



PRIMARY CARE LIABILITY ALERT®

A bi-monthly nationwide review of medical liability for
Family Practitioners ■ General Practitioners ■ Internists ■ Pediatricians
with medical liability analysis and risk management advisory
by Ira J. Zarin, Esq.

Primary Care Malpractice Review with Analysis

- **\$1,000,000 GROSS VERDICT** - Primary care - Neurology - Failure to diagnose stroke 2
Jury finds contributory negligence by plaintiff for pre-treatment smoking habit. *(Atypically, the jury finds liability against a primary care physician and a referred-to neurologist for misdiagnosing a pending stroke as a migraine headache, but then reduces the award finding the patient's smoking habit constituted contributory negligence)*
- **\$475,000 RECOVERY** - Primary care negligence - Failure to diagnose lung cancer - Diagnosis finally made at stage where treatment options were allegedly unavailable 4
Death less than two years later. *(The use of the "Futility of treatment" defense in a medical malpractice case carries with it significant risks and should be carefully considered before proceeding with this strategy)*

Additional Primary Care Malpractice Verdicts

- Primary Care
\$650,000 RECOVERY - Failure to timely diagnose and treat small bowel obstruction - 43-year-old plaintiff dies of cardiac arrest and hypoxia during diagnostic testing . . . 6
- \$300,000 CONFIDENTIAL RECOVERY** - Failure to diagnose prostate cancer - Failure to screen for prostate cancer - Wrongful death. 7
- DEFENDANT'S VERDICT** - Failure to appreciate fracture of right navicular bone on radiology film - Non-union - Surgical repair, bone grafting, bone stimulator and nine months of recovery 7

Medical Practice Liability

BUSINESS PRACTICES/UNFAIR COMPETITION

- An arbitration agreement signed by a patient upon admission to a nursing facility was an unenforceable contract of adhesion because the patient had no other options and was in pain at the time. 8

INFORMED CONSENT

- A physician who performed the same back surgery on a patient a second time soon after the first procedure may have failed to obtain his informed consent to the second surgery 9

PEER REVIEW

- A chiropractor was disciplined for a large number of billing errors related to a patient even though billing was performed by staff in the practice 10

DEFENSIVE ACTIONS/COUNTERMEASURES TO MALPRACTICE SUITS

- An opinion expressed by the plaintiff's expert that was different from when he was the patient's treating urologist helped undermine her claim that a surgeon negligently treated her cystocele 11

NEW/EXPANDED LIABILITY

- Discovery was ordered of redacted charts of six patients on the same floor as a hysterectomy post-operative patient to see if their "acuity" justified the hospital's nursing staffing decision 12

INSURANCE

- Claims for payment of medical services provided by a physician-hospital organization against several insurers and health plans were subject to the limitations period governing open accounts, rather than the period for contract actions 13

Malpractice Review

Malpractice Verdict Review with Analysis

\$1,000,000 GROSS VERDICT - PRIMARY CARE - NEUROLOGY - FAILURE TO DIAGNOSE STROKE - JURY FINDS CONTRIBUTORY NEGLIGENCE BY PLAINTIFF FOR PRE-TREATMENT SMOKING HABIT.

CASE SUMMARY

This medical malpractice case involved a now 62-year-old woman permanently neurologically injured as a result of a stroke. The plaintiff claimed that she had risk factors for stroke, such as high blood pressure, high cholesterol and smoking, and that she had symptoms of TIAs, precursors to stroke. The plaintiff further claimed that the defendants, her primary care physician and the neurologist to whom she was referred, overlooked the risk factors and the symptoms, failed to order proper testing and misdiagnosed her symptoms as those of migraine headaches, directly resulting in a debilitating stroke. The defendant neurologist denied awareness of the plaintiff's symptoms and history. The defendant primary care physician asserted that it was the responsibility of the defendant neurologist to order proper tests.

CASE DETAILS

In 2001, the plaintiff was 54 years old. For a number of years she had had migraine headaches that presented as headache and visual disturbance. In July 2001, she developed unilateral weakness, facial numbness and aphasia. Her primary care doctor ordered an MRI of the brain, but no study of the carotids. The primary care physician also referred the plaintiff to the defendant neurologist. At the time, the plaintiff did not have health insurance.

The neurologist saw the patient six weeks after the PCP. By then, the brain MRI had been performed. The plaintiff claimed that the radiologist's interpretation revealed abnormalities consistent with TIAs. Neither

of the defendants ordered a carotid artery ultrasound which would have revealed the nearly totally occluded vessels. 17 days after the neurology visit, the plaintiff suffered a large right sided stroke which has left her neurologically compromised on the left side of her body. After her stroke, physicians at Boston's Beth Israel Hospital properly diagnosed the blockages in the plaintiff's carotids, placed a stent to open up the blocked artery and restored blood flow to the plaintiff's brain. She has not had another stroke, or interestingly, another migraine, since.

The defendant primary care physician testified that she informed the neurologist of the TIA symptoms in a telephone call some six weeks before the patient's neurology appointment. The defendant primary care physician testified that she called the defendant neurologist in advance of the appointment to be sure that the neurologist would see a patient without insurance. At trial, the PCP testified that in such a call she would have told the neurologist of the patient's history and presentation. The neurologist denied ever getting this call. The defendant neurologist claimed that he was unaware of the plaintiff's symptoms of unilateral arm and leg weakness and aphasia and that he was aware of only her history of headaches. The defendant neurologist testified that the plaintiff's MRI was normal.

The jury found against the neurologist, awarding a \$1,000,000 verdict, reduced by 40% due to the plaintiff's contributory negligence, for a net award of \$600,000.

MEDICAL LIABILITY ANALYSIS

The jury deliberated for four and a-half hours and returned a verdict for the plaintiff against to the neurologist. In a highly unusual move, the jury also attributed 40% fault to the plaintiff herself. Plaintiff's counsel noted that it is atypical for a jury to attribute contributory negligence in a medical malpractice case. Plaintiff's counsel believed that the jury attributed fault to the plaintiff because she continued to smoke long after receiving a diagnosis of high blood pressure and other diagnoses indicating a risk of stroke.

RISK MANAGEMENT ADVISORY

This case presents a highly unusual determination by a jury in a medical malpractice case. The jury decided to reduce the plaintiff's verdict based upon the patient's own contributory negligence, where such contributory negligence was founded upon the patient's personal habit of smoking, which was determined to have contributed to her diverse medical condition for which she went to the accused physicians in the first place. Furthermore, there was no indication in the record that the patient was advised by the defendant physicians to discontinue smoking, or that the treatment being rendered to her could be adversely affected by her continuing to smoke. In fact, the subject of smoking was never brought up



Medical Liability Alert (MLA) has been developed with input from the University of Medicine and Dentistry of New Jersey. Dennis P. Quinlan, M.D., Medical Director, UMDNJ-CME, serves as faculty coordinator for MLA. The University of Medicine and Dentistry of New Jersey is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. For reader response, please contact us via E-Mail at (gary@zarins.com) or via regular mail to: MLA Reader Response, 45 Springfield Ave., Springfield, N.J. 07081.

Although this publication serves to alert Health Care Professionals to litigation affecting their practice, because of variations in fact patterns and local jurisdictions, specific legal consultation should be obtained before acting on any information contained herein.

at any time in accordance with the records in this case by either of the accused physicians.

The attributing of the plaintiff's actions to contributory negligence was not explained by any of the experts nor by the jury's determination, which went unexplained as to how and why they arrived at that conclusion. Plaintiff's counsel indicated that although he is not aware of what the jury had in mind in this regard, he believed that the jury attributed fault to the plaintiff because she continued to smoke long after receiving a diagnosis of high blood pressure and other diagnoses indicating a risk of a stroke. However, this conduct by the patient that the jury found to be contributory negligence all occurred prior to either defendant physician undertaking treatment of the patient.

Despite the outcome of this case, practitioners are reminded that a finding of contributory negligence in medical malpractice litigation is fairly rare and is usually found when the patient's own negligence is proven to have contributed to the poor result caused by deviation on the part of the defendant physician involved. In most jurisdictions, a patient's habits and behavior that brought the patient to the physician in the first place for treatment cannot be considered as contributory negligence. Contributory negligence normally only involves the patient's own conduct in failing to appropriately follow the advisements of a physician which can be proven to have contributed adversely to the patient's recovery.

Said another way, the contributory negligence of a patient for their own conduct cannot be attributed, in most jurisdictions, to the patient's poor health habits and lack of concern for their own health and well-being prior to treatment being rendered by an accused physician in medical malpractice litigation. In this regard, the practitioner is deemed to accept the patient as they find them with all of their infirmities and pre-existing habits that brought about the necessity

for treatment in the first place and to render the appropriate treatment for a patient in that particular condition determined by the practitioner as a basis for the patient undergoing treatment. Therefore, a patient's prior habits such as smoking that may have deteriorated their health cannot be considered as contributory negligence because the physician who undertook to treat that patient accepted the patient with all of their pre-existing infirmities and habits that brought them to the physician in the first place.

Also in this case, the primary care physician testified at the trial that she had called the referred-to neurologist on the telephone prior to her appointment with the patient and told the neurologist of the patient's history and presentation, including the tell-tale TIA symptoms some six weeks before the patient's neurology appointment, as well as the radiologist's interpretation having revealed abnormalities consistent with TIAs. However, the defendant radiologist denied ever receiving this phone call or of receiving this particularly significant information. The jury exonerated the primary care physician, apparently believing her testimony over that of the neurologist's.

Practitioners are reminded by this aspect of the case of the importance, when referring a patient to a specialist for evaluation, of not only communicating directly with the referred-to physician, but also reducing all referral requests to written form so as to establish having provided the specialist with any appropriate and necessary findings of other physicians or their own findings for which the specialty evaluation is being requested. This written documentation should also include copies of all appropriate medical records and reports within the referring physician's file, as well as all prior tests performed or any radiological interpretations which might have a bearing on the specialist's evaluation. This information should be supplied in addition to any telephone

communication that may also be involved in advising the specialist as to the referring physician's impressions pre-existing the specialist's examination.

Furthermore, physicians responsible for the appropriate referral of patients to specialists might also, from a safe practice point of view if not necessarily from a liability standpoint of view, immediately review the report from the referred-to specialist for any indications that the specialist failed to appropriately evaluate or appreciate the situation in accordance with the symptomatology that the referring physician believed formed the basis for the referral. If any questions should arise upon this review, the referring physician should communicate directly with the specialist to determine why the specialist's findings do not comport with the kind of conclusion or finding expected by the referring physician. Furthermore, written documentation of all communication between the referring physician and specialist can go a long way in avoiding any liability that may be involved by the failure of the specialist to appreciate all the necessary facts and circumstances that brought about the referral in the first place.

Practitioners are once again reminded of the importance of not only having written communication with the referred-to specialist containing all the relevant documentation, prior reports and conclusions, but also communicating the impressions of the referring physician through direct verbal communication with the referred-to specialist. Practitioners are also reminded by this case of the significance and importance of questioning the findings of the specialist if they appear to be inconsistent with the reasons for the referral or that may, by its very nature, create a suspicion that the specialist was not considering all of the important relevant evidence

and symptomatology that necessitated the referral in the first place.

Practitioners should also be reminded that where they refer a matter to a specialist for evaluation, particularly in potentially serious situations where the specialist's response appears not to have possibly considered all of the

elements in the case, then they should question it directly with the specialist and, if necessary, order another evaluation by either that specialist or by some other specialist.

REFERENCE

Plymouth County, MA. Jordan vs. Ronan, et al. Case no. PLCV2004-01282.

Attorney for plaintiff: Suzanne C. M. McDonough of Lubin & Meyer in Boston, MA.

\$475,000 RECOVERY - PRIMARY CARE NEGLIGENCE - FAILURE TO DIAGNOSE LUNG CANCER - DIAGNOSIS FINALLY MADE AT STAGE WHERE TREATMENT OPTIONS WERE ALLEGEDLY UNAVAILABLE - DEATH LESS THAN TWO YEARS LATER.

CASE SUMMARY

The plaintiff's decedent, a 78-year-old widower, contended that the defendant physician, primary care physician, failed to diagnose the decedent's lung cancer at a stage when it was still treatable. Thus, the decedent was denied the option of treatment and lost a chance to survive the disease.

CASE DETAILS

In May 2000, the decedent presented to the defendant, his primary care physician, with a persistent cough, respiratory congestion and shortness of breath with exertion. The decedent underwent an x-ray which showed an infiltrate in the right lower lobe and no pleural effusion. The defendant did not inform the decedent that there was an abnormality in the x-ray, nor did the defendant follow up with the decedent.

One year later, the decedent returned to the defendant in declining health. He had lost weight and his cough was worsening. A new x-ray and CT-scan showed consolidation and spread of the tumor seen the year before. There was pleural effusion. Follow-up imaging showed metastases to the brain. His lung cancer was inoperable and the decedent was informed that his condition was terminal. The decedent succumbed to his cancer seven months later.

The plaintiff argued that the defendant's failure to diagnose the decedent's lung cancer and to render appropriate therapeutic interventions was a violation of

the standard of care of the average qualified internist and primary care physician and that said violation resulted in the decedent's untimely death. Had the matter gone to trial, the plaintiff would have called a thoracic oncologist, a thoracic surgeon, a pulmonologist and a primary care specialist. They would have testified that the lesion on the decedent's initial x-ray in May 2000 revealed that he had a Stage I cancer which was operable. As a result of the defendant's negligence, the decedent lost a 40%-50% chance of survival for five years. By the time the cancer was diagnosed one year later, it had progressed to Stage IV and it was terminal.

The defendant employed a causation defense, arguing that the lesion seen on the second x-ray was not the same lesion as was seen in the x-ray of May 2000. The defendant asserted that the decedent had an aggressive form of cancer and would have had an adverse outcome even if he had undergone the surgery one year before. The defendant argued that he would have died when he did anyway despite earlier diagnosis and treatment.

Had the matter gone to trial, the defendant would have presented a primary care, oncologist, pulmonologist, and thoracic surgeon as his expert witnesses. The experts were expected to have testified as to the terminal and aggressive nature of the cancer and that there was no evidence that it was the same lesion in both x-rays. The defendant's experts were expected to testify that the decedent would have died when he did even if surgery had been

performed the previous year because the decedent had an aggressive form of adenocarcinoma. The decedent's wife predeceased him and he was survived by grown children.

The case was settled via mediation with John P. Ryan at Sloane and Walsh in the amount of \$475,000.

RISK MANAGEMENT ADVISORY

In this case, the defendant's experts oncologist and primary care physician each opined in their respective reports that they would testify as to the terminal and aggressive nature of the cancer and that there was no evidence that the cancer was the same lesion in both x-rays. In addition, the defense experts opined in their reports and would be expected to testify at trial that the decedent would have died when he did even if surgery had been performed the previous year because the decedent had a particularly aggressive form of endocarcinoma. This defense is known in medical liability as a "Futility of treatment" defense in which a defendant attempts to avoid liability not by denying that there was any deviation, but through the presentation of expert testimony that regardless of the timeliness of the diagnosis and the treatment rendered, the ultimate outcome would have been the same because any treatment rendered would have been futile and ineffective. Therefore, in the opinion of the defendant's medical experts, any fail-

Primary Care Liability Alert USPS 022-821 is published bi-monthly for \$330/year by Jury Verdict Review Publications, Inc., 45 Springfield, NJ 07081. Periodical Postage Paid at Springfield, NJ and additional mailing offices. Postmaster: Send address changes to *Primary Care Liability Alert*, 45 Springfield Ave., Springfield, NJ 07081.

ure alleged against the defendant in that regard would not be actionable since it did not involve injury or damage to the patient.

Practitioners should be reminded, however, that generally speaking, the utilization of a futility of treatment defense is not looked upon with favor by lay juries who have to ultimately decide these medical malpractice cases. This defense strategy literally implies that the accused defendant physician simply did not attempt treatment because, in his or her judgment, any attempt to appropriately treat and alter the situation would have been futile.

In most medical malpractice cases, this defense is invariably met with an opinion given by an equally-qualified plaintiff's expert to the effect that although the chances of a cure might be low if treatment had been rendered, the fact that treatment was not rendered at all on the basis that it was likely futile guaranteed that the patient would not be cured or their life extended. Furthermore, the expert will go on to opine that the patient had some percentage chance of survival, not necessarily a 100% chance of survival, had the appropriate treatment been rendered. When this chance of survival is expressed in terms of percentages by the available expert, the failure of the accused physician to have undertaken any attempt in treating the patient so as to inure to the benefit of that percentage chance can be seen in the eyes of the lay jury as a serious deviation from acceptable standards of practice in regard to damages because the physician will be looked upon as one who took it upon himself to deny the patient a chance at survival because he didn't think that the chance of survival was significant enough to warrant the undertaking.

In this regard, the utilization of the futility of treatment defense will most likely be made in the face of countering testimony by plaintiff's experts that there was a percentage chance of survival which the patient was deprived of by the failure to institute

such treatment in a timely manner. Unfortunately, juries can often infer by the interposition of this defense that the accused defendant was callous to the regard and respect for the rights of the patient to obtain an effective undertaking of treatment, no matter how difficult such an undertaking might be and no matter that such an undertaking of treatment may have failed to prove effective due to the progression of the disease.

Practitioners are reminded that where the interposition of appropriate treatment could conceivably result in some benefit to the patient in accordance with acceptable opinions of knowledgeable, appropriate experts, then the patient under those circumstances is entitled to an attempt at that treatment, even though the odds of recovery can be in many instances less than a 50% chance of recovery. Furthermore, when the futility of treatment defense is used, the plaintiff need not show that he or she would have definitely survived had there been appropriate treatment, but only that he or she were deprived of a chance of survival or even the extension of life by virtue of not being offered the opportunity for that treatment.

Another aspect of this case involved whether or not the defendant primary care physician deviated from acceptable standards of practice in failing to timely diagnose the decedent's lung cancer and render appropriate therapeutic intervention and whether or not this failure was, in fact, a violation of the appropriate standard of care for a primary care physician. Practitioners are once again reminded that because there are frequently different specializations that may be involved in medical malpractice litigation, the appropriate standard of care is generally measured by that standard of care applicable to the particular specialization of the various defendants and not generally to all of the physicians involved. In this regard, experts testifying on behalf of accused physicians as to the absence of deviation from acceptable standards of practice generally are required to take

into account the particular specialty involved and to opine that there was no deviation for the particular specialist being accused in the particular case. In this case, the defendant, as a primary care physician, needed only to meet that standard of care appropriate to primary care physicians.

In addition, in cases involving a failure to diagnose a condition such as cancer in a timely manner, the experts brought forth on both sides render opinions as to the effect the alleged delay in appropriate diagnosis may have increased the various stages of the cancer, in this case from Stage I to Stage IV. Plaintiff's experts will generally testify as to the progression of the cancerous condition from one stage to a greater stage by virtue of the delay in diagnosis and the defendants' experts would testify, as they did in this case, that it did not alter the various stages and was not sufficient in time to materially affect an increased stage of cancerous growth. Experts testify on behalf of both sides and the judge and jury must ultimately determine whether or not there was a deviation in failing to make a timely diagnosis and, if there was a deviation, what the damages the patient may have sustained were as a percentage chance of cure he or she might be expected to have obtained, as well as the additional pain and suffering involved in the failure to render appropriate and timely treatment. Damages need not be expressed in terms of an actual loss of definitive care or avoidance of death, but can be expressed by the deprivation that the delay caused in denying the patient a percentage chance of recovery or percentage chance of extending longevity that he or she otherwise may have attained had there been appropriate and timely diagnosis and treatment of the condition involved.

REFERENCE

Berkshire County, MA. Case reference information withheld in accordance with settlement agreement. Attorney for plaintiff: Cynthia Spinola of Hashim & Spinola in Pittsfield, MA.

Additional Malpractice Verdicts by Specialty

Primary Care

\$650,000 RECOVERY - Failure to timely diagnose and treat small bowel obstruction - 43-year-old plaintiff dies of cardiac arrest and hypoxia during diagnostic testing.

The decedent in this medical malpractice/wrongful death case was a 43-year-old married mother of three who died of cardiac arrest and hypoxia after the defendant doctors allegedly failed to diagnose that the decedent had a small bowel obstruction caused by a herniated, and subsequently strangulated, bowel. The plaintiffs claimed that the decedent's doctors were negligent in not promptly identifying the decedent's medical condition as a surgical emergency, and that each defendant doctor's negligence was a substantial factor in causing the decedent's death. The defendant doctors countered that their actions were within the relevant standard of care and each defendant contended that his actions were not a substantial factor in the decedent's death.

The decedent was a married 43-year-old woman with three children, ages 24, 22, and six. She presented at a clinic in Los Angeles with nausea, vomiting, abdominal pain, and a periumbilical lump. She was treated by a family practice physician who diagnosed her condition as gastroenteritis and released her with medication. The next morning, the decedent returned to the clinic with the same complaints she had expressed the previous day; however, her condition now included abdominal distention. She was again given medication and discharged.

Later that day, the decedent went to the hospital and was seen by an emergency room physician, who believed that the decedent had appendicitis. He obtained plain films of the decedent's abdomen and ordered a CT-scan. While the decedent was in the process of undergoing the CT-scan,

she suffered cardiac arrest. A code was called and she was successfully resuscitated, but she had suffered severe hypoxic insult. Life support was discontinued and the decedent was declared dead the next morning.

The plaintiffs, the decedent's family members, sued the doctors and the hospital for medical malpractice and wrongful death for allegedly failing to identify the decedent's condition as a medical emergency requiring immediate surgery. They sought to recover her future lost earnings as damages, alleging that although the decedent had not worked since the birth of her youngest child, she planned to go back to work cleaning houses when her youngest child entered first grade that fall. They also claimed that the decedent had made arrangements to provide childcare in her home after work. The plaintiffs contended that the decedent would have earned \$31,000 per year until she was 65.

The defendant doctors argued that they acted with reasonable care. Each doctor further contended that his actions were not a substantial factor in the death of the decedent.

The plaintiffs made a settlement demand of \$925,000; the defendants offered \$200,000. The case was mediated two years after the decedent's death, and settled for \$650,000. The contribution made by each defendant is confidential.

REFERENCE

Plaintiff's critical care expert: James Leo, M.D. from Long Beach, CA. Plaintiff's economist expert: Darryl R. Zengler, M.A. from Pasadena, CA. Plaintiff's emergency

medicine expert: Eric Alcouloumre, M.D. from Newport Beach, CA. Plaintiff's general surgeon expert: Kenneth Deck, M.D. from Laguna Hills, CA. Plaintiff's internist expert: Roy Herndon, M.D. from Orange, CA. Plaintiff's nursing expert: Marlene R. Vermeer, R.N. from Irvine, CA. Defendant's economist expert: Mike Adams from San Marino, CA. Defendant's emergency medicine expert: Joel Guiderman, M.D. from Los Angeles, CA. Defendant's emergency medicine expert: Mark Langdorf, M.D. from Orange, CA. Defendant's emergency medicine expert: Raymond Ricci, M.D. from Newport Beach, CA. Defendant's general surgeon expert: Samuel Wilson, M.D. from Orange, CA. Defendant's internal medicine expert: Alan Weinberger, M.D. from Los Angeles, CA. Defendant's pathologist expert: Andrew Burg, M.D. from Long Beach, CA. Defendant's pathologist expert: Parakrama Tissa Chandrasoma, M.D. from Los Angeles, CA. Defendant's radiologist expert: Samuel Maxwell, M.D. from Fullerton, CA.

REFERENCE

Orange County, CA. Plaintiff vs. Defendant physicians and hospital. Harrison Sommer of Judicate West (mediator), 07-09-10. Attorney for plaintiff: Daniel Hodes of Hodes Milman LLP in Irvine, CA. Attorneys for defendant family practitioner: Raymond Blessey and Dean Smith of Taylor Blessey LLP in Los Angeles, CA. Attorney for defendant internist: Sidney Martin of Schmid & Voiles in San Diego, CA. Attorney for defendant E.R. physician: John E. West of Beam Brobeck West Borges & Rosa LLP in Newport Beach, CA. Attorney for defendant hospital: Steven E. Kushner of Dummit Buchholz & Trapp in Los Angeles, CA.

\$300,000 CONFIDENTIAL RECOVERY - Failure to diagnose prostate cancer - Failure to screen for prostate cancer - Wrongful death.

In this medical malpractice matter, the plaintiff alleged that the defendant family practitioner was negligent in failing to screen and diagnose the decedent with prostate cancer until the cancer had metastasized. The defendant admitted failure to screen, but denied that there was any negligence or that the decedent's death was causally related.

The plaintiff's decedent was under the care of the defendant, family practitioner for regular medical care for a number of years. The plaintiff contended that the defendant at no time screened the decedent for prostate cancer. The decedent ultimately developed prostate cancer which was not diagnosed until it had already metastasized. The decedent died of prostate cancer.

The plaintiff brought suit against the defendant, alleging that the defendant was negligent in failing to perform routine prostate screening on the decedent and in failing to diagnose the decedent's prostate cancer in a timely manner.

The defendant denied the allegations. The defendant did admit that no prostate screenings were performed, but maintained that there was no deviation from acceptable standards of care. The defendant argued that the decedent's death was not proximately caused by any negligence on the part of the defendant.

The matter was resolved in a confidential manner for the sum of \$300,000.

EXPERTS

Plaintiff's internal medicine expert: Raymond Rozman, M.D. from Cleveland, OH. Plaintiff's pathology expert: Thomas Wheeler, M.D. from Houston, TX. Defendant's family medicine expert: Kevin Sherin, M.D. from Orlando, FL. Defendant's hematology-oncology expert: Manish Bhandari, M.D. from Cincinnati, OH. Defendant's urologic oncology expert: Bruce Bracken, M.D. from Cincinnati, OH.

REFERENCE

Muskingum County, OH. Plaintiff vs. Defendant family practitioner. Attorney for plaintiff: Jeffrey Beusay of The Donahay Law Firm in Columbus, OH.

DEFENDANT'S VERDICT - Failure to appreciate fracture of right navicular bone on radiology film - Non-union - Surgical repair, bone grafting, bone stimulator and nine months of recovery.

The plaintiff in this medical malpractice case claimed the defendant family practitioner failed to appreciate an obvious and readily apparent fracture of the right navicular bone upon review of the plaintiff's x-ray. He alleged this resulted in a delayed diagnosis and the development of a severe non-union of the bone. The plaintiff additionally argued the standard of care necessitated the defendant request the x-rays be reviewed by a radiologist to confirm his diagnosis. The plaintiff underwent surgical repair of his navicular bone which required bone grafting, a bone stimulator and nine months of recovery. The defendant claimed the standard of care allowed for family practitioners to review and interpret x-rays under most circumstances without an additional reading by an orthopedist or radiologist. The defendant argued the standard of care for a family practitioner's level of skill did not require that he diagnose a fracture that was not readily apparent and could be easily interpreted as a normal variant.

The plaintiff, a 53-year-old male quality supervisor, claimed he fractured his

navicular bone in his right wrist during a Kung Fu sparring class on July 7, 2007. He presented to the defendant family practitioner two days later with complaints of right wrist pain, swelling and bruising. The defendant's office records reflected the plaintiff reported he bent his wrist backwards using weights as the mechanism of injury. Upon examination and a review of the plaintiff's x-ray, the defendant diagnosed the plaintiff with a severe sprain and ligament tear and recommended rest and compression. No follow-up appointments were scheduled or requested at that time.

The plaintiff presented again in the defendant's office on September 7, 2007 and the plaintiff claimed the purpose of this visit was twofold. He claimed he expressed concern about a lump in his left axilla area and additionally complained of continued wrist pain and discomfort. The defendant's office record reflected the only purpose of the visit was complaints of a lump in the axilla area, yet it was undisputed that the defendant inquired about the plaintiff's wrist during this visit. It was also

undisputed that the plaintiff stated the pain and discomfort were improved, but were not completely resolved.

The plaintiff returned again to the defendant on November 26, 2007 and complained of wrist pain that was significantly worse than it had been in September. The defendant noted increased pain with range of motion in the plaintiff's right wrist and noted the plaintiff experienced an onset of severe pain after sawing branches off of a tree. At this time, the defendant referred him to an orthopedist who diagnosed a fracture of the navicular bone from the July 9, 2007 x-ray done in the defendant's office. New x-rays taken during this office visit found a severe non-union of the navicular bone, and the plaintiff underwent surgery performed by an orthopedic hand specialist.

The plaintiff claimed the defendant was negligent in not requesting the x-ray films by read by a radiologist. The plaintiff also alleged the defendant's review and interpretation of the x-ray as a family practitioner was below the standard of care because he failed to appreciate an obvious fracture. The plaintiff argued the defendant

also should have scheduled follow-up visits and care, which the plaintiff claimed would have diagnosed the fracture before a severe non-union of the bone developed.

The jury noted that the plaintiff's family practice expert did not specifically testify regarding the x-ray, but instead merely testified about why he opined the defendant's review of the x-ray to be negligence. The plaintiff's expert additionally stated the fracture was obvious and claimed it was a fracture he would appreciate approximately eight out of ten times on an x-ray film. The defendant's family practitioner expert testified the fracture was not easily discernable and

could have been easily interpreted as a normal variant of the plaintiff's bone structure.

After a five day trial and two hours of deliberations, the jury concluded they were not convinced the standard of care dictated that the defendant have the x-ray film read by a radiologist, and they rendered a defense verdict.

EXPERTS

Plaintiff's family practice expert: Dr. Jeffrey Barke, M.D. from Newport Beach, CA. Plaintiff's radiology expert: Dr. Frederick Birnberg, M.D. from Newport Beach, CA. Defendant's family practice expert: Dr. Ned Chambers, M.D. from San

Diego, CA. Defendant's orthopedic hand specialist expert: Dr. Bruce Foerster, M.D. from San Diego, CA.

REFERENCE

San Diego County, CA. William Cauble, an individual; Lisa Cauble, an individual vs. Dr. S. Case no. 37-2008-00094149-CU-MM-CT; Judge Linda B. Quinn, 2-26-10. Attorney for plaintiff: Christina M. Rimkus of Marks, Golia & Finch LLP in San Diego, CA. Attorney for defendant: Robert W. Frank of Neil, Dymott, Frank, McFall & Trexler APLC in San Diego, CA.

Medical Practice Liability

Business Practices/Unfair Competition

AN ARBITRATION AGREEMENT SIGNED BY A PATIENT UPON ADMISSION TO A NURSING FACILITY WAS AN UNENFORCEABLE CONTRACT OF ADHESION BECAUSE THE PATIENT HAD NO OTHER OPTIONS AND WAS IN PAIN AT THE TIME.

An arbitration agreement signed by a patient upon admission to a nursing facility was an unenforceable contract of adhesion because it was given to her on a "take it or leave it" basis while she was in pain and had no alternative choices, according to a recent Tennessee appellate court holding.

The female plaintiff, 61 years old, underwent extensive spinal surgery at St. Thomas Hospital. When released she was transported by ambulance to Christian Care Center, a skilled nursing facility for convalescence and rehabilitation. She testified that she was in severe pain prior to getting into the ambulance and that the jolting during the ambulance ride worsened her pain. Medical records from St. Thomas showed she was given a tablet of Lortab for hip pain on the morning of her release and another for back pain shortly after. The medication apparently did not relieve her pain since she scored her pain intensity as a 10 out of 10 after each dose. She was also

medicated with Valium and given two additional Lortabs for back pain just before she was placed in the ambulance.

Soon after arrival at Christian she was approached by the admissions coordinator. The plaintiff testified that she asked for pain medication, but was told no medication could be administered until she completed the admissions process. The admissions packet included a six page arbitration agreement that read: "This agreement waives resident's right to a trial in court and a trial by jury for any future legal claims resident may have against facility." The plaintiff signed the agreement, but the admissions coordinator did not provide her with a copy. A few hours later, the plaintiff fell in the bathroom resulting in a compound fracture of her ankle and the bursting open of her surgical wound. She was taken for surgery and remained hospitalized for more than 30 days. She had rods placed in her ankle and remains incapacitated.

The plaintiff filed a malpractice action against Christian which, in turn, filed a motion to compel arbitration. The trial court found that the arbitration agreement had been presented on a "take or leave it basis," that the plaintiff had no choice but to sign it, and that the defendant's failure to provide copies of the agreement made it probable that the plaintiff was unaware of her right to rescind. It concluded it would be unconscionable to enforce the arbitration agreement and this ruling was affirmed on appeal. The appellate court explained that the circumstances justified a finding that the arbitration agreement was an unenforceable contract of adhesion.

COMMENTARY

A contract of adhesion may exist where a standardized form is given to a patient to sign on a "take it or leave it" basis without affording a realistic opportunity to bargain and under conditions where the patient cannot obtain the service except by acquiescing to the form contract.

This case involved a standardized contract form and there was no suggestion that the plaintiff had the opportunity to bargain for different terms. One clause stated, "If you do not believe binding arbitration is the right choice for you, we will, upon written request, reasonably assist you in finding other nursing facilities in the area or other long term care options such as home care or assisted living facilities."

The proof showed that the plaintiff was a Medicare and Medicaid patient with limited options. There was no nursing facility in her home town that would accept her insurance, and the defendant was one of only two facilities in the county that accepted patients in her position. The other facility had declined to admit the plaintiff because of her weight. The proofs also showed that because of her pain, the plaintiff wanted to get the admissions process over with so she could lie down and take some pain medication. In the appellate court's view, under these circumstances, the plaintiff's only realistic choice was to sign the document.

The nursing home argued that the arbitration agreement was not a contract of adhesion because of a provision giving the plaintiff the right to revoke it by giving written notice of her intention to do so within 30 days. It further asserted that the admissions coordinator did not say anything to indicate that the plaintiff would be discharged from the facility if she revoked the agreement and that in any case, a discharge for such a reason would be unlawful. However, the plaintiff had no opportunity to bargain over the terms of the standardized form contract which was presented to her on a "take it or leave it" basis. Under the circumstances, the language about helping her find other nursing facilities in the area was found to be, at best, "a hollow promise" and, at worst, "a veiled threat."

In general, agreements to arbitrate disputes are favored because arbitration may allow parties to avoid the formalities, delay, expense and vexation of trial court litigation. However, an arbitration agreement may be

found to be a contract of adhesion if there is unfairness in the formation of the contract such that one party is deprived of meaningful choice (e.g., if the contract is presented to a party on a take it or leave it basis and the party is not given the opportunity to understand the agreement) or if the terms of the contract are unreasonably favorable to the drafting party. A court will usually closely scrutinize an alleged contract of adhesion to determine whether mutuality did not exist when entered into and whether the agreement imposes unconscionable terms on the less powerful party.

REFERENCE

McGregor v. Christian Care Center of Springfield, L.L.C., 2010 WL 1730131 (Tenn. App. 2010).

Informed Consent

A PHYSICIAN WHO PERFORMED THE SAME BACK SURGERY ON A PATIENT A SECOND TIME SOON AFTER THE FIRST PROCEDURE MAY HAVE FAILED TO OBTAIN HIS INFORMED CONSENT TO THE SECOND SURGERY.

A physician who performed a second laminectomy/discectomy on a patient shortly after performing the first procedure may have failed to obtain the patient's informed consent to the second procedure, according to a recent Ohio appellate court decision.

The defendant performed a laminectomy/discectomy on the plaintiff who then reinjured the same disc a few months later. Prior to the second surgery, the defendant allegedly failed to disclose the significant additional risks associated with performing the exact same surgery again (e.g., that the existing scar tissue from the old surgery would likely complicate the procedure and the likelihood that pain would be much greater after the second surgery compared to the first). The second surgery left the plaintiff with permanent chronic pain which required him to take heavy narcotic medications.

The plaintiff filed an action against the defendant alleging he failed to obtain his informed consent to the second surgery. The evidence presented during the trial revealed the defendant knew that the second surgery carried a much greater risk of a poor outcome than the first; though he did not mention the greater risk(s) associated with the second surgery; that the plaintiff's condition was significantly worse after the second surgery; and that the second surgery was the most likely cause of his deteriorated condition.

The defendant moved for a directed verdict which was granted. However, this ruling was reversed on appeal. The appellate court explained that the evidence, for instance the defendant's failure to note on the hospital report that he had obtained the plaintiff's informed consent, could have led to a finding in favor of the plaintiff.

COMMENTARY

Generally, a claim for failure to obtain a patient's informed consent is established when a physician fails to disclose and discuss material risks or dangers that are associated with a proposed medical treatment or procedure; the undisclosed risk or danger actually materializes, and is the proximate cause of the patient's injury; and the patient or a reasonable person would have declined the treatment or procedure in the event that the physician had properly apprised him of the potential risks involved.

Reviewing the evidence the appellate court found that it could have supported a conclusion that the defendant failed to obtain the plaintiff's informed consent to the second surgery. For example, his office notes tended to corroborate the plaintiff's testimony, because they failed to mention

any disclosure of the additional risks associated with the second surgery. The court elaborated that the subject of the lengthy discussion between the plaintiff and the defendant was related to pros and cons of having the surgery and its timing. The inferences drawn from the office notes were also confirmed by the hospital pre-procedure forms, in which the defendant signed his name and checked the “yes” box indicating that he had received the plaintiff’s informed consent before the first surgery, but, on the form completed prior to the second surgery, he did not indicate that he received the plaintiff’s informed consent. This pattern was duplicated in the hospital’s operative

reports. In the report from the first surgery, the notations indicated as follows: “The risks of the procedure were explained to the patient, and he requested the procedure after the failure of conservative care.” There was no similar notation in the operative report from the second surgery. Although the defendant did testify that he obtained the plaintiff’s informed consent to performing the second surgery, he did acknowledge the risks associated with a second laminectomy/discectomy were significantly higher than they were with the same procedure when it was performed for the first time.

A patient’s informed consent usually has to be obtained by a physician

prior to each procedure performed. When a second procedure, even the same one, is performed on a patient, a physician cannot rely on disclosures and consent forms from the prior procedure. Not only may the risks be different with the second procedure, but even if they were exactly the same, informed consent procedures (disclosure of risks and alternatives, and obtaining signed consent forms) should nonetheless be followed anew.

REFERENCE

White v. Leimbach, 2010 WL 1544410 (Oh. App. 2010).

Peer Review

A CHIROPRACTOR WAS DISCIPLINED FOR A LARGE NUMBER OF BILLING ERRORS RELATED TO A PATIENT EVEN THOUGH BILLING WAS PERFORMED BY STAFF IN THE PRACTICE.

A chiropractor was properly disciplined by a professional board for a large number of billing errors relating to a patient even though billing was performed by staff and he was not familiar with billing, a California appellate court has ruled.

The patient filed a workers’ compensation claim that was handled by Highlands Insurance Company. A month later, he sought treatment from the defendant for the back injury he sustained. He had over 160 treatments for his back injury over approximately two years. He then sustained another industrial injury, exacerbating his back injury. He filed another workers’ compensation claim, which was handled by Superior National Insurance Company. Again, he obtained over 100 treatments from the defendant over the course of two years. He testified that the treatments alleviated his symptoms.

This patient was the only one during the defendant’s 20-year practice to be treated simultaneously for two industrial injuries at two different job sites covered by two different insurers. The complexity of the billing led to mistakes by an inexperienced billing clerk. For a while, the defendant’s wife assumed responsibility for billing,

hiring and training staff. As far as the defendant and his wife were aware, staff billed competently. They never received any complaints or notification from any insurer indicating error on a bill.

Eventually, the defendant was deposed in one of the patient’s workers’ compensation cases. An attorney representing the insurer accused him of billing irregularities. Although the defendant instructed his wife to audit the patient’s bills, it revealed approximately 114 billing errors, some in favor of the respective insurer and some not. The defendant’s wife sent the correct billings to the insurance company in August 2002. The defendant and his wife both testified that he had very little to do with the billing practices in his offices. He did not know most of the codes they were required to use and relied on his staff to bill for his services.

A disciplinary proceeding was commenced by the California Board of Chiropractic Examiners. Following a hearing, an administrative law judge (ALJ) made findings later adopted by the Board. As to billing, the ALJ found the defendant failed to ensure the accuracy of his billings and that this constituted in aggregate, gross

negligence. The ALJ further reported that the approximately 114 billing errors included double billing (both insurance companies billed for the same treatment), billing of incorrect CPT codes, billing the incorrect carrier, and billing for services not rendered on a particular date of service. The ALJ concluded there was cause for discipline for commission of acts of gross negligence in billing insurers.

The Board then revoked the defendant’s license, but stayed the revocation and instead imposed a three-year term of probation, and directed him to reimburse the Board for costs of \$72,242. These rulings were then affirmed on appeal. The appellate court agreed that the defendant was responsible for the large number of billing errors arising from his practice and that the disciplinary measures taken were appropriate.

COMMENTARY

Health care providers are, as a rule, responsible for presenting accurate billing for their services. A California administrative regulation provides that: “[i]n the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the

overbilling . . . Failure by the licensee, within 30 days after discovery or notification of an error which resulted in an overbilling, to make full reimbursement constitutes unprofessional conduct.”

The defendant contended that the final sentence of this regulation provided a safe harbor, that is, a chiropractor remained immune to charges of professional misconduct relating to billing provided he corrected the errors and made full reimbursement during a 30-day grace period. In his view, he was wrongfully denied the benefit of this “safe harbor” based on the erroneous finding that he was notified of the errors at the deposition in May 2002, rather than at the completion of his in-house audit in July.

However, the appellate court found that the regulation did not provide a 30-day safe

harbor for negligent billing. The court explained that whether the insurers brought the billing to the defendant’s attention was irrelevant to his duty to prevent them from occurring in the first place. In addition, the court interpreted the regulation to mean that chiropractors had 30 days to correct errors; rather, it stated that the failure to correct errors within 30 days constituted unprofessional conduct. Thus, if the Board had evidence the chiropractor either discovered or was notified of an error and did nothing to correct it within 30 days, that in itself was unprofessional conduct. In short, the last sentence spoke to a failure to act once an error was discovered but did not exonerate a chiropractor for gross negligence or repeated acts of negligence relating to billing practices.

A health care office may have staff responsible for many aspects of its operation including billing. However, a professional board may hold the health care professional personally responsible for mistakes made by employees acting on his behalf and on the behalf of his practice. Accordingly, a health care professional may have the obligation to supervise all aspects of his practice in such a manner that professional negligence, including billing, does not occur.

REFERENCE

Davis v. Board of Chiropractic Examiner’s, 2010 WL 1434322 (Cal. App. 2010).

Defensive Actions/Countermeasures to Malpractice Suits

AN OPINION EXPRESSED BY THE PLAINTIFF’S EXPERT THAT WAS DIFFERENT FROM WHEN HE WAS THE PATIENT’S TREATING UROLOGIST HELPED UNDERMINE HER CLAIM THAT A SURGEON NEGLIGENTLY TREATED HER CYSTOCELE.

An opinion expressed by the plaintiff’s expert that was different from when he was her treating urologist helped undermine her claim that a surgeon negligently treated her cystocele, the U.S. Fourth Circuit Court of Appeals has held.

The plaintiff suffered from a cystocele in which the fascia (soft tissue) between the bladder and the vagina degraded such that the bladder bulged into the vagina. A surgeon employed by the U.S. government performed surgery that afforded temporary relief. However, 20 months later, the plaintiff again experienced pain and the surgeon concluded her cystocele had recurred. He performed an anterior colporrhaphy, holding open the vagina with a speculum while looking in to locate the cystocele. He then cut the anterior vaginal wall to reveal the fascia and used sutures to pull together and reinforce strong fascia before closing the vaginal wall.

A week after surgery the plaintiff called her surgeon’s office complaining of pain and requesting medication, which she received. A week later, a renal ultrasound revealed “gross hydronephrosis,” (the

plaintiff’s kidney was swollen and her ureters were likely obstructed). The surgeon referred the plaintiff to another physician who noted in his operative report that the plaintiff’s ureter was deviated, which suggested swelling. He also noted that the ureter was obstructed to the point where he could not pass a sensor wire through it to determine the location of the blockage.

The next day, the plaintiff went to West Virginia University Hospital. First, a urologist, attempted to correct the ureteral blockage using a stent. That attempt failed, leaving surgery as the only option. To allow the plaintiff’s kidney to drain prior to surgery, another doctor placed a tube into the kidney to release the excess fluid into a bag. She noted that the plaintiff’s ureter inserted ectopically (in the wrong place) into the bladder. A surgeon performed ureteral reimplantation surgery (cutting the ureter near the obstruction and then re-inserting it into the bladder, effectively bypassing the blockage) which solved the problem.

The plaintiff filed an action against the U.S. under the FTCA, with West Virginia

law applying. Her complaint advanced two theories of liability: 1) that the original surgeon had stitched in a negligent manner causing an obstruction to her ureter; and 2) that he had negligently failed to perform a cystoscopy to check for ureteral obstruction.

After expert testimony was offered by the plaintiff’s expert (the urologist who had treated her) and by the defendant, the trial court found that the plaintiff failed to establish that a misplaced stitch, standing alone, breached the applicable standard of care. It also found that she failed to establish that a surgical stitch caused her ureteral obstruction. It also found that the standard of care did not require physicians to perform an invasive diagnostic procedure to evaluate the ureters during an anterior repair surgery.

The resulting judgment was then affirmed on appeal. The appellate court found sufficient evidence to justify the trial judge’s decision including that the opinion of the doctor serving as the plaintiff’s

expert was not that expressed by him as her treating urologist, requiring corroboration to be credible.

COMMENTARY

Generally, in a malpractice action the plaintiff has to establish, through the use of expert testimony, both the standard of care, that the treating physician's actions breached that standard and that the breach was the proximate cause of the injuries suffered. The trial court found that a doctor's placement of a stitch through a ureter, in and of itself, did not violate the standard of care. According to the appellate court, there was strong support for this finding. The plaintiff's own expert, although of the opinion that negligence arose when a physician failed to perform an invasive diagnostic procedure to check whether he stitched incorrectly, conceded that an errant stitch, standing alone, did not breach any applicable standard of care.

With regard to causation, the trial court found that the plaintiff had not established that a stitch had obstructed her ureter. Again, the testimony of her own expert acknowledged that he had not personally seen a stitch in the plaintiff's ureter. Instead, he stated that the other possible causes of a blockage to the ureter (edema, a congenital structure and kidney stones) were relatively unlikely. The trial court also found the process-of-elimination rationale that edema could have caused the blockage, and that an ectopically inserted ureter might also have caused the problem by the plaintiff's expert unpersuasive. It also found the expert's testimony not entirely credible because the doctor the plaintiff's treating urologist, had not voiced any concerns about a surgical stitch until after she had retained him as an expert witness. The trial court found that this shift in views "cast a shadow of doubt on the objectivity of his reports," and thus diminished the weight of

his testimony. He conceded that he did not see any stitch, but rather concluded that a stitch probably caused the blockage because, in his opinion, other causes were unlikely. However, absent some concrete proof, his reasoning was only as persuasive as the trial court found his testimony credible.

A treating doctor may appear as an expert witness for a malpractice plaintiff. However, in assessing his credibility, the trial court may compare the opinions he held while functioning as a treating doctor and while functioning as an expert witness. If the two differ, then this doctor's credibility as an expert may be adversely affected requiring additional corroboration.

REFERENCE

Drennen v. U.S., 2010 WL 1650032 (4th Cir. 2010).

New/Expanded Liability

DISCOVERY WAS ORDERED OF REDACTED CHARTS OF SIX PATIENTS ON THE SAME FLOOR AS A HYSTERECTOMY POST-OPERATIVE PATIENT TO SEE IF THEIR "ACUITY" JUSTIFIED THE HOSPITAL'S NURSING STAFFING DECISION.

Discovery was ordered, by the Supreme Court of Utah, of the redacted charts of six patients on the same floor as a hysterectomy patient whose blood pressure fell postoperatively to help determine whether their "acuity" justified the hospital's nursing staffing decision.

The plaintiff underwent a hysterectomy at St. Mark's Hospital. Following surgery, she was sent to floor Four West for postoperative recovery. She was cared for by a registered nurse who had an additional six patients during that same evening. St. Mark's nursing guidelines suggested a minimum of six registered nurses be on duty if there were 34 patients to a floor. These guidelines also provided that if a patient's systolic blood pressure dropped below 90 points, the patient's assigned nurse had to report that drop to the patient's physician. Four West was staffed with only five registered nurses and had a total of 34 patients on the evening after the

plaintiff's surgery. During that evening, the plaintiff's systolic blood pressure dropped from 132 to 86 and her physician was never notified.

The plaintiff filed an action against St. Mark and others, claiming that the nurse assigned to her was negligent and that St. Mark's knowingly and recklessly understaffed floor Four West, and that because of this understaffing, the defendant nurse was unable to adequately monitor and prevent damage to her kidneys resulting from the low blood pressure. To support her negligent staffing claim, the plaintiff requested documentation reflecting the acuity (i.e., the amount of nursing care a patient required) of the other patients assigned to the nurse during the evening following her surgery.

Eventually, St. Mark's was ordered to produce either a chart reflecting the acuity of these patients or a statement discussing how patient acuity was assessed and

communicated on floor Four West. St. Mark's chose the latter. It produced an affidavit of the nursing manager for floor Four West, who explained that patient acuity involved multiple factors including the patient's medical diagnosis and needs that changed from shift to shift. She also indicated that she had personally reviewed the six patient charges assigned the nurse responsible for the plaintiff and that in her opinion, it was an appropriate staffing decision.

The plaintiff then requested the six patient charts, arguing it would be unfair for the nursing manager to have access to these charts without providing her an opportunity to review them too. St. Mark's refused, relying on physician-patient privilege. To overcome this objection, the plaintiff stipulated to redaction of all personal identifying information from these

charts as well as limiting their review to only attorneys and experts. St Mark's rejected this stipulation.

However, the court ordered St. Mark's to produce the charts for redaction and limited review. This ruling was then affirmed on appeal. The appellate court concluded that the six patient charts redacted of all identifying information for limited use in this litigation did not violate the physician-patient privilege.

COMMENTARY

In essence, the defendant contended that the physician-patient privilege (contained in Utah's rules of evidence) permitted neither redaction nor restricted review of patient medical files; and that even if redaction were allowed, the patient files would be only marginally relevant to the plaintiff's negligent staffing claim and, therefore,

would not overcome its interest in protecting patient privacy. The defendant responded that any redaction would not change the privileged character of the records.

However, the appellate court sided with the plaintiff in this case. In its view, without an identified individual connected to a diagnosis, the diagnosis contained nothing more than medical terminology. The court pointed to decisions in other jurisdictions that had come to similar conclusions. It rejected the defendant's contention that due to the sensitive nature of one's medical records, a patient's candid disclosure could be chilled if the patient believes there was a possibility of being identified even after redaction.

The physician-patient privilege is intended to foster candor by promising

protection of confidential disclosures. The purpose of the privilege is to promote full disclosure by a patient to a physician to facilitate more effective treatment. Yet, exceptions to the privilege exist and a court may decide that discovery of patient charts redacted of any information that would identify individual patients, confirmed by a judge's review of the redacted records, might not jeopardize the protection afforded by the privilege.

REFERENCE

Staley v. Jolles, 2010 WL 1133334 (Ut. 2010).

Insurance

CLAIMS FOR PAYMENT OF MEDICAL SERVICES PROVIDED BY A PHYSICIAN-HOSPITAL ORGANIZATION AGAINST SEVERAL INSURERS AND HEALTH PLANS WERE SUBJECT TO THE LIMITATIONS PERIOD GOVERNING OPEN ACCOUNTS, RATHER THAN THE PERIOD FOR CONTRACT ACTIONS.

Claims by a physician-hospital organization against several health care plans and insurers were subject to the statute of limitations governing open accounts rather than the statute governing contract claims, according to a recent Louisiana appellate court decision.

Touro Infirmary submitted claims for medical services rendered to patients who were enrolled as members of certain health or insurance plans provided by the defendants. Touro alleged that all of these patients through their relationship to the defendants were part of the MultiPlan, Inc. preferred provider system in which Touro participated as a physician-hospital organization known as Choice Healthcare PHO. Choice contracted with third parties including physicians and hospitals such as Touro. Choice entered into a contract with Multi-Plan, inc., a national preferred provider organization. Touro as a member of Choice was bound to accept payments at discounted rates for medical services for

MultiPlan's clients in exchange for the prospect of increased patient volume. As members of this system the patients were entitled to receive medical services at pre-negotiated discounted (alternative) rates.

Touro filed an action against the defendants to obtain reimbursement at the full "usual and customary rate" rather than the discounted rate. Touro alleged that the benefit cards of the patients in question did not identify the preferred provider organization as required by Louisiana statute and that, as a result, Touro billed for services rendered to their patient enrollees at the usual and customary rate, rather than the discounted rate. Touro further alleged that the defendants improperly reimbursed it at the MultiPlan alternate rates. The defendants responded that the claims were barred by the statute of limitations. Touro argued these claims were subject to the ten-year limitations period applicable to

contract claims while the defendants argued the claims were subject to a three-year limitations period for open account claims.

The defendants moved to dismiss the claims. The trial judge decided in their favor and this ruling was affirmed on appeal. The appellate court concluded that the claims were open account claims subject to a three-year statute of limitations that had already expired.

COMMENTARY

In jurisdictions such as Louisiana, charges by medical providers for services are generally characterized as open account claims, and the fact that a patient may have been treated on only one occasion would not alter the open account character of the transaction. A Louisiana statute defined "open account" as "any account for which a part or all of the balance is past due, whether or not the account reflects one or more transactions and whether or not at the time of contracting the parties expected

Insurance

future transactions [and] shall include debts incurred for professional services, including but not limited to, legal and medical services.”

According to the appellate court, the fact that there may have been an agreement to bill MultiPlan patients at a certain agreed upon discounted rate did not change the nature of this claim from open account to contractual for purposes of the applicable statute of limitations. The court explained that the plaintiff could not argue that even if the action was based on an open account, it was also a contract action and, as such, there was the option to establish the claim under the contract theory subject to a 10

year limitations period. This choice did not exist since an action on open account, while arising from a contractual relationship, was an established exception to the general limitations period. Louisiana courts have uniformly rejected attempts to circumvent three-year limitations period applicable to action based on an open account by categorizing the action as one for breach of contract.

A statute of limitations sets the time frame in which a claim must be brought. A dispute may arise between a provider of medical services and an insurer as to the statute of limitations to be applied to certain medical

claims. The resolution of this issue, based on local statutes and how they have been interpreted by local courts, that could range from a short to a long limitations period, could be decisive in determining whether a claim can be pursued as timely or has been forfeited due to delays allowing the limitations period to lapse.

REFERENCE

Touro Infirmary v. American Maritime Officer, 2010 WL 46526 (La. App. 2010).

NOTES:

*** Earn 6 Category 1 AMA/PRA CME Credits ***

Subscribers to any **Zarin's Liability Alert Publication** are eligible to earn up to 6 Category 1 AMA/PRA CME credits per year. (The continuing education exam runs independent of the newsletter and is available in its entirety upon subscription commencement. Each calendar year we offer a new continuing education series. The exam series, on-line or hardcopy, includes all the necessary case info. to complete the exam without referring to your subscription issues.)

For additional information call (973) 376-9002; fax (973) 376-1775; Email gary@zarins.com or visit our website at www.zarins.com.

*** Self-Study Open Book Exam ***

This self-study CME activity will include an open-book, multiple choice exam, allowing for up to 3 hours of CME credit per exam section, or up to 6 hours of CME credit for both sections. Credit certificates will be issued if the registrant receives a passing grade of 70% or better. Conveniently available in two formats - hard copy delivered to your office or online at www.zarins.com.

Please check subscription appropriate to your practice:

One CME Program per subscriber, available in its entirety upon subscription commencement for an additional \$35

If you would like to receive the CME, please check here .

- | | | |
|---|--|---|
| <input type="radio"/> OB/GYN Liability Alert
Bi-Monthly (6 issues) \$330 | <input type="radio"/> Surgeon's Liability Alert
Bi-Monthly (6 issues) \$330 | <input type="radio"/> Emergency Dept. Liability Alert
Bi-Monthly (6 issues) \$330 |
| <input type="radio"/> Primary Care Liability Alert
Bi-Monthly (6 issues) \$330
Including Pediatrics | <input type="radio"/> Radiology Liability Alert
Bi-Monthly (6 issues) \$330
Inc. Pathology, Oncology Cases | <input type="radio"/> Medical Liability Alert
All medical specialties
Monthly \$395 |

Print Name _____

Street _____

City _____ State _____ Zip _____

Phone No. _____ E-mail Address _____

Payment Method: Check payable to Zarin's Professional Publications Credit Card (check one) Visa MC Amex

Amount of Check Enclosed \$ _____ Total Amount to Charge \$ _____

Card #: _____ Expiration Date _____

Signature (Required) _____

Mail to the address below.

Published by **Zarin's Professional Liability Publications**

A subsidiary of Jury Verdict Review Publications, Inc.

45 Springfield Ave., Springfield, N.J. 07081

Publishing Office: (973) 376-9002; Fax: (973) 376-1775; Subscription Inquiries: (973) 535-6263

Please visit our website at www.zarins.com