

MEDICAL MALPRACTICE UPDATE

July 2006

PRACTICAL ADVICE FOR HANDLING LAW ENFORCEMENT INTERVIEWS OF HOSPITAL PATIENTS

By Cindy C. Boer, Attorney

Hospitals are often approached by law enforcement officials with requests to interview patients. This situation is particularly common in the emergency room setting, where police often arrive to investigate the aftermath of motor vehicle accidents or violent crimes. Police may want to interview or photograph the patient—a potential criminal suspect, witness, or even victim—as part of their criminal investigation.

What is the health care provider's obligation when a police officer asks to speak to an injured patient? How do health care providers balance the patient's need for privacy and uninterrupted medical care with the public's goal of ensuring criminal justice?

HIPAA and state privacy laws provide ample guidance to hospitals concerning the circumstances under which patient *information* may be released. For example, HIPAA sets forth in detail the circumstances under which hospitals may provide law enforcement officials with information about the medical condition of a criminal suspect when this is a matter of public interest. However, HIPAA does not regulate police *access* to patients. Likewise, most state privacy laws focus on the release of patient information, not requests for patient interviews.

Whether the patient is a victim, witness or criminal suspect, when they become the target of a police investigation, the situation can lead to tension between health care providers and police

officers. Last year, a Toronto newspaper reported that police threatened to charge an emergency room nurse with obstruction of justice because she did not allow them to interview a victim of gun violence. The nurse felt the patient, who had "a devastating wound to his trachea," was not stable enough to communicate. "You get caught [in the middle.] I'm his health care provider and I'm not defending him. I'm not obstructing. I'm doing my job," the nurse said.

Criminal suspects, who are acutely sick, injured or mentally ill, present a particular dilemma, since providing police access to them may result in involuntary self-incrimination. This author is aware of one situation where an officer in plain clothes came to "visit" an inpatient at a mental health facility. The patient had been diagnosed with schizophrenia and was heavily medicated. Unbeknownst to his physicians, the officer proceeded to aggressively interrogate the patient and obtained a "confession," which later provided the basis for a guilty plea. A social worker who witnessed the interview admitted to being confused about her role in the situation, and expressed regret at not interceding once the officer's goal became apparent. Of course, whether the confession was ultimately admissible in a court of law is a question for the legal system, but from a moral and ethical standpoint, health care providers should exercise caution when allowing vulnerable patients to be put in this position. (continued...)

Granting police access to patients involves a delicate balancing act between private and public needs. Private considerations include, how critical is the patient's condition? Will the interview interfere with necessary medical evaluations or procedures? Is the patient able, physically and mentally, to communicate? Will the interview cause excessive agitation or distress, thereby jeopardizing the patient's medical care? Public considerations include, how serious was the crime involved? Is there a risk of harm to third parties if the interview does not proceed? Is time of the essence in the criminal investigation?

A recent JAMA article set forth five guidelines for hospitals to use when dealing with police requests for patient interviews:

- Patients judged by physicians to have the capacity to make medical decisions should decide for themselves whether to speak with police, and when possible, inform police of their decision directly, rather than through intermediaries.
- Except when competent patients knowingly decide to accept the risk of harm, police interviews should not interfere with patient care or risk significant physical or mental harm to patients.
- Hospital staff must take care to comply with HIPAA or other privacy laws, and hospital policies regarding release of information about patients.
- Clinicians observing an interview should make clear to patients that they are not part of the investigation team and are present only to safeguard patients' medical status.
- Hospitals should be encouraged to form committees or working groups to develop and oversee local guidelines.

From a public policy standpoint, law enforcement officials should be permitted access to patients who are capable of giving informed consent and agree to an interview. The determination of whether the patient is capable of consenting to the interview should be made by the attending physician. Physicians routinely evaluate a patient's capacity to give informed consent. If the patient is able to consent to a medical procedure, they should be able to consent to a police interview. However, in certain situations, a psychiatric or other consult may be advisable. The attending physician should determine whether the patient's present medical needs have been met and whether the patient is stable enough to proceed with the interview.

If there is concern that medical care may be delayed or interrupted, the interview should be permitted only if the patient gives his or her consent after a discussion with the physician about the risks involved. Every effort should be made not to interfere with the patient's care. It may be advisable to have a neutral third party (such as a social worker or hospital risk manager) present during the interview. If the health care provider believes that giving the interview is not in the patient's best interests, or if the patient refuses an interview, the health care provider should inform the police officer of that fact and document the incident in the medical chart. Care should be taken to comply with HIPAA and other privacy laws during any discussions with police officers

To ensure consistency, hospitals are encouraged to prepare written policies for dealing with law enforcement requests for information about or access to patients. Cooperation, rather than confrontation, is the goal. If you would like assistance with this project, please contact a member of our Medical Malpractice or Health Law Departments. *Cindy can be reached at cboer@shrr.com.*

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CASE LAW UPDATE

Edited by: Brian Molde

Wrongful Death – Savings Statute

Mullins v St. Joseph Mercy Hosp, (January 31, 2006)
The panel in this case declared a conflict with the earlier court of appeals decision in Ousley v McLaren but reversed the trial court's denial of summary disposition. The decision in Ousley held that retroactive application of the Supreme Court's decision in Waltz v Wyse was appropriate. The decision in Waltz v Wyse held that the savings provision for filing wrongful death actions was not a statute of limitations, and therefore the savings provision was not tolled by filing a Notice of Intent to File Claim. In Mullins, the plaintiff's personal representative failed to file her medical malpractice claim within either the general two-year statute of limitations or within the two-year period after appointment of the personal representative for wrongful death claims. Constrained to follow the earlier decisions in Waltz and Ousley, the panel reversed the trial court and entered summary disposition; however, in declaring a conflict, the panel set in place the framework for reversing the retroactive application of the Waltz decision.

Mazumder v Univ of Michigan Bd of Regents (February 23, 2006) One month after the decision in Ousley was questioned in Mullins, the Court of Appeals once again addressed the application of Waltz and Ousley. In this case, the plaintiff had relied upon tolling to file her claim under the wrongful death savings provision. Once the decisions in Waltz and Ousley were handed down, the defendants moved for summary disposition based on plaintiff's failure to timely commence her claim. The trial court denied the motion, concluding that the claim was commenced within the five-year ceiling for wrongful death actions. The Court of Appeals rejected this argument, finding that the statute requires the claim be filed within two years of the appointment of the personal representative. However, reviewing past decisions of the Supreme Court and Court of Appeals, the Court held that equitable tolling could apply to save plaintiff's claim and avoid injustice.

Verbrugge v Select Specialty Hosp (March 23, 2006)
Taking up the wrongful death savings provision, Waltz, and Eggleston v Bio-Medical Applications of Detroit, Inc, the panel in this case concluded that a wrongful death claim initially filed outside the two-year window from the date of the appointment of a personal representative may be revived by the appointment of a successor personal representative. In Eggleston, the Court of Appeals held that the two-year savings provision applied to any personal representative, not just the initial personal representative. In this case, where the initial claim was dismissed on the basis of Waltz v Wyse, a second claim was filed in the same circuit court under the name of a successor personal representative. The trial court dismissed both cases, and the Court of Appeals reversed the trial court's decision in the second case, finding that under the statutory language and the decision in Eggleston, a claim may be revived by the appointment of a new personal representative who timely files a second Complaint.

Johnson v Hurley Medical Group, (April 13, 2006)
Following the Court of Appeals' decision in Mazumder, this panel applied equitable tolling to reverse a trial court's dismissal of this case based upon Waltz and Ousley. While the panel agreed that they were required to find that the plaintiff had not timely filed her Complaint in this wrongful death action, the panel reasoned that "a panel of this Court [in Mazumder] agreed that separate and apart from the pure retroactivity question decided in Ousley, the doctrine of equitable or judicial tolling applies in situations such as that involved here." On this reasoning, the panel reversed the dismissal and remanded the case for further proceedings.

Ward v Siano, (April 13, 2006) Released five minutes after the decision in Johnson, this panel found itself constrained by Mazumder to reverse a dismissal based on Waltz and Ousley and apply equitable tolling to save plaintiff's claim. However, the panel also declared a conflict with the Mazumder decision, forcing the chief judge to ask the judges on the Court of Appeals whether the decision in Mazumder should

be reviewed. The panel in this case walked through the entire set of precedents, noting that it had to follow the decisions in Waltz, Ousley, and Mazumder to affirm a dismissal on one ground and then reverse the decision based on a subsequent Court of Appeals' decision.

Affidavit of Merit – Family Practice/General Practitioner

Robins v Garg (April 4, 2006) In this case, the defendant was a general practitioner alleged to have failed to properly treat the plaintiff's hyperlipidemia. Plaintiff filed a Complaint with an Affidavit of Merit signed by a Florida Family Practice physician. Defendant moved for summary disposition, alleging that the family practice physician was not qualified to testify to the standard of care for a general practitioner. The trial court agreed and dismissed the case. Reversing the trial court, the Court of Appeals held that "a family practitioner and a general practitioner are physicians engaged in the same type of medical practice. The terms family practitioner and general practitioner have become interchangeable." Accordingly, the Court of Appeals reversed the trial court's dismissal.

Affidavit of Meritorious Defense – Occupational Therapist/Physical Therapist

Brown v Hayes (April 4, 2006) Plaintiff brought her lawsuit against two registered occupational therapists and filed affidavits of merit from both a registered occupational therapist and a licensed physical therapist. In response, the defendants filed only an affidavit of meritorious defense from a physical therapist. Plaintiff then brought a motion to disqualify the physical therapist as a standard of care expert and for default for failure to file a proper affidavit of meritorious defense. The defendants responded by asserting that the statute permitted only licensed health care providers to testify, that occupational therapists were not licensed, and that therefore the physical therapist was qualified and that defendants had a reasonable belief that the physical therapist was qualified. The trial court disagreed, granted plaintiff's motion, and entered a default against the defendants. They appealed. The Court of Appeals first concluded that the Public Health Code treated registered health care providers identically to licensed providers, and rejected defendant's argument. The Court then concluded that prior decisions of the Court of Appeals require the two health professionals to be licensed under the same provision of the Public Health Code in order to testify regarding the standard of care. Because physical therapists and occupational therapists are

separately licensed and registered, the court held that the affidavit of meritorious defense could not be signed by a physical therapist. However, the Court did conclude that defendants had a reasonable belief regarding the propriety of the physical therapist's affidavit, and reversed the default against defendants.

UNPUBLISHED DECISIONS

Medical Malpractice/Ordinary Negligence/Breach of Contract

Woodward Nursing Home, Inc v Medical Arts, Inc (January 24, 2006) Defendants entered into a written contract with the plaintiff to provide medications to plaintiff. Defendants then failed to uphold the terms of the contract by failing to provide medications for more than twelve days after they were ordered by a physician. Plaintiff filed suit, alleging breach of contract, negligence, malpractice, and fraud. The defendant moved for summary disposition, alleging that the claim arose out of medical malpractice and that the plaintiff had failed to properly commence a malpractice action. The trial court denied the motion, and the defendant appealed. Relying upon earlier decisions of the Court of Appeals, the panel concluded that (1) the contract created a professional relationship between the parties, and (2) questions concerning the dispensation of prescription medications necessarily require professional judgment and are outside the realm of common understanding. Thus, the claim was properly brought only as a claim for medical malpractice.

MRE 702 – Expert Causation Testimony

Cochrum v Wm Beaumont Hosp. (February 16, 2006) In this birth trauma claim, the Court affirmed the trial court's dismissal of plaintiff's causation expert, Dr. Ronald Gabriel. Analyzing the record from the trial court, the Court of Appeals found ample evidence to support the conclusion that Dr. Gabriel's causation theory was not reliable and was based upon unproven expert theories as well as an erroneous factual basis. The Court of Appeals also stated that the trial court was not compelled to hold an evidentiary hearing, but must make a "searching inquiry" into the basis for the opinion under MRE 702. In this case, where the plaintiff had submitted voluminous medical literature as well as the deposition transcript of Dr. Gabriel and the plaintiff had not indicated what further information would have been presented at a hearing, the trial court was not required to hold such a hearing. Hunter v Spectrum Health, (March 14, 2006) Plaintiff appealed a trial court's ruling that plaintiff had failed to present sufficient testimony supporting the element

of proximate cause in this case. Plaintiff presented the testimony of Dr. Brazil, who testified during her deposition that there was “no one cause” for the plaintiff’s seizure disorder. Dr. Brazil further testified that there was a list of potential contributing factors, but no agreed upon cause for the disorder. However, when asked a leading question by plaintiff’s counsel, Dr. Brazil seemed to contradict her prior testimony. The Court of Appeals affirmed the trial court’s dismissal, reasoning that answers to leading questions which contradict earlier answers cannot create triable questions of fact. Further, based on the deposition testimony, Dr. Brazil had not sufficiently supported the claim of proximate cause.

Affidavit of Merit – Reasonable Belief

Gaynor v Cilluffo, (March 14, 2006) Plaintiff commenced this claim against Dr. Cilluffo, a board certified neurosurgeon, by filing an affidavit of merit executed by Dr. Austin. Dr. Austin, while board certified, had not performed surgery since 1998. Dr. Austin’s practice in the year prior to the alleged malpractice consisted of performing medical examinations, medical-legal work, and writing books. Defendants moved for summary disposition based on Dr. Austin’s failure to comply with §2169. Plaintiff’s counsel asserted that he had a reasonable belief that Dr. Austin complied with the requirements at the time he filed the affidavit. The trial court and Court of Appeals disagreed, concluding that plaintiff’s counsel failed to adequately investigate whether Dr. Austin’s qualifications conformed to the statutory requirements.

Affidavit of Merit – Statement of Proximate Cause

Zemaitis v Spectrum Health (April 6, 2006) Plaintiff’s claim asserted a failure to promptly diagnose a skin cancer. In support of the Complaint, the plaintiff filed three affidavits of merit: one from a board certified internist/pediatrician (to match the defendant), one from a general surgeon (to testify regarding proximate cause), and one from a dermatologist (to testify regarding the link between the standard of care and proximate cause). The defendants filed a motion to dismiss, alleging that plaintiff’s proximate cause affidavits were insufficient. The trial court agreed, and dismissed the case. On Appeal, the Court held that the statute merely requires a statement of the proximate cause, not a detailed or elaborate finding. Here, where the general surgeon’s affidavit alleged that failure to make the proper diagnosis led to the injury, the affidavit satisfied the requirement. Further, nothing in the statute requires a plaintiff to present testimony in the affidavit relative to the burden of proof at trial, and

thus the defendants were not entitled to summary disposition based on the expert’s failure to set forth percentage calculations of harm in the affidavit.

Affidavit of Meritorious Defense – Sanction for Failure to File

Glenn v Martens, (April 13, 2006) Where the defendants failed to file an affidavit of meritorious defense as required, the trial court imposed a sanction barring defendant from presenting any independently retained standard of care expert witness at trial. The Court of Appeals affirmed the sanction, holding that it was proper given the purpose of the statutory requirement that defendant provide a timely affidavit of meritorious defense.

Discovery Rule – Reasonable Basis for Discovery

Bonucchi v Michigan State Univ Bd of Trustees, (March 28, 2006) Plaintiff brought her malpractice claim more than two years after accrual of the action, and relied upon the discovery rule as an exception to the general statute of limitations. The defendants moved for summary disposition, claiming that plaintiff knew or should have known of her potential claim more than six months before the case was commenced. Finding for the defendants, the Court of Appeals reasoned that a reasonable person experiencing the same symptoms from a different medication would know of a possible connection between the earlier incident and the new medication. Here, where plaintiff had once before filed a lawsuit based on her allergy to a certain chemical, it was not reasonable to conclude that she only learned of her claim upon discovering that the chemical existed in both medications. Thus, plaintiff knew or should have known of her potential claim more than six months before commencing this action, and her claim was properly barred by the statute of limitations.

Notice of Intent to File Claim – Calculation of Tolling Period

Dewan v Khoury, (March 28, 2006) The plaintiff filed her Notice of Intent on the last day of the two-year statute of limitations. Her claim was therefore tolled for 182 days, starting on June 5, 2004 and lasting until December 3, 2004. Upon the expiration of the tolling period, there was no time left on the statute of limitations, and plaintiff was required to file her claim on December 3, 2004 in order to comply with the statute. Because plaintiff did not file on December 3, 2004 (which was a Friday) but waited until the next business day after Friday (Monday, December 6, 2004), plaintiff’s claim was untimely and the trial court properly dismissed her claim.

NEWS AND SUCCESS

Joe Engel was recently reappointed to the State Bar District C Character and Fitness Committee by the Board of Commissioners. Mr. Engel has served on the committee since 2001.

Robert Tubbs recently presented lectures on “Risk Management in the Physician Office Practice” at Northern Michigan Hospital in Petoskey and “Informed Consent: The Pain Management Patient” to the Munson Family Practice Residency Program in Traverse City.

In March, **Jack O’Loughlin** and **Jason Sebolt** obtained a no cause verdict in favor of our client anesthesiologist following a four-day jury trial in Muskegon. The case arose from an cervical epidural steroid injection performed by the client pain management specialist and alleged to have resulted in a spinal cord injury. The jury returned a unanimous verdict finding that there was no violation of the standard of care.

Cara Nieboer successfully convinced a Kalamazoo County Circuit Judge to dismiss a medical malpractice claim based on the plaintiff’s repeated failure to comply with discovery requests and court orders demanding that plaintiff provide answers to discovery.

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