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New Trends In Medical Negligence

By Paul W. Chemnick, J.D.

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I. Changing Social & Economic Influences Affecting Health Care Claims

A. Economic factors increasing risk to patients

1. Declining Reimbursements
2. Depersonalized care (breakdown of physician-patient relationship, telemedicine)
3. Procedures moving out of hospitals

B. Changed public perception of health care providers due to frustrations obtaining care, critical media coverage, recent studies on negligence incidence - causing more people to believe they have claims worth pursuing

II. Legal Developments in Medical Negligence Practice

A. Expanded liability

1. Washington Patient's Bill of Rights
2. Suing HMOs, ERISA preemption (Pegram, ___ U.S. ___ (2000))
3. No Repose (DeYoung, 136 Wash.2d 136 (1998)

B. Confusion about identity of responsible defendants (employee or someone else's employee, actual agent, ostensible agent, independent contractor, separate entity, hospital district, federal employee)

C. Additional Legal Challenges Posed by Changes in Health Care Delivery

1. Telemedicine
2. Systems errors - falls between the cracks

D. Reasonable Care v. "Standard" Care

New developments in the health care industry are changing the relationship between patient and physician. That relationship lies at the heart of every medical negligence case. As the public becomes increasingly concerned with the quality of health care, and how to pay for it, physicians feel new pressures financially and ethically. At the same time, the science of medicine grows in complexity and volume. As the industry tries to cope with new realities of practicing medicine, new challenges are emerging in medical negligence litigation.

I want to talk to you about some of those developments, and some of the ways that the practice of law in this area is changing in response to those developments

I. Changing Social & Economic Influences Affecting Health Care Claims

A. Economic factors

Three related trends in health care have important consequences for malpractice litigation. First, the cost of care continues to rise, and second, care is increasingly depersonalized, and third, medical care itself is ever more technical and specialized.

1. Declining Reimbursements

With health care payers increasingly scrutinizing physicians' medical decisions in efforts to reduce the cost of health care, physicians find themselves between a rock and a hard place. On the one hand what the physician considers an appropriate level of care may not be fully reimbursed. On the other hand, if the physician can't afford to provide what he or she considers adequate care based on current reimbursement rates, a certain number of adverse consequences can be anticipated, and a portion may result in medical negligence suits. As reimbursements decline, this pressure intensifies.

Physicians report that they are spending more time in paper work seeking approval and reimbursement. When too much trouble - less likely to try again.

A recent study in the Journal of the American Medical Association concluded that because of this dilemma, "a sizable minority [39%] of physicians report manipulating reimbursement rules so patients can receive care that physicians perceive is necessary."

Things are not likely to get better.

A month or so ago there was an article in Seattle Times about companies announcing that they will be discontinuing medicare supplemental coverage because no longer profitable. A few days ago, Kaiser and KC Med announced they will no longer provide coverage under the State's healthy options and basic health plan because they lose money on each patient.

2. Depersonalized Care

Doctors have less time to spend with each patient, there is increased use of telemedicine, and there is less freedom to pick your own doctor. This has resulted in fewer long-term personal relationships between patient and physician.

A number of factors can result in patients having to see different health care providers visit after visit. Having to change insurance companies typically leads to having to get to a different provider as well. Furthermore, the fluid health care environment in the Puget Sound area has resulted in shifting alliances between providers, at the cost of patients consistently being able to see the same doctor. One result is that physicians have a harder time getting "the complete picture."

Of particular importance in medical malpractice is the breakdown of communication between doctor and patient. One study has shown that on average a doctor interrupts a patient describing his or her problem within 18 to 24 seconds. Other studies have indicated a close connection between communication and patient satisfaction, health outcomes, and malpractice litigation.

Milenbach case. Night sweats, premature menapause, anemia, iron deficiency, terrible itchy rash, neurodermatitis, asthma, allergy, opthamologist, certain changes in eyes. Hodgkins, fortunately not need new glasses.

One area lack of continuity of quality care is care from residents at teaching hospitals. Case I have, clients went to respected institution for surgery by national expert - complications and died two years later. Found out that surgery done by resident who was known to have marginal surgical skills, and critical care done in ICU by an intern who had only been in the ICU rotation for 7 days after graduating from medical school. Bait and Switch.

Residency programs typically involve extreme working conditions, calling for up to 100 hours per week, and shifts of up to 36 consecutive hours depending upon call schedules. Chronobiology - study of effects of relative levels of sleep deprivation on incidence of mistakes. Moreover, due to the pressures of managed care, nursing under-supply, and the declining numbers of residents and fellows in certain specialty areas due to competition with other fields, the burden placed on those in residency programs today is increasing. This is resulting in increased risk to resident's own mental and emotional well-being as well as to patient safety, and a larger number of claims involving resident care.

A few years ago a resident at the end of his shift missed a diagnosis on a patient named Libby Zion, who later died as a result. Her father was a New York Times reporter who introduced the issue of the resident's schedule into the national press. New York subsequently imposed restrictions of 80 hrs/wk, including call hours, on residents, and recently increased the fines to $6000 per violation. However, New York has been the only state to regulate in this area, and even there compliance is less than enthusiastic.

3. Procedures moving out of hospitals

An increasing number of surgeries are performed in doctors' offices, where its typically much cheaper than in the hospital. In 1996, 51% of the nation's surgical procedures were performed on patients who had not been admitted to the hospital. It was estimated that 26% of those surgeries were performed in doctors' offices, up from 5% in 1981. The most common procedures done at doctors' offices are cataract surgery, examinations and biopsies of the intestines, and plastic surgery.

This change in medical practice raises many safety concerns, especially with regard to the use of anesthesia equipment, and the physician's "back-up plan" if something goes wrong. Last year, the Seattle Times reported on outpatient surgeries:

In most places, including Washington state, no laws restrict the kinds of surgeries that can be done in private offices by licensed doctors, regardless of their surgical or anesthesia training.

Even when patients pick a skilled surgeon, operating in a private office means there is no backup for the rare patient with problems; "the only thing you're left with is calling 911,"

Private offices don't have the same oversight as hospitals, and the almost total absence of reporting requirements makes it very difficult to gather any statistics on the number of mishaps in doctors' offices.

B. Changed Public Perception of Health Care Providers

There is growing public dissatisfaction with the service and quality of the health care industry. Media coverage has been especially critical. Late last year a new report came out estimating the number of deaths caused by medical errors. The Washington Post ran the following headline:

Thousands of Deaths Linked to Medical Errors--More Americans die from medical mistakes than from breast cancer, highway accidents, or AIDS, according to the report from the Institute of Medicine, an arm of the National Academy of Sciences. That costs the nation almost $9 billion a year.

Washington Post, November 30, 1999.

Similar headlines have run locally as well. Patients are particularly wary in light the long running negative coverage of HMOs. The public increasingly believes that physicians' decisions are based on profit motives instead of the patient's health. A study published in the Journal of the American Medical Association last year deals specifically with the issue of patients who distrust their doctors' treatment decisions. One local emergency physician recently wrote an Op-Ed piece on the dangers of coming to the emergency room because of profit motives and the overuse of technology. Seattle Times, Op-Ed, January 10, 2000.

Last month the health care industry was dealt another blow in the press. A new report from the World Health Organization says that the United States spends by far the most money on health care, over $3000 per person per year, but ranks only 37th in health care quality.

II. Legal Developments in Medical Negligence Practice

A. Expanding Liability

1. Washington Patient's Bill of Rights

The public's concern with health care costs and delivery is reflected in tremendous legislative interest in the subject, at both the federal and state levels. Two years ago in Maryland, the state legislature spent more time dealing with managed care than with all other issues combined. In Washington, the legislature has recently passed a Patient's Bill of Rights.

It was passed this legislative session by a near unanimous vote in both houses. It was supported both by WSTLA and by WSMA. I discuss it more in my materials. Briefly, the bill includes disclosure requirements for HMOs to consumers, gives patients the right to independent review of the carrier's decisions, and requires plans to have a grievance process. It includes chiropractic care, the right to a "standing" referral to a specialist for chronic conditions, the right to choose and change at will a primary care physician, and the right to a second opinion.

The bill also includes a right to sue carriers. Two important defenses under the law are (1) that the service is not a benefit provided under the plan, and (2) that any delay in payment was not unreasonable. Further, the patient may not maintain an action under the law unless he or she has sought independent review of the carrier's decision.

Hopefully, companies will be less likely to refuse coverage out of hand both for legal as well as public relations reasons.

2. Suing HMOs where covered under ERISA plans

In the recent United States Supreme Court case of Pegram v. Herdrich, ___ U.S. ___ (2000). The issue was whether treatment decisions are fiduciary acts under ERISA. If so, then denial of a form of treatment could be a beach of such fiduciary duty that could give rise to a direct claim against the HMO. The court held unanimously that they are not.

In that case, the plaintiff presented to her HMO with severe abdominal pain. Instead of ordering an immediate ultrasound (which would have indicated appendicitis), Dr. Pegram decided to have the plaintiff wait eight more days for the ultrasound at an HMO owned facility fifty miles away. Before the eight days were over, the plaintiff's appendix burst, causing peritonitis.

The court unanimously rejected plaintiff's claim. Justice Souter included a lengthy description of how health care delivery in the United States has undergone a dramatic change in recent decades, with enthusiastic Congressional support for cost containment practices.

Seen in this light, the court held that it could not entertain such actions against HMO's under the Federal act, merely because of their structure or financial incentive arrangements.

However, the case is significant because the court seems to open the door for more suits against HMOs in state courts, as I discuss in more detail in my materials. In footnote 9, the court expressly declined to address whether a claim could be brought against an HMO for denial of reimbursement

for emergency care under a state law cause of action.

If the court's dicta does turn out to give litigants more flexibility to litigate claims against HMOs in state courts, the court may not have done the industry much of a favor at all. HMOs may now face more lawsuits, and will have to litigate them in state courts.

On another note, since it is ever more apparent that rights and obligations under ERISA are limited to those specifically set forth in the act, it may well be that ERISA carriers have no present right to sue to enforce subrogation, because they have very limited authority to sue anyone under the Federal statute. Recent article in Trial News -One WSTLA attorney tells me that he is advising clients that they don't have to pay back ERISA liens, and that the carriers seem to be accepting his interpretation. I understand, however, that there is a Petitition for cert to Supreme Court on this issue, because of a conflict between the circuits. Also, if carriers have a contract right, but no enforcement mechanism, what would stop Congress from providing that mechanism within the S/L period. May want to inform clients of that risk.

3. No Statute of Repose, DeYoung v. Providence Medical Center, 136 Wash.2d 136, 960 P.2d 919 (1998)

In DeYoung, the Washington Supreme Court held unconstitutional the 8-year repose on medical malpractice actions contained in RCW 4.16.350(3). The plaintiff sued Providence in 1996 for alleged negligent radiation treatment that she received in 1980. She learned that the treatment had caused injury to her right eye in 1995, and in 1996 that her left eye was also injured. She argued that the 8-year repose unconstitutionally denied the benefits of the discovery rule to a small class of adult medical malpractice claimants who could not reasonably discover their injuries within 8 years, where none of the tolling exceptions applied.

The court concluded that the classification of claims which were subject to the statute did not bear a rational relationship to the purpose of the statute, and so violated the state's privileges and immunities clause. The court determined that the main purpose of the statute was to control malpractice insurance premiums in the 1970's by limiting the threat of long-tail liability. But the court determined that so few claims were actually based on conduct more than 8 years old that the statute could not rationally affect insurance premiums. The argument that the statute had an alternative purpose of eliminating stale claims met a similar fate--because the repose affected so few claims, "the classification was too attenuated to that goal." DeYoung, 136 Wash.2d at 150.

The court was careful, however, to state that limiting both long tail-liability and stale claims were legitimate legislative goals. Needless to say, the court's decision that the repose was unconstitutional only because too few claims were affected for it to make a difference in malpractice rates is not terribly reassuring. Apparently, under the court's analysis, a shorter repose, affecting a more significant number of claims, would have been constitutional. The provisions reasonably must just have some demonstrable impact on the stated purpose for the statute.

B. Increased Risks, Costs and Complexity in Medical Negligence Litigation

A growing problem in medical negligence litigation is whom to sue. Hospital care today often involves treatment by several different types of specialists. For example, a patient may be cared for by different cardiologists, surgeons, and anesthesiologists, as well as various support staff, including nurses, pharmacists and technicians. The patient's care givers may be employees, actual agents, ostensible agents, or independent contractors. The business relationship of these individuals may be so informal that neither the participants nor even their carrier know for sure what the relationship really is until the facts become more clear during the course of discovery. Subcontractors have been known to provide emergency care, anesthesiology, and even house staff.

Often a plaintiff's practical hopes for simplifying the action, keeping costs under control and obtaining adequate recovery will depend on attaching liability to an institutional provider. That is still a risky proposition despite some helpful law on the subject.

The doctrine of ostensible agency generally applies to a relationship that looks for all the world like employment, but that's styled as that of an independent contractor. This doctrine was first applied to an emergency room physician in Washington in Adamski v. Tacoma General Hospital, 20 Wash.App. 98, 579 P.2d 970 (1978).

What some attorneys don't realize, however, is that the law in Adamski was decided on two alternate theories: either the physician was the hospital's

ostensible agent, or its actual agent. Essentially the court will make its own analysis of whether a relationship has the legal effect of being one of principal and agent.

The fundamental aspect of actual agency for hospitals is whether the supposed agent performs "an inherent function of the hospital, a function without which the hospital could not properly achieve its purpose." Adamski, 20 Wash.App. at 112. It is critical for a practitioner to distinguish this from ostensible agency, which is a theory based on the plaintiff's perception and reliance. Hospital consent forms almost always contain language that defendants will claim puts plaintiffs on notice that they will be treated by providers other than the hospital. The actual agency prong of Adamski is a powerful tool for plaintiffs because it does not depend on the plaintiff's reliance.

Additional challenges are posed when claims are brought against health care providers that one would not ordinarily suspect were employees of public hospital districts, the State, or the federal government. This can constitute a trap for the unwary practitioner due to different requirements relating to claim filings, jurisdiction and statute of limitations.

Claims against public hospital districts must follow the strict rules for submitting claims to a public entity. Public hospital districts aren't only small rural hospitals: Stevens, Valley Medical Center in Renton, and Evergreen are all public hospital districts. Some of the districts have recently "purchased" clinics and private physician practices, so that those physicians are employees of the district, and claims based on their care must also follow the claims statute. Moreover, it is sometimes difficult to find out how one is supposed to serve the mandatory claim form. There are often no clear procedural guidelines. It may not be sufficient to serve the claim on the hospital administrator.

In addition, in some cases, a physician practicing in a "private" hospital may be a state employee, such as U.W. residents rotating through a hospital, or U.W. faculty providing care under an agreement (such as with Children's Hospital). Although there may be actual or apparent agency on the part of the hospital, or arguments that the physicians are "borrowed servants," as employees of the state the physicians may be still be protected by the state claims statute.

Also, physicians practicing at small, rural hospitals may be U.S. Public Health Service employees, serving their governmental duty in exchange for scholarship help while in medical school. Those physicians would be subject to the Federal Tort Claims Act, with its two-year statute of limitations for filing a claim. That would also apply to certain federally-funded health clinics for the poor which can opt under federal law to have their employees considered as "federal" employees for purposes of malpractice claims, and therefore subject to the two-year statute for submitting a claim.

C. Additional Legal Challenges Posed by Changes in Health Care Delivery

1. Telemedicine

Telemedicine has the potential to involve dramatically larger numbers of parties in medical negligence litigation. Because it minimizes time and distance constraints in treatment, telemedicine allows many more providers to pool their efforts in treating a single patient.

What was once just a brief telephone consult, which was often not thought to be only a curbside consult which didn't extablish a physician patient relationship and duty, has become internet communication with complete patient history and even x-ray images-attached, and interactive video conferencing. Nuero radiologist in Seattle who reviews films sometimes on a STAT basis from rural emergency rooms throughout Alaska.

Telemedicine raises the issue of when a physician-patient relationship is created, so that the physician will owe a duty to the patient. In my materials, reference to article by Prof Patricia Kuszler a law professor at the U.

She says that the specialist will not be able to claim that her consultation was merely a "curbside opinion." There is likely direct liability attaching to each provider. This can complicate lawsuits, and/or present the possibility of empty chairs.

2. Systems Errors

A fairly high percentage of our cases involve "systems errors" - not so much isolated mistakes of judgment made by a provider, but a mistake that occurs through lack of systems or protocols or simply from the complexity of communication necessary in today's medical environment.

It used to be that this type of error occurred primarily in a hospital setting, where there needed to be timely and accurate communications between nurses, physicians, lab personnel, and technicians. But today any clinic has

some of the same potential problems, and even a sole practice primary care doctor may face these problems because of the need to refer to specialists or for diagnostic tests, understand the implications of their findings, and take appropriate steps to follow up where appropriate.

Primarily, I am talking about communicating information. In any health care setting in which two or more providers are involved, there have to be systems or protocols in place to be sure that information is communicated on a timely basis between the providers, and that the professionals who need to see the information, get it.

Suppose an emergency patient is hospitalized for chest pain and gets an x-ray, ordered by the emergency physician after consulting the cardiologist on call, which shows a lung lesion. The attending physician is shown as the primary care doctor, who hasn't seen the patient in a year or so. The report goes to the ER, but doesn't go to the attending physician or the cardiologist. The report is filed with the patient's hospital chart. In the meantime, the patient has been discharged from the hospital. A year later, lung cancer is diagnosed.

Or suppose laboratory tests are ordered by a primary care physician because of possible side-effects of medication, but the lab results, which are alarming, are placed in the physician's in-basket after he has left on a Friday afternoon. The patient leaves for vacation on Saturday for two weeks, and doesn't find out about the elevated liver enzymes until he returns and has permanent liver damage.

In such cases, who all is at fault? Who has responsibility for assuring that the system works, that important matters are communicated in a timely fashion so that they can be acted upon. Do you need to sue them all? Not clear.

Some entity, primary care physician or hospital should have ultimate responsibility to establish a safe procedure. In my materials, I refer to an article about the causes and prevention of errors in health care which discusses this issue in more detail.

This may be the time when consumers are fed up with the health care system to try to get clearer law allowing recovery of full damages from such system errors from the entity who should be primarily responsible for the system, and that can prevent the same thing from happening again, without having to sue all the involved health care providers in order to avoid empty chairs.

D. Reasonable Care v. "Standard" Care

Care providers today often argue that they can no longer justify expensive diagnostic procedures given the practical effects of managed care. We recently had a defendant cardiac surgeon explain that he discontinued doing enzyme tests to rule out myocardial infarction following surgery because of the pressures to keep costs down due to managed care, despite the fact that he had often used such tests in the past, and they were potentially life saving. The defense is that such relaxations in the thoroughness of care have become "common" due to such practicalities, and therefore tend to define the new lower standard of practice. The issue, however, is whether such "relaxation" is reasonable and prudent taking into account the risks to the patient as well as the costs of such care.

Also, where the standard of practice has been in place for some time, but where research has demonstrated that it isn't working and that there are better ways to treat the patient, then an argument can be made that reasonable care requires more than the generally accepted level of care.

An example of this is the increase in the number of medical negligence wrongful death cases involving a delay in diagnosis and treatment of cardiovascular disease. The fact patterns are often quite similar. In the weeks and sometimes months prior to their deaths, patients report chest pain radiating to their shoulders and arms or a tightness in their chests that was aggravated by exercise. Physicians ruled out cardiac problems based on exercise testing and eletrocardiograms. Recent studies have concluded that "false negative" results from these tests are common. Consequesntly, instead of resulting in diagnosis of ischemic heart disease and use of life-saving procedures such as angioplasty or bypass surgery, patients are treated for a variety of ailments including ulcers, gallstones, and panic disorder. Autopsies reveal atherosclerotic narrowing of coronary arteries with the left anterior descending artery the most common site of disease.

The point is that regardless of current or common practices, which may have either become degraded, or which have just not kept abreast with medical knowledge in the field, the standard for medical negligence is that of a

"reasonably prudent" physician. Experts are sometimes reticent to find fault with care providers when they know others are doing the same thing. But we often need to be willing to challenge the normal practice. Otherwise there is a real risk that the expectations of the health care system will fall to the lowest common denominator. Patients should be entitled to expect more than that despite the forces which are adversely affecting health care delivery.

CONCLUSION

The health care delivery system is evolving rapidly both in response to socio-economic forces and to new developments in technology. These changes present both opportunities for better care, and increased risks associated with declining reimbursement, depersonalized and fragmented care, and from more procedures being performed outside of the hospital setting. There is growing dissatisfaction and frustration on the part of many patients. As a result, there have been some beneficial changes in the law to address these problems, and this matter continues to receive a great deal of public attention. At the same time, there are significant new challenges and risks as well as opportunities to practitioners seeking redress for victims of negligent health care in the civil justice system.