S211793

In the
Supreme Court of California

KATHLEEN A. WINN, ET AL.,
Plaintiffs and Appellants,

v.

PIONEER MEDICAL GROUP, INC., ET AL.,
Defendants and Respondents

After a Decision by the Court of Appeal, Second Appellate District,
Division Eight, Case No. B237712

Application for Leave to File Amici Curiae Brief in Support of Pioneer Medical Group, Inc. et al.; Brief of Amici Curiae California Medical Association, California Dental Association, California Hospital Association, and American Medical Association

TUCKER ELLIS LLP
E. Todd Chayet, SBN 217694
Rebecca A. Lefler, SBN 225414
515 South Flower Street, Forty-Second Floor
Los Angeles, CA 90071-2223
Telephone: 213.430.3400
Facsimile: 213.430.3409
todd.chayet@tuckerellis.com
rebecca.lefler@tuckerellis.com
Counsel for Amici Curiae California Medical Association, California Dental Association, California Hospital Association, and American Medical Association

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APPLICATION FOR LEAVE TO FILE BRIEF AS AMICI CURIAE

The California Medical Association (CMA), California Hospital Association (CHA), California Dental Association (CDA), and American Medical Association (AMA) request permission to file the attached amici curiae brief in support of Respondents Pioneer Medical Group, Inc.; Emerico Csepanyi, M.D.; James Chinuk Lee, D.P.M.; and Stanley Lowe, D.P.M.

I. INTERESTS OF AMICI CURIAE

CMA is a nonprofit, incorporated, professional association of more than 39,000 physicians practicing in California, in all specialties. CDA represents almost 24,000 California dentists, over 70 percent of the dentists engaged in the private practice of dentistry in California. CMA and CDA are the largest organizations representing physicians and dentists engaged in private practice in California. CHA is the statewide leader representing the interests of nearly 400 hospitals and health systems in California. CMA, CDA, and CHA are active in California's courts in cases involving issues of concern to the healthcare community.

CMA, CDA, and CHA filed amicus briefs in the following cases in this Court involving the Elder Abuse and Dependent Adult Civil Protection Act (Elder Abuse Act) (Welf. & Inst. Code, §§ 15600 et seq.):

- *Covenant Care v. Superior Court* (2004) 32 Cal.4th 771
- *Delaney v. Baker* (1999) 20 Cal.4th 23

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy

making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

Some funding for this brief was provided by organizations and entities that share amici's interests, including physician-owned and other medical and dental professional liability organizations and non-profit and governmental entities engaging physicians for the provision of medical services, specifically: Cooperative of American Physicians, Inc.; Kaiser Foundation Health Plan, Inc.; The Mutual Risk Retention Group, Inc.; Medical Insurance Exchange of California; The Dentists Insurance Company; NORCAL Mutual Insurance Company; and The Regents of the University of California.

No party or counsel for a party authored the proposed amici curiae brief in whole or in part, nor has any party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the proposed amici brief.

II. NEED FOR FURTHER BRIEFING

This appeal involves an attempt to reclassify acts of "professional negligence" that are subject to the Medical Injury Compensation Reform Act of 1975 (MICRA) (and related statutory provisions) to acts of "reckless neglect" that are subject to heightened remedies under the Elder Abuse Act. The restrictive effect that such reclassification would have on access to care for the elderly (which is already subject to an impending crisis), and the expansive effect it would have on malpractice

insurance costs for health care providers, is of great interest to CMA, CDA, CHA, and AMA. Allowing artful pleading to result in such reclassification substantially undermines and diminishes MICRA, which was enacted to contain the costs of malpractice litigation, thereby maximizing the availability of medical services to Californians.

Counsel for CMA, CDA, CHA, and AMA have reviewed Appellants' Opening Brief on the Merits, Respondents' Answer Brief on the Merits, and Respondents' Reply Brief on the Merits. Amici believe this Court will benefit from additional briefing. This brief supplements, but does not duplicate, the parties' briefs. Rather, it discusses statutory interpretation and public policy concerns not directly addressed by the parties.

Respectfully submitted,

Dated: March 31, 2014 TUCKER ELLIS LLP

By: Rebecca C. Lefler

Rebecca A. Lefler
Counsel for Amici Curiae
California Medical Association,
California Dental Association,
California Hospital Association,
and American Medical Association

BRIEF FOR AMICI CURIAE

I. INTRODUCTION

Amici have a strong interest in obtaining certainty as to the remedies available in litigation against their members for medical negligence. The question presented here—whether "neglect" within the meaning of the Elder Abuse and Dependent Adult Civil Protection Act (Elder Abuse Act) includes a health care provider's decision as to an appropriate course of treatment—threatens to undermine that certainty by upsetting carefully crafted provisions in the Medical Injury Compensation Reform Act of 1975 (MICRA).

MICRA was the Legislature's response to a medical malpractice insurance crisis. Before its enactment, insurance rates had skyrocketed, making them impossible for some physicians to afford. Some physicians stopped performing high risk procedures, stopped practicing in California, or practiced without insurance—impairing patients' access to care and exposing patients to the prospect of unenforceable judgments. MICRA addressed this crisis through a series of provisions that helped contain costs associated with malpractice litigation, thereby making malpractice insurance more affordable and medical care more accessible. The key to MICRA is its definition of "professional negligence," which brings within its scope any "negligent act or omission to act by a health care provider in the rendering of professional services." (See, e.g., Code Civ. Proc., § 340.5, subd. (2).) Through this definition, any alleged omission by a healthcare provider while providing medical services is subject to MICRA.

Wholly distinct from MICRA, the Elder Abuse Act provides heightened remedies for "reckless neglect" of a person over the age of 65. The Elder Abuse Act was the Legislature's response to a different concern—custodial neglect of a vulnerable population—and has a

different scope. The definition of "neglect" does not target omissions in the *undertaking* of medical services, but rather focuses on the failure to *provide* medical care at all. To make this distinction clear, the Elder Abuse Act specifically excludes claims for professional negligence. (Welf. & Inst. Code, § 15657.2.) In other words, alleged omissions by a health care provider that constitute "professional negligence" within the meaning of MICRA cannot, as a matter of law, constitute "reckless neglect" within the meaning of the Elder Abuse Act.

Plaintiffs allege that their mother Elizabeth Cox's physicians, while treating her on an outpatient basis, improperly failed to refer her to a specialist. The decision to refer a patient to a specialist is one made by trained health care professionals as part of their course of treatment. The question here is whether that medical decision—a decision that MICRA was designed and intended to cover—may also be "reckless neglect" under the Elder Abuse Act simply because the patient was over the age of 65 and was seen repeatedly by the defendant physicians. The answer is no. The plain language and the intent of the Elder Abuse Act, as well as MICRA, forbid such a conclusion.

Maintaining a clear distinction between reckless neglect and professional negligence at the pleadings stage is critically important to the integrity of both the Elder Abuse Act and MICRA. Interpreting "neglect" under the Elder Abuse Act to include alleged omissions by health care providers while providing medical care threatens to undermine both statutory schemes' goals by impairing the elderly's access to care and circumventing procedural requirements for actions based on professional negligence. Because Plaintiffs have alleged an omission by health care providers in rendering professional services, that same conduct cannot also be reckless neglect under the Elder

Abuse Act. The Court of Appeal's majority decision allowing plaintiffs to plead such conduct under the Elder Abuse Act should be reversed.

II. LEGAL ARGUMENT

A. The Elder Abuse Act expressly excludes claims for professional negligence.

1. *The plain language of the Elder Abuse Act and MICRA statutes shows there can be no overlap between "reckless neglect" and "professional negligence."*

The question in this case is whether "neglect" within the meaning of the Elder Abuse Act includes a healthcare provider's failure to refer an elderly patient to a specialist while providing outpatient medical care. Because the Elder Abuse Act specifically excludes from its scope negligent omissions by a healthcare provider that fall under MICRA and other statutes governing professional negligence[1] (Welf. & Inst. Code, § 15657.2), the answer to this question turns in part on the breadth of MICRA.

The scope of MICRA is rooted in its definition of "professional negligence," which is broadly worded to cover any negligent act or omission to act in the rendering of medical care:

> "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the

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[1] Amici herein occasionally refer to statues relevant to professional negligence actions as "MICRA"; this is not intended to exclude other statutes that are not part of MICRA but are directly applicable to professional negligence actions, such as Code of Civil Procedure, section 425.13.

> provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(Code Civ. Proc., § 340.5, subd. (2).)[2] This definition of "professional negligence" applies in all medical malpractice actions, no matter how egregious the negligent conduct; in fact, punitive damages are available upon a proper showing of fraud, malice, or oppression. (See Code Civ. Proc., § 425.13; *Covenant Care v. Superior Court* (2004) 32 Cal.4th 771 (*Covenant Care*).)

The Elder Abuse Act does not sweep that broadly. It defines "[n]eglect" as "[t]he negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." (Welf. & Inst. Code, § 15640.57, subd. (a)(1).) While "'[n]eglect' includes... *[f]ailure to provide medical care* for physical and mental health needs" (Welf. & Inst. Code, § 15640.57, subd. (b)(2), emphasis added), nothing in the definition of "neglect" brings alleged omissions *during* the provision of medical care within the scope of the Elder Abuse Act. Heightened remedies are allowed for "reckless neglect" under the Elder Abuse Act "[w]here it is proven...that a defendant is liable for physical abuse...or neglect as defined in Section 15610.57, and that the defendant has been guilty of recklessness, oppression, fraud, or malice in the commission of this abuse." (Welf. & Inst. Code, § 15657.) But this definition does not expand the scope of "neglect" to include omissions in the provision of medical care. (*Covenant Care*, 32 Cal.4th at

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[2] This broad definition of "professional negligence" is expressly included in each of the other MICRA statutes. (See Civ. Code, §§ 3333.1, subd. (c)(2), 3333.2, subd. (c)(2); Code Civ. Proc., §§ 364, subd. (f)(2), 667.7, subd. (e)(4), 1295, subd. (g)(2); Bus. & Prof. Code, § 6146, subd. (c)(3).)

p. 783 ("[T]he statutory definition of 'neglect' speaks not of the undertaking of medical services, but of the failure to provide medical care.")

The first consideration in statutory interpretation is the language of the statute. "The words of the statute should be given their ordinary and usual meaning and should be construed in their statutory context. [Citation.] If the plain, commonsense meaning of a statute's words is unambiguous, the plain meaning controls." (*Fitch v. Select Products Co.* (2005) 36 Cal.4th 812, 818.) Additionally, statutory provisions "must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible." (*Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735.)

Here, "professional negligence" as defined by MICRA unambiguously *includes* "a negligent act or omission to act by a health care provider in the rendering of professional services." That same conduct is unambiguously *excluded* from the Elder Abuse Act: "[A]ny cause of action for injury or damage against a health care provider, as defined in 340.5 of the Code of Civil Procedure, based on the health care provider's alleged professional negligence, shall be governed by those laws which specifically apply to those professional negligence causes of action." (Welf. & Inst. Code, § 15657.2.)

Furthermore, the definition of professional negligence as including an omission in a patient's medical care comports with decades of California law. An alleged failure to refer a patient to a specialist during the course of medical treatment, as alleged in this case, is classic professional negligence. (See, e.g., CACI No. 508 ("If a reasonably careful [*insert type of medical practitioner*] in the same situation would have referred [*name of patient*] to a [*insert type of medical specialist*], then [*name of defendant*] was negligent if [he/she] did not do so."); BAJI

No. 6.04 ("A physician has a duty to [refer a patient to a specialist] [recommend the assistance of a specialist] if under the circumstances a reasonably careful and skillful physician would do so. [¶] A failure to fulfil any such duty is negligence."); *Sinz v. Owens* (1949) 33 Cal.2d 749, 758 ("If under the circumstances a reasonably careful skillful general practitioner...would have suggested the calling into consultation of a...specialist, the defendant was negligent for failing to do so.") (internal quotes and citation omitted).)

To give effect to both the Elder Abuse Act and MICRA, there can be no overlap between reckless neglect as defined by the Elder Abuse Act and professional negligence as defined by MICRA and decades of California law. The statutory language makes clear that professional negligence is entirely separate from reckless neglect.

2. *This Court's prior decisions explain that "reckless neglect" under the Elder Abuse Act and "professional negligence" are mutually exclusive.*

This Court recognized the express exclusion of professional negligence from the Elder Abuse Act in *Delaney v. Baker* (1999) 20 Cal.4th 23 (*Delaney*) and *Covenant Care.*

In *Delaney*, the plaintiff's elderly mother, who was a resident at a skilled nursing facility, died after suffering from severe bedsores, unhygienic conditions, and failures of the facility staff to provide information to the patient's physicians. (20 Cal.4th at p. 27.) The plaintiff sued the nursing home and two of its administrators, and a jury found the defendants had been recklessly neglectful. (*Id.*) This Court considered whether a nursing home and its administrators were subject to the heightened remedies of the Elder Abuse Act or the limited remedies for professional negligence under MICRA. "[B]ased in part on the recognition that the MICRA statutes specifically applicable

to professional negligence actions implicitly incorporate generally applicable statutes pertaining to civil actions," the Court determined that it was not plausible that a cause of action may be both "based on...professional negligence" within the meaning of Welfare and Institutions Code, section 15657.2 and be for "reckless neglect" within the meaning of section 15657. (*Delaney,* 20 Cal.4th at 30.) "The legislative history...indicates that those who enacted the statute thought that the term 'professional negligence,' at least within the meaning of section 15657.2, was mutually exclusive of the abuse and neglect specified in section 15657." (*Ibid.*)

The *Delaney* Court noted that "'neglect' as defined in former section 15610.57 and used in section 15657 does not refer to the performance of medical services in a manner inferior to the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing, but rather to the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing...." (*Delaney*, 20 Cal.4th at p. 34, internal quotes and citation omitted).)

While *Delaney* interpreted the Elder Abuse Act's definition of "professional negligence" narrowly in the sense that the term does not include certain intentional torts or conduct outside the scope of professional medical services, courts interpret "professional negligence" broadly with respect to the performance of services within the scope of a health care provider's license. (*Williams v. Superior Court* (1994) 30 Cal.App.4th 318, 324-325 ("The test of whether a health care provider's negligence constitutes professional negligence is whether the negligence occurred in rendering services for which the health care provider is licensed.")

The Court revisited the distinction between elder abuse and professional negligence in *Covenant Care*, and held that custodians who egregiously abuse elders in their custody are not afforded the special procedure for pleading punitive damages in Code of Civil Procedure, section 425.13, subdivision (a), which prohibits the pleading of punitive damages without a court's prior authorization in professional negligence actions against health care providers. In determining whether Section 425.13 should apply to claims of elder abuse, the Court noted that "elder abuse as defined in the Act, even when committed by a health care provider, is not an injury that is 'directly related' to the provider's professional services." (*Covenant Care*, 32 Cal.4th at p. 786.) The Court explained that "while in the medical malpractice context 'there may be considerable overlap of intentional and negligent causes of action' [citation], no such overlap occurs in the Elder Abuse Act context, where the Legislature expressly has excluded ordinary negligence claims from treatment under the Act." (*Id.* at 788-789, citing *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 192 (*Central Pathology*).)

Consistent with the language of the Elder Abuse Act and this Court's precedent, there is no overlap between professional negligence and reckless neglect. The two concepts are entirely separate.

B. As a matter of law, this case involves allegations of professional negligence rather than allegations of neglect.

1. Plaintiffs allege facts that constitute professional negligence, not reckless neglect.

Plaintiffs allege that the Defendants, in their capacity as health care providers, evaluated and treated Ms. Cox's foot problems over a number of years. Defendants did not have a custodial relationship with Ms. Cox, but rather examined and treated her on an outpatient basis.

Defendants diagnosed and monitored the condition in Ms. Cox's foot. In office visits over a period of years, Defendants continued to provide medical services—further diagnosing and monitoring Ms. Cox's medical condition, treating wounds on her foot, and prescribing medication. Defendants' actionable conduct, according to Plaintiffs, was that Defendants failed to provide a *particular course* of medical diagnosis and treatment: a recommendation that Ms. Cox see a vascular specialist.

Such claims focus on the manner in which a health care provider supplies professional services, and Plaintiffs' allegations refer to the performance of medical services in a manner inferior to the knowledge, skill, and care ordinarily possessed and employed by members of the profession in good standing. (See, e.g., *Delaney*, 20 Cal.4th at p. 34.) The failure to refer a patient to a specialist is a classic example of medical malpractice. (CACI 508; BAJI 6.04; *Sinz v. Owens*, 33 Cal.2d at p. 758.)

While Defendants did not provide the particular type of medical care Plaintiffs allege they should have provided (i.e., referral to a specialist), such an omission cannot constitute "neglect" by a person having "care or custody" for "[f]ailure to provide medical care" or "failure to protect from health and safety hazards." (Welf. & Inst. Code, § 15640.57, subd. (b)(2), (b)(3).) The Court should reject the argument that allegations of a "pattern of neglect" by physicians "over an extended period of time" allows them to plead elder abuse in addition to professional negligence. (Answer Brief, 50, 57.) The Court of Appeal erroneously applied language from *Sababin v. Superior Court* (2006) 144 Cal.App.4th 81 to the physicians' failure to refer Ms. Cox to a specialist. (Op., 19, quoting 144 Cal.App.4th at 90 ("the trier of fact must determine whether there is a significant pattern of withholding portions or types of care. A significant pattern is one that involves repeated

withholding of care and leads to the conclusion that the pattern was the result of choice or deliberate indifference.").) The Court of Appeal overlooked the fact that the *Sababin* court found triable issues as to whether a facility failed to provide "medical care for physical needs" and to protect a patient from "health and safety hazards" under the Elder Abuse Act because there were allegations of "failing to check [the patient's] skin condition on a daily basis and failing to notify a physician of the need for a treatment order." (*Sababin*, 144 Cal.App.4th at 90.) Here, conversely, Ms. Cox was being treated by the defendant physicians, so there was no such withholding of medical care or failure to protect from health and safety hazards. *Sababin* only speaks to "a significant pattern" of "repeated withholding of care" in the context of caregivers' failure to notify a physician of the need for medical treatment—not a physician's omission in the course of rendering professional services.

"[C]laims under the Elder Abuse Act are not brought against health care providers in their capacity as providers but, rather, against custodians and caregivers that abuse elders and that may or may not, incidentally, also be health care providers." (*Covenant Care*, 32 Cal.4th at p. 786.) Here, that Defendants are health care providers is not at all "incidental" to Plaintiffs' claims; rather, Plaintiffs' claims are brought against Defendants solely in their capacity as health care providers, and are directly based on the outpatient professional services they provided. These facts cannot state a valid claim under the Elder Abuse Act.

2. *"Recklessness" does not transform professional services to elder abuse.*

A demurrer is properly sustained where the plaintiff has failed to state facts sufficient to constitute a cause of action. (Code Civ. Proc., § 430.30, subd. (e).) But the majority in the Court of Appeal held that

"the question whether defendants' conduct was reckless rather than merely negligent is for a jury to decide." (Op., 3.) This holding is erroneous.

An allegation that a health care provider's omission to act in the course of treating a patient over the age of 65 was "reckless" does not change the fact that the action is based on an omission to act in rendering professional services. Just because Plaintiffs have alleged recklessness does not mean their claim is no longer "based on professional negligence"; the provisions of MICRA apply to a broad range of conduct in the performance of such professional services. (See, e.g., Civ. Code, § 3333.2 (applying MICRA's non-economic damages cap to "any action for injury against a health care provider based on professional negligence...."); Code Civ. Proc., § 425.13 (allowing for punitive damages in cases involving fraud, malice, or oppression); see also *Covenant Care*, *supra*, 32 Cal.4th 771.) The Legislature did not provide any exception to MICRA based on recklessness, and the Elder Abuse Act does not provide any such exception.

This Court's decision in *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101 (*Barris*) illustrates how conduct rising to the level of "recklessness" in connection with a health care provider's omission to act in rendering professional services is insufficient to avoid the application of MICRA in favor of a statute providing for specified penalties. In *Barris*, the plaintiff alleged that a hospital and two physicians failed to stabilize her daughter before attempting to transfer her to a different hospital, causing the child's death. The plaintiff asserted causes of action for professional negligence and violation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. A hospital is liable for penalties under EMTALA if it "has 'actual knowledge of the individual's unstabilized

emergency medical condition,' fails to stabilize the condition, and nevertheless transfers the patient." (*Id.*, at 109.) EMTALA's "actual knowledge" requirement—distinct from intent, malice, fraud, or oppression—is analogous to the "recklessness" referenced in the Elder Abuse Act. As Plaintiffs argue, "recklessness" may be found where an actor "realizes or, from facts he knows, should realize that there is a strong probability that harm may result...." (Answer Brief, 37, quoting *Shell Oil v. Winterthur Swiss Inc. Co.* (1993) 12 Cal.App.4th 715, 742.).

Despite the hospital's knowledge of the likelihood the patient would deteriorate upon transfer without first being stabilized, this Court held that MICRA's noneconomic damages limitation applied to the jury's noneconomic damages award in relation to the EMTALA claim. The Court agreed and concluded that "[a] claim under EMTALA for failure to stabilize is thus necessarily 'based on professional negligence' within the meaning of MICRA—it involves 'a negligent...omission to act by a health care provider in the rendering of professional services'—although it requires more." (*Barris*, *supra*, 20 Cal.4th at p. 110, citing Civ. Code, § 3333.2, subds. (a), (c)(2).) The Court stated that a court's task in determining whether to apply MICRA's damages limitation "properly involves examining the legal theory underlying the particular claim and the nature of the conduct challenged to determine whether, under California law, it would constitute 'professional negligence' subject to Civil Code section 3333.2." (*Barris*, 20 Cal.4th at p. 116.) Like the EMTALA claim in *Barris*, Plaintiffs' claim here involves acts that constitutes professional negligence (the failure to refer a patient to a specialist). Consistent with the reasoning in *Barris*, whether Plaintiffs allege that Defendants' actions were "reckless" does not change the fact that Plaintiffs' claims are based on professional negligence.

3. *Questions of duty and which statute applies based on the facts alleged are questions of law for the court, not questions of fact for a jury.*

It is the proper role of the court to determine whether elder abuse has been properly alleged at the pleadings stage, and not to leave it for the jury to decide as a fact question. "When a cause of action is asserted against a health care provider on a legal theory other than medical malpractice, the courts must determine whether it is nevertheless based on the 'professional negligence' of the health care provider...." (*Smith v. Ben Bennett, Inc.* (2005) 133 Cal.App.4th 1507, 1514.)

The scope of a physician's duty is determined based on the circumstances of the underlying care; "reckless neglect" and "professional negligence" are breaches of distinct duties and do not differ only in degree. "As to any given defendant, only one standard of care obtains under a particular set of facts, even if the plaintiff attempts to articulate multiple or alternate theories of liability." (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 998 (*Flowers*).) In *Flowers*, this Court rejected the notion that "the same factual predicate can give rise to two independent obligations to exercise due care according to two different standards," reasoning that "this is a legal impossibility: a defendant has only one duty, measured by one standard of care, under any given circumstances." (*Id.* at 1000.)

Thus, while Plaintiffs' amici argue that "health care providers wear two hats when tending to elderly or dependent adults' medical needs," they are wrong that those two hats—or duties—may be "worn simultaneously." (Amicus Brief of Consumer Attorneys of California, p. 5.) In the context of a given set of circumstances, health care providers can only wear one hat at a time, and for physicians treating a

non-resident patient at office visits, "the law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he [or she] exercise *ordinary care* in applying such learning and skill to the treatment of [the] patient." (*Flowers, supra,* 8 Cal.4th at p. 998, emphasis in original.)

Neglect, by contrast, applies to "the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations." (*Delaney*, 20 Cal.4th at p. 34.) In this case, there are no allegations of a failure to attend to basic needs and comforts—only particular, specialized medical treatment.

Where the facts of a pleading make clear that the defendants had a duty to exercise care in applying their learning and skill to the treatment of a patient—and the pleadings *do not* show that the defendants had a duty to meet the basic needs of a patient unable to do so herself—the cause of action is necessarily one for professional negligence rather than elder abuse. The question focuses not on the status of the health care provider, but instead on the specific actions alleged to have caused the harm.

The analysis in *Central Pathology* is also instructive in determining whether a claim is based on professional negligence. That case considered whether the procedural hurdle for pursuing punitive damages for professional negligence claims in Code of Civil Procedure, section 425.13 applied to intentional torts by a health care provider. The plaintiffs alleged that the defendants—physicians, a clinic, and their medical group—committed fraud and intentional infliction of emotional distress by failing to inform the plaintiffs that a cancer test had abnormal results. This Court said that in order to determine

whether the claims arose out of professional negligence, "[t]he allegations that identify the nature and cause of a plaintiff's injury must be examined to determine whether each is directly related to the manner in which professional services were provided." (*Central Pathology*, 3 Cal.4th at p. 192.) A claim arises out of professional negligence "if the injury that is the basis for the claim was caused by conduct that was directly related to the rendition of professional services." (*Central Pathology*, 3 Cal.4th at p. 192.) This Court held that the plaintiffs' claims did arise from professional negligence: "The claim emanates from the manner in which defendants performed and communicated the results of medical tests, a matter that is an ordinary and usual part of medical professional services." (*Id.* at 192-193.)

Here, it is clear that Plaintiffs' claims are based on professional negligence, as Defendants diagnosed Ms. Cox's medical condition, treated the injuries on her foot, monitored her symptoms, but did not refer her to a vascular specialist for additional treatment—classic professional negligence allegations. Each action Defendants took that allegedly caused harm was "directly related to the manner in which professional services were provided." And unlike *Delaney* and *Covenant Care*, none of these actions relate to custodial care or a duty to care for a patient's basic daily needs.

The question of which law should apply to a given set of facts is not a jury question. It is the court's function to determine the duty alleged to have been breached. "Deciding the existence of a duty and its scope or the standard of conduct to which the duty requires the defendant to conform are questions of law for the court." (*Castaneda v. Olsher* (2007) 41 Cal.4th 1205, 1227, quoting *Ramirez v. Plough, Inc.* (1993) 6 Cal.4th 539, 546.) The jury's province is to determine facts, but there are no facts in dispute on the demurrer at issue. Only the legal

effect of the particular alleged facts—whether those facts constitute reckless neglect of an elder or professional negligence as a matter of law—is at issue. This issue is properly determined by a court at the outset of a case.

C. Maintaining separation of elder abuse and professional negligence is critical to maintaining the distinct goals of MICRA and the Elder Abuse Act.

To the extent there is any uncertainty in the Elder Abuse Act in relation to MICRA, the Court should "consider the consequences of a particular interpretation, including its impact on public policy." (*Wells v. One2One Learning Foundation* (2006) 39 Cal.4th 1164, 1190.) "Ultimately, 'the ascertainment of legislative intent is the paramount principle of statutory interpretation.'" (*Covenant Care*, 32 Cal.4th at p. 782, citing *In re Michael G.* (1988) 44 Cal.3d 283, 289.)

The Elder Abuse Act was not designed to create an exception to MICRA for professional negligence plaintiffs who are over 65. But Plaintiffs urge the creation of two tiers of professional negligence plaintiffs: patients under the age of 65 for whom a failure to adequately treat a medical condition constitutes professional negligence, and patients over the age of 65 for whom a failure to adequately treat a medical condition constitutes elder abuse. As the dissenting Court of Appeal opinion notes, "The only thing that distinguishes this case from a standard medical malpractice claim is that Cox was over 65 years old." (Op., dissent 4.) Allowing professional negligence claims to proceed as elder abuse would be harmful to the goals of the Elder Abuse Act and MICRA.

The Elder Abuse Act is intended to "protect a particularly vulnerable portion of the population from gross mistreatment in the

form of custodial neglect." (*Delaney*, *supra*, 20 Cal.4th at p. 33.) In enacting and revising the Elder Abuse Act, the Legislature noted that "few civil cases are brought in connection with this abuse due to problems of proof, court delays, and the lack of incentives to prosecute these suits." (Welf. & Inst.Code, § 15600, subd. (h).) Therefore, it was the Legislature's intent "to enable interested persons to engage attorneys to take up the cause of abused elderly persons and dependent adults." (Welf. & Inst. Code, § 15600, subd. (j).) To that end, when elder abuse is committed with recklessness, oppression, fraud, or malice the Legislature provided for enhanced remedies. (Welf. & Inst. Code, § 15657.)

By contrast, the field of professional negligence litigation has not experienced a shortage of lawsuits or a need for enhanced remedies. To the contrary, MICRA "reflects a strong public policy to contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state's health care needs." (*Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 112.)

MICRA was enacted because California faced a serious medical malpractice insurance crisis in the 1970s in which insurance rates were so high they became impossible for some physicians to reasonably afford:

> [M]any doctors decided either to stop providing medical care with respect to certain high risk procedures or treatment, to terminate their practice in this state altogether, or to "go bare," i.e., to practice without malpractice insurance. The result was that in parts of the state medical care was not fully available, and patients who were treated by uninsured doctors faced the prospect of obtaining only unenforceable

> judgments if they should suffer serious injury as a result of malpractice.

(*Ruiz v. Podolsky* (2010) 50 Cal.4th 838, 843-844, quoting *Reigelsperger v. Siller* (2007) 40 Cal.4th 574, 577-578; see also *American Bank v. Community Hospital of Los Gatos-Saratoga, Inc.* (1984) 36 Cal.3d 359, 371 [same].) MICRA's goal was to ensure access to care by reducing costs in the resolution of malpractice claims and therefore reducing malpractice insurance premiums. (*Ruiz v. Podolsky*, *supra*, 50 Cal.4th at p. 844.) "The continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with medical malpractice litigation." (*Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital*, *supra*, 8 Cal.4th at p. 111.)

MICRA is specifically targeted to address claims for "professional negligence" as that term is defined throughout the MICRA statutes, as "a negligent act or omission to act by a health care provider in the rendering of professional services, which...is the proximate cause of a personal injury or wrongful death." (See, e.g., Civ. Code, §§ 3333.1, subd. (c)(1), 3333.2, subd. (c)(2), Code Civ. Proc., §§ 340.5, subd. (2), 1295, subd. (g)(2), Bus. & Prof. Code, § 6146, subd. (c)(3).)

To achieve the goals of MICRA, the Legislature enacted specific controls on litigation involving professional negligence, allowing for evidence of collateral source payments (Civ. Code, § 3333.1), limits on noneconomic damages (Civ. Code, § 3333.2); and periodic payments of future damages (Code Civ. Proc., § 667.7). Further, rather than encourage litigation through the award of attorneys' fees, MICRA limits attorney contingency fees. (See Bus. & Prof. Code, § 6146.)

Importantly, MICRA includes provisions that apply early in a lawsuit. For example, a patient must give advance notice to his or her health care provider before commencing an action for professional negligence. (Code Civ. Proc., § 364.) Plaintiffs must obtain prior court authorization before pleading punitive damages. (Code Civ. Proc., § 425.13.) The statute of limitations for professional negligence causes of action is limited to one year after discovery of an injury or three years after the injury, whichever occurs first. (Code Civ. Proc., § 340.5.) Patients and their health care providers may agree that disputes will be resolved through binding arbitration (Code Civ. Proc., § 1295), and this Court has held that such agreements apply to a patient's family members. (*Ruiz v. Podolsky*, *supra*, 50 Cal.4th 838.)

Thus the means to achieve the respective goals of the Elder Abuse Act and MICRA are very different: In elder abuse cases, litigation is encouraged by the availability of increased damages awards and attorneys' fees; in professional negligence cases, procedural controls and limited recovery of non-economic damages reduces frivolous lawsuits and makes litigation more predictable, thus contributing to reasonable malpractice insurance rates. As this Court said in *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 163, "One of the problems identified in the legislative hearings [relating to MICRA] was the unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses." MICRA seeks to diminish that unpredictability.

Allowing elder abuse and professional negligence to be pleaded interchangeably, as the Court of Appeal concluded when it said the difference is a question for the jury, puts the two statutory schemes at odds. For example, awards of attorneys' fees and increased damages

under the Elder Abuse Act are intended to incentivize attorneys to take such cases; MICRA's limits on attorney contingency fees and limits on recovery of non-economic damages are intended to discourage frivolous litigation.

The Legislature's intended predictability of professional negligence actions under MICRA would become meaningless if a plaintiff could bypass notice of a lawsuit, the applicable statute of limitations, evidentiary rules, and arbitration, and seek attorneys' fees and punitive damages for conduct that, as alleged, would otherwise constitute a professional negligence cause of action. Litigation is costly for physicians and their insurers, even in cases in which the physician is not found to be at fault. The average defense cost in 2012 for claims that were dropped was $28,777; for claims that settled, defense costs averaged $70,480; and for tried claims, the average defense cost was $135,747 when there was a defense verdict and $253,920 for a plaintiff verdict. (See American Medical Association, *Medical Liability Reform NOW!: The facts you need to know to address the broken medical system* (2014) p. 6 <http://www.ama-assn.org/resources/doc/arc/mlr-now.pdf> [as of March 12, 2014]; see also Richard E. Anderson, M.D., *Effective Legal Reform and the Malpractice Insurance Crisis* (2005) 5 Yale J. Health Pol'y, L. & Ethics 341, 345-46 (*Effective Legal Reform*).)

MICRA has been extremely successful in lowering insurance costs. As the American Medical Association notes, "[W]hile total premiums in the rest of the United States rose 873 percent between 1976 and 2012, the increase in California premiums was much smaller, only 241 percent." (American Medical Association, *supra*, *Medical Liability Reform NOW!* at p. 20.) MICRA has resulted in "increases in insurance premiums of less than three percent per year, less than one-third the rate at which premiums have risen nationally." (Anderson,

supra, *Effective Legal Reform* at 351 (footnotes omitted).) The continuing problems with medical liability premiums in other states show how important it is that MICRA reforms remain in place to ensure that the medical malpractice insurance crisis of the 1970s does not recur.

Furthermore, allowing professional negligence claims to be subject to elder abuse remedies undermines a paramount goal of both statutory schemes—ensuring access to health care for the growing elderly population of California. According to the 2010 Census, more than 4.2 million Californians are over the age of 65, and that number is growing rapidly. (Carrie A. Werner, *The Older Population: 2010*, United States Census Bureau (Nov. 2011) <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>.) If physicians treating patients over the age of 65 are subjected to enhanced remedies every time a patient's family questions the physician's judgment, treating California's mature population could become a high-risk specialty. Studies show that when a specialty is particularly high-risk, physicians tend to avoid practicing in that specialty. (See, e.g., Emily Chow, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications* (2007) 7 Yale J. Health Pol'y, L. & Ethics 387, 388-89 (noting that medical insurance crises in many states have forced physicians to give up practicing in high-risk specialties, putting patients at risk for decreased availability of skilled medical providers); American Medical Association, *supra*, *Medical Liability Reform NOW!* at p. 9 (reporting that the lack of affordable liability insurance compelled 70% of obstetricians to make changes, including forcing seven percent to stop practicing obstetrics), pp. 9-10 (half of the respondents to an AMA survey reported that the medical liability environment was a factor in choosing a specialty, and nearly forty percent said the medical liability environment was a factor in their choice of a state in which to complete

their residency training).) The result would be to diminish elderly patients' access to medical care, undermining the goals of both MICRA and the Elder Abuse Act.

Access to care is a particular concern in the field of geriatrics. The Institute of Medicine reported in 2008, "The nation faces an impending health care crisis as the number of older patients with more complex health needs increasingly outpaces the number of health care providers with the knowledge and skills to adequately care for them." (Institute of Medicine of the National Academies, *Retooling for an Aging America: Building the Health Care Workforce* (Apr. 11, 2008) <http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx> [as of March 12, 2014].) In more recent years, the number of physicians enrolling in fellowship programs to become geriatricians has continued to decline for a variety of reasons. (American Medical Association, *Fewer trainees choosing geriatrics, numbers show* (Feb. 6, 2013) <http://www.ama-assn.org/ams/pub/amawire/2013-february-06/2013-february-06-rfs.shtml> [as of March 12, 2014].) Limiting the application of MICRA by allowing heightened remedies under the Elder Abuse Act in cases involving patients over the age of 65—where MICRA would otherwise apply—threatens to exacerbate the shortage of geriatricians.

Allowing elder abuse remedies based on professional negligence claims—especially claims such as the ones in this case, which question the ongoing judgment of several physicians as they treated a patient's foot condition on an occasional basis—would place both health care providers and patients in a precarious position. Allowing parallel claims to be asserted in a professional negligence action and a separate elder abuse action could easily result in the same harms that led to the enactment of MICRA in the first place, when many physicians chose to

stop performing certain procedures (thus diminishing patient access to needed care) or practiced without insurance (thus rendering malpractice judgments uncollectible). (*American Bank, supra*, 36 Cal.3d at 371.) If the Court were to allow Plaintiffs' parallel actions to proceed, physicians may choose to stop treating elderly patients rather than risk facing double lawsuits and increased penalties when their professional judgment is second-guessed. It is a far better policy to follow the language of the Elder Abuse Act and ensure that "any cause of action...based on the health care provider's alleged professional negligence, shall be governed by those laws which specifically apply to those professional negligence causes of action." (Welf. & Inst. Code, § 15657.2.)

It is therefore important to ensure that parallel claims or artful pleading, as occurred in this case, do not undermine the intent of both the Elder Abuse Act and MICRA. The Court should read the provisions of the Elder Abuse Act and MICRA in harmony to respect the plain meaning and intent of both statutory schemes: MICRA applies to all actions based on a healthcare provider's omission to act in the course of providing treatment; the Elder Abuse Act applies to reckless neglect *not* arising out of professional negligence—which may be based on the failure to fulfill a basic duty to "provide" medical care to an elder.

III. CONCLUSION

The Court of Appeal in *Smith v. Ben Bennett, Inc.* (2005) 133 Cal.App.4th 1507 may have stated the issue best when determining whether the Elder Abuse Act or MICRA should apply:

> Welfare and Institutions Code section 15657.2 works like a toggle switch. If a claim is a "cause of action...based on...professional negligence," then "those laws which

> specifically apply to...professional negligence causes of action" apply, and the Elder Abuse Act does not. If, on the other hand, a claim is not a "cause of action...based on... professional negligence," then the Elder Abuse Act can apply...; moreover, "those laws which specifically apply to... professional negligence causes of action" cannot."

(133 Cal.App.4th 1507, 1522-23.)

Here, Plaintiffs have alleged a cause of action based on the alleged failures of physicians, in their capacity as physicians, to provide a particular course of outpatient medical treatment for their mother. If the patient were under the age of 65, there would be no question that the claim was one for professional negligence. The fact that the patient is over the age of 65 cannot change Plaintiffs' cause of action into an elder abuse claim, even if they allege the physicians were reckless.

Maintaining a clear distinction between elder abuse and professional negligence is critical to upholding the intent and meaning of both the Elder Abuse Act and MICRA. Allowing such claims to be pleaded interchangeably or allowing a jury to decide them as a fact question would undermine both statutory schemes, ultimately harming California patients and their health care providers. The Court of Appeal should be reversed.

Dated: March 31, 2014 TUCKER ELLIS LLP

By: Rebecca A. Lefler

Rebecca A. Lefler
Counsel for Amici Curiae
California Medical Association,
California Dental Association,
California Hospital Association,
and American Medical Association

PROOF OF SERVICE

Kathleen A. Winn, et al.
Plaintiffs and Appellants
v.
Pioneer Medical Group, Inc., et al.
Defendants and Respondents

In the Supreme Court of the State of California, Case No. S211793
Court of Appeal, Second Appellate District, Division Eight
Case No. B237712

I, **Estella Licon,** declare as follows:

On March 31, 2014, I served the following: **Application for Leave to File Amici Curiae Brief in Support of Pioneer Medical Group, Inc. et al; Brief of Amici Curiae California Medical Association, California Dental Association, California Hospital Association, and American Medical Association** on the interested parties in this action by:

X **U. S. MAIL:** By placing a true copy thereof enclosed in a sealed envelope(s) addressed as above, and placing each for collection and mailing on that date following ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in Los Angeles, California, in a sealed envelope with postage fully prepaid.

PLEASE SEE ATTACHED SERVICE LIST

X **(STATE):** I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at Los Angeles, California on March 31, 2014.

Estella Licon

ESTELLA LICON

SERVICE LIST

Kathleen A. Winn, et al.
Plaintiffs and Appellants
v.
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Clay Robbins III, Esq.
MAGAÑA, CATHCART & MCCARTHY
1801 Avenue of the Stars, Suite 600
Los Angeles, CA 90067-5899
Tel: (310) 553-6630/Fax: (310) 407-2295

Attorneys for Plaintiffs and Appellants Kathleen A. Winn and Karen Bredahl, individually and as Sole Surviving Heirs of Elizabeth M. Cox, deceased

Curtis A. Cole, Esq.
Kenneth Robert Pedroza, Esq.
Matthew S. Levinson, Esq.
Cassidy E. Cole, Esq.
COLE PEDROZA LLP
200 S. Los Robles Avenue, Suite 300
Pasadena, CA 91101
Tel: (626) 431-2787/Fax: (626) 431-2788

Attorneys for Defendants and Respondents Pioneer Medical Group, Inc., Emerico Csepanyi, M.D., James Chinuk Lee, D.P.M. and Stanley Lowe, D.P.M.

Richard D. Carroll, Esq.
David P. Pruett, Esq.
Jennifer A. Cooney, Esq.
CARROLL, KELLY, TROTTER, FRANZEN, MCKENNA & PEABODY
P.O. Box 22636
Long Beach, CA 90801-5636
Tel: (562) 432-5855/Fax: (562) 432-8785

Attorneys for Defendants and Respondents Pioneer Medical Group, Inc., Emerico Csepanyi, M.D., James Chinuk Lee, D.P.M. and Stanley Lowe, D.P.M.

Russell S. Balisok, Esq.
BALISOK & ASSOCIATES, INC.
330 N. Brand Boulevard, Suite 702
Glendale, CA 91203
Tel: (818) 550-7890/Fax: (818) 550-7890

Attorneys for Amicus Curiae California Advocates for Nursing Home Reform, Inc.

Ingrid Evans, Esq.
Elliot Wong, Esq.
EVANS LAW FIRM, INC.
3053 Fillmore Street, #236
San Francisco, CA 94123
Tel: (415) 441-8669/Fax: (888) 891-4906

Attorneys for Amicus Curiae Consumer Attorneys of California

Clerk
California Court of Appeal
Second Appellate District, Division 8
300 South Spring Street
Second Floor, North Tower
Los Angeles, CA 90013-1213

Court of Appeal
Case No. B237712

Los Angeles Superior Court
For The Hon. Joanne B. O'Donnell
Department 37
111 No. Hill Street
Los Angeles, CA 90012

Trial Court
Case No. BC455808