LOOKING AHEAD: THE FUTURE OF MEDICAL MALPRACTICE

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A. DEALING WITH INCREASED MANAGED CARE ISSUES

The effect of the Employee Retirement Income Security Act of 1974 (ERISA)[1] on the liability of managed care providers continues to be a major issue in the ongoing debate about managed care. Claims against employee health benefit plans are often determined by ERISA. Most managed health care services are rendered pursuant to an employee benefit plan. However, since the mid-1990's, there has been some significant erosion in the protection afforded to such plans by ERISA. Both state and federal courts have begun to find new rights for healthcare consumers and physicians based on ERISA.

U. S. Supreme Court decsions in *Pegram v. Herdrich,* 530 U.S. 211 (2000), *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355 (2002), and *Kentucky Association of Health Plans, Inc. v. Miller,* 123 S.Ct. 1471 (2003), underscore the inclination of the Supreme Court to disallow the use of ERISA as a shield against liability under state law and/or regulation by state legislatures.

Lawsuits against managed care organizations have been predicated on a number of theories, including negligence, bad faith denial of care based on benefit determinations, breach of fiduciary duty for non-disclosures, breach of contract, fraud and misrepresentation. There have been actions based on both direct and vicarious liability for negligence of physicians, administrators, and others acting as apparent agents. HMOs may be sued directly under a theory of corporate negligence. *Shannon v. McNulty,* 718 A.2d 828 (Pa. Super. Ct. 1998).

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[1] 29 U.S.C. § 101 *et seq.*

These theories of liability have not replaced traditional bases for legal responsibility. Physicians still have a duty to render care with at least that degree of skill and knowledge ordinarily possessed by practitioners of similar training and experience, practicing in the same or similar communities. The duty extends to the referral of patients and rendering treatment in a timely fashion. Notwithstanding that, the process of healthcare decision making has become much, much more complex.

Congressional intent in the passage of ERISA was to replace a hodge podge of state regulation with a uniform set of federal regulations. For that reason, ERISA contains provisions for preemption of state law, which have been broadly interpreted. See, *Shaw v. Delta Air Lines,* 103 S.Ct. 2890 (1983); *Pilot Life Ins. Co. v. Dedeaux,* 107 S.Ct. 1549 (1987); *N.Y. State Conference of Blue Cross &Blue Shield Plans v. Travelers Ins. Co.,* 115 S.Ct. 1671 (1995) and *Ingersoll-Rand Co. v. McClendon,* 111 S.Ct. 478 (1990). The *Travelers* case in 1995 marks the "high water mark" of expansive reading of ERISA preemption provisions. Since that decision, the literal interpretation of ERISA's "relate to" language has been found to be unworkable, and those earlier cases are simply no longer considered good law. Justice Scalia has stated that the holdings in these early cases on preemption ". . . have in effect been abandoned."

ERISA's Explicit Preemption Clause: This clause says that its provisions "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."[2] This is expansive language and the courts have said so. *Pilot Life Ins. Co. v. Dedeaux, supra.* The preemption clause, Section 514(a), is used by managed care plans in defense of state court actions. It differs from the civil enforcement provision of ERISA, §502(a), discussed below.

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[2] 29 U.S.C. § 1144(a)

The "Well Pleaded Complaint" Rule: A case cannot be removed to federal court, absent diversity of citizenship, unless a federal question appears on the face of plaintiff's "well pleaded complaint." *Franchise Tax Board v. Construction Laborers Vacation Trust,* 103 S.Ct. 2841 (1983). ERISA preemption does not create a federal cause of action, and it cannot convert a state claim into a federal case. Thus, the preemption defense is insufficient, standing alone, to support removal to federal court. *Stewart v. Berry Family Health Center, et al.,* 105 F. Supp.2d 807 (S.D. Ohio 2000).

Complete Preemption: This is an exception to the "well pleaded complaint" rule. *Dukes v. United Healthcare, Inc.,* 57 F.3d 350 (3d Cir. 1995). In the ERISA context, the complete preemption exception will support removal of claims that fit within the civil enforcement provision of §502(a)(I)(B), which authorizes action by a plan participant or beneficiary to recover benefits or to enforce or clarify rights under the terms of the plan. Because the unfettered use of the well pleaded complaint rule might inappropriately "close federal courthouse doors" to cases that merit removal, the doctrine of complete preemption permits removal of an otherwise non-federal action if the claims asserted conflict with a "federal statutory scheme."[3]

Complete preemption is a jurisdictional doctrine and differs from the federal defense of ERISA preemption based on §514(a). A claim that may be preempted because it "relates to" an ERISA plan doesn't necessarily mean it will fit within the narrower scope of §502's civil enforcement provisions. A federal court may not have removal jurisdiction to hear the claim, but the claim may nevertheless be preempted under §514(a).

[3] *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., et al.,* 958 F.Supp. 1137 (E.D. Va. 1997)

The Savings Clause: The ERISA "savings" clause saves state laws regulating insurance. Any state law which is found to regulate insurance is not preempted by ERISA.[4] The states retain the right to regulate insurance.

The Deemer Clause: The "deemer" clause limits the "savings" clause.[5] This clause provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law "purporting to regulate insurance." States may not treat self-insured ERISA plans as insurers subject to state regulation.

CLAIMS PREEMPTED BY ERISA

Medical Malpractic (Quality of Care): Following the *Travelers* case in the U.S. Supreme Court and the *Dukes* case in the Third Circuit, courts have made a critical distinction between claims addressing the quality of health care, as opposed to those addressing the quantity of benefits received. Based on this distinction, medical malpractice claims are usually found to fall within traditional state tort law and are not preempted by ERISA. Defendants have attempted to raise preemption as a defense, and actually had some success prior to 1995.

Cases holding that ERISA preempts medical malpractice include:

- *Ricci v. Gooberman,* 840 F. Supp. 316 (D.N.J. 1993)
- *Nealy v. U. S. Healthcare HMO,* 844 F. Supp. 966 (S.D.N.Y. 1994)
- *Altieri v. Cigna Dental Health, Inc.,* 753 F. Supp. 61 (D. Conn. 1990)
- *Butler v. Wu,* 853 F. Supp. 125 (D.N.J. 1994)
- *Jass v. Prudential Health Care Plan, Inc.,* 88 F.3d 1482 (7th Cir. 1996)
- *Tolton v. American Biodyne, Inc., et al.,* 48 F.3d 937 (6th Cir. 1995)

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[4] 29 U.S.C. § 1144(b)(2)(A)

[5] 29 U.S.C. § 1144(b)(2)(B)

- *Corcoran v. United Health Care, Inc.,* 965 F.2d 1321 (5th Cir. 1992), cert. denied 113 S.Ct. 812 (1992)

Cases finding that malpractice claims based on negligent care or referrals are not preempted include:

- *Dukes, supra*
- *Pappas v. Asbel,* 724 A.2d 889 (Pa. 1998)
- *In re: U. S. Healthcare, Inc.,* 193 F.3d 151 (3d Cir. 1999), cert. denied 530 U.S. 1242 (2000)
- *Moscovitch v. Danbury Hospital, et al.,* 25 F. Supp.2d 74 (D. Conn. 1998)
- *Lancaster, supra*
- *Lewis v. Prudential Healthcare Plan, Inc.,* 77 F.3d 493 (10th Cir. 1996)
- *Nealy v. U. S. Healthcare HMO, N.Y.,* 93 N.Y.2d 209, 689 N.Y.S.2d 406 (1999)
- *Ouelette v. Christ Hospital,* 942 F. Supp. 1160 (S.D. Ohio) 1996)
- *Prihoda, v. Shpritz,* 914 F. Supp. 113 (D. Md. 1996)

There are others.

***Negligent Credentialling*:** Many managed care cases involve claims of negligent selection, supervision and/or oversight of medical personnel. See:

- *McClellan v. HMO of Pennsylvania,* 604 A.2d 1053 (1992)
- *Altieri v. CIGNA, supra*
- *Boyd v. Albert Einstein Medical Center,* 547 A.2d 1229 (1988)
- *Giles v. NYLCare Health Plans, Inc.,* 172 F.3d 332 (5th Cir. 1999)
- *Visconti v. U. S. Healthcare, Inc.,* *** (E.D. Pa. 1998)

Denial of Payment and/or Benefit Due (Quantity of Care): Plaintiff's have increasingly alleged that a managed care organization used its utilization and review to wrongfully deny payment and/or medically necessary care and that this amounts to negligence, fraud, misrepresentation or breach of physician-patient relationship. Claims having to do with the "quantity" of health care are generally preempted.

- *In re U.S. Healthcare, Inc., supra*
- *Turner v. Fallon Community Health Plan, Inc.,* 127 F.3d 196 (1st Cir. 1997)
- *Transitional Hospitals Corp. v. Blue Cross and Blue Shield of Texas, Inc.,* 164 F.3d 952 (5th Cir. 1999)
- *Snook v. Penn State Geisinger Health Plan,* 241 F. Supp.2d 485 (M.D. Pa. 2003)

Delay in Treatment and/or Payment (Quantity and Quality of Care): These claims are not the same as those alleging denial of care, but are claims for delays in the rendering of service. The distinction may make the difference in whether a plaintiff can recover, due to the ERISA preemption doctrine. If the delay is based on approval of treatment by an out-of-network physician, the court may find this to be a challenge to plan administration, preempted by ERISA. See:

- *Huss v. Green Spring Health Services, Inc.,* 18 F. Supp.2d 400 (D. Del. 1998)
- *Cannon v. Group Health Service of Oklahoma, Inc.,* 77 F.3d 1270 (10th Cir.) cert. denied, 117 S.Ct, 66 (1996)
- *Pryzbowski v. U. S. Healthcare, Inc.,* 345 F.3d 266 (3d Cir. 2001)
- *Nealy v. U. S. Healthcare HMO, N.Y.,* 93 N.Y.2d 209, 689 N.Y.S.2d 406 (1999)

B. NURSING HOME LITIGATION

Unlike medical malpractice cases, plaintiffs tend to be successful in trials involving

nursing home negligence. This is especially true if there is evidence of abuse. Median verdicts in these cases, which involve injury or death of the elderly, continue to be much higher than other personal injury or wrongful death verdicts for elderly claimants.[6]

Increasingly, to avoid the prospect of jury trials, nursing homes include arbitration clauses in their contracts with residents and their families. Some of these "mandatory" arbitration provisions are, themselves, subject to litigation, depending on a number of factors.

Some of these clauses are part of the admissions contracts and are clearly designed to avoid responsibility in the event of neglect or abuse of the patient. They not only require arbitration, but also include exculpatory clauses, shorten the limitations period, cap damages and preclude punitive damages. Typically, these clauses are in the "fine print" and are a condition of admission to the nursing home.

Others don't seem as bad - at first. They appear to be optional, stand alone, documents, even to the point of including a revocation clause. They purport only to choose arbitration over courts and juries as a means of dispute resolution. Nevertheless, they always include hidden advantages to the nursing home company. For example, they may adopt the rules and procedures of the arbitration company that may differ from applicable state substantive law.[7] They may provide that arbitration becomes mandatory only if the amount in controversy exceeds a certain level. In discovery, you will find that there is almost no situation in which the nursing home would ever have a claim against the patient for an amount anywhere near this level. As a practical matter, these provisions effectively bind the patient, but not the nursing home company.

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[6] *The 5 Myths of Nursing Home Litigation,* Jury Verdict Research (1998)

[7] *Blankfield v. Richmond Health Care, Inc.,* 902 So.2d 296 (Fla. App. 2005)

Be aware also that nursing home companies may have agreement with dispute resolution organizations promising exclusive use of that organization. The organization may find this to be financially rewarding, and may conclude that if there are too many awards favorable to the patient some other organization will get the business. The lack of neutrality of the arbitration forum may be grounds for finding the arbitration clause unenforceable.[8] For that reason, and others, extensive discovery is necessary if the defendant moves to compel arbitration.

The national nursing shortage (more on that, later) also affects nursing homes. Most nursing home facilities have high staffing turnovers. This is due in part to the nature of the work, and the income paid to nursing home staff compared to what they could make elsewhere. Nursing homes can be creative in how they compute nurse to patient ratios. The staff shortage trend is likely to continue.

Even more than hospitals, nursing homes play the corporate name shell game. There may be one company that owns the facility, another company that manages the facility, and maybe even another company that provides staffing. There may be a holding company, and several other corporations, making it difficult to identify the actual ownership of the facility.

Because the population is aging, medical science is prolonging life expectancies, families are increasingly unable to provide home care for elderly relatives, and managed care companies want patients moved out of hospitals as quickly as possible, the number of skilled nursing beds is likely to continue to grow. This, coupled with increased public awareness of problems in nursing homes, means that nursing home litigation will be around for awhile.

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[8] *Walker v. Ryan's Family Steakhouses, Inc.,* 400 F.3d 370 (6th Cir. 2005)

C. NURSING SHORTAGES, UNDERSTAFFING AND INCREASED NEGLIGENCE

It is estimated that by the year 2020 hospitals will need over 800,000 Registered Nurses.[9] Although numerically, the number of nurses has continued to rise, today many hospitals are understaffed or appropriately staffed. Last year California attempted to help hospital chains in that state by reducing the state's nurse-to-patient ratio from 1:6 to 1:5.[10] Nurses in that state began a protest which resulted in reinstatement of the original ratio. The gravamen of the nurse's argument was that reduction of the ratio would negatively impact patient care. Indeed, there are increasing stories tending to support that argument.[11] Hospitals may seek to save money by cutting back on nursing staff (a large portion of operational costs), but there is evidence that hiring more nurses could actually result in cost savings. One study found that 6,700 patient deaths and 4 million days of hospital care could be avoided annually by increasing the number of registered nurses on staff.[12]

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[9] Delawese, Fulton. "Midstate hospitals hope to find cure for nurse shortage." Knight-Ridder Tribune Business News (2005): 1+.ProQuest. Desert Vista, Tucson. 11/5/05

[10] In 1999 California became the first state to require hospitals to meet fixed minimum nurse-to-patient ratios on all patient care units.

[11] See, "Nursing Shortage: How It May Affect You." abcnews.go.com/WNT/Health/story?id=1529546&WNTad=true (accessed 8/14/06)

[12] Id.

Training new nurses doesn't appear to be the problem. In 2005 nursing schools turned away 125,000 applicants because they didn't have enough faculty to teach them.[13] There are more nurses in the profession now than at any time, and yet there aren't enough to completely or adequately staff many, if not most, hospitals. In 2000 the average age of Registered Nurses in the U.S. was 44.5 years,[14] promising a higher retirement rate and thus a growing shortage.

The shortage produces two problems with potential impact on malpractice. First, nurses are being required to work increasing overtime. Mandatory overtime can be a threat to patient safety due to fatigue after a lengthy shift.[15] Second, understaffing means fewer nurses caring for more patients, again taxing the nursing staff's ability to provide adequate and medically safe patient care. Mandatory overtime also affects morale. A fatigued and worn out nurse will be discouraged from continuing that employment, possibly leaving the active profession or moving out of patient care.

A 2002 study by the Joint Commission on Accreditation of Healthcare Organizations showed staffing levels at hospitals played a role in 24% of 1,600 events, leading to death, serious injury or permanent loss of function, reported to JCAHO since 1997.[16]

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[13] Id.

[14] This is according to research by the Health Resources and Services Administration. See, Tieman, Jeff. "Nurse Shortage Predicted." *Modern Health Care* (2001)

[15] "Working Hours, Fatigue and Medical Malpractice," *Circadian Technologies, Inc.* Nov. 16 2005, at www.circadian.com/expert/medical.html.

[16] Foreman, David. "Nursing Shortage May Harm Patients," *The Business Journal of Jacksonville,* August 16, 2002. Accessed at www.bizjournals.com 8/14/06.

The nursing shortage has created another phenomenon that has the potential for leading to malpractice. More and more hospitals are now recruiting nurses from abroad. Congressional lobbying by hospitals resulted in provisions in the Senate version of the recent immigration bill removing the limits on the number of nurses that can enter the U.S. to work. In the last 10 to 12 years, more than 50,000 nurses have emigrated to the U.S. Most of these come from countries facing their own serious public health problems. An editorial in The Lancet commented: "[f]or a problem of this scope, the Senate appears to be airily applying a band-aid to a gaping wound. Instead of implementing what amounts to a morally problematic and expensive temporary fix to a problem that is not new, Congress should be creating ways to fund and strengthen the nursing infrastructure in the USA."[17]

Aside from the moral consequences of "poaching," problems may arise involving language. Nurses and physicians must communicate effectively, and nurses must also communicate effectively with patients. Barriers to this communication imposed by language can lead to misunderstandings resulting in malpractice.

D. TRENDS IN JURY CONSULTANT USE

A more appropriate title for this segment of the manuscript might be "Trends in Trial Consultant Use." True, in most instances, the use of consultants in trial preparation concentrates on jury selection, but consulting firms increasingly provide an array of trial services, many of which will be discussed. These services include directing focus groups, mock juries, demographic research, exhibit preparation, witness preparation, development of themes, etc.

Typically, medical malpractice cases are already much more expensive to prosecute than other forms of personal injury/wrongful death cases. The use of trial consultants can increase the

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[17] From "Poaching Nurses From Developing World Not the Answer to US Nursing

cost, but the amount in controversy very often justifies this expense.

Trial consultants are probably used most frequently for pre-trial or pre-mediation focus groups. The consultant or consulting firm can organize and run the focus group, or simply guide the lawyer through the process. Selection of the focus group participants is crucial. The group must be representative of the likely jury pool in age, gender, demographics, socioeconomic status, etc. Focus groups are not "predictors" of outcomes. They are particularly useful to identify problem areas in a case and possible juror reactions to witnesses or evidence. Focus groups are also helpful in the development of trial themes. The consultant may be the person presenting the case to the group, or one or more lawyers may perform that function while the consultant serves as moderator. Following the focus group, the consultant provides counsel with an analysis of the experience.

Shortage," Medical News Today at www.medicalnewstoday.com. Accessed 8/14/06.

With regard to jury selection, trial consultants can help direct the lawyer toward the kinds of *voir dire* questions that will develop challenges for cause. By its nature, *voir dire* relies on prospective jurors to "self report" in answer to counsel's questions. It is naive to accept a prospective juror's representation that he or she can be fair and impartial, especially if he or she has shared information that is suspect for bias. Studies have shown that prospective jurors will frequently give responses that they deem to be "socially acceptable," as a way to seek approval.[18] No one will want to be perceived as "biased" or prejudiced. Again, studies have shown that bias will persevere even in the face of contradictory evidence. For those jurors, less information is needed to reach a preferred conclusion, because information (evidence) consistent with the juror's pre-formed belief system will be subject to less critical examination than will be information inconsistent with the pre-formed belief system.[19]

There is also ample evidence that some prospective jurors will lie, despite being under oath. These are called "stealth jurors" and sometimes (not always) a trial consultant can help ferret out these stealth jurors..

Mock trials differ from focus groups in that they are conducted exactly as a trial would be conducted, without pausing to get juror feedback. The mock jury deliberates in the same fashion as a real jury, again without additional input from the lawyers or the moderator. Unlike a focus

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[18] Balch, Griffiths, Hall & Winfree, "The Socialization of Jurors: The Voir Dire as a Rite of Passage. *Journal of Criminal Justice*, Vol. 4 (1976)

[19] Ross, Lepper & Hubbard. "Perseverance in Self-Perception and Social Perception: Biased Attributional Processes in the Debriefing Paradigm," *Journal of Personality and Social Psychology,* Vol. 32 (1975)

There is also strong evidence that an instruction from the trial judge to the jurors to "set aside" their biases is counterproductive. If a juror expresses a prejudicial attitude, but agrees to "set it aside" and be fair at the court's instruction, that attitude is reinforced and becomes more cognitively accessible. See, Wegner and Erber, "The Hyperaccessibility of Supressed Thoughts," *Journal of Personality and Social Psychology,* Vol. 63 (1992). Also, remember the old song about the mother telling the child "not to put beans in my ears."

group, in which the emphasis is on getting feedback, the mock trial is truly a "test case." It may be an entire case presentation or only a portion of the case. Mock trials have more predictive validity than do focus groups.

"Shadow juries" are groups that observe the actual trial proceedings and then will meet to discuss the day's events. Since this is a form of "debriefing," in a sense if the shadow jury discloses a problem, it is akin to the horse being already out of the barn, although the lawyer will now know to close the bard door. This is very expensive and the risk to the lawyer is that he or she will rely too heavily on the shadow jury and ignore the actual jury.

Using research, focus groups, and other resources, trial consultants can guide the lawyer in witness preparation, word usage, and presentation of evidence Trial consultants can advise the lawyer on the types of demonstrative evidence to be used, and in what amount. The appropriate use of language is an important element in the process of persuasion. It is especially difficult for lawyers, whose training and professional language tends toward the formalistic. A good trial consultant can help a lawyer speak to jurors in their everyday language, without being condescending.

In addition to pre-trial preparation, trial consultants, in some cases, can assist in the actual jury selection process. Be very careful with this, not every good trial consultant can reliably "read jurors." I tend to avoid consultants who profess to "read body language." For the most part, I don't think body language can provide a reliable insight on a prospective juror's belief system.

Although it can be prohibitively expense, pre-trial community polling, done by a qualified consulting firm, can be extremely helpful in profiling desirable and undesirable jurors.

A good trial consultant can help with preparation of effective opening statements and/or

closing arguments. "Neurolinguistic programming" (NLP) is a communications technique that combines the use of language, anchoring (moving to the same spot in the courtroom each time a particular element of the case is mentioned, avoiding that spot otherwise), and themes. It has more to do with perception and presentation than with logic and rationale, but some consultants find it an effective communication skill. Others do not. NLP includes other communication techniques such as mirroring.

Trial consulting has been around since the 1970s and any kind of internet search on Google or Yahoo will turn up hundreds of consulting firms.

E. THE FUTURE OF PEER REVIEW

There seems to an increase in the number of responses to discovery requests with an objection on the grounds that the information sought is privileged or confidential or peer review. There is actually very little hospital information immune from discovery and plaintiff's counsel should not give up without a fight (if the information sought is relevant and important to the case). N.C.G.S. §131E-95 affords immunity from discovery of "proceedings of a medical review committee, the records and materials it produces and the materials it considers." A "medical review committee" is a committee of a State or local professional society, of a medical staff of a licensed hospital or a committee of a peer review corporation or organization formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing. N.C.G.S. §131E-76(5).[20]

Neither the hospital Board of Trustees nor the Risk Management Department is a hospital medical review committee. The committee must be comprised only of the hospital's medical

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[20] Similar statutes exist for other health care providers. N.C.G.S. §90-48.10 (dental review committees), N.C.G.S. §130A-45.7 (public health authority), N.C.G.S. §122C-30 (mental health facility peer review committees.

staff, i.e., a committee of physicians. The hospital Medical Staff Bylaws will list the various medical staff committees. If the objection is raised, request identification of the persons who comprise the committee which supposedly generated the materials for which production is opposed. If the committee is not one specified in the Bylaws, or created pursuant to the Bylaws, it should not qualify for the privilege.

Information from original sources is not made immune simply because it may have been given to a medical review committee. For example, data from quality assurance screening may be used by a medical review committee proceeding against a physician, but the initial data was compiled by hospital employees as part of the facilities ongoing quality assurance program. Likewise, complaints by patients or staff against a physician are discoverable (although the treatment of the complaints by a committee would not be discoverable). The seminal case in this area is *Shelton v. Morehead Mem. Hospital, 318 N.C. 76, 347 S.E.2d 824 (1986).*

I believe that, at least in the foreseeable future, defendants in medical malpractice cases will continue to raise peer review claims to avoid disclosure of certain information.

F. OUTSOURCING

While nationally a debate rages about outsourcing American manufacturing and service jobs overseas, outsourcing in some areas of healthcare has quietly established a toe hold. So far, this outsourcing seems to be limited to medical billing and coding, transcription, radiology and claims review. The advent of digital radiological imaging makes this process much easier. The radiology tech takes the x-ray and it is sent electronically to a radiologist in, say, Bangalore, India. The radiologist reads the film and then discusses his findings with the ordering physician via a toll-free telephone line.

Hospitals that are outsourcing radiology, usually at night, argue that it is economical for

the patient (they pay the Indian radiologist a fraction of what a radiologist in the U.S. would be paid), assuming the savings is passed along to the patient-consumer, and that it has been made necessary by a national shortage of radiologists.

Proponents of this practice, called "nighthawking," contend that fears about the quality of service are ill-founded, and it does appear that mostly the physicians reading the films are U.S. trained.[21] In most cases, they say, the hospital staff radiologist will double-read the films the following day.

Nevertheless, worries remain. Not every foreign company reading x-rays or scans uses U.S. trained and licensed doctors. Some radiologists protest that hospitals are not motivated by the lack of qualified radiologists, but by the bottom line. They argue that outsourcing converts radiology from a profession to a commodity.[22]

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[21] "Some U.S. hospitals outsourcing work," www.msnbc.msn.com/id/6621014/ (Dec. 6, 2004)

[22] Brant-Zawadxki, "A Dagger in the Heart of Radiology," Wikipedia: The Free Encyclopedia available at: en.wikipedia.org/wiki/Dagger. Accessed August 11, 2006

Also, there are state licensure issues.. For the most part in the U.S. physicians must be licensed by the state in which services are rendered,[23] but if the interpretation is performed abroad, what jurisdiction will apply? There are similar concerns with physician credentialing.

These concerns apply with greater force in the malpractice arena. If a claim is based on a negligent reading of an x-ray, CT or MRI by a physician who is in another country, and who may not have been trained or be licensed anywhere in the U.S., pursuant to a contractual arrangement with a hospital whereby the physician is an "independent contractor," where does that leave the injured patient? Does the foreign radiologist even have liability insurance?

There are HIPAA concerns as well. India does not have a HIPAA law. If a radiological service in India receives a patient's electronic MRI, how can disclosure be prevented. Contracts may have clauses dealing with non-disclosure, but there is at least one instance in which Indian and Pakistani transcriptionists, embroiled in a payment dispute with their employer, threatened to post U.S. hospital patients' information on the internet if the company didn't pay money they claimed was due.[24]

G. OTHER CONCERNS

Medical technology will undoubtedly lead to new issues in medical malpractice. I read recently of a case in which a surgeon in the U.S. performed surgery in Thailand via computer-controlled robotics.

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[23] One notable exception is certain "telehealth" services which allow for interstate consultations.

[24] www.healthexecutive.com/features/mar_2005/mar05_legal.asp accessed August 11, 2006