HEALTHCARE ARTICLES 2015

WHAT STEPS ARE HELPFUL IN DEALING WITH ELECTRONIC MEDICAL AND HEALTH RECORD SYSTEMS?

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Attorney, Kramer, deBoer & Keane, LLP

Today's health care providers are increasingly using electronic medical record ("EMR") systems, also known as electronic health record ("EHR") systems, which provide benefits for the patient such as wider accessibility to health care providers within a facility, as well as potentially greater ease in distributing records to other healthcare facilities as needed. They represent a very real benefit over manually created records, since typically EMRs and EHRs are uniformly legible and do not feature handwriting that may be difficult to read. With EMRs and EHRs, a healthcare practitioner does not need to wait for a physical file to be retrieved, transported, and delivered from a separate storage area. Errors in adding or keeping records within the patient's file and misplaced charts are reduced. Electronic notification of lab results and efficient transfer of information from referring doctors to consultants are additional potential benefits.

For the EMR/EHR user, the ability to quickly call up historic lab measurements or to create a customized graph of significant data are facets that can help to improve patient care. In addition, electronic medical record systems may provide notifications to the practitioner regarding patient allergies or prompts to effectively interview the patient regarding the medical issues presented. Because there is a wide array of potential benefits to EMRs and EHRs, the federal government provides monetary incentives to adopt them through Meaningful Use programs.

The 2009 Health Information Technology for Economic and Clinical Health ("HITECH") Act introduced incentives to promote "meaningful use" of certified EHRs. These incentives are significant, as a physician or other eligible health care provider can obtain a maximum of $44,000 either through the Medicare Meaningful Use Program or alternatively up to $63,750 under the parallel Medicaid program. Effective this year, Medicare will begin to impose a financial penalty to those providers who do not show "meaningful use" of a certified electronic medical record system by imposing a reduction in their Medicare reimbursement rates below 100% of the normal fee schedule.

Given this background, a majority of healthcare professionals are already and will increasingly use electronic medical record systems. A 2013 survey by the Centers for Disease Control and Prevention found that 78% of direct care physicians already used some form of electronic medical record system versus only 18% in 2001[1]. As of 2013, 48% of office-based physicians used a basic system, and fully 69% of office-based physicians stated they had already applied or planned to apply for "Meaningful Use" financial incentives. Similarly, as of 2013 nearly six of 10 non-federal acute care hospitals had adopted at least a basic electronic medical record system, five times more than in 2008[2].

In light of the dramatic increase in electronic medical record use, healthcare providers can take steps that may be helpful in the event of claims or litigation related to alleged medical malpractice. We recommend our clients take into account several aspects of their practices with respect to EMRs and EHRs. First, we often request that our clients meet with us at a computer workstation where they have full access to and can

[1] http://www.cdc.gov/nchs/data/databriefs/db143.htm
[2] https://www.healthit.gov/sites/default/files/oncdatabrief16.pdf

walk us through the patient's chart in question, if it remains accessible. Due to the complexity of electronic medical record systems, it is often important to have the opportunity when defending a medical practitioner to see first-hand the visual presentation of the system used. The system may present differently to the user on the computer screen when compared to the printouts generated and available for hard copy review. It may not be possible to understand exactly what portions of the record our client has access to unless we are able to participate in such a walk-through. It may be important to know when the screen views differ from a physician's view versus other practitioners such as a registered nurse or a respiratory therapist, and it is often useful to know how the practitioner interacts with the system to have a full understanding of the context of the case.

Because the pull-down menu options often do not show in the print-outs, it is helpful when clients provide a copy of the patient's electronic chart to also provide documentation of the menu choices that were available but were not selected. Any measures to make sure that the printouts provided to the patient under their authorization match the printouts generated in response to defense counsel's request or another party's subpoena help to demonstrate that all necessary records have been provided. Because there may be multiple parameters to apply when printing out the patient's chart, a consistent approach that is uniformly applied will be advantageous.

With respect to locking electronic records following a particular event such as a hospitalization, it is helpful when the healthcare facility can provide information on when the locking trigger occurs, as well as the procedure for making an addendum to the chart or documenting the reason for a late entry. Finally, if a client does upgrade or implement a new electronic medical record system, it is beneficial to ensure that the new system or upgrade is compatible with the prior system, in order to facilitate consistent records that provide a complete, accessible picture of the patient's care and treatment.

AND THE HITS KEEP ROLLING IN: LIMITING THE AMOUNT OF RECOVERABLE MEDICAL SPECIALS IN A POST-*HOWELL* WORLD

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Attorney, Kramer, deBoer & Keane, LLP

In 2011, the Supreme Court of California provided a huge blow to plaintiffs in personal injury actions with the *Howell* decision.[3] California appellate courts continue to follow and extend the purpose behind the *Howell* decision.

Howell v. Hamilton Meats & Provisions, Inc. (2011)

In *Howell*, the Supreme Court established that "a plaintiff may recover as economic damages no more than the reasonable value of the medical services received, and is not entitled to recover the reasonable value if his or her actual loss was less." *Howell* also stated that the full amount billed by medical providers is not an accurate measure of the value of medical services.[4] *Howell* stated that "a medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value." (*Id.* at 564.) "The rule that medical expenses, to be recoverable, must be both incurred and reasonable applies equally to those with and without medical insurance."[5]

Luttrell v. Island Pacific Supermarkets, Inc. (2013)

In Luttrel,[6] Plaintiff was billed $690,548.93 for medical services which were provided subsequent to personal injuries he suffered on Defendant's property. However, he was insured by both Medicare and Medi-Cal, who in turn paid $138,082.25 on a lien basis for complete satisfaction of his incurred medical debts. At trial, Plaintiff was allowed to present the full billed amount of his medical care but, in granting a post-verdict defense motion, the amount was lowered to the actual paid amount pursuant to *Howell*. On appeal, the Court of Appeal stated that, as a general rule, a plaintiff in a tort action is not to be placed in a better position than he would have been if the wrong had not been done.[7]

Plaintiff presented arguments to the Court of Appeal that if he was only allowed to recover the actual amount paid for his medical services, he would be left with essentially no recovery because the recovered sum would go to Medicare and Medi-Cal. The Court was unpersuaded and declared that Plaintiff "receives enough to pay off the lien and ends up financially whole for his past medical expenses." In expanding the reach of *Howell*, the *Luttrell* Court held that the amount of billed, but unpaid, medical expenses is not admissible. "The point of the *Howell-Hanif* line of cases is that the tortfeasor should be held to pay the full cost of its negligence or wrongdoing -- no more and no less. This can be accomplished if the maximum

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[3] *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541 (2011).
[4] *Id.* at 562.
[5] *Id*. at 559.
[6] *Luttrell v. Island Pacific Supermarkets, Inc.* 215 Cal.App.4th 196 (2011).
[7] Citing *Valdez v. Taylor Automobile Co.*, 129 Cal.App.2d 810, 821-822 (1954).

potential recovery is first ascertained by reference to the amounts actually paid for medical expenses and then reducing it by the percentage attributable to the plaintiff's contribution to that expense."

Corenbaum v. Lampkin (2013)

In *Corenbaum*,[8] the Court of Appeal concluded that, "evidence of the full amounts billed for Plaintiffs' medical care was not relevant to the amount of damages for past medical services, damages for their future medical care or non-economic damages." The Court also explained that the admission of the full billed amount at the time of trial is prejudicial error. Moreover, the Court held that evidence of the full billed amount may not be relied upon by experts in providing opinions regarding cost or necessity of future medical care.

Comments and Conclusion

This line of cases supports the longstanding purpose of compensatory damages, i.e., a plaintiff should be made whole, but not placed in a better position than that which she was in prior to the incident. By virtue of the *Howell* decision and its progeny, it appears that California courts have begun to recognize that awards for economic damages, specifically awards for past and future medical expenses, were going above and beyond the principle of compensation. As an example, prior to the *Howell* line of cases, plaintiffs could offer a medical bill into evidence that states a charge of $30 for an aspirin tab that actually cost a nickel.

In order to circumvent the law of *Howell, Luttrell,* and *Corenbaum*, plaintiffs' attorneys argue that these decisions should not limit their ability to present evidence at the time of trial. Specifically, they argue that evidence of the full billed amount for medical services is admissible to demonstrate the extent of physical injuries, general damages, and future medical expenses. Plaintiffs' attorneys also argue that the full billed amount should be admissible because insurance contractual write-offs are essentially collateral source benefits, which should not reduce a plaintiff's recovery. These ploys directly contradict the law, but may be successful where defense attorneys are not primed on these issues or on how the law applies to the facts of a particular case. Accordingly, it is imperative to remain current on the status of the law and conduct individual research on these issues as they may apply to your case.

[8] *Corenbaum v. Lampkin*, 215 Cal.App.4th 1308 (2013).

A HOSPITAL'S STATORY LIEN RIGHTS ON PATIENTS' THIRD-PARTY RECOVERIES ARE NOT ABSOLUTE

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Attorney, Kramer, deBoer & Keane, LLP

In many personal injury situations, an injured party seeks emergency and ongoing care from a hospital. Pursuant to the Hospital Lien Act ("HLA"),[9] a hospital has a statutory right to assert a lien against any recovery that the injured party obtains against a third party tortfeasor. This statutory right is subject to a number of limitations and conditions.

The California Court of Appeal explained: "the purpose of the HLA is to secure part of the patient's recovery from liable third persons to pay his or her hospital bill, while ensuring that the patient retain[s] sufficient funds to address other losses resulting from the tortious injury." [10]

Additionally, the HLA is consistent with the intent of the California Legislature to keep down the costs of insurance. The HLA acts to reduce insurance premiums because it grants hospitals a mechanism for collecting on medical bills without having to incur the expense of initiating litigation or instituting other costly attempts to collect on the medical bill. These costs, at least in part, would otherwise be passed on to patients and insurance companies.

Hospital liens are created by effectuating proper notice, i.e. personal delivery or registered mailing of proper notice.[11] The lien notice must contain: "the name and address of the injured person, the date of the accident, the name and location of the hospital, the amount claimed as reasonable and necessary charges, and the name of each person, firm or corporation known to the hospital and alleged to be liable to the injured person for the injuries."[12]

At first, a hospital lien is not effective unless notice of the lien is given to the injured party *and the alleged tortfeasor and its insurance company*. However, when the effect of the HLA is taken into consideration, the purpose of the notice requirements becomes clearer.

Any tortfeasor or insurance carrier making payment directly to a plaintiff after receiving notice of a hospital lien without first paying the lienholder the amount due pursuant to the HLA, "shall be liable to the [lienholder] for the amount" owed pursuant to the HLA.[13] Accordingly, failure to pay the lienholder appropriately could result in the tortfeasor or its insurance company having to pay both the lienholder and the previously paid injured party.

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[9] Code of Civil Procedure Sections 3045.1-3045.6.
[10] *County of San Bernardino v. Calderon*, 148 Cal.App.4th 1103 (2007).
[11] *Weston v. American Insurance Group*, 174 Cal.App.4th 940 (2009).
[12] Civil Code Section 3045.3.
[13] Civil Code Section 3045.4; *Mercy Hospital v. Farmers Insurance*, 15 Cal.4th 213, 221 (1997).

Hospital liens are not to be reduced to reflect a hospital's share of attorneys' fees.[14] (Thus, mechanically, attorneys' fees for their services are taken from the entire sum of a settlement or judgment, the hospital's share is calculated, and the remaining funds are property of the plaintiff. An attorney lien has priority over a hospital's lien. This rule applies even if the hospital provides notice of the lien to the appropriate parties prior to the creation of the attorneys' lien, i.e. prior to the injured party retaining an attorney. The rationale behind the rules pertaining to attorneys' fees is one that has consistently been applied across many fields of law. Without the attorney's efforts, there may be no judgment or settlement and the medical lien would be worthless.[15]

Does a hospital's recovery under the HLA extinguish the debt owed by the plaintiff to the hospital? In other words, if a hospital obtains funds from a settlement or judgment under the HLA, is acceptance of those funds considered payment in full?

No. Recovery under the HLA does not reduce the patient's contractual liability for the full debt owed to the hospital or its assignee. The hospital can still take other measures to collect on the plaintiff's debt.

Recovery under the HLA, which is limited to 50% of a plaintiff's recovery from a third party tortfeasor, is not exclusive; the hospital may take action against the injured person for payment of any balance which is not paid by the responsible parties under the HLA.[16]

Therefore, a lienholder's recovery under the HLA does not reduce the patient's contractual liability for the full value of the medical services that the hospital provided to the injured party. The HLA simply creates a statutory lien for 50% of a plaintiff's recovery after attorneys' fees/costs are taken out – it does not extinguish the remainder of the debt or effectuate a "payment in full" scenario.

"Within one year after the date of the payment to the [plaintiff]" by a tortfeasor or its insurance company, the hospital may enforce its lien by filing an action against the tortfeasor or its insurance company if the notice requirements have previously been satisfied.[17]

According to the language of Civil Code Section 3045.4, the tortfeasor and its insurance company are liable to the hospital if a properly created hospital lien is not properly paid after settlement or judgment. What happens when a hospital, that ordinarily would have the right to assert a hospital lien, is named as a defendant in the action? Does the defendant hospital maintain its right to assert the lien against the plaintiff's recovery? Who is liable on the lien? Is a hospital entitled to act in the capacity as a both a lienholder and the party responsible for satisfying the lien?

California Courts have not issued any reported opinions directly on point. On first blush, it seems counter-intuitive that a defendant hospital would be entitled to also act in the capacity of a lienholder, e.g., a hospital asserting a lien pursuant to the HLA. However, it seems just as nonsensical to diminish a hospital's right to assert its contractual right to collect payment. If a hospital is not permitted to utilize the HLA because it is named as a defendant in the underlying personal injury action, then plaintiffs may be incentivized to

[14] *City and County of San Francisco v. Sweet*, 12 Cal. 4th 105, 116–118 (1995).

[15] *Gilman v. Dalby*, 176 Cal.App.4th 606, 618–619 (2009).

[16] *Mercy Hospital and Medical Center v. Farmers Insurance Group of Companies*, 15 Cal.4th 213, 217 (1997); *Parnell v. Adventist Health System/West*, 35 Cal.4th 595 (2005); *Newton v. Clemens*, 110 Cal.App.4th 1, 16-17 (2003).

[17] Civil Code Section 3045.5.

artfully and tactfully name a hospital in a lawsuit merely to avoid having to pay the hospital pursuant to the HLA.

According to one California Appellate Court, the patient's debt to the hospital is the foundation for the hospital's right to a lien.[18] However, in that case, the hospital was not a defendant. Nonetheless, this statement may provide guidance on California's position on this issue: a hospital has a right to assert a hospital lien pursuant to the HLA as long as it has a *bona fide* right to payment from the patient even if the hospital is a defendant in the personal injury action.

The HLA enables hospitals to collect on a medical debt owed by a patient who ultimately recovers for the subject injuries from the responsible party. Similar mechanisms exist in the context of government healthcare as well as in the realm of workers' compensation. Hence, it seems fitting that such a mechanism has been established for hospitals providing emergency and ongoing care to injured individuals. Additionally, the HLA appears to be a mechanism that is consistent with the California Legislature's larger pattern of adopting legislation aimed to help the public by reducing healthcare-related costs.

Although the HLA has been heavily litigated, new issues are arising constantly. One such issue is whether a hospital named as a defendant in the underlying personal injury action can maintain a right to assert a lien pursuant to the HLA. This issue and many other issues need to be decided by California Courts or clarified by the California Legislature in order to provide better direction to hospitals, patients, tortfeasors, insurance carriers and other parties who may have an interest in resolving hospital liens.

[18] *Nishihama v. City and County of San Francisco,* 93 Cal.App.4th 298, 308 (2001).

THE SUPREME COURT HAS SPOKEN: NO ALLOCATIONS OF NON-ECONOMIC DAMAGES UNDER MICRA ABSENT A SHOWING OF COMPARATIVE FAULT

© Erik S. Laakkonen
Attorney, Kramer, deBoer & Keane, LLP

The Supreme Court of California has spoken again on issues affecting the Medical Injury Compensation Reform Act ("MICRA"). In the recent case of *Rashidi v. Moser,*[19] the Court held that a non-settling healthcare provider defendant cannot offset a jury's award of non-economic damages, reduced by the court to $250,000 under MICRA, with pretrial settlement amounts attributable to non-economic damages, when the defendant fails at trial to establish the comparative fault of the settling defendant.

California Civil Code section 3333.2, a MICRA provision, limits non-economic damages to $250,000 in medical malpractice lawsuits against healthcare providers. The Supreme Court found in *Rashidi* that neither the text nor the history of section 3333.2 demonstrated an intent to allow a medical malpractice defendant to obtain an offset against damages for which he was solely liable.

The Supreme Court further explained that the limitation on non-economic damages was relevant to pretrial settlements only insofar as it provides a "firm ceiling on potential liability as a basis for negotiation. Only noneconomic damages awarded in court are actually capped." Therefore, to use pretrial settlement amounts attributable to non-economic damages as an offset, the judgment at trial must include a finding of apportionment of fault of the settling defendants.

The facts of *Rashidi* involved a twenty-six-year-old plaintiff who lost his sight after a procedure performed by Dr. Franklin Moser. Prior to trial, co-defendants Cedars Sinai Medical Center and Biosphere Medical, Inc. settled with plaintiff for $350,000 and $2 million respectively. Dr. Moser did not introduce evidence of liability as to these settling defendants, nor did he attempt to place them on the special verdict form. The jury verdict was ultimately entered against Dr. Moser with the jury awarding economic damages and non-economic damages in excess of the MICRA cap, which the trial court later reduced to $250,000. On appeal, the Supreme Court rejected Dr. Moser's argument that he was entitled to offset the award of non-economic damages with the pretrial settlement, because he conceded that he had not made any showing of apportionment of liability to those settling parties.

The *Rashidi* decision should compel non-settling healthcare provider defendants to put on evidence at trial apportioning fault to the settling defendants, and include them on the special verdict form. It might also provide the plaintiffs' bar with a backdoor to subvert the MICRA damages cap, by naming additional parties simply for purposes of settling pretrial, with the expectation that plaintiffs can obtain an additional $250,000 at the time of trial.

[19] *Rashidi v. Moser,* 60 Cal.4th 718 (2014).

OUR FIRM'S TRIAL VICTORY AGAINST A REPTILE PLAINTIFF LAWYER

© Erik S. Laakkonen
Attorney, Kramer, deBoer & Keane, LLP

A lot of ink has been spilled lately about so-called reptile litigation tactics practiced by certain plaintiff lawyers. We see such tactics employed often in many kinds of lawsuits, from commercial disputes to construction claims and personal injury lawsuits. They arise in the ways pleadings are drafted, depositions are taken, and trials are conducted. We recognize them and rebut them as they arise. The following success story involves a case where reptile litigation tactics were attempted at trial . . . and the plaintiff lost.

Our firm recently obtained a defense verdict in favor of two physician clients in a medical malpractice case venued in the Riverside County (California) Historic Courthouse. I had the privilege of second chairing this jury trial with lead counsel, Deborah Olsen deBoer. In the case, plaintiff alleged that the doctors negligently discontinued the blood thinning medication, Coumadin, without obtaining his informed consent, and failed to diagnose a pulmonary embolism/deep vein thrombosis. After a nearly four-week trial, the jury found that each doctor complied with the standard of care in the management of the patient's Coumadin and his medical condition.

This was the first jury trial in which our firm has directly confronted the so-called "Reptile Theory" as part of opposing counsel's litigation and trial strategy.

By way of background, the "Reptile Theory" was popularized by a 2009 book created for the plaintiffs' bar across the nation.[20] This theory holds that the trial goal of the plaintiff's bar should be to get the juror's brain into its "reptilian" survival mode, based on the assumption that a triggering of the "reptilian" portion of the brain by some type of "survival danger" results in an instinctive reaction of the juror to protect his or herself and the community.

The underlying intention is to insert an improper "Golden Rule" argument in attempts to appeal to jurors' concerns about their own safety and the safety of the community, and to have the jurors use their role as a jury to protect the community, rather than decide the facts of the particular case. The theory purports to require that healthcare providers make the "safest possible choice" in all circumstances regardless of what the actual standard of care requires.

The lynchpin of the theory is to have the client agree at deposition to certain "umbrella" (basic) rules or principles of safety and that all similarly-situated individuals have a duty to follow those principles to protect the safety of individuals generally and the community at large. Such questions at deposition can appear innocuous at first blush. This is why defense counsel should prepare their client to respond according to the applicable jury instructions and the law, and not concede or accept any of counsel's "basic safety principles."

For example, in a medical malpractice case, the physician should not simply agree to questions such as: "in your medical training were you taught some *basic safety principles* when caring for patients?" or "would you agree that a doctor is never allowed to *needlessly endanger a patient*?" The kneejerk response is

[20] Don Keenan and David Ball, *Reptile: The 2009 Manual of the Plaintiff's Revolution* (New York:Balloon Press, 2009).

inevitably yes to both questions, but when one appreciates that neither question relates to the legal standards of care applicable to medical negligence, the response must be more nuanced and anticipatory of the looming reptile trial strategy. Appropriate responses should include language echoing the applicable jury instructions, and as it specifically applies to healthcare professionals, ultimately framed in terms of the physician's education, training, experience and independent medical judgment. Similar types of questioning can take place in other settings too.

At our clients' depositions, counsel's intentions became clear as he attempted to construct the umbrella rules. Accordingly, on the eve of trial we filed a Motion in Limine to preclude plaintiff's use of irrelevant and prejudicial evidence or argument regarding the "reptile theory." It was necessary to explain to the court that the "reptile theory," by appealing to the jury's survival instincts based on the umbrella rules attempts to subvert the actual standard of care and expert evidence requirement in medical negligence cases.

In arguing the medical negligence case, the reptile plaintiff's attorney will condition the jury to ignore the jury instructions related to the standard of care, expert testimony and acceptable alternative methods of care, and instead adopt the concept that a "prudent" doctor must choose the safest possible choice of care, regardless of what medical experts may opine. In so doing, the "reptile theory" seeks to appeal to the jurors' subjective judgments about the best interests of themselves and/or the community rather than their impartial judgments predicated on the evidence and the law. In appealing to the jurors' self-interest, the theory attempts to revive "golden rule" arguments that have been prohibited in California and most other jurisdictions.

The Court granted our Motion in Limine and issued an order prohibiting plaintiff's attorney from straying beyond the applicable standard jury instructions, specifically CACI numbers 501, 502, 505 and 506, during the trial, including jury selection. This order rendered the "reptile theory" unavailable for plaintiff's counsel; he was unable to appeal to the self and/or community interests of the jurors, and a fair and impartial trial was had with the jury able to consider the evidence based on the appropriate and relevant jury instructions, rather than irrelevant standards of "safety" and bias.

Regardless of the actual science supporting the "reptile theory," it would behoove all defense counsel to be on notice and preclude such prejudicial and damaging tactics, because at the very least they will confuse, mislead or improperly condition the jury. Additional preparation for clients' depositions and evidentiary motions to preclude irrelevant argument and evidence to the jury are essential to deflecting the modern "reptile" movement.

THE TWIN CLAIMS: MEDICAL BATTERY AND LACK OF INFORMED CONSENT LOOK ALIKE, BUT THEY ARE SO VERY DIFFERENT

© Krista R. Hemming
Attorney, Kramer, deBoer & Keane, LLP

Distinguishing medical battery from lack of informed consent could mean the difference between general damages that either are uncapped or else capped at $250,000, as well as the difference between punitive damages or none at all. Knowing the difference between the two claims changes how the defendant prepares and defends their case.

The most often cited case in this line of jurisprudence is *Cobbs v. Grant*,[21] a California Supreme Court case which stands for the proposition that medical battery arises when a healthcare provider performs a procedure to which the patient has not consented. Lack of informed consent arises when a patient consents to a certain treatment, but the healthcare provider fails to disclose all inherent risks and complications; there is no intentional deviation from the consent given, "rather the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence."[22]

This distinction was clarified further by the California Court of Appeal in *Saxena v. Goffney*:[23] According to that case, it is clear that medical battery and lack of informed consent are separate causes of action. An action should be pleaded in negligence when the healthcare provider performs a procedure on the patient without disclosing sufficient information about the inherent risks and possible complications. When that is the case, the proper cause of action is lack of informed consent, whereas the "battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented."

Additionally, lack of informed consent is separate and different than lack of consent.[24] Lack of informed consent is when the medical provider obtains consent for a procedure, and performs the exact procedure for which he/she obtained consent, but fails to warn the patient about certain inherent risks or complications. In those situations the patient's consent is predicated on a lack of information. This is what gives rise to a medical negligence claim: the medical provider's negligence in failing to warn the patient of those risks.

In contrast, a medical battery claim is simply a lack of consent. Battery is the offensive and intentional touching without the victim's consent.[25] In the medical context, "a battery is an intentional tort that occurs when a doctor performs a procedure without obtaining any consent. A medical battery is predicated on the concept that a patient has the right to refuse medical treatment.[26] In the medical context, when a patient

[21] *Cobbs v. Grant*, 8 Cal.3d 229 (1972).
[22] *Cobbs*, supra 8 Cal.3d at 240-241.
[23] *Saxena v. Goffney*, 159 Cal.App.4th 316, 324 (2008).
[24] *Saxena*, supra 159 Cal.App.4th at 328.
[25] *Kaplan v. Mamelak*, 162 Cal. App. 4th 637, 645 (2008).
[26] *Thor v. Superior Court*, 5 Cal. 4th 725, 735-36 (1993).

refuses to consent to a medical procedure, or when a patient only gives conditional consent, and the medical provider exceeds the bounds of that consent, a battery occurs.

Within the medical context there is further distinction between common law battery and technical battery. "The common law has long recognized this principle: A physician who performs any medical procedure without the patient's consent commits a battery."[27] In contrast, "[w]hen an action is based upon the theory of battery beyond consent, the … theory … [is] technical battery.[28]

Regardless of whether the theory of battery is common law battery or technical battery, the plaintiff must prove intent. In a claim alleging medical battery, the intent requirement is satisfied by showing intent to deviate from the consent given.[29] This can be manifested by deviating from the conditional consent given in a technical battery or by deviating from the lack of consent in a common law battery.

Determining whether a cause of action is for medical battery as opposed to lack of informed consent (i.e. negligence) is vital. As the California Supreme Court noted in *Cobbs*:

> [T]there are significant differences between the two theories, including the evidentiary burdens, the availability of punitive damages, and the applicable limitations period: "[M]ost jurisdictions have permitted a doctor in an informed consent [negligence] action to interpose a defense that the disclosure he omitted to make was not required within his medical community. However, expert opinion as to community standard is not required in a battery count, in which the patient must merely prove failure to give informed consent and a mere touching absent consent. Moreover, a doctor could be held liable for punitive damages under a battery count, and if held liable for the intentional tort of battery he might not be covered by his malpractice insurance."[30]

While Cobbs was decided a few years before MICRA took effect, it has been held subsequently that MICRA explicitly covers only injury or death which occurs as a result of professional negligence. Because medical battery is an intentional act and not a negligent one, medical battery claims are not subject to MICRA.[31] Therefore, medical battery claims are not subject to either the statute of limitation or the delayed discovery rule set forth in California Code of Civil Procedure Section 340.5, but rather the two-year statute of limitation for a common law battery cause of action in California Code of Civil Procedure Section 335.1. Additionally, a medical battery cause of action is not subject to the 90-day tolling provisions of California Code of Civil Procedure Section 364.

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[27] *Thor*, supra 5 Cal.4th at 735.
[28] *Pedesky v. Bleiberg*, 251 Cal.App.2d 119, 123 (1967).
[29] *Cobbs*, supra 8 Cal.3d at 240; *Ashcraft v. King*, 228 Cal. App. 3d 604, 613 (1991); *Conte v. Girard Orthopaedic Surgeons Med. Grp., Inc.*, 107 Cal.App.4th 1260, 1267 (2003).
[30] *Cobbs* supra 8 Cal.3d at 229.
[31] *Noble v. Superior Court*, 191 Cal.App.3d 1189 (1987); *Perry v. Shaw,* 88 Cal. App. 4th 658 (2001).

This proposition is stated explicitly in two California Court of Appeal cases. In the first case, *Noble v. Superior Court*,[32] the Court held that California Code of Civil Procedure Sections 364 and 340.5[33] apply to actions based on professional negligence and not to actions based on a battery theory. The Court reasoned that the Legislature explicitly used the term "medical negligence" when constructing both Section 364 and 340.5. If the Legislature intended the statute of limitation in Section 340.5 and the tolling provision of Section 364 to include actions for battery, then presumably the Legislature would have used different terminology.

For instance, in California Code of Civil Procedure Section 1295, which governs arbitration, the Legislature used the term "medical malpractice," which includes both medical services that are rendered negligently *and* those medical services which are "unnecessary or unauthorized" (the traditional grounds for a battery cause of action). The language of Section 1295 goes beyond mere negligence and encompasses all theories which might be included in a medical malpractice action.

MICRA uses more restrictive terms, such as "professional negligence" and "negligent act or omission to act." The *Noble* court viewed this as a deliberate choice by the Legislature to exclude actions not based on a negligence theory of liability. The Court concluded that:

> The distinction between negligence and battery was not lost on our Supreme Court, and we do not believe it was lost on the Legislature when it enacted section 364 as a *limited* exception to the statute of limitations for "professional negligence." Had the Legislature intended section 364, subdivision (d), to extend to causes of action based upon other theories which the plaintiff might wish to include in the complaint, it could have used language which reflected that intent. It did not.[34]

In the second case, *Perry v. Shaw*,[35] the Court of Appeal upheld the findings in *Noble* and concluded that the 90-day tolling provision of section 364 only applies to negligence causes of action. The *Perry* Court agreed with the *Noble* Court's narrow interpretation of "professional negligence" as stated in California Code of Civil Procedure Section 364. The Court reasoned that this narrow interpretation, which excludes actions for battery, is supported by analysis of the legislative intent underlying Section 364.

Distinguishing between the two theories of liability can be crucial, not just in litigated matters which result in trial, but also in the early stages of claim evaluation. There are instances where a Plaintiff alleges lack of informed consent, for example, but also alleges such phrases as "willfully and intentionally". Such phrases are inconsistent with a negligence-based claim based upon lack of informed consent. Such pleading may be subject to an early Demurrer or Motion to Strike in order to clarify the Plaintiff's legal theory at the outset of litigation.

CAVEAT: THE FOREGOING DOES NOT CONSTITUTE LEGAL ADVICE. PLEASE CONSULT AN ATTORNEY FOR INDIVIDUAL ADVICE REGARDING INDIVIDUAL SITUATIONS.

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[32] *Noble v. Superior Court,* supra 191 Cal. App. 3d 1189.

[33] The *Noble* opinion references California Code of Civil Procedure § 340.6 and not § 340.5. This might be an inadvertent error because the court discussed MICRA and medical professional negligence, which is controlled by §340.5, and not attorneys' professional negligence, which is controlled by §340.6.

[34] *Noble*, supra 191 Cal.App.3d at 1194.

[35] *Perry v. Shaw*, 88 Cal.App.4th 658 (2001).