



EMERGENCY DEPT. LIABILITY ALERT

A bi-monthly nationwide review of medical liability for
PHYSICIANS ■ HOSPITALS ■ HEALTH CARE ADMINISTRATORS
with medical liability analysis and risk management advisory
by Ira J. Zarin, Esq.

Emergency Department Malpractice Review

- **\$3,000,000 VERDICT** - Seven-year-old deaf and autistic boy suffering from fever and congestion taken to defendant emergency department - Defendant doctor orders lumbar puncture and conscious sedation 2
Child goes into full cardio pulmonary arrest 30 minutes later - Transferred to children's memorial hospital where he was pronounced brain dead - Wrongful death several days later. *(An effective process for selection of expert witnesses should include not only their qualifications, but also whether or not they rendered testimony that could conceivably be considered inconsistent with the position now needed to be taken in defense of the practitioner involved so as to avoid the potential for the impeachment of the expert witness selected)*
- **\$325,000 CONFIDENTIAL RECOVERY** - Emergency department physician negligence. 5
Failure to administer plasma. *(The utilization of a "Futility of treatment" defense can, by its very nature, create an untoward jury reaction which can result in a significant verdict on behalf of the plaintiff patient whose treatment was literally abandoned because of the likelihood that such treatment was futile)*

Additional Malpractice Verdicts

- \$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
- \$267,328 RECOVERY** - Decedent brought to respondent hospital with shortness of breath - Breach of care in placing intubation esophageally and in failing to monitor decedent following intubation - Delay in re-intubation contributes to anoxic brain injury. 7
- DEFENDANT'S VERDICT** - Alleged three week delay in diagnosing mandible fracture allegedly results in permanent TMJ dysfunction. 8

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. 9

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 10

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 11

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 12

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 13

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 14

E.D. Malpractice Review

Malpractice Verdict Review with Analysis

\$3,000,000 VERDICT - SEVEN-YEAR-OLD DEAF AND AUTISTIC BOY SUFFERING FROM FEVER AND CONGESTION TAKEN TO DEFENDANT EMERGENCY DEPARTMENT - DEFENDANT DOCTOR ORDERS LUMBAR PUNCTURE AND CONSCIOUS SEDATION - CHILD GOES INTO FULL CARDIO PULMONARY ARREST 30 MINUTES LATER - TRANSFERRED TO CHILDREN'S MEMORIAL HOSPITAL WHERE HE WAS PRONOUNCED BRAIN DEAD - WRONGFUL DEATH SEVERAL DAYS LATER.

CASE SUMMARY

In this malpractice case, the plaintiff's decedent, a seven-year-old boy, was autistic, deaf and suffered from severe learning disabilities. He was suffering from a high fever and congestion and his mother took him to the defendant, St. Francis Hospital. Tests were performed on the boy and the emergency room doctors decided that meningitis needed to be ruled in or out. This would involve a lumbar puncture and the defendant, Dr. French, who was an agent of the defendant Infinity Health Care, decided that conscious sedation would be necessary given the boy's disabilities. The defendant doctor administered morphine intravenously and the lumbar puncture was performed. After the procedure, the boy was taken to a hospital room with his mother and 25 to 30 minutes later went into full cardio pulmonary arrest. He was transferred to Children's Memorial Hospital where he was pronounced brain dead. A couple of days later, he died. The Cook County Medical Examiner's office conducted an autopsy and concluded the boy died of meningoencephalitis. The plaintiff argued that the autopsy was wrong and that the boy died of an overdose of morphine, not

meningoencephalitis. The plaintiff claimed that the defendant doctor gave the boy too much morphine too quickly. The defendant hospital settled prior to trial for \$780,000.

CASE DETAILS

The defense argued that the boy died of brain swelling as a result of meningoencephalitis and that the drug choice and time was appropriate. The defense pediatric infectious disease specialist testified that the child died from fulminant bacterial meningitis, which caused the brain swelling and cardiac arrest. The defense further argued that either the radiologist who misread a CT-scan or the nurses who failed to monitor the boy after the procedure were the sole proximate cause of death. The defense expert anesthesiologist testified that the drugs administered by the defendant doctor were appropriate and not a cause of the death. The plaintiff's attorney argued that meningitis was not the cause of death, as no one had looked at the results of the initial lumbar puncture and if they had; they would have seen that the tests had come back negative. The plaintiff's pediatric intensive care expert testified that the boy died of a morphine overdose and did not have

meningitis. The plaintiff's expert neuropathologist testified that he studied the autopsy that was given and opined that they were wrong. The plaintiff's expert pediatric emergency room doctor testified that the defendant doctor deviated from proper standard of care with the administering of morphine and for not properly monitoring him after the procedure.

After a trial that lasted about two and a half weeks, the jury found for the plaintiff and awarded the plaintiff \$3 million for wrongful death. Post trial motions are pending.

MEDICAL LIABILITY ANALYSIS

The expert witnesses played a very prominent role in this case and it would appear that the fact that the plaintiff's experts were made up of mostly University doctors who took the stance against the hospital made a difference with the jury. The fact that the majority of the defense experts were experts from all over the country who had a great deal of experience as expert witnesses may have backfired for the defense.

An interesting point in the case came when the defense's expert emergency programs administrator had testified that the defendant doctor's administering and



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., Second Floor, 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.

monitoring of the drugs was fine. The expert was a writer of many textbooks that are used in the medical field. Under cross examination, the plaintiff's attorney used the expert's own textbook against him to prove that the dose of morphine was too high. According to the textbook, the dose administered would be considered too high a dose.

This trial was a very emotional one given the age of the decedent and the disabilities that he suffered. Normally in a wrongful death case, friends and family testify as to the relationship that the decedent had with his family and friends. In this case, the mother was the only one to testify. She testified that there was a very strong bond between them because of the autism and that this gave her purpose for her life, which she testified went away when he died. This emotional testimony may have played a large role in the size of the verdict.

RISK MANAGEMENT ADVISORY

In this case, it was felt that the utilization of expert witnesses from the ranks of the defendant hospital itself was thought to have made a significant difference with the jury. In fact, they opined that the hospital to which they were all affiliated deviated from acceptable standards of practice. Practitioners are reminded that where expert witnesses are procured from the practices of the accused involved and who testify against the very practice to which they owe their affiliation, such testimony can, in most instances, be considered particularly persuasive. This is primarily because in so testifying, the practitioners are not only exposing themselves to more than a simple, uncomfortable situation where they are literally accusing the parties to which they are affiliated, but also because the jury will often think of such testimony as an heroic act which is particularly credible because the physicians so involved would not have exposed themselves unless they were coming forth with the truth. In this case, that very circumstance was thought to be one of the most persuasive elements

of the testimony of these physicians who testified as experts for and on behalf of the plaintiff.

Practitioners would do well to remember that where expert witnesses are procured from among their own ranks and testify uniformly to a deviation from acceptable standards of practice, it becomes an added burden upon the defense to contradict such testimony. Jurors will often naturally feel that there must have been a deviation or otherwise these expert physicians would not have taken a stance in testifying against the very people with whom they affiliate on a regular basis and, therefore, whose testimony is probably accurate and true.

Another important factor regarding the expert witnesses in this case was the fact that the majority of the defense experts were, on the other hand, from all over the country and were generally felt to have a great deal of experience in testifying in court cases, primarily as defense expert physicians. Practitioners are reminded that when they select experts who regularly testify primarily on behalf of defendants in medical malpractice litigation, they can create the aura that these witnesses are what practitioners tend to label professional witnesses, whose credibility can be impaired by the fact that they habitually testify, usually with significant fees involved, primarily in defense of accused physicians.

At trial, plaintiff's counsel can and will point to this history to create an implication with the lay jury that these experts are professional witnesses who generally earn their money by testifying on behalf of defendant physicians. Although this implication may not be true, it can nonetheless be conceived in the minds of lay jurors that it is, in fact, true and can go a long way in impairing their testimony before the lay jury.

In this regard, it is appropriate for accused physicians in a medical malpractice litigation to obtain experts

who have a reputation for testifying for and on behalf of plaintiffs as much as they testify for and on behalf of defendants so as to indicate an even hand in selecting the cases to which they will agree to testify which can only enhance the veracity of their testimony. Furthermore, in selecting expert witnesses to testify in defense of a medical malpractice action, practitioners and their counsel should be aware that the experts' prior testimony in other cases can be obtained and utilized by plaintiff's counsel to contradict and impeach what the expert may be saying in the pending litigation if such testimony is inconsistent with the opinion now being offered. Therefore, in situations where an expert witness has previously testified in malpractice actions, inquiry should be made as to whether or not such previous testimony could be considered inconsistent with the position now being taken on behalf of the accused physician in the pending case. Such previous testimony should be procured and read prior to the final selection of the expert so as to avoid a situation where an expert may not have remembered what could be considered inconsistent testimony that can be used to impeach their testimony in the pending litigation.

Practitioners are reminded that where an expert is severely impeached before the lay jury, that very impeachment can go beyond impairing the testimony of the physician involved, and can, in fact, also impair the entire defense posture before the lay jury because of the laymen's rejection of testimony by professionals which they have found to be inconsistent and lacking veracity. In this regard, practitioners are reminded that laymen sitting in judgment in medical malpractice cases will usually forgive honest errors in testimony, but they will not forgive testimony from an expert inconsistent with prior testimony given in other cases, where such testimony is material to the outcome of the case, as an attempt to deceive

them into rendering a judgment for and on behalf of the accused physician.

Furthermore, in regard to the selection of expert witnesses, practitioners should beware of selecting any witness who has testified many times in different litigation because the very frequency of rendering testimony by the expert can itself indicate to the lay jury that the witness is, in fact, a professional witness who is more interested in getting paid for their testimony than necessarily rendering an accurate and honest opinion in the pending litigation. An appropriate selection of expert witnesses should also include whether or not the witness also practices medicine and, if so, whether or not the hours spent in rendering testimony exceeds those of actually treating patients. This question is frequently asked of expert witnesses in medical malpractice litigation and can be a consideration by the lay jury as to the credibility of the particular witness involved.

An additional aspect of this case was the evidence that the primary defense expert witness was responsible for the publication of many medical textbooks that are still in use in the medical field. Under cross-examination, plaintiff's counsel effectively utilized the expert's own textbook information against him to prove that the dose of morphine administered in this case was, in fact, too high. The published textbook became, therefore, a key factor in the case that the dose administered would be considered too high a dose, as was the ultimate determination of the jury in this case.

Practitioners are reminded that whereas obtaining an expert who is a prolific writer of textbooks that are utilized by physicians in the field can be a very positive element enhancing the credibility of that expert, if, however, there are many such textbooks of which any might be interpreted as

having reached conclusions inconsistent with the testimony now being rendered by that witness, this very fact can be utilized, as it was in this case, to impair the credibility of that otherwise very knowledgeable and substantial witness. Therefore, when selecting a witness, no matter how knowledgeable or accredited, accused practitioners should inquire as to whether or not any particular writing by that witness may be inconsistent with the position now being taken in the pending case before agreeing to accept the testimony of that witness. If prior publications could conceivably be considered inconsistent with the position now being taken in the pending case, it should be examined very carefully and discussed with the witness to determine whether or not it can be misinterpreted or actually be interpreted as inconsistent with the position now taken in the case before selection of that witness.

In a situation where an expert witness is particularly knowledgeable, such proven inconsistency can effectively work against that witness even more so than a witness having average credentials and knowledge about the subject matter because of the expectation created by the reputation of that witness in the field in which he or she is deemed an expert. In this regard, the excellent credentials of the witness can work against that witness if, in fact, the jury determines that in this particular case, he or she is less than credible in his or her testimony because they may feel that a well-credentialed and knowledgeable expert should know better than to testify inconsistent with their own writings that cannot be explained away as a simple, honest mistake.

Finally, practitioners who agree to testify in a medical malpractice litigation who are prolific writers and who have issued papers and texts should be aware that all of their particular utterances, speeches, lectures and

text material, or any written material previously published, will be scoured by opposing counsel to determine whether there exists, even seemingly, any inconsistency with the position now taken by the expert and should, therefore, decline to so testify if, in fact, that inconsistency, even innocently made, could be misinterpreted by the lay jury as being an attempt to deceive them, no matter how credible and honest the particular witness may, in fact, be.

EXPERTS

Plaintiff's emergency room medicine expert: Ross Heller, M.D. from Chicago, IL. Plaintiff's neuropathology expert: Robert Wollmann, M.D., Ph.D. from Chicago, IL. Plaintiff's pediatric emergency medicine expert: Jill Glick, M.D. from Chicago, IL. Plaintiff's pediatric infectious disease expert: Robert Daum, M.D. from Chicago, IL. Plaintiff's pediatric intensive care & pediatric anesthesiology expert: Madelyn Kahana, M.D. from Chicago, IL. Plaintiff's treating nurse expert: Deborah Williams, R.N. from Evanston, IL. Defendant's anesthesiology expert: Kenneth Tuman, M.D. from Chicago, IL. Defendant's infectious disease, pediatrics, and critical care expert: Michael Radetsky, M.D. from Albuquerque, NM. Defendant's neuropathology expert: Hannes Vogel, M.D. from Stanford, CA. Defendant's pediatrics and emergency medicine expert: Roger Barkin, M.D. from Denver, CO.

REFERENCE

Cook County, IL. Snyder Gwendolyn, Special Administrator of the estate of Jirvae Dixon vs. Saint Francis Hospital, Dr. F and Infinity Healthcare, Inc. Case no. 02-L-005535; Judge Mary A. Mulhern. Attorneys for plaintiff: Michael Cogan & James Navarre of Cogan & McNabola PC in Chicago, IL. Attorney for defendant: Swanson Martin Bell LLP in Chicago, IL. Attorneys for defendant: Marc Benjoya & John Reid of Cassiday, Schade & Gloor in Chicago, IL.

"Emergency Department Liability Alert" is published bi-monthly for \$330/year by Zarins Liability Alert Publications, Inc., 45 Springfield Ave, Second Floor, NJ 07081. Periodical Postage Paid at Springfield, NJ and additional mailing offices. Postmaster: Send address changes to Radiology Liability Alert, 45 Springfield Ave., Second Floor, Springfield, NJ 07081.

\$325,000 CONFIDENTIAL RECOVERY - EMERGENCY DEPARTMENT PHYSICIAN NEGLIGENCE - FAILURE TO ADMINISTER PLASMA.

CASE SUMMARY

In this medical malpractice action, the plaintiff alleged that the defendant was negligent in failing to administer fresh frozen plasma to the decedent who was hemorrhaging. The defendant denied the allegations and maintained that the treatment of the decedent was appropriate.

CASE DETAILS

The 73-year-old female decedent presented via ambulance with complaints of nausea, vomiting, difficulty breathing, headache and a floppy arm. The decedent presented with a history of coronary artery disease, coronary bypass grafting, asthma, atrial fibrillation and high blood pressure. She came under the care of the defendant physician. Upon examination, she had extremely high blood pressure and congestive heart failure. The decedent had slurred speech. The defendant ordered the administration of Vitamin K and she was only minimally responsive two hours later. A CT-scan disclosed that the woman was suffering from a massive brain bleed. She was transferred to another hospital for care. However, she never made any improvement. She was removed from life support the following day.

The plaintiff brought suit, alleging that the defendant should have administered fresh frozen plasma to the decedent and was otherwise negligent in the treatment of the plaintiff's decedent. The defendant denied the allegations and maintained that there was no deviation from acceptable standards of care and that the administration of Vitamin K was both reasonable and appropriate.

The parties agreed to settle the matter prior to trial for the sum of \$325,000.

RISK MANAGEMENT ADVISORY

In this case, both the accused doctor and nurses maintained through expert testimony that even if the decedent had been diagnosed on June 25th while still in the emergency room, her condition and outcome would not

have been any different because, as they contended, she could not practically have been able to be treated surgically for her condition. To counter this futility defense, the plaintiff presented expert testimony that the decedent would have at least been able to take medication and undergo a catheterization which could have prolonged her life if the defendants had complied with their responsibility.

Practitioners are reminded by this case that raising a "Futility of treatment" defense in a medical malpractice litigation has a definite downside that should be avoided if at all possible. Essentially, the defense must claim to the satisfaction of the judge and lay jury that whatever the defendant(s) did, it would not have really mattered because of the dire condition of the patient at that time. As part of this defense, the defendant must essentially argue that the remedial treatments which were ignored would ultimately have not made a difference in the outcome because of the condition of the patient. This can often be a hard pill to swallow on the part of a lay jury, who generally believe that some attempt at treatment should be made regardless of its likelihood of success.

In this regard, prior trial experience where a "Futility of treatment" defense has been raised indicates that in many instances, the jury tends to be sympathetic to the patient's position and are likely not prone to accept the defense argument that although the accused practitioners may well have deviated from the acceptable standard of care, such deviation cannot be proven to have definitively manifested itself in the poor outcome. Furthermore, in the eyes of the lay jurors, the defendants' failure to at least attempt treatment cannot be excused on the basis that the defense experts contended at a later time that such treatment would most likely have been futile. Finally, juries seem

illprepared to accept the argument that there were no provable damages from the failure of the physicians involved to at least try to assist the patient and ameliorate the condition to at least some definitive degree, as was the situation in this case.

Practitioners are also reminded that in the eyes of lay people who will ultimately decide this case, no matter how thin the probability a full recovery may be, the patient is entitled to every reasonable medical undertaking that could assist that patient in ameliorating some pain or perhaps even prolong that patient's life, as brief as it may be. The failure to at least interpose these types of attempts on behalf of the patient can seldom be excused before a lay jury on the basis of the fact that it might not have effected a full cure in any event and, therefore, the doctor is excused from even trying to assist the patient with that type of serious condition.

Another adverse aspect of physicians raising a futility of treatment defense is that by its very nature, it implies, at least tactically, an admission that there was a deviation from the accepted standard of practice, but that the deviation was not significant because treatment would have been futile anyway and, therefore, such deviation should not bring about a recovery on behalf of the patient due to a lack of proximate cause to the deviation.

Another interesting aspect of this case was the defendant physician's attempt to defend his position by maintaining that he was not negligent because the nurses failed to communicate with him and advise him of the abnormal enzyme studies and the abnormal EKG. Both the accused nurses and the plaintiff's experts successfully argued that the defendant physician was nevertheless at fault since he had the final authority and, most importantly, the final responsibility to re-

view all tests and studies performed before discharging the patient, and that a review of those tests would have indicated the need for further treatment and that a discharge at that point was clearly improper.

Practitioners are reminded by this aspect of the case that prior to discharging a patient, physicians have

the responsibility to review all available test results and studies before undertaking to discharge the patient. Practitioners are legally held responsible, from a liability standpoint, for all the pertinent test results and information contained within the patient's record prior to discharge and, in that regard, cannot avoid liability on the basis of the fact that they were, at

the time of discharge, unaware of positive test results, as was the situation in this case.

REFERENCE

Massachusetts. Case information withheld. Attorneys for plaintiff: Kathy Jo Cook and Ann Marie Maguire of Keches & Mallen in Taunton, MA.

Additional Emergency Department Malpractice

\$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.

\$267,328 RECOVERY - Decedent brought to respondent hospital with shortness of breath - Breach of care in placing intubation esophageally and in failing to monitor decedent following intubation - Delay in re-intubation contributes to anoxic brain injury.

The claimants in this wrongful death case, the three adult children of the decedent, contended the standard of care was breached upon their father's arrival in the respondent hospital with complaints of shortness of breath that had become increasingly worse over the previous several days. The decedent suffered a severe anoxic insult to his brain, never regained consciousness and died several weeks later. The respondents claimed the decedent's oxygen saturations were in excess of 90 after the intubation and that a post-intubation examination confirmed tracheal placement of the endotracheal tube. The respondent physicians claimed the decedent suddenly became bradycardic and ultimately asystolic 13 minutes after intubation. The claimants contended the original intubation performed on the decedent was placed esophageally and that the respondents' claim that the decedent was saturating in the 90s and then suddenly became bradycardic was untrue and physiologically impossible.

The decedent was a 62-year-old retired male who was morbidly obese and had a history of respiratory problems including hypoventilation syndrome, obstructive sleep apnea and chronic obstructive pulmonary disease which had necessitated his intubation on two previous occasions in the year prior to his death. The decedent was brought to the respondent hospital via ambulance on the evening of August 28, 2007 with complaints of increasing shortness of breath. On arrival, his oxygen saturations were noted to be 88 percent on room air. Emergency room physicians at the hospital evaluated the decedent and placed him on BiPap. When oxygen saturations did not improve on BiPap and the decedent became progressively more obtunded, a decision to intubate was made by the emergency

room physicians. Multiple attempts at intubation were made by two separate physicians and the last intubation was believed to be placed tracheally; however, immediately following the intubation, yellow fluid was seen coming from the endotracheal tube.

Once the decedent suddenly became bradycardic, the physicians immediately removed the endotracheal tube and began CPR. During the CPR process, the physicians did not attempt to re-intubate the patient and instead called for an anesthesiologist to perform the intubation. The anesthesiologist arrived seven to ten minutes later and re-intubated the decedent. Following re-intubation, the decedent regained perfusing cardiac rhythm within less than a minute. He suffered a severe anoxic insult to his brain and never regained consciousness.

The respondents alleged their post-intubation examination confirmed tracheal placement of the endotracheal tube. They claimed the decedent's oxygen saturations were in excess of 90 and remained so following the intubation. Yet, the claimants argued the implausibility of these claims and maintained that the medical record did not contain any record of oxygen saturation following the intubation.

The claimants contended the original intubation was placed esophageally, not tracheally, and that the failure to monitor the decedent following intubation allowed his oxygen saturations to progressively drop to the point where he could no longer sustain cardiac function and went into cardiac and respiratory arrest. The claimants further alleged that following the cardiac and respiratory arrest, the respondents fell below the standard of care in failing to attempt to re-intubate

the decedent and instead attempting to ventilate him via bag valve mask ventilation. The claimants maintained that had the respondents appropriately monitored the decedent following intubation, it would have become evident that he was not properly intubated long before he went into respiratory and cardiac arrest. It was argued that the delay in reintubating the decedent further contributed to his anoxic brain injury.

The claimants offered to mediate the case and made an opening demand of \$329,920. The respondents declined mediation and offered nothing. This case proceeded to five days of arbitration and the claimants were awarded \$267,328. This award included \$250,000 in non-economic damages, \$5,528 in future economic damages and \$11,800 in funeral expenses.

EXPERTS

Plaintiff's anesthesiology expert: Dr. Done F. Mills, M.D. from Newport Beach, CA. Plaintiff's emergency medicine expert: Dr. Raymond L. Ricci, M.D. from Newport Beach, CA. Defendant's anesthesiology expert: Dr. Myer H. Rosenthal, M.D. from Stanford, CA. Defendant's emergency medicine expert: Dr. Michael Bresler, M.D. from Emerald Hills, CA.

REFERENCE

San Francisco County, CA. Landon Velarde, Louis Velarde and Lawrence Velarde vs. Northern California Permanente Medical Group, et al.; Judge Carl West Anderson, Arbitrator, 02-15-10. Attorney for plaintiff: Kevin G. Liebeck of Hodes, Milman, LLP in Irvine, CA. Attorneys for defendant: Denis Billups-Slone and Robert Slattery of McNamara, Dodge, Ney, Beaty, Slattery, Bourges & Brothers, LLP in Walnut Creek, CA.

DEFENDANT'S VERDICT - Alleged three week delay in diagnosing mandible fracture allegedly results in permanent TMJ dysfunction.

The 39-year-old plaintiff contended that when he presented to the defendant hospital following a motor vehicle collision with multiple complaints, including wrist and jaw pain, the defendant emergency room physicians and nurse practitioner reviewed the results and determined that they were positive for a fracture of the right wrist's radial head and negative for any fractures to the mandible. The plaintiff was treated for the wrist fracture and released. The plaintiff contended that the following day, the hospital's radiology department reviewed the plaintiff's x-rays and noted a probable fracture of the right mandibular condyle. Radiology then contacted the emergency room personnel that had reviewed the films the night before and notified them about the probable fracture. The emergency room physicians reviewed the films again, but believed that the radiology department was referring to the previously diagnosed wrist fracture, and decided not to call the plaintiff back to the hospital.

The plaintiff saw a subsequent, non-party physician approximately three weeks later, complained of jaw pain and was sent for further x-rays. When the x-ray films came back, the physician diagnosed a fractured mandible, which the plaintiff maintained developed into a deformity of the mandibular joint.

The plaintiff contended that although the emergency room physicians were independent contractors, the hospital should be liable for their actions on an apparent agency theory. The plaintiff further maintained that he called the hospital's emergency room twice during the week of his discharge with complaints of continued jaw pain, but that he was only told to place warm soaks on the area. The plaintiff also contended that the defendant hospital's staff should have

followed through and made sure that the patient was contacted and told of the mandible fracture.

The hospital contended that it acted appropriately, and that any negligence was the result of the emergency room physicians. The hospital brought a third party action against the emergency room physician, alleging that it properly followed its policy of having radiology review x-ray films taken in the emergency room and the department properly notified the emergency room personnel of a suspected fracture. The hospital argued that the obligation to contact the patient was then with the emergency room personnel, but that they failed to do so because they deemed it unnecessary.

The defendant emergency room physician and nurse practitioner contended that when they were contacted by the radiology department, they believed its reference to a probable fracture was a reference to the radial head fracture they had previously diagnosed the night before. They argued that this showed that the hospital's policy between the emergency room and radiology was confusing and inadequate, which contributed to the confusion in the delay in timely diagnosing the mandible fracture. They contended that the hospital's policy was unclear about how to handle discrepancies between the two departments when it came to x-rays, and that as a result, the hospital was at least partially responsible for the plaintiff's treatment.

The plaintiff contended that the three week delay caused him to develop a deformity of the mandibular joint. Despite two subsequent surgeries to reconstruct the jaw, he suffers from temporomandibular joint dysfunction, which remains painful to this day, and which he maintained is permanent in

nature. The defendant hospital, third party defendant, nurse practitioner, and third party defendant emergency room physician maintained that the plaintiff's alleged jaw deformity was actually an old injury dating back to childhood and not related to the events of the motor vehicle collision that brought the plaintiff to the hospital in the first place.

The jury found that there were no departures by the defendant hospital regarding its policies and procedures. They jury also found that the emergency room physician and nurse practitioner had deviated in their review of the x-rays and their failure to contact the patient. The jury also determined, however, that there was no causation established by the plaintiff in regard to the events of the subject emergency room visit and that the plaintiff's injuries stemmed from an earlier injury.

EXPERTS

Plaintiff's emergency room medicine expert: Dean Dobkin, M.D. from Mt. Laurel, NJ. Plaintiff's maxillofacial surgery expert: Michael S. Monto, M.D from Middletown, NY. Defendant's emergency room medicine expert: Timothy G. Haydock, M.D from White Plains, NY. Defendant's emergency room medicine expert: Anthony Mustalish, M.D from New York, NY. Defendant's maxillofacial surgery expert: Gary Orentlicher, D.M.D. from Scarsdale, NY.

REFERENCE

Rockland County, NY. Ronan vs. Nyack Hospital, et al. Index no. 006377/02; Judge Robert Berliner, 2-9-10. Attorney for defendant: David W. Sisskind for defendant hospital of Schiavetti Corgan DiEdwards & Nicholson, LLP in New York, NY.

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 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
Monthly \$395
All medical specialities |

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

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

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