CALIFORNIA SOCIETY OF HEALTHCARE ATTORNEYS (CSHA) 2015 ANNUAL MEETING AND SPRING SEMINAR HEALTHCARE LITIGATION UPDATE

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I. AFFORDABLE CARE ACT

***King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (Nov. 17, 2014) (No. 14-114) [U.S. Supreme Court will decide whether the IRS may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through federal exchanges established under the ACA]**

King v. Burwell is the latest challenge to the Patient Protection and Affordable Care Act (ACA). Here, petitioners are four Virginia residents who, under the ACA's individual mandate provision, are required to purchase individual health insurance coverage or pay a tax penalty. Because of their income levels, petitioners qualify to receive premium tax credits under section 1311 of the ACA, 42 U.S.C. § 18031, if they purchase insurance on the exchanges "established by the state." But without the tax credit, petitioners would be exempt from the individual mandate under the unaffordability exemption. Petitioners argue the plain language of the ACA supports the interpretation that tax credits are available only to individuals who obtain coverage through a state exchange, but not through the federal exchange known as HealthCare.gov. Because Virginia did not establish a state exchange—and therefore petitioners must obtain insurance through HealthCare.gov—petitioners argue they do not qualify for the tax credit. Petitioners also allege the IRS's regulations making the tax credits available to individuals purchasing insurance through the federal exchange exceeds the agency's statutory authority.

The federal government disagrees with petitioners' statutory interpretation, arguing tax credits are available whenever health insurance is purchased on any exchange—state or federal. Under section 1321 of the ACA, 42 U.S.C. § 18041, if a state fails to establish an exchange, "the Secretary [of HHS] shall . . . establish and operate such exchange within the state." The federal government contends this provision means that a federal exchange established by the Secretary of HHS counts as "an Exchange established by the State." The government further contends that its construction of the ACA is consistent with the structure and history of the entire Act, which shows Congress' intent to make tax credits available in every State. The Fourth Circuit agreed with the government. The Supreme Court granted certiorari to address the issue of whether the Internal Revenue Service may permissibly promulgate regulations to extend tax-credit subsidies to coverage

purchased through federal exchanges established under the ACA. Oral argument was held March 4, 2015. The Court will issue a decision before its Term ends in June 2015.

II. ANTITRUST

***North Carolina State Board of Dental Examiners v. FTC,* 574 U.S. ___, 135 S. Ct. 1101 (2015) [U.S. Supreme Court denies antitrust immunity to state dental board]**

Under the North Carolina Dental Practice Act (Act), a state Board of Dental Examiners is the designated "agency of the State for the regulation of the practice of dentistry." The Act provides that six of the Board's eight members must be licensed, practicing dentists. In response to complaints from North Carolina dentists that non-dentists were providing cheaper teeth-whitening services, the Board issued cease-and-desist letters warning that the unlicensed practice of dentistry is a crime. The Act did not specify that teeth whitening is part of "the practice of dentistry," however.

After non-dentists ceased providing teeth-whitening services in North Carolina, the Federal Trade Commission filed an administrative complaint alleging that the Board's efforts were anticompetitive. The Board moved to dismiss, arguing its actions were protected from the FTC's effort to enforce federal antitrust law by the state-action immunity rule from *Parker v. Brown*, 317 U.S. 342 (1943). The Board's argument was rejected by an administrative law judge, by the FTC, and eventually by the Fourth Circuit.

The U.S. Supreme Court granted a writ of certiorari and affirmed (6-3). The Court held that *Parker* immunity was unavailable "[b]ecause a controlling number of the Board's decisionmakers are active market participants in the occupation the Board regulates," yet were not "subject to active supervision by the State." *Parker* confers immunity when state agencies act in a sovereign capacity. A "nonsovereign actor" controlled by active market participants—such as the Board—may invoke *Parker* immunity only if (1) its allegedly anticompetitive conduct is clearly articulated as state policy, and (2) the policy is actively supervised by the State. The Court rejected the Board's argument that it was exempt from the "active supervision" requirement merely because it has been designated as a State agency. And the Court concluded North Carolina did not actively supervise the Board's conduct because the Act was silent on the subject of teeth whitening.

Like the North Carolina Board, the Dental Board of California is comprised of a majority of practicing dentists. *See* Cal. Bus. & Prof. Code § 1601.1(a) ("The board shall consist of eight practicing dentists, one registered dental hygienist, one registered dental assistant, and five public members. Of the eight practicing dentists, one shall be

a member of a faculty of any California dental college, and one shall be a dentist practicing in a nonprofit community clinic."). Other California health care boards have similar licensure membership requirements. *See, e.g.*, Cal. Bus. & Prof. Code §§ 2001 & 2007 (Medical Board), 2462-63 (Board of Podiatric Medicine), 2603 (Physical Therapy Board), 3010.5-3011 (Board of Optometry), 3505 (Physician Assistant Board), 3600-1 (Osteopathic Medical Board).

III. CLASS ACTIONS

***Hale v. Sharpe Healthcare* (2014) 232 Cal.App.4th 50 [emergency department billing class action properly decertified]**

In 2007, Hale received medical treatment and care from the emergency room at Sharp Grossmont Hospital. She was uninsured and signed an agreement obligating her to pay for the services rendered "in accordance with the regular rates and terms of the hospital." When Hale received her bill—which included a substantial discount based on financial assistance—Hale filed suit, alleging that Sharp charged her and other uninsured patients more for emergency services than it did patients covered by private insurance or government plans.

In the first appeal, the Court of Appeal partially reversed the trial court's judgment of dismissal following a demurrer. The trial court then certified the class. Based on evidence obtained from putative class members in discovery, Sharp moved to decertify the class, arguing that individualized inquiries were necessary to identify those individuals in the class definition and to prove entitlement to damages on a classwide basis. The trial court granted the motion, concluding that (1) the class was not reasonably ascertainable, and (2) individualized issues, rather than common issues, predominated, particularly with respect to whether class members were entitled to recover damages. The court then denied Hale's application to amend the class definition.

On appeal, the Court of Appeal, Fourth District, Division One, affirmed, holding that the trial court did not abuse its discretion in decertifying the class or denying the application to amend the class definition. On December 5, 2014, the California Supreme Court certified that the unpublished Court of Appeal opinion meets the standards for publication specified in California Rules of Court, rule 8.1105(c), and ordered the opinion published.

IV. LABOR & EMPLOYMENT

***Fahlen v. Sutter Central Valley Hospitals* (2014) 58 Cal.4th 655 [whistleblower claim alleging retaliatory peer review in violation of Health and Safety Code**

section 1278.5 may proceed regardless whether administrative remedies have been exhausted]

A hospital declined to renew Dr. Fahlen's medical staff privileges in accordance with the recommendation of the Medical Executive Committee of the hospital's medical staff, and that decision was upheld by the hospital's board of trustees after internal peer review proceedings. Dr. Fahlen did not seek judicial review of that administrative decision. Instead, he brought a whistleblower suit against the hospital, claiming that his privileges were denied in retaliation for his complaints about nursing issues. The hospital filed an anti-SLAPP motion seeking to dismiss the complaint, which the trial court denied. The Court of Appeal affirmed in part, holding that Dr. Fahlen's whistleblower cause of action under California Health and Safety Code section 1278.5 could proceed despite his failure to exhaust administrative remedies.

The California Supreme Court granted the hospital's petition for review, but then ruled against the hospital. The Court held that a doctor who believes that a hospital initiated peer review proceedings in order to terminate his staff privileges—in retaliation for his complaints about substandard care—may file a whistleblower action under Health and Safety Code section 1278.5 without first exhausting his judicial remedy of challenging the peer review decision through a state-court mandamus action.

In *Westlake Community Hospital v. Superior Court* (1976) 17 Cal.3d 465, the Supreme Court had held that doctors must exhaust both hospital administrative peer review and judicial mandamus remedies—and must succeed—before initiating any tort suit. Fahlen creates an exception to the exhaustion requirement when a doctor files a section 1278.5 whistleblower action contending that peer review proceedings were the very means of retaliation.

***Shaw v. Superior Court (THC-Orange County, Inc.*), 229 Cal.App.4th 12, *review granted* Nov. 12, 2014 (S221530) [deciding whether there is a right to a jury trial regarding a retaliation claim under Health and Safety Code section 1278.5]**

In this case, the California Supreme Court will decide whether there is a right to jury trial on a retaliation cause of action under Health and Safety Code section 1278.5.

An employee sued a health facility alleging that it retaliated against her by terminating her employment after she complained that the facility employed unlicensed, uncertified, and insufficiently trained health care professionals. She pleaded two causes of action: (1) wrongful termination in violation of public policy; and (2) violation of Health and Safety Code section 1278.5, which protects health care whistleblowers from their employers. The trial court ruled that the statutory cause of action was purely equitable and denied the employee's request for a jury trial, but then stayed the matter to allow her time to seek writ relief from that order.

In a published opinion, *Shaw v. Superior Court* (2014) 229 Cal.App.4th 12, the Court of Appeal, Second District, Division Three, granted the petition and reversed. The court concluded that, because Health and Safety Code section 1278.5 provided for "any remedy deemed warranted by the court pursuant to this chapter or any other applicable provision of statutory or common law," the Legislature contemplated that plaintiffs could pursue both equitable and legal remedies, and therefore were entitled to demand a jury trial.

On November 12, 2014, the Supreme Court granted review. Unless extensions of the briefing deadlines are granted (which is common, especially at the end of the year), the parties' briefing on the merits will conclude in early March 2015, and any amicus briefing should conclude by the end of April 2015. The Supreme Court will then schedule oral argument as soon as at least four justices agree to a tentative opinion, but there is no specific deadline governing when that might occur.

Gerard v. Orange Coast Memorial Medical Center **(Feb. 10, 2015, G048039) 2015 WL 535730, ___ Cal.App.4th ___ [Court of Appeal invalidates wage order to the extent it purports to allow healthcare employees to waive one of the meal breaks on shifts longer than 8 hours required by the Labor Code]**

Labor Code section 512, subdivision (a), requires employers to provide employees with two meal periods for work shifts lasting longer than 12 hours. An Industrial Welfare Commission (IWC) wage order, however, authorizes employees in the healthcare industry to waive one of the two required meal periods on shifts longer than 8 hours.

In this putative class action and private attorney general enforcement action, plaintiff health care workers sued their hospital employer alleging the hospital violated section 512, subdivision (a), by allowing its health care employees to waive their second meal periods on shifts longer than 12 hours. The trial court granted summary judgment in favor of the hospital, denied class certification and struck the class allegations. The trial court stated that plaintiffs were "provided meal periods as required by law," and plaintiffs' illegal meal period waiver argument was "incorrect" in light of *Brinker Restaurant Corp. v. Superior Court* (2012) 53 Cal.4th 1004.

The Court of Appeal, Fourth District, Division Three, reversed and remanded. The Court of Appeal held the IWC wage order was partially invalid to the extent it authorizes second meal period waivers on shifts longer than 12 hours because this part of the order conflicted with section 512(a). The court ordered a remand to determine whether to apply that principle retroactively.

V. MEDICAL BILLING

***Centinela Freeman Emergency Medical Assn. v. Health Net of Cal.*, 225 Cal.App.4th 237, *review granted* July 16, 2014 (S218497) [deciding whether physicians may sue HMOs for negligent delegation of their statutory duty to pay for emergency medical treatment of HMO enrollees]**

California law requires emergency room physicians to treat patients regardless of their ability to pay. California also imposes on Health Maintenance Organizations (HMOs) an obligation to reimburse physicians for emergency treatment provided to HMO enrollees even when the physicians have no contractual relationship with an HMO. HMOs are also permitted by statute to delegate to independent practice organizations (IPAs) their obligation to reimburse physicians for the cost of emergency medical care provided to the HMO enrollees.

In this litigation, emergency room physicians sued an HMO for negligently delegating to a financially troubled IPA the HMO's obligation to pay for emergency services provided to HMO's enrollees. The Superior Court sustained the HMO's demurrer without leave to amend, and the physicians appealed. The Court of Appeal reversed, holding that: (1) a cause of action exists for an HMO's negligent delegation or failure to reassume the obligation to reimburse emergency physicians, who were required by statute to provide emergency care to the HMO members, but (2) the HMO owed no duty to non-emergency radiologists not to delegate its reimbursement obligation. Prior published opinions have reached conflicting results on whether physicians are permitted to sue an HMO for negligently delegating to a financially troubled IPA the HMO's obligation to pay for emergency services provided to HMO's enrollees. (Compare *California Emergency Physicians Medical Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127, 1135-1136 [finding no negligence cause of action] with *Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782, 796-797 [finding such a cause of action exists].)

The Supreme Court granted review, and will decide the following issues:

> 1) Does the delegation by a health care service plan (HMO) to an independent physicians association (IPA), under Health and Safety Code section 1371.4, subdivision (e), of the HMO's responsibility to reimburse emergency medical service providers for emergency care provided to the HMO's enrollees relieve the HMO of the ultimate obligation to pay for emergency medical care provided to its enrollees by non-contracting emergency medical service providers, if the IPA becomes insolvent and is unable to pay?

2) Does an HMO have a duty to emergency medical service providers to protect them from financial harm resulting from the insolvency of an IPA which is otherwise financially responsible for the emergency medical care provided to its enrollees?

***Sarun v. Dignity Health* (2014) 232 Cal.App.4th 1159 [uninsured patient has standing to sue hospital for charging allegedly excessive rates without first seeking discounts or financial assistance covering the allegedly excessive amount]**

An uninsured patient signed an agreement to pay the "full charges" for emergency healthcare services provided by Northridge Hospital (a Dignity facility). The agreement explained that uninsured patients may qualify for government aid or financial assistance from Dignity. Dignity later sent the patient an invoice for more than $23,000 that included an "uninsured discount." The invoice provided a phone number to call for assistance in determining eligibility for financial aid. Without seeking any other discounts or financial assistance, the patient filed an unfair-competition class action alleging that Dignity had violated the UCL and CLRA by failing to disclose that uninsured patients must pay more than other patients for the same services and by charging amounts that exceeded the reasonable value of the services.

Dignity demurred, arguing (among other points) that the patient had conceded he would be willing to pay $3,000, and that until he applied for financial assistance it was speculative whether he would ever need to pay more. The trial court agreed that the patient had not adequately alleged an "actual injury" and sustained the demurrer.

The Court of Appeal reversed. The court held that the patient had properly alleged an injury because, upon receipt of the invoice, the patient was either obliged to pay the full sum, or would be burdened with applying for financial assistance in an effort to eliminate that payment obligation. The argument advanced by Dignity would, according to the court, be akin to requiring a patient to mitigate his damages as a precondition to filing suit—a result at odds with analogous California Supreme Court precedent. The Court of Appeal remanded to allow the trial court to consider Dignity's other demurrer arguments in the first instance.

***Cal. Ins. Guarantee Assn. v. Workers' Comp. Appeals Board* (2014) 232 Cal.App.4th 543 [Court of Appeal upholds Workers' Compensation Appeals Board's determination of reasonable fees for surgical procedures]**

When several surgical centers increased their fees for certain outpatient services provided to injured workers, CIGA and other employers' insurers disputed the increase and paid only the amounts they believed were appropriate for the services performed.

The centers filed liens with the Workers' Compensation Appeals Board (WCAB) to collect the remaining balances. The parties litigated their billing dispute before a workers compensation judge.

The administrative director of the Division of Workers' Compensation maintains an official medical fee schedule (OMFS) for the medical treatment of employees injured at work, but there was no established "reasonable maximum fees" for the procedures at issue during the relevant time period. Accordingly, the judge heard evidence about the percentage of facility fees the centers had collected for arthroscopic knee and shoulder procedures, and for certain epidural injections. The judge also received extensive and competing expert testimony about the usual and customary fees that centers of this type accepted as full payment for facility services. The judge ultimately settled on the appropriate fees using a formula that took into consideration what Medicare allowed, what the centers charged and accepted as payment, what the OMFS for hospitals allowed, and what other centers billed and accepted for the same or similar services.

The insurers sought review before the WCAB, which adopted and affirmed the judge's ruling. The insurers then petitioned for writ relief in the Court of Appeal. The court first held that recent statutory amendments (2012 Senate Bill No. 863) did not divest the WCAB of authority to rule on these medical billing disputes. Resolving an ambiguity in the new law, the court held that the independent bill review procedure established by Senate Bill 893 applied prospectively to new billing disputes, but not to billing disputes pending when the law was enacted. Accordingly, the WCAB had jurisdiction to resolve the billing dispute. On the merits, applying the multi-factor standard enunciated in *Tapia v. Skill Master Staffing* (2008) 73 Cal.Comp.Cases, the court held that the WCAB's resolution of the billing disputes was supported by substantial evidence. The Court of Appeal concluded that fees for arthroscopic knee procedures, arthroscopic shoulder procedures, and epidural injection procedures of $5,207.85, $4,340.95, and $2,337.52, respectively, were reasonable outpatient facility fees.

***Dameron Hospital Assn. v. AAA Northern Cal.* (2014) 229 Cal.App.4th 549 [hospital's agreement with health care insurer failed to preserve hospital's billing rights against third party tortfeasors liable for injuries to its emergency room patients covered by the health care insurer]**

Dameron Hospital Association brought an action to recover on Hospital Lien Act (HLA) liens against the automobile liability insurers of tortfeasors who injured three patients treated in the hospital's emergency room. The hospital sought to recover amounts in excess of the negotiated rates the patients' health care insurer paid to the hospital. The trial court granted summary judgment for the automobile insurers on the grounds the patients' debts had been fully satisfied by their health care insurer. The hospital appealed.

The Court of Appeal affirmed, holding that, although *Parnell v. Adventist Health System / West* (2005) 35 Cal.4th 595 allows a hospital to contractually reserve the right to recover its customary billing rate for emergency room services from third party tortfeasors and/or their liability insurers, the hospital in this case did not do so. Therefore, because the agreement between the hospital and the health care insurer extinguished the patients' debts to the hospital upon payment of the negotiated rates, the hospital could not recover any further payment from the third party tortfeasors' liability insurers.

***Children's Hospital Central Cal. v. Blue Cross of Cal.* (2014) 226 Cal.App.4th 1260 [hospital seeking payment from health care insurer must offer competent evidence of reasonable market value of services, not just evidence of "billed amounts"]**

Children's Hospital Central California sued Blue Cross for breach of an implied-in-fact contract to reimburse the "reasonable and customary" value (as authorized by regulation) of the post-stabilization emergency medical services rendered without a contract to Blue Cross members. At trial, the court admitted evidence of the hospital's "full billed charges," but excluded evidence of the lesser amounts it had historically accepted as payment.

The Court of Appeal reversed, relying on *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 for the proposition that a "medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value." The court held that the trial court had erred by excluding evidence of the historical paid amounts because the reasonable value of the hospital's medical services must be determined after considering all factors, including the amounts the hospital usually accepts as payment for its services.

The Court of Appeal also decided a significant discovery issue, holding that Blue Cross should have been allowed to conduct discovery into the amounts paid by *other* parties for the hospital's medical services. The hospital argued that this discovery would disclose proprietary financial information and trade secrets. But the Court of Appeal held that any such interests could be protected through protective orders.

VI. MEDICAL CONFIDENTIALITY

***Lemaire v. Covenant Care Cal., LLC* (Opinion filed Jan. 27, 2015; Certified for Publication Feb. 23, 2015, B248672) 2015 WL 753304, ___ Cal.App.4th ___ [patients have a private right of action under Health and Safety Code section 1430 to enforce medical records regulations, but may recover only $500 per action in penalties (plus attorney fees) regardless of the number of infractions]**

Under Health and Safety Code section 1430, subdivision (b), a "current or former resident or patient of a skilled nursing facility . . . may bring a civil action against the licensee of a facility who violates any rights of the resident or patient as set forth in the Patients' Bill of Rights in Section 72527 of the California Code of Regulations, *or any other right provided for by federal or state law or regulation*." (Emphasis added.) Section 1430 further provides that the "[t]he licensee shall be liable for up to five hundred dollars ($500), and for costs and attorney fees, and may be enjoined from permitting the violation from continuing."

Laura Clausen suffered a stroke and was admitted to defendant Covenant Care California, LLC's (Covenant) skilled nursing facility in 2010. After she died, her daughter, plaintiff Ana Lemaire, sued Covenant for wrongful death, elder abuse, and violation of "patients' rights" under section 1430. In the patients' right cause of action, Lemaire alleged Covenant violated state regulations requiring it to maintain complete, accurate, and informative medical records at its facility. The jury found against Lemaire on her wrongful death and elder abuse claims, but found for Lemaire on her inadequate health care records claims. The jury awarded Lemaire $270,000 in statutory damages based on its finding of 468 violations of one regulation and 72 violations of a second, times $500 in statutory damages per violation. The jury also awarded Lemaire $841,842 in attorney fees and $26,327.45 in costs.

The Court of Appeal, Second District, Division 6, rejected Covenant's contention that patients do not have a private right of action to sue under section 1430, subdivision (b) for violations of regulations requiring nursing facilities to maintain accurate and complete records. The court held the plain language of section 1430 provides patients with a broad private right of action based on the violation of any "right provided for by federal or state law or regulation."

However, court also agreed with Covenant's contention that section 1430, subdivision (b) does not permit an award of $500 damages for *each* violation. Rather, the plain statutory language allows only a single damage award of up to $500 per lawsuit, plus attorney fees. The court therefore reversed and vacated both the statutory damage award and the award of attorney fees and costs for redetermination by the trial court.

***Lewis v. Superior Court*, 226 Cal.App.4th 933, *review granted* Sept. 17, 2014 (S219811) [deciding whether patient privacy rights prevent the Medical Board from gaining warrantless access to prescription information stored in the CURES database as part of an investigation of a physician for possible disciplinary proceedings]**

A physician petitioned for a writ of administrative mandate seeking to set aside the Medical Board's disciplinary decision subjecting his license to a stayed revocation subject to probation conditions. The Superior Court denied the petition. The physician then filed a petition for writ of mandate in the Court of Appeal seeking to set aside the judgment. The Court of Appeal denied that petition, holding that the Medical Board's access to patients' controlled substance prescription records from the Controlled Substance Utilization Review and Evaluation System (CURES) database did not violate patients' constitutional rights to privacy.

The Supreme Court granted review, and will address the following issues:

1) Is the Medical Board of California permitted, pursuant to the State constitutional right to privacy, to conduct a warrantless search of records of prescriptions for both controlled and non-controlled substances stored on the CURES database, regardless of the nature of the patient complaint(s) involved?

2) May a physician being investigated by the Medical Board assert Fourth Amendment privacy rights under the federal constitution with respect to patient prescription records?

***Medical Board of Cal. v. Chiarottino* (2014) 225 Cal.App.4th 623 [Court of Appeal holds the Medical Board's warrantless access of patients' controlled substance prescription records from the CURES database did not violate patients' constitutional rights to privacy]**

As part of an investigation into the defendant physician's alleged excessive prescribing of medications, the Medical Board of California obtained Controlled Substance Utilization Review and Evaluation System (CURES) reports of defendant's prescribing history, and of the prescription histories for five of his patients. Based on these reports, the Medical Board issued investigative subpoenas to defendant's patients seeking their medical records. After the patients objected to the release of their medical records, the Medical Board filed a petition for an order compelling compliance with the investigative subpoenas. The trial court granted the petition.

The Court of Appeal affirmed, holding that the Medical Board's warrantless access of controlled substance prescription records from the CURES database was justified as part of an investigation regarding the possible need for physician discipline

and did not violate the patients' constitutional rights to privacy. This issue is now presented in the pending case immediately above, *Lewis v. Superior Court* (S219811).

VII. MEDICAL CONFIDENTIALITY

***State Department of Public Health v. Superior Court* (Feb. 19, 2015) [S214679] [California Supreme Court recognizes a limited exception to patient confidentiality for DPH citations under the Long-Term Care Act]**

Under the Long-Term Care, Health, Safety, and Security Act of 1973, the Department of Public Health is empowered to issue citations to long-term health care facilities that violate statutes or regulations. (Health & Saf. Code, § 1417 et seq.) In 2011, the Center for Investigative Reporting asked DPH for copies of citations as part of its investigation into abuse of mentally ill and developmentally disabled individuals in state-owned facilities. The Long-Term Care Act states that citations are public records, but that names of affected patients must be redacted. DPH produced the citations with redactions more extensive than the Long-Term Care Act prescribed; DPH contended that heavier redactions were required by Welfare and Institutions Code section 5328 (part of the Lanterman-Petris-Short Act), which prohibits the release of all confidential "information and records obtained in the course of providing services" to mentally ill and developmentally disabled individuals.

The Center filed a petition for administrative writ of mandate seeking disclosure of the redacted material. The trial court found the Long-Term Care Act and section 5328 irreconcilable, and ultimately ruled that the Long-Term Care Act was controlling on the ground it was more recent and more specific. On review, the Court of Appeal directed the trial court to vacate its judgment. The Court of Appeal concluded that because both statutory schemes are designed to protect the same vulnerable population, they could be harmonized in a way that permitted DPH's extensive redactions.

The California Supreme Court granted review and reversed the Court of Appeal. The Supreme Court agreed with the trial court that the Long-Term Care Act's more recent public accessibility provisions cannot be reconciled with section 5328's older confidentiality provisions. The Court found the Long-Term Care Act more specific—its detailed provisions specify the information that must be included in public DPH citations and "leave little room for concluding that any further redaction is permitted." The Court therefore held that the Long-Term Care Act should be construed as a limited exception to section 5328's general rule of patient confidentiality. Thus, DPH citations issued under the Long-Term Care Act are public records that must be disclosed, subject only to the specific redactions mandated by that Act.

***Sutter Health v. Superior Court* (2014) 227 Cal.App.4th 1546 [nominal damages are unavailable for theft of medical information under the CMIA absent any allegation that anyone viewed the stolen information]**

The Confidentiality of Medical Information Act (CMIA) protects the confidentiality of patients' medical information and provides for an award of $1,000 in nominal damages to a patient if a health care provider negligently releases medical information or records. (Civ. Code, § 56 et seq.)

Here, a thief stole the defendant health care provider's computer containing medical records of about four million patients. Plaintiffs, on behalf of all patients whose records were stolen, brought a class action against defendant seeking $1,000 in nominal damages for each class member. The trial court overruled defendant's demurrer.

The Court of Appeal granted defendant's petition for writ of mandate, holding that plaintiffs failed to state an actionable claim under CMIA absent any allegation that anyone viewed the stolen information. The court further held that the "mere possession of the medical information or records by an unauthorized person was insufficient to establish breach of confidentiality if the unauthorized person has not viewed the information or records."

***Snibbe v. Superior Court* (2014) 224 Cal.App.4th 184 [plaintiffs in wrongful death action entitled to discover surgeon's postoperative orders involving other patients because disclosure of pain management provisions in those orders would not violate patients' privacy rights]**

Mildred Gilbert passed away after receiving a dose of opioid-based pain medication while recovering from hip replacement surgery. Gilbert's heirs filed a wrongful death action against the anesthesiologist and orthopedic surgeon who performed the surgery. Plaintiffs' expert opined that the surgeon's directions for a high dosage of pain medication in his postoperative order to Gilbert was below the standard of care and a substantial factor in her death. The trial court granted plaintiffs' motion to compel production of 160 of the surgeon's postoperative orders, including provisions for the administration of opioids. The surgeon petitioned for a writ of mandate.

The Court of Appeal held that the trial court's discovery order was reasonably calculated to lead to the discovery of admissible evidence to the extent it covered the pain management provisions in the postoperative orders. The court further held that the disclosure of the pain management provisions would not violate the physician-patient privilege or the state constitutional right to privacy.

IX. MEDICAL TORT LIABILITY

***Gregory v. Cott* (2014) 59 Cal.4th 996 [primary assumption of risk doctrine bars claims by home caregiver against Alzheimer's patient and her husband]**

An in-home caregiver sued her patient, who suffered from Alzheimer's disease, and her patient's husband for battery, negligence, and premises liability following a confrontation with the patient that arose during the course of the caregiver's duties and which resulted in an injury to the caregiver. The Superior Court granted summary judgment to defendants (patient and husband), and the Court of Appeal affirmed. The Supreme Court granted review.

The California Supreme Court held that the patient and her husband were not liable for injuries the patient inflicted on the plaintiff caregiver. California and other jurisdictions had already established the rule that Alzheimer's patients are not liable for injuries to caregivers in *institutional* settings, and the Court extended that rule to apply to in-home caregivers in this case. The genesis for the rule is the primary assumption of risk doctrine, which is most often applied in cases involving sports and recreational activity, but which also governs claims arising from inherent occupational hazards. The application of the primary assumption of risk doctrine in the occupational context first developed as the "firefighter's rule," which precludes firefighters and police officers from suing members of the public for the conduct that makes their employment necessary. The Supreme Court held that the primary assumption of risk doctrine likewise applied to the relationship between hired caregivers and Alzheimer's patients because violent behavior is a common symptom of the disease and no duty should be owed to protect caregivers from the very dangers they are hired to confront.

***Winn v. Pioneer Medical Group*, 216 Cal.App.4th 875, *review granted* Aug. 14, 2013 (S211793) [deciding the meaning of "neglect" in the context of elder abuse litigation]**

Defendants provided outpatient medical care to plaintiffs' mother, who suffered from vascular disease in her right leg. Though her condition worsened over a two-year period, defendants never referred her to a vascular specialist. Ultimately, she developed gangrene, underwent amputations, and eventually died from complications. Plaintiffs filed two separate lawsuits: this one for elder abuse, and another for medical malpractice, which is still pending.

The trial court sustained defendants' demurrer to the elder abuse action, ruling that plaintiffs failed to adequately allege that the defendants denied their mother needed care in a reckless manner, and that the professional negligence allegations cannot support an elder abuse action. The Court of Appeal reversed, holding that an elder abuse claim under Welfare & Institutions Code section 15657 does not require the defendant health care provider to have a custodial relationship with the patient, and

that plaintiffs had sufficiently alleged reckless conduct such that the issue should be decided by a jury.

The California Supreme Court granted review to decide the following issue:

> Does "neglect" within the meaning of the Elder Abuse and Dependent Adult Civil Protection Act include a health care provider's failure to refer an elder patient to a specialist if the care took place on an outpatient basis, or must an action for neglect under the Act allege that the defendant health care provider had a custodial relationship with the elder patient?

Briefing was completed on May 5, 2014, with the filing of Winn's answer to the amicus briefs. The Supreme Court has not yet set the case for argument.

***Harb v. City of Bakersfield* (2015) 233 Cal.App.4th 606 [Health care providers may not reduce their potential negligence liability by attributing fault to the plaintiff for causing the injury]**

Plaintiff and his wife sued the City of Bakersfield, the responding officer, the ambulance company, and the paramedic who drove the first ambulance. They alleged the delay in providing medical treatment worsened the consequences of the stroke. A jury returned a defense verdict.

On appeal, plaintiff and his wife argued, among other things, that the jury should not have been instructed on comparative negligence because plaintiff's alleged negligent failure to manage his high blood pressure occurred before the accident and his interaction with the defendants. The Court of Appeal agreed, reversing the defense judgment and ordering a new trial. Addressing an issue of first impression, the Court of Appeal held that "where a plaintiff is seeking damages only for the aggravation or enhancement of an injury or condition, California will follow the majority view that a plaintiff's preaccident conduct cannot constitute comparative negligence when that conduct merely triggers the occasion for aid or medical attention. As a result, defendants who render aid or medical attention cannot reduce their liability for the harm resulting from their tortious acts and omissions by attributing fault to the plaintiff for causing the injury or condition in the first place."

***Uriell v. The Regents of the University of Cal.* (ordered partially published on Feb. 20, 2015, D064098) 2015 WL 737033, ___ Cal.App.4th ___ [Court of Appeal holds that the standard jury instruction on substantial factor causation (CACI No. 430) is adequate in medical malpractice action]**

The heirs of Barbara Kastan sued the Regents for wrongful death, alleging that Dr. Sarah Blair, a UCSD Medical Center surgeon, failed to timely diagnose Kastan's

breast cancer in 2007, which hastened her death in 2010. At trial, plaintiffs' oncology expert, Dr. Robert Brouillard, opined "to a reasonable degree of medical probability" that Kastan would have survived 10 more years if her cancer had been diagnosed and treated in 2007. In contrast, the Regents' oncology expert opined that Kastan had stage 4 cancer in 2007, and therefore would not have lived longer than three years, even if she had been diagnosed and treated in 2007. The trial court denied a nonsuit, and the jury returned a verdict for plaintiffs.

The Regents appealed, arguing that the trial court had erred in using the standard substantial factor jury instruction for negligence cases generally (CACI No. 430), rather than a special instruction tailored to the medical negligence context that would have required plaintiffs to prove causation to "a reasonable medical probability." The Court of Appeal rejected the argument and affirmed. The court held that using the generic substantial factor jury instruction "was appropriate because medical negligence is fundamentally negligence." The court explained that plaintiffs do not face a heightened standard for proving causation in medical malpractices cases, and that the Regents' proposed instruction merely couched the standard substantial factor jury instruction in medical terms (which was unnecessary to fairly present the issue to the jury).

***Worsham v. O'Connor Hospital* (2014) 226 Cal.App.4th 331 [patient failed to state an elder abuse cause of action because the complaint alleged mere negligence, and failed to allege that hospital's conduct toward patient was reckless, oppressive, fraudulent, or malicious]**

The Elder Abuse Act (the Act) defines abuse as "[p]hysical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering," or "[t]he deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering." (Welf. & Inst. Code, § 15610.07, subds. (a)-(b).)

A patient brought an elder abuse action against O'Connor Hospital alleging that understaffing and inadequate training of hospital personnel caused the plaintiff to fall and injure herself. The trial court sustained the hospital's demurrer without leave to amend. The Court of Appeal affirmed, holding that the plaintiff failed to state an actionable elder abuse cause of action because the complaint alleged mere negligence, and failed to allege facts demonstrating reckless, oppressive, fraudulent, or malicious misconduct, which is required for a claim of elder abuse under the Act.

***Coleman v. Medtronic, Inc.*, 223 Cal.App.4th 413, *review granted* Apr. 30, 2014, review dismissed and opinion ordered published Aug. 20, 2014 (S217050) [Federal law does not preempt patient's manufacturing defect or negligence per se claims, but does preempt patient's failure to warn claims based on manufacturer's promotion of off-label uses of federally approved medical device]**

Defendant Medtronic manufactures and sells Infuse, a federally approved bone fusion medical device used in surgery to strengthen the spines of individuals with degenerated vertebral discs. A patient sued Medtronic alleging he suffered painful complications after a spinal surgery in which Infuse was used in an "off-label" manner. Patient's seven causes of action included claims that Medtronic defectively manufactured Infuse, failed to adequately warn of the risks associated with off-label uses of Infuse, and failed to warn patients of the risks of such uses. The trial court sustained Medtronic's demurrer without leave to amend on the ground that each cause of action was preempted by federal law.

The Court of Appeal held that federal law does not preempt the patient's manufacturing defect claim, or the failure to warn and negligence per se claims based on a medical device manufacturer's alleged failure to file adverse event reports, or the patient's negligence per se claim based on the manufacturer's promotion of off-label uses. But the court held that federal law does preempt the patient's failure to warm claims based on the manufacturer's promotion of off-label uses.

X. MICRA (Medical Injury Compensation Reform Act)

***Rashidi v. Moser* (2014) 60 Cal.4th 718 [MICRA's $250,000 cap on noneconomic damages applies only to judgments, not settlements]**

After losing sight in one eye following surgery, plaintiff Hamid Rashidi sued his surgeon, Dr. Franklin Moser, the hospital where he was treated, and the manufacturer of a medical device used during the surgery. Prior to trial, the hospital settled for $350,000 and the manufacturer settled for $2 million. At trial, Dr. Moser failed to prove that the hospital or the manufacturer were liable for Rashidi's loss, so no fault was apportioned to them. The jury awarded $125,000 in economic damages and $1,325,000 in noneconomic damages against Dr. Moser, and the trial court reduced the noneconomic damage award to $250,000 pursuant to the MICRA cap. (See Civ. Code, § 3333.2.) The Court of Appeal, resolving a perceived conflict between Civil Code sections 1431.2 (Proposition 51, which makes liability for noneconomic several, rather than joint) and 3333.2 (the MICRA cap on noneconomic damages against healthcare providers), held Dr. Moser was entitled to offset the $250,000 noneconomic damage award with the portion of his codefendants' pretrial settlements attributable to noneconomic damages.

The Supreme Court reversed the Court of Appeal, holding that there was no conflict between Proposition 51 and the MICRA cap because the MICRA cap applies only to noneconomic damages awarded in a judgment, not to the amount of money paid to settle a claim prior to trial. Settlement amounts are only indirectly influenced by the MICRA cap, since defendants are unlikely to pay more than the statutory cap to settle a claim governed by MICRA. A plaintiff in an action governed by MICRA may recover both the noneconomic portion of a pretrial settlement and the capped award of noneconomic damages at trial. A non-settling defendant seeking to limit his liability for noneconomic damages must prove the liability of any settling codefendants at trial and secure the jury's apportionment of fault between all parties liable for the injury. If the defendant secures such an apportionment of fault, "he would [be] . . . entitled to a proportionate reduction in the capped award of noneconomic damages" pursuant to Proposition 51. (See Civ. Code, § 1431.2.) However, because Dr. Moser failed to prove that any of the settling defendants were at fault in this case, he alone was solely liable for the entire $250,000 in noneconomic damages awarded in the judgment.

***Flores v. Presbyterian Intercommunity Hospital*, 213 Cal.App.4th 1386, *review granted* May 22, 2013 (S209836) [deciding the meaning of "professional negligence" for purposes of MICRA]**

Plaintiff Catherine Flores sued defendant Presbyterian Intercommunity Hospital for premises liability and general negligence, seeking damages for injuries she sustained (more than a year before filing suit) when her bed rail collapsed and she fell to the floor. The Hospital demurred, arguing that the court should apply the one-year statute of limitations for professional negligence under MICRA. (Code Civ. Proc., § 340.5.) The trial court sustained the Hospital's demurrer without leave to amend. Plaintiff appealed, arguing the collapse of the bed rail constituted general negligence subject to the two-year statute of limitations for general negligence. (Code Civ. Proc., § 335.1.) The Court of Appeal reversed, holding that the collapse of the bed rail sounded in general, not professional, negligence because the collapsing bed rail did not occur while the hospital was rendering professional services.

The California Supreme Court granted review, and will decide the following issues:

1) Does the one-year statute of limitations for claims under MICRA or the two-year statute of limitations for ordinary negligence govern an action for premises liability against a hospital based on negligent maintenance of hospital equipment?

2) Did the injury in this case arise out of "professional negligence," as that term is used in section 340.5, or ordinary negligence?

Blevin v. Coastal Surgical Institute **(2015) 232 Cal.App.4th 1321 [One-year MICRA limitations period may be tolled by Insurance Code section 11583]**

The Court of Appeal, addressing an issue of first impression, held that the one-year statute of limitations applicable in medical malpractice actions (Code Civ. Proc., §§ 340.5, 364) could be tolled by operation of Insurance Code section 11583.

Plaintiff Blevin's knee became infected following surgery at the defendant's facility. The defendant paid plaintiff for the initial cost of treating the infection, but failed to inform plaintiff of the applicable statute of limitations governing medical malpractice claims. Plaintiff was not represented by counsel, and did not sign a release in exchange for the payment. When plaintiff filed suit 15 months later, the facility argued the suit was untimely under the one-year MICRA statute of limitations. The trial court ruled that the one-year limitations period was tolled by operation of Insurance Code section 11583, and later entered judgment on the jury's verdict in favor of the plaintiff.

The Court of Appeal affirmed, rejecting the defendant's arguments that the tolling provision of Insurance Code section 11583 should not apply to the MICRA statute of limitation. Section 11583 requires that any person making an advance payment as an accommodation to an injured person who is not represented by counsel must provide the recipient written notice of the applicable statute of limitations governing the causes of action that could be brought as a result of the injury. Section 11583 further states that the "[f]ailure to provide such written notice shall operate to toll any such applicable statute of limitations or time limitations from the time of such advance or partial payment until such written notice is actually given." Relying by analogy on the Supreme Court's decision in *Belton v. Bowers Ambulance Service* (1999) 20 Cal.4th 928, 930, the Court of Appeal held that Insurance Code section 11583 may toll the one-year MICRA limitations period, but not the maximum three-year limitations period applicable to medical malpractice actions.

Arroyo v. Plosay **(2014) 225 Cal.App.4th 279 [plaintiffs' causes of action based on a theory identified by their expert that disfigurement of decedent occurred due to wrongful placement of the patient in the morgue while still alive were timely under the delayed discovery rule, but plaintiffs' cause of action based on negligent postmortem disfigurement was untimely under MICRA statute of limitations]**

A deceased patient's family members brought an action against Dr. Plosay and White Memorial Hospital. Plaintiffs' causes of action for medical negligence and wrongful death were based on allegations that decedent's disfigurement occurred due to the wrongful placement of the patient in the morgue while still alive. Plaintiffs alleged that they did not discover these facts until an expert they had retained in a prior dismissed action against the hospital reviewed discovery material and opined

that the decedent's injuries occurred pre-mortem. Plaintiffs' third cause of action for negligence was based on the alternative factual premise that, after the decedent died from cardiac arrest, her body was mishandled by hospital staff when placing it in the morgue, resulting in facial disfigurement.

The trial court sustained the hospitals' demurrer without leave to amend, concluding that the MICRA one-year limitation period applied to all of plaintiffs' claims, and that this period commenced more than a year before the lawsuit was filed, when plaintiffs learned of the decedent's death and the disfiguring injuries to her face.

The Court of Appeal affirmed in part and reversed in part, holding that plaintiffs' negligence and wrongful death causes of action were timely under the delayed discovery rule, under which a cause of action accrues when the plaintiff is aware, or reasonably should be aware, of the injury. But the court held that plaintiffs' cause of action based on the allegation of negligent post-mortem disfigurement was untimely under MICRA's one-year statute of limitations period.

***Maher v. County of Alameda* (2014) 223 Cal.App.4th 1340 [leaving biliary stent in patient's body triggered MICRA's "foreign body" tolling provision, but hospital's denial of patient's request for records did not violate Patient Access Law]**

Surgeons implanted a biliary stent in plaintiff Brendan Maher during emergency abdominal surgery in 1996. Maher alleged he was unaware of the stent's placement until it was discovered and removed in August 2010 while he was receiving treatment for abdominal pain. In April 2011, Maher sued the health care providers who treated him in 1996 and 1997 for professional negligence in not timely removing the stent or informing him of its placement. The trial court granted defendants' demurrer without leave to amend, finding Maher's professional negligence claim was barred by the MICRA statute of limitations.

The Court of Appeal reversed in part, holding that the "no therapeutic or diagnostic purpose or effect" qualification in the "foreign body" tolling rule of the MICRA statute of limitations means the tolling rule (a) does not apply to objects and substances intended to be *permanently* implanted, but (b) does apply to items *temporarily* placed in the body as part of a procedure and meant to be removed at a later time. Because the stent was intended to be temporary, the statute of limitations period for Maher's professional negligence claim was tolled from 1996 to 2010 under the "foreign body" exception.

The Court of Appeal affirmed the trial court's order sustaining defendants' demurrer to Maher's separate cause of action for denial of access to his medical records. The court explained that a hospital does not violate the Patient Access Law by

declining a patient's attorneys' request for medical records because the attorneys were not "patients" or "patient representatives" within the meaning of the statute.

XI. MEDICAL COVERAGE

Norasingh v. Lightbourne **(2014) 229 Cal.App.4th 740 [IHSS cannot deny protective supervision benefits to a client on the improper ground that psychogenic pseudoseizures were a "medical condition" that required "medical" supervision]**

Amanda Norasingh—a young adult suffering from significant medical and mental disabilities—petitioned for a writ of administrative mandate seeking reinstatement of protective supervision benefits under the In-Home Supportive Services (IHSS) Program administered by the Department of Social Services (CDSS).

According to a CDSS regulation, "protective supervision is available for those IHSS beneficiaries who are non-self-directing, in that they are unaware of their physical or mental condition and, therefore, cannot protect themselves from injury, and who would most likely engage in potentially dangerous activities." Protective supervision is not available, however, when the need is caused by a "medical condition" and the form of supervision required is "medical." After hearing, an administrative law judge (ALJ) concluded that Norasingh was no longer eligible for the protective supervision benefits that she had been receiving since 2005 because her psychogenic seizures qualified as a "medical condition." The trial court subsequently affirmed the decision of the ALJ.

The Court of Appeal reversed, holding that IHSS cannot deny protective supervision benefits on the improper ground that psychogenic pseudoseizures were a "medical condition" that required "medical" supervision because psychogenic seizures are actually a mental illness and not a physical issue. The court held that Norasingh was therefore entitled to a new IHSS assessment considering behaviors related to her psychogenic seizures as a potential basis for protective supervision.

Rea v. Blue Shield of Cal. **(2014) 226 Cal.App.4th 1209 [California's Mental Health Parity Act requires health care service plans to provide residential treatment for eating disorders where medically necessary]**

The California Mental Health Parity Act (part of the Knox-Keene Health Care Service Plan Act of 1975) requires that every health care service plan contract must "provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses . . . under the same terms and conditions applied to other medical conditions." (Health & Saf. Code, § 1374.72.)

Plaintiffs brought a putative class action against Blue Shield for denying residential treatment for eating disorders under their health care service plans, alleging that the Parity Act requires coverage for residential treatment for eating disorders, even where the health plan does not provide such coverage. The trial court sustained Blue Shield's demurrer without leave to amend, holding that the statutory language of the Parity Act and the Knox-Keene Act did not support coverage for a treatment not specifically enumerated in the Parity Act.

The Court of Appeal reversed, holding that the Parity Act requires health care service plans to provide residential treatment for eating disorders where "medically necessary," regardless of whether the treatment qualified as a "basic health service" under the Knox-Keene Act.

XII. PEER REVIEW

DeCambre v. Rady Children's Hospital-San Diego **(March 11, 2015) ___ Cal.App.4th ___ [D063462] [hospital defendants' anti-SLAPP motion asserting peer review protection properly defeats most (but not all) of doctor's discrimination claims]**

Plaintiff Dr. Marvalyn DeCambre, a pediatric urologist, sued her former employers Rady Children's Hospital-San Diego (RCHSD), Children's Specialist San Diego (CSSD), and the Regents of the University of California (Regents), alleging defendants discriminated against her because of her race and gender. DeCambre's complaint alleged nine causes of action including retaliation, harassment, racial discrimination, failure to prevent discrimination, wrongful termination, intentional infliction of emotional distress (IIED), defamation, and violations of the Unfair Competition Law, and the Cartwright Act.

The defendants demurred and filed special motions to strike DeCambre's complaint pursuant to Code of Civil Procedure section 425.16 (commonly referred to as an anti-SLAPP motion). The trial court granted the anti-SLAPP motions on the ground that all of DeCambre's causes of action arose from RCHSD's decision not to renew its contract for DeCambre's services, which was the result of the hospital peer review process that is protected as an "official proceeding authorized by law" under the anti-SLAPP statute. The trial court also sustained defendants' demurrers to DeCambre's claims for IIED, defamation, unfair competition, and violation of the Cartwright Act.

The Court of Appeal reversed in part, holding that the trial court erred in granting the defendants' anti-SLAPP motions as to DeCambre's claims for harassment, IIED, and defamation. The court explained that, although defendants' conduct arising from the peer review proceedings was protected under section 425.16, the "gravamen and principal thrust" of the harassment, IIED, and defamation claims was conduct that

occurred independent of the peer review proceedings. DeCambre's harassment and IIED claims arose from incidents of allegedly disparate treatment that DeCambre claimed occurred throughout her employment by defendants, and her defamation claim was based on defendants' statements allegedly made *after* the peer review process. However, the court affirmed the trial court's order granting defendants' demurrers to the defamation cause of action on the ground the defendants' alleged statement that she was "not a team player" was a nonactionable statement of opinion. Finally, the court affirmed the dismissal of the rest of DeCambre's causes of action because they arose from protected peer review proceedings, and she failed to establish a probability of prevailing on the merits. The court also reversed and remanded the attorney fees awarded to defendants for redetermination pursuant to section 425.16, subd. (c)(1).

XIII. THE CALIFORNIA SUPREME COURT'S NEW JUSTICES & THEIR IMPACT ON HEALTHCARE LAW

The California Supreme Court's two newest justices joined the Court on January 5, 2015. They are former Stanford Law professor Mariano-Florentino Cuéllar and former U.S. Department of Justice attorney Leondra Kruger. They are both quite young—Cuéllar is 41 and Kruger is 38.

(1) *Justice Mariano-Florentino Cuéllar*

Justice Cuéllar joined the Court on January 5, replacing Justice Marvin Baxter.

Justice Cuéllar was born in Matamoros, Mexico, and crossed the border on foot to attend school in Texas. He and his family moved to Calexico, California when he was 14. He earned a bachelor's degree from Harvard, a J.D. from Yale Law School and a Ph.D. in political science from Stanford. He is married to U.S. District Judge Lucy H. Koh of the Northern District of California.

Justice Cuéllar clerked for Judge Mary M. Schroeder of the U.S. Court of Appeals for the Ninth Circuit. He then worked at the U.S. Department of the Treasury, where he focused on anti-corruption initiatives, border coordination, and financial crime enforcement.

A Stanford Law School professor since 2001, Justice Cuéllar taught administrative law, criminal law, international law, executive power and legislation. He was also a professor of political science and director of Stanford's Freeman Spogli Institute for International Studies. Justice Cuéllar was elected to the American Law Institute in 2008 and was elected to the ALI Council in 2014. He has worked on several ALI projects, including Model Penal Code: Sentencing, Principles of Government Ethics, and Restatement Fourth, The Foreign Relations Law of the United States.

From 2009 to 2010, Justice Cuéllar took leave from Stanford Law School and served as a Special Assistant to the President for Justice and Regulatory Policy at the White House Domestic Policy Council. While at working for the Obama administration, he led the Domestic Policy Council's work on public health and safety, regulatory reform, civil rights, immigration, and rural and agricultural policy. He coordinated the Food Safety Working Group, an inter-agency effort tasked with revamping federal food safety efforts. In July 2010, President Obama appointed Justice Cuéllar to the Council of the nonpartisan Administrative Conference of the United States.

Justice Cuéllar has never been a litigator and has no prior judicial experience, so his views on health law issues are almost completely unknown. A *Daily Journal* report contained interviews with several people who have worked with him, and who describe him as "a pragmatic Democrat" who is "very practical, very realistic," is interested in how things really work, and is very careful and thorough.

Jason Lee, chair of the Commission on Judicial Nominees Evaluation told the appointments panel Justice Cuéllar is "a brilliant scholar, an excellent writer and speaker, and enjoys a stellar reputation for his achievements in academia." The evaluators also praised Justice Cuéllar for his "remarkable ability to build and maintain consensus even amongst those with disparate interests."

Justice Cuéllar has written numerous articles and papers on a wide variety of topics. The following articles may be of interest to CSHA members:

Mariano-Florentino Cuéllar, *Coalitions, Autonomy, and Regulatory Bargains in Public Health Law*, *in Preventing Regulatory Capture: Special Interest Influence and How to Limit it* 326-362 (Daniel Carpenter & David A. Moss eds., Cambridge Univ. Press) (2013). In this book chapter, Justice Cuéllar analyzes how three federal government agencies (the USDA, FDA, and CDC) overcame political resistance to "break new ground in protecting public health" by implementing important public health laws. This chapter provides insight into Justice Cuéllar's experience with public health regulation and his interest in protecting the public rather than private economic interests.

Mariano-Florentino Cuéllar, *Rethinking Regulatory Democracy*, 57 Admin. L. Rev. 411 (2005). Here, Justice Cuéllar presents an empirical study analyzing certain aspects of the notice and comment process in three recent regulatory proceedings to demonstrate the complexities of public participation in regulatory policy under existing legal structures [what Justice Cuéllar refers to as "regulatory democracy"] and proposing alternatives to such structures. Though this article does not deal directly with health law, it demonstrates Justice Cuéllar's vast experience in the realm of administrative law, and his dedication to increasing the public's understanding of and participation in the federal regulatory rule-making process.

(2) ***Justice Leondra Kruger***

Justice Kruger also joined the Court on January 5, replacing Justice Joyce Kennard.

Justice Kruger is the daughter of two pediatricians and grew up in South Pasadena, California. Kruger earned a bachelor's degree from Harvard and a J.D. from Yale Law School in 2001. From 2001 to 2002, she was an associate at Jenner & Block. She then clerked for Judge David Tatel on the U.S. Court of Appeals for the D.C. Circuit from 2002 to 2003 and U.S. Supreme Court Justice John Paul Stevens on the U.S. Supreme Court from 2003 to 2004. From 2004 until 2006, Justice Kruger was an associate at Wilmer, Cutler, Pickering, Hale and Door. In 2007, she was a visiting assistant professor at the University of Chicago Law School.

Justice Kruger served as an Assistant to the Solicitor General and as Acting Principal Deputy Solicitor General in the U.S. Department of Justice, Office of the Solicitor General from 2007 to 2013. Since 2013, she has served as Deputy Assistant Attorney General at the U.S. Department of Justice, Office of Legal Counsel. While at the DOJ, Justice Kruger argued 12 cases on behalf of the federal government before the U.S. Supreme Court.

Like Justice Cuéllar, Justice Kruger has no prior judicial experience. A retired justice from the Third District, Justice Sims, criticized her nomination in an op-ed piece based on this lack of judicial experience. And the *San Francisco Chronical* has pointed out that, although she is a Los Angeles native, she hasn't lived in California since she was a teenager. Santa Clara University law professor Gerald Uelmen told the *Los Angeles Times* that the appointment was a "mind blower," because she "barely meets the constitutional qualifications. She has never practiced law in California, and she hasn't been in California for the last 20 years, as far as I can see." Uelmen then noted that Kruger appeared to be "superstar" who had moved up the legal ranks quickly.

People who have worked with Justice Kruger, on both sides of the political aisle, have uniformly praised her brilliance, integrity, and work ethic. "Leondra Kruger is a brilliant, deeply principled and eloquent lawyer who has served the Department of Justice and the country with great distinction in the Solicitor General's Office and more recently in the Office of Legal Counsel," said U.S. Solicitor General Don Verrilli. He added, "Her character, temperament and wise judgment make her ideally suited to serve as a jurist on the California Supreme Court. I am certain she will make great contributions to the law in the years to come."

According to former Acting U.S. Solicitor General Neal Katyal, "Leondra Kruger is perhaps the most outstanding lawyer in America right now under the age of 40. She is known for meticulous preparation before her arguments in the United States

Supreme Court, her absolute dedication to candor and her unwavering commitment to fairness."

(3) ***Justice Goodwin Liu***

Justice Goodwin Liu is also a relatively new addition to the California Supreme Court. Since joining the Court three-and-a-half years ago, on September 1, 2011, Justice Liu has written opinions in the following healthcare-related cases:

State Department of Public Health v. Superior Court (Feb. 9, 2015) [S214679] (See *ante*, p. 12.)

Gregory v. Cott (2014) 59 Cal.4th 996 (concurring opinion by Justice Liu) (See *ante*, p. 14.)

El-Attar v. Hollywood Presbyterian Medical Center (2013) 56 Cal.4th 976 (holding that violation of hospital bylaws in peer review proceeding did not violate physician's statutory fair hearing rights).