Supreme Court of California
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May 9, 2022

VIA TRUEFILING

Honorable Tani Cantil-Sakauye, Chief Justice and Honorable Associate Justices
Supreme Court of California
350 McAllister Street
San Francisco CA 94102-7303

Re: *Khoiny v. Dignity Health*, No. S274246: Amici Curiae Letter in Support of Petition for Review

Dear Chief Justice Cantil-Sakauye and Associate Justices:

Pursuant to California Rule of Court 8.500(g), amici curiae the California Hospital Association (CHA) and Loma Linda University Health Education Consortium (LLUHEC) submit this letter in support of Dignity Health's petition for review.

With the stroke of the pen, an appellate panel has wiped out academic deference in California graduate medical education. *Khoiny v. Dignity Health*, 76 Cal.App.5th 390, 291 Cal.Rptr.3d 496 (2022). By holding that "a residency program's claim that it terminated a resident for academic reasons is not entitled to deference," 291 Cal.Rptr.3d at 506, *Khoiny* abolishes the deference traditionally given to the decision-making of medical faculty at over 400 residency programs in California, which at any given time train more than 10,000 medical residents.

The Court of Appeal's decision to dismantle academic deference is contrary to well-established law, including decisions of this Court. *Ezekial v. Winkley*, 20 Cal.3d 267, 278 (1977) ("expert supervisorial judgment as to a resident's competence must necessarily be accorded great weight"). It also is contrary to fact: the panel reached a sweeping (and incorrect) conclusion regarding the nature of the relationship between all residency programs and all medical residents based on a limited record concerning a single residency program. Moreover, as Dignity Health explains in its Petition, the Court of Appeal misread the record in this case. Pet. at 25-27.

Amici write to explain that the relationship between residency programs and medical residents is fundamentally academic, and to urge this Court to grant review or, at a minimum, depublish the *Khoiny* decision.

Interest of Amici Curiae

CHA is a nonprofit membership corporation representing the interests of more than 400 hospital and health system members in California. CHA's members furnish vital health care services to millions of our state's citizens. CHA provides its members with state and federal representation in the legislative, judicial, and regulatory arenas, in an effort to: support and assist California hospitals in meeting their legal and fiduciary responsibilities; improve health care quality, access, and coverage; promote health care reform and integration of services; achieve adequate health care funding; improve and update laws and regulations; and maintain the public trust in healthcare. CHA counts among its members more than 110 hospitals with residency programs.

Loma Linda-Inland Empire Consortium for Health Education (d.b.a. Loma Linda University Health Education Consortium) is a not-for-profit religious corporation. LLUHEC is affiliated with Loma Linda University and Loma Linda University Medical Center. LLUHEC sponsors 55 accredited graduate medical education programs, and trains 900 residents and fellows to serve current and future residents of California's Inland Empire. As part of its mission, LLUHEC addresses health disparities in the communities it serves by enhancing racial and gender diversity within the clinical learning environment.

Given their roles, amici are uniquely able to assess both the impact and implications of legal issues affecting the healthcare field. The Court of Appeal's misguided decision—effectively destroying academic deference in medical residency programs in California—presents one such important issue.

Reasons for Granting Review

The Court of Appeal was presented with a narrow question: whether a jury instruction applying academic deference in the context of a medical resident's FEHA claim was prejudicial. Petitioner Dignity Health correctly explains why the panel's answer to that question is incorrect and worthy of review. Pet. at 15-28. The *Khoiny* decision went far beyond FEHA, however, categorically eliminating academic deference in *every* situation involving medical residents. Amici write separately to urge review because the panel's per se rule (i) is contrary to a settled body of academic deference law, and (ii) fundamentally misunderstands the nature and purpose of medical residencies.

I. *Khoiny* threatens the academic deference that courts have long given educational institutions, including medical residency programs.

In *Ezekial*, this Court held that "a surgical resident in a private teaching hospital must be accorded notice of charges and an opportunity to respond, pursuant to the 'common law right of fair procedure' … prior to dismissal from [a] residency program." 20 Cal.3d at 269-70 (quoting *Pinsker v. Pacific Coast Society of Orthodontists*, 12 Cal.3d 541, 555 (1974)). In so ruling, the Court recognized that "*expert supervisorial judgment as to a resident's competence must necessarily be accorded great weight.*" *Id.* at 278 (emphasis added); *Regents of Univ. of Michigan v. Ewing*, 474 U.S. 214, 221 (1985) ("When judges are asked to review the substance of a genuinely academic decision, … they should show great respect for the faculty's professional judgment.").

This Court has applied similar deference to decisions concerning other types of students, noting that "[t]here is a widely accepted rule of judicial non-intervention into the academic affairs of schools," so long as schools do not act "arbitrarily or in bad faith." *Paulsen v. Golden Gate Univ.*, 25 Cal.3d 803, 808 (1979) (affording deference in law student's declaratory relief action); *Banks v. Dominican Coll.*, 35 Cal.App.4th 1545, 1548 (1995) ("well settled" that "we exercise a highly deferential and limited standard of review."); *Shuffer v. Bd. of Trustees*, 67 Cal.App.3d 208, 219–20 (1977) (recognizing "so-called rule of judicial nonintervention in scholastic affairs").

"The reason for this rule" is that "school authorities are uniquely qualified by training and experience to judge the qualifications of a student, and efficiency of instruction depends in no small degree upon the school faculty's freedom from interference from other noneducational tribunals." *Wong v. Regents of Univ. of Cal.*, 15 Cal.App.3d 823, 830 (1971); *Ewing*, 474 U.S. at 221 (courts are not "suited to evaluate the substance of the multitude of academic decisions that are made daily by faculty members," which "require an expert evaluation of cumulative information and [are] not readily adapted to the procedural tools of judicial or administrative decisionmaking.") (internal quotes omitted).

"The rule of judicial nonintervention in scholastic affairs *is particularly applicable in the case of a medical school*" because "[c]ourts are not supposed to be learned in medicine and are not qualified to pass opinion as to the attainments of a student in medicine." *Wong*, 15 Cal.App.3d at 830-31 (emphasis added) (noting that whether an individual is "unfit for the practice of medicine" is "not a matter for judicial review"); *Gupta v. New Britain Gen. Hosp.*, 239 Conn. 574, 595 (1996) ("Judicial circumspection is particularly warranted in the context of academic decisions concerning medical competency.").

Courts have extended the same rationale to decisions involving medical residents: "Successful completion of the residency program depends upon subjective evaluations by trained faculty members into areas of expertise that courts are poorly equipped to

undertake in the first instance or to review." *Davis v. Mann*, 882 F.2d 967, 974 (5th Cir. 1989). "The decision to terminate a resident from a hospital-based residency program is the same as any other decision to fail a graduate student for inability to meet academic requirements. Courts have historically deferred to the decisions of academic institutions on the academic achievements or failures of their students." *Ross v. Univ. of Minnesota*, 439 N.W.2d 28, 32 (Minn.Ct.App. 1989); *Gupta*, 239 Conn. at 586 ("A residency committee's decision to dismiss a resident physician for poor performance in the clinic mirrors a professor's decision to fail a medical school student for poor performance in the classroom").[1]

In the cases discussed above, courts applied the academic deference doctrine in a wide array of cases, ranging from ADA, contract, tort, and declaratory relief actions, to claims alleging violations of due process rights. Yet *Khoiny* holds that academic deference can *never* apply to decisions concerning medical residents no matter the legal or factual context—a breathtakingly broad rule that squarely conflicts with the cases just discussed and goes far beyond the narrow question actually presented to the Court of Appeal. For this reason alone, amici urge this Court to grant review, or at a minimum, depublish the decision. (The consequences of *Khoiny* remaining published are discussed below).

II. *Khoiny* fails to understand that medical residencies are academic programs.

Amici write to explain that the assumptions underlying *Khoiny*'s categorical rule are based on a grave misunderstanding of the nature and purpose of medical residency programs.

A. The mistaken assumptions underlying *Khoiny*.

Khoiny held that a "medical residency program is not primarily an academic program and that the decision to terminate the employment of a resident cannot be assumed to be academic." 291 Cal. Rptr.3d at 507. The panel also held "that a residency program's claim that it terminated a resident for academic reasons is not entitled to deference." *Id.* To arrive at this sweeping conclusion, the court made a series of analytical errors.

First, the panel relied *not* on any relevant law, residency program standards, or pertinent facts—it relied on a dictionary, *id.* at 593 ("The Cambridge Dictionary… defines

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[1] *See also Allahverdi v. Regents of Univ. of New Mexico*, 2006 WL 1313807, at *18 (D.N.M. Apr. 25, 2006) (affording deference to decision to terminate medical resident from residency program); *Kling v. Univ. of Pittsburgh Med. Ctr.*, 2021 WL 2882442, at *2 (W.D.Pa. July 9, 2021) (granting summary judgment on medical resident's ADA claim: "the context of [plaintiff's] enrollment in a medical residency program raises a presumption of a heightened deference").

'academic' as 'relating to schools, colleges, and universities, or connected with studying and thinking, not with practical skills'")—and it relied on a stopwatch. *Id.* at 504 (a "minimum of 66 percent of a resident's time [must] be spent in patient care," rather than "in traditional academic activities (i.e., didactic sessions)").

Second, the panel set up a dichotomy between "patient care" and "academics," embracing a per se rule that provision of patient care can *never* be academic. *Id.* at 506 ("evidence of [Dr. Khoiny's] performance deficiencies involved almost exclusively patient care, that is, her provision of services to patients, or 'deficiencies' in her personality, such as a lack of assertiveness," which "is not what is traditionally meant by 'academic' performance.").

And third, the panel set up a false binary choice between whether medical residents are "students" or "employees," relying on cases holding that medical residents are employees for purposes of collective bargaining and taxation. *Id.* at 505-06.

But there is no dispute that medical residents are employees—everyone agrees that they are. That determination only begins the inquiry, it does not end it. The question then becomes whether medical residents are *also* students, such that employment decisions concerning residents should be accorded academic deference. Based on the nature and purpose of residency programs, which amici explain next, the answer is yes.

B. Residencies are academic programs.

The structure of residency programs, and the experience of medical residents, reflect that the primary function of residencies is education.

Residents are not full-fledged physicians. "[M]edical education is divided into three phases: medical school (undergraduate medical education), residency training (graduate medical education [GME]), and continuous education and improvement (continuing medical education)." Association of American Medical Colleges, *Policy Priorities to Improve Our Nation's Health*, p. 1 (2016).[2] Completion of at least one year of a residency is an educational prerequisite to becoming a fully licensed physician in all 50 states, without which physicians cannot practice medicine.[3]

In California, residents must obtain a special, limited Postgraduate Training License (PTL) within 180 days of enrolling in a board-approved residency program. Bus. & Prof. Code §2064.5. Residents with PTL licenses generally "may engage in the practice of medicine only in connection with his or her duties as an intern or resident physician in a

[2] www.aamc.org/system/files/c/2/472906-howmedicaleducationischanging.pdf
[3] Medical Board of California, Physicians and Surgeons (www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Apply/).

board-approved program…." *Id.*, § 2064.5(b). Consequently, medical school graduates do not enter residencies just to have a paid job, but because completion of a residency is a necessary step to becoming a physician who can practice independently.

After receiving credit for 12 months of training in a residency program, residents may apply for a Physician's and Surgeon's License (P&S License).[4] While a P&S License allows residents to practice medicine, completing a residency program (which can last 3-7 years, depending on the specialty) is necessary if the resident wishes to attain "board certification" in his or her medical specialty (*e.g*., Anesthesiology)—a credential that hospitals generally require for physicians who wish to be granted hospital privileges. *See* Federation of State Medical Boards, *About Physician Licensure* ("practical considerations — such as obtaining hospital privileges — lead most physicians to obtain specialty certification").[5] "About 87% of American physicians are certified." Trans Am Clin. Climatol. Assoc., *Professionalism and Accountability: The Role of Specialty Board Certification*, vol. 119 (2008).[6]

Residency programs are, therefore, a critical component of the educational process that permits medical school graduates to obtain a medical license (at a minimum) and—for a vast majority of doctors—to learn the skills necessary to achieve board certification in their chosen specialty. *Davis*, 882 F.2d at 974 ("It is well-known that the primary purpose of a residency program is not employment or a stipend, but the academic training and the academic certification for successful completion of the program."); *Allahverdi*, 2006 WL 1313807, at *18 ("The primary purpose of the residency is not to spend one's life as a resident, but to gain the necessary experience and knowledge to serve as a fully licensed doctor.").

Residencies must be accredited educational programs. Consistent with their function of providing residents with the education necessary to practice medicine independently, residency programs must be accredited by the Accreditation Council for Graduate

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[4] Medical Board of California, Postgraduate Training Licensees (www.mbc.ca.gov/Licensing/Postgraduate-Training-Licensees/Apply.aspx); Physicians and Surgeons (www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Apply/Physicians-and-Surgeons-License/)

[5] www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure/; *see also* American Board of Medical Specialties, *What is ABMS Board Certification?* (www.abms.org/board-certification/) ("To become certified, physicians and medical specialists complete residency training following medical school, meet all training requirements, and successfully complete the board examination process.").

[6] www.ncbi.nlm.nih.gov/pmc/articles/PMC2394686/

Medical Education (ACGME) in order to receive Medicare funding.[7] *See* 42 C.F.R. §§ 413.75(b), 415.152.

As the ACGME notes, "[i]t is in this vital phase of the *continuum of medical education* that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship." ACGME Common Program Requirements at 3 (2021) (emphasis added).[8] For that reason, the residency "curriculum must be structured to *optimize resident educational experiences*, the length of these experiences, and supervisory continuity." *Id.*, p. 24 (emphasis added).

Learning to provide patient care is a central feature of residency. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 507 (1994) ("Because participants learn both by treating patients and by observing other physicians do so, [graduate medical education] programs take place in a patient care unit (most often in a teaching hospital), rather than in a classroom.").

As the ACGME recognizes, "[f]aculty members are a foundational element of graduate medical education—faculty members *teach residents how to care for patients*." ACGME Common Program Requirements at 12 (emphasis added). "Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents." *Id.* at 14.

Another core component of ACGME accreditation is the "Educational Program" for residents. *Id.* at 18. Residents must achieve certain "Milestones" in various "competency domain[s]," and "must be provided with protected time to participate in core didactic activities" such as "lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence." *Id.*[9]

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[7] Medicare is the largest explicit payer of graduate medical education in the United States. Medicare relies on ACGME accreditation as the standard for making payments, rather than making independent judgments about residency programs.

[8] www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2021.pdf

[9] The core competencies that residencies "must integrate … into the curriculum" are: Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Professionalism, Interpersonal and Communication Skills, and Systems-based Practice. ACGME Common Program Requirements at 19-24. The Court of Appeal was wrong to simply assume that Dr. Khoiny's "lack of assertiveness" was not an "academic" deficiency. In actuality, lack of

Because patient care *is* education in a residency program, the ACGME requires faculty to be evaluated at least annually with respect to their "clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities." *Id.* at 31. Medical residents also are subject to continual evaluation, both by faculty, who "must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment," *id.* at 27, and, at least semi-annually, by the program director with input from the Clinical Competency Committee. *Id.* at 28.

Reflecting that, for residents, patient care is hands-on clinical education, it is attending physicians—not residents—who are "ultimately responsible for the care of the patient." *Id.* at 39. "Appropriate supervision" of residents "is essential for patient safety and high-quality teaching" and, as a result, programs "must demonstrate that the appropriate level of supervision is in place for all residents," based on "each resident's level of training and ability, as well as patient complexity and acuity." *Id.* at 39-40.

As the above makes clear, *Khoiny*'s artificial distinctions—between "patient care" and "academics"; between "employees" vs. "students"; and between students and medical residents—are divorced from the reality of graduate medical education. As other courts have recognized, "[t]he residency program is distinct from other types of employment in that the resident's 'work' is what is academically supervised and evaluated." *Davis*, 882 F.2d at 974; *Allahverdi*, 2006 WL 1313807, at *18 ("A resident's education and employment are inseparable because a resident is, in effect, being paid to learn" and "[h]is work is supervised and evaluated—much like a student's—by faculty members."); *Ross*, 439 N.W.2d at 32 ("A resident position is more a hybrid, bearing some of the attributes of a student and some of an employee.").

C. Academic deference in graduate medical education must be preserved.

The United States is a world leader in medical education and training. Residencies, as explained above, play a key role in ensuring that physicians receive the education necessary to safely and independently practice medicine. Hospitals have a strong interest in assuring that residency program directors and faculty can exercise academic judgment, in order to ensure that graduates are fully qualified. In fact, fully-trained physicians

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assertiveness reflects a failure to achieve the Interpersonal Communication Skills core competency. Further, lack of assertiveness can have patient safety implications because a failure to speak up can allow a medical error to occur.

typically have hospital admitting privileges and are granted credentials to perform procedures based foundationally on their graduate medical education records.

When residents fall short, it can put patient safety at risk. For this reason, as explained above, the ACGME accreditation standards require hands-on training, observation, and regular evaluations by faculty members, program directors, and Clinical Competency Committees. Struggling residents "may require intervention to address specific deficiencies," including, as needed, "more significant intervention that may alter the time course of resident progression." ACGME Common Program Requirements at 28.

And "when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident," the ACGME standards require "compliance with the Sponsoring Institution's policies and procedures for due process." *Id.* at 11; *see also id.* at 28 ("To ensure due process, it is essential that the program director follow institutional policies and procedures."). On top of that, as noted, *Ezekial* requires residents to be "accorded notice of charges and an opportunity to respond, pursuant to the 'common law right of fair procedure' … prior to dismissal from the residency program." 20 Cal.3d at 269-70.

Given the rigorous evaluation process undertaken by faculty and committee members who are experts in their fields, and the "fair procedure" already required by *Ezekial* and the ACGME, applying academic deference makes even more sense. Courts are ill-equipped to substitute their own judgments, particularly when patient care and medical competency are an essential part of evaluating a medical resident's academic performance.[10]

Wiping out academic deference will be detrimental to graduate medical education—and patient care. Faculty will be more reluctant to give frank evaluations of resident performance, and programs will be hesitant to take corrective action to deal with poor performers, for fear that their decisions will be second-guessed and micro-managed in costly litigation. The result may well be that residents who are struggling are nevertheless given a pass, thus lowering academic standards and the quality of patient care. The lack

[10] Complicating any judicial inquiry even further, there are a wide variety of residency programs (around 40 specialties and 88 subspecialties) operating in many different types of sponsoring institutions—from medical systems (e.g., Kaiser Permanente, Cedars Sinai), to institutions directly sponsored by private or public medical schools (e.g., USC and UCLA), to freestanding community hospitals. *See* ABMS Board Certification Report, (2020-2021), p. 3 (www.abms.org/wp-content/uploads/2022/01/ABMS-Board-Certification-Report-2020-2021.pdf).

of academic deference will also be an invitation to more litigation by unhappy residents looking for a do-over in the courts.

Opening the floodgates in this fashion benefits no one. Preserving academic deference, on the other hand, strikes the right balance by respecting the expert judgment of trained physician-faculty (along with clinical competency committees) while also ferreting out decisions that are arbitrary or the product of bad faith or discrimination.

Because the elimination of academic deference in graduate medical education represents an urgent and important issue for all residency programs in California, amici request that this Court grant plenary review.

Reasons for Ordering Depublication

If the Court does not grant review, amici request depublication of the *Khoiny* decision pursuant to California Rule of Court 8.1125.

The *Khoiny* ruling treads much farther than necessary. As explained above, rather than confining itself to whether a specific jury instruction was prejudicial in the context of a specific FEHA action, the panel eliminated academic deference for all residency programs in every context—and it did so without supplemental briefing from the parties. Pet. at 27-28.

Further, the panel condemned all residency programs based on the deficiencies it saw in one residency program that was on probation with ACGME. In fact, after noting that "the specific residency program at SMMC was not in compliance with ACGME's guidelines concerning the academic aspects of its program," and was "less academic … than an average residency program," the Court of Appeal made a leap to all programs: "SMMC is not primarily an academic institution and treating its residency program as 'primarily' an academic program does not match the realities of medical residency programs. They are employment programs with an educational component." *Khoiny*, 291 Cal.Rptr.3d at 506.

In addition, as explained above, *Ezekial* and the ACGME rules require residents to be afforded fair procedure with respect to termination decisions, a factor which supports applying academic deference to such decisions. But *Khoiny* does not state what fair procedure, if any, was followed with respect to Dr. Khoiny's termination. If no such procedures were followed, then it only reinforces that the particular facts of this case should not be the basis for a blanket rule against academic deference. For this additional reason, the decision should be depublished.

In sum, the Court of Appeal got it exactly backwards: residency programs are not "employment programs with an educational component," *id.* at 506, they are *educational*

programs with an employment component. Depublication of this overbroad decision is appropriate so as not to bind all trial courts, which may confront the academic deference doctrine in a different factual and procedural context more suited to its application.

Very truly yours,

SEYFARTH SHAW LLP

/s/ Kiran Seldon

Kiran Aftab Seldon

cc: Jeffrey A. Berman (amicus counsel)
Christian J. Rowley (amicus counsel)
Linda Miller Savitt (counsel for defendant Dignity Health)
Eric Christian Schwettmann (counsel for defendant Dignity Health)
John J. Manier (counsel for defendant Dignity Health)
Ilana Makovoz (counsel for plaintiff Noushin Khoiny)

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of eighteen years and not a party to the within action; my business address is 2029 Century Park East, Suite 3500, Los Angeles, California 90067.

On May 9, 2022, I served the following documents described as: **LETTER OF AMICUS CURIAE IN SUPPORT OF DIGNITY HEALTH'S PETITION FOR REVIEW** as follows:

■ **BY USING THE TRUEFILING, WEB-BASED, E-SERVICE AND E-FILING SYSTEM:** I caused to be served the foregoing document(s) on all interested parties listed on the TrueFiling e-service system with regard to the matter of ***Khoiny v. Dignity Health.***

MAKOVOZ LAW GROUP Ilana Makovoz 3500 W. Olive Ave., Suite 300 Burbank, CA 91505 Phone: 818-827-7137 Fax: 818-394-6655 *Attorneys for Plaintiff and Appellant*	BALLARD ROSENBERG GOLPER & SAVITT, LLP Linda Miller Savitt Eric C. Schwettmann John J. Manier 15760 Ventura Boulevard, 18th Floor Encino, CA 91436 Phone: 818-508-3700 Fax: 818-506-4827 *Attorneys for Defendant and Respondent*

■ **BY MAIL:** I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed below. I am readily familiar with the firm's practice of collection and processing correspondence for

mailing. Under that practice it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

Los Angeles County Superior Court Spring Street Courthouse 312 N. Spring Street Los Angeles, CA 90012 Attention: Clerk, Dept. 16 Hon. J. Stephen Czuleger	California Court of Appeal Second Appellate District, Division Eight Ronald Reagan State Building 300 S. Spring Street 2nd Floor, North Tower Los Angeles, CA 90013

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on May 9, 2022, at Los Angeles, California.

Rachel D. Victor