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PRACTICE BRIEF · MEDICAL MALPRACTICE

Recent Developments in California Medical Malpractice Law (2025–2026)

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California medical malpractice law is in a period of structural transition. The legislative overhaul of MICRA's damages cap, the tactical ascendancy of elder abuse causes of action in nursing facility cases, emerging liability frameworks for AI-assisted clinical decision-making, refined expert methodologies in birth injury litigation, and unresolved jurisdictional questions raised by telehealth expansion together define the current practice landscape.

Each of these developments carries distinct implications for case evaluation, litigation strategy, and client counseling. This article surveys five areas that practitioners should be tracking in 2025 and 2026, with analysis of the statutory framework, leading case authority, and practical considerations that inform how these issues arise in active litigation.

2026 **AB 35: Phased MICRA Cap Now at $400,000 / $600,000**

As of 2026, the phased schedule established by AB 35 sets the non-economic damages cap at $400,000 for injury cases and $600,000 for wrongful death cases under Civil Code section 3333.2. The caps increase by $40,000 and $50,000 respectively each year through 2033, at which point both figures adjust annually for inflation at a fixed 2% rate. This trajectory has immediate consequences for settlement negotiations: in complex cases with lengthy discovery timelines, both plaintiff and defense counsel must model the cap that will be in effect at the time of trial, not the cap at the time of filing. A case filed in 2026 that does not reach trial until 2028 will be subject to a $450,000 injury cap and a $700,000 wrongful death cap. This forward-looking dynamic gives plaintiffs strategic leverage to pursue thorough case development rather than accepting early, lower-cap valuations, and it requires defense carriers to reserve against a moving target.

2025–2026 **Elder Abuse Claims Expanding in Skilled-Nursing Context**

The strategic value of claims under the Elder Abuse and Dependent Adult Civil Protection Act (EADACPA) over traditional MICRA-capped malpractice claims in skilled-nursing facility cases continues to grow. Post-pandemic understaffing, pressure-wound epidemics, and well-documented care failures in California skilled-nursing facilities have provided strong factual foundations for the recklessness showing required by *Delaney v. Baker* (1999) 20 Cal.4th 23. Where custodial neglect can be established — particularly through staffing records, incident reports, and regulatory citations — EADACPA claims avoid MICRA's non-economic damages cap entirely and permit recovery of attorney fees. Practitioners increasingly lead with elder abuse rather than malpractice in these cases, structuring discovery from the outset around the facility's corporate knowledge of understaffing and its conscious disregard of the resulting risks to resident safety. The distinction between professional negligence and custodial neglect remains the critical pleading boundary, and defendants will aggressively seek reclassification through demurrers and motions for summary adjudication.

2025–2026 **AI Diagnostic Tools and Emerging Malpractice Questions**

AI-assisted diagnostic tools — including radiology image analysis, dermatology screening algorithms, and pathology review systems — are now in active clinical use at California hospitals and outpatient clinics. The malpractice questions these tools generate are novel and largely untested in California courts. Three theories are emerging: first, whether a physician's over-reliance on AI output without independent clinical review constitutes a breach of the standard of care, particularly where the AI recommendation conflicts with clinical signs the physician should have independently assessed; second, whether a hospital's institutional decision to deploy an AI tool with known accuracy limitations creates a basis for direct hospital liability under corporate negligence principles; and third, whether the AI developer itself is subject to products liability as the manufacturer of a defective medical device. The FDA's evolving regulatory framework for Software as a Medical Device (SaMD) will likely inform the standard-of-care analysis, but California courts have not yet addressed how FDA clearance of an AI diagnostic tool affects the negligence inquiry. Practitioners handling cases involving AI-assisted diagnoses should retain both clinical experts and technical experts who can evaluate the algorithm's training data, validation methodology, and known failure modes.

2025–2026 **Birth Injury Litigation: Evolving Expert Standards**

California birth injury cases involving hypoxic-ischemic encephalopathy (HIE) and shoulder dystocia are seeing increased scrutiny of fetal monitoring interpretation and the timing of intervention decisions. Plaintiffs are deploying cardiotocograph (CTG) expert analysis with greater precision, using electronic fetal monitoring strips to establish the exact moment at which the standard of care required operative intervention — whether by vacuum extraction, forceps delivery, or emergency cesarean section. This approach narrows the window of physician decision-making that defense counsel typically relies on to argue that the injury was an unavoidable complication rather than a preventable one. Defense experts, in turn, are increasingly challenged on whether their interpretation of fetal heart rate tracings conforms to the National Institute of Child Health and Human Development (NICHD) three-tier classification system. Courts are also seeing more

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refined neonatal neurology testimony linking the timing of brain injury to specific patterns of fetal distress, which strengthens causation arguments that were historically difficult to establish with the certainty California requires.

2025–2026 **Telehealth Malpractice Jurisdiction Issues**

The post-COVID expansion of telehealth practice has raised unresolved questions about malpractice jurisdiction that affect both plaintiffs and defendants. When a California-licensed physician treats a patient located in another state via telehealth, which state's standard of care applies, and where may the patient bring a malpractice action? California's Business and Professions Code sections 2290.5 through 2290.6 govern telehealth practice within the state but leave significant gaps regarding interstate encounters. The Interstate Medical Licensure Compact, which California has not joined, provides a partial framework in other states but does not resolve choice-of-law questions for the standard of care itself. For California practitioners, the jurisdictional exposure is bidirectional: a California physician may face suit in the patient's home state under that state's malpractice framework, and a patient treated by an out-of-state physician via telehealth may need to pursue claims in the physician's licensing state rather than in California. These ambiguities create practical challenges in case evaluation, particularly where the applicable damages cap, statute of limitations, or expert qualification requirements differ between the two states involved.

KEY TAKEAWAYS FOR PRACTITIONERS

- The 2026 MICRA caps ($400,000 injury / $600,000 death) require updated case valuations; settlement models should account for future cap increases through 2033 if trial is likely delayed
- Elder abuse claims in skilled-nursing cases avoid MICRA caps entirely when custodial neglect and recklessness are properly pled; discovery should target staffing records and regulatory history from the outset
- AI diagnostic malpractice cases require dual retention of clinical and technical experts; the liability theory determines whether the physician, the hospital, or the AI developer is the primary defendant
- Birth injury plaintiffs should lead with NICHD-compliant CTG analysis to pin the intervention timeline; defense experts who deviate from the three-tier classification system are vulnerable to challenge
- Telehealth cases crossing state lines demand early jurisdictional analysis, including choice-of-law for the standard of care, applicable damages limitations, and statutes of limitation in both states

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California's medical malpractice landscape in 2025 and 2026 reflects both legislative reform and the practical consequences of technological and structural changes in healthcare delivery. The common thread across these five developments is that familiar doctrinal categories — negligence, causation, damages, jurisdiction — are being tested by new facts on the ground.

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Practitioners who track these developments and adapt their case evaluation, discovery strategy, and expert retention accordingly will be better positioned to serve their clients in a legal environment that is changing faster than at any point since MICRA's original enactment in 1975.

Practice	Medical Malpractice
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