Professional Medical Negligence - Louisiana, a Primer - Part II

by: Franklin D. Beahm
Beahm & Green
New Orleans, LA

Louisiana Judicial Council/
National Bar Association Seminar Program
July 2004
Negril, Jamaica

Professional Medical Negligence - Louisiana, a Primer-Part II[1]

by: Franklin D. Beahm
Beahm & Green
New Orleans, LA

Created in 1975, the Louisiana Medical Malpractice Act (LSA-R.S. 40:1299.41 et seq.) created, for qualified healthcare providers, the following:

A. Limitation on recovery of damages;
B. Provision for future medical expenses;
C. Pre-litigation Medical Review Panel;
D. The Patient's Compensation Fund; and
E. Limitation of the addendum demand.

All aspects of the Medical Malpractice Act have been declared constitutional by Louisiana Supreme Court and will be addressed in each subsection which follows.

SECTION A. LIMITATION ON RECOVERY OF DAMAGES

LSA-R.S. 40:1299.42 provides the total amount which may be recovered for injuries to or death of a patient, with the exception of future medical expenses, shall not exceed $500,000 plus interest and cost. A qualified healthcare provider shall not be liable in excess of $100,000 plus interest "because of injuries to or death of any one patient." The Louisiana Supreme Court in a case of Williams v. Kushner 549 So.2d 294 (La. 1989) held the $400,000 "cap" recovery against the Patient's Compensation Fund is constitutional thus reducing the verdict of $1,929,000 to $500,000. This was based upon the district courts decision after a Sibley hearing[2]. The district court concluded there was a medical malpractice insurance crisis and in the absence of remedial legislation (LSA-R.S. 40:1299.42) the state's legitimate interest of guaranteeing continued health care services to the citizens would be jeopardized. The appellate court did not find manifest error in the trial court's decision nor any violation of the individual dignity clause of the Louisiana

---

[1] Updated and supplemented version of the original paper "Professional Medical Negligence - Louisiana, a Primer" presented Jamaican Sunset CLE July 2003.

[2] Sibley v. Board of Supervisors of Louisiana, 477 So.2d 1094 (La. 1985) The Supreme Court, in view of the malpractice act, remanded to the district court to conduct a hearing to balance the state's interest against the discriminatory restriction on malpractice awards to determine if the legislation was "arbitrary, capricious and unreasonable."

Constitution. Because of the procedural presentation of the Williams case, supra, the court left for another day the question of the constitutionality of limiting the healthcare providers exposure to the maximum of $100,000. In the matter of Butler v. Flint Goodrich Hospital 607 So.2d 517 (La. 1992) the Louisiana Supreme Court considered and found the overall recovery of $500,000 to plaintiff per instance of malpractice was constitutional. In so ruling the Court stated the offset of benefit for the $500,000 is the:

> (1) greater likelihood that the offending physician or other healthcare provider has malpractice insurance; (2) greater assurance of collection from a solvent fund; and (3) payment of all medical care and related benefits. Id at 521.

Compensation and full medical care for those grossly injured by medical malpractice are legitimate social interests, and is furthered by the malpractice legislation. The discrimination in the act against those with excessive injuries (above $500,000) is accompanied by a quid pro quo: a reasonable alternative remedy has been provided. "Since the legislature's statutory solution to the medical malpractice problem furthers the state purpose of compensating victims, it is not constitutionally infirm." Id at 521. Separate independent acts of medical negligence which results in one injury is limited to one cap recovery of $500,000. See Turner v. Massiah 656 So.2d 636 (La. 1995) when the Supreme Court stated:

> If the damage, or injury, could have been divided into two parts, one part cased by one defendant and the other part caused by the other there would have been, in effect, two injuries. In that case, there having been two torts and two injuries, the question of two caps might have been present. In this case there were two torts but only one injury. Id at 640.

In this matter, two physicians, independent to one another failed to timely diagnose breast cancer. Finding the failure to diagnosis breast cancer was an indivisible injury, there is only one tort and therefore only one $500,000 recovery by the plaintiff.

SECTION B. FUTURE MEDICAL CARE AND RELATED BENEFITS

Because of the disparate treatment between seriously injured patients who could not be fully compensated under the $500,000 limit versus patients not as seriously injured whose recovery would be sufficiently covered by the $500,000 cap, the legislature amended the Medical Malpractice Act and added provisions for future medical care and related benefits to an injured patient.

Under LSA-R.S. 40:1299.43 A (1), cases which proceed to trial before a jury must include a special interrogatory to the jury asking whether the patient/plaintiff is in need of future medical care and related benefits. Absent such a special interrogatory to the jury, no

award may be given for future medical. See, Merritt v. Karcioglu 668 So.2d 469 (La. 4th Cir. 1996) wherein the court found an affirmative duty on a part of the trial court to issue a special interrogatory to the jury for future medical care. Absent same, it is the plaintiff's obligation to object in order to correct this error and preserve the right to plaintiff for future medical benefits. If the case is tried to the bench, the court has an obligation to determine any need of future medical care and related benefits. If the amount of the overall award plus future medical is less than $500,000 then the payment for future medical benefits is limited to the amount determined by the fact finder be they a jury or judge. If the amount of award exceeds $500,000 cap plus future medical expenses, future medical care and benefits is unlimited. The cookbook method to collect same is set forth in the statute.

SECTION C. PRE-LITIGATION MEDICAL REVIEW PANELS

The first case to challenge the constitutional scheme of the Medical Malpractice Act involved the medical review panel process. In the case of Everett v. Goldman 359 So.2d 1256 (La. 1978) the Louisiana Supreme Court stated:

> A second advantage to a health care provider who has qualified under the act is that his patient must provoke a medical review panel and receive an opinion from it before it before he can file suit in a court of law. Although this requirement can be waived by the agreement of both parties, it is assumed that most malpractice cases against healthcare providers will be filtered though such a panel. Id at 1263.

Finding the medical review panel is designed to "weed out" frivolous claims the court relied upon multi-jurisdictional case law and numerous law review articles in stating:

> In requiring pre-suit medical review panel act is not unreasonable; it has no far reaching or especially adverse effect upon the malpractice victim's or health care provider's rights. While the savings in overall costs are yet to be proven we cannot say that this legislative effort will not further the accomplishment of what is surely a plausible goal... we hold that the medical review panel does not exceed constitutional limits. Id at 1267.

Interestingly, in a statement by the Supreme Court in its conclusion of Everett, supra, is found on page 1270 "Courts do not rule on the social wisdom of statutes, nor on their work ability and practice. Imperfections in legislation are not in themselves grounds for judicial intervention unless those imperfections result in denial of constitutional rights or infringement or paramount statutory rights."

1. Request for Medical Review Panel

A. Must be filed with the Division of Administration

i. La. R.S. 40:1299.47A(2)(a).

ii. Jurisprudence

a. The patient initially filed her medical malpractice claim under the "public" malpractice act, La. R.S. 40:1299.39 et seq. After notification from the agency that administered the act the physician was a qualified provider under the "private" malpractice act, La. R.S. 40:1299.41 et seq., she waited 16 months before filing her claim with the correct agency. The physician filed a rule to dissolve the medical review panel in district court, contending the claim had prescribed. The court held the patient would be afforded the suspension of prescription under the public act, even though the physician was a qualified provider under the private act. The patient's claim under the public act was timely. The liberative prescriptive period was suspended pursuant to La. R.S. 40:1299.39A(2)(a) until 60 days after the patient received notice the provider was not qualified under the public act. At that point, she had eight months to toll prescription again by filing her claim under the correct act. Her claim under the private act, filed 16 months later, was untimely. Bordelon v. Kaplan, App. 3 Cir. 1997, 692 So.2d 581.

b. As La. R.S. 40:1299.47(A)(2)(a) provides a claim is deemed filed on the date it is received by the PCF, when a medical malpractice claim is sent either to the PCF or to the Division of Administration, prescription is suspended. Patty v. Christis Health Northern Louisiana, App. 2 Cir. 2001, 794 So.2d 124 as well as Holmes v. Lee, App. 2 Cir. 2001, 795 So.2d 1232.

iii. Time Deemed Filed - La. R.S. 40:1299.47A(2)(b)

iv. New Mandatory Filing Fee - La. R.S. 40:1299.47A(1)(c)

v. Waiver of Filing Fee - La. R.S. 40:1299.47A(1)(d)

vi. Failure to Pay Fee - La. R.S. 40:1299.47A(1)(e)

vii. Use of Fees by PCF - La. R.S. 40:1299.47A(1)(f)

viii. Waiver of Medical Review Panel

a. La. R.S. 40:1299.47B(1)(c)

b. Jones v. Hartford Ins. Co., (La. 4/30/90), 560 So. 2d 442. Health care provider who fails to file exception of prematurity prior to filing answer waives right to review of malpractice claims by medical review panel.

B. Prematurity of Suit Prior to Medical Review Panel

i. La. R.S. 40:1299.47B(1)(a)(i)

ii. Jurisprudence - See Section C5G, infra

2. Selection of the Medical Review Panel

A. Attorney Chairman

i. Joint Selection - La. R.S. 40:1299.47C

ii. Strike List

a. La. R.S. 40:1299.47C

b. Kimmons v. Sherman, App. 1 Cir. 2000, 771 So.2d 665. By requesting list of attorneys' names within 90 days of receiving notice from PCF that plaintiffs were required to appoint attorney chairman for medical review panel, plaintiffs in medical malpractice action prevented dismissal of claim for failure to appoint attorney chairman.

B. Health Care Providers

i. Plaintiff's Nominee - La. R.S. 40:1299.47C(3)(a)

ii. Defendant's Nominee - La. R.S. 40:1299.47C(3)(b)

iii. Third Nominee - La. R.S. 40:1299.47C(3)(d)

iv. Multiple Plaintiffs or Defendants - La. R.S. 40:1299.47C(3)(f)(iii)

v. Failure of Plaintiff or Defendant to Nominate

a. Warning by Attorney Chairman - La. R.S. 40:1299.47C(3)(c)

b. Nomination by Attorney Chairman - La. R.S. 40:1299.47C(3)(d)

vi. Failure of Two Healthcare Provider Panelists to Nominate Third Member - La. R.S. 40:1299.47C(3)(e)

vii. Qualifications of Physician Nominees - La. R.S. 40:1299.47C(3)(f)(i)

viii. Excusing Panel Members from Service - La. R.S. 40:1299.47C(3)(f)(iv)

ix. Physician Panelists Based on Specialty of Defendants

a. La. R.S. 40:1299.47C(3)(f)(v)

b. Jurisprudence

1) In re Medical Review Panel for Claim of White, App. 4 Cir. 1995, 655 So.2d 803. Where there are multiple defendants who include hospital, patients may name physician from one of specialties of defendant physicians, but are not required to do so.

2) Francis v. Mowad, App. 5 Cir. 1988, 523 So.2d 8 Plaintiffs alleged Defendant/Podiatrist was negligent in treating her for a foot condition and a medical review proceeding was instituted. Plaintiffs nominated an orthopedic surgeon as a member of the medical review panel. The Defendant objected to the orthopedic surgeon on the grounds orthopedic surgery is not within the same class and specialty of practice as podiatry. The Court of Appeal agreed with the

trial judge's decision an orthopedic surgeon is not from the same class and specialty of practice as a podiatrist, as required by La. R.S. 40:1299.47 (C)(3)(f)(v).

C. Conflict of Interest by Panel Member

i. La. R.S. 40:1299.47C(7)

ii. Jurisprudence

a. Whitt v. McBride, App. 3 Cir. 1995, 651 So.2d 427. Member of medical review panel does not have to be viewed as similar to judge so any potential bias, conflict of interest, or appearance of impropriety requires removal; panel is merely body of experts assembled to evaluate and render opinion on claim, and such opinion is not binding on litigants.

b. Landry v. Martinez, App. 3 Cir. 1982, 415 So.2d 965. Doctor could not sit as medical review panelist where one of his partners had served as medical consultant to the medical malpractice claimant and would probably continue to do so.

3. Duties of The Members of the Medical Review Panel

a. Attorney Chairman

i. General Duties - La. R.S. 40:1299.47 C(1)(b)(2).

ii. Specific Duties

a. Advise Panel Members on Legal Issues - La. R.S. 40:1299.47D(5)

b. Send Copy of Panel Opinion to All Parties - La. R.S. 40:1299.47J

c. Oath of Office - La. R.S. 40:1299.47C(5)

b. Nominated Members

i. Oath of Office - La. R.S. 40:1299.47C(5)

ii. Determination of Fault

a) La. R.S. 40:1299.47G

b) Maxwell v. Soileau, App. 2 Cir. 1990, 561 So.2d 1378. The sole duty of the medical review panel is to express its expert opinion, no findings made by the panel as to damages, and the findings of the panel are not binding on the litigants.

iii. Possible Panel Opinions - La. R.S. 40:1299.47G

iv. Written Opinion - McCallister v. Zeichner, App. 3 Cir. 1995, 664 So.2d 848. Under statute, medical review panel must render opinion "with written reasons," and opinion is not complete without such reasons and panel has not fulfilled its statutory duty.

v. Use of Panel Members as Expert Witnesses - Medine v. Roniger, 862 So. 2d 160, 163 (La. Ct. App. 5 Cir., 2003) the provisions of the malpractice act do not distinguish between an expert witnesses' testimony as a panel member or as a witness retained by one of the parties. (N.B. This case is currently before the La. S.Ct.)

4. Life of Medical Review Panel

a. One Year From Appointment of Attorney Chairman - La. R.S. 40:1299.47B(1)(b)

b. 180 Days from Appointment of Final Panel Member - La. R.S. 40:1299.47G

c. 90 Days After Notification of All Parties of Dissolution or after Court-Ordered Extension

i. La. R.S. 40:1299.47B(3)

ii. LeBlanc v. Lakeside Hospital, App. 5 Cir. 1999, 732 So.2d 576. Medical review panel automatically dissolves upon the expiration of any court-ordered extension.

d. Extending the Life of the Medical Review Panel

i. La. R.S. 40:1299.47B(1)(b)

ii. In re Medical Review Panel ex rel. Chiasson, App. 5 Cir. 1999, 749 So.2d 796. Trial court acted within its discretion in determining that hospital did not show cause for extending life of medical review panel in medical malpractice action as no explanation for panel's delay in ruling was provided, and no hearing was requested.

5. Prescription Associated with Medical Review Panels

a. Interruption of Prescription During Panel Proceedings

i. Statutory Law - La. R.S. 40:1299.47A(2)(a)

ii. Jurisprudence

a. Guitreau v. Kucharchuk, 763 So. 2d 575 (La. 2000). The Court held when the ninety-day period of suspension after the decision of the medical review panel is completed, plaintiffs in medical malpractice actions are entitled to the period of time, under LSA-R.S. 9:5628, which remains unused at the time the request for a medical review panel is filed. Once a medical malpractice claim is submitted to the medical review panel, the prescriptive period is temporarily discontinued. Prescription then commences to run again ninety days after the plaintiff has received notice of the panel's decision. Thus, when the ninety day period expires, the period of suspension terminates and prescription commences to run again; once prescription begins to run again, counting begins at the point at which the suspension period originally began.

b. Baum v. Nash, 97-233 (La. App. 3 Cir. 10/8/97); 702 So. 2d 765. Filing a claim for a medical review panel suspends prescription as to non-named solidary obligors "to the same extent that it is suspended for those named in the request by the panel."

c. Commencement of the medical review panel proceedings will serve to suspend prescription. However, a written inquiry as to the status of a health care provider under the PCF, even if it includes allegations and conclusions of malpractice by the healthcare provider for whom the qualification

information is being sought, will not, in and of itself, serve to suspend prescription. (See In re Medical Review Panel Leday 96-2540 (La. App. 1 Cir. 11/7/97) 707 So. 2d 1267, writ granted, cause remanded by 97-3068 (La. 2/13/98)l 706 So.2d 985, reh. denied 97-3068 (La. 3/27/98); 716 So.2d 369, which stated, because the letter did not "request for review of a claim" under LSA-R.S. 40:1299.39.1 or LSA-R.S. 40:1299.47, same did not serve to suspend prescription.)

b. Failure of Panel to Render a Decision and Prescription

i. 180 Day Rule - La. R.S. 40:1299.47 K

ii. Bankston v. Alexandria Neurosurgical Clinic, App. 3 Cir. 1991, 583 So.2d 1148. Medical review panel's failure to render formal opinion did not deprive district court and Court of Appeal of jurisdiction over medical malpractice claim where panel had been dissolved without necessity of obtaining court order of dissolution upon its failure to issue written opinion within extension of time granted for rendering of opinion; once panel was dissolved, no procedural bar prevented patient from filing suit in district court, and it was incumbent upon patient to file suit to preserve her rights as dissolution of panel affected suspension of prescription with respect to defendants.

iii. One Year Rule Takes Precedence - Metrejean v. Long, App. 3 Cir. 1999, 732 So.2d 1240. Once 12-month period expires for medical review panel to render expert opinion, patient may file suit, even if the 180-day period for rendering opinion after selection of last panel member happens to extend beyond the one-year period.

c. Panel Renders a Late Decision -180 Day Rule - La. R.S. 40:1299.47L

d. Filing with Wrong State Agency - Bordelon v. Kaplan, App. 3 Cir. 1997, 692 So.2d 581. Filing of medical malpractice claim in the wrong or improper agency suspends, rather than interrupts, liberative prescriptive period, and at termination of period of suspension, prescription commences to run again.

e. Prescription in Hepatitis C Cases

i. Ginn v. Woman's Hospital Foundation, Inc., 770 So.2d 428 (LA. 2000). This is a Hepatitis C case following a blood transfusion in February of 1976. The blood transfusion occurred prior to the amendment to the Medical Malpractice Act which specifically included defects in blood which occurred on August 5, 1976. Therefore, at the time the plaintiff's injury occurred, she acquired a cause of action in strict tort liability under Civil Code Article 2315, which is a vested property right protected by the guarantee of due process. Therefore, the Court held legislation enacted afer the acquisition of such a vested property right cannot be retroactively applied so as to divest plaintiff of her cause of action in this matter.

ii. In Williams v. Jackson Parish Hospital, La. 2001, 798 So.2d 921, the Louisiana Supreme Court, apparently overruling their recent decision in Boutte, held pre-1982 claims in strict liability arising out of a defective blood transfusion are not traditional medical malpractice claims and, therefore, not governed by the Medical Malpractice Prescription Statute (La. R.S. 9:5628), but were governed by the General Tort Prescriptive Statute (La. C.C. Art. 3492.) .

f. PCF's Right to Raise Prescription - If a qualified healthcare defendant pays less than $100,000.00, the PCF may raise an exception of prescription, but the PCF cannot raise the issue of prescription if the defendant pays more than $100,000.00. McGrath v. Scel Home Care, Inc., App. 5 Cir. 2002. See also, Miller v. Southern Baptist Hospital, La. 2001, 806 So.2d 10.

g. Premature Suit DOES NOT Interrupt Prescription

i. The Louisiana Supreme Court in LeBreton v. Rabito, 97-C.C. - 2221 (La. 7/8/98) overruled the case of Hernandez v. Lafayette Bone and Joint Clinic, 467 So. 2d 113 (La. 3rd Cir. 1985) in holding:

> [T]he specific statutory provision providing for the suspension of prescription in a context of medical malpractice should have been applied alone, not complimentary to the more general codal articles which addresses interruption of prescription.

After discussing the purpose behind liberative prescription, the Court contrasted the general Civil Code Articles of Prescription dealing with interruption as compared to the Medical Malpractice Act for qualified health care providers which suspends the running of prescription during the pendency of medical review panel proceedings. The Court, believing the statutes were in conflict, and in order to "harmonize" the law, held special rules (here the Medical Malpractice Act) will always outweigh the general rules otherwise the special legislative provisions will be canceled out by the application of general laws. In such a conflict, the Court goes on to point out the purpose behind suspension of liberative prescription, is to accord plaintiffs an equal playing field during the pendency of the Medical Review Panel Proceedings.

ii. In Schulingcamp v. Ochsner Clinic, App. 5 Cir. 2002, the plaintiff filed suit, then entered a consent judgment dismissing one of the defendants without prejudice because the claim was premature, but keeping other defendants in the suit. A medical review panel was not filed against the dismissed defendant until 8 years later. The plaintiff argued the pending suit against the other defendants interrupted prescription against the dismissed defendant. Citing Lebreton v. Rabito for the proposition it was inappropriate to apply La. C.C. Art. 3463 (which interrupts prescription as long as the suit remained against the remaining obligors), the Court held the claim against the dismissed defendant was prescribed. The Court noted the later, more specific statute, the Medical Malpractice Act, applies and, because the plaintiff did not file the malpractice claim within one year, the claim was prescribed.

iii. In Wesco v. Columbia Lakeland Medical Center, App. 4 Cir., 801 So.2d 1187, the plaintiff filed a premature suit and a Medical Review Panel Claim which was dismissed after two years for failure of the plaintiff to select an attorney chairman. The defendant then had the suit dismissed as premature. When the plaintiff filed a second PFC claim within one year of the dismissal of the suit, but not within one year of the first PCF claim, the defendant filed an Exception of Prescription. The Court held the premature suit did not suspend prescription and

the plaintiff's claim was prescribed.

h. Wrongful Death Claim and Suspension of Prescription - Brown v. Our Lady of the Lake, App. 1 Cir., 803 So.2d 1135. A mother and son filed a Medical Review Panel Complaint alleging treatment the mother received was negligent, but the mother died during the pendency of the Medical Review Panel and the complaint was not amended to allege the mother's death. Within ninety days of the Panel Opinion, but more than one year after the mother's death, the son filed a wrongful death and survival action. The Court held the wrongful death claim was prescribed as it was not filed within one year of the death and the Medical Review Panel proceeding did not suspend prescription on the wrongful death claim because no notice of the death was given.

6. Submission of Evidence to Medical Review Panel

a. Written Evidence - La. R.S. 40:1299.47D(1)

b. Other Attachments to Submission of Evidence - La. R.S. 40:1299.47D(2)

c. Requirements of Claims for a Medical Review Panel - La. R.S. 40:1299.39 E(2)

7. Miscellaneous

a. Convening of Panel - La. R.S. 40:1299.47E

b. Additional Information Requested by Panel - La. R.S. 40:1299.47F.

c. Costs of the Medical Review Panel

i. Attorney Chairman - La. R.S. 40:1299.47I(1)(b)

ii. Physician Members - La. R.S. 40:1299.47I(1)(a)

iii. Who pays for the Panel

a) If the Defendant Wins - La. R.S. 40:1299.47I(2)(a)

b) If the Claimant Wins - La. R.S. 40:1299.47I(2)(b)

c) If There is a Material Issue of Fact - La. R.S. 40:1299.47I(3)

d. Admission of Panel Opinion in Subsequent Lawsuit - La. R.S. 40:1299.47H

e. Accrual of Legal Interest - La. R.S. 40:1299.47M

f. Bond Required at Onset of Laswsuit - La. R.S. 40:1299.47I(2)(c) and (d) as well as (3) and (4)

SECTION D. PATIENT'S COMPENSATION FUND

The Louisiana Patient's Compensation Fund is essentially a nonentity when it comes to its presence in a court of law. Under the first Prince Williams' case of Williams v. Kushner 449 So.2d 455 (La. 1984), the court found an action for amount of money in excess of the $100,000 paid by the settling physician in a continuation action "against the health care provider." Consequently, the settling defendant is retained as a nominal defendant through which the plaintiff's claim for in an amount in excess of $100,000 to continue against the Patient's Compensation Fund. In so finding, the court in Williams, supra page 458, stated "Hence, the only party defendant contemplated by the medical malpractice act is the health care provider."

1. Liability of the Patient's Compensation Fund

a. Bankruptcy of Defendant's Insurance Company

Ceasar v. Barry, 772 So.2d 331 (La. App. 3rd Cir. 2000). This case is an out shoot of the bankruptcy liquidation of Physicians National Risk Retention Group. After being placed in receivership, plaintiffs and Physicians National Risk Retention Group entered into the settlement agreement for the underlying $100,000.00. The settlement was approved by the bankruptcy court. The district court approved the settlement and liability was triggered under LSA-R.S. 40:1299.44. The insurer being in liquidation however, plaintiff only received the pro rata distribution of the insurer's assets which was estimated to be approximately 30% (i.e. $30,000.00). The fund perfected this appeal arguing the liability was not triggered insofar as plaintiff's did not actually receive $100,000. Relying on the 4th Circuit Court of Appeals opinion in Morgan v. United Medical Corporation of New Orleans, 697 So.2d 307 (La. 4th Cir. 1997), the 3rd Circuit stated:

> [P]laintiff should not be penalized by the bankruptcy of the insurer of a negligent health care provider and hold the continuing settlement obligation to pay $100,000, rather than the actual payment of $100,000, is sufficient to trigger the statutory admission of liability under LSA R.S. 1299.44(C)(5). Ceasar,772 So.2d at 35.

The mere agreement by the insurer to pay $100,000 regardless of its receipt by the patient is efficient to trigger statutory liability. The Court found the plaintiff should not bear their burden of establishing liability against the Patient's Compensation Fund because the underlying carrier is bankrupt.

b. PCF Cannot Create an Issue of Fact

Perkins v. Coastal Emergency Medical Services, 2001 La. App. 3rd Cir. Lexis 160. In the instant medical malpractice action, Plaintiffs received the underlying $100,000 statutory maximum triggering liability against the fund, and moved for summary judgment for the balance of $400,000 from the Patient's Compensation Fund. Summary judgment was granted by the trial court and the Patient's Compensation Fund perfected this appeal. The Court of Appeal held the malpractice victim is clearly entitled to the statutory limit of $500,000, summary judgment is appropriate to "eliminate the need for unnecessary litigation and promote judicial economy." The Court stated:

> "The PCF cannot create an issue of material fact by introducing the affidavit of the malpracticing physician recanting his admission of liability and substituting for that admission a scenario removing any causative relationship between his fault and the harm suffered."

The Court granted the plaintiff' s Motion for Summary Judgment noting plaintiff had proved damages in excess of $500,000 for the death of a wife of seventeen years and the PCF had failed to establish the existence of a genuine issue of material fact.

c. Settlement Terminates Issue of Liability as to the PCF

Judalet v. Kusalavage, 762 So.2d 1128 (La. App. 3rd Cir. 2000) This case involves a premature rupture of a mother's amniotic sac resulting in premature birth of a child and the child's acquisition of a

bacterial infection with permanent complications Dr. Kusalavage tendered $100,000 in settlement under LSA R.S. 40:1299. 41 et seq. The plaintiff moved for summary judgment for the balance of the $500.000 cap against the Patient's Compensation Fund. In opposition to the plaintiff's motion for summary judgment, the Patient' s Compensation Fund argued through expert testimony the fetus was not born prematurely. The trial court rendered a judgment in favor of plaintiff holding the fetus prematurity was a component part of the doctor's admission of liability.

The PCF then contended Dr. Kusalavage admitted only to the artificial rupturing of the membranes, not the permanent infirmities resulting from premature birth. Calling the PCF's argument "feeble," the 3rd Circuit confirmed the district court's summary judgment in favor of plaintiff stating it was extremely improbable a physician would pay $100,000 merely for the premature birth of a fetus absent any implications. The Court also pointed out treating physicians of the infant testified harm had resulted from the premature birth and extensive medical problems flowing therefrom included respiratory failure, Streptococcus Sepsis, intra ventricular hemorrhages, seizure disorder, ventriculus shunt surgeries, brain damage, global development delays, and life long physical and cognitive disabilities.

The Court instructed once a malpractice victim settles with a health care provider or its insurer for $ 100,000, the liability of the health care provider has been admitted or established. Settlement for a health care provider's maximum liability of $ 100,000 activates liability of the PCF and precludes it from contesting the health care provider's liability. La. R.S. 40:1299.42(B)(3). Thus, liability is admitted and settlement terminates the issue of liability in relation to the PCF as payment by one health care provider of the maximum amount of his liability statutorily establishes the plaintiff is a victim of the health care provider's malpractice. Once payment by one health care provider has triggered the statutory admission of liability, the Fund cannot contest the admission. The only issue between the victim and the Fund thereafter is the amount of damages sustained by the victim as a result of the admitted malpractice. The Court here found there were no genuine issues of material facts on issues of causation and damages flowing from the admitted malpractice.

In Stuka v. Flemming 561 So.2d 1371 (La. 1990) and Graham v. Willis-Knighton Medical Center 699 So.2d 368, the Supreme Court found specifically the only issue to be determined once the healthcare

provider has paid $100,000 is the amount of damages sustained by the plaintiff "as a result of the admitted malpractice."

Once payment by one health care provider has triggered the statutory admission of liability, the Fund cannot contest that admission. The only issue between the victim and the Fund thereafter is the amount of damages sustained by the victim as a result of the admitted malpractice. We recognize that this literal interpretation of the statute affords less rights to the Fund when claims against multiple health care providers are settled than when such claims are tried. In the case of a trial the Fund has the opportunity for reduced exposure when more than one health care provider is determined to be liable. But in the case of a settlement with one health care provider for $100,000 the Fund does not have this opportunity in the subsequent litigation with the victim. However, the Legislature chose in cases of settlement simply to declare the admission of liability by the $100,000 payment of one health care provider and did not provide for the Fund's affirmative right to litigate liability on the part of any other named or unnamed health care providers. Id at 1374.

See, Bridges v. Southwest Louisiana Hospital Association 746 So.2d 731 (La. 3rd Cir. 1999). But see, Conner v. Stelly, 807 So.2d 817 (La. 2002) where the Louisiana Supreme Court completely ignored Stuka, supra in a per curiam opinion stated:

Although payment of $100,000 in settlement establishes proof of liability for the malpractice and for damages of at least $100,000 resulting from the malpractice, at the trial against the Fund, the plaintiff has the burden of proving that the admitted malpractice caused damages in excess of $100,000. Graham v. Willis-Knighton Med. Ctr., 97-0188 (La. 9/9/97), 699 So.2d 365. Accordingly, that portion of the trial court's judgment prohibiting the PCF from arguing or presenting evidence before the jury that victim or third-party fault caused any of the damages in this case is reversed. Id at 827

The Court made no mention of Stuka, supra, not even a statement that Stuka case was now overruled. The plaintiff in Conner, supra, settled with one health care provider before trial and dismissed the other defendant and proceeded to trial against the PCF, just as was done in Stuka.

SECTION E. ADDENDUM CLAUSE

In the original act adopted in 1975, LSA-R.S. 40:1299.41(E) stated a specific dollar amount cannot be pled in the petition once a case advanced to suit. Instead, the prayer for relief shall be "for such damages as are reasonable in the premises." This was declared constitutional by Louisiana Supreme Court in Everett v. Goldman 359 So.2d 1256 (La. 1978). It is of little consequence in today's world in view of the amendment to Louisiana Code of Civil Procedure Article 893 which states no specific monetary amount shall be included in the allegations of the petition but the prayer for relief shall be "for such damages as are reasonable in the premises."

SECTION F. BURDEN OF PROOF - LSA-R.S. 9:2794

Physicians, dentists, optometrists, and chiropractic physicians; malpractice; burden of proof; jury charge; physician witness expert qualification

A. In a malpractice action based on the negligence of a physician licensed under R.S. 37:1261 et seq., a dentist licensed under R.S. 37:751 et seq., an optometrist licensed under R.S. 37:1041 et seq., or a chiropractic physician licensed under R.S. 37:2801 et seq., the plaintiff shall have the burden of proving:

(1) The degree of knowledge or skill possessed or the degree of care ordinarily exercised by physicians, dentists, optometrists, or chiropractic physicians licensed to practice in the state of Louisiana and actively practicing in a similar community or locale and under similar circumstances; and where the defendant practices in a particular specialty and where the alleged acts of medical negligence raise issues peculiar to the particular medical specialty involved, then the plaintiff has the burden of proving the degree of care ordinarily practiced by physicians, dentists, optometrists, or chiropractic physicians within the involved medical specialty.

(2) That the defendant either lacked this degree of knowledge or skill or failed to use reasonable care and diligence, along with his best judgment in the application of that skill.

(3) That as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

B. Any party to an action shall have the right to subpoena any physician, dentist, optometrist, or chiropractor for a deposition or testimony for trial, or both, to establish the degree of knowledge or skill possessed or degree of care ordinarily exercised as described in Subsection A of this Section without obtaining the consent of the physician, dentist, optometrist, or chiropractor who is going to be subpoenaed only if that physician, dentist, optometrist, or chiropractor has or possesses special knowledge or experience in the specific medical procedure or process that forms the basis of the action. The fee of the physician, dentist, optometrist, or chiropractor called for deposition or testimony, or both, under this

Subsection shall be set by the court.

C. In medical malpractice actions the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the negligence of the physician, dentist, optometrist, or chiropractic physician. The jury shall be further instructed that injury alone does not raise a presumption of the physician's, dentist's, optometrist's, or chiropractic physician's negligence. The provisions of this Section shall not apply to situations where the doctrine of res ipsa loquitur is found by the court to be applicable.

D.(1) In a medical malpractice action against a physician, licensed to practice medicine by the Louisiana State Board of Medical Examiners under R.S. 37:1261 et seq., for injury to or death of a patient, a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care only if the person is a physician who meets all of the following criteria:

(a) He is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose.

(b) He has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim.

(c) He is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of care.

(d) He is licensed to practice medicine by the Louisiana State Board of Medical Examiners under R.S. 37:1261 et seq., is licensed to practice medicine by any other jurisdiction in the United States, or is a graduate of a medical school accredited by the American Medical Association's Liaison Committee on Medical Education or the American Osteopathic Association.

(2) For the purposes of this Subsection, "practicing medicine" or "medical practice" includes but is not limited to training residents or students at an accredited school of medicine or osteopathy or serving as a consulting physician to other physicians who provide direct patient care, upon the request of such other physicians.

(3) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness is board certified or has other substantial training or experience in an area of medical practice relevant to the claim and is actively practicing in that area.

(4) The court shall apply the criteria specified in Paragraphs (1), (2), and (3) of this Subsection in determining whether a person is qualified to offer expert testimony on the issue of whether the physician departed from accepted standards of medical care.

(5) Nothing in this Subsection shall be construed to prohibit a physician from qualifying as an expert solely because he is a defendant in a medical malpractice claim.

1. Need for an Expert Witness

Fortenberry v. Berthier, 503 So.2d 596, 598 (La. App. 4th Cir. 1987)

"[P]laintiff could produce no expert testimony to support the malpractice suit in accordance with R.S. 9:2794."

Pfiffner v. Correa, 643 So.2d 1228, 1234 (La. 1994)

"We hold that expert testimony is not always necessary in order for a plaintiff to meet his burden of proof in establishing a medical malpractice claim. Though in most cases, because of the complex medical and factual issues involved, a plaintiff will likely fail to sustain his burden of proving his claim under LSA-R.S. 9:2794's requirements without medical experts, there are instances in which the medical and factual issues are such that a lay jury can perceive negligence in the charged physician's conduct as well as any expert can, or in which the defendant/physician testifies as to the standard of care and there is objective evidence, including the testimony of the defendant/demonstrates a breach thereof. Even so, the plaintiff must also demonstrate by a preponderance of the evidence a causal nexus between the defendant's fault and the injury alleged."

2. Res Ipsa Loquitur Doctrine

Cangelosi v. Our Lady of the Lake Regional Medical Center, 564 So.2d 654, 665 (La. 1990)

"In order to utilize the doctrine of res ipsa loquitur the plaintiff must establish a foundation of facts on which the doctrine may be applied. The injury must be of the type which does not ordinarily occur in the absence of negligence".

"The plaintiff does not have to eliminate all other possible causes or inferences, but must present evidence which indicates at least a probability that the injury would not have occurred without negligence".

"The facts established by plaintiff must also reasonably permit the jury to discount other possible causes and to conclude it was more likely than not that the defendant's negligence caused the injury. Again, the plaintiff does not have to eliminate completely all other possible causes, but should sufficiently exclude the inference of his own responsibility or the responsibility of others besides the defendant in causing the accident. The

inference of negligence points to the defendant when the conduct of others is eliminated as a more probable cause. The plaintiff must show not only that an accident occurred or that the accident was caused by the negligence of someone, but also that the circumstances warrant an inference of defendant's negligence".

"The plaintiff must also establish that the defendant's negligence indicated by the evidence falls within the scope of his duty to the plaintiff. This is often, but not necessarily, proved by a showing that the defendant was in exclusive control of the injury-causing instrumentality".

"Use of the doctrine of res ipsa loquitur in a negligence case, as in any case involving circumstantial evidence, does not relieve the plaintiff of the ultimate burden of proving by a preponderance of the evidence all of the elements necessary for recovery".

SECTION G. LOUISIANA MEDICAL CONSENT LAW (LSA-R.S. 40:1299.50 ET SEQ.) AND INFORMED CONSENT (LA. R.S. 40:1299.40).

1299.53. Persons who may consent to surgical or medical treatment

A. In addition to such other persons as may be authorized and empowered, any one of the following persons in the following order of priority, if there is no person in a prior class who is reasonably available, willing, and competent to act, is authorized and empowered to consent, either orally or otherwise, to any surgical or medical treatment or procedures including autopsy not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician:

(1) Any adult, for himself.

(2) The judicially appointed tutor or curator of the patient, if one has been appointed.

(3) An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions.

(4) The patient's spouse not judicially separated.

(5) An adult child of the patient.

(6) Any parent, whether adult or minor, for his minor child.

(7) The patient's sibling.

(8) The patient's other ascendants or descendants.

(9) Any person temporarily standing in loco parentis, whether formally serving or not, for the

minor under his care and any guardian for his ward.

B. If there is more than one person within the above named class in Paragraphs (A)(1) through (9), the consent for surgical or medical treatment shall be given by a majority of those members of the class available for consultation.

1299.54. Emergencies

A. In addition to any other instances in which a consent is excused or implied at law, a consent to surgical or medical treatment or procedures suggested, recommended, prescribed, or directed by a duly licensed physician will be implied where an emergency exists. For the purposes hereof, an emergency is defined as a situation wherein: (1) in competent medical judgment, the proposed surgical or medical treatment or procedures are reasonably necessary; and (2) a person authorized to consent under Section 1299.53 is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected, or could reasonably result in disfigurement or impair faculties.

B. For purposes of this Section, an emergency is also defined as a situation wherein: (1) a person transported to a hospital from a licensed health care facility is not in a condition to give consent; (2) a person authorized to give consent under 1299.53 is not readily available; and (3) any delay would be injurious to the health and well being of such person.

Hondroulis v. Schuhmacher, 553 So.2d 398 (La. 1988)

Brought the disclosure panel informed consent forms

SECTION H. PRESCRIPTION - LSA-R.S. 9:5628

Actions for medical malpractice

A. No action for damages for injury or death against any physician, chiropractor, nurse, licensed midwife practitioner, dentist, psychologist, optometrist, hospital or nursing home duly licensed under the laws of this state, or community blood center or tissue bank as defined in R.S. 40:1299.41(A), whether based upon tort, or breach of contract, or otherwise, arising out of patient care shall be brought unless filed within one year from the date of the alleged act, omission, or neglect, or within one year from the date of discovery of the alleged act, omission, or neglect; however, even as to claims filed within one year from the date of such discovery, in all events such claims shall be filed at the latest within a period of three years from the date of the alleged act, omission, or neglect.

B. The provisions of this Section shall apply to all persons whether or not infirm or under disability of any kind and including minors and interdicts.

C. The provisions of this Section shall apply to all healthcare providers listed herein or defined

in R.S. 40:1299.41 regardless of whether the healthcare provider avails itself of the protections and provisions of R.S. 40:1299.41 et seq., by fulfilling the requirements necessary to qualify as listed in R.S. 40:1299.42 and 1299.44.

Crier v. Whitecloud, 496 So.2d 305 (La. 1986)

Suit filed more than three years after the implantation of a Harrington Rod was deemed prescribed under LSA - R.S. 9:5628. This was the decision even though the rod did not fail until after the passage of three years after it's placement. This was the court's decision on rehearing. After it's original opinion, the Court found against prescription "because the onset of injury marked the first point in time that the courts could take cognizance of plaintiff's claim... the commencement of prescription... from the initial act or omission was suspended until the injury actually occurred."

Burden of Proof Regarding Prescription

In Campo v. Correa, 2001-2707 (La. 6/21/02), the Louisiana Supreme Court held a medical malpractice petition should not be found to be prescribed on its face if: it is brought within one year of the date of discovery; the facts alleged with particularity in the petition show the patient was unaware of malpractice prior to the alleged date of discovery; and the delay in filing suit was not due to willful, negligent, or unreasonable action of the patient. Therefore, as long as the plaintiff asserts the malpractice was not discovered until less than one year prior to filing the petition, the defendant retains the burden of showing the claim is prescribed.

Participating in Medical Review Panel of a Prescribed Action

In Tuazon v. Eisenhardt, 725 So.2d 553 (La. 5th Cir. 1998), the Court held to the long standing rule of solidary obligations interrupting prescription as to other solidary obligors finding, once prescription is accrued, it cannot be interrupted. Finding the original complaint filed on June 29, 1995, was beyond the date of prescription, the court concluded the proceedings did not serve to suspend the tolling of the prescriptive period as same was untimely. Regardless of the fact, the hospital chose to proceed through the medical review panel proceedings, its choice did not serve to suspend the running of prescription.

Constructive Knowledge

In Harold v. Martinez, 715 So.2d 660 (La. 2nd Cir. 1998), the Court of Appeal indicated the only necessary ingredient to begin the running of prescription is "constructive knowledge." It is not required an attorney or another health care provider inform the possibility of a malpractice action before prescription begins to run.

Amending Date of Alleged Malpractice and Prescription

In In Re: Medical Review Panel of David Wempren, 726 So.2d 477 (La. 5th Cir. 1999), Plaintiff's counsel filed a request for medical review panel within one year of the complained of event. However, in the complaint, the wrong date was set forth as to when the offending event occurred. More than a year after the event in question, plaintiff's counsel amended the original complaint and the hospital filed an exception of prescription which was denied by the trial court. The trial court and the Fifth Circuit Court of appeal relied upon Louisiana Civil Code of Procedure Article 1153 to find adequate and timely notice to the named defendants of the event in question and the amending petition related back to the original filing of the complaint for medical review panel proceedings. Accordingly, the court affirmed the denial of the exception of prescription.

Contra Non Valentum

Collum v. E.A. Conway Medical Center, 763 So.2d 808 (La. App. 2nd Cir 2000). Plaintiff argued her claim fell under the third category of *contra non valentem* because her ignorance of a potential cause of action was in some way "induced" by the defendants when they allegedly neglected to inform her of their actions. The Court rejected plaintiff's argument citing the Louisiana Supreme Court has specifically limited application of this third category to instances where a physician's conduct rose "to the level of concealment, misrepresentation, fraud or ill practices."

Plaintiff also argued the three year prescriptive period should be interrupted because the alleged malpractice falls under the "continuing tort" doctrine. The Court of Appeal rejected plaintiff's argument in citing prescription runs on a continuing tort from the "cessation of the wrongful conduct that causes of damages where the cause of injury is a continuous one given rise to the successive damages," Collum So.2d at 815 In Crump v. Sabine River Authority, 737 So.2d 720 (La. 1999). The Court clarified stating a continual tort is occasioned by unlawful acts, not "the continuation of the ill effects of an original, wrongful act." Id at 728. In this instance, the Court found plaintiff was merely suffering the continuation ill effects of the original act same is not a continuing tort.

SECTION I. SOLIDARITY OBLIGATION V. JOINT TORT FEASOR INTERRUPTION OF PRESCRIPTION DOCTORS V. HOSPITALS

SECTION J. HOSPITAL CORPORATE LIABILITY AND INSTITUTIONAL NEGLIGENCE - UNDER MMA

1. Employee Negligence

a. **Patin v. The Administrators of the Tulane Educational Fund,** 770 So.2d 816 (La. 4th Cir. 2000). As with all limiting laws, the Medical Malpractice Act is strictly construed against coverage. In this instance, the Court held the transfer of blood from Touro Infirmary to Tulane did not fall within the Malpractice Act because there was no health care provider patient relationship between Touro Infirmary and Plaintiff. The Court rejected Touro's argument which asserted the plaintiff's claim fell within the Malpractice Act of the State of Louisiana as it had an implicit contract with Mr. Patin because Tulane sought blood from Touro on behalf of Mr. Patin.

b. **George vs. Our Lady of Lourdes Regional Medical Center, Inc.**, 774 So.2d 350 (La. App. 3rd Cir. 2000). Plaintiff fell down the steps of the mobile unit after donating blood. The 3rd Circuit Court of Appeal held the plaintiff's claim did not fall within the medical malpractice act stated:

> To constitute malpractice, health care or professional services must be rendered to a patient. *Citations omitted*. Ms. George's sole remedy against Medical Center is based on the general law of negligence and not on the special tort of malpractice. George 774 So.2d at 356.

c. In **Williams v. Jackson Parish Hospital**, La. 2001, 798 So.2d 921, the Louisiana Supreme Court, apparently overruling their recent decision in Boutte, held pre-1982 claims in strict liability arising out of a defective blood transfusion are not traditional medical malpractice claims and, therefore, not governed by the Medical Malpractice Prescription Statute (La. R.S. 9:5628), but were governed by the General Tort Prescriptive Statute (La. C.C. Art. 3492.) .

d. **Fuentes v. Doctors Hospital of Jefferson**, 4 Cir. 2001, 802 So.2d 865. Patient's claims against an ultrasound technician in a hospital who took inappropriate sexual liberties with the patient following the performance of an ultrasound was an intentional tort which is not

covered under the Medical Malpractice Act. The patient's claim against the hospital for negligent hiring was not covered as it did not involve patient care. Only the claims against the hospital stating the presence of a third person during the examination were required fell under the Medical Malpractice Act.

e. Test to Determine Coverage under Medical Malpractice Act

The Louisiana Supreme Court, in overruling the 4th Circuit's holding patient dumping allegations against a physician were not governed by the Medical Malpractice Act, uses the following factors to determine whether allegations fall under the Medical Malpractice Act:

a. Whether the wrong was treatment related;

b. Whether expert evidence is needed to determine if the standard of care was breached;

c. Whether the act or omission involved assessing the patient's condition;

d. Whether the incident occurred in the context of a physician/patient relationship; and whether it was within the scope of activities the hospital was licensed to perform; and

e. Whether the injury would not have occurred if the patient had not sought treatment. Coleman v. Deno, 01-1517 (La. 1/25/02), 813 So.2d 303.

2. Nursing Home Coverage Under the MMA -

a. In **Pender v. Natchitoches Parish Hospital**, App. 3 Cir. 2001, a nursing home patient, left unrestrained in a wheelchair, fell and died after she struck her head. The Court held the nursing home Residents' Bill of Rights creates a cause of action for violations of nursing home residents' rights, the enforcement of which does not require adherence to the Medical Malpractice Act. Furthermore, the Court noted the petition was not rooted in medical malpractice as the fall from a wheelchair was not related to any specific treatment and did not meet the criteria set forth in Coleman v. Deno for determining a claim falls under the MMA.

b. In **Richard v. Louisiana Extended Care Centers, Inc.**, La. S.Ct. 2003, the Louisiana Supreme Court held "to be covered under the MMA, the negligent act must be related to medical treatment." It reiterated the six part test from Coleman to determine whether a negligent act by a health care provider is covered under the MMA. The Court concluded "the legislature's enactment of the Nursing Home Bill of Rights Act was not intended to remove malpractice claims against qualified health care providers from the coverage of the MMA, but was instead intended to provide nursing home residents with important rights to preserve their dignity and personal integrity, and to provide a means by which they could enforce these rights." Therefore, "to constitute a medical malpractice claim, the alleged negligent act must be related to the nursing home resident's medical treatment at the nursing home under the requirements of Louisiana law."

3. Withdrawal of Life Support

In **Causey v. St. Francis Medical Center**, 719 So.2d 1072 (2nd Cir. 1998), the decision to discontinue life support procedures on a comatose patient whose family objected to the discontinuation was found to be an issue falling under the medical malpractice act, and the matter had to be submitted to a medical review panel before suit could be filed. After the family refused to grant permission to withdraw life support, the physician turned to the hospital's Morals and Ethics Board which agreed with the withdrawal. The Morals and Ethics Board is covered under the Medical Malpractice Act as it is a board of the hospital.

4. LeJeune Claims -

Trahan v. McManus, 728 So.2d 1273 (La. 1999). Plaintiffs were the parents of a decedent attempting to recover 2315.6 damages for mental anguish and emotional distress resulting from their son's injury and death. The two issues before the Louisiana Supreme Court were whether the claim fell within the medical malpractice act and whether "by-stander damages" (also known as Lejuene damages) are recoverable when the event at issue was an act or omission by a health care provider the Louisiana Supreme Court held:

> The fact damages recoverable under article 2315.6 are limited to mental anguish damages and to specifically required facts and circumstances does not serve to remove article 2315.6 claims from the applicability of the Medical Malpractice Act, as long as the mental

> anguish arises from the injury to or death of a patient caused by the negligence of a qualified health care provider. Id. at 1277.

The Louisiana Supreme Court reiterated tort damage for medical malpractice falls under article 2315, et seq., and it is not the quality of the claimant, but the context within which the claim arises through medical care and treatment provided to a patient. The medical malpractice act does not create a cause of action for negligent medical care as same is created under article 2315, et seq. The Medical Malpractice Act only provides the procedural mechanism for the presentation of such claims. The Louisiana Supreme Court in this case states:

> The requirements of Article 2315.6, when read together, suggest a need for temporal proximity between the tortious event, the victim's observable harm and the plaintiff's mental distress arising from and an awareness of the harm caused by the event. Id. at 1279.

5. EMTALA Claims (See also Section K below for more in depth coverage)

Spradlin v. Acadia-St. Landry Medical Foundation, 758 So.2d 116 (La. 2000). The Supreme Court held EMTALA claims must also be submitted for review to a medical review panel and explained although the courts have construed EMTALA as creating a federal cause of action separate and distinct from, and not duplicative of, state malpractice cause of action, medical malpractice claims and "dumping" claims often overlap. Since EMTALA only preempts state law to the extent state law "directly conflicts" with federal law, the only issue is whether imposing a mandatory pre-suit medical review panel requirement "directly conflicts" with EMTALA. As dual compliance was not physically impossible, there was no actual conflict. Also, state law "actually conflicts" with federal law "where state law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress." Plaintiffs in this matter, demanded damages under EMTALA based on defendant's alleged breach of its duty to properly stabilize or to appropriately transfer Mrs. Spradlin; if plaintiffs prove a violation of the requirements of EMTALA (which does not distinguish between intentional and unintentional conduct), they will be entitled to recover the appropriate damages.

The facts recited in plaintiffs' petition do not state a claim under EMTALA based on failure to perform a medical screening examination (or based on disparate treatment in that examination, as opposed to pay patients); therefore, whether there was any negligence in the diagnosis and treatment

by the emergency room doctor prior to the decision to transfer is a matter to be addressed in the separate medical malpractice action.

Plaintiffs also alleged in this action conduct by defendant's employees fell below the professional standard of care and constituted medical malpractice. The Court held this claim must be submitted first to a medical review panel before plaintiffs can file the claim in district court. It recognized that requiring separate suits based on related claims growing out of the same transaction or occurrence appears to be judicially inefficient and may produce inconsistent results; however, the court in the EMTALA action (which must be filed within two years) may consider whether it is appropriate under the particular facts and circumstances to grant a motion to stay the action, while urging expeditious action in the medical review panel proceeding. Thus plaintiffs were entitled to recover damages on both claims, whether in one or two trials, despite the fact the law requires exhaustion of an administrative remedy in one action which is not applicable to the other.

6. Under staffing

1. ACOG/AWHONN recommend the following staffing levels in Labor and Delivery Units:

a. Antepartum testing 1:1-2
b. Laboring patients 1:2
c. Patients in 2nd stage of labor 1:1
d. Ill patients with complications 1:1
e. Oxytocin induction/augmentation of labor 1:2
f. Coverage of epidural anesthesia 1:1
g. Circulation for cesarean delivery 1:1
h. Antepartum/postpartum patients without complications 1:6
i. Postoperative recovery 1:2
j. Patients with complications, stable 1:3

2. In **Merritt v. Karcioglu**, La. 4 Cir. 1996, 668 So.2d 469, the Fourth Circuit indicated “on the day in question, there were 6 critical care patients on the ward, but only 4 nurses, one of whom was there strictly for observation, such that there were only 3 active nurses for the six patients. Accordingly, the jury could have concluded that Tulane was negligent in under staffing the ward and in requiring Nurse Wolff to be in two places at the same time, i.e. watching Mrs. Boutte and being with the code patient. Accordingly, we cannot conclude that the jury was manifestly erroneous.” Although the Louisiana Supreme Court amended the damages to confirm with the statutory cap, they did not reverse this finding of fact.

3. Our courts have formulated duties of care on an individual basis to determine when a hospital's governing body is responsible for its own acts or omissions which cause injury to a patient. Sibley I, 477 So.2d at 1099.

Examples:

a. The governing board's duty to select its employees with reasonable care, Grant v. Touro Infirmary, 254 La. 204, 223 So. 2d 148 (1969), overruled on other grounds by Garlington v. Kingsley, 289 So.2d 88 (La. 1974.)

b. The board's duty to furnish the hospital with reasonably adequate supplies, equipment and facilities for use in treatment and diagnosis of patients; Snipes v. Southern Baptist Hospital, 243 So. 2d 298 (La. App. 4th Cir. 1971); Lauro v. Travelers Ins. Co., 261 So. 2d 261 (La. App. 4th Cir.), writ denied, 262 La. 188, 262 So. 2d 787 (1972).

c. Duty to provide adequate procedures for maintenance and safety of its grounds and buildings, Head v. St. Paul Fire & Marine Ins. Co. 408 So. 2d 1174 (La. App. 3d Cir.), writ denied, 412 So. 2d 99 (La. 1982); Roark v. St. Paul Fire & Marine Ins. Co., 415 So. 2d 295 (La. App. 2d Cir.), writ denied, 416 So. 2d 557 (La. 1982).

d. A breach of one of the above listed duties or a similar duty which causes injury to the patient may constitute independent negligence of a hospital's governing board even in the absence of any finding of negligent conduct by an employee. Sibley I, 477 So. 2d at 1099. Alternatively, a hospital may be required to answer for the negligence of its employees, even though no negligence is proved against its governing board. Sibley I, 477 So. 2d at 1099.

7. Non-Employee Negligence

a. Physician Status as Employee Versus Independent Contractor.

In Powell v. Fuentes, 786 So. 2d 277 (La. App 2nd Cir. 2001), the plaintiff sought care at Winn Parish Medical Center's (WPMC) emergency room for an accidental injury and was treated by Dr. Fuentes, who failed to remove a foreign object from the wound,

resulting in infection and a subsequent removal and hospitalization. WPMC asserted the physician was an independent contractor. While there was an independent contractor agreement between WPMC and the physician's employer, that was not necessarily dispositive of whether Dr. Fuentes was an independent contractor. The degree of control which the hospital could exert over Dr. Fuentes, whether or not it actually exerted that control, determined whether Dr. Fuentes was truly an independent contractor. WPMC 's by-laws and its agreement with Dr. Fuentes' employer, demonstrated he was bound by the hospital's rules which controlled the activities of an emergency room physician. A genuine issue of material fact existed as to whether WPMC had the right to control the manner in which Dr. Fuentes rendered his services, so the hospital was not entitled to summary judgment. Id.

Of primary concern is whether the principal retained the right to control the work. The important question is whether, from the nature of the relationship, the right to do so exists, not whether supervision and control was actually exercised. Hickman v. Southern Pacific Transport Co., 262 La. 102, 262 So. 2d 385 (1972); Roberts v. State, Through La. Health, etc., *404 So. 2d 1221 (La. 1981);* Smith v. Crown Zellerbach, 486 So. 2d 798 (La. App. 3d Cir. [1986]), writ denied, 489 So. 2d 246 (1986). The distinction between employee and independent contractor status is a factual determination to be decided on a case-by-case basis. Fontenot v. *J.K.* Richard Trucking, 97-220 (La. App. 3 Cir. 6/4/97); 696 So. 2d 176, 180. Id. at 281.

The existence of an independent contractor agreement is not necessarily dispositive of the issue of whether a doctor is an independent contractor, as opposed to an employee of a hospital, and courts will inquire as to the real nature of the relationship and the degree of control exercised or ability of control by the hospital over the doctor's activities. Prater v. Porter, 98-1481 (La. App. 3d Cir. 1999), 737 So. 2d 102; Suhor v. Medina, 421 So. 2d 271 (La. App. 4th Cir. 1982). Whether an emergency room physician is an employee or an independent contractor is a factual issue turning on the control exercised by the hospital over his activities. Hastings v. Baton Rouge Gen. Hosp., 498 So. 2d 713 (La. 1986); Suhor, supra. In fact, "[a] hospital's duty and corresponding liability for breach of that duty is in direct proportion to its right to control the medical treatment rendered there."

In Prater v. Porter, 737 So. 2d 102 (La. App. 3rd Cir. 1999), Plaintiff was injured in a car accident and was taken to defendant hospital, Beaureguard Memorial Hospital, where defendant doctors treated him. The plaintiff alleged the defendant doctors failed to diagnose

and treat fractures located in his cervical spine, which later rendered him paralyzed. Beaureguard Memorial was dismissed without prejudice by consent. The plaintiff later added defendant corporation, Spectrum, alleging that it contracted with the hospital to provide emergency room physicians resulting in an employee/employer or principal/independent contractor relationship between it and defendant doctors. Spectrum introduced five exhibits into the record in support of its motion for summary judgment, one being answers to interrogatories and requests for production where it was stated the "Independent Contractor Physician Agreements" between Spectrum and Drs. Driggs and Small were in effect in September 1995, and provided that the physicians were independent contractors and that Spectrum would not exercise any type of control relating to the manner or means in which they performed medical services or decisions in the emergency department.

The agreements, entitled "Independent Contractor Physician Agreements," provide the average number of hours per week and the number of weeks per year that the physicians are to provide emergency services for Beauregard Memorial; the hourly fee to be paid to the physician, a definite term that the agreement will last, and the manner in which it might be terminated. The agreement provides, in pertinent part,:

2. Physician agrees to abide by the working rules and to maintain the high professional, ethical, and moral standards of the Hospital Medical Staff. *Physician's services and the manner of providing them are under the supervision of the Hospital Medical Staff* ...

5. This Agreement shall in no way be construed to mean or suggest Corporation is engaged in the practice of medicine.

6. *The relationship between Corporation and Physician pursuant to this Agreement shall be that of Independent Contractor. Corporation shall not exercise control of any nature, kind or description, relating to the manner or means in which Physician performs medical services or decisions in the emergency department. Physician shall be responsible for Physician's own actions and shall be subject to the application of the By-laws, Rules, and Regulations of the Medical Staff of Hospital.*

10. (c) The parties hereto recognize that providing services to

emergency patients is a mixture of clinical skill and interpersonal relationships with patients, their families, hospital medical staff and administrator. *Therefore, this Agreement is contingent upon Hospital's approval of Physician and its granting of medical staff privileges to Physician.* If Hospital withdraws its approval of Physician and requests that Physician no longer be scheduled at Hospital or withdraws medical staff privileges, then Corporation may terminate this Agreement immediately by giving written notice to Physician by U.S. Certified Mail, Return Receipt Requested.

The Third Circuit granted summary judgment in Spectrum's favor. The plaintiff conceded during argument that Spectrum had no control over how the physicians performed their professional medical services. It is obvious from the agreements that the physicians were under the control and supervision of Beauregard Memorial. *The right of control is the single most important factor considered in determining employer/employee status*. Id. ; Suhor, 421 So.2d 271(La. App. 4th Cir. 1982).

In Royer v. St. Paul Fire & Marine Insurance Company, 502 So. 2d 232 (La. App. 3rd Cir. 1987), the plaintiff sued a radiologist who was a member of a radiological group performing services at Lafreneirre General Hospital, and attempted to convince the court the radiologist was an employee of the hospital as opposed to being an independent contractor. The court found the radiologist was part of a group providing services, pursuant to a contract, with the hospital. Id. at 237. The group provided and maintained its equipment and hired its own employees. Id. The hospital had no supervision or control over the professional medical judgment of the radiologist. However, the hospital reserved the right to terminate the contract, if the hospital and a third party opinion, determined the services provided by the radiologist was sub-standard. Id.

Further, the hospital collected payments from patients and remitted a percentage to the radiology group. The radiology group paid its own social security and FICA and provided for its own malpractice and workers' compensation insurance. This court held the radiologist was not an employee of the hospital and the hospital could not be held vicariously liable for the actions of the radiologist. Id.

In Marchetta v. CPC of Louisiana, 759 So. 2d 151 (La. App. 4th Cir. 322, 2000), the plaintiff alleged malpractice of a psychiatrist, claiming the psychiatrist was an employee of the treatment center; thus,

making the treatment center vicariously liable for the actions of the psychiatrist. . The Fourth Circuit held the defendant psychiatrist was an independent contractor and not an employee of the hospital. Id. at 157. In its reasons for judgment, the Fourth Circuit determined the psychiatrist was not full-time, nor worked exclusively for the treatment center and stated the psychiatrist had a private practice, which included working with other facilities. Id.

Again, the right of control determined employee status.

In Suhor v. Medina, 421 So. 2d 271 (La. App. 4th Cir. 1982), the Fourth Circuit determined the physician was an employee of the hospital. In its reasons supporting its holding, the Fourth Circuit stated the physician worked full-time and exclusively for the hospital, pursuant to a contract receiving a salary without receiving any patient's billings collected by the hospital. Id. at 274. The physician had no expenses to pay and works according to a pre-determined schedule with administrative responsibilities over hospital personnel, and must perform all services to those who present themselves and to in-patients as needed. Id. The court found the hospital controlled the working time and the physical activities of the physician. The physician offered his personal services for a stipulated sum and was voluntarily subject to the supervision and various administrative controls of the hospital. Id. The totality of these facts mandate the physician be characterized as an employee of the hospital. Id.

Section K. EMTALA

1. Louisiana Statutory Law

La. R.S. 40:2113.4 Duty to provide services; penalty

A. Any general hospital licensed under this Part, which is owned or operated, or both, by a hospital service district, which benefits from being financed by the sale of bonds are exempt from taxation as provided by Louisiana law, or which receives any other type of financial assistance from the state of Louisiana and which offers emergency room services to the public and is actually offering such services at the time, shall make its emergency services available to all persons residing in the territorial area of the hospital regardless of whether the person is covered by private, federal Medicare or Medicaid, or other insurance. Each person shall receive these services free from discrimination based on race, religion, or national ancestry and from arbitrary, capricious, or unreasonable

discrimination based on age, sex, or physical condition and economic status. However, in no event shall emergency treatment be denied to anyone on account of inability to pay. Any such hospital found to be in violation of this Section shall not receive any client referrals from the Department of Health and Hospitals.

B. For purposes of this Section, "emergency" means a physical condition which places the person in imminent danger of death or permanent disability, or in cases of rape; however, the person may be directed to another hospital which has been designated by the coroner of the parish as a facility which specializes in care and treatment of rape victims. "Emergency services" means those services which are available in the emergency room and surgical units in order to sustain the persons' life and prevent disablement until the person is in condition to be able to travel to another appropriate facility without undue risk of serious harm to the person. Those general hospitals which do not have emergency room physician services available at the time of the emergency shall not be in violation of this Section, if after a good faith reasonable effort a physician is unavailable to provide those medical services, which according to law, only physicians are authorized to perform.

C.(1) In all cases in which a child under fourteen has been raped or physically or sexually abused, the coroner of the parish may direct the person to a facility which has been designated by said coroner as a facility which specializes in the care and treatment of such victims.

(2) The coroner, in conjunction with the designated facility and the district attorney and local law enforcement authority, may provide for and equip a room for videotaping a child pursuant to R.S. 15:440.1 through 440.6.

LSA-R.S. 40:2113.5 Services to elderly persons

Any general hospital licensed under this Part, which is owned or operated, or both, by a hospital service district, or which benefits from being financed by the sale of bonds from the state or guaranteed by the state that are exempt from taxation as provided by Louisiana law, or which receives any other type of financial assistance from the state, is directed to give, when possible, priority to the treatment of elderly, physically handicapped, or mentally handicapped persons in the delivery of non-emergency health care services.

LSA-R.S. 40:2113.6 Emergency diagnoses and services; denial for inability to pay; discriminatory practices

A.(1) No officer, employee, or member of the medical staff of a hospital licensed by the Department of Health and Hospitals shall deny emergency services available at the hospital to a person diagnosed by a licensed physician as requiring emergency services because the person is unable to establish his ability to pay for the services or because of race, religion, or national ancestry. In addition, the person needing the services shall not be subjected by any such person to arbitrary, capricious, or unreasonable discrimination based on age, sex, physical condition, or economic status.

(2) This Section shall not prohibit or apply to any action taken by a hospital, officer, employee, member of the medical staff, or physician which substantially complies with applicable federal law or regulation.

B. No officer, employee, or member of the medical staff of a hospital licensed by the Department of Health and Hospitals shall deny a person in need of emergency services access to diagnosis by a licensed physician on the staff of the hospital because the person is unable to establish his ability to pay for the services or because of race, religion, or national ancestry. In addition, the person needing the services shall not be subjected by any such person to arbitrary, capricious, or unreasonable discrimination based on age, sex, physical condition, or economic status.

C. "Emergency services" means services that are usually and customarily available at the respective hospital and that must be provided immediately to stabilize a medical condition which, if not stabilized, could reasonably be expected to result in the loss of the person's life, serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or which is necessary to provide for the care of a woman in active labor if the hospital is so equipped and, if the hospital is not so equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.

D. No hospital or any officer or employee who makes a good faith effort to comply with the provisions of this Section shall be found in violation of this Section for the failure of another officer, employee, or member of the medical staff or physician to provide or delegate the provision of medical services or diagnosis as required by this Section.

E. Each hospital to which this Section applies shall provide written notice of the provisions of this Section to all officers, employees, and members of the medical staff, and other appropriate personnel who have duties related to access to and delivery of emergency services.

F. An officer, employee, or member of the medical staff of a hospital who intentionally or recklessly violates the provisions of this Section may be subject to a fine of not more than five thousand dollars and may be suspended from the

state medical assistance program. Subsequent intentional or reckless violations shall be punishable by a fine of five thousand dollars and termination of participation in the state medical assistance program. For the purposes of this Section, any violation occurring more than six months after the last such violation shall not be considered a subsequent violation.

2. Federal Statutory Law

42 USCS § 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title [*42 USCS § § 1395* et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor.

(1) In general. If any individual (whether or not eligible for benefits under this title [*42 USCS § § 1395* et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either–

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c)

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or

a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized.

(1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless–

(A) (i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1) [*42 USCS § 1395x*(r)(1)]) has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1) [*42 USCS § 1395x*(r)(1)]), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer–

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility–

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility with all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of

individuals transferred.

(d) Enforcement.

(1) Civil monetary penalties.

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $ 50,000 (or not more than $ 25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1128A [*42 USCS § 1320a-7a]* (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a) [*42 USCS § 1320a-7a*(a)].

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who–

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,is subject to a civil money penalty of not more than $ 50,000 for each such violation and, if the violation is [is] gross and flagrant or is repeated, to exclusion from participation in this title [*42 USCS § § 1395* et seq.] and State health care programs.

The provisions of section 1128A [*42 USCS § 1320a-7a]* (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or

proceeding under section 1128A(a) [*42 USCS § 1320a-7a*(a)].

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I) [*42 USCS § 1395cc*(a)(1)(I)]) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement.

(A) Personal harm. Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations. In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the

appropriate utilization and quality control peer review organization (with a contract under part B of title XI [*42 USCS § § 1320c* et seq.]) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) Definitions. In this section:

(1) The term "emergency medical condition" means–

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in–

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women [woman] who is having contractions–

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 [*42 USCS § 1395cc].*

(3) (A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such

medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during from the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1861(mm)(1) [*42 USCS § 1395x*(mm)(1)]).

(f) Preemption. The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination. A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment. A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistle blower protections. A participating hospital may not penalize or

take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

3. Louisiana Jurisprudence

In Coleman v. Deno, 813 So2d 303 (La. 2002), Louis Coleman, then thirty-two years old, underwent surgery at Charity Hospital in New Orleans (CHNO). During the surgery, his left arm was amputated to save his life. Coleman initially sought emergency treatment at JoEllen Smith Hospital (JESH), where he presented twice within a forty-hour interval on June 7 and 8, 1988. On the second visit to JESH, the emergency room physician transferred Coleman to CHNO. Id.

Dr. Deno diagnosed Coleman with left arm cellulitis, and determined Coleman required inpatient intravenous antibiotic treatment. At that point, the treatment decision became where Coleman should receive such treatment. Ultimately, Dr. Deno determined a transfer for inpatient admission at CHNO was appropriate for two reasons: (1) given Coleman's lack of insurance he would not be able to financially afford private hospitalization at JESH, and (2) given CHNO–a Level I Trauma Center with a full-scale, on-site laboratory--was better equipped and more experienced than JESH–a Level II Trauma Center lacking such an in-house laboratory--at treating complicated infections of the type experienced by Coleman. Id. at 308.

While the trial court granted Dr. Deno's exception of no cause of action as to Coleman's "patient dumping" allegations, the court of appeal characterized the claim as an intentional tort of improper patient transfer based on Louisiana tort law, La. Civ. Code Art. 2315. As such, the court reasoned it was not "malpractice" under the MMA. In so holding, the appellate court concluded Coleman pled two distinct causes of action: (1) negligent failure to treat--malpractice, and (2) an intentional tort based on EMTALA for transfer to CHNO because of lack of funds-not malpractice. For the following reasons, the Supreme Court reversed the appellate court's conclusion Dr. Deno was additionally at fault under general tort law for the intentional tort of "patient dumping". Id. at 313.

In both Spradlin v. Acadiana St. Landry Medical Foundation, 758 So.2d 116 (La. 2000) and Fleming v. HCA Health Services of Louisiana, Inc., 691 So.2d 1216 (La. 1997) the defendant was a hospital; the defendant in the Coleman case is an emergency room physician. The significance of this distinction is two-fold. First, the statutory duties imposed by EMTALA, and the Louisiana statutory counterpart, apply only to participating hospitals, not physicians. Second, hospitals are distinct legal entities that do not, in the

traditional sense of the term, "practice" medicine; whereas, physicians do "practice" their profession, and their negligence in providing such professional services is termed "malpractice." *Frank L. Maraist & Thomas C. Galligan*, Jr., *Louisiana Tort Law* §§ 21-2 (1996). The significance of the term "malpractice" is that it is used to differentiate professionals from nonprofessionals for purposes of applying certain statutory limitations of tort liability. Coleman, 813 so.2d at 314. The limitation of tort liability at issue in this case is the MMA.

In Spradlin, the Supreme Court discussed the nature and purpose of both EMTALA and the Louisiana statutory counterpart and the relationship between those two "anti-dumping" statutes and the MMA. Simply stated, EMTALA imposes two statutory obligations on participating hospitals; to wit (i) to provide an appropriate medical screening, and (ii) to provide individuals who are found to have an "emergency medical condition" with treatment needed to "stabilize" the condition before transferring them to another hospital or back home. To ensure compliance with those obligations, EMTALA provides a private cause of action against participating hospitals for two distinct types of dumping claims: (i) failure to appropriately screen, and (ii) failure to stabilize an emergency medical condition. Spradlin, 758 So.2d 116; Coleman, 813 So.2d at 315. Consistent with the statutory language, the legislative history of the EMTALA evinces a clear Congressional intent to bar individuals from pursuing civil actions against physicians. Id.; Eberhardt v. City of Los Angeles, 62 f.3rd 1253.

Section L. Hospital Liability and Negligence Arising out of Granting of Privileges and Discipline of Physicians

Geiger v. Dep't of Health & Hosp., 815 So. 2d 80, (LA 2002)

Plaintiffs were the parents of a seven-month-old child who fell from an indoor swing and was treated at Earl K. Long Hospital in Baton Rouge. Plaintiffs filed suit on July 14, 1993 against Spalding & Evenflo Companies, Inc., Evenflo Juvenile Furniture Co., and Infanseat for products liability, and against the Department of Health and Human Resources and Earl K. Long Memorial Hospital for medical malpractice. The plaintiffs alleged the products liability defendants and the medical malpractice defendants were liable "jointly, severally and in solido."

On August 4, 1993, the state filed exceptions of prematurity because plaintiffs had not presented their complaint to a state medical review panel before filing suit, as required by La. R.S. 40:1299.39.1(B)(1)(a)(i). Plaintiffs filed a request for a medical review panel on August 20, 1993. In June of 1996, the medical review panel rendered an opinion in favor of plaintiffs. On June 26, 1996, plaintiffs filed a second lawsuit against the state for medical malpractice.

Plaintiffs waited 402 days, more than a year from the date of the act to file the medical review panel request. The petition did not specify a date on which the act of alleged malpractice occurred, nor did the record contain any hospital records indicating when the child was admitted to or released from the hospital. Plaintiffs contended for the first time on appeal the state failed to prove the malpractice suit had prescribed from the date of discovery of the act of alleged malpractice and asserted they had not yet discovered the alleged malpractice until July 14, 1992 or sometime thereafter.
The court believed the petition was poorly written, but took into consideration the case involved a head injury to a seven-month-old child in exercising its discretionary power and remanding the case to the trial court to determine when the plaintiffs discovered the alleged medical malpractice.

The court relied on White v. West Carroll Hosp., Inc., 613 So. 2d 150 (La. 1992) in holding a remand for new evidence must be based upon examination of the merits and is warranted only when the state of the record is such that new evidence is likely to affect the outcome of the case. See White, 613 So. 2d at 154 (*citing* Herbert, 232 So. 2d at 464-65).

Williams v. State, 801 So. 2d 463, (La. App. 1st Cir. 2001)

Plaintiffs alleged the defendant hospital was negligent in hiring the surgeon who performed the operation on Mr. Williams which caused his damages. The hospital asserted negligent hiring is malpractice and must first be presented to a medical review panel. Thus, the issue became whether the hospital's alleged negligent hiring of the surgeon meets the applicable definition of medical malpractice.

The court relied upon Garnica v. Louisiana State University Medical Center, 744 So. 2d 156, 158-160 (La.App. 4th Cir. 1999), writ denied, 751 So. 2d 879 (La. 1999), in holding the alleged negligent hiring of the surgeon by the hospital was an independent, non-medical act which pre-dated the surgical admission and the hiring or employment of the surgeon did not constitute "health care" by the hospital "during the medical care, treatment or confinement of the patient," Mr. Williams.

The dissents in this case were very strong.

Judge Parro in his dissent cited Armand v. State, Dep't of Health and Human Resources, 729 So. 2d 1085, 1089 (La. App. 1st Cir. 1999), writ denied, 741 So. 2d 661(La. 1999). In Armand, this court determined "administrative negligence" claims were included within the coverage of the state medical malpractice act when the negligent acts, whether performed by physicians or others in an administrative or managerial capacity, were associated with medical treatment of a patient. The claims asserted here are "administrative negligence" claims. However, the only way "negligent hiring" or "negligent employment" of the physician in this case could have

caused damage to the plaintiffs was through the medical treatment the physician provided to the decedent. Thus, plaintiffs' claims against the hospital for "negligent hiring" fall within the provisions of the medical malpractice act and are premature unless first presented to a medical review panel.

Judge Guidry in his dissent pointed out although the focus of the majority's opinion limits the alleged wrongdoing by the defendant hospital to a time "pre-dating" the medical care, treatment and confinement of the deceased, the plaintiffs' assertions, as found in the supplemental and amending petition, encompass a time inclusive of the date of medical care, treatment and confinement. Thus, plaintiffs assert the deceased was injured by the "employment" of the physician, which is inclusive of not only the hiring of the physician, but his continued employment up to the date of discharge. As such, the hospital's acts of hiring, continuing to employ, and failing to discharge the physician directly involved and impacted the provision of health care afforded Mr. Williams during his medical care, treatment or confinement, and therefore should fall under the provisions of the state malpractice act. As a result, in accordance with the law of this circuit, as articulated in Armand v. State, Department of Health and Human Services, 729 So. 2d 1085 (La. App. 1st Cir. 1999) writ denied, 741 So. 2d 661 (La. 1999), since the hospital's act of hiring the physician is alleged to have impacted the treatment of Mr. Williams, then the action by the defendant hospital falls within the definition of medical malpractice and the provisions of La. R.S. 40:1299.39.1 should apply.

Section M. Peer Review

Peer review is a vital part of the credentialing process and is essential to the function of the medical staff. Peer review provides for honest, self-critical analysis, and allows the medical staff to strive toward higher standards and better quality patient care. It is important, from the legal standpoint, the medical staff act reasonably in deciding to whom they will grant privileges. Although the evaluation of medical staff may vary from setting to setting, certain general guidelines should be followed in the peer review process.

HCQIA credentialing requirements

Hospitals, as well as other health care providers and health care entities, must perform certain credentialing procedures mandated by the Health Care Quality Improvement Act of 1986, or HCQIA, 42 U.S.C. 11101 et seq., as it is amended. These minimum credentialing procedures are set forth in the HCQIA, 42 U.S.C. 11135, as well as in 45 C.F.R. 60.10:

> ***42 U.S.C.*** Sec. ***11135***
>
> Sec. 11135. Duty of hospitals to obtain information
>
> (a) In general
>
> It is the duty of each hospital to request from the Secretary (or the agency designated under section

11134(b) of this title), on and after the date information is first required to be reported under section 11134(a) of this title

(1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this subchapter concerning the physician or practitioner, and

(2) once every 2 years information reported under this subchapter concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

A hospital may request such information at other times.

(b) Failure to obtain information

With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) of this section is presumed to have knowledge of any information reported under this subchapter to the Secretary with respect to the physician or practitioner.

(c) Reliance on information provided

Each hospital may rely upon information provided to the hospital under this chapter and shall not be held liable for such reliance in the absence of the hospital's knowledge that the information provided was false.

45 C.F.R. 60.10

60.10 Information which hospitals must request from the National Practitioner Data Bank.

(a) When information must be requested.

Each hospital, either directly or through an authorized agent, must request information from the Data Bank concerning a physician, dentist or other health care practitioner as follows:

(1) At the time a physician, dentist or other health care practitioner applies for a position on its medical staff (courtesy or otherwise), or for clinical privileges at the hospital; and

(2) Every 2 years concerning any physician, dentist, or other health care practitioner who is on its medical staff (courtesy or otherwise), or has clinical privileges at the hospital.

(b) Failure to request information.

Any hospital which does not request the information as required in paragraph (a) of this section is presumed to have knowledge of any information reported to the Data Bank concerning this physician, dentist or other health care practitioner.

(c) Reliance on the obtained information. Each hospital may rely upon the information provided by the Data Bank to the hospital. A hospital shall not be held liable for this reliance unless the hospital has

knowledge that the information provided was false.

Physician challenges of adverse decisions

It is possible a physician faced with an adverse decision will challenge the validity and legality of the credentialing procedures and adverse privilege actions taken by a medical staff against him or her. In that instance, it is relevant to discuss the levels of exposure which may exist for the members of the medical staff involved in the review of the physician. Equally important are the due process rights of the physician throughout the administrative process, and then in court if a lawsuit is filed in challenge of a privilege or credentialing decision. As will be stated below, certain requirements must be followed by the medical staff in making these privilege or credentialing determinations in order to preserve immunity granted by state and federal law to participants in the peer review process.

There is some concern about exposure through antitrust actions. To avoid this type of exposure, strict compliance with the HCQIA to qualify for immunity as well as use of physicians who are not the direct economic competitors of the adversely affected physician are warranted. Also, objective criteria should be used in evaluating a physician.

Immunity for participants in self-critical analysis; due process

The HCQIA, as well as Louisiana state law at LSA-R.S. 15:3715.3 provides a broad immunity to peer review process participants. Generally, these statutes will provide for limitation of liability for members of the medical staff who take an action adverse to a peer; however, certain requirements must be met. The requirements which must be followed for limitation of liability to attach are set forth at 42 U.S.C. 11112. The requirements for adequate notice and hearing set forth in 42 U.S.C. 11112 must be adhered to so that peer review participants will be afforded the limitation on liability and so that the due process rights of the physician under review may be honored. The medical staff by laws should track the language of the statute so the HCQIA requirements for immunity are always in place. Also, the bylaws should be followed rigorously to avoid the possibility of a challenge of an adverse decision for failure to comply with the bylaws. There should be a “fair hearing plan” contained within the bylaws which guarantees due process to the physician under review and which, if followed, will protect the members of the review committee from liability for any adverse action taken. Due process protections granted under state and U.S. constitutions should also be considered.

Sec. 11112. Standards for professional review actions

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken -

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating -

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating -

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B) -

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) -

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right -

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right -

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as -(1) requiring the procedures referred to in subsection (a)(3) of

> this section -(A) where there is no adverse professional review action taken, or
> (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need
> for a professional review action; or (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

As stated previously, Louisiana state law provides for immunity as well in LSA-R.S. 13:3715.3, stating:

> C. No member of any such committee designated in Subsection A of this Section or any sponsoring entity, organization, or association on whose behalf the committee is conducting its review shall be liable in damages to any person for any action taken or recommendation made within the scope of the functions of such committee if such committee member acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to him.

Under Louisiana's law, the requirement for statutory immunity is less specific than in the HCQIA, requiring only lack of malice and reasonable belief that the action is warranted under the facts known to the peer review (or similar) committee member. The seminal Louisiana case on this is ***Smith v. Our Lady of the Lake Hosp., Inc***., (La. 7/5/94), 639 So.2d 730, rehearing denied.

Manasra v. St. Francis Medical Center, Inc., et al, La. App. 2 Cir. 2000, 764 So.2d 295. If the professional review action meets the applicable standards, then neither the professional review body, any person acting as a member or staff to the body, any person under a contract or other formal agreement with the body, or any person who participates with or assists the body with respect to the action shall be liable in damages with respect to the action taken by the review body. HCQIA's immunity is triggered when the professional review action is taken:

1. In the reasonable belief the action was in the furtherance of quality health care;
2. After a reasonable effort to obtain the facts of the matter;
3. After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and;
4. In the reasonable belief the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of Paragraph (3).

The standard for determining whether the immunity applies is one of objective reasonableness. This standard is met "if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients." citing Austin v.

McNamara, 979 F.2d 728, 734 (9th Cir. 1992).

Rogers v. Columbia/HCA, 971 F.Supp. 229, gives an in-depth examination of these four elements and the analysis to be performed in determining whether the requirements were met.

Confidentiality of the peer review process under statute

A concern in the self-critical analysis employed by peer review, credentialing, and other such committee is the proceedings and findings of such committees be kept confidential. Louisiana Revised Statutes 44:7(D) and 13:3715.3(A) provide for confidentiality of peer review committee records in Louisiana. They provide peer review committee records are confidential, not subject to discovery, and they cannot be obtained through a court subpoena. The legislature granted these protections so hospitals and other health care providers could engage in honest, self-critical analysis without fear their analysis via the peer review committee could be used against them in legal proceedings. The Health Care Quality Improvement Act, found at 42 U.S.C. 11111, et seq. provides additional protections of confidentiality for the peer review process. The Act provides, at 42 U.S.C. 11137, information reported under the Act will be kept confidential *except with respect to professional review activity*.

There are few Louisiana cases interpreting the state statutes as to the scope of the protections which they provide. In the case ***Smith v. Louisiana Health and Human Resources Admin***, 477 So.2d 1118 (la. 1985), the Supreme Court considered the extent to which hospital committee records are protected by statute and decided records pertaining to both policy-making and personnel matters fell within the protective scope of La. R.S.

13:3715.3 and 44:7(D). However, in ***Smith v. Lincoln General Hospital***, 605 So.2d 1347 (La. 1992), the Louisiana Supreme Court held:

> When a plaintiff seeks information relevant to his case that is not information regarding the action taken by a committee or its exchange of honest self-critical study but merely factual accountings of otherwise discoverable facts, such information is not protected by any privilege as it does not come within the scope of information entitled to that privilege. (Id., at 1348)

The above was upheld in a second Louisiana Supreme Court decision, ***Gauthreaux v. Frank,*** 95-1033 (La. 6/16/95); 656 So.2d 634. In these decisions, the Louisiana Supreme Court ruled some information discussed within the peer review process may be subject to discovery. The court noted in the Smith v. Lincoln General case:

> These provisions are intended to provide confidentiality to the records and proceedings of hospital committees, not to insulate from discovery certain facts merely because they have come under the review of any particular committee. Such an interpretation could cause any fact which a hospital chooses to unilaterally characterize as involving information relied upon by one of the sundry committees formed to regulate and operate the hospital to be barred from an opposing litigants discovery, regardless of the nature of that information. Such could not have been the intent of the legislature especially in light of the broad scope given to discovery in general. La. C.C.P. 1442. Further, privileges, which are in derogation of such broad exchange of facts, are to be strictly interpreted.
>
> Id. 1348

Reiterating the above portion of its decision in the Smith v. Lincoln General matter, the court stated in ***Gauthreaux v. Frank***:

> In the present case, the trial court interpreted La. R.S. 13:3715.3 as protecting form discovery any information passing before a hospital committee or otherwise discussed in a committee meeting. Such a reading of the peer review committee privilege is clearly too expansive in light of our decision in Smith, supra. ***Gauthreaux***, at 634.

Generally, these cases are interpreted to mean documents generated by the committee itself are privileged and should be kept confidential and are not subject to

discovery or court subpoena, but those simply used by the committee in its investigation remain discoverable. The courts generally opt to conduct an *in camera* inspection of documents in disputes to determine which are discoverable and which are not.

Reporting requirements; National Practitioner Data Bank

The National Practitioner Data Bank was created by the HCQIA, and licensing boards, hospitals, and other entities are required to report certain information to the Data Bank which could have detrimental impact on the physician concerned. Also, as stated above, hospitals must consult the Data Bank in making decisions regarding granting or expanding medical staff privileges and must follow up with the data bank every two years for physicians with staff privileges.

It is advisable for the physician to consult with his attorney prior to filing the required reports, particularly because the definitions set forth at 45 C.F.R. 60.3, are quite broad. Generally the information which must be reported to the Data Bank includes reporting medical malpractice payments, reporting licensure actions taken by Boards of Medical Examiners, and reporting "adverse actions on clinical privileges."

Sec. 60.3 Definitions.

Act means the Health Care Quality Improvement Act of 1986, title IV of Pub. L. 99-660, as amended.

Adversely affecting means reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.

Board of Medical Examiners, or Board, means a body or subdivision of such body which is designated by a State for the purpose of licensing, monitoring and disciplining physicians or dentists. This term includes a Board of Osteopathic Examiners or its subdivision, a Board of Dentistry or its subdivision, or an equivalent body as determined by the State. Where the

Secretary, pursuant to section 423(c)(2) of the Act, has designated an alternate entity to carry out the reporting activities of Sec. 60.9 due to a Board's failure to comply with Sec. 60.8, the term Board of Medical Examiners or Board refers to this alternate entity.

Clinical privileges means the authorization by a health care entity to a physician, dentist or other health care practitioner for the provision of health care services, including privileges and membership on the medical staff.

Dentist means a doctor of dental surgery, doctor of dental medicine, or the equivalent who is legally authorized to practice dentistry by a State (or who, without authority, holds himself or herself out to be so authorized).

Formal peer review process means the conduct of professional review activities through formally adopted written procedures which provide for adequate notice and an opportunity for a hearing.

Health care entity means: (a) A hospital; (b) An entity that provides health care services, and engages in professional review activity through a formal peer review process for the purpose of furthering quality health care, or a committee of that entity; or (c) A professional society or a committee or agent thereof, including those at the national, State, or local level, of physicians, dentists, or other health care practitioners that engages in professional review activity through a formal peer review process, for the purpose of furthering quality health care. For purposes of paragraph (b) of this definition, an entity includes: a health maintenance organization which is licensed by a State or determined to be qualified as such by the Department of Health and Human Services; and any group or prepaid medical or dental practice which meets the criteria of paragraph (b).

Health care practitioner means an individual other than a physician or dentist, who is licensed or otherwise authorized by a State to provide health care services. Hospital means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act.

Medical malpractice action or claim means a written complaint or claim demanding payment based on a physician's, dentists or other health care practitioner's provision of or failure to provide health care services, and includes the filing of a cause of action based on the law of tort, brought in any State or Federal Court or other adjudicative body.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery by a State (or who, without authority, holds himself or herself out to be so authorized).

Professional review action means an action or recommendation of a health care entity: (a) Taken in the course of professional review activity; (b) Based on the professional competence or professional conduct of an individual physician, dentist or other health care practitioner which affects or could affect adversely the health or welfare of a patient or patients; and (c) Which adversely affects or may adversely affect the clinical privileges or membership

> in a professional society of the physician, dentist or other health care practitioner. (d) This term excludes actions which are primarily based on: (1) The physician's, dentist's or other health care practitioner's association, or lack of association, with a professional society or association; (2) The physician's, dentist's or other health care practitioner's fees or the physician's, dentist's or other health care practitioner's advertising or engaging in other competitive acts intended to solicit or retain business; (**3**) The physician's, dentist's or other health care practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis; (4) A physician's, dentist's or other health care practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional; or (5) Any other matter that does not relate to the competence or professional conduct of a physician, dentist or other health care practitioner.
>
> Professional review activity means an activity of a health care entity with respect to an individual physician, dentist or other health care practitioner: (a) To determine whether the physician, dentist or other health care practitioner may have clinical privileges with respect to, or membership in, the entity;(b) To determine the scope or conditions of such privileges or membership; or (c) To change or modify such privileges or membership. Secretary means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.
>
> State means the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

JCAHO Requirements

The requirements of the JCAHO must also be followed.

Medical Staff Bylaws

While there is no Louisiana case on point, there are a number of cases from other jurisdictions which hold the medical staff bylaws create a contract between the hospital and its medical staff and may be enforceable as a contract. See, for example, the federal court cases, ***Pariser v. Christian Health Care Systems, Inc.,*** 681 F.Supp. 1381 (E.D. Mo.

1988); ***Robinson v. Magovern***, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd 688 F.2d 824 (3rd Cir. 1982). However, there are courts in several states, including Texas, which have failed to recognize the medical staff bylaws are contracts. See ***Weary v. Baylor University Hospital***, 360 S.W. 2d 895. Considering the controversy, the hospital bylaws should contain a provision addressing whether the medical staff bylaws constitute a contract between the members of the medical staff and the hospital. Similarly, the medical staff bylaws should contain a statement of the nature of the relationship between the medical staff and the hospital.

The medical staff bylaws should make appropriate reference to the HCQIA and to state legislation, discussed above, which provides for privileges and immunities as well as for due process and fair hearing rights for members of the medical staff. There should be a section in the bylaws covering what law governs the medical staff bylaws and what conflict of laws principles should apply. All professional review committees or bodies should be defined and identified as such in the medical staff bylaws, thus invoking privileges and immunities granted to professional review committee members by HCQIA and LSA-R.S. 3715.3. Additionally, hospital committees such as risk management, should be identified so these committees are afforded the privileges set forth in the above laws. Appropriate releases should also be included within the medical staff bylaws themselves, granting immunity to those who make decisions regarding applications or re-applications for privileges.

Additionally, the medical staff bylaws should clearly state the scope of clinical privileges granted to members of the medical staff, under whose authority and with whose approval such privileges are granted (the governing board of the hospital), and the bylaws should clearly set forth the hospital's ability to limit membership of the medical staff in various

departments and specialties. Similarly, the medical staff bylaws should clearly denote who may initiate taking any corrective action against a member and should clearly denote that the governing body of the hospital does not give up or waive its own prerogative to institute corrective action of its own. In the case of an adverse action, it is important the medical staff bylaws clearly have set forth the identify of the individual person or group who may impose suspension, termination of staff privileges, or other such adverse action against a physician.

There should also be clearly set forth and very limited provisions for automatic termination. These provisions must be carefully drafted due to potential derogation of the due process rights of the affected professionals. For the same reason, as stated above, it is important a hearing procedure be outlined in the medical staff bylaws, clearly stating what the hearing and appeals process is in the case of professional review activity.

Additionally, the medical staff bylaws should clearly articulate the methods by which they may be amended, the medical staff's policy on alternative dispute resolution, its appointment and reappointment procedure and the processes by which applications and re-applications for privileges are reviewed.

The bylaws of the medical staff outline the powers and duties of the body; however, they are also a protective tool. If the bylaws are properly drafted and strictly followed, they should offer vast protections to those members the medical staff participating in professional review activities.

HEALTHCARE QUALITY IMPROVEMENT ACT

§ 11112. Standards for professional review actions

(a) In general. For purposes of the protection set forth in section 411(a) [42 USCS § 11111(a)], a professional review action must be taken--

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) [42 USCS § 11111(a)] unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing. A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action. The physician has been given notice stating--

(A) (i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B) (i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing. If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice. If a hearing is requested on a timely basis under paragraph (1)(b)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right--

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the

physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right--

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3).

(c) Adequate procedures in investigations or health emergencies. For purposes of section 411(a) [42 USCS § 11111(a)], nothing in this section shall be construed as--

(1) requiring the procedures referred to in subsection (a)(3)--

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to

subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

Smith v Ricks, 798 F Supp 605 (1992, ND Cal)

Hospital and staff members who conducted professional review action resulting in revocation of cardiologist's staff privileges are immune from federal antitrust liability pursuant to 42 USCS §11111, where review process began after hospital staff was notified that cardiologist's staff privileges had been revoked at another hospital due to inadequate care, and revocation occurred after staff reviewed files on cases, and provided proper notice of hearings to cardiologist, who attended recorded hearings with attorney and was allowed to present evidence and examine and cross-examine witnesses, and written recommendation was presented at end of hearing process, because based on evidence cardiologist is unable to overcome presumption that staff and hospital met standards of 42 USCS §11112(a) in conducting professional review.

Bryan v James E. Holmes Regional Medical Ctr., 33 F3d 1318 (1994 CA11 Fla)

Hospital was entitled to protection from monetary liability under Health Care Quality Improvement Act in terminating physician's staff privileges where it did so in reasonable belief that action was in furtherance of quality health care, made reasonable effort to obtain facts of

matter, adequately notified physician, and afforded him hearing.

Pamintuan v Nanticoke Mem'l Hosp., 192 F3d 378 (1999, CA3 Del)

Health Care Quality Improvement Act precluded award of damages to physician against hospital for suspending her privileges where she failed to show that totality of information available to hospital reviews did not provide basis for reasonable belief that their actions would further health care.

Fobbs v Holy Cross Health Sys. Corp., 789 F Supp 1054 (1992, ED Cal)

Physician's antitrust case against health system must fail, where hospital and staff committees, acting on concerns raised as to possible irregularities in physician's handling of cases involving laser surgery, imposed monitoring system on physician and ultimately suspended his medical staff membership when he refused to comply with mandatory monitoring, because immunity extends to physician and corporate defendants under Health Care Quality Improvement Act of 1986 (42 USCS § 11111 et seq.) in their capacity as professional review body with regard to professional review action against physician since compliance with all aspects of § 11112 was clearly shown.

Imperial v Suburban Hosp. Ass'n, 862 F Supp 1390 (1993, DC Md)

Physician's claim against peer review committees arising out of his failure to be reappointed to staff because of quality assurance problems is denied summarily, where (1) Credentials Committee took one-month recess to review quality assurance summary, patient records in questions, and another physician's recommendations, and (2) Medical Executive Committee held hearing in order to investigate matter before making recommendation and reviewed quality assurance summary and specific charts involved in charges, because peer review committees made reasonable effort to obtain facts of matter and committees' actions were fair.

Monroe v AMI Hosps., 877 F Supp 1022 (1994, SD Tex)

Physician's claim against hospital, arising out of peer review process that led to recommendation that his hospital privileges be revoked, is dismissed, where concerns about physician's professional competence and judgment in providing patient care were impetus for peer review and adverse recommendation, because physician failed to overcome presumption that peer review action was taken in reasonable belief that it would further quality of health care under 42 USCS § 11112(a)(1).

Chalal v Northwest Med. Ctr., Inc., 147 F Supp 2d 1160 (2000, ND Ala)

Hospital is immune from monetary liability for its decision to terminate doctor's staff privileges and mandatory reporting thereof to National Practitioner Data Bank, where several incidents

resulting in poor outcomes for patients occurred on his watch, and record overwhelmingly reflects that hospital's decision was reasonable, based on legitimate concern for patients, supported by facts and medical evidence, and reached only after proper notice and hearing procedures were afforded, as set forth in 42 USCS §11112(a), because this is precisely type of litigation Health Care Quality Improvement Act (42 USCS § 11101 et seq.) was designed to prevent.

Crosby v Hospital Auth., 873 F Supp 1568 (1995 MD Ga)

Claim of osteopathic doctor against county hospital authority, its board members, and staff physicians, arising out of defendants' refusal to grant him orthopedic surgical staff privileges, is denied summarily, where decision was based on doctor's inability to become board certified, because decision to recommend denial of surgical privileges was professional review action entitled to immunity under 42 USCS § 11112.

Meyers v Logan Mem. Hosp., 82 F Supp 2d 707 (2000 WD Ky)

Hospital board of trustee decision to deny physician's application for reappointment to medical staff, but not investigatory proceedings leading up to decision, constituted "professional review action" that had to meet statutory criteria to be immune from money

damages under 42 USCS § 11112(a).

Singh v Blue Cross & Blue Shield of Mass., Inc., 182 F Supp 2d 164 (2001, DC Mass)

Health insurer's decisions not to admit physician to insurer's new health-care plan, and to prohibit physician from accepting new patients under existing plan were immune from challenge under 42 USCS § 11112(a), where physician failed to show that insurer did not act in furtherance of quality of health care, since audit of physician's practice found "excessive" and "inappropriate" use of prescription medications, insurer made reasonable effort to obtain facts by hiring independent reviewer, and no hearing was required, since physician agreed to format for audit.

Gabaldoni v Wash. County Hosp. Ass'n, 250 F3d 255 (2001, CA4 Md)

Ultimate decision maker is not required to investigate matter independently; all that is required is reasonable effort to obtain facts.

Gladney v. Sneed, 742 So. 2d 642, (La. App. 2nd Cir. 1999)

After plaintiff was struck by a vehicle, she reported to Huckabay Hospital emergency room where a second year pediatric resident was the attending emergency room physician. The

patient died from treatable shock. The obvious symptoms of shock were not identified by the physician or the emergency room nurse. The court felt the experienced nurses should have identified the symptoms and used the chain of command in order to get the patient transferred to a hospital where he could be properly treated. Chain of command was a factor in apportioning fault between the hospital and the physician.

Brown ex rel. Brown v. State Dep't of Health & Hosps., 832 So. 2d 351, (La. App. 4th Cir. 2002)

The Fourth Circuit followed the holding of LeBreton v. Rabito, 714 So2d. 1226, (La. 1998) in determining the La. R.S. 40:1299.47(A)(2)(a), the specific statutory provision providing for the suspension of prescription in the context of medical malpractice, **must be applied alone**, not complementary to La. C.C. art. 3472, the more general codal article that addresses interruption of prescription. Interestingly, in his dissent Judge McKay noted he agrees with Justice Calogero in that he believes LeBreton should be overruled.

Garnica v. Louisiana State Univ. Med. Ctr., 744 So. 2d 156, (La. App. 4th Cir 1999)

In 1979, plaintiff was treated at LSU Dental School for jaw problems and surgery on her right temporomandibular joint included the implantation of a Proplast prosthesis in her jaw. In 1990 the manufacturer of the prosthesis notified oral surgeons to stop using the implants and the United States Food and Drug Administration sent out a safety alert to oral surgeons to notify

their patients of the defective product so that any problems or potential problems could be corrected by remedial surgery or other means. Physician's failure to notify the patient of the problems of the prosthesis did not fall under the medical malpractice act. Specifically the court held the duty to notify the patient is a ministerial or clerical function and does not require any specialized training or knowledge. The duty did not arise from the performance of health care and was not during the patient's medical care, treatment or confinement under the definition of "health care."

Armand v. Department of Health & Human Resources, 729 So. 2d 1085, (La. App. 1st Cir. 1999)

Hospital had a policy where if a patient under 16 years old is brought to the emergency room, the emergency room physician should consult the pediatric on-call team to evaluate a patient presenting with medical and/or surgical conditions requiring specialty consultation. In this matter the Court held the plaintiffs' claim fell under the medical malpractice act even though the hospital did not properly instruct the residents regarding the hospital's policies and procedures.

The Court stated the September 1988 amendments to LSA-R.S. 40:1299, the legislature closed the window on recovery for medical malpractice caused by administrative negligence. The legislature accomplished this by broadening the definitions of "malpractice" and "health care" so that LSA-R.S. 40:1299.39 would extend to cover all acts associated with medical treatment of a patient, whether those acts are performed by physicians or others in an

administrative or managerial capacity.

Our courts have formulated duties of care on an individual basis to determine when a hospital's governing body is responsible for its own acts or omissions which cause injury to a patient.

Examples include:

> **Grant v. Touro Infirmary,** 254 La. 204, 223 So. 2d 148 (1969), overruled on other grounds by, **Garlington v. Kingsley**, 289 So. 2d 88 (La. 1974);
>
> the governing board's duty to select its employees with reasonable care;
> **Snipes v. Southern Baptist Hospital**, 243 So. 2d 298 (La. App. 4th Cir. 1971); __
> **Lauro v. Travelers Ins. Co.,** 261 So. 2d 261 (La. App. 4th Cir.), writ denied, 262 La. 188, 262 So. 2d 787 (1972);
>
> > the board's duty to furnish the hospital with reasonably adequate supplies, equipment and facilities for use in treatment and diagnosis of patients;

Head v. St. Paul Fire & Marine Ins. Co., 408 So. 2d 1174 (La. App. 3d Cir.), writ denied, 412 So. 2d 99 (La. 1982)

a duty to provide adequate procedures for maintenance and safety of its grounds and buildings

A breach of one of the above listed duties or a similar duty which causes injury to the patient may constitute independent negligence of a hospital's governing board even in the absence of any finding of negligent conduct by an employee. Sibley v. Board of Supervisors of Louisiana State University (Sibley I), 477 So. 2d 1094, 1099 (La. 1985).

J. Nursing Negligence

1. Derouen v. State ex Rel. Dept. of Health can Hospitals, App. 3 Cir. 1999, 98-1201 (La. App. 3 Cir. 2/3/99), 736 So.2d 890. Plaintiff who alleged a blood sample was drawn for purpose of performing testing for HIV was a “patient” who was receiving “health care” for purposes of Malpractice Liability.

2. LeJeune Claims - Trahan v. McManus, 728 So.2d 1273 (La. 1999). Plaintiffs were the parents of a decedent attempting to recover 2315.6 damages for mental anguish and emotional distress resulting from their son's injury and death. The two issues before the Louisiana Supreme Court were whether the claim fell within the medical malpractice act and whether "by-stander damages" (also

known as Lejuene damages) are recoverable when the event at issue was an act or omission by a health care provider the Louisiana Supreme Court held:

> The fact damages recoverable under article 2315.6 are limited to mental anguish damages and to specifically required facts and circumstances does not serve to remove article 2315.6 claims from the applicability of the Medical Malpractice Act, as long as the mental anguish arises from the injury to or death of a patient caused by the negligence of a qualified health care provider. Id. at 1277.

The Louisiana Supreme Court reiterated tort damage for medical malpractice falls under article 2315, et seq., and it is not the quality of the claimant, but the context within which the claim arises through medical care and treatment provided to a patient. The medical malpractice act does not create a cause of action for negligent medical care as same is created under article 2315, et seq. The Medical Malpractice Act only provides the procedural mechanism for the presentation of such claims. The Louisiana Supreme Court in this case states:

> The requirements of Article 2315.6, when read together, suggest a need for temporal proximity between the tortious event, the victim's observable harm and the plaintiff's mental distress arising from and an awareness of the harm caused by the event. Id. at 1279.

SECTION N. MISCELLANEOUS

Professional vendor - Shortess v. Touro, 520 So.2d 389, 391 (La. 1988)

> Selling blood to plaintiff placed strict liability in tort upon the hospital. "The responsibility of a professional vendor or distributor is the same as that of a manufacturer."

Loss of chance - Hasting v. Baton Rouge General, 496 So.2d 713, 720 (La. 1986)

> "It is not necessary to prove that a patient would have survived if proper treatment had been given but, only that there would have been a chance of survival. Defendants conduct must increase the risk of a patient's harm to the extent of being a substantial factor in causing the result, but not be the only cause."

Also, see Martin v. East Jefferson General Hospital, 582 So.2d 1272 (La. 1991)

Per se negligence -

Unsuccessful course of treatment - Magos v. Feerick, 690 So.2d 812, 817 (La. 3rd Cir. 1996)

"An unsuccessful course of treatment is not a per se indication of malpractice."

Retained lap sponge - Johnston v. Southwest Louisiana Association, 693 So.2d 1195 (La. 3rd

Cir. 1997)

> [T]he surgeon had exclusive control of the sponge from the time he physically placed it inside his patient until he removed it," and "the nurse's count is a remedial measure that cannot relieve the surgeon of his non-delegable duty to remove the sponge in the first instance."

Diagnostic error - Tillman v. Lawson, 417 So.2d 111, 114 (La. 3rd Cir. 1982)

> "As to the diagnostic duties required of a dentist or a physician, an error of diagnosis is not malpractice per se. A physician or dentist is not obligated to always be correct in making a diagnosis. A diagnosis is an act of professional judgment and, in case of a misdiagnosis, malpractice exists only if it results from a failure by a physician or dentist to exercise the standard or degree of care in diagnosing which would have been exercised by a member of his profession in good standing in his locality, under similar circumstances. Whether a physician was negligent in making a diagnosis must be determined in light of conditions existing and facts known at the time thereof, and not in the light of knowledge gained through subsequent developments."