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Substantive Sub-Areas

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A. **Surgical and Anesthesia Errors**

Surgical and anesthesia errors are paradigmatic medical-malpractice claims and frequently the most evidentiarily challenging. Liability theories include wrong-site or wrong-patient surgery, retained foreign objects, anesthesia overdose or hypoxic injury, nerve injury from improper positioning, and failure to obtain informed consent. The doctrine of *res ipsa loquitur*, recognized in California medical-malpractice cases since *Ybarra v. Spangard* (1944) 25 Cal.2d 486, can shift the burden of producing evidence to multiple defendants where the plaintiff was unconscious during the negligent event and the injury is of the type that ordinarily does not occur absent negligence. *Ybarra* itself involved a shoulder injury sustained during an appendectomy while the patient was anesthetized; the Supreme Court permitted the inference of negligence to be drawn against all defendants who had control over the plaintiff's body, even though the plaintiff could not identify which defendant caused the injury.

California also requires hospitals to report serious "adverse events" — including surgical retention of foreign objects, wrong-site surgeries, and patient deaths from medication error — to the Department of Public Health under Cal. Health & Safety Code § 1279.1. These reports are an underutilized investigative tool for plaintiffs' counsel and can establish pattern evidence that supports both standard-of-care expert opinions and EADACPA reckless-neglect theories.

B. **Misdiagnosis and Delayed Diagnosis**

Misdiagnosis and delayed-diagnosis cases — particularly cancer, cardiac event, stroke, and infection cases — present distinctive causation challenges. The plaintiff must establish not only that the standard of care required earlier or different diagnosis but also that the delayed diagnosis

caused a worse outcome.

California **rejects** the loss-of-chance doctrine. In *Bromme v. Pavitt* (1992) 5 Cal.App.4th 1487, the Court of Appeal squarely held that, in a wrongful-death action, the plaintiff must prove that earlier diagnosis would have, more likely than not, prevented the death. A showing that earlier diagnosis would have given the patient a "better chance" — for example, a 30% rather than 15% chance of survival — is insufficient as a matter of law. *Bromme* makes California one of the more restrictive jurisdictions on this issue; many other states recognize the loss-of-chance doctrine as an independent theory or as a damages-allocation rule.

Plaintiff's counsel must therefore obtain expert testimony establishing that earlier diagnosis would have produced a probability of better outcome exceeding 50%. Where the underlying disease has a poor prognosis even with timely diagnosis, *Bromme* may be fatal to the wrongful-death theory and may push counsel toward a survival action focused on conscious pain and suffering during the period of delay.

C. Birth Injuries and Obstetric Negligence

Obstetric negligence presents a constellation of distinctive doctrinal and evidentiary issues. Causation in hypoxic-ischemic encephalopathy (HIE) and cerebral-palsy cases requires sophisticated expert review of fetal heart-rate tracings, umbilical-cord blood gases, neonatal MRI imaging, and Apgar scores. The standard of care in shoulder-dystocia cases turns on the application of standardized maneuvers (HELPERR, McRoberts) and the documentation of the timeline.

The minor-injury limitations rules in § 340.5 are particularly consequential here. A child injured at birth has, at most, until the eighth birthday to bring suit (where the injury occurred before the sixth birthday), and the limitations period is not tolled by minority. Counsel handling birth-injury claims should therefore commence record review and expert evaluation immediately upon retention, regardless of the child's age, because expert availability and record completeness deteriorate over time.

D. Hospital and Nursing-Home Negligence (and the EADACPA Distinction)

California's Elder Abuse and Dependent Adult Civil Protection Act (EADACPA), Cal. Welf. & Inst. Code § 15600 et seq., provides an independent and substantially more powerful cause of action against custodial healthcare facilities — typically nursing homes, residential care facilities, and skilled-nursing units — that engage in **neglect, abuse, or fiduciary abuse** of elders (65 and older) or dependent adults. EADACPA is not merely a relabeled negligence claim: it is a separate statutory scheme, the application of which has been the subject of a substantial body of California Supreme Court authority.

In *Delaney v. Baker* (1999) 20 Cal.4th 23, the Supreme Court held that EADACPA's enhanced remedies, codified in Cal. Welf. & Inst. Code § 15657, are available where the plaintiff establishes by clear and convincing evidence that the defendant engaged in **recklessness, oppression, fraud, or malice** in the commission of neglect. *Delaney* held that "neglect" under EADACPA refers to

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the failure of those responsible for attending to the basic needs and comforts of an elderly or dependent adult, not the negligent provision of medical services as such. The statute thus targets the custodial relationship rather than the professional-medical relationship.

In *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, the Supreme Court reinforced the *Delaney* line, holding that the heightened pleading requirements of Cal. Code Civ. Proc. § 425.13 — which requires court permission to plead punitive damages against a healthcare provider — do not apply to EADACPA claims because such claims sound in elder-abuse rather than in professional negligence.

The practical significance is enormous. A successful EADACPA claim entitles the plaintiff to:

- **Reasonable attorney's fees and costs** under § 15657(a) — a fee-shifting provision that fundamentally changes the economics of nursing-home litigation;
- **Pre-death pain and suffering** under § 15657(b) — overriding the general California rule that survival actions cannot recover the decedent's pre-death non-economic losses;
- **No MICRA cap** — because EADACPA recklessness damages are not "professional negligence" damages within the meaning of § 3333.2.

The doctrinal line is not always crisp. A nursing-home pressure-ulcer case may sound in EADACPA where the gravamen is the systematic failure to reposition, hydrate, and feed a vulnerable resident; the same case framed as a deviation from a written wound-care protocol may sound in professional negligence. *Delaney* and its progeny require heightened pleading specificity: the plaintiff must allege facts establishing recklessness, not merely negligence, and must identify the conduct of identifiable defendants — typically through a combination of medical records, staffing logs, and citation history from the Department of Public Health.

The doctrine of *res ipsa loquitur* recognized in *Ybarra v. Spangard* (1944) 25 Cal.2d 486 retains particular force in nursing-home cases involving unwitnessed falls, pressure ulcers, and medication errors, because the resident is often unable to testify and the facility controls the only contemporaneous documentation. *Landeros v. Flood* (1976) 17 Cal.3d 399, while arising in the pediatric battered-child context, established a parallel principle that healthcare providers can be liable for failure to recognize and respond to a recognizable pattern of injury — a principle increasingly applied in elder-abuse cases involving recurrent falls or unexplained bruising.

Practice	Medical Malpractice
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