Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 9/8/05 **Meeting Type:** Public Hearing

Location: 412 East State Capitol

Committee Member	Present	Absent	Excused
Representative Curtis Gielow, Chair	☑	☐	☐
Representative Mike Huebsch	☑	☐	☐
Representative Ann Nischke	☑	☐	☐
Representative Jason Fields	☑	☐	☐
Representative Bob Ziegelbauer	☑	☐	☐
Mr. David Strifling	☑	☐	☐
Ms. Mary Wolverton	☐	☐	☑
Dr. Clyde "Bud" Chumbley	☑	☐	☐
Mr. David Olson	☑	☐	☐
Mr. Ralph Topinka	☑	☐	☐

Totals: 9 ∅ 1

Julie Sawyer

Julie Sawyer
Task Force Clerk

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cont. Pt. 3

PIC WISCONSIN

Insurance Products • Risk Management Solutions

Cont.

Testimony of PIC Wisconsin to the Medical Malpractice Task Force

September 8, 2005

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

The defendants-appellants health care providers request oral argument and publication of the decision in this case. Oral argument likely will be of assistance to the Court because of the nature and complexity of the issues. They further believe that the Court's decision will provide important precedent for trial courts, lawyers and parties involved in similar cases, and therefore requested that the decision be published.

ARGUMENT

The Zaks raise two issues on their cross appeal: (1) whether the circuit court erred in reducing the $1 million verdict for non-economic damages to the amount of the statutory cap in Wis. Stat. §§ 655.017 and 893.55(4)(d) because the cap is unconstitutional; and (2) whether the circuit court erred in ordering that amounts awarded for future medical expenses in excess of $100,000 be paid into a medical expense fund to be administered by the Wisconsin Patients Compensation Fund pursuant to Wis. Stat. § 655.015 because that statute allegedly works a taking in violation of the Wisconsin Constitution.

If this Court rules in defendants' favor on the direct appeal, this matter will be remanded for a new trial. In that case, the issues raised by the Zaks' cross-appeal are moot unless and until the jury's verdict in the new trial exceeds the relevant amounts set forth in those statutes.

If the Court rejects defendants' direct appeal, however, then this Court must determine what effect the Wisconsin Supreme Court's decision in *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125, ___ Wis. 2d ___, 701 N.W.2d 440, has on the issues raised on cross appeal.

Ferdon held the cap on non-economic damages set forth in Wis. Stat. §§ 655.017 and 893.55(4)(d) is unconstitutional. That does not answer the question of what amount should be awarded to the Zaks here, however, because *Ferdon* did not resolve the question of whether that decision should be applied retroactively to cases, like this one, that were already pending.[1] As explained below, it

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[1] Although the Court held the cap unconstitutional, as detailed below, *infra* § I.D, the Court did not order that additional amounts be paid to the plaintiffs in that case because the Court remanded *Ferdon* to the circuit court to address the related issue as to whether the Wisconsin Patients Compensation Fund (the party who defended the constitutionality of the cap in *Ferdon*) would be obligated to

would be inequitable to retroactively apply a new rule of law with such a substantial impact, like that announced in *Ferdon*, without allowing those likely to be affected to adjust their behavior accordingly. Thus, *Ferdon* should not be applied retroactively to reverse the trial court's ruling here. Alternatively, this Court should remand the case to the trial court for first consideration of the question of the retroactive application of *Ferdon* upon a fully developed record.

The Zaks' challenge to the validity of Wis. Stat. § 655.015 fails because they waived it by failing to comply with the required procedures set forth in Wis. Stat. § 227.40. Alternatively, as in *Ferdon*, this case should be remanded to allow those procedures to be invoked.[2]

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pay any amount in excess of the cap in *Ferdon* or in any case irrespective of whether the cap is constitutional.

[2] It is anticipated that the constitutional issues presented in Zaks' cross-appeal would be addressed in detail in the Fund's responsive brief. PIC hereby joins in, and incorporates by reference, the Fund's argument on the two issues to the extent not inconsistent with the discussion in this brief.

I. *FERDON* SHOULD ONLY BE APPLIED PROSPECTIVELY TO CASES ARISING AFTER THAT DECISION; IT SHOULD NOT BE APPLIED IN THIS CASE.

A. Where A Decision Announces A New Rule Of Law, The Wisconsin Supreme Court Generally Applies Its Decision Prospectively Only To Allow Parties Who Have Reasonably Relied On The Old Rule To Adjust Their Behavior Accordingly.

The *Ferdon* decision should be applied prospectively only, i.e. to cases arising from facts that occurred after the date the decision was released on July 14, 2005. Wisconsin courts generally limit the application of judicial decisions that change settled tort law to prospective cases.

For example, in *Sorensen v. Jarvis,* 119 Wis. 2d 627, 350 N.W.2d 108 (1984) (superceded by statute), the Wisconsin Supreme Court created, for the first time, tort liability for vendors who sell alcoholic beverages to a minor who later injures another while intoxicated. The Court held that its decision would apply only to the parties in that case and prospectively to causes of action that arose on or after September 1, 1984, because the decision overruled three prior cases that had addressed the issue and prospective application would allow Wisconsin residents to prepare for the new potential liability by obtaining insurance. *Id.* at 647, 350

N.W.2d at 118-19. *See also Delvaux v. Vanden Langenberg*, 130 Wis. 2d 464, 488-92, 387 N.W.2d 751, 762-64 (1986) (affirming prospective application of *Sorenson* and refusing to apply new rule to cause of action which arose five months before *Sorensen* was released, even though the case would be remanded and tried substantially after the decision).

A similar result has been reached in numerous cases. For example, in *Koback v. Crook*, 123 Wis. 2d 259, 366 N.W.2d 857 (1985) (superseded by statute), the Wisconsin Supreme Court overturned prior law by making social hosts who knowingly served alcohol to a minor liable to third parties who were injured by the intoxicated minor. Despite the Court's recent *Sorensen* decision, which created liability for vendors under similar circumstances, the Court applied *Koback* only to the parties in that case and otherwise to any injury that occurred on or after September 1, 1985. *Id.* at 277, 366 N.W.2d at 865. The Court reasoned that it was important to allow social hosts sufficient time to obtain proper insurance. *Id.*

Likewise, in *Antoniewicz v. Reszczynski*, 70 Wis. 2d 836, 236 N.W.2d 1 (1975), the Wisconsin Supreme Court abolished the distinction between the duty a property owner

owes to a licensee and the duty owed to an invitee. The Court ordered its decision to be applied to the parties in that case, but otherwise prospectively. *See id.* at 858, 236 N.W.2d at 12. In doing so, the Court relied on its previous decision in *State v. Michels Pipeline Construction, Inc.*, 63 Wis. 2d 278, 303b, 217 N.W.2d 339, 219 N.W.2d 308 n.5 (1974). In *Michels*, the Court noted that prospective application of a new rule of law is appropriate where, among other reasons, "there has been great reliance on an overruled decision by a substantial number of persons and considerable harm or detriment could result to them" if the rule were applied retroactively. *See also Theama v. City of Kenosha*, 117 Wis. 2d 508, 344 N.W.2d 513 (1984) (creating new liability for negligence which causes a child to lose the society and companionship of a parent, but ordering that the new rule be applied prospectively to causes of action arising on or after the date the decision was released).

In *Steinberg v. Jensen*, 194 Wis. 2d 439, 534 N.W.2d 361 (1995), the Wisconsin Supreme Court overruled established case law when it reinterpreted the scope of the physician-patient privilege and held that opposing counsel can contact a plaintiff's treating physician and have *ex parte*

discussions with respect to certain issues. The Court applied the new rule to the parties in the case, but otherwise prospectively because it "represent[ed] a change in the law." *Id.* at 473, 534 N.W.2d at 374.

The Court also voiced concern about the parties' reliance on previous precedent in *Colby v. Columbia County*, 202 Wis. 2d 342, 550 N.W.2d 124 (1996). In that case, the Wisconsin Supreme Court reinterpreted a statute of limitations governing tort actions against municipalities, and overruled past precedent. The Court decided to apply the new rule prospectively only to avoid the injustice and hardship that would apply to parties who had depended on the old rule. *Id.* at 364-65, 550 N.W.2d at 133-34.

B. *Ferdon* Changes The Law.

In each of the cases cited above, the Court was concerned with providing an opportunity for parties who would be affected by the new law to take the change into account when conducting their affairs. There is no dispute that *Ferdon* is a major change in the law of Wisconsin. *See* Pl. Cross Appeal Br. at ix ("If the court decides that the caps on non-economic damages in a non-death case are unconstitutional, *it will change the law* in the State of

Wisconsin." (emphasis added)). Nor can there be any dispute that applying *Ferdon* to cases which arose before that decision was announced would implicate the same concerns which led the Court to require prospective application in the decisions cited above.

Before *Ferdon*, the Wisconsin Supreme Court and Court of Appeals had upheld the statutory scheme governing medical malpractice against every challenge since it was enacted in the mid-1970s, including challenges to the caps on non-economic damages for injury due to medical malpractice.[3] In particular, in 2001, the Wisconsin Court of Appeals upheld the constitutionality of the very cap at issue in *Ferdon* and here. *Guzman v. St. Francis Hosp., Inc.*, 2001 WI App 21, 240 Wis. 2d 559, 623 N.W.2d 776. In 2000 and 2004, the Supreme Court rejected constitutional challenges to caps on non-economic damages for medical malpractice resulting in wrongful death, a provision also included in Wis. Stat. § 655.017, and closely related to the cap at issue in

[3] In *Makos v. Wisconsin Masons Health Care Fund,* 211 Wis. 2d 41, 564 N.W.2d 662 (1997), the Court held that the statute of repose relating to medical malpractice actions set forth in Wis. Stat. § 893.55(1)(b) was unconstitutional, but that decision was overruled in *Aicher*.

Ferdon. See Czapinski v. St. Francis Hosp., Inc., 2000 WI 80, 236 Wis. 2d 316, 613 N.W.2d 120; *Maurin v. Hall*, 2004 WI 100, 274 Wis. 2d 28, 628 N.W.2d 866.

Similarly, addressing the statutory scheme relating to actions for medical malpractice set forth in chapter 655 generally, the Supreme Court in 1977 also rejected a constitutional challenge alleging that the formal review panels provided by the statute violate equal protection. *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1977). And, in *Aicher v. Wisconsin Patients Compensation Fund,* 2000 WI 98, 237 Wis. 2d 99, 613 N.W.2d 849, the Court rejected a constitutional challenge to the statute of repose applicable to medical malpractice actions. *See also Miller v. Kretz,* 191 Wis.2d 573, 583, 531 N.W.2d 93, 97 (Ct.App. 1995) ("medical malpractice statutes in general have been upheld as constitutional").

C. PIC And Others Reasonably Relied On The State of The Law Prior To *Ferdon*.

Given the Wisconsin appellate courts' uniform rejection of constitutional challenges to the caps in particular and chapter 655 in general, it was unquestionably reasonable for PIC to conduct its business in reliance on the cap.

Specifically, PIC and other insurance companies have relied on the non-economic damages cap when calculating premiums and deciding which applicants to insure. R. Biondi & A. Gurevitch, *The Evidence Is In: Noneconomic Damages Caps Help Reduce Malpractice Insurance Premiums*, CONTINGENCIES 30, 32 (Nov/Dec 2003) (available at http://www.contingencies.org/novdec03/evidence.pdf) (insurance premiums are based in material part on actuarial predictions about the amounts that will actually be paid with respect to claims made, and noneconomic damages make up a large percentage of total malpractice costs). Thus, due to the damage caps, PIC charged substantially less for premiums than it otherwise would have. PIC cannot now charge clients increased insurance premiums for past years simply because the law has changed.

Similarly, numerous claims have been compromised or litigated to judgment based on the cap. Those settlements and judgments have been paid and satisfied, and the plaintiffs cannot now seek to reopen. It would be unfair to the parties who pressed their claims in reliance on the validity of the caps under the courts' numerous precedents and were thus left to receive substantially lower awards than those identically

situated plaintiffs who, either by conscious choice or luck, delayed in bringing their claims. Prospective application of *Ferdon* eases this inequity as well. *See Harmann v. Hadley*, 128 Wis. 2d 371, 381, 382 N.W.2d 673, 677 (1986) (noting inequity to parties who previously settled or litigated their claims when new rule is applied retroactively).

When a decision changes the law, as *Ferdon* has, reasonable reliance on the prior state of the law creates interests that the courts take very seriously. This concern, as well as courts' fear of overburdening the judicial system prompt them to provide for prospective application of the new rule of law. *Id.; see also Michels Pipeline*, 63 Wis. 2d at 303b, 217 N.W.2d at 308 n.5.

Although this issue has not been directly decided by the Wisconsin Supreme Court, that Court has made clear in three recent cases that changes in the damage caps should not be applied retroactively. In all three cases, *Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995), *Neiman v. Amer. Nat'l Prop. and Cas. Co.*, 2000 WI 83, 236 Wis. 2d 411, 613 N.W.2d 160, and *Schultz v. Natwick*, 2002 WI 125, 257 Wis. 2d 19, 653 N.W.2d 266, the Court determined that it was unconstitutional to apply changes in the cap retroactively,

whether the change was to increase or decrease the amount of the cap. In each, it was important to the Court that "the amount of recovery, when set by a statute is fixed on the date of injury." *See Martin*, 192 Wis. 2d at 206, 531 N.W.2d at91; *Neiman*, 2000 WI 83, ¶ 19, 236 Wis. 2d at 423, 613 N.W.2d at 165; *Schultz*, 2002 WI 125, ¶ 14, 257 Wis. 2d at 27-28, 653 N.W.2d at 270. Further, both plaintiffs and defendants alike had a strong interest in maintaining the right of recovery and liability in place when the injury at issue occurred, and it was "unfair . . . to unsettle tortfeasors' rights to have their liability fixed as of the date the cause of action accrued." *Schultz*, 2002 WI 125, ¶ 30, 257 Wis. 2d at 34, 653 N.W.2d at 273. *See also Martin*, 192 Wis. 2d at 211-12, 531 N.W.2d at 93; *Neiman*, 2000 WI 83, ¶ 2, 30, 236 Wis. 2d at 417, 428, 613 N.W.2d at 162.

In particular, the *Neiman* and *Schultz* decisions discussed the right of insurers and liable parties to avoid having their liability increased after the injury has occurred. In *Neiman*, the Court reasoned:

> Defendants such as ANPAC, as well as individuals who have purchased a specific level of insurance, would reasonably rely upon the law as set forth by the courts and the legislature. The retroactive application of 1997 Wis. Act 89

> deprived ANPAC, as well as other defendants in tort actions, of a meaningful notice of the potential increase in exposure to claims or an opportunity to increase premiums to pay the expense of this increased exposure.
>
> An individual who purchased insurance in reliance upon the terms of Wis. Stat. sec. 895.04(4) and this court's decisions regarding the constitutionality of retroactive legislation, may not have sufficient coverage for liability in wrongful death claims if the amendment to the statute is applied retroactively.

2000 WI 83 at ¶¶ 21-22, 236 Wis. 2d at 424, 613 N.W.2d at 165-66. *See also Schultz*, 2002 WI 125 ¶ 17, 257 Wis. 2d at 29, 653 N.W.2d at 270.

The *Ferdon* decision certainly raises these same concerns. Coming on the heels of nearly 30 years of decisions upholding the constitutionality of chapter 655, including the very cap at issue here, applying *Ferdon* retroactively would deprive PIC, "as well as other defendants in tort actions, of a meaningful notice of the potential increase in exposure to claims or an opportunity to increase premiums to pay the expense of this increased exposure." *Neiman*, 2000 WI 83, ¶ 21, 236 Wis. 2d at 424, 613 N.W.2d at 165-66. Thus, *Ferdon* should be applied only to cases arising from facts occurring after July 14, 2005 to allow PIC and others affected by that decision to adjust their behavior to take the

change in the law into account. To do otherwise would subject PIC to liability many magnitudes larger than it believed was possible, without allowing PIC a chance to prepare and account for that potential liability. *See Neiman*, 2000 WI 83, ¶ 21-22, 236 Wis. 2d at 424, 613 N.W.2d at 165-66; *Schultz*, 2002 WI 125, ¶ 17, 257 Wis. 2d at 29, 653 N.W.2d at 270.[4]

D. Another Reason Not To Apply *Ferdon* Retroactively Is That It Is Not Yet Final As To How It Will Apply Even To The Parties In That Case, So Its Repercussions Remain Speculative.

Applying *Ferdon* retroactively here could be unfairly prejudicial to the vested interests of other parties as well. While the majority in *Ferdon* held that the statutory cap was unconstitutional, the Court did not reach the related issue raised by the respondent Wisconsin Patients Compensation Fund ("Fund") that the Fund is not required to pay any amount in excess of the cap irrespective of its constitutionality. The Court remanded *Ferdon* to the trial

[4] If the Court believes that a factual record is necessary to establish the extent of PIC's and others reliance on the law pre-*Ferdon*, then PIC respectfully requests that the issue be remanded to the circuit court to allow the development of that record.

court to address that issue. *See Ferdon* at ¶¶ 11 and 118, 701 N.W.2d at 447, 469-70. Should the circuit court sustain the Fund's position on remand, it remains to be seen whether the plaintiffs in *Ferdon* or future cases will contend that the health care defendants, the primary carriers, or some other party(ies) should be liable for the uncapped amounts of the verdict the Fund is not obligated to pay. These collateral consequences of retroactivity obviously would further upset the settled expectations and vested rights of many parties who justifiably relied on the validity of the statute.

II. THE ZAKS' CHALLENGE TO WIS. STAT. § 655.017 HAS BEEN WAIVED; ALTERNATIVELY, THE CASE MUST BE REMANDED TO ALLOW THAT CHALLENGE TO BE RESOLVED PURSUANT TO WIS. STAT. § 227.40.

The exclusive procedure for challenging the validity of an administrative rule is set forth in Wis. Stat. § 227.40, which provides:

> [T]he exclusive means of judicial review of the validity of a rule shall be an action for declaratory judgment as to the validity of such rule brought in the circuit court for Dane County. . . .

Wis. Stat. § 227.40(1). *See also State v. Town of Linn*, 205 Wis. 2d 426, 448, 556 N.W.2d 394, 404 (Ct. App. 1996)

("Sections 227.40 and 806.04(11), Stats., provide the exclusive means for judicial review of the validity of an administrative rule.")[5] If the alleged invalidity of a rule is material to a cause of action or defense in a separate action, "the assertion of such invalidity shall be set forth in the pleading of the party so maintaining the invalidity of such rule in that proceeding" and that party must seek an order suspending the proceedings to allow it to initiate a declaratory judgment action in Dane County Circuit Court consistent with Wis. Stat. § 227.40(1). *See* Wis. Stat. § 227.40(3)(a). Once the Dane County Circuit Court has rendered a declaratory judgment, the court in the underlying stayed proceeding "shall be bound by and apply the judgment so entered." Wis. Stat. § 227.40(3)(b).

The right to assert the invalidity of a rule may be waived, however:

> Failure to set forth invalidity of a rule in a pleading or to commence a declaratory judgment proceeding within a reasonable time pursuant to such order of the court ... shall

[5] There are several exceptions to the general rule set forth in Wis. Stat. § 227.40(2), but none of them are applicable here.

> preclude such party from asserting or maintaining such rule is invalid.

Wis. Stat. § 227.40(3)(c). *See also Racine Educ. Ass'n v. WERC*, 2000 WI App 149, ¶ 24, 238 Wis. 2d 33, 52, 616 N.W.2d 504, 514 (refusing to address plaintiffs' constitutional challenge to Wis. Admin. Code § ERC 33.10 on appeal because "REA did not pursue an action for declaratory judgment.").

The Zaks failed to set forth the invalidity of Wis. Stat. § 655.017 in their pleadings. (R. 2, 7, 15) Nor did they bring the declaratory judgment action required by Wis. Stat. § 227.40(1). Rather, the Zaks first raised the issue in their motions after verdict (R. 52, 54) and, even then, made no effort to comply with the requirements of § 227.40. Accordingly, under § 227.40, the Zaks are precluded from asserting the invalidity of the rule at this late date and this Court should reject the Zaks' cross-appeal.

If the Court declines to find that the Zaks' challenge has been waived then, at minimum, this issue should be handled as it was in *Ferdon*. There, the same attorney who is representing the Zaks also challenged the constitutionality of § 655.015. The Court refused to hear the Ferdons' challenge,

however. As the *Ferdon* court explained the issue in that case:

> Third, is Wis. Stat. § 655.015, which requires the portion of the jury's award for future medical expenses exceeding $100,000 to be deposited into an account over which the Fund has control, constitutional? The parties argue the constitutionality of § 655.015 and the administrative rule implementing it, Wis. Admin. Code § Ins 17.26. The parties have not adhered to the procedure set forth in Wis. Stat. § 227.40 before challenging the constitutionality of the rule and have not considered whether the rule exceeds the authority delegated under § 655.015. Accordingly, we remand this question to the circuit court for the parties to comply with § 227.40 and address the validity of the rule, as well as to be heard on the constitutionality of the statute and rule.

Ferdon, 2005 WI 125 ¶ 12, 701 N.W.2d at 447. If The Zaks' challenge is not rejected outright, then for the same reasons that the issue was remanded in *Ferdon*, their challenge should be remanded here.

CONCLUSION

If the Court reverses the decision of the circuit court and orders a new trial for the reasons set forth in defendants' briefs on their direct appeal, then the Zaks' cross appeal should be dismissed as moot.

If the Court does not order a new trial, however, then for all the reasons set forth above, defendants request that the Zaks' cross appeal be rejected and the decision of the circuit court affirmed. Alternatively, defendants request that this matter be remanded to the circuit court to allow the development of the record concerning the inequity of applying *Ferdon* retroactively to the facts of this case and to require the Zaks to comply with the requirements of Wis. Stat. § 227.40 as to their challenge to Wis. Stat. § 655.015.

Dated this 1st day of September, 2005.

Michael B. Van Sicklen, WBN 1017827
Roberta F. Howell, WBN 10000275

Attorneys for Defendants-Appellants Dr. Jocko Zifferblatt, Infinity Healthcare Physicians, S.C., and Physicians Insurance Company of Wisconsin, Inc.

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. §§ 809.19(8)(b) and (c) for a brief produced with a proportional font. The length of this brief is 3805 words.

Dated this 1st day of September, 2005.

Roberta Howell

Roberta F. Howell

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Wisconsin Court of Appeals

COURT OF APPEALS NOTICE

DECISION

DATED AND FILED

August 31, 2005

Cornelia G. Clark

Clerk of Court of Appeals

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. *See* Wis. Stat. § 808.10 and Rule 809.62.

Appeal No. **2004AP849** **Cir. Ct. No. 1999CV360**

STATE OF WISCONSIN IN COURT OF APPEALS

DISTRICT II

Sean Kaul, a minor, by his Guardian ad Litem,

Attorney Don Prachthauser, Timothy Kaul,

and Susan Kaul,

Plaintiffs-Respondents-Cross-Appellants,

State of Wisconsin Department of Health

and Family Services,

Involuntary-Plaintiff,

v.

St. Mary's Hospital – Ozaukee, d/b/a Cedar

Mills Medical Group, and Wisconsin
Patients

Compensation Fund,

Defendants-Appellants-Cross-Respondents.

APPEAL and CROSS-APPEAL from a judgment of the circuit court for Ozaukee County: Joseph D. mcCormack, Judge. *Affirmed in part, reversed in part and cause remanded with directions.*

Before Anderson, P.J., Nettesheim and Snyder, JJ.

¶1 PER CURIAM. St. Mary's Hospital-Ozaukee, d/b/a Cedar Mills Medical Group, appeals from a medical malpractice judgment in favor of Timothy and Susan Kaul, and their son, Sean Kaul. The first jury trial resulted in a no causation verdict. Cedar Mills claims that the circuit court erred in granting the Kauls a new trial on the issue of causation because of confusion caused by the jury instructions and verdict direction. Cedar Mills also contends that the amount of past medical expenses paid by a collateral source should not be included in the judgment. The Kauls cross-appeal and challenge the amount of postverdict interest, the constitutionality of the cap on noneconomic damages under Wis. Stat. §§ 655.017 and 893.55(4) (2003-04),[1] and the constitutionality of the requirement in Wis. Stat. § 655.015 that future medical expense damages in excess of $100,000 be paid to the Wisconsin Patients Compensation Fund and paid out in periodic payments. We affirm the circuit court's ruling that a new trial was warranted and conclude that the new trial on causation did not violate the five-sixths verdict rule. In accordance with ***Lagerstrom v. Myrtle Werth Hospital-Mayo Health System***, 2005 WI 124, ___ Wis. 2d ___, 700 N.W.2d 201, we uphold the inclusion of the subrogated past medical expenses in the judgment. We also conclude that postverdict interest runs from the first jury verdict and reverse that portion of the judgment. We also reverse that portion of the judgment reducing noneconomic damages by the statutory cap in § 655.017 because the cap was held unconstitutional in ***Ferdon v. Wisconsin Patients Compensation Fund***, 2005 WI 125, ¶187, ___ Wis. 2d ___, 701 N.W.2d 440. No relief is afforded on the other issue raised in the cross-appeal.

¶2 Sean was born on January 3, 1997, at St. Mary's Hospital-Ozaukee. On the morning of January 6, 1997, the Kauls contacted the Cedar Mills clinic to report concerns they had about a change in Sean's feeding. At 12:30 p.m. that same day, the Kauls again contacted the clinic about Sean's condition. The clinic's triage nurse made an appointment for Sean to be seen later that afternoon. When Sean was examined later that day he was lethargic and hypoglycemic (abnormally low blood glucose). He was immediately transported to the Children's Hospital of Wisconsin in Milwaukee. It was determined that Sean had suffered a brain hemorrhage. Sean was rendered profoundly mentally and physically disabled as a result of the brain injury.

¶3 The Kauls commenced this action against Cedar Mills alleging that the clinic's nursing staff was negligent in not arranging for Sean to be seen immediately for examination in response to the Kauls' phone calls on January 6, 1997. At trial, the Kauls' experts testified that Sean developed hypoglycemia and hypovolemia (decreased volume of circulating blood) during the morning of January 6 and that had Sean been evaluated for treatment earlier in the day, he would not have suffered devastating brain damage. The defense experts opined that Sean's brain injury occurred prior to January 6, possibly in utero.

¶4 The special verdict asked the jury to determine if Cedar Mills was negligent and, if so, whether such negligence was a substantial factor in causing Sean's injuries. The verdict directed the jury to answer the damage questions regardless of how the negligence and causation questions were answered.[2] During deliberations the jury asked the circuit court whether the answers to the damage questions should reflect the percentage of liability for which Cedar Mills is responsible or the total amount of damages sustained by the Kauls. The jury wrote that "confusion stems from contradictory interpretations" of portions of the jury instructions. The jury attached to its question portions of the instructions it believed to be contradictory with these passages highlighted:

The amount of damages, if any, found by you should in no way be influenced or affected by any of your previous answers to questions in the verdict.

....

... nor should you make any deductions because of a doubt in your minds as to liability of any party to this action.

....

If you are satisfied that Sean Kaul will require health care or treatment for injuries sustained *as a result of the care and treatment rendered by Cedar Mills Medical Group*, you will insert as your answer to this question the sum of money you find will reasonably and necessarily be expended in the future for that care and treatment.

....

If you are satisfied that Sean Kaul has suffered a loss of future earning capacity as a result of the injuries sustained *as a result of the care and treatment rendered by Cedar Mills Medical Group*, your answer to this question will be the difference between what Sean Kaul will reasonably be able to earn in the future in view of the injuries sustained and what he would have been able to earn had he not been injured. (Emphasis added.)

¶5 The jury was reinstructed to follow the statement that the damage determination "should in no way be influenced or affected by any of your previous answers to questions in the verdict." The jury was also told, "To the extent that you believe that the other highlighted material ... conflicts with that statement, follow that statement." On November 18, 2002, the jury returned a verdict finding that Cedar Mills was negligent but that the negligence was not a substantial factor in causing Sean's injuries. The answers to the damage questions totaled more than $7 million in damages.

¶6 The Kauls moved for a new trial under Wis. Stat. § 805.15(1)[3] on two grounds. They first asserted that the instruction on causation failed to include the paragraph of the standard jury instruction relating to causation and whether
negligence is a substantial factor in producing the injury.[4] They further claimed that the jury instructions and verdict direction to answer the damage questions regardless of how the negligence and causation questions were answered were contradictory, created jury confusion, and resulted in an inconsistent verdict. The circuit court found that the manner in which the damage questions were framed resulted in conflicting instructions to the jury such that it could not determine if the jury properly followed the law. It granted a new trial only on the issue of causation.

¶7 Nearly a year after the first verdict, the trial on causation commenced. The sole verdict question was:

"Was the absence of treatment between 11:30 a.m. and 3:15 p.m. on January 6, 1997 a substantial factor in bringing about Sean Kaul's injuries?" The jury's November 14, 2003 verdict answered "yes." By its motion after verdict, Cedar Mills sought judgment on the original 2002 verdict on the grounds that the order for a new trial was error, the second verdict violated the five-sixths verdict rule because the same jurors had not agreed on negligence and causation, and there were other errors committed prior to and during the second trial. The Kauls moved for judgment on the 2003 verdict and for reconsideration of the circuit court's earlier determination that they had waived the omission of the causation portion of the jury instruction in the first trial. The circuit court granted those portions of the Kauls' motions. It found that the omission of the causation paragraph of the jury instruction undermined the fundamental fairness of the trial and required a new trial in the interests of justice. It was an additional reason for granting a new trial on causation. Judgment was entered and postverdict interest allowed from the date of the verdict on November 14, 2003. The taxation of costs and interest was based on the whole amount of the judgment.

¶8 We review the circuit court's order granting a new trial under Wis. Stat. § 805.15(1) for a proper exercise of discretion. *See* ***Burch v. American Family Mut. Ins. Co.***, 198 Wis. 2d 465, 476, 543 N.W.2d 277 (1996). Cedar Mills contends that we need only examine whether the jury instructions correctly reflect the law and since the instructions here pass legal muster, no further inquiry is needed. *See* ***Lutz v. Shelby Mut. Ins. Co.***,70 Wis. 2d 743, 750-51, 235 N.W.2d 426 (1975). However, the instructions need not be legally incorrect to support the granting of a new trial. "Misleading instructions and verdict questions which may cause jury confusion are a sufficient basis for a new trial." ***Runjo v. St. Paul Fire & Marine Ins. Co.***, 197 Wis. 2d 594, 603, 541 N.W.2d 173 (Ct. App. 1995).

¶9 ***Runjo*** illustrates how legally correct instructions, when viewed in light of the direction on the special verdict, can result in jury confusion supporting a new trial. *See* ***id.*** at 604 ("The fact, however, that each instruction *alone* was not erroneous does not salvage the reversible error."). In ***Runjo***, a new trial was ordered because of a very similar juxtaposition of the special verdict direction and the jury instructions at issue here—the jury was directed to answer the damage questions regardless of how other questions on the verdict were answered and yet the jury was instructed that damages were to be related to the harm caused by the defendant's medical malpractice. *Cf.* ***id.*** at 603-04. Here, the jury found that Cedar Mills' negligence was not causal but then entered damages caused by Cedar Mills' treatment. It was inconsistent.[5] As in ***Runjo***, the result could only have arisen from confusion. ***Id.*** at 605.

¶10 Cedar Mills charges that the circuit court engaged in mere speculation in theorizing that the jury was confused. It equates the circuit court's ruling with that made by the circuit court in ***Burch***, 198 Wis. 2d at 472, that "the jury either didn't understand or didn't listen to the 1021 jury instruction ... which I gave them and they may or may not have been sidetracked by [defense counsel's closing] argument." (Alteration in original.) In ***Burch***, the circuit court's order granting a new trial was reversed because the circuit court's rationale was "purely speculative." ***Id.*** at 477. Here, the circuit court's ruling cannot be characterized as speculative as that in ***Burch***. The circuit court pointed out that the jury itself exhibited confusion and that it was unable to assess whether the jury properly followed the law. That the circuit court made reference to being able to only "speculate" on the effect of the supplemental instruction does not detract from its conclusion that the jury instructions and verdict direction conflicted. The circuit court was not confident that the supplemental instruction actually cured the jury's confusion. It certainly did not correct the conflict between the instructions and the verdict direction. The circuit court stated adequate grounds for granting a new trial in the interests of justice and we defer to that determination.[6] *See* ***Krolikowski v. Chicago & Nw. Transp. Co.***, 89 Wis. 2d 573, 581, 278 N.W.2d 865 (1979); ***Sievert v. American Family Mut. Ins. Co.***, 180 Wis. 2d 426, 431, 509 N.W.2d 75 (Ct. App. 1993), *aff'd*, 190 Wis. 2d 623, 528 N.W.2d 413 (1995).

¶11 We also conclude that the Kauls did not waive their right to seek a new trial based on the confusion

created by the instructions and direction in the verdict. Cedar Mills contends that the potential confusion issue was waived when the Kauls agreed to the supplemental instruction. *See* ***Olson v. Williams***, 270 Wis. 57, 69-70, 70 N.W.2d 10 (1955) ("By participating with the court in formulating the written statement and consenting to such means of communication with the jury, the counsel waived possible error with respect to the procedure employed in so further instructing the jury."). The Kauls had earlier raised their contention that confusion would exist. The issue was preserved for further review. They were not required to reassert the same argument. *See* ***Peil v. Kohnke***, 50 Wis. 2d 168, 211, 184 N.W.2d 433 (1971); ***State v. Bustamante***, 201 Wis. 2d 562, 571, 549 N.W.2d 746 (Ct. App. 1996). ***Olson*** does not apply here because the Kauls are not objecting to the supplemental instruction. Also, the failure to object does not preclude the circuit court from granting a new trial in the interests of justice. *See* ***Richards v. Gruen***, 62 Wis. 2d 99, 110-11, 214 N.W.2d 309 (1974) ("It does not follow [from the lack of objection] that a trial court cannot grant a new trial in the interest of justice when it is of the opinion that justice has miscarried or a verdict is returned based upon erroneous instructions [of] law."); ***Behning v. Star Fireworks Mfg. Co.***, 57 Wis. 2d 183, 188, 203 N.W.2d 655 (1973) (circuit court judge may, sua sponte, order a new trial).

¶12 Because the circuit court's order granting a new trial is affirmed on the ground of jury confusion and the conflict between the verdict direction and the jury instructions, we need not fully address the circuit court's determination that omission of the causation portion of the negligence instruction also necessitated a new trial. *See* ***Runjo***, 197 Wis. 2d at 596 n.1 (only dispositive issues need be addressed). We summarily reject Cedar Mills' contention that the circuit court lacked competency to reconsider its decision that the Kauls waived the error in omitting a portion of the instruction and that the omission was not of sufficient import to support a new trial. Causation was a critical inquiry in this case because of the progressive development of Sean's condition and the possibility that it developed in utero. The omitted causation paragraph would have provided the jury with critical information on that inquiry.

¶13 Wisconsin Stat. § 805.09(2) provides: "A verdict agreed to by five-sixths of the jurors shall be the verdict of the jury. If more than one question must be answered to arrive at a verdict on the same claim, the same five-sixths of the jurors must agree on all the questions." Cedar Mills argues that judgment on the 2003 verdict violates this five-sixths rule because the causation question was not answered by the same jurors who answered the negligence and damage questions in the 2002 verdict. We first observe that Cedar Mills waived this issue. At the final pretrial conference before the second trial, Cedar Mills raised a concern that the five-sixths rule would be violated. However, its concern was limited to having the second jury informed of the first jury's finding of negligence.[7] When the circuit court explored whether everything but damages should be retried, counsel for Cedar Mills replied, "I see that problem arising only if we tell this jury that there was a prior finding of negligence. If we don't tell them that, we don't have the problem ...." The pretrial conference ended with the parties agreeing to work on what to tell the jury. Upon the parties' agreement, the jury was not told that a prior negligence finding had been made. The basis for Cedar Mills' objection regarding the five-sixths rule did not come to fruition.

¶14 Cedar Mills asserts that the circuit court improperly bifurcated the negligence and causation issues, thereby ensuring that the essential elements of the case would not be decided by the same jurors. This is a nonissue. "The power of the court, trial and appellate, to limit the issues to be retried is generally recognized." ***Leonard v. Employers Mut. Liab. Ins. Co.***, 265 Wis. 464, 470, 62 N.W.2d 10 (1953). Although the circuit court may not from the outset bifurcate the issues of liability and damages to be heard by different juries, ***Waters v. Pertzborn***, 2001 WI 62, ¶27, 243 Wis. 2d 703, 627 N.W.2d 497, it is not precluded from ordering a retrial on a limited issue. The five-sixths rule applies to the issues that are the subject of a particular trial.

¶15 The final issue in Cedar Mills' appeal is whether the amount of the subrogation lien for past medical expenses ($259,876.83) should be excluded from the judgment under Wis. Stat. § 893.55(7), which in a

medical malpractice trial permits evidence of compensation received from other sources.[8] Cedar Mills suggests that by enacting § 893.55(7), the legislature intended to exempt medical malpractice cases from the collateral source rule. It contends that recovery of sums paid by collateral sources, particularly where, as here, the subrogated party has waived the subrogation lien, is a windfall.

¶16 In ***Lagerstrom***, 700 N.W.2d 201, ¶22, the Wisconsin Supreme Court held that the correct interpretation of Wis. Stat. § 893.55(7) does not give rise to constitutional infirmities.[9] The supreme court held that § 893.55(7) simply modifies the evidentiary aspect and not the substantive aspect of the collateral source rule. ***Lagerstrom***, 700 N.W.2d 201, ¶46. The substantive aspect of the collateral source rule precludes crediting against damages the compensation the plaintiff receives from collateral sources. ***Id.***, ¶56. Section 893.55(7) "does not require an offset or reduction of any malpractice award by the amount of collateral source payments." ***Lagerstrom***, 700 N.W.2d 201, ¶69. Indeed, the court held that the jury must be instructed to consider collateral source payments only in determining the reasonable value of the medical services rendered and that it must not reduce the reasonable value of medical services on the basis of the collateral source payments. *See* ***id.***, ¶¶72, 74. The jury cannot make discretionary offsets. ***Id.***, ¶73.

¶17 Thus, because the jury did not exclude the past medical expenses paid by collateral sources, the Kauls are entitled to judgment for those sums. This is consistent with the holding in ***Anderson v. Garber***, 160 Wis. 2d 389, 402, 466 N.W.2d 221 (Ct. App. 1991), that medical expenses paid by an insurer are properly awarded even when the insurer waives its subrogation rights.

¶18 In their cross-appeal, the Kauls first argue that postverdict interest should have been computed from the time of the first verdict on November 18, 2002. The circuit court determined that postverdict interest would be calculated from the 2003 verdict because damages were not liquidated until that verdict. However, ***Fehrman v. Smirl***, 25 Wis. 2d 645, 659, 131 N.W.2d 314 (1964), holds that the damages determined at a first trial in a medical malpractice action are liquidated even though the same verdict does not impose liability. In so holding the court recognized that

a defendant, victorious at the first trial, would scarcely contemplate a tender of damages; however, it does not follow that upon an ultimate loss of the case such defendant is protected from the burden of paying interest on the previously ascertained damages. This is especially true when, as here, no question of damages was involved upon the second trial.

Id. *See also* ***Nelson v. Travelers Ins. Co.***, 102 Wis. 2d 159, 170, 306 N.W.2d 71 (1981) ("the existence of multiple verdicts does not render [Wis. Stat. § 814.04(4)] inapplicable, provided the final judgment rests in part upon both verdicts"). We are not persuaded that the constitutional challenge the Kauls launched against the application of the cap on noneconomic damages is sufficient to render the damages unliquidated. *See* ***Nelson***, 102 Wis. 2d at 171 ("the resulting 'uncertainty' in the computation of the amount is not sufficient to overcome the plaintiffs' statutory right to interest under sec. 814.04(4)"). The Kauls are entitled to interest commencing with the November 18, 2002 verdict. The portion of the judgment pertaining to postverdict interest is reversed.

¶19 The Kauls argue that the statutory cap on noneconomic damages under Wis. Stat. § 655.017 is unconstitutional because it violates the equal protection guarantees of the Wisconsin Constitution. Recently the Wisconsin Supreme Court held the cap unconstitutional for that very reason. ***Ferdon***, 701 N.W.2d 440, ¶187. ***Ferdon*** controls and, therefore, we reverse the circuit court's ruling that the cap is constitutional and operates to reduce the judgment.[10]

¶20 Existing precedent controls the Kauls' equal protection challenge to Wis. Stat. § 655.015, which

requires that future medical expense damages in excess of $100,000 be paid to the patients compensation fund and paid out in periodic payments. *See* ***State ex rel. Strykowski v. Wilkie***, 81 Wis. 2d 491, 510-11, 261 N.W.2d 434 (1978) (the delayed disbursement of future medical expense awards and annual installment payments under Wis. Stat. ch. 655 do not deny equal protection of the law). We are bound by that controlling precedent. *See* ***Cook v. Cook***, 208 Wis. 2d 166, 190, 560 N.W.2d 246 (1997). The Kauls assert that no court has yet addressed the arguments they make that § 655.015 violates their right to trial by jury, their right to substantive due process, or that it constitutes an unconstitutional taking without just compensation.[11] The circuit court did not address these claims. Because we are primarily an error-correcting court, not a law-declaring court, and because the Kauls assert these claims primarily to preserve them for review by the supreme court, we need not and do not address constitutional challenges to the periodic payments statute. *See* ***Sussex Tool & Supply, Inc. v. Mainline Sewer and Water, Inc.***, 231 Wis. 2d 404, 416 n.4, 605 N.W.2d 620 (Ct. App. 1999) (declining to address the application of the economic loss doctrine because the supreme court is the appropriate body to decide the issue). The supreme court addressed one constitutional challenge to § 655.015 in ***Strykowski***, and it is appropriate to leave other constitutional challenges to the supreme court.

¶21 We reverse the judgment in part and remand with directions that judgment be entered in an amount not reduced by the application of Wis. Stat. § 655.017, and to include postverdict interest from the November 18, 2002 verdict. Because we affirm on the appeal and reverse on the cross-appeal, the Kauls are entitled to costs under Wis. Stat. Rule 809.25(1).

By the Court.—Judgment affirmed in part; reversed in part and cause remanded with directions.

This opinion will not be published. *See* Wis. Stat. Rule 809.23(1)(b)5.

[1] All references to the Wisconsin Statutes are to the 2003-04 version unless otherwise noted.

[2] The Kauls objected to this direction in the special verdict.

[3] Wisconsin Stat. § 805.15(1) provides:

A party may move to set aside a verdict and for a new trial because of errors in the trial, or because the verdict is contrary to law or to the weight of evidence, or because of excessive or inadequate damages, or because of newly-discovered evidence, or in the interest of justice. Motions under this subsection may be heard as prescribed in s. 807.13. Orders granting a new trial on grounds other than in the interest of justice, need not include a finding that granting a new trial is also in the interest of justice.

[4] The missing portion is found at Wis JI—Civil 1023 and provides in relevant part:

The cause question asks whether there was a causal connection between negligence on the part of (doctor) and (plaintiff)'s (injury) (condition). A person's negligence is a cause of a plaintiff's (injury) (condition) if the negligence was a substantial factor in producing the present condition of the plaintiff's health. This question does not ask about "the cause" but rather "a cause." The reason for this is that there can be more than one cause of (an injury) (a condition). The negligence of one (or more) person(s) can cause (an injury) (a condition) or (an injury) (a condition) can be the result of the natural progression of (the injury) (the condition). In addition, the (injury) (condition) can be caused jointly by a person's

negligence and also the natural progression of the (injury) (condition).

[5] The inconsistency is further highlighted by Cedar Mills' argument to the jury that the damage questions should be answered "$0" on the ground that Cedar Mills did not cause any of Sean's injuries.

[6] We reject Cedar Mills' contention that the circuit court was required to determine that different instructions probably would have produced a different result. That determination is related to whether an erroneous jury instruction probably misled the jury. *See* ***Lutz v. Shelby Mut. Ins. Co.***,70 Wis. 2d 743, 751, 235 N.W.2d 426 (1975). Here we are not concerned with erroneous instructions but with the conflict between the instructions and the verdict direction. Neither ***Runjo v. St. Paul Fire & Marine Insurance Co.***, 197 Wis. 2d 594, 541 N.W.2d 173 (Ct. App. 1995), nor its predecessor, ***Behning v. Star Fireworks Manufacturing Co.***, 57 Wis. 2d 183, 203 N.W.2d 655 (1973), imposed a requirement that the circuit court find a probability of a different result on retrial. We read the circuit court's decision to grant a new trial in the interests of justice for the reason that the real controversy was not fully tried. The circuit court need not find a substantial likelihood of a different result on retrial when it orders a new trial on the ground that the real controversy was not fully tried. ***State v. Harp***, 161 Wis. 2d 773, 775, 469 N.W.2d 210 (Ct. App. 1991).

[7] Counsel for Cedar Mills explained:

I think right out of the box tell[ing] this jury that there was a prior trial and a prior finding of negligence puts us behind in a way that is unfair.... [W]e don't know what the prior jury determined was a negligent act and how that intertwines then with causation because as the court knows, this whole thing was a continuum of progressing events ... and if the prior jury made the determination that the negligent act occurred early at the time of the first phone call, say, versus making a finding on the other hand that it occurred during the second phone call, that affects the whole causation issue and what was causal, and then that translates into do we have unanimity between these two juries, do we truly have a five-sixths verdict.

[8] Wisconsin Stat. § 893.55(7), provides:

Evidence of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for the injury is admissible in an action to recover damages for medical malpractice. This section does not limit the substantive or procedural rights of persons who have claims based upon subrogation.

[9] ***Lagerstrom v. Myrtle Werth Hospital-Mayo Health System***, 2005 WI 124, ___ Wis. 2d ___, 700 N.W.2d 201, was pending when Cedar Mills filed its appellant's brief. In its brief, Cedar Mills asks this court to stay the appeal pending the ***Lagerstrom*** decision and for an opportunity for each party to present its respective arguments on the issue after the decision. We do not need additional submissions from the parties on the issue.

[10] In response to the Kauls' submission of additional authorities, Cedar Mills argues that ***Ferdon v. Wisconsin Patients Compensation Fund***, 2005 WI 125, ___ Wis. 2d ___, 701 N.W.2d 440, should not be applied retroactively to this case. We reject that argument because the Kauls raised their constitutional challenge in the circuit court and preserved it for appellate review. *See* ***Olson v. Augsberger***, 18 Wis. 2d 197, 201, 118 N.W.2d 194 (1962) (a judgment under attack at the time the controlling decision was rendered is entitled to receive the benefits of the new rule announced in the decision). We are bound by controlling precedent on an issue properly raised in this court. *See* ***Cook v. Cook***, 208 Wis. 2d 166, 190, 560 N.W.2d 246 (1997).

[11] Although the constitutionality of Wis. Stat. § 655.015 and the administrative rule implementing it, Wis. Admin. Code § Ins 17.26, was raised in ***Ferdon***, the supreme court did not address the issue because the parties did not adhere to the procedure in Wis. Stat. § 227.40 before challenging the constitutionality of the rule. ***Ferdon***, 701 N.W.2d 440, ¶12. We do not consider whether the Kauls' challenge implicates the administrative rule so that § 227.40 must be complied with. We note that the Kauls gave the attorney general notice of their constitutional challenges to the statute. *See* Wis. Stat. § 806.04(11).

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PIC WISCONSIN

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KEY CONSIDERATIONS

Leading Through Ingenuity

BARIATRIC SURGERY

Bariatric Surgery

"Key Considerations" is PIC WISCONSIN's newest risk management communication. It strives to objectively profile risks associated with new technologies, medical and surgical interventions, treatment protocols, and general care plans. Our risk management team selects issues with high liability risks. They review five to ten years of literature. The team also solicits professional specialty society opinions to augment the data and provide a minimal standard of care benchmark. Our Underwriting/Risk Management Committee reviews their findings and sets guidelines which are distributed to our insured as "Key Considerations." Although PIC WISCONSIN is not in the business of practicing medicine, we hope our vigilance will lead to policies and practices by our insured that will enhance patient safety and contribute to quality outcomes.

The effects of obesity and the increasing use of bariatric surgery as a treatment modality have received considerable publicity and discussion. In the past several months, PIC WISCONSIN received several reports of incidents involving bariatric procedures.

To assist our insureds and mitigate risks associated with bariatric procedures, the Risk Management Committee at PIC WISCONSIN recently reviewed the literature and discussed key risk management considerations of bariatric procedures including patient selection, physician training, and related post-operative care needs.

We strongly encourage our insureds to review the following information and take appropriate steps to limit liability exposures when offering bariatric surgery.

Introduction:

Obesity has reached epidemic proportions in the United States, affecting 30% of adults. Annual direct costs for treating obesity-related medical illnesses are estimated at nearly $51.6 billion; the annual U.S. expenditure on weight reduction exceeds $30 billion.[1] Bariatric surgery is a treatment option recommended for severe obesity in patients who have tried unsuccessfully to reduce their weight through nonsurgical methods. Bariatric surgery includes a variety of techniques using open or laparoscopic approaches. The 1991 National Institute of Health Consensus Development Panel published the following criteria for bariatric surgical candidates from 18 to 55 years of age:

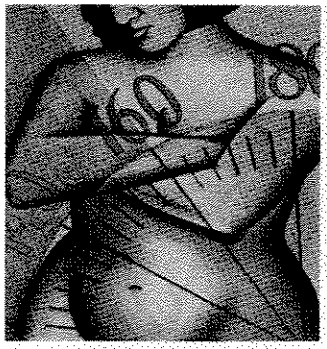
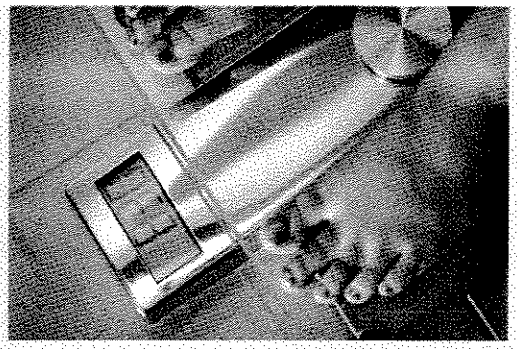
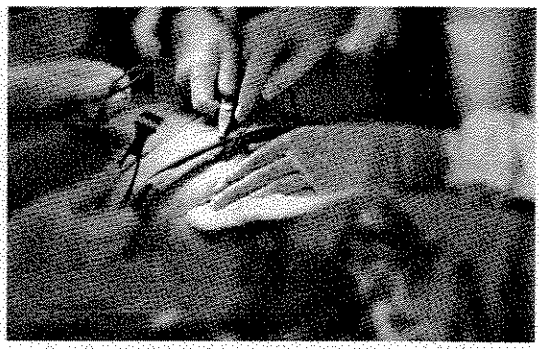
- Body weight
  - Body weight ≥ 45 kg or 100% above ideal weight
  - Body mass index (BMI) ≥ 40
  - BMI ≥ 35 with medical comorbidities (e.g., diabetes, severe sleep apnea, or heart disease)
- Failure of nonsurgical attempts at weight reduction
- Absence of endocrine disorder that can cause morbid obesity
- Psychological stability
  - Realization that surgery itself does not guarantee good results
  - Preoperative psychological evaluation for selected patients[2]

Background:

Bariatric surgery originated in 1953 and 1954 with malabsorptive procedures. Current categories of gastric surgery include: malabsorptive (jejunoileal bypass, biliopancreatic diversion, and duodenal switch), restrictive (vertical banded gastroplasty, silastic ring vertical gastroplasty, and gastric banding) and malabsorptive-restrictive (Roux-en-Y gastric bypass and distal (extended) Roux-en-Y).

Malabsorptive procedures reduce nutrient absorption, typically by bypassing a part of the small intestine. Restrictive procedures decrease the capacity of the stomach, limiting the volume of food consumed before feeling satiated. Malabsorptive-restrictive procedures combine the malabsorptive process with caloric restriction.[3] The trend in approach is shifting from an open procedure to laparoscopic.

Based on research and medical malpractice claims, bariatric surgery involves high-risk procedures on high-risk patients. Bariatric surgery requires the overall care of patients in a

program that addresses both perioperative care and long-term management. Patient education and support is critical to the success of any treatment modality, but with this high-risk population, a well-constructed program that includes careful patient selection and surveillance is crucial. This includes a multi-disciplinary approach to help manage co-morbidities, diet, exercise, and psychosocial issues.[3] Bariatric surgery should only be done with a multidisciplinary process that includes a team of trained professionals that evaluate the patient. The team should include members with a special interest in obesity medicine, behavioral health, nutrition, and bariatric surgery. Having a physician that works with obese patients can be key to providing valuable information and management of other health issues such as sleep apnea.[6]

Research:

The number of bariatric procedures performed has increased from 16,000 in 1992 to 47,000 in 2001 with an estimated 60,000 in 2002. Utilization rates between 1990 and 1997 increased from 2.7 to 6.3 per 100,000 adults. Operative mortality in large clinical series averaged 0.24% after vertical banded gastroplasty and 0.4% after both gastric bypass and biliopancreatic diversion, with a range of 0% to 2% across a large volume of clinical literature. Noted complications include gastrointestinal leak (1-2%), small bowel obstruction (1-3%), hemorrhage (1-4%), pulmonary emboli (0.5-1%), anatomic stricture (5-10%), reoperative rates (1-3.1%), respiratory complications (5.8-10.5%) and a total morbidity rate of 10-15%.[5,6]

Roux-en-Y gastric bypass is the most commonly performed operation for treatment of morbid obesity and the trend is to perform the procedure laparoscopically. Since the laparoscopic approach was introduced, the type and frequency of complications has changed. There appears to be a decrease in wound-related complications (infection, dehiscence/evisceration, and hernia), need for iatrogenic splenectomy, and mortality. In addition, there is reduced risk of retained instruments and laparotomy pads. However, with the laparoscopic approach there appears to be a higher frequency of anastomotic leak, early and late bowel obstruction, GI tract hemorrhage, and stomal stenosis. Anastomotic leak frequency appears to decrease (equals open procedure rates) as surgeons pass the learning curve. A decrease in complications appears to be related to the small access incision and better visualization. Increases in certain complications appear to be related to technique and the learning curve for the laparoscopic approach.[7] Advanced hands on training to master the techniques needed to perform these operations is recommended. Physicians taking this training in bariatric surgery should lead to lower complication rates, improved outcomes, and new research that enrich the surgical treatment of obesity.[8]

Conclusion:

We strongly encourage our insureds to consider all aspects of risk. Physician training and credentialing should receive a great deal of focus. Appropriate training and knowledge of a comprehensive bariatric surgery program are keys to success. The learning curve is generally 100 cases, which results in a decrease in morbidity and mortality rates.[6] In addition, a bariatric surgery program focused on patient safety and mitigating risk needs to be incorporate the following crucial elements:

- Patient selection (contraindications, appropriate services to meet the management needs of patient population)
- Marketing and promotion of bariatric medicine and surgery programs (avoiding potential for misrepresentation/fraud, patient confidentiality)
- Informed consent (adequate information provided to make an informed decision)
- Patient education and follow-up care (multidisciplinary program with procedures and protocols)
- Accurate and high-quality educational materials
- Facility and equipment needs (adequate equipment to accommodate obese patients)
- Services for adequate patient management
- Team of trained professionals including primary care physician with interest in obesity, behavioral health, nutrition

[1] "Bariatric surgery and long-term control of morbid obesity: Contempo Updates," *JAMA 2002*. December 11; 288(22):2793-2796.
[2] "Gastrointestinal surgery for severe obesity: National Institutes of Health Consensus Development Conference Statement." *Am J Clin Nutr*. 1992(55 suppl 2):615S-619S.
[3] "Bariatric Surgery for Morbid Obesity," *Obesity Surgery*. 2000;10:391-401.
[4] SAGE's guidelines for laparoscopic and conventional surgical treatment of morbid obesity. SAGES and ASBS joint collaboration, www.sages.org, 2003.
[5] "National trends in utilization and in-hospital outcomes in bariatric surgery." *Journal of Gastrointestinal Surgery*. November/December 2002; 6(6):855-861.
[6] Tarnoff M, Assistant Professor of Surgery at Tufts – New England Medical Center, 2003.
[7] "Complications after laparoscopic gastric bypass. *Archives of Surgery* Sep 2003. 138:957-961.
[8] "Training and credentialing for the performance of laparoscopic bariatric surgery," *JSLS*. Laparoscopy and SLS Report 2003;15-21.

Key Consideration	Intervention
Patient Selection	BMI greater than 40 kg/m2 or BMI greater than 35kg/m2 with significant co-morbidities and documented failure of nonsurgical (dietary) attempts at weight reduction. Absence of endocrine disorder that can cause morbid obesity. Obesity-induced physical problems that are interfering with lifestyle (e.g., musculoskeletal, neurologic, or body size precluding or severely interfering with employment, family function, or ambulation). Psychological evaluation to rule out any psychopathology that may contraindicate surgery and to provide support for those considering surgery.
Physician Credentials and Training	Credentials to perform gastrointestinal, biliary, and advanced laparoscopic surgery. Successful completion of bariatric surgery course which includes both didactic and one week hands-on program with trained preceptors. Documentation of proctored cases of both open and laparoscopic in which the assistant is a fully trained bariatric surgeon or completion of an approved mini-fellowship program. Documented training in all aspects of bariatric surgery including patient education, support groups, operative techniques, and long-term postoperative follow-up with fully trained bariatric surgeon. Documented successful outcomes of procedures performed. At six months, review of physician's outcome data and comparison to benchmarks in terms of patient safety and results.
Multidisciplinary Program	Specialized nursing care focused on the morbidly obese and postoperative bariatric surgery management. Dietary and nutritional instruction. Counseling—psychological assistance. Patient support groups. Exercise training. Systems in place to provide regular follow-up for five years and manage short- and long-term complications.
Informed Consent	A balanced informed consent process including benefits, risks, and alternatives with appropriate documentation of patient's understanding and acceptance of the risks. Comprehensive patient education that discusses patient expectations, family support, and willingness to comply with post-operative requirements; all aspects should be discussed and well documented.
Facility, Staff, and Equipment Resources	Specialized operating suites with tables to accommodate patients weighing up to 750 pounds. Appropriate retractors, staplers, longer instruments, and other special equipment/supplies unique to the procedure. Radiology and other diagnostic equipment that can accommodate the morbidly obese, if needed. Anesthesiologists specially trained in bariatric surgery and regularly assigned to bariatric surgeries as members of the team. Availability of specialists in cardiology, pulmonology, rehabilitation, and psychiatry. Recovery room and intensive care unit capable of providing critical care to obese patients. Nursing and ancillary staff specially trained in the care of the morbidly obese and management of bariatric surgery patients including intensive respiratory care regimens; assistance with ambulation; recognition of potential problems with intravascular volume; cardiac, diabetic, and vascular conditions; and the use of special beds, chairs, and commodes.
Marketing and Promotion	Carefully worded marketing and promotional materials that are reviewed by legal counsel before publication. Avoid any language that could be construed as a guarantee of weight loss. Avoid the use of superlatives to describe the program/practice (e.g., safer, more successful, routine). Caution in use of patient-specific information (e.g., before and after pictures) without appropriate consent and authorization from patient in writing; keep authorization on file. ■

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Insurance Products • Risk Management Solutions

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PIC WISCONSIN

TRENDWATCH®

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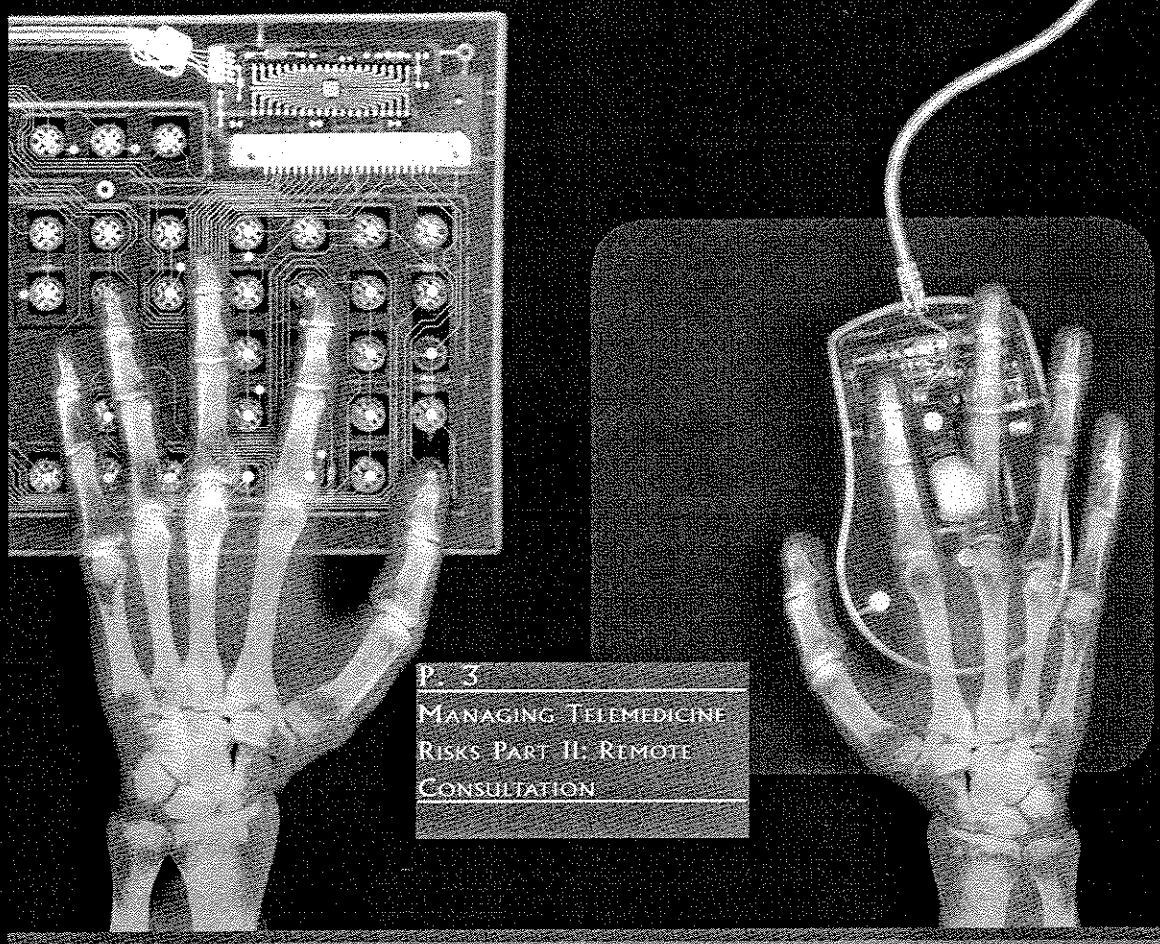

Message from the President

Welcome to our 2004 annual report issue of *TrendWatch*. With so many companies still struggling to manage through the tough market of these past few years, we are proud that PIC WISCONSIN not only weathered the storm better than most, but has returned to its traditional financial norms so quickly, culminating in A.M. Best reaffirming our A– rating with a stable outlook for the eighth year in a row.

This past year, we took the opportunity to update our mission, vision, and values. We started by articulating our passion, which resulted in our new tagline "Defending the Practice of Medicine." Management and the Board collaborated on new versions of our mission and vision. From that, we focused on how to use that foundation to reinvigorate our service, our products, and our brand in new and fresh ways. As you have seen, starting with the last *TrendWatch*, we are instilling that fresh energy in virtually everything you will experience at PIC WISCONSIN.

Meanwhile, we continue to work on several major initiatives. First and foremost is our shareholder's desire for liquidity. While we felt it necessary to withdraw our most recent plan for shareholder value because of the AP Capital hostile share purchase attempt, the extensive time needed for the Insurance Commissioner's review of their request gives us the opportunity to pursue alternative mechanisms. We expect these will satisfy both large and small shareholders' desire for liquidity while maintaining the essential character of PIC WISCONSIN. We have an aggressive timeframe, and certainly hope to have this major project completed by the end of the year. In the meantime, we continue to staunchly oppose the acquisition of shares by AP Capital. From their financials to their culture and mission, we believe they simply are not a fit and proper owner.

We are also in the final phases of upgrading our infrastructure. We are reprogramming how we do business using advanced processes and software named "Catalyst." Our ability to connect, communicate with, and serve our policyholders and agents will lead the industry.

We continue to build our book of business wisely, cultivating accounts that match our values and desire for partnership. To that end, we soon will open the door of our new third-party claims administration unit, taking the knowledge and experience of our claims defense and offering it to self-insureds and risk retention groups who are attracted to our philosophy and our results. The market has become much more competitive, but we have prepared wisely in order to remain a few steps ahead of the competition.

"Defending the Practice of Medicine" is a natural for a company that defends claims as successfully as we do. It is far more than just claims defense: it is preventing claims, it is allowing health care providers to practice medicine the way it should be practiced. This issue of *TrendWatch* continues that dialogue with the second part of our series on managing telemedicine risks, as well as an update on proposed e-prescription regulations. More importantly, whether we are exploring contemporary issues of helping physicians work through delicate communications or defending a claim to the Supreme Court, we want every policyholder's experience of PIC WISCONSIN to validate in bold relief that we are the best in the business.

That has been our mission from the beginning. It remains our passion today.

William T. Montei
President & CEO

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Managing Telemedicine Risks

Part II: Remote Consultation

As technology becomes increasingly sophisticated, so do telemedicine applications. The conclusion of our two-part series discusses the benefits of teleradiology and teleICU programs and suggests strategies for managing their associated risks.

"Telemedicine is new enough that its issues have yet to make their way through the courts," says Wanda Hurr, PIC WISCONSIN senior risk management consultant. "Although the jury is out on many of the legal issues, we can put safeguards in place." While the first part of this series covered cybermedicine and telehealth applications that already affect many physicians' practices, this issue focuses on managing risks for telemedicine applications that can affect the outcomes of critically ill patients in emergency departments and ICUs.

Raising the Bar

Remote consultation is the use of telecommunications to transmit patient information from a local clinic or hospital to a specialist in another location. It is prevalent in cardiology, dermatology, pathology, psychiatry, and radiology. Remote consultation can leverage specialists as part of a clinic or network's telehealth program or as support for emergency departments and ICUs.

"Previously, either the specialist or the patient had to travel for this type of consultation," says Patty Pate, a PIC WISCONSIN senior risk management consultant. "Now the Marshfield Clinic (WI) uses digital electronic stethoscopes and fiber-optic scopes with mini-cameras to examine patients in their local clinic. The information is beamed to a specialist where the sound or image can be manipulated or magnified, making it much easier to diagnose the patient's condition."[1] Tim Flaherty, MD, a Neenah (WI) radiologist and National Patient Safety Foundation Chair adds, "With telemedicine, community clinics and hospitals are able to benefit patients by using specialists at larger hospitals for consultations."

Rising Expectations

A new study reports that lifesaving improvements in technology can also open the door for errors in diagnosis and treatment. In addition, medical advances and media hype can spur unrealistic expectations of complication-free surgery whether the specialist is on-site or consulting remotely. "I blame the media for not using the word 'medical' without putting the word 'breakthough' after it," says AMA President John C. Nelson, MD, MPH. "Not everybody with a heart attack can be saved."[2] Hurr adds, "Patients see spectacular results on TV shows with little discussion of the risks. In today's environment, you must help patients understand the benefits and risks of a given procedure or a remote consultation."

Communication

Good communication begins with a strong informed consent process with your patient and a clear set of roles and responsibilities among members of the medical team.[3] Telehealth settings that have a comprehensive orientation and consent process can help patients and families keep their expectations realistic. Pate also recommends that the physician or telemedicine nurse at the patient's location help the patient get the most out of the consultation by acting as a "host." The host describes what the patient can expect, makes the introductions, closely monitors the patient's body language, encourages questions, and helps the patient feel comfortable.

"While expectations may be more difficult to manage when the patient is critically ill or injured, the same rules apply in telemedicine as in care that is provided in person," Pate adds. The basics include informed consent, a skilled primary contact for the family's questions and updates, and compassionate, frequent, and honest disclosure. (See "The Art of Full Disclosure" in *TrendWatch*, Summer 2004.)

Specialist Consultations

Remote specialist access like the Marshfield Clinic program is usually part of a larger telehealth program with many safeguards already in place. "When you establish a full-blown telehealth program with videoconferencing capabilities and high-speed data transmission, the planning process needs to include a risk assessment that covers the usual areas of concern," says Pate. "Since these programs are typically built on a strong administrative foundation, many of the information technology, disaster planning, licensing, credentialing, and privacy issues are already being managed. It's the marketing communications risks that are sometimes overlooked."

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PROMISES, PROMISES

"Be careful what you tell the press and your patients about your services," says Pate. Your risk manager, attorney, and affected physicians or vendors should review news releases, brochures, and patient fact sheets. Physicians should also obtain legal review on detailed patient fact sheets, preferably from their own attorneys. "I would recommend a legal review for the physician since the other reviewers are looking for corporate issues. For very general materials, a review by the risk manager and a courtesy copy to the physician may suffice, but it's better to be safe than sorry." Avoid problem statements like the following in your materials:

- "You will receive the highest level of care possible" implies that a remote consultation is better than an on-site one. Instead, focus on access to specialists without the inconvenience and expense of travel.
- "We're here for you 24/7" may suggest that your patient has remote access to specialists even when the clinic is closed. Describe the after-hours services you offer.
- "Here's how you can benefit from our program" could be considered a guarantee of a good outcome. "May benefit" is a better choice.

TELERADIOLOGY

Teleradiology—the remote interpretation of radiology studies when an on-site radiologist is unavailable—has become well-established with interpretation sites located throughout the U.S. and abroad. Overseas teleradiology groups offer the very real benefit of nighttime coverage by radiologists who are working days on the other side of the world. These services benefit both providers and patients. The contracting hospital saves money and patients receive quicker turnaround than they would if an on-call radiologist had to be summoned.

WHAT HAPPENS AT NIGHT?

Night services support emergency departments and ICUs from a remote location by providing a preliminary read for the requesting physician's immediate use. An on-site or remotely located radiologist reviews the images the next morning, writes the official interpretation, and takes responsibility for the quality of the images viewed. According to the American College of Radiology (ACR), this radiologist must be board certified, licensed in the states where the transmitting and receiving sites are located, and appropriately credentialed and privileged at

MANAGING REMOTE CONSULTATION RISKS

- Start with a risk assessment and cost/benefit analysis.
- Make sure your insurer covers telemedicine services.
- Enlist top management support and funding.
- Address needs such as additional staffing or hardware upgrades that may be obstacles to your project.
- Encourage staff involvement by emphasizing benefits to both patients and staff.
- Before choosing a vendor, investigate the following:
  - Proof of vendor's insurance.
  - State(s) where vendor is licensed to practice.
  - Whether the vendor can be credentialed by your organization.
  - Vendor's HIPAA compliance.
  - Vendor's finances, business practices, reputation, and customer satisfaction.
  - Installation, service, support, and training the vendor offers.
  - Vendor's risk management resources.
  - Reporting mechanisms to measure patient outcomes and provide feedback.
- Contract carefully. Do the following before you sign:
  - Know your contract.
  - Look for gaps and close them.
  - Plan to use the vendor's expertise in creating protocols, policies, and procedures.
  - Create a clear set of communication guidelines and chain of command.
  - Define documentation requirements.
  - Identify privacy and security safeguards.
  - Establish emergency backup plans.
  - Describe vendor's responsibilities in the event of an insurance claim.
- Develop policies and procedures, including backup plans for power outages, equipment failure, and operator error.
- Be careful what you and your vendor promise in marketing materials, news releases, and online.
- Overcommunicate, train, reinforce, and reward staff.
- Establish an informed consent process that clearly defines roles for on-site and off-site providers.
- Start small and enlarge the program using lessons learned in the pilot phase.
- Track results, reward, and improve.
- Share your successes and keep progressing toward improved patient outcomes.

any hospital for which he or she performs official interpretations.[4]

Observes Hurr, "Because the study is read twice, teleradiology can add a lot of value in terms of access and accuracy." Although the signing radiologist takes most of the risk, both the on-site provider and remote radiologist must have liability insurance.

Remote and On-Site Coverage

Radiology groups with a geographically concentrated service area can offer teleradiology services to smaller hospitals and also provide on-site radiologists who travel to the hospital one or more times a week. Says Gregg Bogost, MD, of Madison Radiologists (WI), "These groups' 3-D work stations, high-speed data transmission, and high quality digital images make it possible for hospitals to receive excellent support from on-site or remote radiologists." A part- or full-time radiologist on-site during the day enables community hospitals to provide a wider range of diagnostic services locally.

Uniform E-Prescription Standards Ahead

The Medicare Prescription Drug Benefit final rule requires that Medicare Part D Prescription Drug Plan sponsors, Medicare Advantage Organizations offering Medicare Advantage-Prescription Drug plans, and other Part D sponsors comply with electronic prescribing standards when the program begins in 2006. As a first step, the Centers for Medicare & Medicaid Services (CMS) are proposing uniform standards for an electronic prescription program to meet Medicare Prescription Drug, Improvement and Modernization Act of 2003 objectives. These goals include patient safety, quality of care, and delivery of care efficiencies and cost savings. CMS expects to have uniform standards in place in 2005 that will be piloted in 2006.[6]

Managing the Risks

The contracting process is critical when choosing a teleradiology service. Both the service and the client must have insurance that covers teleradiology. "While we're not aware of any teleradiology claims appearing in the courts or risk management literature, it continues to bear watching as each decision will shape how we manage telemedicine risks going forward," says Pate. "Technology has evolved more quickly than the law," adds Dr. Flaherty.

As part of the planning process, hospitals must have a teleradiology backup plan in the event of equipment or power failure, operator error, or a disaster. "Hospitals should have a range of solutions from a radiologist who can take call on an emergency basis to a mutual aid agreement with other hospitals similar to what might be developed as part of an emergency preparedness plan," recommends Pate.

Choose Wisely

"Investigate thoroughly before you choose a teleradiology group," Hurr says. "Make sure the following concerns are addressed in the contract and written policies: proof of liability insurance, online security, privacy, ability to subpoena, licensing, credentialing, technology requirements, image quality, archiving and retrieval, reliability, and redundancy." She also advises working with your insurer to make sure all parties understand what is covered and what is not. "Insist that your service provide 'preliminary reads only' unless they are located in your state or in a state with similar laws so jurisdiction shopping won't be an issue in the event of a lawsuit."

TeleICU Programs

Electronic ICUs or teleICUs are, like teleradiology, an innovative response to increased demand for services and a shortage of specialists. In 2000, The Leapfrog Group, a patient safety initiative sponsored by Fortune 500 companies, determined that full-time intensivist staffing in the nation's intensive care units could save 50,000 lives a year. With fewer than 13% of ICU patients receiving intensivist care and demand projected to grow as the population ages, it was time for a new paradigm.

Air Traffic Control

The current dominant teleICU solution is a proprietary software system developed by two Johns Hopkins intensivists, the founders of VISICU, Inc. Their eICU®[5] care model provides software and technology that links the hospital's off-site, intensivist-led team to the hospital's on-site ICU. "Think of it as an air traffic control system," says Martin Doerfler, MD, VISICU's vice president of clinical services. "It provides a comprehensive monitoring system that alerts pilots to changing conditions and works with them to respond safely."

A teleICU program should include the following features:

- On-site ICU staffed by the hospital's medical staff with appropriate hospital credentials and privileges, including intensivists and specialists
- Off-site intensivist-led care team hired and supervised by the hospital
- High-resolution, high-speed, and secure audiovisual and data transmission technology
- Software with the following features:
  - Alerts when a patient's vital signs and other data stray beyond predetermined thresholds
  - Online decision support using frequently updated, evidence-based care guidelines
  - Tracking that measures outcomes, use, and operational efficiency measures tied to Agency for Healthcare Research & Quality (AHRQ) and JCAHO recommendations
  - Dashboard-style interface that gives both the remote and on-site ICU staff access to the patient's chart, plus a review of assigned tasks, and a snapshot of the patient's condition
- Installation, training, and technical support

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Message from the Chair

As your new Chair, I am pleased to present you with PIC WISCONSIN's 2004 financial results. A member of the Board since its founding in 1986, I came to PIC WISCONSIN after serving as a Wisconsin Medical Society (WMS) Director and Chair of the WMS Task Force on Medical Liability. I understood then—and continue to support now—PIC WISCONSIN's role as a physician-governed, stabilizing force in Wisconsin's medical liability market.

In 2004, PIC WISCONSIN stayed the course, focusing on actuarially responsible pricing, loss prevention, vigorous claims defense, and excellent customer service. As a result, we have quickly returned to our usual benchmarks:

- We ended the year with a net income of more than $3.1 million, a return on equity of 3.7%, and an increase in surplus of $13 million, including a $12 million surplus note.
- Our A.M. Best rating remains "A– (Excellent) with a stable outlook" for the eighth year in a row.
- PIC WISCONSIN's combined ratio of 105% substantially outperforms A.M. Best's industry estimate of 133%. Although other industry measures are not yet available, we expect our financial results to again be among the very best in the industry.

Due in part to our company's efforts, Wisconsin is one of only six states the AMA considers stable. In addition to making professional liability insurance available and affordable, PIC WISCONSIN is a strong defender of tort reform. We have defended existing reforms and pushed for new ones by participating in State Supreme Court cases, meeting with legislators, and providing expert testimony. These are some of the ways we support and defend the practice of medicine.

Physicians govern PIC WISCONSIN for the benefit of all our insureds. Of the twelve Directors on the Board, seven are practicing physicians. In addition, both our claims and underwriting committees are composed of physicians who advise our highly qualified technical staff about the medical side of the issues our policyholders face. We work hard to minimize the stress and disruption physicians experience when they're named in medical liability actions. Year after year, 90% of our claims close without an indemnity payment and 80% win at trial, which has made a real difference in the practices and lives of our policyholders.

PIC WISCONSIN will continue to support and protect our policyholders by providing excellent coverage at affordable rates, and effective risk management and claims defense strategies. We plan to continue our measured growth in other states while maintaining our strong position in Wisconsin.

We expect new challenges as the market softens and other insurers enter the market. A proposed purchase of our stock by a publicly traded competitor is a recent example. We have responded by making protective changes to the Company bylaws, and by filing our objections with the Office of the Commissioner of Insurance, which may result in a hearing.

We will maintain our physician-centered values and unmatched defense of non-meritorious claims. I thank our staff and policyholders for a successful 2004, and I look forward to an even better 2005.

William J. Listwan, MD
Board Chair

Physicians Insurance Company of Wisconsin, Inc.
Analysis of Statutory Financial Statements (unaudited)
for the year ended December 31, 2004

The Company posted improved results over the past year, and we continue to build a strong financial profile to serve our customers for years to come. While overall industry results show some improvement, many companies continue to struggle, resulting in additional rating downgrades, insolvencies, and market contraction. The national health care crisis debate continues as providers push for legislative relief from rising numbers of lawsuits and corresponding higher premium rates. The Company is responding to these changing forces, focusing on serving our customers' needs and defending the practice of medicine.

During 2004, the Company recorded statutory net income of $3.1 million, compared to $2.5 million in 2003. The increase in net income was primarily the result of improved underwriting results. In addition, the Company realized $1.9 million in tax benefits related to the deduction of software development costs and improved discount rates applied to unpaid losses.

Our net underwriting loss narrowed to $2.8 million, compared to $4.4 million in 2003. While loss costs continue to increase as a result of rising claim severity and defense costs, the Company has selectively implemented rate increases where appropriate and has taken steps to improve the overall quality of the book of business. As a result of these actions, our net loss and loss adjustment expense ratio improved to 82.9% in 2004, compared to 90.5% in 2003. The operating expense ratio increased approximately four percentage points to 21.7%, primarily due to the elimination of $3 million in ceding commission paid in 2003. The Company's combined ratio decreased 3.4 % to 104.6%, much better than the A.M. Best projected industry result of 133.3%.

The Company's gross written premiums during 2004 decreased $2.5 million to $79.4 million, primarily due to a $4.0 million (27%) reduction in hospital-related business. Most of this reduction was related to higher deductibles and selective non-renewals, including the completed withdrawal of larger hospital accounts in Illinois. The Company recognized modest premium growth in the physician and dental markets. During 2004, 50% of the Company's gross written premiums were derived from Wisconsin, compared to 47% in the prior year. Net premiums earned decreased $5.4 million to $56.5 million in 2004, reflecting the decrease in written premium and adjustments in ceded premium associated with our reinsurance contracts. While management expects to seek further opportunities for profitable revenue growth, we expect increased competitive pressures and smaller base rate increases to slow our rate of growth from previous years.

The Company's 2004 loss and loss adjustment expense ratio was 82.9%, a decrease from 90.5% recorded a year ago. As of December 31, 2004, reported claims for accident year 2004 were down for the third consecutive year, despite a 61% increase in written premiums over the same time period. While we have experienced adverse reserve development on prior year losses in recent years, ultimate losses related to prior coverage years were reduced $3.8 million in 2004. Reported losses from recent years are not fully developed, requiring estimates of future development based on projected loss trends. Where our loss experience is insufficient to discern any meaningful trends, we must rely on industry patterns to estimate our loss reserves. Actual results may differ from these projections. Historically, we have closed 90% of our medical professional liability claims without indemnity payment. During 2004, we won 88% of our trials, consistent with our historical track record. We have been able to achieve these results in all the markets we serve, suggesting that our claims management has proven successful in other states. Over the past several years, the Company's average incurred loss and loss adjustment expense ratio was significantly better than our industry peer group.

The Company recorded net investment gain of $7.8 million, down $274 thousand from a year ago. Net investment income earned was $5.8 million, a $167 thousand decrease from the prior year, despite an increase in invested assets of approximately $30.4 million. The decrease is mostly related to $780 thousand of investment expense associated

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with the surplus note issuance costs and related interest. In addition, a significant amount of cash and cash equivalents were held for a portion of the year in conjunction with funding requirements for the proposed Shareholder Value Plan. These short-term funds have subsequently been reinvested at higher rates. The short duration of our portfolio over the past two years, coupled with strong cash flows from operations, resulted in the reinvestment of funds at a lower rate of interest. Despite historically low interest rates in recent years, the Company continues to generate strong cash flow to meet obligations to our policyholders. As the economic recovery continues, the Company is well positioned to reinvest funds at higher interest rates. The Company realized $2.0 million of net capital gains in 2004, compared to a net gain of $2.1 million last year. The majority of gains relate to our equity portfolio. As of December 31, 2004, the Company had 6.9% of its portfolio invested in high-yield corporate bonds, and 10.6% invested in a diversified equity portfolio. The high-yield and equity portfolios produced respective returns of 10.2% and 15.0% during 2004.

The Company realized $236 thousand in federal income tax expense during 2004, compared to $1.2 million during 2003. Significant book/tax adjustments during 2004 mostly relate to the upfront deduction of software development costs and the continued growth of the Company's loss reserves. The tax penalty associated with growth will decrease as our premium growth rate slows and claims are paid.

Total invested assets amounted to $247.3 million as of December 31, 2004, an increase of $30.4 million from a year ago. Invested assets at year end consisted of the following categories: bonds, 83.7%; short-term investments, 2.1%; common stock, 10.6%; affiliates, 2.3%; and real estate, 1.3%. The bond portfolio, which carries an average overall Moody's rating of Aaa, is composed mainly of short-duration government agency mortgage-backed securities. In addition, the Company holds $16.4 million of high-yield corporate bonds to improve our cash flow yields. Short-term investments consist of money market funds principally invested in government securities. Managed equity investments have a time horizon of seven to ten years and are primarily intended to build surplus. Management continues to focus on opportunities to further diversify our invested assets.

Our strategy is to maintain a high-grade, fixed-income portfolio that ensures funds are available to meet our obligations to policyholders. That accomplished, we augment our overall return by further diversifying investments to maintain a good risk-to-reward balance. Stress testing indicates that we have adequate cash flow to meet our obligations under various interest rate scenarios.

Reserves for unpaid losses and loss adjustment expenses were $140.8 million at year end, an increase of $19.2 million or 16% from the prior year. We determine loss and loss adjustment expense reserves from individual claims and actuarial estimates of future losses based on our actual experience, assumptions, and projections of claims frequency, as well as severity, inflationary trends, settlement patterns, and other factors impacting the health care industry. Reserve estimates may vary significantly from the actual outcome. We continually review and update the assumptions used in establishing reserve levels. We retained a leading actuarial consulting firm to review our reserve assumptions. Our independent actuary analyzed and certified our statutory reserve levels for the years ended December 31, 2004 and 2003.

The National Association of Insurance Commissioners (NAIC) uses a risk-based capital (RBC) formula for property and casualty insurers to help regulators identify insurers who are in financial difficulty. The RBC formula establishes minimum capital requirements based on the risk attributes of each insurer. Also, each state has minimum surplus requirements. The Company exceeds all capital thresholds established by regulatory authorities. In addition, the Company maintains an A- (Excellent) rating with a stable outlook from A.M. Best.

We continue to demonstrate our long-term commitment to the industry we serve. We lead through strong defense and a commitment to claims prevention, remaining adaptable to the needs of the market. Above all, we remain committed to maintaining and enhancing our strong financial profile. ■

Statutory Balance Sheets (Unaudited)
As of December 31, 2004 and 2003

Assets	12/31/04	12/31/03
Investments		
Bonds	**$207,265,713**	$154,473,901
Cash and short-term investments	**5,087,584**	23,956,919
Common stock, at market	**26,168,457**	23,035,933
Common stock of affiliate	**5,566,062**	12,066,420
Real estate, at cost	**1,376,740**	1,376,740
Office building, net of accumulated depreciation of $1,033,607 and $917,845, respectively	**1,855,053**	1,971,740
Other invested assets	–	24,750
Premiums receivable	**17,075,644**	17,797,390
Reinsurance recoverable on paid loss and loss adjustment expenses	**288,983**	97,151
Amounts receivable from deductible policies	**1,234,568**	827,091
Accrued investment income	**1,128,863**	954,880
Data processing equipment	**204,670**	205,356
Income tax receivable	**2,806,322**	3,411,865
Net deferred tax asset	**3,969,951**	3,797,735
Receivable from broker for securities sold	**925,822**	540,250
Total Assets	**$274,954,432**	$244,538,121

Liabilities and Policyholders' Surplus		
Liabilities		
Losses and loss adjustment expenses	**$140,804,458**	$121,635,096
Unearned premiums	**19,193,200**	18,516,072
Suspense premiums	**6,009,736**	4,358,277
Ceded reinsurance premiums payable	**558,410**	4,842,553
Reinsurance funds held	**14,892,084**	15,220,076
Reinsurance payable on paid losses and loss adjustment expenses	**(1,286)**	6,524
Taxes, licenses, and fees payable	**(149,502)**	97,965
Payable for securities	–	112,659
Commissions payable	**1,696,407**	1,823,727
Accrued expenses and other liabilities	**2,650,950**	1,624,871
	185,654,457	168,237,820
Policyholders' Surplus		
Contributed surplus	**17,468,966**	17,422,055
Treasury stock	**(10,200,731)**	(9,849,240)
Surplus note	**12,000,000**	–
Unassigned surplus	**70,031,740**	68,727,486
	89,299,975	76,300,301
Total Liabilities and Policyholders' Surplus	**$274,954,432**	$244,538,121

Statutory Statements of Income (Unaudited)
For the periods ended December 31, 2004 and 2003

	2004	2003
Operating Results		
Direct premiums written	**$79,437,681**	$81,914,848
Ceded premiums written	**(22,271,898)**	(23,288,271)
Net premiums written	**57,165,783**	58,626,577
Change in unearned premiums	**(677,129)**	3,252,065
Net premiums earned	**56,488,654**	61,878,642
Losses and loss adjustment expenses incurred	**(46,813,376)**	(56,024,264)
Other underwriting expenses incurred	**(12,448,709)**	(10,255,374)
Total underwriting deductions	**59,262,085**	66,279,638
	(2,773,431)	(4,400,996)
Net Investment Gain		
Investment income earned, net of expenses of $1,896,034 and $995,349, respectively	**5,819,084**	5,986,329
Net realized capital gains	**1,979,223**	2,085,815
	7,798,307	8,072,144
Retroactive reinsurance gain (loss)	**(643,275)**	–
Other income and expenses, net	**67,247**	(2,137)
Income before dividends to policyholders and income taxes	**4,448,848**	3,669,011
Dividends to policyholders	**(1,108,982)**	–
Income before income taxes	**3,339,866**	3,669,011
Income taxes	**(236,474)**	(1,162,273)
Net income	**3,103,392**	2,506,738

	PIC WISCONSIN		Industry	
Key Ratios:	**2004**	**2003**	**2004**	**2003**
Loss ratio	**82.9%**	90.5%	105%	92%
The loss ratio measures net indemnity and loss adjustment expenses (defense costs) to net premium earned. The lower the ratio, the better the loss experience for the given year.				
Operating expense ratio (based on net premiums)	**21.7%**	17.5%	17%	17%
The expense ratio indicates the proportion of written premiums used to pay acquisition costs, general operating expenses, and taxes. The lower the ratio, the more efficiently the company is operating.				
Combined Ratio	**104.6%**	108.0%	109%	122%
The combined ratio is the total of the loss ratio and the operating expense ratio. A combined ratio <100 indicates the company is earning more premium than it is incurring in loss and operating expenses. Since this ratio does not take into account investment income, it is not a measure of an insurer's overall profitability.				
Net Premium Leverage	**64%**	77%	90%	88%
Net premium written divided by policyholders' surplus. This ratio shows how much exposure the company has to pricing errors on its book of business relative to its "safety cushion" (policyholders' surplus). In general, the lower the ratio, the less impact pricing errors have on a company's financial results.				
Loss Reserve Leverage	**157.7%**	159.4%	228%	239%
Net loss and loss adjustment expense reserves divided by policyholders' surplus. This ratio shows how much exposure the company has to estimation errors in settling policyholder claims relative to its "safety cushion" (policyholders' surplus). In general, the lower the ratio, the less impact claims estimation errors have on a company's financial results.				
Statutory Book Value per Share	**$3,952.95**	$3,887.12		
Excludes the surplus note.				

Board of Directors

William J. Listwan, MD
Board Chair
Internal Medicine – West Bend

Richard G. Roberts, MD, JD
Board Vice Chair
Family Medicine – Madison

Steven C. Bergin, MD
Obstetrics/Gynecology – Stevens Point

Ronald H. Dix
Senior Vice President Administration
Badger Meter, Inc. – Milwaukee

Kevin T. Flaherty, MD
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Results

Although most remote ICU systems belong to urban health networks, Avera Health (SD) has a rural installation. Dave Kapaska, DO, the network's senior vice president, medical affairs, notes that the installation monitors a total of fifty beds in three South Dakota locations, but will add 75 beds and three new states—Nebraska, Minnesota, and Iowa—over the next 18 months. "A remote ICU will really help patient outcomes in rural areas," he says. "Community hospitals often 'stabilize and ship' patients to a larger facility, but out here, we need a better safety net. You can't fly anyone out during a blizzard."

The remote ICU program at Avera McKennan Hospital, Sioux Falls (SD) is only four months old, but Dr. Kapaska has already begun to see the benefits. "Soon after we installed the system, an intubated patient with five IV lines had a twelve point increase in his pulse, which triggered an alert. The remote ICU staff zoomed in with the camera and saw that the patient was trying to crawl out of bed. They immediately alerted the on-site staff who prevented a fall that would have otherwise badly injured the patient." He adds, "Our remote ICU system takes a lot of the pressure off our on-site staff. Before, they always had to have eyes in the back of their heads. Now they can concentrate on the patient at hand, knowing that they will be notified if someone else needs their immediate attention." In addition, nursing turnover in the ICU has been cut in half since the system was installed.

Team Communication Issues

"So many of the concerns staff have about the new system can be addressed by open, honest communication," says Mary Leedom, director of risk management for Avera McKennan Hospital. For example, staff may be concerned that increased monitoring may result in an increase in lawsuits, or fuel disagreements regarding a patient's treatment. "The on-site physician is the boss. However, the remote ICU staff has the same ability to take an issue up the chain of command as they would if they were part of the on-site team. These discussions are part of peer review so they are not discoverable," says Dr. Doerfler.

Patient outcome data is collected and analyzed so if there are quality issues, they are identified and addressed as part of the hospital's patient safety process. Dr. Doerfler adds, "In some ways, there are fewer opportunities for misunderstandings or conflicting information. Both sides use the same software to write orders and update charts. They have access to the same, real time information so problems like one physician not having information about a lab or a newly written prescription are unlikely to occur."

"Innovative telemedicine solutions will continue to find ways to make health care more accessible and affordable, while improving patient outcomes," concludes Dr. Flaherty. "We look forward to future advances as technology and the practice of medicine continue to change." ■

TrendWatch

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TrendWatch is published quarterly and circulated to more than 12,000 PIC WISCONSIN policyholders, certificate holders, and risk managers. It is designed to inform readers of new issues and trends in loss prevention—our ongoing goal at PIC WISCONSIN. We welcome your comments and suggested topics for future issues.

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Resources

1. Rudavsky, "Teledoctoring: Video technology brings together physician and patient over long distances," *Indianapolis Star*, February 7, 2005, pp. 1-4.
2. Albert, T., "Technology raises expectations—and tort risk," amednews.com, 1/13/03, pp. 1-6, www.ama-assn.org/amednews/2004/12/13/prl21213.htm, accessed 12/14/04.
3. "The Art of Full Disclosure," *TrendWatch*, Summer 2004 9(3), pp. 3-8.
4. ACR Technical Standard for Teleradiology effective 1/1/03, pp. 712-713.
5. eICU® is a registered trademark of VISICU, Inc.
6. To view and comment on the proposed rule, visit a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1773.pdf. For more information, see www.cms.hhs.gov/medicarereform/pdbmed/.

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IN THIS ISSUE

DELAYED CONSULTATION

A few months ago, an arbitration panel awarded 1,276,335 to a woman for nerve damage caused by a umbar disc that herniated during labor and delivery.

The patient had previously hurt her back in a fall and ad been on short-term disability. Plain films had been egative. She had a normal labor and delivery in August 002. When the epidural wore off, the patient began aving severe back and leg pain. The next morning, an nesthesiologist saw the patient and requested a eurology consultation. The neurologist examined her nd found no evidence of **cauda equina syndrome**.

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COMMENT: Cauda equina syndrome is caused by compression of spinal nerve roots below the L1 level as they travel through the spinal canal. The symptoms can include varying degrees of radicular leg pain and weakness, saddle anesthesia, back pain, and bladder and anal sphincter dysfunction.

The next day, Friday, the patient had developed numbness in a saddle-type distribution, but on one side only. An MRI that evening showed a large **herniation** of an **intervertebral disc**. A different neurologist reviewed the film and wrote two orders. The first was for a physiatry consult, to try to get the patient some pain relief. The second was for a **neurosurgical consultation**.

When the ward clerk was taking off the orders, he overheard the obstetrician make two phone calls. The first was to the physiatrist, who recommended the obstetrician ask anesthesia to give the patient an epidural steroid injection. The obstetrician hung up and called an anesthesiologist to come and do this. Unfortunately, the ward clerk thought the obstetrician had called a physiatrist and a **neurosurgeon**, so he did **not** call neurosurgery as ordered.

The neurologist had removed himself from the case when he referred the patient to neurosurgery. When the obstetrician rounded on the patient the next morning (Saturday), he figured the neurosurgeon would be coming by soon. But when the obstetrician returned for rounds on Sunday morning, there was still no neurosurgical consultation, so the obstetrician called neurosurgery himself. But it was too late: despite an operation, the patient suffered permanent harm caused by the delay, including pain, sexual dysfunction, and intermittent fecal incontinence.

The patient and her husband asked for approximately $1.1 million to settle their claims for malpractice and loss of consortium. The defense offered $250,000 so the case went to **binding arbitration**. The defense argued the

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physicians were reasonable in initially attributing the patient's symptoms to birth trauma. They had made a timely referral to a neurosurgeon, but an unusual clerical mistake had delayed the consultation.

The arbitration panel agreed that each of the physicians involved had acted reasonably, but the panel held the integrated health care organization—which was responsible for both the physicians and the hospital—liable for the clerical error and awarded the plaintiffs **$1,276,335**.

DISCUSSION

There was some dispute in the case about whether cauda equina syndrome should have been considered sooner and the MRI done earlier, but the patient's unilateral numbness was somewhat atypical. The clear problem in care was that, once the problem had been diagnosed and the need for neurosurgical consultation and possible surgical intervention had been appreciated, there was a significant delay in getting the process moving.

Orders can fail to be executed for countless reasons, yet physicians and patients have to count on orders to be implemented consistently and properly—especially key time-sensitive orders. The order fulfillment system—whether in hospitals or physicians' offices—is a good example of a vital, complex system that is inherently prone to occasional failure in different and often unpredictable ways, both internally and in its interaction with other systems. Although organizations can try to anticipate as many types of errors as possible before they occur and develop safeguards to prevent them, in practice this is often not done, and many latent errors cannot be anticipated.

Two additional steps can help. The first is learning from so-called near misses: errors or problems that did not result in harm but could have. If health care personnel were encouraged to report and discuss such occurrences, previously hidden vulnerabilities of the system could be analyzed and preventive changes instituted in time to prevent harm. Although it is too late for this patient, this hospital has changed its procedures to help prevent this type of error from happening again. As I've commented before, improving the system is the best method of prevention. One would like the ordering system to depend less on error-free performance by individuals. At the extreme, computerized physician order entry (CPOE) would have prevented this error if the consultation request were automatically self-executing (i.e., the consultation request would be routed to and reach the correct destination without the intervention of a ward clerk).[1]

A second important step is fostering a culture of safety among all health care personnel. This includes an awareness that errors inevitably will occur and vigilance for situations in which a problem might arise. After the obstetrician hung up the phone, the ward clerk could have verified explicitly that he had taken care of both the physiatry and neurosurgery consultations. The neurologist could have ensured the timeliness of the neurosurgery consultation in a number of ways, such as by calling the neurosurgeon himself, leaving a note in the chart for the neurosurgeon to call him with the results of the consultation, and involving the patient and her husband in the plan of care. When the obstetrician saw the neurosurgery consultation had not been done by the time he rounded on Saturday morning, he could have called the neurosurgeon to confirm he or she was coming, asked the ward clerk to check with the neurosurgeon, called in that afternoon to check on what was happening with his patient, or asked an in-hospital physician to check later.

Because of the integration of the physicians and the hospital organization in this case, the arbitration panel did not have to decide whether the standard of care **required** the physicians to take any of these steps. But the care would have been **safer** if the physicians had done so.

My impression from reviewing countless charts is that most physicians save time by writing orders for consultations, but calling the consultant and discussing what you want and a timeframe for the consultation has some advantages—especially for a time-critical consultation.

TELEPHONE ADVICE

Giving medical advice over the telephone poses two risks. The diagnostic process can be impaired because the physician has only the history of present illness, no physical exam or laboratory tests, and often no chart for a reliable past medical history and current list of medications. Second, documentation of the telephone encounter can be omitted or sketchy. Two cases demonstrate how minimizing these risks can benefit the doctor if not the patient.

In the first case, a family physician did a vasectomy on his 34-year-old patient on July 26, 2002 (a Friday). The informed consent discussion had included risks of bleeding, hematoma, and infection. The physician used lidocaine with epinephrine, but he encountered a bleeder on the left side that he ligated with a suture. No additional bleeding was seen after 10-20 minutes and the physician closed the incision.

Over the weekend, the patient's wife called the physician twice to report pain and extreme swelling of the patient's testicles. She says the physician just recommended increasing the dose of pain medicine. The physician's dictated notes say he offered to take the patient back to surgery to explore and stop the bleeding, but both times the patient elected conservative management. On Monday, July 29, the patient went to a local emergency department and was seen by a urologist. The swelling was decreasing and the urologist thought continued watching was appropriate.

But swelling and discomfort persisted, so on August 8 the urologist operated to remove a blood clot that had developed in the upper left scrotum. On August 9, considerable fluid had re-accumulated and the wound culture from the day before was growing *Staph. aureus*, sc

1. Computerized physician order entry, while a big step forward in most respects, is not error-free. Every change in a system creates new vulnerabilities and potential for errors, even as previous vulnerabilities are closed. See, e.g., Koppel R, Metlay JP, Cohen A, et al. Role of computerized physician order entry systems in facilitating medication errors. *Journal of the American Medical Association* 2005;293(10):1197-203.

another incision and drainage was done on the abscess. The patient was hospitalized for several days and his recovery was lengthy: he did not return to work for two months. He sued the family physician for malpractice.

At trial, the plaintiff argued that, because the physician used lidocaine with **epinephrine**, he should have waited longer to look for bleeding before closing the incision. The defense expert thought the 10-20 minute observation period was sufficient because the physician had identified and ligated the bleeding vessel.

The plaintiff also claimed the physician should have seen the patient, or sent him to an urgent care or E.D. to be seen, over the weekend when a bleeding complication was evident and the swelling was large. Had the bleeding been treated sooner, the area would not have become infected and he would have recovered quickly. The physician's dictated notes backed up his version of the telephone conversations: the swelling was not extreme, and the patient preferred expectant management. The plaintiff attacked the credibility of these notes because they had been transcribed much later, although the physician said he had dictated them soon after the calls. The plaintiff asked for damages of $55,000 to $75,000.

After deliberating for less than three hours, the jury found 10-2 in favor of the **physician**.

In the second case, a 64-year-old school security guard suffered rib fractures in an accident at work. He was seen by a worker's compensation physician and stayed off work for a while. One month later, he experienced some chest pain and went to an emergency department. After a workup including a chest x-ray, he was diagnosed with a mild **pneumonia**. The emergency physician started him on an antibiotic and instructed him to follow up with his regular physician in two days. He did so, telling his physician about the pneumonia and that he was feeling better. He did not mention the month-old rib fractures. His lungs sounded clear and his physician told him to finish the course of antibiotics. The patient had some unrelated problems for the physician to address as well, which he did.

Two days later, he called his physician's after-hours service to report he was experiencing **chest pain** and **shortness of breath**. The group's call-in nurse advised him to go right away to the urgent care clinic at a nearby hospital, but the patient **declined**, saying he would go see another physician in the morning.

COMMENT: During each call, the call-in nurse recorded the patient's history and her advice on a fill-in computer screen. This patient's call was fully documented, including his decision to decline the recommendation to go to the hospital's urgent care clinic.

Later that night, he died from a **pulmonary embolism**. His widow sued the patient's regular physician and his nurse for wrongful death.

At the arbitration, the plaintiff claimed the physician and his call-in nurse should have suspected and diagnosed pulmonary embolism. The physician did not obtain the history of the rib fractures; the immobility they had caused were the patient's risk factor for pulmonary embolism. The physician defended his care as perfectly appropriate given the patient's workup in the emergency department two days earlier. And the nurse was protected by recommending the patient be seen right away.

The arbitrator ruled in favor of the **defense**.

COMMENT: The risks posed by the telephone can be lessened by referring patients to a clinic or medical center whenever you do not fully understand the problem and an acute deterioration is possible, and by carefully and completely documenting all telephone advice. Improper telephone triage and advice by office personnel—medical and administrative—without the knowledge of the physician are notorious sources of claims; careful training of office staff is essential.

STANDARD OF CARE

A family physician settled a delay-of-diagnosis claim for his policy limit of $1 million because he was going to be held to a specialty standard of care that he had not met. Ironically, the specialist he eventually consulted did not meet the specialty standard of care, either; he paid an additional $250,000.

The 58-year-old plaintiff was a longstanding patient of the family physician, who had also cared for the plaintiff's mother when she died of lung cancer. The plaintiff had smoked cigarettes but had stopped long ago.

In 1990, a chest x-ray was normal (the family physician took and read his chest films himself). The next x-ray, in 1996, had a new **1-cm density** in the right lung, but the family physician did not spot it. He saw it on the next chest x-ray, however, in December 1998, and he pulled out the 1996 film for comparison. He took the two films (but not the normal 1990 film) to a **radiologist** for review. The radiologist thought the lesion had not changed, and it looked the same on a repeat film three months later in February 1999. The physicians concluded it was a scar and did not obtain a biopsy.

In **2002**, the patient and her husband celebrated Valentine's Day by treating each other to **total-body CT scans** at a self-pay commercial scanning facility. Her scan showed widely **metastatic lesions**, including to the brain. The lung primary was now 3-4 cm across. The shocked patient carried her chest x-rays over to the CT radiologist, who on careful examination pointed out that the primary lesion had increased slightly in size and density between the 1996, 1998, and 1999 chest x-rays. An oncologist certified the cancer was probably still curable back then.

The patient sued the family physician and the radiologist for medical malpractice. The family physician had completely missed the tumor on the 1996 x-ray. After he saw it 2 years later, he failed to realize it was a new lesion because he did not compare it with the 1990 x-ray. His attorney conceded he would be held to the standard of care of a typical radiologist, who would have seen the lesion in 1996 and compared it with the available earlier films.

The radiologist failed to appreciate the increase in size and density of the lesion (he had compared the x-rays visually but did not measure them). He contended the changes in the lesion over time were attributable to variations in technique; they were not impressive enough to

warrant the risks of an invasive workup. The radiologist also failed to ask to see earlier films for comparison. His defense for this was that he simply did what he was asked: to review a set of films handed to him.

The plaintiff's damages for pain and suffering were limited by California's MICRA law to $250,000, but she also claimed substantial economic losses from a business she had launched. The defendants, who were insured by the same company, eventually settled the case for a total of $1.25 million.

DISCUSSION

There are at least two circumstances in which a physician might be held to the standard of care of another specialty. Although there is no hard and fast rule, one situation is when physicians provide care that is ordinarily provided by another specialty. Another circumstance is when a reasonable physician exercising due care should have consulted a specialist under the circumstances, but did not do so; the only way the physician can escape liability for failure to consult is to have provided care at the level of the specialist, anyway.

In this case, the radiologist's defense for not asking to see earlier films for comparison—that he only did what he was asked to do by the referring physician—is clearly untenable. As a consultant, even without seeing the patient he had a duty to the patient to exercise reasonable care, which should have included looking at the prior films.

The self-pay total-body CT scan turned up a real (but incurable) lesion in this case, but these types of self-referred radiologic screening tests are revealing scores of incidental lesions to bedevil physicians, patients, and insurers. Most of them will be benign, but a few will not.

BATTERY REVISITED

The last issue of PLN explained how a physician could be liable for battery if he or she does something substantially more or different than what the patient gave consent for. A different case asks whether it is a battery if a physician does **less** than what was planned.

The 27-year-old patient fractured his shoulder in a motocross accident, although it was not diagnosed until 2 weeks later. He worked at a hospital and had obtained informal opinions that an open repair was required, but his treating orthopedist planned an arthroscopic evaluation with possible arthroscopic or open repair. The consent form, however, specified an **ORIF** (open reduction and internal fixation). The form also said the doctor was authorized to do any procedure that he judged advisable for the patient's well being.

The arthroscopy showed the fracture was displaced less than the imaging studies had indicated, and the orthopedist decided not to place a screw because he thought it would disrupt the fracture fragment. After the operation, the patient was upset when he learned his shoulder had not been repaired. By the time he could see another orthopedist, too much time had passed since the injury for a repair. He sued the orthopedist for **medical malpractice** and **battery**.

The trial judge threw out the battery claim and an appellate court agreed with the defense.[2] As a matter of law, it is not a battery when a physician does **less** than what the consent allows, because what was done is still encompassed within the consent. The patient's only cause of action was for medical malpractice, and he lost that trial.

DISCUSSION

The appellate court's decision was correct. If this patient wanted to put a condition on his operation, the proper vehicle for doing so was a conditional consent, which should have been explicit and in writing. The orthopedist then could have (and should have) refused to operate under the requirement that he do a repair no matter what he finds.

I think it is advisable for surgical consent forms to include a statement explicitly authorizing the surgeon to use his or her best judgment during the operation and do (or not do) whatever he or she believes best for the patient based on the circumstances at the time. There are no guarantees, but this statement could be helpful when an unexpected situation is encountered, a valid surrogate decision maker is not available, and the patient's health would be put at risk if something is not done right then.

DUKE TRANSPLANT CASE SETTLES

As expected, a settlement has been reached between Duke and the family of Jesica Santillan in the nationally publicized heart/lung transplant case (organs of the wrong blood type were transplanted into the 17-year-old girl; a second heart/lung transplant with the correct blood type was unsuccessful). The terms of the settlement are confidential. The case served as a patient safety wake-up call for Duke. The institution created a senior executive position of Patient Safety Officer and took a number of steps to improve patient safety in the transplant program and the medical center at large (see http://www.dukemednews.org/mediakits/detail.php?id=6498).

2. *Conte v. Girard Orthopaedic Surgeons Medical Group, Inc.* (2003) 107 Cal.App.4th 1260.

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