



SURGEON'S LIABILITY ALERT®

A bi-monthly nationwide review of medical liability for

SURGEONS ■ SURGICAL SUPPORT PROVIDERS

with medical liability analysis and risk management advisory

by Ira J. Zarin, Esq.

Surgeon's Malpractice Review with Analysis

- **\$20,525,000 VERDICT INCLUDING \$15 MILLION PUNITIVE AWARD** - Negligent performance of liposuction - Laceration of blood vessel in the neck - Delay in transporting decedent to the hospital 2
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\$20,525,000 VERDICT INCLUDING \$15 MILLION PUNITIVE AWARD - NEGLIGENT PERFORMANCE OF LIPOSUCTION - LACERATION OF BLOOD VESSEL IN THE NECK - DELAY IN TRANSPORTING DECEDENT TO THE HOSPITAL - ADULT RESPIRATORY DISTRESS SYNDROME - DISSEMINATED INTRAVASCULAR COAGULATION - WRONGFUL DEATH OF 18-YEAR-OLD COLLEGE STUDENT.

CASE SUMMARY

The plaintiff contended that the defendant plastic surgeon negligently caused an injury to a blood vessel in the decedent's neck during liposuction and that the defendants delayed in transporting her to a hospital. The certified registered nurse anesthetist who treated the plaintiff was also named as a defendant in the case based on the theory that he also caused a delay in transporting the decedent to a hospital. The plaintiff claimed that fat entered the decedent's bloodstream through the cut vessel, eventually causing fat embolism syndrome, adult respiratory distress syndrome "ARDS" and disseminated intravascular coagulation "DIC", which led to the decedent's death. The defense denied that the decedent sustained a lacerated blood vessel during the liposuction procedure. The defendants also maintained that earlier transport of the decedent to a hospital would not have prevented her ultimate death.

CASE DETAILS

The plaintiff contended that the defendant utilized a negligent technique in performing the liposuction on May 23, 2001, causing a laceration to one of the blood vessels in the decedent's neck. The plaintiff pointed to documented evidence

that the plaintiff was bleeding into her neck following the procedure. The plaintiff claimed that the defendants were also negligent in causing a delay of some two and a-half hours before transporting the decedent to a hospital, significantly reducing her chances of survival. The plaintiff contended that the decedent was not receiving adequate treatment, particularly, mechanical ventilation with positive pressure, in the defendant's office.

The plaintiff alleged that the defendant plastic surgeon's privileges to perform the liposuction procedure at local hospitals were restricted and thus, he was using his office to perform procedures he could not perform at the hospital. The plaintiff also alleged that the defendant did not have an adequate procedure for dealing with emergencies, including an agreement with a local ambulance company to transfer any patients who had problems to the hospital, as required under the law for ambulatory surgical facilities. A Department of Health representative testified that the defendant was wrongly operating an ambulatory surgical facility without a license.

The plaintiff argued that the defendant nurse anesthetist, as well as prior testimony from the defendant plastic surgeon, indicated that the decedent's

neck swelled to twice its normal size during the procedure. The plaintiff's experts contended that the swelling was due to a collection of blood that records showed, was expressed twice by the defendants. EMTs, who arrived to transport the decedent to the hospital from the defendant's office in King of Prussia, testified that they found her cyanotic and in severe distress.

The plaintiff's mother testified that when she requested the EMTs take her daughter to Paoli Hospital instead of Montgomery Hospital, the paramedic replied "Lady, she won't make it to Paoli." The decedent, an 18-year-old college student at the time, died two days later on March 25, 2001. The plaintiff alleged that the death was caused by fat embolism syndrome and the complicating factors of ARS and DIC. DIC, also called consumptive coagulopathy, is a pathological process whereby the blood starts to coagulate throughout the whole body. The plaintiff contended that the decedent's death was directly related to laceration of the blood vessel during the liposuction. The decedent was survived by her mother.

The defendant doctor argued that his liposuction technique met the required standard of care and there was no injury to the decedent's neck during the



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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.

procedure. The defense maintained that there was no concrete evidence as to how the fat embolism occurred and that it could have occurred as a result of an injury to the decedent's lung. The defendant plastic surgeon contended that the "collegial intervention", which the plaintiff claimed restricted him from performing the liposuction at hospitals, referred to a specific type of liposuction, not the type of liposuction performed for the decedent. The doctor maintained that he had an adequate procedure for transport of patients who had difficulty, but he did not require a formal ambulance contract because his office did not meet the definition of an ambulatory surgical facility.

Two nurses testified that the decedent was fine following the liposuction which was concluded at approximately 2:00 p.m. and she talked about college and her family until there was a vague concern about a funny sound in her right lung at approximately 4:00 p.m. The defendant nurse anesthetist testified that the decedent started to exhibit slightly rapid breathing within a half hour of the surgery. He testified that he was attempting to rule out certain causes, but the decedent was not in respiratory distress. The defendant nurse anesthetist testified that he administered reversal medication and the decedent was sitting up, talking and seemed normal except for the slightly rapid breathing. He testified that he monitored her closely and stayed with her until she exhibited decreased breath sounds in one lung, at which time she was immediately transported to the hospital. The defense argued that a fat embolism is a rare, but known risk of liposuction. The defendant's experts opined that earlier transport of the decedent to the hospital would not have made a difference in her medical outcome.

The jury found the defendant plastic surgeon 75% negligent and the defendant nurse anesthetist 25% negligent. The plaintiff was awarded \$20,525,000 in damages, including \$15 million in punitive damages against the defendant doctor. The award also included \$20,000 for the wrongful death claim, \$3.5 million for the

survival action, \$5,000 on the informed consent count and \$2 million to the decedent's mother for emotional distress. Post-trial motions are pending. The defendant nurse anesthetist is responsible for 25% of the survival action and the wrongful death claim for a total of \$880,000.

MEDICAL LIABILITY ANALYSIS

In-house research conducted by the plaintiff's law firm indicates that this \$15 million punitive damage award is the highest punitive damage award ever rendered against a doctor in a medical malpractice case in Pennsylvania and the fourth highest in that category nationally. The magnitude of the punitive damages hinged on the plaintiff's successful effort to undermine the defendant doctor's credibility on many issues. The plaintiff called an attorney with the Department of Health who testified that the defendant was operating an ambulatory surgical facility from his office and that the department had demanded that he get a license. However, the defendant doctor refused to relent on that issue and maintained that an ambiguous provision of the law accepted his office and that the state Department of Health had never enforced this provision until this medical malpractice case arose. The defendant also vehemently denied that he was prohibited from performing the liposuction at hospitals, contending that the prohibited liposuction was a different procedure.

There were over 10,000 pages of documents in the case, including dozens of depositions, over 30 expert reports, years of pleadings and the full investigation by the Departments of Health and the State of Pennsylvania. The case was tried over the course of five weeks from jury selection to verdict. Of some note was the fact that the wrongful death damages were almost exactly equal to the funeral/burial costs, while the informed consent damages were exactly the cost of the surgery, which the defendant plastic surgeon had not refunded. The case was tried over the course of 25 days. The defendants offered

\$1.4 million to settle the case prior to trial. The plaintiff made no settlement demand.

RISK MANAGEMENT ADVISORY

In this case, there were numerous proven allegations of deviation from acceptable standards of practice. The plaintiff contended that the defendant utilized a negligent technique in performing liposuction on May 23, 2001, thereby causing a laceration to one of the blood vessels in the decedent's neck. The plaintiff's experts, who pointed to the documented evidence that the plaintiff was bleeding into her neck following the procedure, opined that this type of untoward event would not have normally occurred in the absence of negligence in the performance of the procedure itself. The plaintiff's experts also successfully opined that the defendant was negligent in causing a delay of some 2-1/2 hours before transporting the decedent to a hospital, thereby significantly reducing her chances of survival. Finally, the evidence indicated that the decedent was not receiving adequate treatment following the laceration, particularly in the form of mechanical plaintiff ventilation with positive pressure in the defendants' office, which it was contended contributed to bringing about the decedent's untimely death.

Beyond these obvious departures from the standard care, there was further evidence presented that contributed to the significant punitive damages award in this case including testimony that the defendant was using his office to perform procedures he could not perform at the hospital because, as the plaintiff alleged, the defendant's privileges to perform this liposuction procedure at local hospitals were restricted and thus he was forced to use his office to perform these procedures. The plaintiff also alleged that the defendant did not have an adequate protocol for dealing with emergencies, including an agreement with a local ambulance com-

pany to immediately transfer any patients who had problems to the hospital, as required under the law for ambulatory surgery facilities. In addition, testimony was presented during the trial from a Department of Health representative that the defendant was wrongfully operating an ambulatory surgical facility without a license.

Practitioners are thus reminded by this case that where an untoward event occurs during or as a result of an in-office procedure, practitioners so involved have a duty to timely and appropriately transport the patient if there is an indication that the patient needs hospitalization. In this case, the delay of some 2-1/2 hours was found to be a serious deviation from the acceptable standard of practice which contributed to the patient's untimely death. Practitioners would do well to remember that where, within an office facility, an untoward event occurs that requires or conceivably could require hospitalization, then arrangements should be made to transport the patient immediately without delay. The 2-1/2 hour delay in this case contributed to the fatal outcome and should have been avoided in accordance with the testimony of plaintiff's experts in the case.

Furthermore, as this case indicates, where a defendant such as a plastic surgeon is utilizing his office to perform procedures that are normally performed in a hospital, then the physician under those circumstances, as this case indicates, must have adequate procedures and protocols for dealing with emergencies, including an agreement with a local ambulance company to timely transport any patients who have problems to the hospital as required under law for ambulatory surgical facilities.

Finally, in this case, it was determined by the Department of Health representative that the defendant physician

was wrongfully operating an ambulatory surgical facility without a license. Practitioners are reminded that where the law requires particular compliance by a physician for the legal operation of an ambulatory surgical facility, they have the responsibility to obtain such a license to do so, which in most jurisdictions, includes adequate procedures for dealing with emergencies.

The very significant punitive damages award of \$15 million is reported to be the highest punitive damages award ever rendered against a doctor in medical malpractice in Pennsylvania, and the fourth highest in that category nationally. Practitioners are reminded by this case of the serious nature of conduct which can create punitive damages for a particularly significant deviation from acceptable standards of practice. Furthermore, punitive damages can be awarded by juries for what has been determined to be serious wrongdoing with callous disregard for the rights of the patient and the patient's well-being which, because of the misconduct, can be considered tantamount to intentional wrongdoing because of the repetitive or serious nature of the acts of deviation leading to serious consequences for the patient. An award of punitive damages can also be many times the actual compensatory award and although the compensatory damages awarded in a case are usually covered under an existing insurance policy, any award of punitive damages may not be covered under many insurance policies because of the fact that such damages involve a degree of callous disregard that can be considered intentional and, therefore, will often not be covered by the average insurance company policy.

In addition, punitive damages are not necessarily discharged in bankruptcy in many jurisdictions because of the intentional nature of the callous wrongdoing in disregard for the rights

of the patient tantamount to an intentional act. Therefore, where punitive damages are being sought in a medical malpractice litigation, the practitioners involved through their counsel should consider seriously attempting to dismiss that aspect of the case on the basis that the punitive damages allegation does not meet the necessary requirement that the action of the accused physician was tantamount to gross negligence and was not callous disregard to the point of being tantamount to intentional wrongdoing and, therefore, was subject to an appropriate dismissal by the court prior to the commencement of the actual trial involved.

EXPERTS

Plaintiff's plastic surgeon expert: Patrick R. Felice from Bloomfield, CT. Plaintiff's pulmonary critical care expert: Ian H. Newmark, from Syosett, NY. Plaintiff's anesthesiologist expert: John Dombrowski, from Washington, DC. Defendant's plastic surgeon's pulmonary critical care expert: Melvin R. Pratter from Voorhees, NJ. Defendant's plastic surgeon expert: Mark P. Solomon from Bala Cynwyd, PA. Defendant's radiologist expert: Stefan Skalina from Philadelphia, PA. Defendant nurse anesthetist's anesthesiologist expert: Vincent S. Cowell, from Philadelphia, PA. Defendant nurse anesthetist's certified registered nurse anesthetist expert: Michael J. Booth, from Langhorne, PA.

REFERENCE

Philadelphia County, PA. Estate of Amy Fledderman vs. Dr. G., et al. Case no. 01-08-3619; Judge Sheldon Jelin. Attorney for plaintiff: Slade H. McLaughlin and Maxwell S. Kennerly of The Beasley Firm, LLC, in Philadelphia, PA. Attorney for defendant plastic surgeon: Dean F. Murtagh of German, Gallagher & Murtagh in Philadelphia, PA. Attorneys for defendant certified registered nurse anesthetist: I. Steven Levy and Eileen Monaghan of White & Williams in Philadelphia, PA.

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\$2,636,000 VERDICT - LACERATION OF LIVER DURING CORONARY BYPASS SURGERY - FAILURE TO TIMELY DIAGNOSE AND TREAT LACERATION - INTERNAL BLEEDING - CARDIOPULMONARY ARREST - BRAIN DAMAGE.

CASE SUMMARY

This was a medical malpractice action brought against two cardiovascular surgeons, their practice group and the hospital where the plaintiff underwent coronary bypass surgery. The plaintiff claimed that the first defendant surgeon negligently performed the surgery causing a liver laceration. The plaintiff also claimed that both defendant doctors and the staff of the defendant hospital were negligent in failing to timely diagnose and treat internal bleeding caused by the liver laceration, resulting in cardiopulmonary arrest and brain injury. The plaintiff died approximately five years after the surgery, as a result of unrelated heart failure, and was survived by her husband. The first defendant doctor denied lacerating the plaintiff's liver and the defense disputed that the plaintiff's cardiopulmonary arrest was caused by negligence.

CASE DETAILS

The plaintiff was a 44-year-old Hispanic female in May of 2001 when she underwent coronary artery bypass graft surgery (CABG) performed by the first defendant doctor. The surgery involved placement of two mediastinal drain tubes in the upper abdomen. The plaintiff's expert opined that the defendant negligently lacerated the plaintiff's liver with a surgical instrument known as a chest tube trocar during placement of the mediastinal drain tubes at the conclusion of the surgery.

The plaintiff's expert testified that it was a deviation in the standard of care for a cardiovascular surgeon to lacerate the liver during a CABG surgery. The plaintiff claimed that it was also a deviation to fail to recognize and immediately treat the liver laceration. The plaintiff's experts testified that the plaintiff exhibited bruising in the upper abdomen, below the rib cage over the area of the liver laceration. Records showed she also suffered abdominal pain, commencing on the second post-operative day following extubation

and removal of the mediastinal drain tubes. The abdominal pain became severe in the early morning hours of the third post-operative day, according to the plaintiff's claims.

The plaintiff reported that in the early morning hours of the third post-operative day, she felt she was having a heart attack and felt like she was going to die. In addition, the plaintiff's experts testified that on the morning in question, the plaintiff exhibited progressive hypotension, blue fingertips and nail beds, tachycardia, bradycardia and profoundly elevated liver enzymes, all indications of internal bleeding.

Three days post-surgery, on May 13, 2001, the plaintiff suffered a cardiopulmonary arrest while the first defendant cardiovascular surgeon was out of town and his partner, the second defendant cardiovascular surgeon, was covering for him. Emergency exploratory surgery revealed a liver laceration.

Approximately three liters of blood was removed from the plaintiff's abdomen. The plaintiff was on a ventilator for approximately three weeks following her arrest. She sustained moderate to severe permanent brain damage as a result of the arrest, according to the plaintiff's forensic psychiatrist and forensic neuropsychologist.

The plaintiff was employed as a social worker and attempted to return to work following the cardiopulmonary arrest. The plaintiff contended that she was unable to perform at work due to memory problems and that she was terminated secondary to her brain injury. The plaintiff's doctors testified that the plaintiff was also left with limited self-care ability, her speech was slower and she had difficulty ambulating. The plaintiff alleged that the arrest and brain damage could have been avoided by earlier intervention to repair the liver laceration.

The first defendant cardiovascular surgeon testified that it was impossible for him to have lacerated the plaintiff's

liver in the manner asserted by the plaintiff's experts because that organ was not in the operative field. The defense argued that the scars on the plaintiff's abdomen supported the defendant's position that a liver laceration could not have occurred during the surgery. The defense maintained that there was never any evidence that a trocar was utilized during the plaintiff's open-heart surgery and that the plaintiff's surgeon, who introduced the concept, was speculating that such an instrument was used.

The defendant also argued that there was no evidence of a liver laceration during the plaintiff's open-heart surgery and that there was no evidence of bleeding until an exploratory laparotomy was performed three days later. The defendant argued that the plaintiff's theory of causation could only be explained by a hypothetical series of events which were not supported by factual evidence.

The jury found that the first defendant cardiovascular surgeon was 100% negligent and that the second defendant cardiovascular surgeon and the hospital were not negligent. The plaintiff was awarded \$2,636,000 in damages against the defendant doctor/practice group only. The award included \$1 million to the surviving husband, \$1.5 million to the plaintiff's estate for pain and suffering and \$136,000 to her estate for lost wages. Post-trial motions were recently denied and an appeal is anticipated.

MEDICAL LIABILITY ANALYSIS

The plaintiff's experts were able to utilize the plaintiff's medical records combined with expert testimony to detail multiple signs and symptoms which they opined indicated internal hemorrhage which was not detected by the defendants.

The plaintiff's presentation required some alteration after the plaintiff died unexpectedly from heart failure five years post-surgery. There was no video, depicting her condition or preserving her

testimony, as her death was not anticipated. Plaintiff's counsel relied on the experts, as well as lay witnesses, to detail the plaintiff's disabilities, including speech deficits, ambulatory difficulties and memory problems caused by her brain injury. Evidence also showed that the plaintiff attempted to return to her work as a social worker, but was terminated as a result of her inability to function in that capacity.

Although asserting that the plaintiff's liver bleeding could have resulted from a number of causes, defense experts were not able to articulate with specificity the probable cause of the bleeding. All of the defendant's experts offered opinions as to the possible cause, but none could state the cause within a reasonable degree of medical probability in order to rule out negligent laceration of the liver.

It is interesting to note that the second defendant doctor, who was in charge of the plaintiff's care at the time of her cardiopulmonary arrest, was found not negligent. Apparently, the jury placed more significance on the claimed cause of the internal bleeding (liver laceration during the surgery performed by the first defendant cardiovascular surgeon) as opposed to the allegations involving the failure to timely diagnose the injury.

The defense contends that the jury was permitted to consider an impermissible stacking of inferences in order to support a claim against the operating surgeon and he will appeal this decision. Defense counsel reports that the damages will also be appealed as being the product of sympathy or prejudice, as the damage claim was limited to the relatively brief five-year period between the surgery and the plaintiff's unrelated death.

RISK MANAGEMENT ADVISORY

In this case, the plaintiff's experts successfully opined that the defendant negligently lacerated the plaintiff's liver with a chest tube trocar during placement of the mediastinal drain tubes at the conclusion of the surgery. The plaintiff's experts successfully testified that it was a deviation for a cardiovascular surgeon to lacerate the liver during CABG surgery. The plaintiff claimed

that it was also a deviation to fail to recognize and immediately treat the liver laceration.

Practitioners are reminded by this case that although patients are deemed to have assumed certain risks involved in difficult surgical interventions, such as open heart surgery, particularly of events which can and do occur as a result of the procedure itself and not to any provable deviation from acceptable standards of practice, practitioners can nonetheless be rendered liable for the occurrence of events during such surgeries which are not normally a risk of the surgery. In this case, the laceration of the liver outside the operative field was deemed a clear deviation from the accepted standard of care and was not the type of adverse event which can be deemed to have been assumed by the patient in agreeing to undergo open heart surgery. It was not a normal risk of the surgical intervention and, therefore, the occurrence of this event bespoke deviation through traumatization of an unintended body part such as the liver and resulted in a finding of liability.

Another important aspect of this case claimed to be a deviation by the plaintiff's experts was the failure of the defendants to immediately recognize that there had been a liver laceration. The plaintiff's experts testified that the patient exhibited bruising in the upper abdomen below the rib cage over the area of the liver laceration. Records showed that she also suffered abdominal pain commencing on the second post-operative day following extubation and removal of the mediastinal drain tubes. The abdominal pain became severe in the early morning hours of the third post-operative day according to the evidence in the case. The evidence as to the failure to appropriately appreciate the signs of an impending serious complication also included the fact that on the morning

in question, the plaintiff exhibited progressive hypotension, blue fingertips and nail beds, tachycardia, bradycardia, and profoundly elevated liver enzymes, all indicative of internal bleeding which were not timely addressed.

Practitioners are reminded that even in situations where an event occurs by the very nature of the procedure itself and not through any deviation, they may nevertheless be responsible for their failure to timely recognize the symptoms of an ongoing complication and take timely action to address those symptoms. Where a patient suffers injury due to a delay in addressing evidence of complication following serious surgical intervention, the practitioners involved can incur liability for that delay and responsibility for the damages sustained by that delay even where there may not have been any deviation in the performance of the surgical intervention that brought about the complication. It is the failure to timely and appropriately address the results of that complication in itself that are actionable, independent of whether or not the occurrence of the untoward event occurred as a result of a deviation in the performance of the surgical intervention.

Practitioners should note that the failure to address the symptomatology of the occurrence of a complication to surgery stands on its own as a basis of liability against surgeons or attending physicians without the necessity of that particular complication occurring initially through deviation. This is so even in situations where that complication occurred by the very nature of the procedure itself and not through any deviation. Liability can frequently be successfully alleged against the physicians in charge as a result of their failure to take all necessary actions in treatment of the results of the occurring complication in an appropriate, timely manner.

Furthermore, even in situations where a patient can be deemed to have assumed the risk of the occurrence of a particular complication because it can and did occur as a result of a known and accepted risk, they nevertheless are not deemed to have assumed the risk of a failure to timely and appropriately treat that complication in the event of its occurrence so as to avoid liability for the failure

of physicians to react accordingly and appropriately to timely and properly treat that complication.

EXPERTS

Plaintiff's cardiovascular surgeon expert: Andrew Wechsler from Philadelphia, PA. Plaintiff's forensic psychiatrist expert: Michael Gutman from Orlando, FL.

REFERENCE

Orange County, FL. Mix vs. Cardiovascular Surgeons, P.A. Case no.

48-2003-011918-0; Judge Thomas Turner. Attorney for plaintiff: Mark V. Morsch of Morsch Law Group in Winter Park, FL. Attorney for defendant hospital: Michael A. Estes of Estes, Ingram, Foels & Gibbs in Orlando, FL. Attorney for defendant cardiovascular surgeon and his practice group: Francis Pierce, III of Cooney, Mattson, Lance, Blackburn, Richards & O'Connor in Orlando, FL.

Additional Surgical Malpractice Verdicts

Orthopedic Surgery

DEFENDANT'S VERDICT - Defendant allegedly negligently performs surgery on right humerus resulting in two surgeries and permanent disability.

In this action for medical malpractice, the plaintiff alleged that the defendant doctor improperly treated a fracture of her right humerus; resulting in subsequent surgery and permanent disability. The defendant generally denied the allegations.

Specifically, the 57-year-old plaintiff was treated by the defendant after she suffered a fracture of her right proximal humerus when she fell off a horse. She was transported to the defendant hospital and treated in the emergency room by the defendant doctor. A few days later, the defendant doctor surgically placed an intramedullary rod into her arm in order to repair the fracture. Thereafter, the plaintiff failed to show up for all but one post-operative visit. Instead, the plaintiff was treated by a different doctor for two years during which time her arm healed and the rod was removed. The plaintiff also underwent surgery for adhesive capsulitis and impingement syndrome.

According to the plaintiff, the resultant surgery would not have been necessary had the defendant doctor treated her fracture within appropriate standards of care. Instead, the plaintiff argued that the defendant doctor acted below the standard of care by improperly placing the rod. As a result, the plaintiff argued that she was placed on permanent disability and suffered a loss of earnings and future earning capacity as a floor nurse.

The defendant generally denied the allegations; arguing instead that the surgery was performed within appropriate standards of care. The defendant doctor testified specifically that the placement of the rod, where it was slightly proud, was necessary for the proper fixation of the distal and proximal portion of the fracture. In addition, the defense argued that the surgical removal of the rod was always an option after the fracture had stabilized and that the adhesive capsulitis

and the impingement syndrome were not caused by the defendant doctor's care and treatment.

Ultimately, the jury found in favor of the defense.

EXPERTS

Plaintiff's orthopedic surgery expert: Fredrick Menninger, Jr. III, M.D. from Ventura, CA. Defendant's orthopedic surgery expert: Boyd Flinders, M.D. from Burbank, CA.

REFERENCE

Ventura County, CA. Smith vs. Dr. R. Case no. 56-2008-00318544-CU-MM-SIM; Judge Bruce Sottile, (Ret.), 5-18-10. Attorney for plaintiff: Greg Garrotto of Law Offices of Garrotto & Garrotto. Attorneys for defendant: Ramune E. Barkus of Barkus & Associates.

Surgery

\$750,000 VERDICT - Negligent treatment of severe degloving injury - Negligent performance of contraindicated reverse radial forearm flap - Muscle tissue death - Diminished use of hand - Scarring.

The plaintiff in this medical negligence case underwent a reverse radial forearm flap following a severe degloving injury in a motor vehicle accident. He claimed the defendant plastic surgeon who recommended the surgery and the co-defendant surgeon who performed the surgery did so knowing it was contraindicated. The plaintiff contended that because the co-defendant was negligent in causing the muscle tissue in his forearm to die, the plaintiff lost the full use of his hand and suffered an unsightly scar on his left forearm. The defendants argued the reverse radial forearm flap is the flap of choice for an injury such as the plaintiff's. They claimed the plaintiff's inability to regain the full use of his hand was due to his hand being crushed in the rollover and the explosive effect of the original injury.

In May 2006 the plaintiff was rear-ended and his vehicle rolled over, crushing his hand underneath the top of the vehicle. The 52-year-old male plaintiff presented to the emergency room with a degloving injury and he had lost most of the skin from his distal palm and four fingers, including tendons and blood vessels. The defendant, Dr. Munish Batra, M.D., was on call for hand injuries and proceeded to irrigate and debride the hand and attempt at repairing the plaintiff's torn tendons.

Three days later, the co-defendant, Dr. Abhay Gupta, M.D., performed the reverse radial forearm flap, which brings a

flap from the involved arm to the palm and further involves ligation of the radial artery. The defect in the hand was covered and healed with no infection. The plaintiff planned to have reconstruction by a hand surgeon and some months later he underwent two subsequent reconstructive surgeries.

The plaintiff claimed the defendants were negligent in recommending and performing the flap, which he alleged was contraindicated because of a compromise of blood flow in the hand. The plaintiff contended the co-defendant caused the muscle tissue in his forearm to die which resulted in the inability of the tendons in his fingers to flex. The plaintiff maintained that the inability to regain the full use of his hand was solely due to the decision by the defendant to perform the reverse radial forearm flap, as opposed to another flap such as a cross arm flap, a groin flap or a free flap.

The defendants argued the flap performed was accepted medical practice for the injury suffered by the plaintiff. They contended there was not a compromise of blood flow and that subsequent electrodiagnostic tests demonstrated that the muscles and nerves were functioning adequately. Both of the defendants' expert witness and the hand surgeon who performed the plaintiff's further reconstructive surgery opined that the plaintiff's inability to use his hand was due to the crushing and explosive effect of the original injury.

The plaintiff, a salesman, argued he suffered the inability to use his left hand in order to move furniture in his sales work. He claimed \$140,000 in future medicals for further reconstructive surgery and demanded \$237,500 from both defendants prior to trial. At trial, the plaintiff asked for \$400,000 in future non-economic loss and \$100,000 for past non-economic loss in addition to his claimed past and future medicals.

The jury found the defendants not guilty of malpractice.

EXPERTS

Plaintiff's plastic surgeon expert: Dr. Darrell R. Henderson, M.D. from Lafayette, LA. Defendant's hand surgeon expert: Dr. Robert J. Gelb, M.D. from Encinitas, CA.

REFERENCE

San Diego County, CA. Nicholas Barone vs. Dr. B. and Dr. G., individually. Case no. 37-2008-00093269-CU-MM-CTL; Judge Ronald L. Styn, 06-02-10. Attorneys for plaintiff: Michael E. Moore of Law Office of Michael E. Moore, APC in San Diego, CA and Jason A. Rodenbo in San Diego, CA. Attorneys for defendant: Michael I. Neil and Andrew R. Chivinski of Neil, Dymott, Frank, McFall & Trexler APLC in San Diego, CA.

\$605,000 CONFIDENTIAL RECOVERY - Negligence during laparoscopic surgery results in perforated colon.

In this medical malpractice matter, the plaintiff alleged that she sustained a perforated colon and had to undergo additional surgery and a temporary colostomy as a result of the defendant's negligence during laparoscopic surgery. The defendant denied the allegations and

disputed the causal relationship and the nature and extent of the plaintiff's damages.

The plaintiff underwent same-day laparoscopic surgery on November 1, 2005 regarding pelvic pain and was discharged home. She began to experience severe abdominal pain two days later and was brought back to the

hospital by ambulance. It was determined that the plaintiff was suffering from a perforated colon. The plaintiff had to undergo open resection of her sigmoid colon and a temporary colostomy. She developed an incisional hernia and had to undergo a separate surgery to correct that condition.

The plaintiff brought suit against the defendant, alleging negligence in perforating her colon during the laparoscopic procedure. The defendant denied negligence and maintained that the perforation occurred after the surgery and was not related.

The parties agreed to settle the plaintiff's claim prior to trial for the sum of \$605,000.

EXPERTS

Plaintiff's ob/gyn expert: Robert Luciani, M.D. from Millburn, NJ.
Plaintiff's ob/gyn expert: Scott Smilen, M.D. from New York, NY. Plaintiff's pathology expert: Angelo Ucci, M.D. from Boston, MA.

REFERENCE

Connecticut. Plaintiff vs. Defendant surgeon.; Judge Emmet L. Cosgrove,

4-07-10. Attorney for plaintiff: Peter J. Bartnik, Sr. of Bartnik Law Firm in Groton, CT.

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 deter-

mine 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. Accord-

ingly, 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 func-

tioning 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).

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