05-11-16

Medical Jurisprudence

Behavioral Sciences Term
St. Georges University
School of Medicine

Visiting Professor
Thaddeus Pope, JD, PhD

Friday
July 29

Segment

4 of 8

Medical Malpractice
(Duty & Breach)

Objectives

At the conclusion of this unit, the medical student should be able to answer the following 11 questions

1. What is the **prevalence** of medical error?
2. What are the main **types** of medical error?
3. How is the **standard of care** typically established

4. What are 4 ways in which the standard of care is **geographically** defined
5. What effect does board certification have on geographical variations

6. When/how are resources (economic variation) considered?

7. Other than through expert witnesses, how **else** is the standard of care defined
8. What is a "school of thought"
9. How is a school of thought established

10. When is the standard of care set by the judge
11. When is the standard of care set by CPGs

Note: We will continue medical malpractice on Tuesday, with a fresh set of objectives

Medical Error (prevalence)

Iatrogenic injuries

Injuries induced by physician, medical treatment, or diagnostic procedures

4 major reports

1999

98,000 deaths each year from preventable medical error

2010

Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

ADVERSE EVENTS IN HOSPITALS:
NATIONAL INCIDENCE AMONG
MEDICARE BENEFICIARIES

Daniel R. Levinson
Inspector General

November 2010
OEI-06-09-00090

Injured
1.4 million

Killed
180,000

Just Medicare beneficiaries

Just hospitals

2013

REVIEW ARTICLE

A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care

John T. James, PhD

400,000

premature deaths from preventable harm to patients

2016

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016) Page 1 of 5

ANALYSIS

Medical error—the third leading cause of death in the US

250,000

but understated

Heart disease	597,689
Cancer	574,743
COPD	138,080
Stroke	129,476
Accidents	120,859

Medical Error

(types)

Saber Tehrani AS, *et al*. *Quality and Safety in Health Care* 2013;0:1–9. doi:10.1136/bmjqs-2012-001550

Malpractice allegation group	n (%)	Mean, US$
Diagnosis related	100249 (28.6)	386849
Treatment related	95635 (27.2)	196960
Surgery related	84980 (24.2)	280257
Obstetrics related	22951 (6.5)	651670
Medication related	18697 (5.3)	257333
Anesthesia related	10525 (3)	419126
Monitoring related	7101 (2)	354131
Other miscellaneous	6929 (2)	176781
Equipment/product related	1872 (0.5)	128204
Intravenous and blood-rroducts related	1080 (0.3)	294011
Behavioural health related	687 (0.1)	212494
Total	350706 (100)	313813

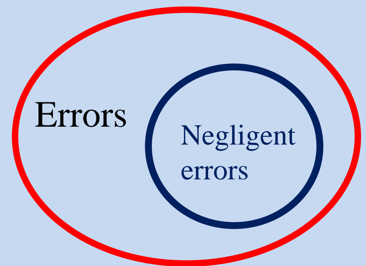
Malpractice Litigation

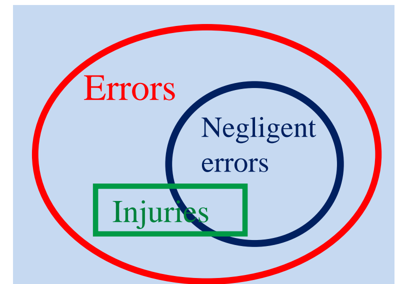
(basic nature)

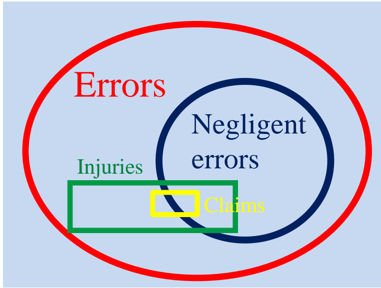
Goals

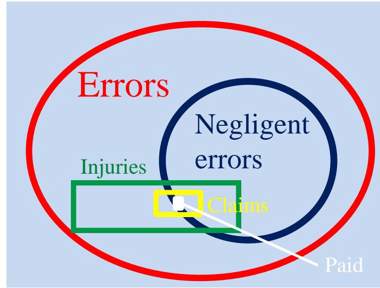
Deter unsafe practices

Compensate the injured









100,000 patients
- 4000 adverse events
  - 1000 from malpractice
    - 125 claims (only)
      - 60 compensation
        - (+ to some of 3000 non-negligent)

60 compensated claims
- 20 before lawsuit
- 35 after lawsuit filed
- 5 at trial

Malpractice Litigation

(prevalence)

760,000 civil cases

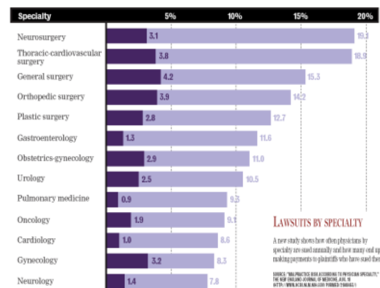
Tort = 50% = 380,000

Med Mal = **2.5%** = 18,000

DOJ 1992 study 75 large counties

10,000 paid claims per year

the DataBank
NATIONAL PRACTITIONER



Standard of Care

Analogize to informed consent

PTF claims DEF failed to disclose X

PTF must establish that had **duty** to disclose X

Medical malpractice

PTF claims DEF deviated from standard of care

PTF must establish SOC

Almost always, PTF needs **expert witness** to establish SOC

Basic Flowcharts:

Establishing SOC

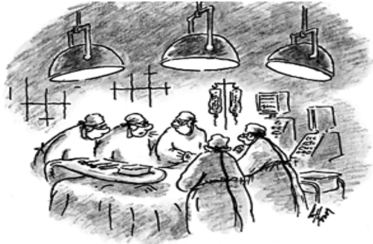
No expert → no SOC

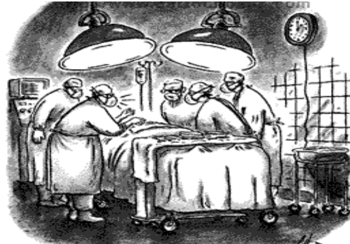
No SOC → no breach

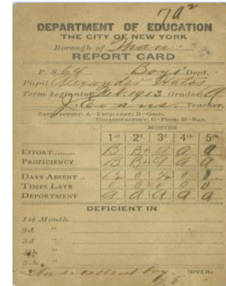
No breach → no case

What question does the expert answer

What would the **reasonable physician** have done in the circumstances


"You're doing it wrong."


"If I knew where I'd lost the sponge, it wouldn't be lost, now, would it?"



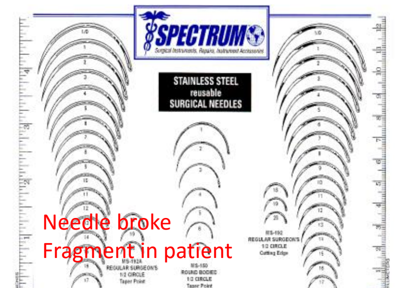
Objective standard: effort does not matter

No Forrest Gump defense

You can be below average yet not negligent

- Optimal care
- Very good care
- Good care
- Average Care
- Substandard care **Negligence**
- Reckless care
- Gross incompetence

Locke v. Pachman



PTF claims:

- Wrong size needle
- Used it wrong
- Should have found it

But PTF expert testified “it happens”

Bad expert

Expert must establish

1. RPP would have used bigger needle

2. RPP would have pushed with curve

3. RPP would have found needle

Standard of Care

(variations)

There is no single standard of care applicable to all physicians

Geography
Economic factors
Specialization
School of thought
Judicial
CPG

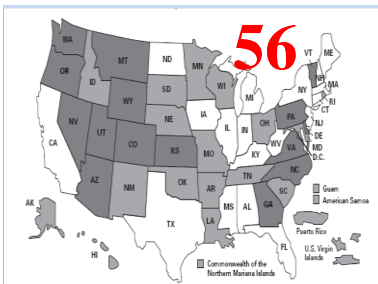
Geographical SOC variations

DEF measured against the **reasonable physician**

What would the **reasonable physician** have done in the circumstances

But **which** reasonable physician

The reasonable physician **where**



1. Strict locality
2. Statewide
3. Same or similar
4. National

MD in locality
MD in state
MD in same/similar
MD in USA

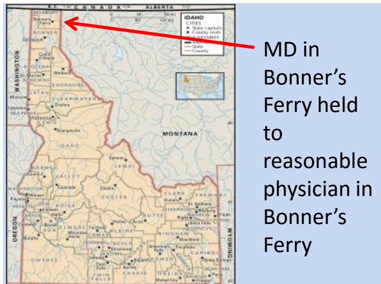
Strict locality

Used to be the rule everywhere

No longer followed anywhere, except Idaho

". . . as an essential part of his or her case in chief . . . negligently failed to meet the applicable standard of health care practice **of the community** in which such care allegedly was or should have been provided . . . ."

"in comparison with similarly trained . . . providers . . . in the **same community, . . . that geographical area** . . . nearest to which such care was or allegedly should have been provided."



VERY few physicians know the standard of care in specific Idaho towns

Hard to sue an Idaho physician

Mass General expert **can know** SOC

Formerly Boise

or

Learns it - for the case

Statewide

Statewide Standard‡

Arizona: Ariz Rev Stat §12-563 (2005)

Virginia: Va Code Ann §8.01-581.20 (2006)

Washington: Wash Rev Code §7.70.040 (2006)

DEF duty =
reasonable MD in **state** of DEF

Dr. Merenstein followed EBM

Yet he still **loses**

Legal duty

What RP WA physician would do

What a RP WA physician would do might not be best

Same or similar

Same or Similar Community Standard¶

Arkansas: Ark Code Ann §16-114-206 (2006)

Illinois: *Jinkins v Lee*, 209 Ill2d 320, 282 Ill Dec 787, 807 NE2d 411 (2004)

Kansas: *Tompkins v Bise*, 259 Kan 39, 910 P2d 185 (1996)

Maryland: Md Code Ann, [Cts & Jud Proc] §3-2A-02(c) (2006)

Michigan: Mich Comp Laws Serv §600.2169 (2006)

Minnesota: *Lundgren v Eustermann*, 370 NW2d 877 (Minn 1985)

Nebraska: Neb Rev Stat §44-2810 (2006)

North Carolina: NC Gen Stat §90-21.12 (2006)

North Dakota: *Winkjer v Herr*, 277 NW2d 579 (ND 1979)

Oregon: Or Rev Stat §677.095 (2006)

Tennessee: Tenn Code Ann §29-26-115 (2005)

DEF duty to act as reasonable physician in DEF community ***or*** one similar to it

---

Community size

Hospital size

Number & type medical facilities

Discussed with providers

Visited hospital

Johnson v. Richardson (Tenn. App. 2010)

Tennessee is a “same or similar jurisdiction”

Expert: Springfield, MO

Defendant: Memphis, TN

Chapel v. Alison

DEF	Livingston, MT GP
PTF expert	Denman, MA Orthopedic surgeon

PTF expert need not be from Bozemon

PTF expert must be familiar with SOC in place like Bozemon

Expert can acquire that knowledge specifically for litigation

e.g. visit Bozemon (or similar)

National

National Standard+

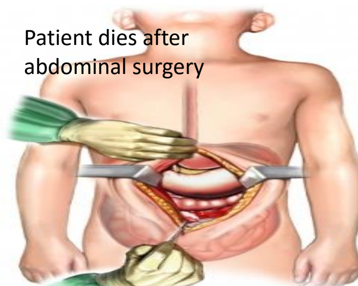
Alabama: Ala Code §6-5-548 (2005)
Alaska: Alaska Stat §09.55.540 (2006)
California: *Barris v County of Los Angeles*, 20 Cal 4th 101, 972 P2d 966, 83 Cal Rptr 145 (1999)
Connecticut: Conn Gen Stat §52-184c (2006)
Delaware: Del Code Ann, tit 18, §6801 (2006)
Florida: Fla Stat §766.102 (2006)
Georgia: *McDaniel v Hendrix*, 260 Ga 857, 401 SE2d 260 (1991)
Hawaii: *Hirahara v Tanaka*, 87 Haw 460, 959 P2d 830 (1998)
Indiana: *Vergara v Doan*, 593 NE2d 185 (Ind 1992)
Iowa: *Estate of Hagedorn ex rel Hagedorn v Peterson*, 690 NW2d 84 (Iowa 2004)
Kentucky: *Branham v Nazar*, 2004 Ky App LEXIS 312
Maine: *Downer v Veilleux*, 322 A2d 82 (Me 1974)
Massachusetts: *Brune v Belinkoff*, 354 Mass 102, 235 NE2d 793 (1968)
Mississippi: *Hall v Hilbun*, 466 S2d 856 (Miss 1985)
Missouri: Mo Rev Stat §538.225 (2006)
Nevada: Nev Rev Stat Ann §41A.009 (2006)
New Hampshire: NH Rev Stat Ann §507-C:2 (2006)
New Jersey: *Velazquez v Portadin*, 163 NJ 677, 751 A2d 102 (2000)
New Mexico: *Pharmaseal Laboratories Inc v Goffe*, 90 NM 753, 568 P2d 589 (1977)
Ohio: *Bruni v Tatsumi*, 46 Ohio St 2d 127, 346 NE2d 673 (1976)
Oklahoma: Okla Stat tit 76, §20.1 (2005)
Rhode Island: *Sheeley v Memorial Hospital*, 710 A2d 161 (RI 1998)
South Carolina: *Durham v Vinson*, 360 SC 639, 602 SE2d 760 (2004)
Texas: *Am Transitional Care Centers of Tex Inc v Palacios*, 44 Tex Sup Ct J 720, 46 SW3d 873 (2001)
Utah: *Dalley v Utah Valley Regional Medical Center*, 791 P2d 193 (Utah 1993)
Vermont: Vt Stat Ann tit 12, §1908 (2006)
Washington, DC: *Morrison v MacNamara*, 407 A2d 555 (DC 1979)
West Virginia: W Va Code §55-7B-3 (2006)
Wisconsin: *Phelps v Physicians Ins Co of Wis Inc*, 282 Wis2d 69, 698 NW2d 643 (2005)
Wyoming: Wyo Stat Ann §1-12-601 (2006)

DEF duty to act as reasonable physician **in USA**

(majority standard)

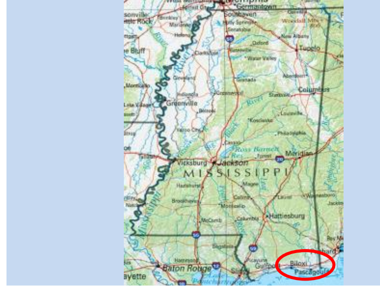
Physician expected to possess medical **knowledge** and to exercise medical **judgment** as possessed by reasonable doctor **anywhere in the United States**

Hall v. Hillbun



4 theories of negligence

1. Decision to operate
2. Surgery itself
3. Post-op care
4. Sponge left



Okay if plaintiff experts have never been to MS before

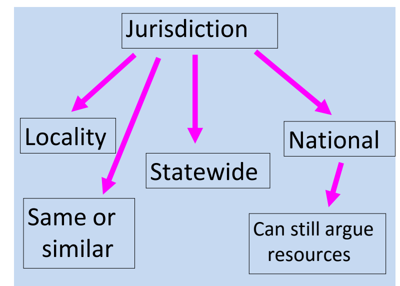
Economic SOC Variations

This is a variation ONLY when already using **national standard**

Still a **national** standard re knowledge & judgment

But DEF can argue variation / adjustment for **resource** reasons

But physician only must use **resources** as are reasonably available



Specialization SOC variations

Standard of care adjustment for medical credentials

Board Certification goes beyond basic medical licensure

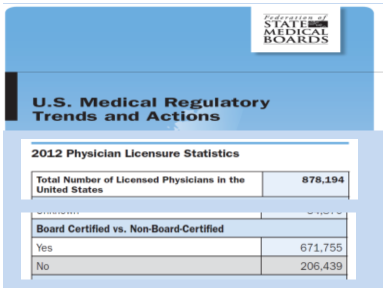
- 3-6 years of training
- Examination

- Dermatology
- Emergency Medicine
- Surgery
- Orthopedic surgery
- Pediatrics
- Anesthesiology

Board certified **always** held to national standard

Even in

- Idaho (strict locality)
- Minnesota (same or similar jurisdictions)
- Virginia (statewide)



2012 Physician Licensure Statistics

Total Number of Licensed Physicians in the United States	878,194
Board Certified vs. Non-Board-Certified	
Yes	671,755
No	206,439

Geography Recap

Assume expert is from Mayo Clinic (Rochester, MN)

Is medicine really different in Idaho - NO

Strict locality
Statewide
Same or similar
Nationwide

May be same standard

But still an important rule of **evidence** re: how standard established

Let's move from geographic SOC to SOT

Standard of care variations by school of thought

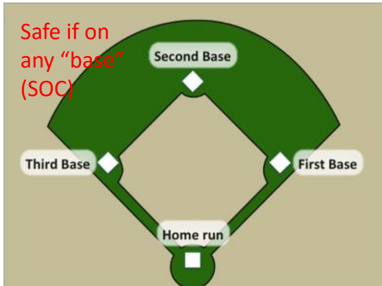
Standard of care
established
through PTF
experts

DEF can
establish
a 2nd SOC

SOC 2
Established
by DEF experts

SOC 1
Established
by PTF experts

Sufficient that
DEF conduct
complies with
either one



Compliance with
SOT **as good as**
compliance with
SOC established
by PTF

Jury does **not**
determine
which SOC is
"better"

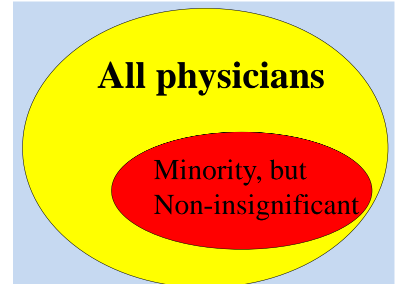
Jury instruction:

Sufficient that DEF
complied with **either**
school of thought if has
"respected advocates
and followers"

DEF has **burden** to establish SOT

How does she do that?

Not enough that you and your SGU roommate do it that way



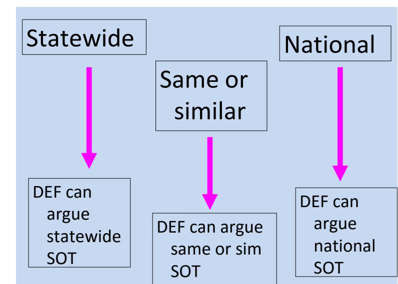
BOTH

Reputable and respected

AND

Considerable number

SOT can be used in **any** jurisdiction -- no matter how SOC is established



DEF must establish SOT in the **same way** PTF establishes SOC (e.g. geographical)

e.g. in Arizona

(reputable & respected **in Arizona**)

+

(considerable number **in Arizona**)

Jandre

v.

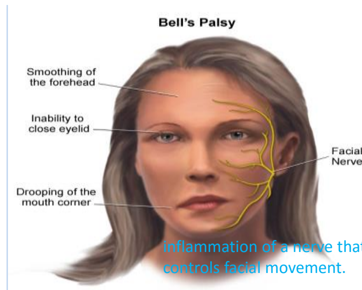
WIPFCF

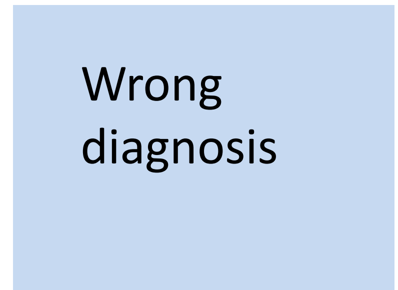
Minneapolis
West Bend, WI
Chicago
Detroit
Omaha
Indianapolis
Kansas City
St. Louis

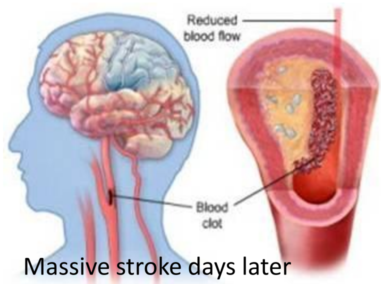
Pt arrives ED at St. Joseph Hospital

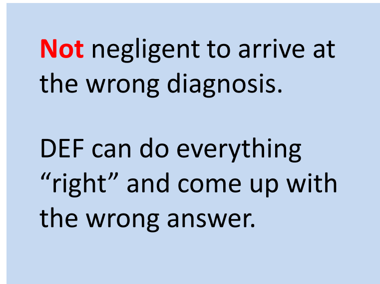
FACE.
ARMS.
SPEECH.
Has their face fallen on one side? Can they smile?
Can they raise both arms and keep them there?
Is their speech slurred?

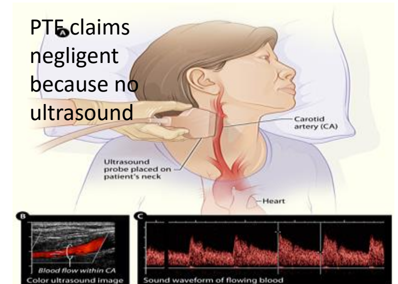
Auscultate the carotid artery to determine if a bruit (blowing, swishing sound indicating blood flow turbulence)


Bell's Palsy
Smoothing of the forehead
Inability to close eyelid
Drooping of the mouth corner
Facial Nerve
Inflammation of a nerve that controls facial movement.


Wrong diagnosis


Reduced blood flow
Blood clot
Massive stroke days later


Not negligent to arrive at the wrong diagnosis.
DEF can do everything "right" and come up with the wrong answer.


PTF claims negligent because no ultrasound
Carotid artery (CA)
Ultrasound probe placed on patient's neck
Heart
Blood flow within CA
Color ultrasound image
Sound waveform of flowing blood

But **not** negligent to use stethoscope, if supported by "school of thought"

Recap

Malpractice duty: do what **reasonable physician** would do in circumstances

Lay juries do not know what reasonable physician would do

Need **expert witnesses** to establish SOC

almost always

2 **OTHER** ways to set standard of care

Court / Judicial

CPG

Judicial (court) set standards of care

Rest. Torts 2d § 285(c)

The standard of conduct . . . may be established by judicial decision

PTF claims negligent to not have a radio

The T.J. Hooper (2d Cir. 1932)

DEF argues nobody uses a radio

Court: "In most cases reasonable prudence is in fact **common prudence**, but strictly it is never its measure."

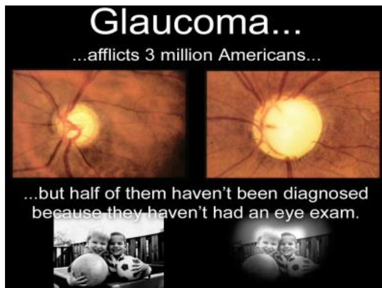
"A **whole calling** may have unduly lagged in the adoption of new and available devices."

Extremely **rare** in med mal

Helling v. Carey

Infamous

Much criticized



Expert witnesses

"SOC is **not** to test for glaucoma under age 40"

NORMALLY

"**compliance** with . . . standard of the profession . . . **insulates** from liability"

SCOW: "Who cares! They **should** test the under 40s."

But Helling rare, rare exception

With the medical profession common prudence "strictly is the measure" of the standard of care

Conformance to **their own** rules, protocols, practices is a complete defense for clinician

Standard of care set with CPGs

CPG

Clinical practice guideline

Guideline based on **systematic review** of clinical evidence.

Legislature
comply with CPG = safe harbor

Legal experiments are limited & unsuccessful

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