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Health Law Practice Update January-June 2014

We are pleased to provide information about the activity in the courts and legislatures of Minnesota, Iowa and Wisconsin. This update also highlights federal and other health care-related advances.

Case Decisions

Minnesota

Allan v. Paulson, 2014 WL 684695 (Minn. Ct. App. Feb. 24, 2014). The plaintiff underwent multiple surgeries on his hand, and then years later underwent surgery on it to remove a benign tumor. The Minnesota Court of Appeals agreed with the trial court that the plaintiff failed to submit adequate expert affidavits to meet the requirements of Minn. Stat. § 145.682 and did not offer any evidence to prove the delay of treatment for the tumor that led to substantial risk of harm, a requirement for his constitutional violation claim. It therefore affirmed the trial court's grant of summary judgment to the defendant.

Murillo v. Heegaard, 2014 WL 274102 (Minn. Ct. App. Jan. 27, 2014), *review denied* (Minn. Apr. 15, 2014). The plaintiff had an additional surgery in the abdomen for an infection two weeks after abdominal and pelvic surgery. The trial court determined that the plaintiff's amended expert affidavit was untimely and that the expert's opinion was too conclusory as it did not adequately describe how and why the doctor's malpractice claims led to the plaintiff's injuries. The court of appeals affirmed the district court's decision that the expert's affidavit did not sufficiently meet the standards set forth under Minn. Stat. § 145.682.

Iowa

Pottenger v. Nieves, 2014 WL 2341358 (Iowa Ct. App. May 29, 2014). The Iowa Court of Appeals affirmed the trial court's judgment following a jury trial denying the plaintiff's medical malpractice claim. In this appeal, the court reviewed whether the jury's verdicts were inconsistent and the jury's finding the plaintiff did not provide sufficient evidence to disclaim her comparative fault. The plaintiff alleged her obstetrician and gynecologist was negligent in his care of her and led to her developing cervical cancer. The defendant argued the plaintiff failed to follow-up on the care he recommended and plaintiff was also negligent. With the first issue on appeal, the court of appeals determined that the jury instructions were clear on finding the defendant negligent but the jury could also find the plaintiff negligent if the doctor adequately advised the patient to complete follow-up care and the plaintiff did not do so. The court said there were no logical inconsistencies with this finding. Further, the appellate court determined that substantial evidence supported the plaintiff's negligence in failing to obtain follow-up care that would have prevented her development of cervical cancer. The court of appeals affirmed the jury's determination that the defendant was 49% at fault and the plaintiff was 51% at fault.

Nelson v. Mercy Health Servs.-Iowa, 843 N.W.2d 478 (Iowa Ct. App. 2014). The plaintiff alleged that the doctors and medical centers were responsible for her gall bladder removal and post-surgery treatment. The plaintiff consented to her original attorney's withdrawal and the court extended the deadline for the disclosure of expert witnesses, as required by Iowa Code § 668.11. The Iowa Court of Appeals found that the trial court set reasonable pretrial dates and that the plaintiff failed to meet Iowa's statutory requirements for expert disclosure. Therefore, the court of appeals held that there was no legal error in the trial court granting defendant summary judgment.

Jack v. Booth, 844 N.W.2d 469 (Iowa Ct. App. 2014). The plaintiffs brought a medical malpractice action against two doctors. During trial, one of the jurors fainted during an opening statement, and a defendant doctor rendered aid to the juror. The Wisconsin Court of Appeals was persuaded by other jurisdictions in previous cases in which rare, but similar incidences like this have occurred that the plaintiffs were entitled to a mistrial based on inherent prejudice by other jurors as a result of the doctor's assistance to the juror during the trial. It therefore reversed and remanded judgment of the jury verdict in favor of the defendant.

Wisconsin

Engen v. Grelle, 2014 WI App 24, 352 Wis.2d 753, 843 N.W.2d 710. The plaintiffs brought a medical malpractice claim against their doctor arising out of the birth of their son. In a special verdict, the jury found the doctor at fault for not consulting with an obstetrician and not informing the plaintiff of the option for cesarean section, but it did not find the doctor at fault as to the cause of death of the plaintiff's son. The Wisconsin Court of Appeals concluded that the jury found the doctor negligent but that the negligence was not a cause of newborn's death, and it affirmed the trial court's decision

denying the plaintiffs' motion to change the jury verdict and order a new trial for juror misconduct.

Rupert v. Tandias, 2014 WI App 24, 352 Wis.2d 756, 843 N.W.2d 712. The plaintiff had bunionectomy surgery on her right foot. With continued pain after the surgery, she had a different surgeon fuse her toe joint. She then initiated a lawsuit against the first surgeon. The Wisconsin Court of Appeals determined that the trial court did not err in deciding that the plaintiff did not meet the expert witness requirements of Wis. Stat. ∫ 907.02(1), i.e., she failed to establish the *Daubert* standard of care requirement set forth in the statute.

Eighth Circuit

Halsne v. Avera Health and Avera McKennan, 2014 WL 1153504 (D. Minn. Mar. 21, 2014). The plaintiff's son sustained severe neurologic injuries arising from his birth at Pipestone County Medical Center (PCMC). The plaintiff initiated a lawsuit against several parties, and she claimed that Avera Health was directly liable for the injuries to her son, based on its deficient policy and procedures. Avera Health provides support services for hospitals, long-term care facilities, clinics, and other shared service areas. Avera McKennan owns and operates an acute care hospital in Sioux Falls, South Dakota, and it can provide certain hospital management services. On June 1, 2007, PCMC, Avera Health, and Avera McKennan entered into an agreement under which Avera McKennan contracted to provide hospital management services to PCMC in the form of an administrator. The administrator, an employee of Avera McKennan, reports to the PCMC Board of Directors and receives direction from the Board. Although Avera McKennan can recommend policies and procedures for PCMC to implement, the final decision-making authority to implement them rests with PCMC. Dr. Michael Lastine, plaintiff's obstetrician, was an employee of Avera McKennan. Avera McKennan conceded that, under a theory of respondeat superior, it would be responsible for the alleged acts and omissions of Dr. Lastine, should he be found liable for medical malpractice. The Minnesota Federal District Court held that the plaintiff did not establish standard of care or causation as related to Avera Health, and, therefore, did not set forth a prima facie claim of medical malpractice against that health care entity. However, the court denied the defendant summary judgment on its request that the potential amount of any award should be reduced, based on benefits the plaintiff received through the Affordable Care Act.

Lawrey v. Good Samaritan Hosp., 751 F.3d 947 (8th Cir. June 4, 2014). The plaintiff's daughter was born with permanent nerve damage to her right shoulder and arm that occurred prior to delivery. The plaintiff subsequently initiated a lawsuit against the hospital where she was born. At trial, the Nebraska Federal District Court excluded plaintiff's expert testimony finding that the testimony did not provide sufficient facts to establish that the newborn's injury was from the physician applying force during delivery. The court also determined that the plaintiff failed to prove lack of informed consent. The jury rendered a verdict for the defendants. The Eighth Circuit Court of Appeals affirmed the federal district court's holding that denied the plaintiff's motions for judgment as matter of law and for a new trial, and entered judgment on the jury verdict in defendants' favor.

MINNESOTA STATUTES

Board of Cosmetologist Examiners. Minn. Stat. § 155A.20 (2014). The total number of members on the board increased from four to seven and the categories of members is expanded. Board members will now include two cosmetologists, two cosmetology instructors, one esthetician, one nail technician, and one public board member. Prior to July 31, 2014, the Board consisted of three cosmetologists and one public board member. Other changes within chapter 155A involve new licensing and new school or professional association standards, clarification of the language of "health and sanitary" that changed to "infection control," and new state authorization standards. These changes are effective August 1, 2014.

Certification of Expert review; Affidavit. Minn. Stat. § 145.682 (2014). The new change requires all affidavits in medical malpractice cases to be served on the defendant no later than 180 days after the commencement of discovery. The old requirement was 180 days after the commencement of the action filed. The change was made to be consistent with Minnesota's new rules of civil procedure. It was effective on April 4, 2014.

Medical Marijuana Use Authorization. Minn. Stat. §§ 152.22-152.38 (2014). Minnesota will allow the use of medical marijuana through pills, oils, or vaporizing of a cannabis compound through a device similar to an e-cigarette. However, it will not allow smoking of marijuana leaves. The bill permits eight dispensaries and two manufacturing facilities to be opened throughout Minnesota. Operational setup for these manufacturers is underway and must be ready by July 1, 2016. This new law was enacted on May 30, 2014. *See* Kevin Riach, *High Hopes: The Future of Medical Marijuana in Minnesota*, Bench & Bar of Minnesota, May/June 2014, at 21.

Nurse Practice Act. Minn. Stat. §§ 148.171-148.285 (2014). Minnesota passed a new law to allow advanced nurse practitioners to diagnose and treat patients, as well as to prescribe drugs and devices, without physician supervision. Under the previous law, advanced nurse

practitioners were required to have a working agreement with a physician ("collaborative agreement"). Further, additional certification or recertification and educational requirements must be completed under the new law. Those who do not have a certification or recertification and license will be fined a penalty fee of $200 a month and additional $200 for each subsequent month that this is not completed. These changes are effective January 1, 2015.

Women's Economic Security Act (WESA). Minn. Stat. §§ 181.941-181.943 (2014). A number of statutes under WESA have been modified to include updates to the law. As related to health care, the following statutes have been changed. The effective date for the changes was May 12, 2014.

- Minn. Stat. § 181.941 (2014). **Pregnancy and Parenting Leave.** The statute now allows for "pregnancy" leave in addition to "birth or adoption" of a child. A biological or adoptive parent may take leave for prenatal care, incapacity due to pregnancy, childbirth or adoption, or related health conditions. The employee may request leave up to twelve weeks, and the leave must begin within twelve months after the child leaves the hospital, rather than six weeks.

- Minn. Stat. § 181.9413 (2014). **Sick Leave Benefits; Care of Relatives**. Employees may now use sick leave to care for relatives, instead of only immediate family members.

- Minn. Stat. § 181.9414 (2014). **Pregnancy Accommodations**. A new law has been added to accommodate pregnant women. Employers now need to provide reasonable accommodations for pregnant woman, including seating, frequent restroom breaks, and limits to heavy lifting.

- Minn. Stat. § 181.943 (2014). **Relationship to Other Leave**. The slight modification changes include a total length of leave not to exceed 12 weeks, rather than 6 weeks, and clarification with a reduction of the length of leave based on other benefits such as accrued vacation.

- Minn. Stat. § 181.939 (2014). **Nursing Mothers**. Employers must provide a closed room free from outside intrusion, with access to an electrical outlet. In addition, a new subdivision states that there can be no retaliation for an employee asserting rights under this section. Prior to this change, the privacy, access to an electrical outlet and no retaliation provisions were not available to employees.

WISCONSIN STATUTES

Inadmissibility of Apology or Condolence, Wis. Stat. § 904.14. Wisconsin's new apology law, enacted on April 8, 2014, provides that apologies from health care providers are not admissible as evidence in any civil action, whether this is an administrative hearing, disciplinary proceeding, mediation, or arbitration regarding the health care provider, as evidence of liability or as an admission against interest. The act first applies to statements, gestures, or conduct that occurs on the date the act became effective.

FEDERAL LEGISLATIVE ACTIVITIES

At the federal level of legislative activity, the following bills regarding health care professionals are of interest. Both bills, which are still in process, protect health care professionals, individuals and entities, from liability.

Good Samaritan Health Professionals Act of 2014, S. 2196, 113th Cong. § 2 (2014). This bill amends the Public Health Service Act to shield a health care professional from liability under federal or state law for harm caused by any act or omission if: (1) the professional is serving as a volunteer in response to a disaster; and (2) the act or omission occurs during the period of the disaster, in the professional's capacity as a volunteer who is acting in a good faith belief that the individual being treated is in need of health care services.

Quality Health Care Coalition Act of 2014, H.R. 4077, 113th Cong. § 2 (2014). This bill proposes that all health care professionals be exempt from the federal and state antitrust laws in connection with negotiations between groups of health care professionals and health plans and health care insurance issuers.

OTHER HEALTH CARE ACTIVITIES

Adverse Health Events – Minnesota Department of Health (2014). The Minnesota Department of Health (MDH) completed a ten year evaluation of patient safety with health care providers. Minnesota passed a law in 2003 that required all hospitals, and later ambulatory surgical centers, to report all adverse health events. The tenth year's collection of data proved valuable to MDH with results of a decline of 18 percent of the total number of events reported under the law. In 2012, the number of events was 258. Some highlights from the report include:

- A significant improvement in wrong site surgeries/ invasive procedures, with a decrease by more than 35 percent, the lowest point since 2005.

- With a three percent increase in fall-related deaths and injuries reported in 2013, compared to 2012 data. MDH collaborated with the Minnesota Hospital Association to issue a safety alert, which provided key practices that should be implemented to reduce the risk of fall injuries.

- Due to a slight increase in suicides or attempted suicides at Minnesota hospitals, MDH worked with Suicide Awareness Voices of Education (SAVE) to provide free suicide prevention and assessment training in the spring of 2013.

- In response to a rising need from facilities, MDH formed the 'Violence Prevention in Healthcare Workgroup' with stakeholders from hospitals, surgical centers, clinics and long term care associations, in order to look at the issues of patient to staff violence and develop best practices and/or recommendations.

MDH recommended that more focus is required around reducing falls and eliminating fall injuries, strengthening the Time Out process to eliminate all wrong surgical/invasive procedure events and preventing medication errors in Minnesota hospitals and surgical centers. Further, the report also provides that "these issues are deeper than human error and are often system issues that take dedicated time, resources and consistent leadership to correct." Continued efforts are underway to improve these and other areas for patient safety. *See Adverse Health Events Report in Minnesota,* Minnesota Department of Health, January 2014. http://health.state.mn.us/patientsafety/ae/2014ahereport.pdf.

Telemedicine Policy Changes – American Medical Association. The American Medical Association (AMA) developed a list of guiding principles to improve appropriate coverage of and payment for telemedicine services. With telemedicine, patients are able to receive health care services remotely via technology for care, including certain chronic conditions. It saves time and costs associated with patient visits. *See* Alexis S. Gilroy, Soleil E. Teubner, Stephanie L. Resnik, *American Medical Association Offers New Telemedicine Recommendations*, June 16, 2014. http://jonesday.com.

The new telemedicine policy places restrictions on telemedicine, but provides greater access and quality care to patients. Some of the policy changes include:

Location and State Licensure. Physicians must be licensed in the same state as the patient's location. The change also requires providers to be licensed according to state requirements and that the same standards of care that apply in traditional health care settings should apply to telemedicine. No location requirements or state licensures were in place before this new policy recommendation.

Patient-Physician Relationships. Valid patient-physician relationships should be established. This includes a *three prong test*: (1) face-to-face examination, or prior consultation of the same services with the patient; (2) consultation with a doctor with whom the patient has an established relationship; or (3) meeting standards of the patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as radiology and pathology. Further, other recommendations such as on-call, emergency medical services, or medical home availability have been identified as improved standards. Prior to this, the requirement was that doctors had to have at least one in-person patient visit, but the patient-physician relationship did not require the three-prong test listed above.

Coverage and Payment Standards. The policy proposes that a reimbursement system for telemedicine care, which is similar to payment for traditional consultations, be developed by AMA working with the Centers for Medicare & Medicaid Services and others. It will allow these providers to have a system that will pay them for these services completed. The current system exempts Medicaid Advantage plans and some physicians and other health practitioners who participate in alternative payment models.

Other Changes. Other policy recommendations include: patients must have a choice of provider; information available on provider credentials; consistent standards and scope of telemedicine services related to in-person services; compliance with evidence-based practice guidelines; transparency of services delivered; patient history data collection; documentation of the visit summary; care coordination with the patient's medical home and/or existing treating physicians; emergency referral protocols and other administrative improvements.

These policy changes will ensure that proper diagnoses and appropriate follow up care are exercised. It will also improve communications to patients and provide greater patient safety. Overall, these changes will strengthen telemedicine services for future growth.

If you have any questions regarding any legislative change or case law provided here or elsewhere, please contact Marlene S. Garvis or Pat J. Skoglund.