GRAND PARK LAW GROUP
A PROFESSIONAL CORPORATION

WESTSIDE TOWERS
11835 W. Olympic Boulevard #870E
Los Angeles, California 90064

O:+1 888.629.4754
F: +1 310.900.0805

PRACTICE BRIEF · MEDICAL MALPRACTICE

Recent Developments in California Medical Malpractice Law (2024-2025)

Grand Park Law Group · January 2025 · 10 min read



The 2024-2025 period marked a transformative chapter in California medical malpractice law. The convergence of legislative reform, post-pandemic institutional pressures, and evolving healthcare delivery models produced a litigation environment that departed significantly from the relatively stable framework practitioners had navigated for decades. This article examines five developments that reshaped case strategy, liability exposure, and the substantive standards governing medical negligence claims in California.

> *"California's medical malpractice framework is undergoing its most significant structural evolution since MICRA's enactment in 1975. Practitioners on both sides must reassess long-held assumptions about case valuation, liability theories, and evidentiary strategy."*

January 2023 – 2025

AB 35 First Cap Increases Take Effect

The first phased increases under Assembly Bill 35 set the MICRA non-economic damages cap at $350,000 for non-death cases and $500,000 for wrongful death cases beginning January 1, 2023, with annual increases of $40,000 and $50,000 respectively. This represented the first adjustment to the cap since MICRA's enactment in 1975, when the original $250,000 ceiling was imposed under Civil Code section 3333.2. For nearly half a century, that cap had remained fixed while inflation eroded its real value to a fraction of its original purchasing power.

The new cap structure immediately affected case valuations and settlement negotiations, particularly in high-value catastrophic injury cases where non-economic damages historically constituted the most significant component of plaintiff recovery. Defense counsel began adjusting reserve calculations and settlement authority to reflect the annual escalator, recognizing that delay no longer favored defendants in the same way it had under the static cap regime. Insurers recalibrated actuarial models to account for predictable year-over-year increases in exposure.

For plaintiffs' counsel, the phased schedule introduced a genuine strategic dimension to case timing. Cases with strong liability positions and substantial non-economic exposure warranted careful consideration of whether to pursue earlier resolution at a lower cap or invest in additional preparation to reach trial in a higher-cap year. The interaction between the escalating caps and MICRA's unchanged attorney fee schedule also required recalculation of net recovery projections for client counseling purposes.

2024 – 2025

Nursing Shortage and Standard of Care Litigation

California's post-pandemic nursing shortage created significant litigation around the standard of care in understaffed facilities. Hospitals and skilled nursing facilities across the state operated with vacancy rates that, in many cases, fell below the staffing levels required to provide safe patient care. Plaintiffs argued that institutions that operated below safe staffing ratios bore direct institutional liability for patient injuries attributable to inadequate nurse-to-patient ratios, rather than limiting malpractice theories to the conduct of individual clinicians.

California's nurse staffing ratios under Title 22, California Code of Regulations sections 70217 and 72329 became central evidence in these cases. These regulations establish minimum nurse-to-patient ratios for various hospital units and skilled nursing facility settings. Plaintiffs relied on documented staffing data to demonstrate that facilities systematically operated below regulatory minimums, while defense counsel contended that regulatory compliance represented a floor rather than a definitive standard of care and that staffing decisions involved resource allocation judgments entitled to deference.

The tension between regulatory minimum staffing and the standard of care required under tort law generated competing expert opinions that proved difficult for juries to reconcile. Plaintiffs' experts testified that staffing below regulatory ratios created foreseeable risks of medication errors, delayed response to patient deterioration, and inadequate monitoring. Defense experts countered that staffing ratios were blunt administrative tools that did not account for patient acuity, skill mix, or technological supports. This area of litigation is expected to intensify as workforce shortages persist across California's healthcare system.

2024 – 2025

| Beverly Hills • San Francisco • San Diego • Chicago |
| Main: (888) 629-GPLG (4754) • Fax: (310) 900-0805 • www.GrandParkLawGroup.com |

Informed Consent in Elective Procedures

A wave of litigation emerged around informed consent failures in elective cosmetic and bariatric procedures, driven in part by the rapid expansion of outpatient surgical centers offering these services. Courts examined whether surgeons adequately disclosed material risks specific to the patient's individual health profile, rather than merely presenting generic risks listed in standardized consent forms. The distinction between personalized and boilerplate disclosure became the central issue in numerous cases where patients with significant comorbidities experienced complications that were foreseeable given their medical histories.

The *Cobbs v. Grant* (1972) 8 Cal.3d 229 framework was applied with renewed vigor in this context. Courts scrutinized whether the reasonable-patient standard required personalized risk disclosure for patients with conditions such as diabetes, obesity, or cardiovascular disease that materially altered the risk profile of elective procedures. Several trial courts found that surgeons who used identical consent forms for all patients, regardless of individual risk factors, failed to satisfy the disclosure obligation articulated in *Cobbs*. The reasonable-patient standard, these courts reasoned, necessarily incorporated the patient's known health circumstances into the materiality analysis.

Medical tourism and cross-border procedure complications added jurisdictional complexity to this litigation trend. Patients who underwent initial procedures in Mexico or other countries and sought follow-up care or corrective surgery in California presented novel questions about the scope of California practitioners' duty to disclose risks associated with revision procedures, as well as the evidentiary challenges of establishing the original standard of care applied abroad. These cases tested the boundaries of California's informed consent doctrine in an increasingly globalized healthcare marketplace.

2024 – 2025

Hospital Consolidation and Corporate Practice of Medicine

California's wave of hospital mergers and acquisitions raised questions about the corporate practice of medicine doctrine and its intersection with tort liability. When private equity firms acquired physician practices or hospital systems, plaintiffs pursued theories of direct corporate liability, arguing that cost-cutting directives from non-physician owners created unsafe conditions that contributed to patient injuries. These cases moved beyond traditional respondeat superior analysis to assert that corporate defendants bore independent liability for institutional decisions that compromised clinical care.

The Business and Professions Code section 2400 prohibition on the corporate practice of medicine intersected with these tort liability theories in significant ways. Plaintiffs contended that corporate entities that exercised de facto control over clinical decision-making through productivity quotas, staffing reductions, and resource limitations effectively practiced medicine in violation of section 2400, and that this unlawful conduct should give rise to tort liability. Courts examined

| Beverly Hills • San Francisco • San Diego • Chicago |
| Main: (888) 629-GPLG (4754) • Fax: (310) 900-0805 • www.GrandParkLawGroup.com |

whether corporate defendants could be held directly liable for setting productivity quotas that pressured physicians to see more patients per hour, reduce procedure times, or limit diagnostic testing.

The consolidation trend also raised questions about the erosion of physician autonomy and its consequences for patient safety. Expert testimony in several cases documented how corporate ownership structures created financial incentives that conflicted with clinical judgment, including pressure to discharge patients prematurely, defer referrals to specialists, and substitute less experienced providers for complex cases. As private equity investment in California healthcare continues to accelerate, this intersection of corporate governance and medical liability is likely to generate an expanding body of case law.

2024

AB 1544 Patient Safety Reporting

Assembly Bill 1544 enhanced patient safety reporting requirements for California hospitals, expanding the categories of adverse events that must be reported to the California Department of Public Health (CDPH) and shortening reporting timelines. The legislation responded to concerns that the existing reporting framework, which had not been substantially updated in over a decade, failed to capture significant categories of preventable patient harm and permitted delays that undermined the public health purpose of mandatory reporting.

For malpractice practitioners, the significance of AB 1544 lay primarily in the discoverability of these reports and whether CDPH investigation records could be used as evidence in civil litigation. The expanded reporting requirements generated a substantially larger universe of documented adverse events, creating a richer evidentiary record that plaintiffs' counsel could potentially access through discovery. However, Evidence Code section 1157, which establishes the peer review privilege for proceedings of medical staff committees, remained a contested barrier to the use of internal quality review materials related to reported events.

The interaction between AB 1544's reporting mandates and section 1157's privilege protections created a complex evidentiary landscape. Hospitals argued that internal investigations triggered by reportable events fell within the peer review privilege, shielding root-cause analyses and corrective action plans from discovery. Plaintiffs countered that the reports submitted to CDPH were not peer review materials but regulatory compliance documents outside the scope of section 1157. The resolution of these competing positions varied across trial courts, and appellate guidance on the precise boundaries of the privilege in the context of mandatory safety reporting remained limited through the end of 2025.

KEY TAKEAWAYS FOR PRACTITIONERS

- AB 35's phased cap increases require recalculation of case valuations annually; the applicable cap depends on the year of judgment, making trial timing a strategic variable under Civil Code section 3333.2
- Nursing shortage litigation has elevated institutional staffing decisions from an operational concern to a direct liability theory, with Title 22 staffing ratios serving as persuasive evidence of the standard of care
- Informed consent claims in elective procedures now demand individualized risk disclosure under *Cobbs v. Grant*; standardized consent forms alone are insufficient for patients with material comorbidities
- Corporate practice of medicine theories under Business and Professions Code section 2400 provide a pathway to direct liability against non-physician corporate owners who influence clinical decision-making
- AB 1544's expanded adverse event reporting creates new discovery opportunities, though Evidence Code section 1157 peer review privilege remains a significant obstacle to admission of related internal investigation records

The developments surveyed in this article reflect a California medical malpractice landscape in transition. The convergence of legislative reform, workforce pressures, evolving delivery models, and enhanced regulatory oversight has expanded the theories available to injured patients while simultaneously presenting new complexities for both sides of the litigation.

Practitioners who understand these developments and their interrelationships will be better positioned to evaluate claims, develop case strategy, and advise clients in this evolving environment. As AB 35's cap schedule continues its upward trajectory and the healthcare industry navigates ongoing structural changes, the 2024-2025 developments outlined here will serve as the foundation for an increasingly dynamic area of California tort law.

Practice	Medical Malpractice
Topics	AB 35 · Standard of Care · Informed Consent
Publication	Recent Developments · 2024-2025

Available online at grandparklawgroup.com/practices/medical-malpractice/insights/articles/recent-developments-2024-2025. This publication is provided for general information and is not legal advice.
© 2026 Grand Park Law Group, A.P.C. Attorney Advertising.