Date of Hearing: March 24, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2311 (Schiavo) – As Introduced February 19, 2026

SUBJECT: Health care districts: employment.

SUMMARY: Authorizes a health care district, as defined, or a nonprofit corporation with a health care district as its sole corporate member, that owns or controls a general acute care hospital to employ licensees and charge for professional services rendered by those licensees. Prohibits the health care district from interfering with, controlling, or directing the professional judgement of a physician and surgeon.

EXISTING LAW:

1) Prohibits, within the Medical Practice Act, corporations and other artificial legal entities from having any professional rights, privileges, or powers. Permits the Medical Board of California (MBC), in its discretion, to grant approval of the employment of physicians on a salary basis by licensed charitable institutions, foundation, or clinics, if no charge for professional services rendered to patients is made by any such institution, foundation, or clinic. This is known as the ban on the corporate practice of medicine (CPM). [Business and Professions Code (BPC) § 2400]

2) Establishes certain exemptions from the ban on the CPM, including the following:

    a) Clinics operated primarily for the purpose of medical education by a public or private nonprofit university medical school, are permitted to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made; [BPC § 2401(a)]

    b) Certain nonprofit clinics organized and operated exclusively for scientific and charitable purposes, that have been conducting research since before 1982, and that meet other specified requirements, are permitted to employ physicians and charge for professional services, but are prohibited from interfering with or directing a physician's professional judgment; [BPC § 2401(b)]

    c) A narcotic treatment program regulated by the Department of Alcohol and Drug Programs is permitted to employ physicians and charge for professional services rendered by those physicians, but is prohibited from interfering with or directing a physician's professional judgment; [BPC § 2401(c)]

    d) A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, and that employed physicians prior to January 1, 2013, is permitted to charge for professional services, under certain specified conditions; and, [BPC § 2401(d)]

    e) Existing case law (not in statute) establishes an exemption from the ban on the CPM for county hospitals to employ physicians. [People v. Pacific Health Corp. (1938)]

3) Exempts from the ban on the CPM, a federally certified critical access hospital (CAH), to enable CAHs to employ physicians, provided the medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital, and the hospital does not interfere with, control, or otherwise direct a physician's judgment. [BPC § 2401(e)]

4) Establishes "The Local Health Care District Law," under which a local hospital district may be organized, incorporated and managed. Permits a district to include incorporated or unincorporated territory, or both, in any one or more counties. Requires health care districts to be governed by an elected board of five members, who are required to live within the healthcare district. [Health and Safety Code (HSC) § 32000 *et seq*., § 32001, § 32100]

5) Provides local health care districts with certain powers, including establishing and operating health facilities or other health care programs, and to establish and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services providers, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district. [HSC § 32121]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, the passage of H.R. 1 will result in deep cuts to Medi-Cal patients across California. As a result, physicians contracting with high Medi-Cal volume employers face substantial revenue losses, rendering district hospitals even less competitive as employment options. This bill will allow a district hospital to offer a physician a set salary to practice, without it mattering how many Medi-Cal or uninsured patients they see. Right now, the contract model dictates a physicians' reimbursement based on the type of patient they see. Some of the hospitals looking to utilize this benefit, Antelope Valley Hospital and Watsonville Community Hospital for example have inpatient and outpatient Medi-Cal numbers ranging from 60 to 90%.

   Despite being the sole or closest source of health and medical services for many families and seniors, district hospitals are the only public hospitals not allowed to directly employ physicians. The author concludes that this bill will allow wholly owned and operated public hospitals to directly hire physicians, a tool currently available to every other public hospital, Federally Qualified Health Centers, and academic medical centers.

2) **BACKGROUND.**

   a) **Overview of CPM laws**. CPM laws vary significantly across the United States. While some states, such as California, New York, North Carolina, and Texas strictly regulate corporate involvement in medical practice, others have more permissive or ambiguous rules. These laws aim to protect the independence of medical professionals and prioritize patient care over corporate interests. As of 2024, 33 states and the District of Columbia have implemented some form of CPM doctrine. These laws typically limit the ability of corporations or non-licensed entities to employ physicians or control medical practices.

The states with CPM laws include: Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia (D.C.), Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Washington, West Virginia, and Wisconsin. In these states, the restrictions often require medical practices to operate as professional corporations or professional limited liability companies, owned and managed by licensed professionals.

Seventeen states do not have formal CPM restrictions. However, even in these jurisdictions, other healthcare regulations and professional licensing laws may impose limitations on corporate involvement in medical practice. The states without CPM laws are: Alabama, Alaska, Delaware, Florida (requires Health Clinic License for non-physician owners), Hawaii, Idaho, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, Ohio, Oklahoma, Utah, Vermont, Virginia, and Wyoming.

b) California's CPM law. California enforces one of the most stringent CPM doctrines in the United States, primarily through statutory provisions and reinforced by case law. The Medical Practice Act, specifically California Business and Professions Code § 2400, states that "[c]orporations and other artificial entities shall have no professional rights, privileges, or powers." This provision effectively prohibits unlicensed entities from practicing medicine or employing physicians. The California Supreme Court, in People v. Pacific Health Corp. (1938), upheld this principle, emphasizing that corporations cannot possess the personal qualifications necessary for medical licensure.

Despite the general prohibition, California allows certain exceptions where specific entities can employ physicians without violating CPM laws. These exceptions include:

i) Professional Medical Corporations: Under the Moscone-Knox Professional Corporation Act, licensed physicians may form professional corporations to render medical services;

ii) Health Maintenance Organizations (HMOs): Entities licensed under the Knox-Keene Health Care Service Plan Act are permitted to employ physicians to provide care within their networks;

iii) Certain Nonprofit Organizations: Charitable institutions and teaching hospitals may employ physicians under specific conditions, provided they do not interfere with clinical judgment.

c) California's Physician Shortage. According to the California Health Care Foundations' 2025 *California Physician Almanac*, California is facing a significant physician shortage, particularly in primary care, with many regions lacking adequate healthcare providers to meet the needs of the population.

i) Physician Supply vs. Demand: Although the number of active physicians in California increased by 33% from 2006 to 2022, many areas still experience substantial shortages, especially in primary care and specialist fields. For instance, regions like the Central Coast, Inland Empire, and San Joaquin Valley do not meet the recommended supply of primary care physicians.

ii) **Demographics**: Approximately 25% of California's physicians are aged 65 and older, which raises concerns about future availability as many are nearing retirement. Additionally, California's Latino/x population is underrepresented among physicians, with only 6% of the state's physicians being Latino/x, despite this demographic making up 40% of the population.

The physician shortage in California is a complex issue influenced by demographic trends, economic factors, and geographic disparities. While efforts are underway to address the shortage, significant challenges remain, particularly in ensuring that all Californians have access to adequate healthcare services. Continued focus on training, recruitment, and retention strategies will be essential to mitigate this ongoing crisis.

d) **2023 Survey of Medical Residents**. A 2023 Survey of Final-Year Medical Residents: *Many Job Choices, Many Reservations* by AMN Healthcare's Physician Solutions division (formerly known as Merritt Hawkins), found that:

i) Medical residents are inundated with job opportunities. The majority of medical residents surveyed (56%) received 100 or more job solicitations during their training, the highest number since the survey was first conducted in 1991.

ii) Despite the robust job market, 30% of residents indicated they would not choose medicine if they had their careers to do over, the highest number since the survey was first conducted.

iii) Lifestyle and personal time are of highest importance to residents considering job opportunities. 82% of residents said "lifestyle" is very important to them as they consider a first practice, followed by "adequate personal time" (80%), "good financial package" (78%) and geographic location (76%).

iv) Only 4% of residents would prefer to practice in a community of 25,000 or less, underscoring the challenges rural communities face when recruiting new physicians.

v) Residents prefer "hospital employment" as a practice setting. 68% said "hospital employment" was their first or second preference in a practice setting, while only 6% selected "solo practice."

vi) Close to one half of residents (48%) said they are unprepared for the business side of medicine.

e) **Health Care Districts**. The Local Hospital District Law was established in 1945 to authorize special districts to build and operate hospitals and other health care facilities in underserved areas. Legislation in 1994 renamed it the Local Health Care District Law to reflect the fact health care was increasingly being provided outside of the hospital setting. Health care districts are a form of special district. Special districts are local governments that are legally separate from counties and cities, and they have the authority to build public works projects and run programs, and the power to impose taxes to raise funds to pay for these services. Special districts have the ability to enter into contracts, purchase property, exercise eminent domain, issue debt, and hire staff. Each health care district is governed by a locally elected five-member board of directors and are subject to state

policies and regulations as applied by each county's Local Agency Formation Commission.

There are currently 77 health care districts, and most of these were established in the first two decades following enactment of the Local Hospital District Law. Of these, 33 own and operate hospitals, while a handful of others own either the hospital or the land and lease the hospital to another entity to operate the hospital. The remainder operate ambulance services, clinics, skilled nursing facilities, or do not provide any direct health services. Most health care districts receive a share of local property taxes, which varies among districts. Some health care districts have received two-thirds approval to levy special "parcel taxes," such as Alameda Health Care District, which was formed in 2002 when voters approved a $298 annual parcel tax to assume operation of Alameda Hospital. Health care districts can also generate revenues from other resources, including property lease income and interest earnings from investments, or by creating debt to borrow money for capital projects.

f) **Pilot project for some district hospitals from 2004-2010**. SB 376 (Chesbro), Chapter 411, Statutes of 2003 created a limited exemption from the CPM for some district hospitals. Under this pilot program, a district hospital that was located in a county with less than 750,000 people, that had net losses in a previous year, and that served a high proportion of Medi-Cal and Medicare patients, could directly employ up to two physicians for a maximum of four years, with the maximum number of employed physicians statewide capped at 20. The pilot program required a report from the MBC to be provided to the Legislature by October 1, 2008, and sunset the pilot project on January 1, 2011. According to the MBC's report, unexpectedly, only six physicians were hired by five eligible hospitals during the years the pilot was operational. The MBC stated that such a low number would not offer a significant, quantifiable improvement in access to healthcare nor would such a low number offer much information to MBC in preparing a valid and useful analysis of the pilot. Only four of the six participating physicians, and three of the five participating hospitals, responded for requests for input. The MBC stated that there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians could be made. While several bills sought to either extend or expand the pilot project, these bills did not pass and the pilot project expired.

g) **Pilot project for Critical Access Hospitals**. AB 2024 (Wood), Chapter 496, Statutes of 2016 created a new pilot project that allowed federally certified Critical Access Hospitals (CAHs) to employ physicians until January 1, 2024. CAHs are licensed general acute care hospitals that are certified to receive cost-based reimbursement from Medicare in order to reduce hospital closures in rural areas. To be certified as a CAH, a hospital can have no more than 25 beds, must be located in a rural area, and cannot be close to another hospital. There are 36 federally certified CAHs in California. Unlike the pilot program for district hospitals created by SB 376 in 2003, the CAH exemption did not limit the number of physicians that a CAH could employ, and there is no statewide cap. According to the California Department of Health Care Access and Information, of the 36 CAHs, 18 have hired at least one physician, for a total of 123 physicians employed by CAHs at some point during the pilot program. One hospital (Tahoe Forest Hospital District in Truckee) employed the most at 54 physicians. Mark Twain Medical Center in San Andreas hired 16 physicians, Healdsburg Hospital hired 10 physicians, and Ridgecrest Regional Hospital hired 6 physicians, with most of the remaining hospitals hiring one to

two physicians. AB 242 (Wood) Chapter 641, Statutes of 2023 deleted the sunset on the pilot project, permanently allowing CAHs to hire physicians (see Previous Legislation).

h) **Overlap of district hospitals and CAHs**. A number of CAHs are also district hospitals, therefore some district hospitals are already permitted to hire physicians under AB 242. According to the Association of California Healthcare Districts, 17 of the 33 district hospitals are CAHs, so this bill would only affect the remaining 16 district hospitals that are not certified as a CAH. The hospitals affected by this bill are as follows:

   i) Antelope Valley Hospital

   ii) Watsonville (Pajaro Healthcare District)

   iii) Salinas Valley

   iv) Sonoma Valley

   v) Pioneer Memorial Hospital (Imperial Valley Healthcare District)

   vi) El Centro Regional Medical Center (Once fully integrated into Imperial Valley Healthcare District)

   vii) Washington Hospital

   viii) El Camino Hospital (2 hospitals)

   ix) Palomar Hospital (2 hospitals)

   x) Delta

   xi) Marin Healthcare District

   xii) Lompoc District Hospital

   xiii) Sierra View Hospital

   xiv) Tri-City Healthcare District

3) **DOUBLE REFERRAL.** This bill is double-referred, upon passage of this committee, it will be referred to the Assembly Committee on Business and Professions.

4) **SUPPORT.** The Association of California Healthcare Districts (ACHD) is the sponsor of this bill and states that currently, district hospitals are **the only public hospitals** in the State that cannot directly employ physicians. Of the 33 wholly owned and operated districts hospitals, 17 already have access to this tool through their CAH designation. The remaining district hospitals, however, must rely on contracting with physician groups, or individual doctors to provide care. As a result, district hospitals are forced to compete in competitive labor markets without the tools necessary to do so. ACHD notes that this bill would allow district hospitals to employ physicians directly with clear guardrails preventing any interference with clinical judgement.

Of the remaining hospitals that cannot hire physicians, at least one is proposed for non-public affiliation, making the universe of applicable hospitals just over a dozen. This handful of district hospitals alone provide more than a million-emergency department visits annually and on average, more than half of these visits are Medi-Cal patients. California has made significant strides in expanding access to health care for all Californians; however, the districts that service these patients in more urban areas of the state do not have physicians available to meet the demand. California is one of five remaining states with the strictest version of the ban on the CPM, which has been interpreted to mean that certain types of entities may not directly employ physicians. ACHD notes that even the American Medical Association has said that physicians should be able to enter into contractual agreements including employment options with hospitals.

California currently allows for several exceptions to the ban on the CPM, including all designated public hospitals (UC and county facilities), CAHs, certain academic medical centers, and federally qualified health centers (FQHCs) to directly employ physicians. In fact, over half of the State's CAH's are district hospitals, who have successfully utilized the tool with success and no adverse patient care outcomes. ACHD states this bill would in no way prevent or replace relationships with physician groups but merely offer an additional option. In particular, the ability to employ physicians would allow these districts to attract specialty providers that otherwise may not reach their communities through physician groups, including: OBGYN, cardiologists, and behavioral health doctors. Employment or similar models are extremely attractive to graduates coming out of residency. In fact, some district hospitals have residency programs to help address the looming physician shortage in California. However, unlike foundation models or employment opportunities, once these residents graduate, they must find a physician group or contract directly with the hospital should they wish to continue to serve that community.

Data from 2023 shows that California has 159,012 active physicians (MDs) in the state. Kaiser Permanente alone shows data to suggest they employ 25,605 of those physicians. Sutter Health has 8 medical groups and self-reports employing 12,000 physicians. The UC Health System approximates 11,000 employed doctors, and 19,300 medical students, many of which are residents. In total across just those three, nearly a third of California's doctors are already accounted for in largely closed system models.

Allowing district hospitals the opportunity to offer set salaries, offer generous benefits, and set schedules, will make serving in public settings more attractive. It additionally, would allow the districts the ability to grow their own workforce, making it more attractive to stand up residency programs or increase slots, where the investment previously may not have penciled out. ACHD states that many districts, including Sierra View District Hospital, Salinas District Hospital, and Palomar District Hospital (just to name a few) have extensive workforce pipeline programs. They aim at engaging children early on and educating them on the potential pathways into the field of medicine. The districts do this with the hope they may see some of these students pursue careers in medicine and return to the community to serve. With increasing tuition costs and other economic considerations, however, the harsh reality is many will chose to leave the community permanently to serve elsewhere.

Some district hospitals are well resourced. However, these districts invest significant dollars in subsidizing care and ensuring that illness is avoided, patient costs are reduced, and the specific health needs of the community are supported. They are not affiliated with private

equity, but rather community owned. Often, a physician or several even sit on the healthcare districts governing board. ACHD concludes that this bill is about equity and preserving and expanding care for Californians in a time where costs are increasing and care is decreasing.

The District Hospital Leadership Forum (DHLF) supports this bill to allow district and municipal hospitals (DMPHs) to directly employ physicians without interfering with the professional judgement of the physicians they hire. DMPHs, are independent local governments responsible for meeting the healthcare needs of their communities, including uninsured and Medi-Cal populations. More than two-thirds of these hospitals are rural and eighteen CAH designations. As independent public hospitals, many DMPHs operate without the scale, capital access, and system support available to large health systems, while still maintaining 24/7 readiness and essential service lines for their communities. California is one of only five states that still interprets the ban on CPM to include a prohibition on direct employment of physicians. However, countless other hospital and clinic settings have long enjoyed the ability to employ doctors. With the unprecedented health care cuts our state is facing, we must embrace tools that create efficiencies in our system and provide safety net hospitals with the ability to continue to serve all Californians, regardless of coverage type.

Palomar Health supports this bill and states that it is a modest approach to allow public district hospitals to effectively recruit and retain providers to their facilities, giving a small number of public hospitals a tool that has proven to be effective. Palomar Health notes that University of California and county hospitals have long enjoyed the ability to employ doctors as public providers regardless of their location. Palomar Health asserts that this bill is about provider equity and will ensure California's underserved populations get quality and timely access to primary and specialty care.

5) **OPPOSITON.** The California Chapter of the American College of Emergency Physicians (California ACEP) is opposed to this bill and states that this exemption to California's bar on the CPM is a threat to physician autonomy and to patient safety. California ACEP contends that it is of the utmost importance that physicians have the ability to treat patients according to their specific medical needs without the influence or pressure of an administrator. Hospital CEOs and administrative staff have different motivations and mandates and are bound by different ethical and professional licensure standards than physicians. California ACEP concludes that patients deserve to be treated by clinicians exclusively motivated by their medical care needs.

The California Society of Pathologists (CSP) is opposed to this bill and states that, for pathologists, independent medical judgment is essential to ensuring accurate diagnoses, appropriate utilization of laboratory testing, and overall patient safety. CSP concludes that pathology serves as the foundation of clinical decision-making across nearly every area of medicine, and even subtle pressures to increase testing volume, prioritize certain services, or align with institutional financial goals can undermine diagnostic integrity and patient care.

The California Orthopaedic Association (COA) is opposed to this bill and states that California's CPM doctrine is a critical safeguard that ensures medical decisions remain between physicians and their patients, free from institutional or financial influence. COA argues that this bill would weaken these protections by allowing health care districts to directly employ physicians and bill for professional services, increasing the risk that clinical decision-making is influenced by administrative priorities rather than patient needs.

6) **OPPOSE UNLESS AMENDED.** The California Medical Association (CMA) is opposed to this bill unless it is amended. CMA argues that while the bill attempts to prohibit interference with physicians' professional judgment, these provisions fail to meaningfully safeguard independent clinical decision-making. CMA states that in practice, physicians employed by hospitals or hospital districts remain subject to numerous institutional pressures, such as credentialing authority, employment terms, productivity expectations, and compensation structures. CMA contends that even in the absence of explicit directives over clinical judgment, these dynamics can influence medical decision-making. CMA requests amendments that: limit the eligibility to hospitals serving a high Medi-Cal population; include a sunset on the CPM exemption with a reporting requirement; impose stronger safeguards to protect physician autonomy; and ensure physicians currently working in a region are not displaced.

7) **PREVIOUS LEGISLATION.**

a) SB 784 (Becker) of 2023 would have exempted health care district hospitals from the ban on the corporate practice on medicine, enabling these hospitals to directly employ physicians. SB 784 was held in the Senate Appropriations Committee.

b) AB 242 (Wood), Chapter 641, Statutes of 2023 deleted the sunset date on a provision of law exempting CAHs from the ban on the CPM, thereby making this exemption permanent, and deleted reporting requirements related to this exemption.

c) AB 2024 (Wood), Chapter 496, Statutes of 2016 established an exemption, until January 1, 2024, from the prohibition on the CPM in order to allow federally certified critical access hospitals to employ physicians and charge for those services.

d) SB 1274 (Wolk), Chapter 793, Statutes of 2012, permits a hospital that is owned and operated by a charitable organization and offers only pediatric subspecialty care to begin billing health carriers for physician services rendered, notwithstanding the prohibition in the CPM if specified conditions are met.

e) AB 648 (Chesbro) of 2009 would have established a demonstration project to permit rural hospitals, as defined, whose service area includes a medically underserved or federally designated shortage area and which meet certain specified requirements, to directly employ physicians and surgeons. AB 648 failed passage in the Senate Business, Professions and Economic Development Committee.

f) AB 646 (Swanson) of 2009 would have permitted health care districts and certain public hospitals, independent community nonprofit hospitals, and clinics, as specified, to directly employ physicians and surgeons. AB 646 failed passage in the Senate Business, Professions and Economic Development Committee.

g) SB 726 (Ashburn) of 2009 would have revised and extended the MBC pilot project that allows qualified district hospitals, as defined, to employ a physician, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician. SB 726 failed passage in the Senate Business, Professions and Economic Development Committee.

h) AB 1944 (Swanson) of 2008 would have allowed health care districts to employ a physician. AB 1944 failed passage in the Senate Committee on Health.

i) SB 1294 (Ducheny) of 2008 would have expanded the pilot project enabling health care districts to directly employ physicians. SB 1294 failed passage in the Assembly Appropriations Committee.

j) SB 376 (Chesbro), Chapter 411, Statutes of 2003 authorized, until January 1, 2011, a hospital owned and operated by a health care district meeting specified criteria to employ a physician, and to charge for professional services rendered by the physician if the physician approves the charges.

8) POLICY COMMENT. CMA has requested several amendments to this bill including: sunsetting the provisions of this bill on January 1, 2032, limiting a district hospitals' ability to hire physicians to no more than five, and requiring medical staff at the hospital to concur in a hire. CMA also proposes to limit district hospitals participating in the bill to those with a "high governmental payor mix" (those that serve a large population of Medi-Cal and Medicare enrollees) and only if both the hospital and health system to which it belongs meet a combined payor mix of 90% or greater. Additionally, CMA requests that the Department of Health Care Access and Information (HCAI) provide a report to the Legislature and district hospitals provide a report to HCAI.

While some of the amendments seem reasonable, such as requiring existing medical staff at a hospital to concur in a hire, others appear more problematic, such as the 5-year sunset. As noted above most Medical Resident graduates desire hospital employment, and only a very small portion wish to work in communities of less than 25,000 individuals. A 5-year limit on employment would not appear to be enough of an enticement for a physician to accept a job at a rural district hospital. Additionally, the requested reporting provisions seem vague and may not produce the desired results.

The Committee may wish to encourage the author, sponsors, and other stakeholders to continue to negotiate regarding the proposed parameters of employment to ensure the author's goal of continued access to health care providers in traditionally under-served areas.

REGISTERED SUPPORT / OPPOSITION:

Support

Association of California Healthcare Districts (sponsor)
Antelope Valley Healthcare District
California Hospital Association
California Special Districts Association
Community Services Agency
Del Puerto Health Care District
Desert Healthcare District and Foundation
District Hospital Leadership Forum
El Camino Health
Fallbrook Healthcare District
Health Petaluma District & Foundation
Imperial Valley Healthcare District

Kaweah Health
Northern Inyo Healthcare District
Palomar Health
Plumas District Hospital
Ravenswood Family Health Network
Salinas Valley Health
Santa Clara Family Health Plan

Oppose

California Chapter of the American College of Emergency Physicians
California Orthopedic Association
California Radiological Society
California Society of Pathologists

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