The landscape of medical malpractice litigation is being transformed as physicians and medical institutions prepare to meet the demands of the Patient Protection and Affordable Care Act and an estimated 32 million newly insured health consumers entering the medical insurance system from 2014 to 2016. The changes taking place before our eyes are so profound and many so subtle that lawyers who are not closely observing the medical field could easily miss both the great opportunities and the perils posed by the new era.

Medical malpractice cases that will succeed in the future may look quite different from the cases of the past. The defendants will be different, grounds for liability will be different, and even the forums for dispute resolution will be different. To win, a lawyer must be prepared to approach new legal and factual challenges for which their experience in the field may not have prepared them. This chapter briefly surveys these changes in order to offer a foundation for subsequent chapters dealing in depth with the legal ramifications of these changes. We recognize that others will have divergent views of this revolution (or evolution) and that this controversial field invites strong adversarial feelings. The new medical malpractice case is different. A prudent lawyer must discard old assumptions of what a medical malpractice case looks like and see it through a new set of lenses.

1:1 The World of Rapid Change

The medical world is rapidly changing from private physician practices to a combination of service locations including hospitals, community care and private clinics, storefront kiosks, and walk-in centers.

With the extension of medical care to new settings, new legal considerations come into play. A charity or nonprofit hospital may be immune from liability under state law. Community care centers and free clinics are likely to be immune from
state-court malpractice claims under the Federal Tort Claims Act (FTCA). A store-front kiosk located in a Kmart, Kroger, Target, CVS, or supermarket chain store is part of a larger business corporation and no longer will be treated the same legally as a private medical practice—and certainly not subject to the immunities historically granted to hospitals or community clinics. Hence, where the alleged medical malpractice took place matters. A lawyer must take a higher-level view of each new institution where medicine is being practiced in the new era. A lawyer must know the legal status of each institution, the institution’s available defenses, and its corresponding vulnerabilities. The new medical malpractice case is different. A prudent lawyer must discard assumptions of what a medical malpractice case looks like, and this chapter offers a bird’s-eye view of a rapidly changing landscape.

1.2 The Care Environment Is Changing

The rapid rise of community care clinics and free clinics requires a radically different approach to legal cases of medical malpractice that will arise in these settings. The Affordable Care Act may greatly expand the number of community health centers, if Congress actually provides funding for Health and Human Services (HHS) to implement the law. The act authorized $11 billion over the next five years, $1.5 billion supporting major construction projects at community health centers, and $9.5 billion providing community health centers in underserved areas. The Health Centers Trust Fund (“the Fund”) is found in section 10503 of the Patient Protection and Affordable Care Act1 and section 2303 of the Health Care and Education Reconciliation Act of 2010.2 In the latter law, Congress increased the Fund from $7 billion to $9.5 billion. Three hundred fifty new sites were expected in 2011, but the actual number is constrained by each year’s appropriations.3 The full expansion would build upon the 8,100 sites of neighborhood health centers across the nation, treating 19 million Americans. The government expects these centers to take on a great burden when 32 million Americans enter the system in 2014.4 8 of an estimated 32 million uninsured begin to “enter the system for the first time in 2014. Only 8 million have entered so far. But, it is picking up speed. The New York Times just reported that health care costs are highest in close to a decade due to the spike in new visits. This will continue.

The little-known fact that makes malpractice lawyers cringe is that Congress directed that these community care and free clinics be immune from liability under

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3. See generally chapter 8: Health Centers’ Immunity from Medical Malpractice.
4. Id.
the FTCA. Hence, the very fact that a medical error had taken place in one of these institutions may require an entirely different legal approach. Strict administrative and procedural rules must be followed. The FTCA provides that there are no punitive damages, no state-court jurisdiction, no prejudgment interest, and no trial by jury in a federal district court. The administrative claims are filed with an office deep within HHS, not in a local court. Most importantly, the individual medical personnel are completely immune from liability. The medical malpractice claim is against the U.S. government alone. The shift of care from private practitioners to clinics has radical legal implications for the lawyer evaluating a medical malpractice claim.

Chapters 8 and 9 explain how the FTCA requires acquiring a new set of skills in building a case and a set of stringent rules to understand. The defendant’s lawyer must be ready to claim the jurisdictional protection, for the FTCA extinguishes the liability of the defendant and shifts it onto the federal government. The initial claim filing must insist on a specific “sum certain,” and exactitude in figures is important. The civil tort practitioner is compelled to shift from the mindset of a litigator to that of a forensic accountant, constructing a case for the damages claim from invoices and expert analyses of future costs. For the plaintiff, the likely opponent is no longer a local medical malpractice lawyer but a distant bureaucrat or U.S. Attorney. It is a different kind of case to build or defend, requiring different strategies, skills, and legal considerations.

1:3 The Shift of Physicians from Private Practice to Hospital Employment Is Changing the Fundamental Experience of the Patient

The rapid rise of hospital-employed physicians requires a different approach to legal cases of medical malpractice arising in this context. The Affordable Care Act’s passage led to the acceleration of the exodus of physicians from private-practice settings to become affiliated with hospitals and other health-care systems. By the end of 2013, Accenture predicted over two-thirds of physicians would be employed by hospitals and health-care systems. This changes the fundamental nature of the experience of the patient, historically treated by local physicians in private offices and now, by necessity, turning to health systems for the delivery of medical care.

A medical error arising in a hospital today requires a different set of considerations. While historically lawsuits against hospitals have a far higher rate of success

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than those against individual physicians, other legal theories and strategies must come into play in litigating against an institution.

The common law governing hospitals arises out of a historical societal consensus about the benevolent nature of their work. For example, the classic doctrine of charitable immunity meant hospitals did not have to endure the risk of state tort judgments. While the majority of jurisdictions have abolished this doctrine, it is still the law in a number of states and, where available, it shields hospitals from tort liability. In Massachusetts, the damages for medical malpractice are capped at $20,000 for verdicts against a charity hospital. Thus, when evaluating a medical injury in a hospital, a state-specific analysis is necessary to determine if a hospital can even be held liable for substandard medical care. Similarly, there are different immunities that can come into play in the course of a patient’s stay in a hospital that would not even have been considered if medical malpractice takes place in a private medical practice. Emergency medical services personnel may be immune from liability or held to the more difficult-to-prove standard of gross negligence. Emergency room professionals may be given statutory immunity or held to higher standards of gross negligence as well. In today’s world, lawyers cannot presume that hospital mishaps will result in liability until the nature of the institution, the players, and sites of care are all explored.

In the next chapters, we will summarize the different legal theories that lawyers are successfully using today to attach liability to hospitals and other institutions. The theories that have taken on a new relevancy in this emerging era of institutional affiliation include:

1. respondeat superior, a doctrine that permits a hospital to be vicariously liable for the acts of employees;
2. negligent supervision, a doctrine that allows the institution to be held accountable for its hiring, retention, and supervision of an employee;
3. enterprise liability, a doctrine holding the hospital wholly responsible for negligence that takes place within the institution, absolving the individual employees of liability for their own negligence; and
4. apparent agency, holding the hospital responsible for the negligence of non-employees if representations led the patient to believe the institution was in charge of care.

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6. See chapter 2: The New Medical Malpractice Defendants.
In addition, garden-variety principles of negligence will be discussed here, as hospitals are increasingly held accountable for nonmedical failures to exercise reasonable care, such as failing to have emergency generators for electricity or evacuation plans in the case of an emergency.

In this new era, defense lawyers must be careful in determining whether they seek to shield the institution, the individual employee, or both. For example, contracts that clearly define medical professionals as independent contractors may prevent the doctrines of respondeat superior or negligent supervision from being asserted because the medical professionals are making all their own decisions without direction from the hospital. Similarly, well-crafted consent forms signed by patients may explicitly release the hospital from responsibility for the medical care after the patients acknowledge that their care is being provided by an entirely separate entity. Hospital-wide “quality control” programs provide another defensive shield against the imposition of liability, if properly documented.

Thus, the evaluation of a medical malpractice case in a hospital setting will require a different approach to tackling the legal issues. The lawyer needs to determine the nature of the hospital, profit or not, whether forms of immunity apply, and if so, how and whether the medical professional could be deemed an employee or agent subject to the control or supervision of the institution. The different times when an injury could have occurred need to be checked off against various potential immunities that may shield the institution and the medical practitioners. The lawyer needs to determine where the blame can reasonably fall: with the hospital, the medical professionals, or both. The way to systematically approach these legal issues from the first client interview to the jury verdict will be further discussed in the next chapters.

1.4 Retailer Medical Service “Kiosks” Are Changing the Way Medicine Is Practiced

The rapid rise of commercial health-care kiosks in supermarket and department-store chains requires a different approach to the future legal cases of medical malpractice that will arise in this setting.

Pharmacy giants and general retailers are expanding their health care kiosks in anticipation of the 32 million new patients. “Kiosk” is a generic term for walk-in medical clinics in pharmacies, grocery stores, and retail stores, which are expanding in anticipation of the new surge in business that may appear with the expansion of Affordable Care Act in 2014. Already, visits to these clinics increased from 1.48 million in 2007 to 5.97 million in 2009, and soared to 10
million in 2011–2012. The number of these kiosk clinics is up to 1,432 and is expected to almost double to 3,200 by 2014. The services will also be expanding from routine check-ups, prescriptions and vaccinations to providing regular care of common chronic conditions such as diabetes and high blood pressure.

The effective response to medical malpractice in walk-in clinics requires a different legal approach. The lawyer is not looking at suing a long-trusted hospital, a well-established medical clinic, or even a private medical practice. Instead, the lawyer is looking at a supermarket, a superstore, or a commercial enterprise that has created a systematic approach to the hiring and supervision of nurse practitioners, physicians, and assistants to deliver routine care. Many of these chains are self-insured and many have lawyers who view these on-site injury claims matters in practical terms, like slip-and-falls. These chains have explicit rule books, clear practice guidelines, and documentation required of the nurse practitioners and assistants ordinarily entrusted with care. Hence, this is an area where medical malpractice claims may be easier to settle, as there are ample resources, no immunities, and a businesslike approach to legal matters. It is not clear whether the traditional defendant’s medical specialty defense lawyer will have a significant role in this new world where corporate law departments manage these claims with all other types of claims.

In chapters 4 and 5, we discuss why litigating a medical malpractice case against a retail store’s health clinic is different, and why these cases will require a different approach to succeed. In chapter 7, we hone in on the special risks for retailers.

1:5 The Expansion of the Practice of Medicine to Nonphysicians Changes the Face of Medical Malpractice

The medical professionals who provide the first line of treatment to patients will increasingly not be physicians. This will necessitate a different approach to legal
cases alleging medical malpractice by nonphysicians, as they are systematically taking on the traditional roles of physicians in front-line diagnosis and care decisions.

Just as the scope of medical institutions is expanding, so is the scope of what society defines medical professionals to be, and again, the change carries profound legal implications. As of July 2013, at least 17 states have already permitted nurse practitioners to diagnose, treat, and prescribe medications to patients without physician oversight. Legislation is pending in five big states.10

Reports have estimated that 32 million newly insured persons with Medicaid or with a newly subsidized health insurance policy, bought through an Affordable Care Act state exchange, will enter the medical insurance system in 2013. There are not enough physicians to meet the needs of these patients in 2014. As of April 2013, efforts to expand the scope of medical practice to allow use of more nonphysicians were pending in 38 state legislatures.11 Does this mean optometrists, nurse practitioners, and pharmacists may be hanging their own shingles? Not necessarily. But the dynamics of medical care are changing rapidly, and so the medical liability environment is changing inexorably.

If the recent effort in California retail-store kiosks signals a trend, we can expect medical care to be rendered over pharmacy counters and optometrist chairs, as well as in physician exam rooms. This alters the landscape that once had been one patient versus one doctor. This is a significant change; the law has not yet caught up with the wholesale movement toward use of nonphysicians to provide first-line medical care, a trend that is taking place across the nation. Traditionally, a medical professional nonphysician was deemed to be directed or supervised by a physician. The physician was liable for that person’s acts under the theory of respondeat superior. Who will be accountable now? Will the newly deputized nurse practitioners, optometrists, and other nonphysicians treating the patient be held to the same standard of care as physicians? Or when medical errors occur, will there be two standards of care: one for those who can afford to see physicians in sleek offices and concierge-care settings, and a lower standard for those who cannot afford to pay for the top level of medical care?

A lawyer must be aware of the novel nature of medical malpractice cases that may arise. This uncharted terrain is yet to be explored in the legal literature. Advanced practice nurses can obtain their own medical malpractice insurance. But can the nurse still receive protection if the scope of care goes beyond what has been permitted in


the past? Will insurers feel comfortable with this new proposition? Will state legisla-
tures, judges, or juries be comfortable with the substitution of a nurse practitioner for
a physician? Will it matter who provides the care once an institution is implicated?

In the next chapters, we will discuss the practical steps needed to determine
both the scope of practice and standard of care for a nonprofessional. In chapter 7,
we will discuss the role of the nonprofessional within the context of the retail care
center kiosk.

1:6 The Affordable Care Act Is Transforming
the Medical Malpractice Landscape

In summary, the movement of medical care to new supermarket kiosks, hospitals,
and clinics and away from physicians to nurse practitioners and others will require
a new look at medical malpractice law.

In 2014, the realities of how medicine is practiced have changed. A lawyer’s
approach to a potential client’s litigation request must yield to the realities of our
time. Immunities abound to shield doctors and hospitals from the prospect of judg-
ments arising from their medical errors. The data shows that the medical errors
continue, but the remedy will be decided by three paralegals in a federal office in
Washington, and not in the state trial courts.

The market’s changes will be reflected in the “strange bedfellows” of tort actions
arising out of these remarkably different medical contexts. Negotiations may take
place with corporate lawyers at headquarters of grocery chains. The defendants
may not be physicians, but may be the corporate employers of nurse practitioners
or other nonphysicians who are entrusted by profitable (or nonprofit, in some
cases) institutions to provide front-line diagnostics and treatment to families seek-
ing medical care. It is a new world, not “your father’s old way of suing doctors,”
and a lawyer must see it with fresh eyes.

Individual defendant doctors’ home offices would have been the venue in the
1960s or 1970s model of malpractice litigation. Trusted neighborhood family prac-
titioners smiled at the jury pool from behind the defense table, and jurors could
show them courtesy in the recognition of their individual sacrifices and commu-
nity involvements. That was then—this is now. As institutions play a greater role
in shaping the delivery of medical care, we can expect the increasing acceptance
of legal doctrines that recognize the new realities. “Enterprise liability,” a concept
touted in law-reform journals, should begin to gain greater acceptance, as it holds
accountable the organization that had supervisory responsibility and imposes on
that mega-institution a financial liability for medical errors and shoddy malpractice.
“Negligent supervision,” a closely related concept, should begin to be considered as
well in the context of remote delivery of care. For the plaintiff seeking redress, these theories need to be plumbed because they permit discovery of the guidelines, the rules, and the medical and employee records that reveal the role of the institution vis-à-vis the medical professional who was rendering primary care.

For the doctor-as-defendant, these new theories can absolve the medical professional by shifting the liability onto the institutional sponsor of his or her clinic or kiosk. Sitting at the defense table is the polished executive of the grocery or drug store chain whose corporate jet flew in for the trial. Whatever merciful acceptance of error jurors might have given to a generous local doctor will be absent from these corporate defense trials.

The following chapters will elaborate on what a lawyer must do to succeed in the new world of medical malpractice and the impact of the big changes on even the smallest actions that are ordinarily taken for granted as routine, such as ordering medical records or filing a case in court.

1:7 A Technological Revolution Is Changing the Way Medicine Is Practiced and Lawyers Prepare Cases

Federal incentives have sparked a technological revolution transforming the way medicine will be practiced day in and day out. In a new world where virtual medical visits will be recorded by electronic digital recordings and consent granted in video frame 03:22 of virtual meetings, the lawyer will need to understand the legal and technological impact of this revolutionary shift in care.

The shift from paper to electronic medical records has profound legal implications. For medical practitioners, notes have been written on paper for as long as paper has aided healers and shamans. Now, the doctors’ trusty notepads have been exchanged for the tablet computer, and physicians have a new parameter: each doctor’s notes of clinical interactions with each patient are prompted on the display screen and must follow the format of the computer programs. To maximize efficiency, the screens are meant to be written concisely and read in a short passage of narrative. The use of screens leads to a more concise way of discussing medical histories. It allows for the easy-to-read transfer of medical information from one doctor to another or from one office to another.

On the whole, electronic records represent a huge leap forward in patient care. But the new format creates its own medical malpractice risks. Word limits on records management software often mean that the subtleties of medical diagnosis are the length of a “tweet,” so the minute details and nuances may be missed. The patient’s medical history may be repeatedly copied, pasted, and duplicated; hence, errors are magnified as they take on a life of their own. The entire security of support of
documents rests on the decisions of corporate executives in headquarters far off from the operating rooms where consequences may be felt when security is breached. The decision to end full security on April 8, 2014, for Windows XP operating system, creates a “hackers’ field day” for the 30.5% of the Windows-based operating systems in the world that rely on that software, showing how security can be compromised by decisions far away from the hospital suite. Experts have already warned that Windows XP-based documents will not receive continuous security support when the Microsoft maintenance of XP formats is no longer protected from hackers. Hospitals using XP-based formats may become vulnerable to hackers until the Windows 7, 8, or later software displaces the older format. Technological glitches create new risks as the care of the patient is no longer handed off among medical professionals who are sharing notes, but is reliant on the messages being securely and accurately recorded and stored in the “cloud.”

Why should patients and their counsel be concerned? The Economic Cycle Research Institute issued a 48-page report documenting 171 errors in 36 hospitals over a nine-week period. The errors were caused by human error in 47 percent of the cases and by computers that moved too slowly, could not communicate, or crashed in 53 percent of the cases. This study shows how the reliance on technology creates entirely new possibilities for medical malpractice. One patient in the study died after transplant information failed to “sync.” Errors continue, yet their impacts expand in severity of risk consequences.

The other major revolution ushered in by the new technology of electronic medical records is the way that the facts of a single malpractice case should be investigated. Built into the patient’s electronic medical record are audit trails that show the time and date the record was accessed, what specific portion was displayed, and what notes are added. In the past, lawyers would sometimes suspect that exculpatory medical records had been created after the fact to embellish a false assertion of diligent responsiveness by the medical staff, but there was no “smoking gun.” Forensic handwriting experts or ink analysis experts would be hired and the question would

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be presented to the jury. Now, the audit trail shows exactly when a particular note had been entered into an electronic record. It shows the moment-by-moment conduct of medical practitioners as the electronic medical record is built. For example, MIT professor Catherine Tucker wrote how a patient was left quadriplegic after surgery. The electronic medical records left a time stamp showing that the anesthesiologist had left his post during surgery on that patient, so the plaintiff’s lawyer changed the focus of the case from the surgeon to the anesthesiologist, who was the proper defendant.\(^{15}\)

This technological revolution changes discovery in medical malpractice. What was once left to surmise is not the certainty of a record that pinpoints lapses in care. This objective record will uncover the record of the surgeon who leaves the room mid-operation but also protect the one who stays.

Discovery is different today than it may have been in 1980 or 1990. As one lawyer advises in his blog, the very nature of the document request should now be worded in 21st-century terms, as both paper and PDF copies, and in the “native” format, so the documents can be viewed through the use of the medical institution’s software program.\(^{16}\) The “native” format can show where alterations were made, the hidden metadata telltale signs of an effort to change seemingly immutable electronic records as if they were paper.

Other electronic records such as the doctor’s cell phone and computer records may also point to lapses of care and provide an objective record of what had transpired and when.\(^{17}\) A peer-reviewed survey of 439 medical technicians published in *Perfusion*, a journal on cardiopulmonary bypass surgery, found that during surgery, 55 percent of the technicians who monitor bypass machines talk on the phone and 49.2 percent texted, 21 percent checked e-mail, and 3 percent posted to social networking sites. Over 78 percent of the respondents believed these practices were significant safety risks.\(^{18}\)

The plaintiff’s discovery team’s electronic records requests should include a request for the “electronic log” showing all the aspects of the medical care recorded in the electronic health record. Cell phone data should be requested at the time of

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operations from all medical personnel. The “smoking guns” are now embedded in the electronic records, and old-fashioned patterned document requests for paper files are a thing of the past. Electronic health records have transformed pretrial discovery, and in the future, electronic health records will reshape aspects of the practice of medicine and the practice of law.

In the next chapters, we will further discuss the practical implications of using electronic records to determine the strengths and weaknesses of a medical malpractice case.

A new set of legal considerations arises when considering medical malpractice assertions in the new forms of medical service. Web-based tools offer “virtual” doctor visits on screen that last about 10 minutes and start at $45. A lineup of physicians and specialists provide virtual visits through videoconferencing software to diagnose a range of conditions. The virtual physicians can write prescriptions for common medications like antibiotics, subject to state pharmacy laws. This “telemedicine market” is expected to grow more than 28 percent from 2011 to 2012, and to reach $27.3 billion in 2016. While telemedicine has long been practiced to reach the few most remote, far-off patients, it is now being viewed as an integral arsenal of the modern medical kit, the 21st-century equivalent of a home visit.19 For instance, in Ohio, Anthem just unrolled its new partnership with a telemedicine company in time for 2014. Doctors chosen by the insurer will offer members live consultations from 7:00 a.m. to 11:00 p.m. over the Web.

The state health regulatory laws have yet to catch up with this 21st-century doctor’s “virtual visit.” Only 10 states allow a special-purpose license or certificate to practice telemedicine across state lines.20 Fifty-seven boards of medicine regulators require telemedicine physicians to be licensed in the state in which the patient is located.21 Fifteen states require private insurance companies to cover telemedicine as if these were face-to-face consultations.22 But the 35 other states leave this issue to the discretion of insurance companies.23 Hence, a lawyer cannot presume a virtual medical visit does not constitute the unauthorized practice of medicine. Nor can a lawyer presume an insurance company will provide coverage for a non-face-to-face encounter, if that physician’s advice would normally have been shielded by

22. Id.
23. Id.
the malpractice policy. A lawyer must examine the state laws and the insurance policy itself to see if language explicitly limits medical treatment and coverage to “face-to-face” encounters by a state-licensed practitioner.

When evaluating the medical error itself, the lawyer should treat the virtual visit as if it were face-to-face. There is no law yet to indicate this kind of medical visit will be treated differently than a traditional doctor’s visit. The “virtual visit” should meet the standard of care that would apply in a face-to-face encounter, with a clearly defined commencement and termination of the relationship. Will symptoms that could only be discovered by a physical examination be missed? It may be the “virtual” visit carries foreseeable medical malpractice risks by the very nature of its limited diagnostic capabilities.

How will the standard of care for telemedicine be determined? A virtual visit by its nature can and often does travel across state lines. What standard will be followed when a virtual visit is with an out-of-town physician? This is a choice of law question: will the court follow the standard of the state of the patient, the physician, or a national standard? It is a contractual question: does the consent agreement require the patient to submit to the jurisdiction of another state? It is also a research question. Each lawyer must check the law of his or her state to determine if physicians must accept the jurisdiction of the patient’s state and/or the insurer to provide medical malpractice coverage to the virtual physician.

The legal complexity of evaluating a 21st-century virtual physician’s visit is shown by the advice offered by lawyers Tara Kepler and Charlene L. McGinty:

Based on the novel jurisdictional issues presented by many telemedicine encounters, telemedicine malpractice risk analyses should begin with the following key questions:

- In what state is the patient located?
- In what state is the physician located?

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25. The Federation of State Medical Boards provides a state-by-state listing of requirements to practice telemedicine. It is updated to 2012. Telemedicine Overview-Board by Board Approach, supra note 19.
26. Id. The list includes the statutory language so it is a very good place to begin any inquiry.
To which state medical board(s) has the physician subjected herself in performing the telemedicine act in question?

Is the physician properly trained to use the telemedicine equipment and did the physician use the equipment properly?

Did the physician fail to utilize available telemedicine technology which could have prevented injury to the patient?

What traditional medical encounters are most similar to the telemedicine encounter in question?

Which state’s laws are more favorable for your client (i.e., statutes of limitations, medical malpractice damages caps, medical licensure laws, standards of care, elements of malpractice, and burden of proof)?

Does either state have telemedicine laws that heighten physician requirements and standards when performing telemedicine acts (i.e., informed consent, medical records, Internet advertising, quality of care, or prescribing medication)?

Does the physician’s malpractice insurance cover the telemedicine act in question? and

Does the physician or telemedicine provider have sufficient assets in the state (or in the United States in the case of international telemedicine activities) in which the patient and hospital are located?

As this laundry list shows, virtual physician’s visits will require a 21st-century approach to lawyering that goes beyond the patient-physician relationship to the relationship of the physician to the telemedicine provider, the use of technology, and choice-of-law questions.

In chapter 6, we will discuss in detail how a lawyer should approach a medical malpractice assertion arising out of a telemedicine encounter.

1:8 The Potential “Gold Rush” of Lucrative Medical Malpractice Cases

Since 2000, medical malpractice cases have declined in frequency. Tort reforms have been enacted by state legislatures across the nation. Required screening or arbitration panels, medical noneconomic caps, periodic payments, limits on lawyer fees, requirements for expert testimony, and other requirements, have discouraged

28. Appendix 3 lists all the statutes in 50 states requiring affidavits of merit or certificates of merit.
29. Appendix 6 lists all the statutes in 50 states providing damage caps.
30. Appendix 9 lists all the statutes in 50 states providing periodic payments of medical malpractice verdict awards.
plaintiffs’ lawyers from pursuing medical malpractice cases. But this trend is likely to reverse, for many reasons.

First, the gold rush of large institutions entering the medical field is likely to create an incentive for plaintiffs’ lawyers to enter the field. For years, there has been a gap between the size of the jury’s medical malpractice award and what actually could be collected after appeal or remittitur. The high cost of medical malpractice insurance for private practitioners often leads to lower levels of coverage than needed to meet the needs of an injured patient, easily rising to millions of dollars over a lifetime. Depending on the state, individual practitioners may carry no or very little coverage. Only seven states require coverage at all, ranging from $100,000 to $1 million an occurrence. Even this coverage is hardly enough for an injured patient who will need lifetime medical care. Jury verdicts are routinely slashed to fit within the physician’s coverage limits. With the entrance of corporations, drug stores, hospitals, insurers, and the government, the chances of actually collecting a judgment have changed for the better. This “gold rush” of large institutions entering the medical field is likely to create an incentive for plaintiffs’ lawyers to enter the field.

Second, the 32 million patients who received subsidized insurance options in 2014 will create statistically greater odds of medical malpractice cases being filed in 2014, simply because there will be more patients that will be diagnosed, many for the first time. John Hopkins researchers reviewed 25 years of U.S. Medical Malpractice payouts and found diagnostic errors account for the largest fraction of medical malpractice claims and payments, totaling $38.8 billion between 1986 and 2010. In one recent review of electronic records, researchers found diagnostic errors from over 70 different doctors in primary care settings in two large healthcare systems, 80 percent of the mistakes arising in the initial medical examination by a primary care physician. Seventy-three percent of the errors could have led to
serious or considerable harm and 14 percent to death. Professor Barry R. Furrow writes in *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*:

Health care institutions, and their doctors and nurses, injure and kill patients one at a time—unlike pilots in airplane crashes. This statistical phenomenon of scattered casualties over more than five thousand hospitals and thousands of outpatient clinics diffuses the visibility of harm and fogs our awareness of the volume of harms that occur.

In 2014, it is anyone’s guess what the increased risk will be when millions of newly insured consumers converge on the clinics, the retail kiosks, and the community care centers, seeking care for the first time. They would be seen—more likely than not—by practical nurses and not by physicians. The rate of diagnostic errors, already shockingly high by studies from a more relaxed era, is likely to rise.

The risk of a catastrophic medical error does not end with the examination room but continues to the hospital room. A recent study found 27 percent of Medicare patients have at least one “adverse event” or suffered temporary harm while receiving hospital care. Another recent medical study found one in three hospital patients suffered “adverse events” in the course of a hospital stay. For all Americans, at least one million will be injured this year in the course of medical treatment; of these, 98,000 will die.

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40. This famous study predicted between 44,000 to 98,000 deaths per year. Inst. Med., *To Err is Human: Building a Safer Health System* 26–27 (Linda T. Kohn et al. eds., 2000). More recent studies relying on new electronic medical records indicate even this high figure may be woefully low. see Classen, *supra* note 38.