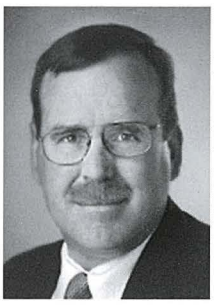
Case Summaries



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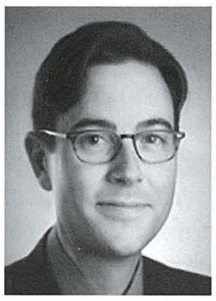

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Pouzbaris v. Prime Healthcare Services-Anaheim, LLP (Apr. 23, 2015, G048891) ___ Cal.App.4th ___ [2015 WL 1851003]

A patient at the defendant hospital allegedly slipped and fell on a recently mopped floor that lacked any warning signs. The patient sued the hospital for negligence nearly two years later. The trial court granted summary judgment in defendant's favor on the ground plaintiff's action was barred by the one-year statute of limitations for professional negligence under MICRA. (Code Civ. Proc., § 340.5.) The trial court reasoned that section 340.5 applied to any lawsuit alleging negligence "committed in the act of rendering services for which the hospital is licensed" and therefore applied regardless "whether [the] plaintiff fell because she was not supervised or assisted on her trip to the restroom, or because a 'cleaning lady' mopped her room while she was in the restroom ..."

The Court of Appeal reversed, holding that the hospital's alleged conduct of mopping a floor and failing to provide warning signs constitutes ordinary negligence subject to the two-year statute of limitations for ordinary negligence under section 335.1 of the Code of Civil Procedure, rather than "professional negligence" under section 340.5. The court defined the pertinent inquiry as whether the negligence occurred "in the rendering of professional services." The court concluded that mopping the floor and failing to provide a warning sign did not involve rendering professional services. The court also stated generally that the statutory definition of professional negligence does not embrace a negligently maintained, unsafe condition on hospital premises that causes injury to a patient.

The distinction between ordinary negligence and "professional negligence" for purposes of the MICRA statute of limitations is currently pending before the California Supreme Court in Flores v. Presbyterian Intercommunity Hospital (2013) 213 Cal.App.4th 1386, review granted May 22, 2013, S209836. There, the Court will decide whether the plaintiff's injury from a fall after her hospital bed rail collapsed occurred as a result of professional negligence under MICRA, or ordinary negligence, for the purpose of determining which limitations period applies.

Nolte v. Cedars Sinai Medical Center (May 21, 2015, B252606) ___ Cal. App.4th ___ [2015 WL 2408188]

Justin Nolte filed a class action complaint against Cedars Sinai Medical Center (Cedars), alleging that Cedars engaged in unfair business practices by charging a facility fee without providing him with prior notice that the charge would be incurred. A copy of "Cedars-Sinai Medical Center Conditions of Admission" (COA) form executed by Nolte was attached to his complaint. The COA stated that Nolte was being admitted to Cedars for outpatient treatment subject to the COA's terms and conditions, one of which was that the physician was an independent contractor who may bill separately for services. The COA also obligated Nolte to "pay the account of the Hospital in accordance with the regular rates and terms of the hospital." Nolte was charged for the doctor's services as well as a "facility fee" from Cedars for creating Nolte's patient record in its computer system. Cedars demurred to Nolte's complaint on the ground the fee was part of the "regular rates and terms of the Hospital" which

Nolte agreed to pay by signing the COA. The trial court sustained the demurrer without leave to amend. Nolte appealed.

The Court of Appeal affirmed, holding that Cedar's failure to "specifically, separately, and individually disclose to Nolte that it would charge a facilities fee" did not state a claim for unfair business practices. The court reasoned that Nolte had signed the COA agreeing to separate billing by his physician and by Cedars and to pay Cedars' charges. Moreover, because there was no allegation that Cedars had failed to make a written or electronic copy of its schedule of charges available to consumers as required by Health and Safety Code section 1339.51, Cedars had no obligation to separately and specifically disclose and explain the facility fee to Nolte.

Sela v. Medical Board of California
(May 28, 2015, B253860) ___ Cal. App.4th ___ [2015 WL 3413547]
http://www.courts.ca.gov/opinions/documents/B253860.PDF

Dr. Michael Sela filed a petition for writ of administrative mandate in the trial court seeking to overturn the Medical Board's decision denying his request for early termination of probationary restrictions on his medical license based on his acquittal in related criminal proceedings. After the trial court entered judgment denying the petition, Sela filed a notice of appeal.

The Court of Appeal issued an order to show cause why the appeal should not be dismissed because it was taken from a judgment made nonappealable by Business and Professions Code section 2337. Section 2337 governs judicial review of Board decisions revoking, suspending or restricting a physician's license, and provides that appellate review of a superior court decision granting or denying a petition for writ of mandate "shall be pursuant to a petition for an extraordinary writ." Sela argued (and the Board agreed) that he could appeal notwithstanding section 2337 because the Board's decision did not revoke, suspend or restrict his license — but merely left in place the existing probation period.

In a split decision, the Court of Appeal majority rejected this argument and dismissed Sela's appeal. The majority opinion concluded that section 2337 applied because the Board's refusal to terminate Sela's probation early restricted his medical license — "[i]n effect, the Board decided that notwithstanding petitioner's new evidence, there was a present need to restrict petitioner's right to practice." Accordingly, the trial court's judgment upholding the Board's decision could be reviewed only by writ petition pursuant to section 2337. The Court of Appeal declined to treat Sela's appeal as a writ petition because Sela had failed to justify why he had not timely sought writ review.

Whitlow v. Rideout Memorial Hospital
(June 9, 2015, C074810) ___ Cal.App.4th ___ [2015 WL 3561730]

Plaintiffs in this wrongful death action alleged that Rideout Memorial Hospital was responsible for the actions of an emergency room physician who had failed to diagnose and treat the decedent's brain hemorrhage. The trial court granted summary judgment to the Hospital, ruling that the physician was not an ostensible agent as a matter of law based on the plain language of the hospital's Conditions of Admission form and signs declaring the emergency room physicians to be independent contractors. Plaintiffs appealed, arguing there were triable issues of material fact despite the hospital's admission form and the emergency room signage.

The Court of Appeal reversed, holding that the "mere existence" of the form and the signs did not "conclusively indicate that the decedent should have known that the treating physician was not the hospital's agent." The court reasoned that the issue of ostensible agency is typically resolved by the factfinder. Here, the court concluded that a jury must weigh the significance of the signs, and whether the decedent was capable of understanding the form while suffering from a brain hemorrhage. Under this standard, it seems the issue of ostensible agency will seldom be capable of summary adjudication regardless of the amount of information available to a sick or injured patient.

The Court of Appeal had requested supplemental briefing on whether liability could be established on the alternative ground that the Hospital owed a nondelegable duty of care in these circumstances. In an unpublished portion of its decision, the court discussed, but ultimately declined to resolve, whether the nondelegable duty doctrine applies to care provided by emergency room physicians. The court acknowledged that hospitals cannot legally employ physicians, and observed that because the field of medicine is heavily regulated, the legislature may be in a better position to "weigh the relative pros and cons of the public policy to be employed."

Chan v. Curran (June 9, 2015, A138234) ___ Cal.App.4th ___ [2015 WL 3561553]

Plaintiff Jessica Chan prevailed in a medical malpractice action in which the jury awarded her $1 million in noneconomic damages and other damages. The trial court reduced the noneconomic damages award to $250,000, as required by the Medical Injury Compensation Reform Act of 1975 (MICRA). (See Civ. Code, § 3333.2.) Chan appealed, arguing that the MICRA cap on noneconomic damages violated her constitutional rights to equal protection, due process and trial by jury.

The Court of Appeal affirmed, rejecting each of Chan's constitutional arguments. The court observed that California courts have consistently rejected constitutional attacks on MICRA because they are contrary to well-established legal principles for determining the constitutionality of economic and social welfare legislation under the extremely deferential rational basis test. The court discussed previous California Supreme Court cases upholding section 3333.2 and other MICRA provisions against similar constitutional challenges. The court also rejected Chan's argument that MICRA's constitutionality should be reexamined due to "changed circumstances" in today's medical malpractice insurance climate; the court held that she failed to demonstrate that the circumstances leading to MICRA's enactment no longer exist. The court acknowledged that MICRA may inhibit medical malpractice plaintiffs from finding counsel willing to accept cases on a contingency basis, but concluded that result did not offend due process. Finally, the court held that the Supreme Court and other Courts of Appeal had previously considered and properly rejected Chan's argument that MICRA infringed on the right to a jury trial.

In conclusion, the Court of Appeal determined that "the legitimate debate over the wisdom of MICRA's noneconomic damages cap remains a matter for the Legislature and state electorate."

King v. Burwell 576 U.S. _____ (2015) (No. 14-114)

The Patient Protection and Affordable Care Act (ACA) mandates that most people either purchase health insurance or pay a tax. The ACA allows each state to create an exchange through which persons can shop for health insurance, and requires the federal government to create an exchange for any state that does not do so. The ACA also provides for tax credits to certain low-income people so they can purchase insurance. Four low-income citizens of Virginia—which did not establish a state exchange, but instead had one established for it by the federal government—challenged the ACA's insurance-or-tax mandate. They claimed that, because of their low incomes, they would be exempt from the mandate if they did not receive ACA tax credits, and that those tax credits were unavailable in states like Virginia that do not have state-established exchanges.

The Supreme Court found that the challengers had "strong" arguments about the plain meaning of key ACA provisions, but concluded that those provisions are ambiguous when viewed in light of the Act as a whole. Under the ACA, tax credits are available to persons enrolled in insurance plans offered through "an Exchange established by the State." 26 U.S.C. § 36B. If a state does not establish an exchange, then the federal government "shall . . . establish and operate such Exchange within the State." 42 U.S.C. §18041(c)(1) (emphasis added). The challengers argued that an exchange established by the federal government is not "an Exchange established by the State," hence no tax credits are available to those purchasing insurance through a federal exchange. The Court believed this argument had force, but also thought it possible to construe the phrase "such Exchange" as meaning that the federal government would operate the very same exchange the State was directed to establish. In other words, the ACA could be read to mean that a federal exchange counts as "an Exchange established by the State" under § 36B.

Concluding that the critical statutory phrase was ambiguous, the Court observed that a "fair reading of legislation demands a fair understanding of the legislative plan." (Slip op. 21.) Turning to other interpretive aids, the Court held (6-3) that the ACA's statutory scheme supported the federal government's position. The challengers' position, in contrast, "would destabilize the individual insurance market in any State with a Federal Exchange, and likely create the very 'death spirals' that Congress designed the Act to avoid." (Slip op. 15.) According to the Court, under the challengers' statutory interpretation, tax credits would become unavailable to the vast majority of persons who purchase health insurance on a federal exchange; all of those persons would become exempt, pushing individual state insurance markets into a death spiral in which only the sickest would purchase health insurance and insurers could not price policies to account for that fact. In sum, tax credits for insurance

purchased on federal exchanges "are necessary for the Federal Exchanges to function like their State Exchange counterparts, and to avoid the type of calamitous result that Congress plainly meant to avoid." (Slip op. 21.)

The Court did not reach questions about the challengers' Article III standing to sue that had arisen after the completion of briefing. And the Court declined to address the interpretive issues through the framework of Chevron deference to a related IRS regulation; because of the deep significance of the issues, the Court interpreted the statutes themselves, not the IRS's regulatory actions in response.

Hambrick v. Healthcare Partners Medical Group, Inc. (June 1, 2015, B251643) [2015 WL 3457257], ordered published June 26, 2015

Plaintiff Corey Hambrick brought a class action against various healthcare entities (collectively, HCP) that provided medical services to her HMO plan's subscribers. She alleged causes of action for common-law fraudulent concealment and for statutory violations of the unfair competition law (UCL) and false advertising law (FAL). Hambrick admitted that HCP was not a statutory "health care service plan" (see Health & Saf. Code, § 1345, subd. (f)(1)), but argued that HCP should nevertheless be treated as a health care service plan due to the level of risk it had assumed for the cost of medical care. On that basis, Hambrick alleged HCP was illegally operating without the license required by the Knox-Keene Health Care Service Plan Act of 1975 and without complying with various healthcare regulations applicable to health care service plans. HCP demurred to Hambrick's complaint arguing that the trial court should abstain because Hambrick could pursue administrative remedies. The trial court sustained the demurrer without leave to amend.

The Court of Appeal affirmed the abstention ruling as to Hambrick's UCL and FAL causes of action. The court explained that, even if it were to find that a medical group accepting "global risk" must have a license under the Knox-Keene Act as a health care service plan, neither that Act nor the Department of Managed Health Care (DMHC) regulations define what level of risk assumed by a medical group under a capitation agreement would cause it to be characterized as a health care service plan. "[D]etermin[ing] an acceptable risk level is a regulatory decision involving complex economic policy considerations that should be made by [the DMHC], the regulatory agency tasked with interpreting and enforcing the Knox-Keene Act." Moreover, abstention was appropriate because Hambrick had an adequate administrative remedy—asking DMHC to enforce the Knox-Keene Act licensing provisions against HCP.

Finally, as to Hambrick's common-law fraudulent concealment claim seeking damages, the Court of Appeal held that the trial court should not have abstained. But the Court of Appeal nonetheless concluded that the trial court properly dismissed that claim because Hambrick failed to establish that HCP owed any duty to disclose its financial arrangement with the health care service plan to the subscribers for whom it arranged medical services.

Lattimore v. Dickey (August 21, 2015, H040126) ___ Cal.App.4th ___ [2015 WL 4970057]

Yvonne Lattimore brought a wrongful death action against two doctors—James Dickey (a general surgeon) and John R. Carlson (a gastroenterologist)—and a hospital (the Salinas Valley Memorial Healthcare System) after her father suffered internal bleeding and died while in their care. Each doctor moved for summary judgment and submitted an expert declaration from a specialist in his field declaring that the doctor did not breach the standard of care; Dr. Dickey also argued that any breach did not cause the father's death. The hospital likewise moved for summary judgment relying on a declaration from an experienced nurse. Lattimore opposed summary judgment and produced a competing declaration from a Dr. Turner, who was board-certified in family and emergency medicine. The trial court found Dr. Turner incompetent to testify about the standards of care applicable to the doctor-defendants because he was not a specialist in their fields; the trial court also agreed with Dr. Dickey's expert that Lattimore could not establish causation. Finally, the trial court found that Lattimore had not shown any factual disputes concerning the conduct of the hospital's nurses. The trial court granted summary judgment to all defendants, and Lattimore appealed.

The Court of Appeal partially reversed. The Court of Appeal acknowledged that Lattimore's expert, Dr. Turner, lacked specific training and experience in gastroenterology or general surgery, but nevertheless held that his qualifications in

emergency medicine, "liberally construed, were sufficient to demonstrate skill and experience in treating patients who may be experiencing internal bleeding or are otherwise in need of immediate treatment." For this reason, the doctor-defendants were not entitled to summary judgment as to breach of the applicable standards of care. That was Dr. Carlson's only ground for summary judgment, so the Court of Appeal reversed as to the claims against him.

The Court of Appeal ultimately affirmed as to Dr. Dickey and the hospital, however, because they had raised additional grounds to sustain summary judgment. Dr. Dickey had contested Lattimore's evidence of causation, and Dr. Turner's declaration created no triable issue on causation because he could state only that timely intervention or surgery would have given the father "a chance of survival." The Court of Appeal also concluded that Dr. Turner lacked knowledge about the standards of care applicable to nurses and hospitals, and affirmed the judgment for the hospital because Lattimore had no other evidence supporting her claim that the hospital had been negligent.

Nosal-Tabor v. Sharp Chula Vista Medical Center (Aug. 3, 2015, D065843) [2015 WL 4608224], order published Aug. 27, 2015

Plaintiff Karen Nosal-Tabor, a registered nurse who had worked in the cardiology department at defendant Sharp Chula Vista Medical Center (Sharp), brought wrongful termination and retaliation claims against Sharp after it terminated her for refusing to perform "nurse-led" cardiac stress testing. Prior to her termination, Nosal-Tabor had complained to Sharp's management that its policy of allowing nurses to perform unsupervised cardiac stress tests constituted an illegal practice of medicine because Sharp had not created legally adequate standardized procedures to allow nurses to perform such testing. Properly adopted "standardized procedures" permit nurses to perform functions that would otherwise be an improper practice of medicine. (Bus. & Prof. Code, §§ 2051, 2725, 2726.) California regulations specify eleven mandatory components for standardized procedures pursuant to Guidelines adopted by the Board of Registered Nurses in conjunction with the Medical Board of California. (See Cal. Code Regs., tit. 16, §§ 1470, 1472, 1474.) The trial court granted Sharp's motion for summary judgment, ruling that Sharp had adequate "Standardized Procedures" for nurse-led cardiac stress testing in place before terminating Nosal-Tabor for refusing to perform that testing.

The Court of Appeal reversed. The court held that Sharp's written procedures for nurse-led cardiac stress testing failed to comply with the required Guidelines as a matter of law because they failed to include numerous components (including a method for the continuing evaluation of the competence of the nurses performing the procedure, a method of maintaining a written record of who is authorized to perform the procedure and a method of periodic review). The court further held that Nosal-Tabor had adequately identified a fundamental public policy on which to base her wrongful termination claim — the refusal to perform acts that were unlawful under the Business and Professions Code and the Guidelines. Finally, the court held that Nosal-Tabor's evidence adequately supported her claims that Sharp retaliated against her in violation of Labor Code section 1102.5, subdivision (c), and Health and Safety Code section 1278.5.

Sternberg v. California State Board of Pharmacy (Aug. 6, 2015, B255862), __Cal. Rptr. 3rd __ [2015 WL 5031230], order published Aug. 26, 2015

This disciplinary proceeding by the California Board of Pharmacy (the Board) stemmed from the theft by pharmacy technician, Imelda Hurtado, of several hundred thousand Norco tablets (a controlled substance containing narcotic hydrocodene) over a two-year period during which plaintiff Andrew Sternberg was the pharmacist-in-charge. Due to Sternberg's lax supervision, Hurtado was able to use the pharmacy's access code to place weekly orders for Norco from anywhere (including her home), and to sign for some of the deliveries illegally. She accepted the deliveries at the pharmacy, hid them in a storeroom, destroyed the packing invoices and then smuggled the Norco to her car. After Sternberg eventually discovered a Norco bottle in the storeroom, Hurtado was caught on a surveillance camera and arrested.

The Board filed an accusation against Sternberg alleging six causes for discipline. An administrative law judge (ALJ) issued a proposed decision finding Sternberg liable on five of the six charges and recommending public reproval. The Board disagreed with the ALJ's recommended rejection of one charge and found Steinberg liable on all six charges, including failing to maintain complete and accurate records of controlled substances and failing to

secure the pharmacy facilities or to provide effective controls to prevent drug theft. The Board imposed discipline by staying revocation Sternberg's pharmacy license pending three years of probation with conditions. The trial court denied Sternberg's petition for a writ of administrative mandate and Sternberg appealed.

The Court of Appeal affirmed, rejecting Sternberg's contention that California law (Bus. & Prof. Code, § 4081) required proof of guilty knowledge or intent (which he claimed did not exist because he was unaware of Hurtado's unlawful conduct and therefore incapable of adequately recording it). The Court of Appeal held that the statute has no knowledge requirement; to protect the public, the statute imposes strict liability that incentivizes pharmacists-in-charge to take "necessary precautions" to adequately supervise and maintain the inventory of controlled substances. The Court of Appeal also rejected Sternberg's sufficiency of the evidence arguments. Although the court agreed that the Board erred by suggesting Sternberg bore the burden of proving proper maintenance of the pharmacy facility and by faulting Sternberg for not using locked cabinets for controlled drugs (since Hurtado's scheme would have evaded any such physical security), evidence that Sternberg failed to restrict employees' access to ordering drugs supported the Board's finding that he had failed to properly maintain the pharmacy facilities and equipment. Additionally, the Court held that Sternberg's failure to perform random checks of delivery containers, review delivery invoices or participate in the inventory process supported the Board's determination that he had failed to properly oversee the operations of the pharmacy.

Marquez v. Department of Health Care Services (Sept. 2, 2015, A140488)___ Cal. App.4th ___ [2015 WL 5144975]

State and federal law requires Medi-Cal beneficiaries to utilize all health care benefits available through other health coverage (OHC) they may have before accessing Medi-Cal benefits. To implement this requirement, the Department of Health Care Services (DHCS) maintains a database with codes that indicate whether a Medi-Cal beneficiary has OHC that Medi-Cal providers may access when a beneficiary seeks services.

Petitioners, three Medi-Cal beneficiaries, sought a writ of mandate to compel DHCS to: (1) provide Medi-Cal beneficiaries with notice and an opportunity to be heard whenever DHCS assigns new or different OHC codes to a beneficiary; (2) provide medically necessary services that are not in fact available from an OHC; (3) ensure that beneficiaries are not charged a co-pay in excess of the federal limit; and (4) follow "pay-and-chase" procedures for certain beneficiaries (i.e., those seeking prenatal or pediatric preventative care or have medical support orders). Petitioners alleged that because DHCS permits Medi-Cal providers to refuse nonemergency services to beneficiaries with OHC, and because the OHC codes are not always correct, beneficiaries may (improperly) be denied immediate service and referred to OHC providers when, in reality, the service is not available from an OHC. The trial court declined to issue a writ, ruling that petitioners had failed to prove DHCS had violated a ministerial duty, and that the DHCS process for coding OHC does not result in any denial, termination, or reduction of services that would require notice and a hearing.

The Court of Appeal affirmed, holding that neither Welfare and Institutions Code section 10950, nor California Code of Regulations, title 22, section 50951, nor the California Constitution requires DHCS to provide a hearing or notice whenever it assigns a new or different OHC code. The court explained that a hearing is required only for actions resulting in a termination, suspension, or reduction of the beneficiary's Medi-Cal eligibility or covered services. OHC coding, in contrast, merely assigns a status that might, in the future, lead a private provider to delay the beneficiary's receipt of the service. The court concluded that "[c]oding events are therefore qualitatively distinct from a determination that a beneficiary is ineligible for a benefit program overall or a direct denial of a specific request for treatment . . . This distinguishing characteristic of OHC coding . . . ultimately compel[s] the conclusion that OHC coding does not affect a beneficiary's receipt of services so significantly as to require a state hearing." Moreover, the record failed to support petitioner's claim that delays caused by coding errors were a significant problem that needed to be redressed, especially by a burdensome notice and hearing requirement that would provide only marginal, if any, benefit to the petitioners. Finally, the court held petitioners failed to demonstrate that DHCS had violated its ministerial duty to pay for services as required by state and federal law.