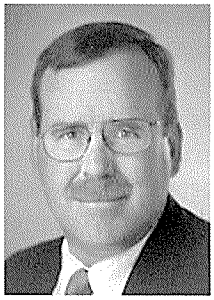
APPELLATE CASE SUMMARIES



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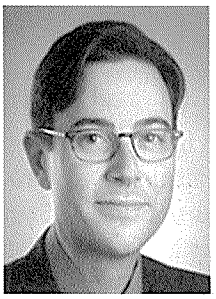

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BRAND-NAME DRUG MAKER OWES DUTY TO WARN GENERIC DRUG MAKER'S CUSTOMERS OF PRODUCT RISKS

T.H. v. Novartis Pharmaceuticals Corp.
(Dec. 21, 2017, No. S233898)
___ Cal.5th ___ [2017 WL 6521684]

Plaintiffs' mother was prescribed terbutaline, the generic bioequivalent of the brand-name drug Brethine, to suppress premature labor during her pregnancy. Plaintiffs were later diagnosed with developmental delays and autism. Alleging they were injured in utero by terbutaline, plaintiffs sued Novartis, the manufacturer of Brethine, for failing to warn of the risk to fetal brain development. According to plaintiffs, the generic manufacturer was legally required to follow brand-name warnings, so Novartis had continuing liability for failing to warn about Brethine's hazards. Novartis argued it owed plaintiffs no duty to warn because it had stopped manufacturing Brethine and sold its rights to the product before plaintiffs' mother received terbutaline. The trial court sustained Novartis's demurrer, but the Court of Appeal reversed and allowed plaintiffs leave to amend. The Supreme Court then granted review.

In a 4-3 decision, the Supreme Court affirmed the Court of Appeal's decision. The Supreme Court majority explained that, under federal law, the manufacturer of Brethine (brand-name) controlled both the form and content of the terbutaline (generic) warning label. The Court therefore concluded that plaintiffs could allege a cause of action against Novartis for failing to warn. Because the same warning label must appear on the brand-name drug and its generic bioequivalent, a brand-name drug manufacturer owes a duty of reasonable care in ensuring that the label includes appropriate warnings, regardless of whether the end user has been dispensed the brand-name drug or its generic bioequivalent. The majority also endorsed plaintiffs' predecessor liability theory. The majority explained that, if the person exposed to the generic drug can reasonably allege that the brand-name drug manufacturer's failure to update its warning label foreseeably and proximately caused physical injury, then the brand-name manufacturer's liability for its own negligence does not automatically terminate merely because the brand-name manufacturer transferred its rights in the drug to a successor.

Three justices dissented in part, disagreeing with the Court's holding that predecessor manufacturers have a duty to warn their successors' customers about risks of a product they no longer make or sell. According to the dissenters, this "theory of 'predecessor liability' represents a substantial and unprecedented expansion of tort duties. The majority cites no case holding a predecessor manufacturer liable for failing to warn about injuries caused by its successor's product."

MEDICAL BOARD MAY DISCIPLINE ARRESTED LICENTIATES EVEN IF THEY SUCCESSFULLY COMPLETE DIVERSION PROGRAMS

Medical Board of California v. Superior Court of City and County of San Francisco
(Jan. 8, 2018, A151175)
__ Cal.App.5th __ [2018 WL 316557]

The Medical Board filed an accusation against Dr. Brandon Erdle, who had been arrested for cocaine possession and then

successfully completed a pretrial diversion program. The administrative law judge (ALJ) excluded Dr. Erdle's arrest records and prohibited the arresting officer from refreshing his recollection with them while testifying. (Under Penal Code section 1000.4, an arrest is deemed not to have occurred if a diversion program is completed.) But the ALJ allowed the arresting officer to testify, and ultimately recommended that the Board publicly reprove Dr. Erdle and reinstate his license on a probationary basis. Dr. Erdle filed a petition for writ of administrative mandate, which the superior court granted. The Board then sought writ relief in the Court of Appeal.

The Court of Appeal granted the Board's writ petition in a published opinion, holding that Business and Professions Code section 492 created a "blanket exception" to Penal Code section 1000.4's restrictions regarding the use of arrest records. Section 492 permits "healing arts agencies" to take disciplinary action against licensees for professional misconduct "[n]otwithstanding any other provision of law, successful completion of any diversion program," or evidence "that misconduct may be recorded in a record pertaining to an arrest." The court explained that section 492 was "more recent and more specific" than section 1000.4, and that section 492's legislative history supported a broad construction of the statute. Furthermore, the court reasoned that adopting a blanket exception furthered public safety concerns specific to the healing arts licensees covered by section 492. Accordingly, because the trial court implicitly found that the officer's testimony would have supported the disciplinary action, and this finding was supported by substantial evidence, the Court of Appeal upheld the Board's disciplinary action.

MICRA DAMAGES CAP AND AMOUNT ACTUALLY PAID FOR SERVICES WERE PROPER CONSIDERATIONS IN CALCULATING MEDI-CAL LIEN AMOUNT

Martinez v. Department of Health Care Services (Dec. 13, 2017, B2728117) ___ Cal.App.5th ___ [2017 WL 6939086], ordered published and modified Jan. 12, 2018

The California Department of Health Care Services (DHCS) asked the trial court to determine the amount of a Medi-Cal lien on plaintiff Solomon Martinez's $150,000 settlement of a medical malpractice action. Although Martinez had received $86,676.46 in Medi-Cal payments, the court determined the value of the lien to be $39,004.41. The court determined the value by first adding the $250,000 maximum recovery of noneconomic damages permitted under the Medical Injury Compensation Reform Act (MICRA) to the $86,676.76 in medical costs. Then the court calculated the $150,000 settlement amount to be 45 percent of the total case value, and awarded the DHCS 45 percent of the medical costs. Martinez appealed, arguing that the court erred by failing to value his noneconomic damages at $2.5 million, by failing to consider his $300,000 lost wage claim, and by failing to utilize the full $171,000 amount of the hospital bill, rather than the $86,676.46 actually paid for medical services.

The Court of Appeal affirmed in part. Following Arkansas Department of Health and Human Services v. Ahlborn (2006) 547 U.S. 268, the court held it would have been irrational for the trial court to credit Martinez with (1) $2.5 million in noneconomic damages, when $250,000 is the maximum award allowed under MICRA, (2) the full $171,000 hospital bill, instead of the $86,676.46 amount actually paid, since the lien was based on the lower amount paid, or (3) $300,000 in lost wages, because Martinez failed to identify any evidence supporting his lost earnings claim. However, the court did reduce the lien amount by 25 percent to account for statutory attorney fees, as required by Welfare and Institutions Code section 14124.72, subdivision (d).

STATUTE PROHIBITING DISCLOSURE OF IMR REVIEWERS IS CONSTITUTIONAL

Zuniga v. Workers' Compensation Appeals Board (Jan. 12, 2018, A143290) ___ Cal.App.5th ___ [2018 WL 550255]

Saul Zuniga received pain management treatment for a work-related injury. The workers' compensation insurer for Zuniga's employer submitted his physician's prescription of five pain medications for utilization review, which approved only one of them. Zuniga appealed the utilization review decision to deny four prescriptions through the independent medical review (IMR) process. The initial IMR decision affirming the denial of three prescriptions was reversed by the Workers' Compensation Appeals Board. While a second IMR was pending, Zuniga petitioned the Board to disclose the identity of the physicians who were the first and second IMR reviewers. The Board declined, citing Labor Code section 4610.6, subdivision (f), which requires IMR organizations to keep confidential the names of reviewers. Zuniga filed a writ petition contending that section 4610.6 did not prohibit the Board from compelling disclosure and that any contrary reading violated his due process rights.

The Court of Appeal affirmed, holding section 4610.6, subdivision (f) unambiguously prohibited the Board from compelling disclosure of IMR reviewers. The court rejected Zuniga's claim that the confidentiality requirement conflicted with section 4610.6, subdivisions (h)(1)-(4), which specify the authorized grounds for appealing an IMR determination, because the confidentiality provision at most made it more difficult, but not impossible, to prove those grounds.

The Court of Appeal also rejected Zuniga's due process challenges. First, the court held that section 4610.6, subdivision (f) did not violate the California Constitution, which grants the Legislature plenary power to create a workers' compensation system unlimited by any other provision, including the due process clause. Second, the court agreed with Stevens v. Workers' Comp. Appeals Bd. (2015) 241 Cal. App.4th 1074, 1096-1101, which held that the confidentiality provision did not violate the federal Constitution because the IMR process provided adequate due process protections, such as the extensive conflict-of-interest and reporting requirements imposed on IMR organizations.

HEIR SUING HOSPITAL FOR WRONGFUL DEATH CAN EVADE MICRA STATUTE REQUIRING ARBITRATION BY PLEADING ELDER ABUSE CLAIM

Avila v. Southern California Specialty Care, Inc. (Feb. 26, 2018, G054269) __ Cal.App.5th __ [2018 WL 1044668]

Alex Avila sued Kindred Hospital for negligence and elder abuse, on behalf of his deceased father, and for wrongful death. Avila alleged that his father died due to the hospital's negligence, willful misconduct, and neglect in connection with a dislodged feeding tube that caused aspiration and cardiopulmonary arrest. Avila had previously executed a Voluntary Alternate Dispute Resolution (ADR) Agreement under a statutory power of attorney after admitting his father to the hospital. The hospital petitioned to compel arbitration pursuant to the ADR agreement. The trial court denied the petition. The trial court first ruled that the ADR agreement did not apply to Avila's wrongful death claim, and then exercised its discretion, under Code of Civil Procedure section 1281.2, subdivision (c), to deny arbitration of the remaining negligence and elder abuse claims to avoid the risk of inconsistent rulings. The hospital appealed.

The Court of Appeal affirmed. First, it rejected Hospital's argument that the Federal Arbitration Act (FAA) rather than California law applied, holding that the procedural aspects of the FAA did not apply in these state court proceedings because the ADR agreement did not state it was governed by the FAA. Second, without citing Flores v. Presbyterian Intercommunity Hospital (2016) 63 Cal.4th 75, 88 [holding that MICRA applies broadly to all negligence claims regarding tasks that are "integrally related to the medical treatment and diagnosis of the patient"] or cases such as Larson v. UHS of Rancho Springs, Inc. (2014) 230 Cal.App.4th 336, 347 [holding that, when a plaintiff "asserts a claim against a health care provider on a legal theory other than professional negligence, courts must determine whether the claim is nonetheless based on the health care provider's professional negligence, which would require the application of MICRA"], the Court of Appeal held that Avila had successfully evaded the MICRA arbitration statute (Code Civ. Proc., § 1295 [patient's arbitration agreement is binding on heirs who sue for wrongful death]) by pleading an elder abuse claim. While Avila's complaint included allegations that could have been categorized either as professional negligence or elder abuse, the court held the fact Avila "could have also pleaded a claim for medical malpractice . . . is irrelevant." Third, the Court of Appeal held that Avila was not bound by the ADR agreement he signed as his father's agent because there was no evidence he had intended to waive a jury trial on his personal claims. Finally, the Court held that the trial court did not abuse its discretion by refusing to compel arbitration of the negligence and elder abuse claims because there existed a strong possibility of inconsistent rulings.

PHYSICIANS ARE PROPERLY SERVED AT ADDRESSES OF RECORD FILED WITH MEDICAL BOARD

Medical Board v. Superior Court (Feb. 21, 2018, A152607) __ Cal.App.5th __ [2018 WL 1102588], mod. and certified for publication Mar. 1, 2018, and Selvidge v. Tang (Mar. 5, 2018, C083427) __ Cal.App.5th __ [2018 WL 1150039]

The Court of Appeal published two decisions addressing similar issues concerning proper service of process on a physician. In both cases, the courts rejected physicians' challenges to service at their addresses of record with the Medical Board.

In Medical Board v. Superior Court, the Board filed an accusation against Dr. Alfred Adams, alleging he prescribed himself controlled substances, failed to participate in a Board interview, and failed to provide the Board with an accurate address. The Board served the accusation and a subsequent notice of default by certified mail on Dr. Adams's address of record, but both were returned, unopened, and stamped "Return to Sender, Unable to Forward." The Board then issued a default decision revoking Dr. Adams's medical license. Dr. Adams filed a petition for writ of administrative mandate contesting service. Dr. Adams contended that, under Government Code section 8311, proper service requires proof of actual receipt, which the Board lacked here. The trial court agreed and ordered the Board to set aside its revocation of Dr. Adams's medical license. But the Court of Appeal granted the Board's subsequent writ petition, holding that section 8311 required proof of actual receipt only for means of physical delivery other than certified mail.

Similarly, in Selvidge v. Tang, plaintiffs mailed a notice of intent to file a malpractice action against Dr. Sullyvan Tang to his address of record with the Board (an address belonging to a business that received mail on his behalf) before the one-year statute of limitations expired, and then filed suit 85 days after the limitations period expired. The trial court granted Dr. Tang's motion for summary judgment, ruling that the MICRA tolling statute (Code Civ. Proc., § 364) did not apply because, absent proof of actual notice, plaintiffs were required to serve the notice at Dr. Tang's residence pursuant to Code of Civil Procedure section 1013, subdivision (a). The Court of Appeal reversed, holding that service at the address Dr. Tang provided to the Board was sufficient. The court explained that the test for proper notice of malpractice actions was whether plaintiffs took adequate steps to achieve actual notice. Since it was reasonable to assume a physician would receive actual notice of documents mailed to an address the physician identified as one where he or she could reliably be contacted for professional purposes, plaintiffs' service triggered the 90-day tolling period and their suit was therefore timely.

DHCS REIMBURSEMENT RATE SURVIVES PRIVATE AMBULANCE COMPANIES' CONSTITUTIONAL CHALLENGE

Sierra Med. Servs. Alliance v. Kent, 883 F.3d 1216
(9th Cir. Mar. 6, 2018)

Numerous private ambulance companies sued the Director of the California Department of Health Care Services (DHCS), alleging that the rate set for reimbursing their cost of providing emergency medical transportation to Medi-Cal patients—which the companies alleged covered only one-fifth of their actual cost—violated various constitutional provisions. The district court granted the DHCS's motion for summary judgment, ruling that, despite Health and Safety Code section 1317(d) (which required the companies to provide emergency services regardless of the patient's ability to pay) the plaintiffs lacked a constitutionally protected property interest in a particular reimbursement rate and that Medi-Cal did not compel plaintiffs to furnish their resources for public use. The companies appealed.

The Ninth Circuit affirmed. Although the district court had erred when it reasoned that plaintiffs' voluntary enrollment as Medi-Cal providers deprived them of a constitutionally protected property interest, the companies had failed produce evidence that section 1317(d) effects a regulatory taking. The companies did not present evidence demonstrating (1) the overall economic impact of section 1317(d); (2) any investment-backed expectations or interference with such expectations; or (3) the character of the government action. The companies' due process claim regarding the adequacy of the reimbursement rate failed because they voluntarily elected to become Medi-Cal providers, and therefore could not have a constitutionally protected interest in any particular reimbursement rate. Finally, the equal protection challenge—that higher rates were being paid to public ambulances—failed rational basis review. DHCS reasonably favored public providers over the private companies since payments to them counted toward the state's share of the cost of covering its Medicaid population.

PHYSICIAN ENTITLED TO ATTORNEY FEES WHERE DHCS UNREASONABLY WITHHOLDS MEDI-CAL PROVIDER APPROVAL

Al-Shaikh v. State Department of Health Care Services (Mar. 27, 2018, A147939) __ Cal.App.5th __ [2018 WL 1281674]

Dr. Raad Al-Shaikh sought writ relief in the trial court from a final decision by the Department of Health Care Services (DHCS) denying his application to continue as a Medi-Cal provider in his new office location because his percentage-based fee arrangement with a third-party billing service allegedly violated federal law. The trial court dismissed Dr. Al-Shaikh's petition as moot because DHCS had approved his application as soon as he cited an Office of the Inspector General (OIG) publication stating the fee arrangement he used did not violate federal law. The trial court then denied Dr. Al-Shaikh's motion for attorney fees under Code of Civil Procedure section 1028.5 for prevailing over an adverse administrative decision, finding DHCS did not act without substantial justification because it reasonably believed the fee arrangement was illegal. Dr. Al-Shaikh appealed the denial of fees in pro per.

The Court of Appeal reversed, holding that DHCS had acted without substantial justification because, as the state agency responsible for implementing Medicaid and Medi-Cal, it had an obligation to know the law, which in this case was neither unclear nor disputed. The court rejected DHCS's argument that its unfamiliarity with the law was excused by the OIG publication appearing within a massive federal register. The court observed that the OIG publication had been published for over a decade and was prepared with the same formality accompanying formal rulemaking; no regulatory body or court had questioned the publication, which had been heavily publicized and cited in health care industry reference manuals. Furthermore, because it took Dr. Al-Shaikh three years to secure provider approval at his new office location (decimating his practice), the discretion to award fees under section 1028.5 had to be exercised in favor of awarding him the full $7,500 in attorney fees authorized by the statute.

MARKET PARTICIPANT EXCEPTION TO DORMANT COMMERCE CLAUSE PERMITS DHS TO PAY LOWER MEDI-CAL REIMBURSEMENTS TO OUT-OF-STATE HOSPITALS

Asante v. Cal. Dep't of Health Care Servs. (9th Cir. Apr. 2, 2018) __ F.3d __ 2018 WL 1570659

Nineteen hospitals located outside California filed a federal action against the California Department of Health Services and its director. They asserted that DHS violated the dormant Commerce Clause of the United States Constitution—which prohibits states from burdening interstate commerce—by adopting certain Medi-Cal reimbursement policies favoring in-state hospitals over out-of-state hospitals. The district court found a violation of the dormant Commerce Clause and granted the out-of-state hospitals partial summary judgment, but the court denied monetary relief. Both sides appealed.

The Ninth Circuit reversed, holding that DHS was exempt from the dormant Commerce Clause because it acted as a market participant (rather than a regulator) in setting reimbursement rates for hospitals providing services to Medi-Cal beneficiaries. Like other market participants, the hospitals and beneficiaries were not required to deal with DHS, but they voluntarily chose to participate in its Medi-Cal insurance program. And like private insureds, Medi-Cal beneficiaries must ascertain whether a hospital they wish to use participates in the Medi-Cal program. Furthermore, DHS did not act as a regulator because it did not impose restrictions reaching beyond the parties with whom it transacted business; DHS dealt only with Medi-Cal providers and did not regulate third parties. The fact that federal funds (and regulations) were used when DHS paid benefits did not take the case outside the market participant exception.

PHYSICIAN'S MISREPRESENTATIONS REGARDING LOSS OF PRIVILEGES IN ANOTHER STATE JUSTIFIED HOSPITAL'S DENIAL OF MEDICAL STAFF MEMBERSHIP

Powell v. Bear Valley Community Hospital (Mar. 26, 2018, D072616) __ Cal.App.5th __ [2018 WL 1790674], certified for publication April 16, 2018

Dr. Robert Powell obtained provisional membership in the medical staff of Bear Valley Community Hospital about a decade after having his staff membership and clinical privileges terminated by a Texas hospital based on findings of

dishonesty and obstructive behavior. Dr. Powell later applied for active membership on the medical staff. Bear Valley's Board of Directors determined his application was incomplete because he had not fully explained his loss of privileges in Texas. The Board notified Dr. Powell that his provisional membership had expired, but encouraged him to reapply. Dr. Powell reapplied, submitting additional (albeit misleading) information regarding his loss of privileges in Texas. After the Board made an initial decision to deny Dr. Powell's renewed application, he requested a judicial review committee (JRC) hearing regarding that decision. The JRC found that the Board's decision was reasonable, warranted, and supported by substantial evidence that Dr. Powell displayed fundamental character defects for dishonesty and deceitfulness based on (1) his repeated failure to produce a letter from the Texas Board of Medical Examiners regarding his earlier loss of privileges (2) his attempt to deceive Bear Valley by producing a different letter by the Texas Medical Board, and (3) his misrepresentations regarding the circumstances that led to his loss of privileges in Texas. The Board affirmed the JRC's findings as its final decision after Dr. Powell waived his right to an administrative appeal. Dr. Powell filed an unsuccessful petition for writ of administrative mandamus in the superior court, and then an appeal.

The Court of Appeal affirmed. First, the court explained that a lapse in provisional privileges while a physician submits a more complete application is not a reportable event under Business and Professions Code section 805 and does not trigger the right to a JRC hearing. Thus, the court held that Dr. Powell was not entitled to a hearing relating to his initial provisional staff privileges. As to the Board's denial of the renewed provisional membership, the court held that the Board properly exercised independent judgment and did not exceed its delegated authority to protect patients by denying Dr. Powell's reapplication. Dr. Powell's misrepresentations and repeated failure to produce relevant evidence showed a propensity for dishonest and unethical conduct that could negatively impact his and other physicians' provision of medical care. Furthermore, the Court of Appeal held that the Board gave due weight to the Hospital's medical executive committee (MEC) on matters within its expertise and about which the MEC was fully informed (i.e., the MEC's review of Dr. Powell's proctored cases). The court recognized that the MEC had been largely misled by Dr. Powell when it recommended approval of his reapplication.

CALIFORNIA LIKELY VIOLATES COMMERCE CLAUSE BY ENFORCING STATE LAW TO CONTROL MEDICAL WASTE DISPOSAL IN OTHER STATES

Daniels Sharpsmart, Inc. v. Smith
(9th Cir. May 2, 2018) __ F.3d __ No. 17-16424, 2018 WL 2033767

Daniels Sharpsmart, Inc., manufactures and markets reusable container systems for the disposal of medical waste (such as syringes and IVs), and handles disposal and treatment of such waste at a facility in Fresno. The California Medical Waste Management Act ("MWMA") requires medical waste to be incinerated. In 2014, there were no incineration facilities for certain biohazardous waste in California, so Daniels transported medical waste to facilities in Kentucky and Indiana for disposal using autoclave and thermal deactivation procedures authorized in those states. Following an inspection of the Fresno facility, the California Department of Public Health found Daniels had violated the MWMA 618 times by disposing of medical waste without incinerating it, and imposed a $618,000 penalty. Daniels sued four state officials, seeking an injunction on the ground that applying the MWMA to disposal of medical waste in other states violated the dormant Commerce Clause. The officials asserted qualified immunity and moved to dismiss. The district court agreed with Daniels, rejected qualified immunity, and entered a preliminary injunction. The state officials appealed.

The Ninth Circuit affirmed in part, holding that the district court did not abuse its discretion by granting a preliminary injunction. The court explained that Daniels was likely to succeed on the merits; enforcing the MWMA to control out-of-state transactions involving medical waste would violate the dormant aspect of the Commerce Clause under the extraterritoriality doctrine. To the extent that Daniels sought money damages in addition to injunctive relief, the Ninth Circuit also held that three of the four state officials were entitled to qualified immunity because Daniels' Commerce Clause rights were not sufficiently clearly established in this context.

HOSPITAL ETHICS COMMITTEE ENTITLED TO IMMUNITY FOR DECLINING TO PROVIDE MEDICALLY INEFFECTIVE CARE REQUESTED BY HEALTH CARE DIRECTIVE

Alexander v. Scripps Memorial Hospital La Jolla (Apr. 16, 2018, D071001) __ Cal. App.5th __ [2018 WL 1790545], certified for partial publication May 11, 2018

Elizabeth Alexander, a 70-year-old woman suffering from terminal pancreatic cancer, died four days after she was transferred from a skilled nursing facility to Scripps Memorial Hospital. Elizabeth had an advance health care directive stating she wanted all measures taken to prolong her life. Her doctors at Scripps believed certain advanced life support measures would be medically ineffective and harmful. They involved Scripps's Appropriate Care Committee—a team of physicians who provide recommendations and ethical guidance—which discussed the tension between Elizabeth's health care directive and her treating physicians' views. After reviewing Elizabeth's records and observing her condition, the Committee recommended against advanced life support measures and informed Elizabeth's son, Christopher, that Scripps's doctors could not embark on ineffective care. Christopher requested that Elizabeth be transferred to another facility, but she died before her scheduled transfer. Elizabeth's estate and children later sued Scripps and numerous providers (including members of the Committee) for negligence (of several varieties) and elder abuse, alleging they failed to provide the life-sustaining treatment requested in her advanced health care directive. The trial court entered judgment for defendants after sustaining demurrers and granting summary judgments. Plaintiffs appealed.

The Court of Appeal affirmed; three aspects of its decision merit attention. First, the court held that disagreements between physicians and patients (or their family members) about the type of care provided do not give rise to elder abuse claims. Second, the court held that members of the Committee lacked a physician-patient relationship, meaning they owed no duty of care to Elizabeth. Third, recognizing the valuable role that ethics committees play in patient care, the court interpreted provisions of the Health Care Decisions Law (Prob. Code, §§ 4735, 4740) to confer immunity on institutions that act in good faith and in accordance with generally accepted health care standards in declining to comply with an individual health care directive that would require medically ineffective care. The Court of Appeal also explained that hospitals are not health care providers within the meaning of the Health Care Decisions Law; they are institutions and the law distinguishes providers from institutions.

WHISTLEBLOWER PHYSICIAN MAY SUE UNIVERSITY WITHOUT JUDICIALLY CHALLENGING ADVERSE ADMINISTRATIVE DECISION

Taswell v. Regents of University of California (May 14, 2018, G053960) __ Cal.App.5th __ [2018 WL 2191561]

Dr. Carl Taswell was employed by UC Irvine Medical School as a nuclear medicine physician with responsibility for radiation safety issues. Dr. Taswell complained to the chair of his department about potential safety and compliance problems, and later expressed similar concerns at a safety committee meeting, in an email to a radiation safety officer, and in a report to the California Department of Public Health. When Dr. Taswell entered a nearby radiochemistry lab to document perceived safety violations, UCI placed him on a paid leave of absence pending investigation into his allegedly unauthorized lab entry. UCI later notified him his contract would not be renewed due to his alleged refusal to do his job, interpersonal issues, and improper behavior at the safety committee meeting. Dr. Taswell initiated a grievance procedure claiming whistleblower retaliation, which resulted in an adverse finding by UCI. Rather than filing a petition for writ of mandamus, Dr. Taswell filed a whistleblower action for damages in superior court. The trial

court granted summary judgment against Dr. Taswell based on his failure to exhaust judicial remedies and because his retaliation claims were barred by res judicata and/or collateral estoppel. Dr. Taswell appealed.

The Court of Appeal reversed, holding that Dr. Taswell was not required to exhaust his judicial remedies by seeking a writ of mandamus challenging the adverse administrative decision before filing his whistleblower retaliation action, and that the administrative decision lacked res judicata or collateral estoppel effect. Specifically, Dr. Taswell was authorized to sue for damages under (1) Government Code section 8547.10, which allows whistleblowers to seek a remedy "if the university has not satisfactorily addressed the complaint," because UCI's adverse administrative decision was not satisfactory to Dr. Taswell; (2) Health and Safety Code section 1278.5, which does not condition the right to seek civil remedies on a prior successful mandamus challenge; and (3) Labor Code section 1102.5 and Government Code section 12653, because each statute reflects the Legislature's intent to permit a claim of damages without first challenging an administrative decision by a writ of mandamus. The Court of Appeal further held that the University's administrative decision lacked preclusive effect in the whistleblower action under Runyon v. Board of Trustees of California State University (2010) 48 Cal.4th 760, 774. Finally, the court determined that a triable issue prevented summary judgment as to whether UCI's decision to place Dr. Taswell on leave (and not renew his contract) had a causal connection to his whistleblower activities, since the employment decision was made in close temporal proximity to his disclosures regarding potential safety violations.

EXPERT DECLARATION REGARDING HOSPITAL'S DUTY OF CARE HAS NO EVIDENTIARY VALUE ABSENT A DETAILED FACTUAL BASIS

Doe v. Good Samaritan Hospital
(May 4, 2018, F073934) __ Cal.App.5th __ [2018 WL 2077993], certified for publication May 21, 2018

John Doe, a 12-year-old patient voluntarily admitted to Good Samaritan Hospital for psychiatric treatment, was placed in a room with a 10-year-old patient admitted under a psychiatric hold. The Hospital observed both patients every 15 minutes as ordered by the admitting physicians. Doe was discharged after nine days, but then began exhibiting signs of posttraumatic stress disorder. He eventually informed his parents that his hospital roommate had sodomized him in the bathroom. Doe sued the Hospital for negligence, alleging it should not have assigned him to share a room with his assailant and it should have observed them more vigilantly. The Hospital filed a motion for summary judgment on the ground it did not breach its duty of care. The Hospital supported its motion with a conclusory three-page expert declaration by a registered nurse who opined that the Hospital had met the standard of care. Doe failed to file an admissible opposing expert declaration. The trial court granted summary judgment; Doe appealed.

The Court of Appeal reversed, holding that the nurse's threadbare declaration supporting the Hospital's motion lacked evidentiary and legal weight. "Without any elaboration regarding the applicable standard of care and what conduct was required to meet it, the expert declaration is legally insufficient." The declaration had failed to specify the precise standards of care or the protocols, policies, or guidelines governing room assignments and patient observations. Absent that information, the Court of Appeal found no basis on which the trial court could conclude the Hospital had satisfied the standard of care. Accordingly, because the Hospital had failed to undermine Doe's negligence theories, the summary judgment was reversed.