



OB/GYN LIABILITY ALERT®

A bi-monthly nationwide review of medical liability for

OBSTETRICIANS ■ GYNECOLOGISTS

with medical liability analysis and risk management advisory

by Ira J. Zarin, Esq.

Ob/Gyn Malpractice Review with Analysis

- **\$1,990,000 VERDICT** - Wrongful death - Obstetrical malpractice - Ob/Gyn allegedly fails to diagnose pregnancy induced cardiomyopathy and prescribes the contraindicated medication Labetalol 2
Heart failure - Wrongful death. *(The fact that the deterioration of a patient's condition occurred while she was being treated by subsequent physicians did not offer any defense to the defendant for her prior deviations which ultimately manifested in the subsequent deterioration and wrongful death of the patient)*
- **\$1,750,000 VERDICT** - Ob/Gyn - Negligent use of fundal pressure during shoulder dystocia - Brachial plexus injury - Erb's palsy. 4
Verdict rendered for maximum amount under state malpractice cap. *(Defendant's denial that the use of fundal pressure after encountering shoulder dystocia was a deviation was not sustained where the proofs and opinions clearly indicated that to do so was a deviation from acceptable standards of practice)*

Additional Malpractice Verdicts

- Ob/Gyn
\$750,000 PRE-SUIT RECOVERY - Plaintiff inaccurately advised she has breast cancer after her tissue is mixed with another patient's - Unnecessary lumpectomy 7
- \$89,033 VERDICT - Failure to remove mesh following surgical procedure - Infection - Failure to timely diagnose cause of infection. . . 7
- DEFENDANT'S VERDICT - Alleged failure to obtain informed consent - Alleged negligent burning of portions of small intestine during tubal ligation - Three subsequent surgeries to remove necrotic tissue and repair bowel - Chronic diarrhea 8

Medical Practice Liability

BUSINESS PRACTICES/UNFAIR COMPETITION

- A dentist who sold his clinic to another dentist may have violated a noncompete clause by practicing dentistry in a community clinic 9

PEER REVIEW

- A variance report prepared by hospital staff after a wrong kit was used to refill a patient's pain pump was a protected peer review document 10

INFORMED CONSENT

- A woman who signed two consent forms for a bilateral tubal ligation gave her informed consent to the procedure even though she was allegedly under distress. 11

DEFENSIVE ACTIONS/COUNTERMEASURES TO MALPRACTICE SUITS

- A patient who suffered ulnar neuropathy following shoulder rotator cuff surgery did not present sufficient expert testimony linking the injury to negligence during the surgery 12

NEW/EXPANDED LIABILITY

- A doctor's warranty claims against the manufacturer of a medical device allegedly causing ulnar nerve damage were barred by the statute of limitations, but her tort claims were not. 13

INSURANCE

- Disputes over repayment requests by blue cross/blue shield form several chiropractors were subject to arbitration as per their provider agreements 14

Ob/Gyn Malpractice Review

Ob/Gyn Malpractice Review with Analysis

\$1,990,000 VERDICT - WRONGFUL DEATH - OBSTETRICAL MALPRACTICE - OB/GYN ALLEGEDLY FAILS TO DIAGNOSE PREGNANCY INDUCED CARDIOMYOPATHY AND PRESCRIBES THE CONTRAINDICATED MEDICATION LABETALOL - HEART FAILURE - WRONGFUL DEATH.

CASE SUMMARY

In this medical malpractice case, the 32-year-old decedent suffered from pregnancy-associated cardiomyopathy that her ob-gyn failed to diagnose even though she knew her patient was experiencing tachycardia, pitting edema in her ankles, coughing, shortness of breath and rapid weight gain. She then allegedly recommended administration of Labetalol, a powerful antihypertensive drug, to the pregnant patient, which caused the decedent's blood pressure, as well as the fetal heart rate, to plummet. The decedent's child was saved by an emergency caesarean section, but the decedent died of heart failure. The ob-gyn contended that an emergency room doctor was responsible for her patient receiving Labetalol because he actually wrote the order.

CASE DETAILS

The decedent in this medical malpractice case was a 32-year-old teacher who suffered a lingering cough when she was eight months pregnant with her second child. She visited the school nurse, who, after noticing that the teacher's ankles were swollen with pitting edema, told the pregnant woman to contact her ob-gyn. The decedent saw her doctor that afternoon, complaining of a cough and edema in her ankles. The doctor performed a pelvic exam and checked her

patient's blood pressure, but did not take her pulse or listen to her lungs. The doctor's office recorded, in the patient's chart, that the mother-to-be had gained ten pounds in one week. After examining her, the doctor sent her patient home with instructions to take Robitussin to relieve her cough. The next day the decedent felt worse, and again went to the school nurse, who found that the pregnant woman's pulse was an abnormally high 142 beats/minute and that her breathing was labored. The alarmed nurse called the ob-gyn, who, after initially resisting the nurse's insistence that the decedent was seriously ill, instructed the patient to go to the hospital. At the emergency room, the decedent was given an EKG and chest X-ray which showed that she was suffering from congestive heart failure and tachycardia. Her blood pressure was normal. When the E.R. physician called the ob-gyn for instructions on what medication to administer to the patient, the ob-gyn told him that he could give her Labetalol, a powerful antihypertensive drug which causes a rapid drop in blood pressure. The decedent's blood pressure quickly plummeted, as did the fetal heart rate. A caesarian section was performed to save the child, but the decedent went into cardiopulmonary arrest. She was resuscitated and sent by MedFlight to a hospital in Boston where she died.

The decedent's fetal-maternal medical expert, Dr. James Balducci, testified that the mother-to-be suffered from pregnancy-associated cardiomyopathy which sometimes occurs during pregnancy. He related that he had seen twenty-five such cases, none of which resulted in death. He testified that the symptoms of pregnancy-associated cardiomyopathy are tachycardia, edema, coughing or wheezing, shortness of breath, and fatigue, and that the ob-gyn should have diagnosed the decedent's condition when the school nurse told her of the patient's symptoms. He related that Labetalol should never be given for pregnancy-associated cardiomyopathy because it causes an unwanted rapid decrease in the patient's blood pressure.

The ob-gyn argued that she was not responsible for the decedent's death because she did not have privileges at the hospital and did not order Labetalol. She claimed that she did not recommend the administration of Labetalol by the E.R. physician; she claimed that she and the E.R. doctor discussed hypothetically what medications might be safely given to a pregnant patient.

After an eight day trial, the jury deliberated for five hours and returned a plaintiff's verdict for \$1,990,000, which, together with prejudgment interest, amounts to \$2,900,000.



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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.

MEDICAL LIABILITY ANALYSIS

The school nurse was a valuable witness for the plaintiff. Not only did she provide knowledgeable testimony about the patient's symptoms, she had talked directly to the defendant before the decedent went to the emergency room. Based on the patient's symptoms, even the school nurse, with her less rigorous training, testified at deposition that she suspected that the decedent was suffering from congestive heart failure. Dr. Balducci, the plaintiff's maternal-fetal medical expert, testified that the ob-gyn should have diagnosed her patient's condition after she talked to the nurse on the phone.

The ob-gyn did not appear apologetic at trial. Some of her testimony seemed implausible; for example, she claimed that the emergency room doctor had simply asked her hypothetically about medications that might be given to pregnant patients, and denied that they discussed what medication the E.R. doctor should give to the decedent. Under the emergency circumstances of their conversation, that version of events did not ring true.

Considering the sympathetic facts of this case, \$1,990,000 is not a huge verdict. The plaintiff's lawyer related that Essex County, where this case was tried, is known for its conservative awards as compared to other counties such as Suffolk County, where Boston is located. That fact is somewhat mitigated by the 12% prejudgment interest that accrues on wrongful death awards.

RISK MANAGEMENT ADVISORY

In this case, the plaintiff's medical expert testified that the decedent mother-to-be suffered from pregnancy-associated cardiomyopathy which can occur during pregnancy. He further testified that the symptoms of pregnancy-associated cardiomyopathy are tachycardia edema, coughing or wheezing, shortness of breath and fatigue. This expert successfully opined that the accused ob/gyn should have diagnosed the decedent's condition when the

school nurse told her of these symptoms. He further testified that it was a deviation for the defendant to administer Labetalol for the pregnancy-associated cardiomyopathy because it tends to cause an unwanted, rapid decrease in the patient's blood pressure.

The defendant ob/gyn argued that she was not responsible for the decedent's death because she did not have privileges at the hospital where the later events occurred which lead to the decedent's death, and also maintained that she did not order the administration of Labetalol nor did she recommend the administration of that medication to the E.R. physician. In fact, the defendant indicated that it was the E.R. physician who was responsible for the patient receiving Labetalol, which she testified was evidenced by the fact that he actually wrote the order for that medication. The jury, however, found the defendant ob/gyn responsible for the administration of the medication because at the time the medication was administered, the E.R. physician was relying on the advice and recommendations of the defendant ob/gyn being rendered during a telephone conversation between the two physicians.

Unfortunately, the defendant's attempt to avoid liability by arguing that she was not at the hospital and had not, in fact, been the one who ordered the administration of Labetalol, failed. The jury rejected this defense based upon the judge's charge that where a physician's conduct sets in motion a course of events that leads to serious injury or the death of a patient, that physician remains responsible for all resulting injuries from the original deviation despite the fact that the results of that earlier deviation manifested themselves at a later time. In this regard, the fact that the patient in this case was later under the care of another physician at another facility when she suffered the effects of the prior inadequate diag-

nosis and treatment rendered by the defendant did not in any way exonerate the defendant for the deviation that brought about the exacerbation of a condition which ultimately resulted in the patient's death.

Stated another way, the fact that a patient suffers injury at a later time while being treated by other physicians following negligent earlier treatment being rendered when the results of that prior negligent treatment manifest themselves in serious injury to the patient will not prevail as a defense. The defendant's contention in this case that she was not in charge at the time the patient deteriorated and ultimately died could not avoid liability to the defendant for her inadequate and substandard treatment previously rendered simply because the injury suffered by the patient stemming from that deviation occurred while the patient was then in the hands of other physicians, in this case, at the hospital facility.

Practitioners are also reminded by this case that where they find themselves in charge of a patient's care, and deviations were committed in the previous treatment of that patient which deviations bring about, or materially contribute to the deterioration of the patient's condition leading to a poor result or the death of the patient at a later time while under their care, then they may well be able to avoid liability based upon the existence of the prior deviations causing the poor outcome. Correspondingly, the prior treating physician cannot avoid liability simply by arguing that at the time the patient's condition manifested itself, the patient was in the hands of the subsequent physicians attempting to remedy the situation. Such a contention will not affect the liability of the prior treating physician or facility for having deviated and created the condition in the first place.

In this case, the E.R. physician was found not responsible for the patient's

death nor was he implicated in the judgment against the defendant ob/gyn because of the fact that at the time he administered the offending medication, he was doing so under the directions and instructions of the defendant ob/gyn. Although the E.R. physician was successful in avoiding liability due to his total reliance on the defendant ob/gyn in this regard, practitioners should be aware of the potential liability that may be involved for a physician who deviates on the basis of such a reliance in other situations.

Practitioners are reminded that they indeed have an individual, personal responsibility when treating a patient, to conform to all reasonable, existing standards of care in the treatment of that patient. The cannot generally expect to avoid liability, particularly where they administer contraindicated medication, as was the allegation in this case, on the basis of the fact that at the time, they were relying on the advice of another physician who presumably knew more about the

situation, such as the patient's own personal physician indicating that such medication should be administered.

Practitioners are further reminded that the duty to conform to the acceptable standard of care includes the responsibility of the physician to avoid administering contraindicated medication that could be harmful to the patient under the circumstances then involved. The fact that the administering physician was doing so in reliance of the patient's personal physician does not necessarily excuse him or her for doing so where the prevailing medical literature at the time indicates that the administration of such medication was, in fact, contraindicated.

Physicians would do well to remember that where they administer any medication inconsistent with the prevailing, existing literature or information pertaining to the appropriate administration of that medication, to the peril of the patient, they may not normally avoid liability on the basis of the

fact that they were unaware that the administration of the medication at that time, under those particular conditions, was considered contraindicated and not in accordance with accepted medical practice. In this regard, any practitioner who administers medication is assumed to know not only the appropriateness of such medication to the condition involved, but also all aspects including when, where and how the administration of that medication is contraindicated and thereby avoid administering that medication where it is known to be contraindicated for the particular situation at hand.

EXPERTS

Plaintiff's economist expert: Dana Hewins from Lakeville, MA. Plaintiff's maternal-fetal medicine expert: James Balducci from Phoenix, AZ.

REFERENCE

Essex County, MA. Estate of Jardine vs. Dr. K. Case no. 050532; Judge Timothy Feeley. Attorney for plaintiff: Lisa G. Arrowood and Jed DeWick of Todd & Weld in Boston, MA.

\$1,750,000 VERDICT - OB/GYN - NEGLIGENT USE OF FUNDAL PRESSURE DURING SHOULDER DYSTOCIA - BRACHIAL PLEXUS INJURY - ERB'S PALSY - VERDICT RENDERED FOR MAXIMUM AMOUNT UNDER STATE MALPRACTICE CAP.

CASE SUMMARY

In this medical malpractice action, the plaintiff contended that the defendant ob/gyn utilized contraindicated fundal pressure when shoulder dystocia occurred. The plaintiff contended that as a result, the impaction of the shoulder worsened, resulting in the baby sustaining a brachial plexus injury that manifested in moderate to severe right sided Erb's Palsy. The defendant did not dispute that shoulder dystocia had been encountered or that fundal pressure was utilized. The defendant denied, however, that the use

of fundal pressure was a deviation, or that the method of delivery contributed to the brachial plexus injury.

CASE DETAILS

The defendant passed away before discovery. The nurse who was present testified that when shoulder dystocia was encountered the defendant gave an order for the use of "pressure." The nurse indicated that she was about to begin using suprapubic pressure entailing the use of a closed fist above the pubic bone and pushing in an inward and downward motion to allow the baby's shoulder to go under the pubic bone and deliver. The nurse related that as she began, the

defendant redirected her to use fundal pressure, entailing pushing downward from an area immediately below the breast bone.

The plaintiff contended that the use of fundal pressure constituted a deviation. The plaintiff's expert ob/gyn maintained that the use of such fundal pressure resulted in worsening of the impaction, which required the defendant to use excessive force, causing a widening of the angle between the head and shoulder. The plaintiff's expert ob/gyn and treating pediatric neurologist, who had worked with numerous children suffering Erb's Palsy, contended that although it was

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essential to complete the delivery as soon as possible to avoid a deprivation of oxygen once shoulder dystocia was encountered, the use of fundal pressure heightened the impaction, and that it was clear that excessive traction was applied to the baby's head, causing the nerve injury. The nurse's notes reflected that the physician had ordered fundal pressure and not suprapubic pressure. The plaintiff maintained that once shoulder dystocia occurs, the physician can utilize a number of accepted maneuvers, such as the use of suprapubic pressure, The McRobert's maneuver (in which the mother's legs are flexed toward her shoulders as she lays on her back), or the Woods corkscrew maneuver, that entails the turning the shoulder of the baby by placing fingers behind the shoulder and pushing in 180 degrees.

The defendant denied that such fundal pressure continues to be considered a deviation and contended that the medical literature is evolving and that there is no evidence that such pressure causes injury. The defense maintained that Erb's Palsy generally occurs in utero and is not related to the maneuvers during delivery.

The plaintiff confronted one of the defense experts, who denied during the subject trial that the use of fundal pressure was a departure, with a transcript from his testimony in a prior case in which he testified that if he saw a nurse giving fundal pressure, it would be his duty to stop him or her. The plaintiff maintained that in view of this testimony, the defendant's position should clearly be rejected.

The plaintiff contended that the baby suffered brachial plexus injuries at the C5,C6 and part of the C7 levels that resulted in moderate to severe right sided Erb's palsy. The child was three and a-half years of age at the time of trial. The plaintiff's maintained that the child will permanently suffer a severe loss of use, a cosmetic deficit and that surgery would not be helpful. The physician related that the child used his right leg to kick a ball that was rolled to him and that he could determine thereby, that the child was naturally right handed and that the injury was sustained on the dominant side.

The plaintiff contended that the jury should consider that as the child ages and goes through various stages of life, he will experience very extensive embarrassment and will be frustrated in attempting to engage in the various activities of daily living. The plaintiff argued that the jury should take into account that when he is in grade school, he will probably be picked on by other children, and will probably be the last person chosen to be on a team. The plaintiff maintained that the jury should also consider that the when in high school and attempting to date, he will also suffer very significant impediments, including attempting to use his right arm to dance. The plaintiff also contended that the infant plaintiff will continuously be reminded of the injury each time he attempts to perform a simple task, such as turning on a lamp or reaching for a doorknob.

The jury found for the plaintiff and awarded \$250,000 for past pain and suffering and \$1,500,000 for future pain and suffering.

MEDICAL LIABILITY ANALYSIS

The case was subject to Virginia's medical malpractice cap, which is determined by the year the injury was sustained. The subject birth occurred in 2005 and the cap controlling the case was \$1,750,000. The jury rendered the full amount and accepted the plaintiff's counsel's suggestion of awarding \$250,000 for past pain and suffering and \$1,500,000 for future pain and suffering. It is thought that when discussing the lengthy life expectancy through which the infant plaintiff will suffer the effects of the Erb's Palsy, the plaintiff effectively depicted the myriad of day to day difficulties which will be faced by the child as he goes through various stages of life. This enabled the jury to better appreciate the manner in which such day to day impediments warrant very significant compensation. In this regard, the plaintiff stressed that the child will have to deal with the injury and be reminded of the Erb's Palsy every time he engaged in activities otherwise taken for granted, such as opening a door or turning a door knob.

Regarding liability, the defendant, who did not dispute that fundal pressure was utilized, denied that the use of this technique constituted a departure. The plaintiff productively confronted one of the defendant's experts with a transcript from a prior case in which the expert indicated that if he saw a nurse using fundal pressure, he would feel duty bound to stop him or her from continuing.

RISK MANAGEMENT ADVISORY

In this case, the plaintiff successfully contended that the defendant ob/gyn utilized contraindicated fundal pressure after a shoulder dystocia occurred during the delivery. The plaintiff further contended that as a result, the impaction of the shoulder became more severe, resulting in the infant sustaining a brachial plexus injury manifesting in significant right-sided palsy. Although the defendant did not dispute that a shoulder dystocia had been encountered or that fundal pressure was utilized, the defendant denied that the use of such fundal pressure constituted a deviation or that the method of delivery contributed to the brachial plexus injury. Unfortunately, the plaintiff's expert physicians, an ob/gyn and a pediatric neurologist with extensive experience in treating children with Erb's palsy, successfully opined that the use of fundal pressure, rather than suprapubic pressure, was, in fact, a deviation from acceptable standards of practice and caused the infant plaintiff's permanent injury.

In this regard, the plaintiff's experts explained to the satisfaction of the judge and jury that the use of such fundal pressure resulted in a worsening of the impaction, which required that the defendant use excessive traction to extricate the baby, caused a widening of the angle between the head and shoulder. Both experts agreed that although it was essential to complete the delivery as soon as possible to avoid a deprivation of oxygen once the shoulder dystocia was encountered, the use of fundal pressure heightened the impaction and that it was clear that excessive trac-

tion was applied to the baby's head, causing the nerve injury involved. In addition, the nurses' notes in this case actually reflected that the defendant physician had ordered fundal pressure and not the suprapubic pressure that the plaintiff's experts and most of the authorities seemed to indicate was the appropriate maneuver in this situation.

The generally accepted maneuvers, as testified to by the plaintiff's experts, that should have been utilized to avoid injury to the baby once the dystocia occurred would be either the McRobert's maneuver, in which the mother's legs are flexed toward her shoulders as she lays on her back, or the Wood's corkscrew maneuver, which entails turning of the baby's shoulder by placing fingers behind the shoulder and pushing in 180 degrees. The evidence indicated that neither of these maneuvers were utilized in accordance with the proven appropriate standard of care involved in this situation.

Although the defendant admitted that the method and manner of the delivery he performed may have previously been considered a deviation from acceptable standards of practice in accordance with the medical literature, it was his personal opinion that his delivery method was no longer a deviation because the prevailing literature is in the course of evolving and, therefore, there is no clear standard to have failed to comply with in this particular situation. In this regard, the defendant indicated that compliance with what he considered to be an existing, but old standard, was not essential or necessary to avoid liability because of the evolving, changing medical literature which now seems to indicate the possibility that the prevailing opinion enunciated in the literature used to establish the standard is not actually mandating compliance because such literature has been questioned by some authorities and, therefore, may not necessarily be binding upon physicians such as

himself, who are following their own opinion regarding what is appropriate and what is not.

Practitioners are once again strongly reminded by this aspect of the case that as licensed physicians, they have a non-equivocable duty to comply with the acceptable standards of practice followed by most physicians in the particular circumstance or situation involved, and they also have the responsibility to continue to comply to such standards despite the fact that the prevailing standards may have come under question from a limited number of authorities, but not the prevailing majority of authorities on the subject. Practitioners should be aware that where they decline to follow the prevailing opinion of appropriate texts and authorities in their medical practice in any particular situation, they may well be assessed liability despite the fact that they do not necessarily agree with those authorities. In this regard, practitioners are indeed reminded that although they are entitled to their personal opinion on any medical subject matter, they cannot interpose that personal opinion and also avoid liability when they fail to follow the prevailing existing standard of care followed by most physicians in the particular situation and where such a failure to do so results in injury to their patient. In addition, although their opinion and judgment does not necessarily have to be infallible, where they render an opinion inconsistent with the prevailing existing standard of care relevant to the particular opinion or judgment being rendered, they cannot avoid liability on the basis of the fact that they were exercising their medical judgment in doing so at the time.

Of further significance in this case was the situation created when plaintiff's counsel confronted one of the defense experts, who denied during the trial that the use of fundal pressure was a departure from acceptable standards of practice, with the transcript of testimony he had given in a prior case in which he testified that to

the contrary, if he saw a nurse using fundal pressure, it would be his duty to stop him or her. Plaintiff's counsel argued to the jury that in view of this conflicting testimony, this expert physician's opinions should clearly be rejected.

Practitioners would do well to remember the importance of maintaining the credibility of the testimony and opinions proffered by experts in medical malpractice litigation. Where an expert is produced on behalf of a defendant who then gives testimony or an opinion that is clearly inconsistent with an opinion rendered by that same expert in some other matter, then the expert at that point can be considered to not only have impaired his own credibility beyond repair, but may well have also impaired the credibility of the entire defense in the malpractice case involved. Jurors in medical malpractice trials may sometimes accept certain inconsistent statements made due to lapses in memory which are not particularly material to the situation involved, but they will seldom forgive an outright statement made by a proffered expert or defendant which is clearly inconsistent with what they have testified to under oath in some other similar litigation.

In this regard, practitioners should be aware of the serious impairment of credibility that can be caused by a proffered professional produced as an expert in a medical malpractice litigation whose testimony and opinion is subsequently impeached, which can conceivably not only fatally impair the credibility of that expert, but which can also impair the credibility of the entire defense for having offered that testimony in the first place. Care should, therefore, be taken to avoid such impairment by close questioning of proffered experts as to whether or not there exists any conceivable inconsistencies between what they are now contending and what may have contended on a prior occasion and recorded in that prior litigation.

EXPERTS

Plaintiff's ob/gyn expert: Jeffery Soffer from NJ. Plaintiff's treating pediatric neurologist expert: Ralph Northam from Norfolk, VA.

REFERENCE

Circuit Court, Norfolk, Virginia. Williams vs. Jones, et al. Case no. CL07-6370; Judge Junius P. Fulton III, 5-09. Attorneys for plaintiff: Preston J.

Douglas of Gurfein Douglas, LLP in New York, NY and Stanley Sacks of Sacks & Sacks in Norfolk, VA.

Medical Malpractice by Specialty

Ob/Gyn

\$750,000 PRE-SUIT RECOVERY - Plaintiff inaccurately advised she has breast cancer after her breast tissue is inadvertently mixed with another patient's - Unnecessary lumpectomy and approximate one inch breast scar - Short term emotional distress.

The plaintiff, in her late 30s, contended that after the defendant ob/gyn found a suspicious breast lump, she underwent a biopsy and that the defendant hospital negligently mixed up her tissue with that of another patient. The plaintiff maintained that she was then inaccurately advised that she suffered from breast cancer and underwent an unnecessary lumpectomy.

The plaintiff contended that there was no justification for the clear deviation and

maintained that had appropriate checks been made, the mistake simply would not have occurred. The plaintiff was advised of the mistake several days later. The plaintiff maintained that she needlessly went through the emotional trauma of believing she had cancer. The plaintiff also contended that the surgery was unnecessary and left an approximate one inch scar which will be permanent to

some degree, notwithstanding the possibility of improvement from plastic surgery.

The case settled prior to the institution of suit for \$750,000.

REFERENCE

New York County, New York. Eriksomen vs. St. Luke's Roosevelt Hospital, et al. 06-08-10. Attorney for plaintiff: Philip A. Russotti of Wingate Russotti & Shapiro in New York, NY.

\$89,033 VERDICT - Failure to remove mesh following surgical procedure - Infection - Failure to timely diagnose cause of infection - Abscess necessitating additional surgery - Lost earnings.

In this medical malpractice matter, the plaintiff alleged that the defendant ob/gyn failed to remove mesh from the plaintiff following a surgical procedure, which led to an infection. The plaintiff contended that the defendant failed to timely diagnose the foreign object as the cause of the infection, resulting in injury to the plaintiff.

The female plaintiff was a patient of the defendant ob/gyn and her practice. The plaintiff underwent an IVS Tunnel/vaginal slip procedure at the hands of the defendant on January 28, 2005. In the month following the procedure, the plaintiff was seen by the defendant in follow-up and prescribed Flagyl for complaints consistent with a vaginal infection. The plaintiff alleged that during the next year she was given

additional prescriptions for the same medication without any further follow-up or office visits with the defendant or anyone in her office.

The plaintiff alleged that the defendant ob/gyn failed to follow-up or to determine the cause of the infection which the plaintiff learned in 2007 was a foreign object, namely mesh left in her vagina during the procedure two years earlier. The foreign object caused an infection and later an abscess which required surgical intervention.

The plaintiff brought suit against the defendant, alleging negligence on the part of the defendant ob/gyn for failing to remove the mesh during the procedure and in failing to determine the cause of the infection. She also sued the defendant's practice alleging that they

were negligent in prescribing the medication to the plaintiff without any follow-up office visits to assess her condition.

The defendants denied negligence and maintained there was no deviation from acceptable standards of care. Further, the defendants disputed the nature and extent of the plaintiff's injuries.

The matter proceeded to trial. At the conclusion of the trial, the jury found in favor of the plaintiff and against the defendants. The jury awarded the plaintiff the sum of \$89,033, which consisted of \$5,000 for past and future loss of normal life, \$5,000 for past and future pain and suffering, \$74,883 for medical expenses and \$4,200 for lost earnings.

EXPERT

Plaintiff's ob/gyn expert: Brett Vassallo, M.D. from Park Ridge, IL.

REFERENCE

Cook County, IL. Wendy Salas vs. Female Health Care Associates, Ltd., et al. Case no. 07L13714; Judge William J.

Haddad, 08-31-10. Attorney for plaintiff: Charles V. Falkenberg, III of Karlin & Fleisher in Chicago, IL.

DEFENDANT'S VERDICT - Alleged failure to obtain informed consent - Alleged negligent burning of portions of small intestine during tubal ligation - Three subsequent surgeries to remove necrotic tissue and repair bowel - Chronic diarrhea.

In this medical malpractice case, the plaintiff contended that the defendant negligently performed a tubal ligation and failed to obtain the plaintiff's informed consent for the procedure. The defendant denied any malpractice and contended that the plaintiff's injury was caused by malfunctioning equipment.

The plaintiff gave her consent to undergo a tubal ligation via insertion of falope rings. During the procedure, the falope rings did not deploy properly and, because a tube became lacerated during the attempt, the defendant completed the tubal ligation via cauterization instead. The plaintiff maintained that she never gave consent for cauterization. Also, during the procedure, the plaintiff suffered burns to portions of her small intestine. The plaintiff asserted that these burns were caused by the defendant employing improper technique during the cauterization.

The plaintiff was discharged on the day of the procedure, but returned the next day whereupon burned portions of the small intestine were discovered. The plaintiff underwent surgery to remove and reconnect sections of the small intestine. Several days later more portions of necrotic bowel were discovered and the plaintiff underwent an additional procedure to remove those sections. In total 80 cm of small intestine were removed.

The plaintiff claimed that she was left with chronic diarrhea from the injury. Further, the plaintiff required another surgery four years later where a portion of reconnected intestine broke down and had to be repaired. The plaintiff contended that she underwent a total of

three surgical procedures that she otherwise would not have had due to the defendant's malpractice.

At trial, the plaintiff presented an expert in obstetrics and gynecology who testified that the plaintiff's burns were the result of poor surgical technique. The plaintiff's expert also opined that no informed consent was obtained from the plaintiff.

The defendant argued that the only way the plaintiff's injury could have happened was through a malfunction of the bipolar cauterization device. The device used by the defendant during the surgery is designed to only burn the area between two tines. Thus, the plaintiff's multiple burns in different areas could not be explained except by malfunction of the device. With regard to the informed consent, the defendant pointed to the plaintiff's deposition testimony wherein she stated that the defendant had discussed with her the risks of the tubal ligation procedure, including burns. The plaintiff then gave her informed consent knowing all the risks up to and including death.

At trial, the defendant called an expert in obstetrics and gynecology who testified that there were three possible explanations when this type of injury occurs. The first is if the doctor grabs bowel thinking it is part of a tube. The defendant's expert opined that it was inconceivable that the plaintiff's injury happened in this fashion because even the most inexperienced surgeon would not grab several different areas of the bowel and the plaintiff had sustained burns in several different areas.

The second way for burns to occur was if there were adhesions between the

bowel and the tubes whereby the heat from the cauterizing device could transfer. However, due to the surgical positioning of the plaintiff, it was clear that there were no adhesions. Also in the operative report from the plaintiff's subsequent two surgeries, it was noted that the surgeon found no adhesions.

The third manner in which burns such as the plaintiff sustained could occur was if the device used to perform the cauterization was defective. The defendant's expert testified that defects in cauterization tools are a known issue especially if the device is old. The defendant's expert described how microscopic holes can occur in the device's insulation allowing electrical current to escape. The defendant's expert also noted that there is no way for the surgeon to know that tiny currents are escaping from the device. The defendant's expert also reviewed the plaintiff's consent form and showed the jury where informed consent was obtained.

The jury found in favor of the defendant on both counts.

EXPERTS

Plaintiff's obstetrics/gynecology expert: John DiOrio from RI. Defendant's obstetrics/gynecology expert: Keith Merlin from Brockton, MA.

REFERENCE

Middlesex County, MA. Pacheco vs. McGovern, Executrix of the Estate of Philip McGovern. Case no. NICV2006-03640, 8-20-10. Attorney for defendant: Doyle C. Valley of Morrison Mahoney, LLP in Boston, MA.

Medical Practice Liability

Business Practices/Unfair Competition

A DENTIST WHO SOLD HIS CLINIC TO ANOTHER DENTIST MAY HAVE VIOLATED A NONCOMPETE CLAUSE BY PRACTICING DENTISTRY IN A COMMUNITY CLINIC.

A dentist who sold his clinic to another dentist may have violated a noncompete clause in the sales agreement by practicing dentistry in a community clinic within the restricted area, the Alaska Supreme Court has decided.

The plaintiff entered into an agreement to purchase from the defendant, the Turnagain Dental Clinic. The sales agreement contained a restrictive covenant. It provided that, “In connection with the sale to Buyer of the goodwill of the practice . . . , Seller [] shall not carry on or engage in the practice of dentistry, either directly or indirectly, as an owner, operator, or employee, within a fifteen (15) air mile radius of the Buyer’s practice . . . for a period of two (2) years from the closing date and then for the ensuing three (3) years for a radius of ten (10) air miles, without the prior written permission of the Buyer.”

Following the sale, the defendant moved to Mexico, where he intended to stay for the duration of the restrictive covenant, but he returned roughly a year later. He then began employment at the Alaska Native Medical Center (ANMC), located within fifteen miles of Turnagain Dental Clinic and provided free dental services to Alaska Natives, other Native Americans, and their children. He performed dental examinations, reviewed x-rays, drilled and filled cavities, and occasionally pulled teeth.

The plaintiff sent a letter demanding that the defendant cease practicing dentistry within fifteen miles of Turnagain

Dental Clinic. According to the defendant, his employment at ANMC did not violate the agreement because he did not compete with the Turnagain Dental Clinic. The plaintiff then filed an action against the defendant for violation of the anticompete provision. The trial judge held that the “practice of dentistry” as used in the agreement did not include employment at ANMC and therefore granted the defendant summary judgment. However, this ruling was reversed on appeal and sent back to the trial judge to determine whether practicing dentistry at ANMC violated the covenant by actually competing with the Turnagain Dental Clinic given the patient base of ANMC.

COMMENTARY

The issue in this case was whether the defendant violated the restrictive covenant by practicing dentistry that competed with the plaintiff’s dental clinic. The appellate court agreed with the trial judge that the parties intended to prohibit the defendant from practicing dentistry in competition with the plaintiff’s clinic. It was a covenant not to compete, the purpose of which was to prevent the defendant from competing with the plaintiff and to protect the goodwill associated with the clinic for which the plaintiff had paid the defendant.

The plaintiff argued that the “practice of dentistry” should be interpreted as “private, competitive, fee-for-service practice,” which would exclude his employment at ANMC. The trial court

agreed, holding that “practice of dentistry” did not include employment at ANMC. However, the appellate court disagreed. In its view, the defendant’s employment at ANMC constituted “the practice of dentistry.” He saw individual patients, performed their dental examinations, reviewed their x-rays, drilled and filled their cavities, and pulled teeth on occasion. Moreover, he admitted that he was practicing dentistry at ANMC. Nevertheless, the appellate court sent the case back to the trial court to decide whether the defendant’s practice at ANMC was in competition with the plaintiff’s clinic, for example, by drawing patients away from the plaintiff clinic, reducing the number of referrals it received or otherwise harming the clinic and the goodwill the plaintiff purchased.

Courts generally are reluctant to place a restraint on an individual’s ability to work. However, restrictive covenants associated with the sale of a business such as a health care practice is a frequent exception to this rule. Also, the restriction imposed usually has to be reasonable in scope as to the geographic area and the time period covered, and should not result in harm to the public by denying them access to health care.

REFERENCE

Wenzell v. Ingram, 228 P.3d 103 (Alaska 2010).

Peer Review

A VARIANCE REPORT PREPARED BY HOSPITAL STAFF AFTER A WRONG KIT WAS USED TO REFILL A PATIENT'S PAIN PUMP WAS A PROTECTED PEER REVIEW DOCUMENT.

A Variance Report prepared by hospital staff after the wrong kit was used to refill a patient's pain pump was ruled a peer review document not subject to discovery, by a federal court in Michigan.

An anesthesiologist from South Oakland Anesthesia Associates, P.C. (SOAA) attempted to perform a procedure to refill a patient's Medtronic pain pump at William Beaumont Hospital. The procedure required the use of a "refill kit." However, a Beaumont nurse retrieved a "catheter access kit" instead. As a result, the medication was delivered directly into the patient's intrathecal space causing an overdose.

The patient sued Beaumont, SOAA, and others. Medtronic was made aware of the incident and the lawsuit, and participated in discovery. Counsel for Beaumont and SOAA invited Medtronic to participate in discussions to settle the litigation, but Medtronic refused. Beaumont and SOAA settled the case.

Beaumont (and SOAA) then initiated an action in a federal court seeking contribution from Medtronic for its allocable share of fault in causing the injury. Beaumont alleged that approximately two to three weeks before the incident, a representative of Medtronic offered to provide free samples of "pain pump refill kits" for use in refilling Medtronic's implanted pain pumps. Medtronic then delivered three "free samples" to Beaumont, but only two were "refill kits," the third being a "catheter access kit." Medtronic admitted that a "catheter access kit" should not have been delivered to the Beaumont Department of Anesthesia

because such kits were used primarily for diagnostic procedures, not for pain management.

Beaumont alleged Medtronic was negligent in delivering a diagnostic kit to the anesthesiology department and also for stating that the kit could be used for refill procedures. Medtronic served Beaumont with a request for various documents. Beaumont objected to several on the grounds of statutory privileges protecting peer review documents from disclosure. Medtronic filed a motion to compel discovery of the documents withheld. Focusing on a particular Variance Report, the trial judge denied Medtronic's motion, ruling it was a protected peer review document.

COMMENTARY

As a rule, a party may obtain discovery regarding any non-privileged matter that is relevant to any claim or defense in a lawsuit. However, in medical litigation, a privilege may exist for peer review documents. A Michigan statute requiring hospitals to review their professional practices and procedures to improve the quality of patient care and reduce morbidity and mortality has led to the establishment of peer review committees. To maximize the effectiveness of such committees, Michigan has also created a privilege for records collected at the direction of a peer review committee.

The plaintiffs asserted that a particular Variance Report was privileged. It was prepared by staff nurses on the day of the incident in this case and given to Nursing Administration and Medical Quality Program Management. It was also provided to the Patient Safety Officer, the director of Medical Quality Program Management and the Director of

Anesthesia Quality Assurance. A hospital policy statement provided that "[a]ny records, data, and information collected for or by individuals involved with a Variance and the subsequent review and analysis are part of a professional peer review function, performance improvement effort, or other quality initiative and are confidential and protected from discovery." Similarly, at the bottom of the Variance Report it stated: "This report is CONFIDENTIAL and protected from discovery . . . Its primary use is for professional review purposes in the interest of reducing morbidity and mortality and improving the care provided patients."

The court concluded that the Variance Report at issue was a protected peer review document. Its primary use was for professional review purposes in the interest of reducing morbidity and mortality, and improving care provided patients and as such was non-discoverable.

Hospital peer review committees are created to reduce morbidity and mortality and improve patient care. To perform this task effectively, confidentiality is commonly given to documents generated by peer review committees. However, certain documents may be excluded from such protection including those generated as part of the process of rendering patient care and those delivered to, rather than generated by, a peer review committee.

REFERENCE

William Beaumont Hospital v. Medtronic Inc. 2010 WL 1626408 (E.D. Mich. 2010).

Informed Consent

A WOMAN WHO SIGNED TWO CONSENT FORMS FOR A BILATERAL TUBAL LIGATION GAVE HER INFORMED CONSENT TO THE PROCEDURE EVEN THOUGH SHE WAS ALLEGEDLY UNDER DISTRESS.

A woman who signed two consent forms for a bilateral tubal ligation gave her informed consent to the procedure even though she claimed she signed under distress, according to a decision by a Louisiana appellate court.

The plaintiff presented to the Lakeland Medical Center Midwife Clinic with pre-term contractions and was brought to Lakeland Medical center. At the hospital, she saw the defendant for the first time. Upon reviewing her chart, he observed that during one of the plaintiff's pre-natal visits, she had signed the State Consent Form. According to the defendant, the plaintiff reconfirmed her desire to have a tubal ligation at the time of delivery. He then discussed with her a plan of care, which included a bilateral tubal ligation as part of her delivery and admission into the hospital for monitoring.

For the first three days of her hospital stay, the plaintiff was given medical care and monitored. On the fourth day, she suffered pulmonary edema and congestive heart failure. Her team of treating physicians, including the defendant, jointly determined that she should have an emergency Cesarean. The defendant stated that he met with the plaintiff and discussed the plan of care, which included an emergency C-Section and an elective bilateral tubal ligation, which she again confirmed. Shortly before the surgeries, the plaintiff signed the hospital's standard consent form for both procedures. She delivered by C-Section a premature baby boy and the defendant then performed the bilateral tubal ligation.

The plaintiff requested a medical review panel and included a claim that the

defendant failed to secure her informed consent to the bilateral tubal ligation because she had signed the second form while under distress having just suffered pulmonary edema and congestive heart failure. After the panel found for the defendant, the plaintiff filed an action. A jury also found in favor of the defendant and this ruling was affirmed on appeal. The appellate court explained that the two consent forms, one which was signed much earlier during a pre-natal visit, and other evidence supported the dismissal of the plaintiff's action.

COMMENTARY

Ordinarily, to obtain a patient's informed consent, a physician must disclose the material risks of the proposed medical procedure. In Louisiana, the determination of materiality is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. Generally, expert testimony is required to establish this aspect of materiality. The second step is for the fact finder (in this case the jury) to determine if the probability of that type harm is a risk that a reasonable patient would consider in deciding on treatment. The second step usually does not require expert testimony. To recover damages for a doctor's failure to disclose a material risk, a plaintiff also has to establish causation. Causation is established if adequate disclosure reasonably would be expected to have caused a reasonable person to decline treatment because of the disclosure.

In this case, the tubal ligation obtained the intended result (i.e., the plaintiff could no longer have children) and the plaintiff

did not develop any complications from the surgery. Nor did she contend that she suffered increased pain or discomfort because the defendant performed a tubal ligation. Instead, she claimed that the defendant did not obtain her informed consent because it was given under distress. The plaintiff elaborated that the tubal ligation was not an emergency and that she was unable to read or sign an "informed consent" while "fighting for her life." The defendant countered that the fact that the plaintiff signed two consent forms (one at a much earlier pre-natal visit) for the procedure together with the medical records and testimony supported the jury's finding of valid informed consent. The appellate court sided with the defendant, concluding that the evidence supported the jury's finding that the plaintiff gave her informed consent to the bilateral tubal ligation.

In non-emergency situations, a physician is usually required to obtain a patient's informed consent to a procedure. This process includes explaining the material risks of the proposed procedure and available alternative and their risks. Whenever possible, physicians would be well-advised not to obtain a patient's informed consent where their judgment might be impaired by factors such as distress due to medical emergencies or after drugs or anesthesia have been administered.

REFERENCE

Martin v. Berthier, 39 So.3d 774 (La. App. 2010).

Defensive Actions/Countermeasures to Malpractice Suits

A PATIENT WHO SUFFERED ULNAR NEUROPATHY FOLLOWING SHOULDER ROTATOR CUFF SURGERY DID NOT PRESENT SUFFICIENT EXPERT TESTIMONY LINKING THE INJURY TO NEGLIGENCE DURING THE SURGERY.

A patient who suffered ulnar neuropathy following rotator cuff surgery did not present expert testimony sufficient to raise a question of fact as to whether his injury was caused by the negligence of medical personnel who performed the procedure, the Court of Appeals of North Carolina has held.

The plaintiff suffered an injury to his right shoulder while working at Cape Fear Valley Hospital. An MRI showed a large rotator tear. A physician diagnosed a combination of joint degenerative disease and a rotator cuff tear. He injected pain medication but informed the plaintiff surgery would be needed. An orthopedic surgeon also concluded that the plaintiff should undergo surgery. He performed a right shoulder arthroscopy and right open rotator cuff repair at Duke Raleigh Hospital.

The surgeon and an anesthesiologist were responsible for positioning, padding, and monitoring the plaintiff's left arm. They placed the plaintiff in the "beach chair" position (the standard position used for many shoulder surgeries). In this position, the patient is placed in a semi-reclining, semi-sitting position with the patient's arms resting at either side and padded with various pads and foams to keep the patient in the position safely.

The plaintiff contended that he began to feel severe pain and numbness in his left arm, elbow, and fingers approximately one hour after the surgery. During his first follow-up visit, the surgeon felt that the plaintiff was doing well. The plaintiff first noted his painful condition during the second follow-up visit. At that time, the surgeon found the plaintiff was suffering from continued ulnar

neuropathy at his left elbow. An EMG confirmed the left elbow ulnar neuropathy and the surgeon performed a subcutaneous nerve transfer on the left elbow.

The plaintiff eventually was discharged to a long term pain management clinic. He stated that he did not experience pain or medical problems with his left arm prior to the surgery. Despite the corrective surgery, the plaintiff contended that he experiences pain in his left arm on a daily basis and that his arm was permanently damaged.

The plaintiff filed a malpractice action against the surgeon, the anesthesiologist, Cape Fear Valley, and others. After both sides presented expert testimony, the trial judge granted summary judgment to the defendants and this ruling was affirmed on appeal. The appellate court concluded that the plaintiff's medical expert offered only "speculative" testimony and failed to link the plaintiff's injury to any negligence by the defendants.

COMMENTARY

In jurisdictions such as North Carolina, a complaint alleging malpractice may be dismissed unless the plaintiff specifically asserts that the medical care has been reviewed by a person reasonably expected to qualify as an expert witness who is willing to testify that the medical care did not comply with the applicable standard of care.

The plaintiff contended that there was sufficient evidence to raise issues of fact that the defendants were negligent while caring for him. Specifically, the plaintiff alleged that he did not suffer from a pre-existing ulnar nerve neuropathy and

that his left arm was not padded and positioned in accordance with the standard of care for rotator cuff surgery. This evidence included expert testimony from an anesthesiologist. However, according to the appellate court, this expert's testimony constituted "mere speculation" as to the proximate cause of the plaintiff's injuries. For instance, the expert testified that he was unable to point to any specific incident or action of any defendant during the surgery that would have caused the plaintiff's injuries. Furthermore, he admitted that he presumed the defendants were negligent because the plaintiff sustained an injury where there was none prior to the surgery. According to the appellate court, the expert did not connect any action or inaction of the defendants to the injuries sustained.

A heightened pleading requirement in which a plaintiff has to present together with the complaint an expert affidavit indicating the culpability of the defendant or identify an expert who would so testify is a common malpractice reform measure enacted in various jurisdictions in recent years. An expert who only assumes negligence occurred due to the fact of the plaintiff sustaining an injury may not meet this requirement. Furthermore, failure to present the requisite testimony at this early stage in the proceeding may result in, or require, dismissal of the case.

REFERENCE

Campbell v. Duke Univ. Health Syst., Inc., 691 S.E.2d 31 (N.C. App. 2010).

New/Expanded Liability

A DOCTOR'S WARRANTY CLAIMS AGAINST THE MANUFACTURER OF A MEDICAL DEVICE ALLEGEDLY CAUSING ULNAR NERVE DAMAGE WERE BARRED BY THE STATUTE OF LIMITATIONS, BUT HER TORT CLAIMS WERE NOT.

Warranty claims brought by a doctor against the manufacture of a medical device alleging ulnar nerve damage caused by repetitive use of its device were barred by the statute of limitations, but her tort claims for negligence and products liability were not barred, a federal court in Maryland has held.

The plaintiff physician began working at the Maryland Laser, Skin and Vein Institute (MLSVI) as a cosmetic dermatology research fellow. Within her first month, she began treating patients using the ThermaCool device developed by Thermage to reduce the signs of aging in skin. Two physicians at MLSVI taught her how to use the device. The device had a handheld component, or handpiece, which the operator held to the patient's skin while pressing a manual button or a foot pedal to deliver radio frequency pulses. The design of the handpiece required the plaintiff to hold her wrist and arm "in a bent, flexed position at a very odd angle for the entire treatment."

At first, the plaintiff experienced temporary soreness in her right hand, arm, shoulder, and neck, but her symptoms progressed to intermittent "shooting pain" and "clawing up of [her] ring and pinky fingers" for up to a few days after she performed a Thermage treatment. The physicians who had trained her responded that such pain was "normal." Upon their advice, she took over-the-counter pain medications and rested her arm, which completely relieved her symptoms. Because the pain was transient and manageable, the plaintiff attributed her discomfort to use of new muscle groups.

Several months later, the plaintiff developed pain that was more severe. She

was diagnosed with irritation of her right ulnar nerve secondary to repetitive motion, which appeared directly related to her use of the Thermage machine. Although the plaintiff never again used the device, her ulnar neuropathy and resulting chronic pain syndrome persisted.

The plaintiff filed an action in a federal court against Thermage for negligence, products liability, and breach of warranty. Thermage asserted as a defense the expiration of the statute of limitations. The court ruled that the statute of limitations did not bar the plaintiff's tort claims allegations, but that her breach of warranty claims were barred.

COMMENTARY

A statute of limitations defines the time period a plaintiff has to file a lawsuit. The defendant argued that the plaintiff's breach of warranty claims were barred by a four-year statute of limitations. Under Maryland law, an action for breach of any contract for sale had to be commenced within four years after it accrued. Generally, an action for breach of warranty accrues when tender of delivery was made. Because the plaintiff did not bring her breach of warranty claims within four years of the ThermaCool handpiece's delivery, those claims were barred by the statute of limitations.

Thermage argued that the plaintiff's tort claims were barred by the three-year statute of limitations. Under Maryland law, a tort action has to be filed within three years from the date it accrued. To determine when an action "accrued," Maryland followed a "discovery rule," which started the limitations period when the plaintiff had notice of a claim. Notice required actual knowledge, either express or implied, of the facts underlying the

action. Accordingly, in a products liability action, the statute of limitations did not begin to run until the plaintiff knew or through the exercise of due diligence should have known of injury, its probable cause, and either manufacturer wrongdoing or product defect.

The plaintiff argued that she was not on notice of her injury until January of 2005. Her treating neurologist testified that neuropathic nerve injury could be difficult to diagnose and that the symptoms the plaintiff experienced in 2004 may have indicated that her ulnar nerve was being temporarily compressed, but that minor temporary compression of the ulnar nerve did not ordinarily result in clinically significant injury to the nerve. By contrast, the severe and unabating pain she experienced in January 2005 was indicative of a "clinically significant injury."

A doctor may assert various theories of recovery against the manufacturer of a medical device that has allegedly caused her injury. Each may have its own statute of limitations and different characteristics such as a discovery rule. To bar a claim on the ground that the statute of limitations has elapsed, the defendant has to establish the elements of this defense as to each theory of recovery.

REFERENCE

Goyal v. Thermage, Inc., 2010 WL 2651185 (D. Md. 2010).

Insurance

DISPUTES OVER REPAYMENT REQUESTS BY BLUE CROSS/BLUE SHIELD FROM SEVERAL CHIROPRACTORS WERE SUBJECT TO ARBITRATION AS PER THEIR PROVIDER AGREEMENTS.

Disputes arising from repayment requests by Blue Cross Blue Shield (BCBS) to several chiropractors were subject to arbitration since this was required by their provider agreements, a federal court in Illinois has held.

Several chiropractors signed a provider agreement with at least one BCBS entity in the region where they practiced. They filed an action against BCBS in a federal court claiming it was the practice of BCBS to improperly recoup money that had previously been paid to them for medical services they had provided to BCBS insureds by paying for services and then later making a false determination that they had been overpaid. BCBS would demand repayment of the supposedly overpaid amounts but would not provide information about which claims, services, or patients were allegedly the subject of overpayment.

The plaintiffs alleged that when BCBS made these demands, they often offered no appeal process. When an appeal process was available, the plaintiffs alleged BCBS refused to provide details about which patients, claims, and plans were affected. The plaintiffs further alleged that BCBS threatened to, and in some cases actually did, force individual plaintiffs to repay the amounts they allegedly owed by withholding payments to which they were otherwise entitled for unrelated claims submitted on behalf of other insureds.

BCBS moved to compel arbitration of these claims, contending that several of the plaintiffs signed provider agreements that contained mandatory arbitration provisions for disputes arising out of their agreements. The court granted the motion as to all of the chiropractors that signed a provider agreement containing an arbitration provision. It explained that these chiropractors' claims were covered by the arbitrations requirement because the dispute arose out of the provider agreements.

COMMENTARY

Ordinarily, there is a presumption in favor of arbitration although the parties' intentions as stated in their agreement usually controls. The defendant contended that the repayment demands and recoupments were made for a variety of reasons, all of which involved the terms of their contracts. These included that the individual plaintiffs used the wrong code when billing for the service provided, the patient was no longer covered by the insurance plan when the service was performed, the patient's claims were covered by another insurer, or the individual plaintiff mischaracterized services as "mechanical traction" when it was not in an effort to bring the service under the umbrella of "covered services."

All of these reasons, the defendant argued, arose out of or were related to the plaintiffs' provider agreements and, therefore, had to be arbitrated. The

plaintiffs argued that the repayment demands and subsequent recoupment efforts actually amounted to "adverse benefit determinations" (i.e., post hoc determinations that the services provided were not covered by the terms of the patient's insurance plan).

The court agreed with the defendant that the plaintiffs' claims, at least arguably, arose out of or were related to the provider agreements they signed with the defendant. Given the broad policy in favor of arbitrability and the fact that all that was needed to trigger arbitration was a clause that arguably covered the disputes, the court found that the plaintiffs should be compelled to arbitrate their claims.

Arbitration clauses in medical insurance provider contracts often contain language that mandates arbitration for any dispute "arising out of or relating to" the contract. Many courts have construed such arbitration language broadly, finding a presumption of arbitrability. However, in evaluating a motion to compel arbitration, a court will usually carefully ascertain whether it was the intent of the parties to enter into a binding arbitration agreement.

REFERENCE

Pennsylvania Chiropractic Associates v. Blue Cross Blue Shield Ass'n., 2010 WL 1979440 (N.D. Ill. 2010).

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