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SUPREME COURT
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KATHLEEN A. WINN, *et al.*,
Plaintiffs and Appellants,

v.

PIONEER MEDICAL GROUP, INC., *et al.*,
Defendants and Respondents.

After a Published Decision by the Court of Appeal,
Second Appellate District, Division Eight
Case No. B237712

OPENING BRIEF ON THE MERITS

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ISSUE PRESENTED

Does "neglect" within the meaning of the Elder Abuse and Dependent Adult Civil Protection Act (Welf. & Inst. Code, § 15657) include a health care provider's failure to refer an elder patient to a specialist if the care took place on an outpatient basis, or must an action for neglect under the Act allege that the defendant health care provider had a custodial relationship with the elder patient?

SUMMARY ANSWERS

The elder patient in this case, who received medical care on an outpatient basis, was not a victim of "neglect."

First, providing care, but allegedly failing to refer a patient to a specialist states, at most, a claim for professional negligence, not neglect. This Court has made it clear that claims for professional negligence and neglect are mutually exclusive. What is more, a claim for failure to refer a patient does not involve the level of culpability required for enhanced remedies under the Act.

Second, a claim for neglect against a health care provider only arises in the context of a custodial relationship. When, as here, medical care is provided on an outpatient basis, no such custodial relationship exists.

Therefore, plaintiffs' claim for neglect fails.

STATEMENT OF THE CASE

A. Plaintiffs' Decedent Voluntarily And Independently Sought And Received Outpatient Podiatric Care From Defendants On An As-Needed Basis

Plaintiffs are the heirs of Elizabeth Cox ("patient" or "decedent"), who was a competent and independent elderly adult. (Slip Opn., p. 3.) She was autonomous, meaning that she was not a resident in a nursing home or other custodial care facility. She retained control over her medical decisions.

Decedent was a patient of defendant Pioneer Medical Group, which has offices in Cerritos and Long Beach. (Appellants' Appendix ("AA") 71; Slip Opn., p. 3.) Decedent received outpatient care for nearly a decade from defendant, Emerico Csepanyi, M.D., a general practitioner at Pioneer Medical Group offices. (AA 71; Slip Opn., p. 3.) She also voluntarily sought and received outpatient treatment from other defendant physicians at the Group for ongoing foot problems. (Slip Opn., pp. 3-5.) In 2004, decedent sought treatment from defendant Stanley Lowe, D.P.M., a podiatrist, for a toenail infection. (AA 71; Slip Opn., p. 3.) Dr. Lowe evaluated decedent again in late 2007 and early 2008 for a toenail infection. (AA 72-73.) Dr. Lowe drained the infection, prescribed medication, and recommended follow-up treatment. (AA 72-73.)

During this time, decedent continued to treat with her general practitioner, Dr. Csepanyi. In 2007, Dr. Csepanyi diagnosed decedent with peripheral vascular disease. (AA 72.) Neither Dr. Csepanyi nor Dr. Lowe referred decedent to a vascular specialist. (AA 73.)

In December 2008, decedent presented to defendant James Chinuk Lee, D.P.M., for a laceration on her right foot. (AA 73.) Dr. Lee cleaned the wound, prescribed antibiotics, and instructed decedent to return for follow-up care as needed. (*Ibid.*) Decedent returned to Dr. Lee one month later, complaining that the wound was not healing. (*Ibid.*) She also saw Dr. Csepanyi that month with the same complaints. (*Ibid.*) Dr. Csepanyi diagnosed pain in the foot, and he prescribed medications and foot soaks. (*Ibid.*) According to plaintiffs' complaint, these symptoms "are evidence of cellular deterioration and tissue destruction due to peripheral vascular ischemia[.]" (*Ibid.*)

Decedent treated with Dr. Lowe and Dr. Csepanyi several more times in February and March 2009. (AA 73-74.) Their treatment for decedent's ongoing foot problems included topical creams, special shoes, and recommendations for follow-up care. (*Ibid.*)

A day after visiting Dr. Csepanyi in March 2009, decedent was admitted to Lakewood Regional Medical Center with symptoms of ischemia in her right leg. (AA 74.) An attempt to restore blood supply to the affected area was unsuccessful. (*Ibid.*) Ultimately, decedent's right leg was amputated. (AA 74-75.)

Almost one year later, in January 2010, decedent was admitted to Marshall Medical Center due to sepsis. (AA 75.) She was placed on palliative care and died on January 8, 2010, at the age of 83. (*Ibid.*)

Plaintiffs have identified no issues of purported "neglect" arising from the conduct of the defendants during either hospitalization. Instead, plaintiffs claim that, in the course of treating

decedent as an outpatient, defendants failed to recognize the need for a vascular specialist to evaluate decedent's foot, which led to the amputation of her leg and, ultimately, her death. (See Slip Opn., pp. 6, 16-17.) Plaintiffs contend that defendants violated the standard of care because they failed to refer decedent to a vascular specialist. They allege that by February 2009, "the only appropriate care at that time (after cleaning the wound) would have been a referral to a vascular specialist[.]" (AA 73.) They also assert, "[b]y no later than March 3, 2009, a standard revascularization procedure, either by an endovascular approach . . . or an alternative procedure would, more probably than not, have saved [decedent's] leg." (AA 75.)

B. Plaintiffs Filed Two Lawsuits Based On The Same Set Of Facts – The First For "Medical Malpractice" And The Second For "Elder Abuse"

Plaintiffs filed two separate lawsuits based on the same set of facts – one for professional negligence, which is governed by the Medical Injury Compensation Reform Act ("MICRA"), a series of statutes aimed at controlling the increasing costs of medical malpractice litigation, and one for neglect under the Elder Abuse and Dependent Adult Civil Protection Act (the "Elder Abuse Act"), which gives rise to "enhanced remedies" and which is not subject to the protections of MICRA. (Slip Opn., p. 6.)

The professional negligence action is pending in the Superior Court (Super. Ct. L.A. County, No. BC434184). The elder abuse action ended with a judgment of dismissal when the trial court sustained a demurrer on the ground that plaintiff failed to allege a

claim for neglect under the Elder Abuse Act. (AA 158.) The trial court relied on *Carter v. Prime Healthcare Paradise Valley LLC* ("*Carter*") (2011) 198 Cal.App.4th 396, 408, to find that plaintiffs' elder abuse action amounted to nothing more than professional negligence. (Slip Opn., pp. 6-7.)

C. The Court Of Appeal Reversed The Trial Court's Judgment On Demurrer To Plaintiffs' Elder Abuse Action

In a split decision, the Court of Appeal, Second Appellate District, Division Eight, reversed the judgment of dismissal (the "Opinion"). The majority held that plaintiffs' allegations that defendants repeatedly failed to refer decedent to a specialist, despite the fact that they knew there was a "strong probability" of harm if they did not, was sufficient to plead a claim for elder abuse. (Slip Opn., pp. 16-17.)

The Court of Appeal rejected the governing precedent on the issue of health practitioner liability for neglect under the Elder Abuse Act. It failed to adhere to this Court's careful distinction between neglect and professional negligence articulated in *Delaney v. Baker* ("*Delaney*") (1999) 20 Cal.4th 23 and *Covenant Care, Inc. v. Superior Court* ("*Covenant Care*") (2004) 32 Cal.4th 771. (Slip Opn., pp. 11-18.) Although the Court of Appeal acknowledged that "professional negligence, on the one hand, and abuse and neglect, on the other, are distinct and mutually exclusive[,]" the Court was willing to leave the distinction between the two theories to a jury to sort out. (Slip Opn., 19-20.)

Presiding Justice Bigelow dissented. She found that the distinction drawn in *Delaney*, between elder abuse and professional negligence, requires dismissal of the elder abuse action because the set of facts plaintiffs allege "is classic professional negligence." (Slip Opn., dis. opn. of Bigelow, P.J., p. 5.)

SUMMARY OF ARGUMENT

The Opinion erroneously conflates claims for neglect and professional negligence. What is more, the Opinion impermissibly expands the reach of neglect claims to the health practitioners who provide outpatient care in their own offices – a context where a health practitioner and a patient are certainly not in a custodial relationship.

In cases such as this, where plaintiffs allege that a doctor provided medical care, but allegedly failed to refer the patient to another health care provider, the claim sounds in professional negligence. In fact, CACI 508 and BAJI 6.04 cover this very type of claim for professional negligence. Understanding this, plaintiffs filed a separate suit for professional negligence.

Nevertheless, plaintiffs attempted to fit their professional liability allegations into a claim for neglect. Claims for neglect under the Elder Abuse Act require, among other things, that health care providers deprive their patients of all care.

Additionally, entitlement to the enhanced remedies of the Elder Abuse Act requires plaintiffs to specifically plead facts giving rise to a much higher level of culpability than negligence. Especially egregious abuse is required. This case presents the opportunity for the Court to continue drawing the line of distinction between claims for professional negligence and neglect.

Equally critical is the prerequisite of a custodial relationship to a claim for neglect. Health care providers who treat elder patients at their offices are in a physician-patient relationship with their patients, and are liable for professional negligence if their treatment falls below

the standard of care. But, such treatment does not create a custodial relationship. That is to say, by treating patients over the age of 65, the health care providers are not exposing themselves to the expansive liability created by the enhanced remedies of the Elder Abuse Act. If it were otherwise, health care providers would face a tremendous disincentive to treat such patients.

Both *Delaney* and *Covenant Care* underscore the prerequisite of a custodial relationship to a claim for neglect. This Court now has an opportunity to explain that a claim for neglect cannot be stated against a health care provider when medical treatment is provided on an outpatient basis. This is because the outpatient context does not give rise to the requisite custodial relationship.

The Legal Analysis section of this brief begins with a recount of the pertinent statutory language of the Elder Abuse Act and a discussion of this Court's opinions interpreting it. The brief then separately discusses both aspects of the issue presented ("neglect" and "custodial relationship"). Finally, it analyzes the practical implications of this Court's decision for this case and future cases.

LEGAL ANALYSIS

I. THE ELDER ABUSE ACT PROVIDES ENHANCED CIVIL REMEDIES FOR CASES OF RECKLESS NEGLECT, BUT NOT FOR PROFESSIONAL NEGLIGENCE

A. The Elder Abuse Act Defines Neglect

The Elder Abuse Act makes certain enhanced remedies available to a plaintiff who proves abuse of a person who is 65 years of age or older. (Welf. & Inst. Code, §§ 15610.27 & 15657.) A plaintiff must prove by "clear and convincing evidence" that a defendant is liable for neglect (as defined by the Elder Abuse Act) and the defendant acted with "recklessness, oppression, fraud, or malice" while committing that neglect. (Welf. & Inst. Code, § 15657.)[1]

Neglect, as defined in the Elder Abuse Act, is the "negligent failure of any person having the care or custody of an elder . . . to exercise that degree of care that a reasonable person in a like position would exercise." (Welf. & Inst. Code, § 15610.57, subd. (a)(1).) Neglect includes failure to assist in personal hygiene or in the provision of food; the failure to provide medical care for physical and mental health needs; the failure to protect from health and safety hazards; and the failure to prevent malnutrition or dehydration. (*Id.*, subd. (b).)

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[1] Because plaintiffs limit their claim to neglect, and not physical abuse or financial abuse, defendants' discussion of the Elder Abuse Act will be similarly limited. Likewise, because decedent was an elder, not a dependent adult, defendants will focus upon that aspect of the Elder Abuse Act.

The "statutory definition of 'neglect' speaks not of the *undertaking* of medical services, but of the failure to *provide* medical care." (*Covenant Care, supra,* 32 Cal.4th at 783.) Thus, acts of negligence in the rendition of medical services are not governed by the Elder Abuse Act. (*Delaney, supra,* 20 Cal.4th at 34.)

Recklessness is not defined in the Elder Abuse Act. This Court has held that for purposes of the Elder Abuse Act, it is "a subjective state of culpability greater than simple negligence, which has been described as a 'deliberate disregard' of the 'high degree of probability' that an injury will occur[.]" (*Delaney, supra,* 20 Cal.4th at 31.) "Recklessness, unlike negligence, involves more than 'inadvertence, incompetence, unskillfulness, or failure to take precautions' but rather rises to the level of a 'conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it.' [Citation]." (*Id.* at 31–32.)

B. The Elder Abuse Act Intended To Provide Civil Protection To Elders Who Are So Infirm As To Be Dependent On Others For Their Basic Needs

The Elder Abuse Act begins with the Legislature's declarations and statement of intent. Section 15600 recognizes that infirm elders are a disadvantaged class. They may have mental and verbal limitations, be in poor health, be in a dependent and vulnerable position, and at risk of abuse, neglect, or abandonment by their families or caretakers. (Welf. & Inst. Code, § 15600, subds. (a)-(e), & (h).) The Elder Abuse Act does not mention professional negligence.

Nor does the statement of legislative intent suggest that the Elder Abuse Act's purpose is to protect elders from professional negligence.

In other words, the legislative purpose of the Act is to protect those elders who cannot provide for their own basic needs from abuse by the very persons upon whom they are dependent for those basic needs. More simply stated, it is to protect those elders who are "vulnerable" to abuse.

Thus, the gravamen of an elder abuse action is that the defendant abused the elderly person who was vulnerable to abuse and incapable of asking for help and protection. That is not this case.

This Court previously interpreted the legislative intent of the Elder Abuse Act. As noted in *Delaney*, "one of the major objectives of this legislation was the protection of residents of nursing homes and other health care facilities." (*Delaney, supra,* 20 Cal.4th at 37.) The Court recounted the studies of elder abuse in *health care facilities* that led to passage of section 15657. (*Delaney, supra,* 20 Cal.4th at 35-36.) Once the extent of the problem was known, the Legislature sought to deter elder abuse through criminal penalties, regulatory sanctions, and civil penalties. (See Pen. Code, § 368; Health & Saf. Code, § 1418.91; Welf. & Inst. Code, § 15657.)

The role of health practitioners is to facilitate this deterrence by reporting suspected abuse in exchange for protection from civil liability resulting from the reporting. In effect, the Elder Abuse Act functions to deter elder abuse by protecting those health practitioners and other individuals who report the abuse and by providing incentives in the form of "enhanced remedies" for those who prosecute civil actions against abusers. In other words, health

practitioners are not the group of persons from whom vulnerable elders needed protection.

1. The Intent Of The Elder Abuse Act Was To Distinguish Between Health Practitioners And Care Custodians

Under the statutory framework of the Elder Abuse Act, all three individual defendants in this case fall within the definition of "health practitioner" set forth in Section 15610.37. The phrase "health practitioner" does not appear anywhere else in the civil provisions of the Elder Abuse Act. The term "health practitioner" does not appear in Section 15610.07, which defines "abuse of an elder or a dependent adult." Likewise, the term does not appear in Section 15610.57, which defines "neglect."

Another way to describe a "health practitioner" is as a "health care provider." The only section in the Elder Abuse Act where the phrase "health care provider" appears is Section 15657.2, which states that "any cause of action for injury or damage against a health care provider, as defined in Section 340.5 of the Code of Civil Procedure, based on the health care provider's alleged professional negligence, shall be governed by those laws which specifically apply to those professional negligence causes of action." (Welf. & Inst. Code, § 15657.2.)

In addressing the concerns of the California Medical Association to the broad reporting requirements of the Elder Abuse Act, the Legislature explained that only those health practitioners with custodial obligations to elders would be liable under the Elder Abuse

Act: "The California Medical Association argues that doctors should not be responsible for the acts or omissions of another, and this bill will make them responsible in this regard. However, this argument is flawed in that the only doctors who will be liable under this law will be either those with direct supervision of the elder or doctors in charge of facilities or others with supervision over the elder." (Assem., Republican Caucus, Analysis of Sen. Bill No. 2199 (1997-1998 Reg. Sess.) as amended Apr. 28, 1998 (June 26, 1998) p. 1.)

2. The Elder Abuse Act Should Be Construed In Its Entirety, Bearing In Mind The Legislative Intent

Plaintiffs' overly simplistic interpretation of the Elder Abuse Act requires portions of the Act to be read out of context. Focusing on the phrases "care or custody" and "failure to provide medical care" contained in section 15610.57, subdivisions (a)(1) and (b)(1), plaintiffs argue that claims for "neglect" extend to a health practitioner's failure to refer the patient to a specialist. Plaintiffs take the phrases out of context in an attempt to expand liability under the Elder Abuse Act further than the Legislature intended.

Reading these phrases out of context as a means to create health practitioner liability for a failure to refer an elderly patient to a specialist is not what the Legislature intended. (*Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735 ["The meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same

subject matter must be harmonized to the extent possible"].) This Court should not ignore the statutory scheme.

C. This Court, Construing The Elder Abuse Act, Explained That Claims For Professional Negligence Are Mutually Exclusive From Claims For Neglect

This Court has twice distinguished neglect and professional negligence in the context of the Elder Abuse Act. First, in *Delaney*, the Court rejected plaintiffs' argument that conduct can give rise to both claims. (*Delaney, supra,* 20 Cal.4th at 29-30.) The Court examined the legislative history of the Act and found that "those who enacted the statute thought that the term 'professional negligence,' at least within the meaning of section 15657.2, was *mutually exclusive* of the abuse and neglect specified in section 15657." (*Id.* at 30, emphasis added.) This Court explained,

> [N]eglect within the meaning of former section 15610.57 appears to cover an area of misconduct distinct from "professional negligence" in section 15657.2: "neglect" as defined in former section 15610.57 and used in section 15657 does not refer to the performance of medical services in a manner inferior to "the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing" . . . but rather to the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations. It is instructive that the

> statutory definition quoted above gives as an example of "neglect" not negligence in the undertaking of medical services but the more fundamental "[f]ailure to *provide* medical care for physical and mental health needs."

(*Delaney, supra,* 20 Cal.4th at 34, emphasis added and citations omitted.)

Actionable conduct under the Elder Abuse Act was held to exclude "acts of simple professional negligence," and limited to "forms of abuse or neglect performed with some state of culpability greater than mere negligence." (*Delaney, supra,* 20 Cal.4th at 32.) The Court quoted a statement of the legislation's sponsor, that the Elder Abuse Act "protects providers of care from acts of simple negligence, or even gross negligence." (*Ibid.,* quoting Sen. Rules Comm., Off. of Sen. Floor Analysis, 3d reading analysis of Sen. Bill. No. 679 (1991-1992 Reg. Sess.) as amended Sept. 10, 1991, p. 2.)

Five years after its decision in *Delaney*, this Court reaffirmed that "neglect" under the Elder Abuse Act is distinct from professional negligence. In *Covenant Care,* the Court held that "the Legislature intended the Elder Abuse Act to sanction only egregious acts of misconduct distinct from professional negligence[.]" (*Covenant Care, supra,* 32 Cal.4th at 784.) The Court again explained,

> [E]lder abuse triggering the Act's heightened remedy provisions entails by its nature egregious conduct. [Citations.] And while in the medical malpractice context "there may be considerable overlap of intentional and negligent causes of action" [citation], no such overlap occurs in the

> Elder Abuse Act context, where the Legislature expressly has excluded ordinary negligence claims from treatment under the Act [citations]. [¶] In order to obtain the Act's heightened remedies, a plaintiff must allege conduct essentially equivalent to conduct that would support recovery of punitive damages.

(*Covenant Care, supra*, 32 Cal.4th at 788-789.)

Thus, "neglect refers not to the substandard performance of medical services but, rather, to the 'failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations.'" (*Covenant Care, supra,* 32 Cal.4th at 783, citing *Delaney, supra*, 20 Cal.4th at 34.)

The Courts of Appeal have generally followed this Court's lead, recognizing neglect and professional negligence are completely "different paradigms." (*Benun v. Superior Court* (2004) 123 Cal.App.4th 113, 124, 126 ["'professional negligence' is mutually exclusive of the elder abuse and neglect specified in section 15657"]; *Smith v. Ben Bennett, Inc.* (2005) 133 Cal.App.4th 1507, 1521-1523 ["section 15657.2 works like a toggle switch. If a claim is a 'cause of action . . . based on . . . professional negligence,' then 'those laws which specifically apply to . . . professional negligence causes of action' apply, and the Elder Abuse Act does not"]; *Berkley v. Dowds* (2007) 152 Cal.App.4th 518, 529 ["Acts of simple or even gross negligence will not justify the additional civil damage remedies"]; *Carter, supra*, 198 Cal.App.4th at 405-407 [same].)

The Opinion, however, departed from the distinction between professional negligence and elder abuse. While the *Winn* majority acknowledged *Delaney* and the mutually exclusive nature of claims for professional negligence and neglect, it nevertheless stated that plaintiffs may allege claims for *both* professional negligence and elder abuse on the same set of facts. (Slip Opn., p. 19.)

II. PLAINTIFFS' ALLEGATIONS BASED UPON THE HEALTH PRACTITIONERS' FAILURE TO REFER A PATIENT TO A SPECIALIST ARE INSUFFICIENT TO STATE A CLAIM OF NEGLECT

A health practitioner who fails to refer an elder patient to a specialist does not commit neglect. Far more than that must be alleged. There must be factual allegations that the practitioner refused to provide any care to the patient. There also must be factual allegations that the provider's refusal was subjectively culpable.

There are no such allegations in this case, nor can there be. The patient saw several health practitioners, all of whom provided care to the patient.[2] That care occurred over the course of several years. The fact that the patient received care – *any* care – from the practitioners

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[2] The phrase "health care provider," as it is used in Welfare and Institutions Code section 15657.2, refers to all California health care providers, including hospitals and skilled nursing facilities. The phrase "health practitioner," as it is defined in Section 15610.37, refers only to individual providers, such as the defendant "physician" and the two defendant "podiatrist[s]" of the defendant Pioneer Medical Group. Hospitals, skilled nursing facilities, and other facilities where patients receive care on an inpatient basis are not "health practitioners."

each time she went to their offices indisputably rebuts a claim of neglect under the Elder Abuse Act.

A. Alleged Omissions Occurring During Medical Treatment Give Rise, At Most, To A Claim For Professional Negligence, But Not Neglect

Plaintiffs allege that, during the course of outpatient treatment for foot problems over several years, defendant health practitioners did not refer the patient to a vascular specialist. (AA 73-75.) Plaintiffs allege that decedent's condition worsened and that "the only appropriate care at that time (after cleaning the wound) would have been a referral to a vascular specialist[.]" (AA 73.) In particular, plaintiffs allege that,

> Notwithstanding the deterioration of the vascular flow in the legs of the Plaintiffs' Decedent, Defendants decided not to make a referral to a vascular specialist. In February 2008, Dr. Lowe noted that [decedent]'s vascular examination was "unremarkable," while also noting that she "had an abscess of the lateral aspect of the right hallux nail plate and cellulitic [acute spreading bacterial infection below the surface of the skin] changes of the left hallux nail plate." These findings are well known in the health care profession to be consistent with tissue damage due to vascular insufficiency.

(AA 72.)

These omissions are alleged to have occurred during the rendition of medical care. Most notably, plaintiffs do not allege that

defendants *deprived* the patient of medical treatment. To the contrary, plaintiffs allege that defendants "were engaged in the practice of medicine and/or podiatry," but that they "failed to recognize the need for a specialist referral." (AA 3, 70, 162.)

The care that defendants provided to decedent, as alleged in the First Amended Complaint, includes treatment for "painful onychomycosis" (AA 71), drainage of a bacterial infection in decedent's toe (AA 72-73), and prescription medication for a bacterial infection and a laceration on decedent's foot (*ibid.*). Plaintiffs allege that the defendant health practitioners were negligent "in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death[.]" (Code Civ. Proc., § 340.5; Civ. Code, § 3333.2, subd. (c)(2).)

Viewed merely from the perspective of the type of conduct at issue, this Court's opinions in *Delaney* and *Covenant Care* lead to an inescapable conclusion: this is not a case of neglect. Defendants are alleged to have not only provided medical care, but to have done so for years. Defendants never refused care, but are faulted by plaintiffs for failing to refer their patient to a vascular specialist.

Long ago, this Court recognized that physicians have a duty to refer their patients to a specialist if other reasonably careful physicians would have done so under the circumstances. (*Sinz v. Owens* (1949) 33 Cal.2d 749, 758-759; *Simone v. Sabo* (1951) 37 Cal.2d 253, 257.) Failing to do so may constitute professional negligence. For nearly 65 years this duty has been a core medical negligence theory. Of course, this negligence theory long predates the Elder Abuse Act.

In fact, this is such a standard theory of professional negligence that it has long been reduced to a form jury instruction. CACI has a jury instruction addressing precisely this theory, as does BAJI. (See Judicial Council of California, *Civil Jury Instructions* (Spring 2013) No. 508 ("Duty to Refer to a Specialist"); see also West's Committee on California Civil Jury Instructions, *California Jury Instructions, Civil* (Spring 2013) No. 6.04 ("Duty to Refer to Specialist").)

The fact that defendants' alleged conduct constitutes professional negligence was not lost upon plaintiffs. Understanding that failure to refer to a specialist is a theory of medical negligence, they filed and pursued a separate medical negligence action. (AA, 110-114.) It is not surprising that they did so. What is puzzling, however, is why they did so in a separate lawsuit.

Delaney, Covenant Care, and their progeny recognize the mutual exclusivity of claims for professional negligence and neglect. (*Delaney, supra*, 20 Cal.4th 23, 30, 34; *Covenant Care, supra,* 32 Cal.4th at 783.) The *Winn* majority's willingness to allow plaintiffs to state a neglect claim under the Elder Abuse Act where the gravamen of the action is professional negligence contravenes *Delaney*, *Covenant Care,* and their progeny.

The same set of facts does not give rise to both professional negligence and neglect claims, especially when the theory at issue is a failure to refer the patient to a specialist – a theory of professional negligence.

B. Additionally, A Claim Of Neglect By A Health Practitioner Requires That The Practitioner Have Deprived The Patient Of *All* Medical Care

There is yet another reason why plaintiffs' neglect claim fails. In order for plaintiffs to pursue a neglect claim against health practitioners, they would have to allege and prove that the defendants refused to render *any* medical care themselves to the patient in addition to refusing to refer the patient *to any other* practitioners for medical care.

"Neglect" is statutorily defined as the "negligent *failure*" of a custodial caregiver to exercise that degree of care that a reasonable person in a like position would exercise. (Welf. & Inst. Code, § 15610.57, subd. (a)(1), emphasis added.) Webster's New College Dictionary defines "failure" as "[n]onperformance of what is requested or expected: Omission." (Webster's New College Dict. (3d ed. 2005) 410.) It follows then that the "[f]ailure to provide medical care for physical or mental health needs" does not mean the provision of deficient medical care. (Welf. & Inst. Code, § 15610.57, subd. (b)(2).) It means the nonperformance – or complete absence – of care.

Delaney noted that "the statutory definition quoted above gives as an example of 'neglect' not negligence in the undertaking of medical services but the more fundamental '**[f]ailure** to *provide* medical care for physical and mental health needs.'" (*Delaney, supra,* 20 Cal.4th at 34, emphasis in bold added.) This distinction was repeated in *Covenant Care*, in which the Court characterized "neglect" as including "the egregious *withholding* of medical care[.]" (*Covenant Care, supra,* 32 Cal.4th at 786, emphasis added.)

To be sure, both *Delaney* and *Covenant Care* arose in the nursing facility context and involved defendants who refused to provide any medical care to the elder and prevented the elder from receiving care from another person. (*Delaney, supra,* 20 Cal.4th at 27-28 [nursing staff prevented necessary information from being transmitted to the decedent's personal physician and the decedent had stage IV bedsores]; *Covenant Care, supra,* 32 Cal.4th at 777-778 [nursing facility owners admitted and ordered discharge of decedent from health facilities, withheld essential care, and ultimately transferred decedent to a facility ill-equipped to handle his needs].)

Similar language, such as "failure," "withholding," and "denial," has been repeated in the Court of Appeal opinions construing the statute. (See, *e.g.*, *Smith v. Ben Bennett, Inc.*, *supra*, 133 Cal.App.4th at 1512 [decedent was denied medical care at skilled nursing facility]; *Benun v. Superior Court*, *supra*, 123 Cal.App.4th at 124-125; *Carter*, *supra*, 198 Cal.App.4th at 408 [demurrer affirmed where no allegation hospital "denied or withheld" care or treatment].)

In short, to state a claim for neglect under the Elder Abuse Act, plaintiffs must allege facts demonstrating that the health practitioner defendant refused to provide any medical care. That, of course, is not the case here.

C. Neglect Also Requires Factual Allegations Of A High Level Of Culpability Plead With Particularity

It is not enough for plaintiffs to allege that a health practitioner owed custodial obligations to an elder and that the defendant deprived

the elder of any medical care whatsoever. Section 15657 requires that plaintiffs must also allege that the health practitioner "has been guilty of recklessness, oppression, fraud, or malice in the commission of this abuse[.]" "In order to obtain the Act's heightened remedies, a plaintiff must allege conduct essentially equivalent to conduct that would support recovery of punitive damages." (*Covenant Care*, *supra*, 32 Cal.4th at 789.)

Plaintiffs allege in conclusory terms that the health practitioners acted "recklessly" in failing to refer decedent to a specialist. Recklessness is more than "simple or even gross negligence." (*Carter, supra,* 198 Cal.App.4th at 405.) It is more than "inadvertence, incompetence, unskillfulness, or a failure to take precautions." (*Delaney, supra,* 20 Cal.4th at 31-32.) Recklessness is the "deliberate disregard of the high degree of probability that an injury will occur and rises to the level of conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it." (*Carter*, *supra*, 198 Cal.App.4th at 405, internal quotations omitted.)

The mere failure of a health practitioner to refer a patient to a specialist is not sufficient to constitute "reckless neglect" of an elder. This Court held in *Delaney* that reckless neglect is extreme and that enhanced remedies under the Elder Abuse Act are available only for acts of "egregious abuse." (*Delaney, supra,* 20 Cal.4th at 35.) Then in *Covenant Care*, the Court described the standard as even higher, noting that the Elder Abuse Act requires plaintiffs to prove not just "egregious" abuse, but "especially egregious" abuse. (*Covenant Care*, *supra*, 32 Cal.4th at 779.)

Plaintiffs did not allege facts demonstrating that the health practitioners were reckless – instead they relied on hyperbole and conclusory language in attempt to elevate what is simply a claim for professional negligence. Such conclusory allegations are insufficient. Addressing this very issue, the Court of Appeal in *Carter* held that the plaintiffs' allegations that the defendant "acted 'recklessly' or 'fraudulently'" were not sufficient to plead neglect under the Elder Abuse Act. (*Carter*, *supra,* 198 Cal.App.4th at 410.) Plaintiffs must allege facts, not conclusions. (*Ibid.*) This is because for purposes of demurrer, courts do not assume the truth of contentions, deductions, or conclusions of law. (*Aubry v. Tri-City Hospital Dist.* (1992) 2 Cal.4th 962, 966-967.) And, those facts "must be pleaded with particularity," because statutory remedies are invoked. (*Ibid*, citing *Covenant Care*, *supra*, 32 Cal.4th at 790.)

D. The Court Must Determine From The Allegations If The "Gravamen" Of The Claim Is Professional Negligence Or Neglect

Courts look to the "gravamen" of a plaintiff's action against a health practitioner to determine whether the Elder Abuse Act applies. (*Covenant Care*, *supra*, 32 Cal.4th at 790 [statutory limitation on pleading punitive damages claims against health care providers in professional negligence actions does apply where "the gravamen of an action is violation of the Elder Abuse Act"]; see, e.g., *Country Villa Claremont Healthcare Center, Inc. v. Superior Court* (2004) 120 Cal.App.4th 426, 429 ["the gravamen of real parties' claims, both statutory and nonstatutory, is elder abuse"]; *Smith v. Ben Bennett,*

Inc., *supra*, 133 Cal.App.4th at 1525 [plaintiff's elder abuse allegations were sufficient to "alter[] the gravamen of what would otherwise have been professional negligence causes of action"].)

The "gravamen" of this case – in which plaintiffs' claim is based on nothing more than the practitioners' failure to refer their patient to specialist – is not elder abuse; it is professional negligence. That was correctly noted in the dissent to the Opinion. (Slip Opn., dis. opn. of Bigelow, P.J., p. 8, fn. 3.) The dissent states that the "gravamen" of plaintiffs' claim is professional negligence and that "[t]he only thing that distinguishes this case from a standard medical malpractice claim is that [decedent] was over 65 years old." (*Id.* at p. 4.)

The dissent concluded the "gravamen" of plaintiffs' claim is professional negligence based on a number of factors. The patient visited the defendant physicians only on an outpatient basis and the patient was not inhibited from seeking a second opinion. (*Id.* at p. 5.) The dissent also emphasized that there were no allegations that decedent was in a nursing home or had diminished cognitive abilities, that defendants acted intentionally or fraudulently, or that there was a complete failure to treat her condition. (*Ibid.*) While the absence of any one of these allegations is not determinative, the fact that none is alleged means that the "gravamen" of the claim is not elder abuse.

III. A CLAIM FOR NEGLECT REQUIRES ALLEGATIONS THAT THE HEALTH PRACTITIONER HAVE A CUSTODIAL RELATIONSHIP WITH THE PATIENT

In order for a patient or patient's family to pursue an action for neglect against a health practitioner, the plaintiffs must allege sufficient facts to show that the practitioner had a custodial relationship with the patient. Analysis of whether that type of relationship existed between the patient and the practitioner begins with a determination of whether the patient was dependent upon the practitioner, rather than herself or another person, for her basic needs. If so, the next step in the analysis is to determine whether the practitioner knew about and accepted the additional custodial obligations for the patient's basic needs. Only then would the deterrent function of the "civil protection" feature of the Elder Abuse Act be directed at the practitioner.

There are no such allegations in this case, nor can there be. The patient saw the health practitioners on an outpatient basis, which means she was independent. She was not dependent on others for her basic needs. Stated in terms of the Legislature's intent, decedent was not "vulnerable to abuse and incapable of asking for help and protection" such that she was "more subject to risks of abuse, neglect, and abandonment." (Welf. & Inst. Code, § 15600, subds. (b) & (c).) Nothing about decedent's condition placed her within the "disadvantaged class" sought to be protected by the Act. (*Id.* at subd. (h).)

A. Under The Plain Language Of The Statute, Plaintiffs Must Allege That The Health Practitioner Was Obligated To Provide Custodial Services – Not Just Health Care – To The Patient

"Neglect" is defined by the Legislature to mean "[t]he negligent failure of any person *having the care or custody of an elder* or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." (Welf. & Inst. Code, § 15610.57, subd. (a)(1), emphasis added.) "Having the care or custody" means that the defendant must have "custodial obligations," not merely provide care.

Related statutory provisions corroborate that treating or providing care to a patient is not the same as "having the care or custody" of the patient. That is, "treat[ing] an elder or a dependent adult" is recognized by statute to be distinct from "having the care or custody" of an elder or dependent adult. Indeed, Section 15610.37 defines "health practitioner" as a specified class of person "who treats an elder or a dependent adult for any condition." (Welf. & Inst. Code, § 15610.37.) Section 15630, which defines mandated reporters of elder abuse, distinguishes between those persons who have "assumed full or intermittent responsibility for the *care or custody* of an elder" and health practitioners. (Welf. & Inst. Code, § 15630, subd. (a), emphasis added.) The implication is that health practitioners serve a purpose different from what the Legislature calls "having the care or custody of an elder[.]"

This is further supported by the Legislature's stated intent in Section 15600, which lists the "factors" contributing to neglect under

the Elder Abuse Act: "factors which contribute to . . . neglect . . . of elders and dependent adults are economic instability of the family, resentment of caretaker responsibilities, stress on the caretaker, and abuse by the caretaker of drugs or alcohol." (Welf. & Inst. Code, § 15600, subd. (e).) Those factors apply to persons with custodial obligations to elders and dependent adults, such as family members. They do not apply to health practitioners who "treat[] an elder or a dependent adult[.]" (Welf. & Inst. Code, § 15610.37.)

Additionally, the Legislature's use of the definite article "the" preceding the term "care or custody" indicates the need of a relationship more significant than merely between someone who provides, or is in the position to provide, care and the recipient of that care. Had the Legislature intended to include within the ambit of Section 15610.57, subdivision (a), anyone who provides "care," it could have easily excluded the modifiers "having" and "the" from the subdivision (a), and instead written the operative phrase in Section 15610.57 as: ". . . any person caring for an elder or dependent adult . . . ." (See *CD Investment Co. v. California Insurance Guarantee Assn.* (2001) 84 Cal.App.4th 1410, 1421 ("In construing [a] statute, [the] definite article 'the' particularizes the subject which it precedes and is [a] word of limitation as opposed to [an] indefinite or generalizing force [such as] 'a' or 'an.'").)

Furthermore, the Legislature's decision not to repeat the definite article "the" before the word custody (e.g., "having the care or the custody") means that "care" and "custody" should be read as identical or synonymous. (See Bryan A. Garner, *A Dictionary of Modern Legal Usage* (2d ed. 1995), p. 77 ("When two or more nouns

are connected by a conjunction, it is usually best to repeat the article before each noun. When the article is not repeated, the sense conveyed is that the nouns are identical or synonymous.").]

B. This Court Confirmed In *Delaney* And *Covenant Care* That Custodial Obligations Are Prerequisite To A Claim For Neglect

To the extent there exists any doubt as to the necessity of "custodial obligations" for elder abuse liability, this Court stated it twice. In *Delaney*, the Court described "neglect" in terms of the defendant's responsibilities to the elder: "the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations." (*Delaney, supra,* 20 Cal.4th at 34.) Such "custodial functions" include, for example, the furnishing of nutrition to someone too infirm to attend to that need herself. (*Id.* at 34-35.) As this Court explained, "one of the primary purposes of section 15657 [is] to protect elder adults through the application of heightened civil remedies from being recklessly neglected *at the hands of their custodians*, which includes the nursing homes or other health care facilities in which they reside." (*Delaney, supra,* 20 Cal.4th at 42, emphasis added.)

On revisiting the Elder Abuse Act in *Covenant Care*, this Court stated it even more expressly: "statutory elder abuse includes neglect as defined in Section 15610.57 (Welf. & Inst. Code, § 15657), which in turn includes negligent failure of an elder *custodian* to provide medical care for [the elder's] physical and mental health needs."

(*Covenant Care, supra,* 32 Cal.4th at 783, internal quotations and citations omitted, emphasis added.) The Court explained,

> Without question, health care provider and elder custodian "capacities" are conceptually distinct. "Health care provider" means any person licensed or certified pursuant to specified licensing provisions and any licensed clinic, health dispensary, or health facility and their legal representatives. [Citation.] Neglectful elder abuse, by contrast, as noted, is "the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, *regardless of their professional standing,* to carry out their *custodial* obligations."

(*Covenant Care, supra*, 32 Cal.4th at 785.)

This Court described the analysis as whether the plaintiffs allege that the defendant breached "custodial obligations" to the patient or whether they breached health care provider duties. The Court even recognized that some facilities such as nursing homes perform both functions. (*Covenant Care, supra,* 32 Cal.4th at 786.) But that is not the case here where defendants only provided medical care.

The Courts of Appeal have generally followed suit in acknowledging that liability under Section 15610.57 requires custodial obligations. (*Carter, supra,* 198 Cal.App.4th at 406 (responsibility for meeting basis needs); *Country Villa Claremont Healthcare Center, Inc. v. Superior Court, supra,* 120 Cal.App.4th at 432 (claims based on custodial neglect rather than professional negligence); *Benun v. Superior Court, supra*, 123 Cal.App.4th at 123

(custodial obligations); and *Smith v. Ben Bennett, Inc.*, *supra*, 133 Cal.App.4th at 1522 (conduct by the "custodian of an elder").)

C. The *Winn* Majority Rejected *Delaney* And *Covenant Care*, Opting Instead To Rely On Inapposite Court of Appeal Authority

The Majority Opinion dismissed this Court's references to "custodial neglect" and "custodial obligations" based on the context of the previous cases, concluding that those decisions did not propose to construe the Elder Abuse Act in a context other than nursing facilities where custodial obligations are necessarily owed. (Slip Opn., pp. 11, 14.)

Instead, the Opinion followed *Mack v. Soung* ("*Mack*") (2000) 80 Cal.App.4th 966, to conclude that neglect is the provision of inadequate medical care in contexts other than where the defendant had control over the elder's basic needs. (Slip Opn., pp. 10-11.) The majority's reliance upon *Mack* is misplaced given the fact that it arose in a nursing home context and the defendant indisputably was responsible for providing custodial care to the decedent. (*Mack, supra,* 80 Cal.App.4th at 969.)

Mack does not govern here. First, *Mack* is readily distinguishable. The elder patient in *Mack* resided in a nursing facility, where the defendant health practitioner attended to her. Plaintiffs' allegations were that the defendant actively concealed the existence of bedsores, opposed/prevented hospitalization of the elder, and then abruptly abandoned the patient. (*Id.* at 969.) There are no similar allegations in this case. These distinctions are significant. As

the Opinion's dissent noted, "the differences between *Mack* and this case are telling." (Slip Opn., dis. opn. of Bigelow, P.J., p. 4.)

Moreover, the defendant in *Mack* took the extreme position that no health practitioner can ever be liable under the Act because it applies only to "institutional health care facilities and cannot apply to physicians such as [the defendant], who merely treat elderly patients on an 'as needed' basis." (*Mack, supra*, 80 Cal.App.4th at 974.) Here, however, defendants acknowledge that a health practitioner may be civilly liable for neglect under the Elder Abuse Act – but *only if* the health practitioner assumed custodial obligations to an elderly patient who depended on the practitioner for his or her basic needs, and only if practitioner culpably deprived the patient of any medical care or otherwise prevented the patient from receiving care. The *Mack* Court merely concluded that a defendant's "status as a physician does not immunize him from liability for elder abuse." (*Id.* at 975.)

Second, *Mack*'s continuing vitality is questionable given the fact that it was decided before *Covenant Care,* which explained that actions brought against health care providers in their capacity as health care providers are not subject to the Elder Abuse Act. (*Covenant Care, supra,* 32 Cal.4th at 786.)

Third, the *Mack* court misinterpreted the language of the Elder Abuse Act. *Mack* incorrectly states that the Legislature intended all health practitioners to fall within that group of persons who provide "care and custody" of elders. (*Mack, supra,* 80 Cal.App.4th at 974.) In fact, *Mack*'s interpretation and quotation of the statute omits critical language from the statutory text. The mandatory reporting provision of the Elder Abuse Act states verbatim:

> Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, ***or*** any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

(Welf. & Inst. Code, § 15630, subd. (a), emphasis added.)

But, the court's quotation and interpretation omits a disjunction. The key word is "or" because it distinguishes "person who has assumed full or intermittent responsibility for the care or custody of an elder" from a "health practitioner." The court in *Mack* misread this provision, however, by ignoring the "or." The court misquoted the statute as follows:

> [*a*]*ny person who has assumed full or intermittent responsibility for care or custody of an elder* or dependent adult, whether or not that person receives compensation, *including* . . . any elder or dependent adult care custodian, *health practitioner*, . . . is a mandated reporter. (§ 15630, subd. (a), italics added.)

(*Mack, supra,* 80 Cal.App.4th at 974.)

The *Mack* Court erroneously determined that health practitioners automatically fall within the category of persons who assume "care or custody" of elders. That interpretation contravenes

the language of the Elder Abuse Act, the Legislature's intent in enacting the civil protections, and this Court's interpretation of the Elder Abuse Act. To plead neglect, plaintiffs must allege that the health practitioners were in a custodial relationship with the elderly patient.

IV. PLAINTIFFS' ALLEGATIONS OF THE DEFENDANTS' CONDUCT IN CONCLUSORY TERMS WERE INSUFFICIENT TO STATE A CLAIM OF NEGLECT

A cause of action for elder abuse against health practitioners is not established by simply characterizing the defendants' care in conclusory terms such as "*abuse* and/or *neglect*" or even "*abandonment.*" Nor is an elder abuse claim against health practitioners established by adding adjectives such as "*egregious*," "*willful*," or even "*reckless*."

Addressing this very issue, the Court of Appeal in *Carter* held that plaintiffs' allegations that defendant "acted 'recklessly' or 'fraudulently'" were insufficient to plead neglect under the Elder Abuse Act. (*Carter*, *supra,* 198 Cal.App.4th at 410.) Plaintiffs must plead facts, not conclusions, and those facts "must be pleaded with particularity." (*Carter*, *supra,* 198 Cal.App.4th at 410, citing *Covenant Care*, *supra*, 32 Cal.4th at 790.)

Turning to plaintiffs' First Amended Complaint, in this case it is apparent why the trial court sustained the demurrer. In sustaining the demurrer to the original complaint, the trial court explained "in some detail why plaintiffs' complaint failed to state a cause of action"

for neglect. (AA 157.) This shortcoming persisted in the First Amended Complaint. It remained replete with conclusory allegations.

First, there are no allegations that decedent was dependent on defendants – or anyone else for that matter – for her basic needs. Based on the facts alleged, no inference can be drawn that decedent was a "vulnerable" elder who was "incapable of asking for help and protection." (Welf. & Inst. Code, § 15600, subd. (c).) To the contrary, decedent voluntarily sought outpatient treatment over the course of several years from defendants.

Second, plaintiffs acknowledge that the defendant health practitioners provided treatment to decedent, which treatment was chronicled throughout the complaint. (AA 71 ["Defendants, and each of them, agreed and undertook to care for, treat and attend the decedent"]; *id.* at AA 70-74 [e.g., drained infection, prescribed medication, cleaned wound, recommended medications and other therapies].) Plaintiffs do not allege that defendants completely withheld treatment.

Third, the alleged conduct did not rise to the level of "egregious abuse." The conduct complained of is defendants' alleged failure to recognize the need for a specialist referral. (AA 73, 158.) Plaintiffs alleged that "Defendants' conscious failure to make such a vascular referral at any time during that period constitutes abuse and/or neglect as defined under the Act." (AA 75.) "Said failure by Defendants reflects a deliberate disregard for the high degree of probability that significant injury and certain suffering would befall Plaintiffs' Decedent . . . ." (*Ibid.*) These conclusory allegations are completely devoid of any facts evidencing malice, conscious disregard,

oppression, or fraud in egregiously withholding medical care. There is no contention that defendants deliberately or willfully refused to refer decedent to a vascular specialist.

Plaintiffs alleged, at most, professional negligence. The Opinion's dissent is correct in stating: "It is indisputable that plaintiffs' complaint concerns defendants' allegedly negligent undertaking of medical services, rather than a failure of those responsible for attending to [decedent]'s basic needs and comforts to carry out their custodial or caregiving obligations." (Slip Opn., dis. opn. of Bigelow, P.J., p. 3.) The majority's analysis is wrong.

The majority's view that the same set of facts may constitute professional negligence and neglect is based upon a misimpression that negligence is tantamount to a lesser included offense of neglect. Not so. "[W]hile in the medical malpractice context there may be considerable overlap of intentional and negligent causes of action . . . no such overlap occurs in the Elder Abuse Act context, where the Legislature expressly has excluded ordinary negligence claims from treatment under the Act." (*Covenant Care*, *supra*, 32 Cal.4th at 789, citing Welf. & Inst. Code, § 15657.2; *Delaney, supra*, 20 Cal.4th at 30.) In other words, the statute and the controlling authorities make clear that neglect under the Elder Abuse Act and professional negligence differ *by definition*. The same set of facts cannot give rise to both claims.

Having failed to sufficiently allege a claim for neglect, the trial court's order of dismissal after sustaining the demurrer should have been affirmed. Accordingly, the Opinion should be reversed.

V. TRIAL COURTS SHOULD BE ENCOURAGED TO EVALUATE THE SUFFICIENCY OF NEGLECT CLAIMS ALLEGED AGAINST HEALTH PRACTITIONERS TO AVOID THE IRREPARABLE HARM CAUSED BY ARTFUL PLEADING

The issue presented in this case almost always will be capable of determination by demurer. The question of whether a plaintiff sufficiently states a cause of action for neglect under the Elder Abuse Act against a health practitioner is an issue of law, not fact. (See Code Civ. Proc., § 589.) It is an issue to be decided by the trial court, not the jury. Judicial efficiency demands that trial courts make this decision.

The Opinion deferred to the jury to decide which paradigm to apply – neglect under the Elder Abuse Act or professional negligence. (Slip Opn., p. 19.) But, the Opinion's analysis is erroneous. It is for the trial court, not the jury, to decide whether the elder abuse "paradigm" has been sufficiently alleged. Elder abuse arises when there is a custodial relationship between the patient and health care provider, as this Court held in *Delaney* and *Covenant Care*. The other "paradigm" – professional negligence – arises when there is a professional relationship but no custodial relationship.

As succinctly summarized in the dissent, given the factual allegations of the complaint, "the gravamen of plaintiffs' claim is one of professional negligence, not elder abuse." (*Id.* at p. 9.) The dissent reached this conclusion, in part, because "[t]here are no allegations identifying any obligations defendants had to [decedent] that were distinct from the provision of professional medical care." (*Id.* at p. 9.) The additional conclusory allegations that defendants'

conduct was "reckless" and "egregious" does not limit a court's ability to construe the gravamen of the claim.

If anything, such conclusory allegations make it all the more important that trial courts carefully review the allegations of the complaint on demurrer. The Opinion would frustrate the purpose of California's tort reform statutes by permitting plaintiffs to artfully plead their claims against health practitioners in terms of neglect under the Elder Abuse Act, rather than professional negligence. Worse, the majority effectively encourages plaintiffs to simultaneously pursue claims for professional negligence and neglect, leaving it for the jury to sort out these issues. This will have far-reaching consequences for health practitioners who treat elders.

The specter of artful pleading is real in medical malpractice cases. The Legislature recognized this practice, and passed Code of Civil Procedure section 425.13 to protect health care providers from having to defend against unfounded claims for punitive damages. This procedural device is intended to relieve health practitioners from the "drastic effects" of defending against uncovered punitive damages claims at the time they are pleaded. (*College Hospital Inc. v. Superior Court* (2004) 8 Cal.4th 704, 709, 720; *Aquino v. Superior Court* (1993) 21 Cal.App.4th 847, 853.) In construing the scope of Section 425.13, this Court rejected an interpretation that "effectively permits artful pleading to annul the protection afforded by that section." (*Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 191.)

The Legislature also recognized that the practice of artful pleading in elder abuse cases is not only real, but it continues. In

2004, facing a proposed amendment that would eliminate MICRA (more specifically, Section 15657.2) from the Elder Abuse Act, the Legislature acknowledged the problem: "We have seen an enormous growth in civil actions filed against physician which allege both malpractice and elder/dependent adult abuse. Since the latter action has a provision for attorney fees beyond those specified in MICRA, this is perhaps not surprising. The *routine pleading of elder/dependent adult abuse* is contributing to rising malpractice premiums. Legislation, such as AB 2611, that would make these claims even more attractive to trial attorneys will exacerbate the situation." (Assem. Republican Caucus, Analysis of Assem. Bill No. 2611 (2003-2004 Reg. Sess.) as amended Aug. 9, 2004 (Aug. 24, 2004), p. 3.) The Legislature rejected the proposed amendment.

Yet the *Delaney* and *Covenant Care* Courts were seemingly not concerned with the threat of artful pleading in the context of elder abuse claims, presumably due to the mutually exclusive nature of professional negligence and neglect claims, coupled with the fact that there is no overlap of these claims since "the Legislature expressly has excluded ordinary negligence claims from treatment under the Act[.]" (*Covenant Care*, *supra*, 32 Cal.4th at 788-789, internal quotations and citations omitted.) That is to say, professional negligence is not subject to the Elder Abuse Act. But, the Opinion has created that very overlap of claims that was not supposed to exist, thereby blurring the line between professional negligence and neglect claims, and pushing the door wide open to artful pleading.

Allowing the pleading of neglect claims against health practitioners to continue will only exacerbate the problem. Make no

mistake, this issue is real. If the Opinion is affirmed, plaintiffs will side-step California's tort reform statutes. The threat of unregulated claims for punitive damages and other "enhanced remedies" will artificially elevate the settlement value of plaintiffs' claims. Meritless elder abuse allegations wreak havoc on settlements by unreasonably inflating plaintiffs' expectations. Plaintiffs are able to achieve artificially inflated settlements because "enhanced remedies" under the Act are not covered by malpractice or liability insurance. (See Ins. Code, § 533; *Community Care and Rehabilitation Center v. Superior Court* (2000) 79 Cal.App.4th 787, 791, fn. 5, disapproved of on another ground in *Covenant Care*, *supra*, 32 Cal.4th at 791, fn. 12.) Thus, defendants facing such claims risk personal exposure and pay an inflated "professional negligence" settlement to avoid the risk of an elder abuse finding.[3]

Health care providers should be encouraged to treat California's growing elderly population. According to the U.S. Census Bureau, as of 2010, California has the largest number of elderly persons in the nation, with over 4.2 million. (Admin. on Aging, U.S. Dept. Health & Human Services, A Profile of Older Americans: 2011 (2011) p. 9; Bureau of the Census, U.S. Dept. of Commerce, The Older Population: 2010 (Nov. 2011) p. 9.) That number will rapidly increase by almost 200% by the year 2060. (Cal. Dept. of Finance,

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[3] This may also explain why few elder abuse cases are tried and why so many of the appellate cases involve either a pleading challenge or arise from a petition for writ of mandate. To an individual defendant, the potential personal exposure to uncovered liability under the Elder Abuse Act is too great to risk going to trial, no matter the likelihood of a defense verdict.

Rep. P-2: Population Projections by Race/Ethnicity and 5 Year-Age Groups (Jan. 2013) <http://www.dof.ca.gov/research/demographic/reports/projections/P-2> [as of Sept. 30, 2013].) The practical effect of the Opinion, if unreversed, would likely scare many doctors away from treating the elderly with risks of greatly expanded civil liability.

The supply of health practitioners, particularly those specializing in geriatric medicine, is unlikely to keep pace with this growth. A report by the Association of American Medical Colleges estimates that there will be a shortage of 130,000 physicians by 2025. (Assn. of American Medical Colleges, Physician Shortages to Worsen Without Increases in Residency Training <https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf> [as of Sept. 30, 2013].) This will be compounded by the increase in demand for health care under the Affordable Care Act. With millions of new patients set to gain insurance coverage, the availability of care will be further strained.

Moreover, an expansion of liability under the Elder Abuse Act may encourage health practitioners to increase the degree of "defensive medicine" they practice, significantly increasing the cost of delivery of health care and further impeding access to care. Worse yet, with an expansion of liability, some health practitioners may limit their practice to avoid the increased personal exposure.

CONCLUSION

An allegation that a health practitioner provided medical care but allegedly failed to refer a patient to a specialist sounds in professional negligence, not neglect. This type of conduct is not what the Elder Abuse Act was meant to address. By the same token, the Elder Abuse Act was not meant to apply to health practitioners in their role as providers of medical care. Rather, it is limited to care custodians in a custodial relationship with the elder.

The allegations of the First Amended Complaint are insufficient. The Opinion should be reversed.

DATED: October 15, 2013

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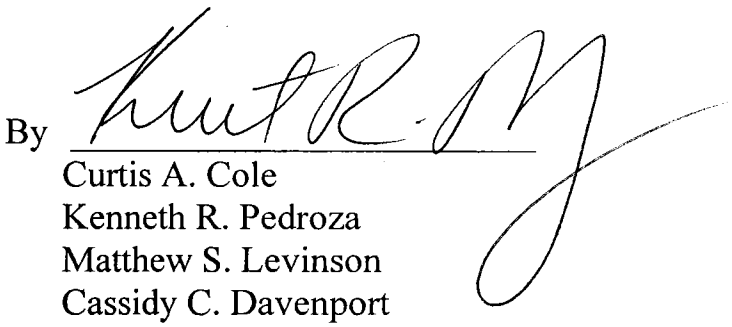
By 

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CERTIFICATION

Appellate counsel certifies that this brief contains 9,979 words. Counsel relies on the word count of the computer program used to prepare the brief.

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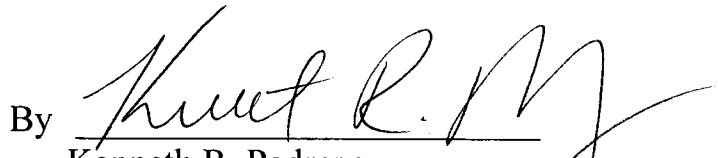
By 

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PROOF OF SERVICE

I am employed by Cole Pedroza LLP, in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 200 S. Los Robles Ave., Suite 300, Pasadena, California 91101.

On the date stated below, I served in the manner indicated below, the foregoing document described as: OPENING BRIEF ON THE MERITS on the parties indicated below by placing a true copy thereof, enclosed in a sealed envelope addressed as follows:

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By United States Postal Service – I am readily familiar with the business's practice for collecting and processing of correspondence for mailing with the United States Postal Service. In that practice correspondence would be deposited with the United States Postal Service that same day in the ordinary course of business, with the postage thereon fully prepaid, in Pasadena, California. The envelope was placed for collection and mailing on this date following ordinary business practice.

I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 15th day of October, 2013.

Cynthia Michelena

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