is discontinued before it is complete. In the second scenario, withdrawal, the physician voluntarily withdraws his or her application before the review process is complete. In the third scenario, denial, the physician's application is fully reviewed, and the application is denied based on the reviewing body's recommendation of the individual applicant.

Under California law, the physician's right to a hearing can arise only in the third scenario, denial. "[T]he right to a hearing for a denial of staff privileges is limited to when the denial of privileges is for a 'medical disciplinary cause or reason.'" (*Powell v. Bear Valley Community Hospital* (2018) 22 Cal.App.5th 263, 275 [quoting Business and Professions Code section 809.1].) In *Powell*, the court found that plaintiff physician had no right to a hearing when his privileges lapsed due to his failure to comply with the reappointment application process and "neither the MEC [medical executive committee] nor the Board had reached a decision to terminate his privileges for a medical disciplinary cause." (*Id.* at pp. 275–276.) In the same way, neither discontinuation nor the mere withdrawal of an application is reportable, and neither event entitles the physician to a hearing.[3] In both scenarios, the application process is incomplete, and no final decision has been recommended by the medical staff or made by the hospital board. The right to a hearing arises only when an individual application is fully processed, and the hospital decides to deny an individual applicant based on a medical disciplinary cause or reason. That did not happen in Appellant's case. His application was not denied based on any individualized judgment about his clinical competency and ability to care for patients, but simply because he did not meet a threshold standard applicable to all applicants. This same result

[3] A physician's withdrawal of an application is reportable if they have notice of a pending investigation or denial of the application; these circumstances not present in Appellant's case. Bus. & Prof. Code § 805, subd. (c)(2).

regularly occurs in hospitals throughout California based on quasi-legislative rules. The position Appellant advocates would create huge disruptions in the day-to-day operations of hospitals and medical staffs.

VII. HOSPITALS AND MEDICAL STAFFS ARE SEPARATE LEGAL ENTITIES

A. Medical Staffs, Not Hospitals, Are Peer Review Bodies

Appellant makes yet another startling claim: that Mercy Hospital is a "peer review body" within the meaning of Business and Professions Code section 805 ("Section 805"). (AOB, p. 26.) CHA agrees with Dignity Health's analysis that hospitals are clearly not peer review bodies. To argue that they are defies both law and reality. As Dignity Health states in its brief, Appellant's claim contradicts California statutory and case law. (RB, pp. 30–35.) Because "[t]he medical staff is a separate legal entity from the hospital itself" (*Natarajan v. Dignity Health* (2021) 11 Cal.5th 1095, 1114, reh'g denied (Oct. 13, 2021)), they are separately regulated. Hospitals are "health facilities" licensed and regulated under Division 2 of the Health and Safety Code, while medical staffs are inarguably "peer review bodies" as defined by Section 805. (Health & Saf. Code, § 1250; Bus. & Prof. Code, § 805, subd. (a)(1)(B)(i).)

Hospitals and medical staffs throughout California uniformly operate in line with this legal reality. For example, when a medical staff's medical executive committee meets to

conduct its business, hospital chief executives, medical officers, and other members of the hospital administration are routinely invited to attend as guests but are excused during executive sessions.

B. A Hospital's Chief Medical Officer Does Not Act on Behalf of the Medical Staff Without Express Delegation of Authority

Appellant also argues that Mercy Hospital is a peer review body because its CMO was appointed by the Medical Staff as the Medical Staff's designee. (AOB, pp. 27–28.) In this case, Dignity Health rightly counters that there was no express grant to the CMO of any authority to make peer review recommendations on behalf of the Medical Staff. (Ibid; RB, p. 36.) Because the record shows no such delegation of authority to the CMO to make peer review recommendations on the Medical Staff's behalf, Mercy Hospital's CMO did not do so on the Medical Staff's behalf.

Among California hospitals, Chief Medical Officers are usually part of the hospital administration's executive leadership. (See *Natarajan*, 11 Cal.5th at p. 1114 ["[t]he medical staff is a separate legal entity from the hospital itself"].) As members of the administration, CMOs may provide support services to the medical staff, but hold only such authority to do so as the Medical Staff expressly delegates to them. For example, CMOs often function as a liaison between hospital leadership and medical staff leadership, which may include providing hospital administration's perspectives to medical staff leadership or

coordinating programs involving both entities. Accordingly, CMOs are often ex officio members of the medical staff's medical executive committee that are welcome to attend committee meetings but are not authorized to vote.

Here, it is undisputed that the Medical Staff Bylaws describe the CMO's role as the "administrative liaison among Hospital administration" who shall "[a]ssist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Hospital" and "supervise the day-to-day performance of the Medical Staff Office." (AOB, p. 28; RB, p. 36.) This widely adopted bylaw provision contains no grant of authority to the Hospital's CMO to make peer review recommendations on the Medical Staff's behalf, including recommending the denial of an application for privileges.

VIII. CONCLUSION

For the foregoing reasons, the trial court correctly granted Dignity Health's motion for summary judgment, and CHA urges the Court to affirm the judgment of the trial court.

Dated: September 11, 2023

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 Century Schoolbook type including footnotes and contains 3870 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.

Respectfully submitted,

Dated:September 11, 2023 **ARENTFOX SCHIFF LLP**

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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 DIGNITY HEALTH

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:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on September 11, 2023, in Orange County, California.

Katryn Smith

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