2008

Standard of Care for Medical Malpractice Claims in Idaho

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The Standard of Care for Medical Malpractice Claims in Idaho: Time for Reassessment

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This article reflects the personal viewpoint of the author and not of the *The Advocate* or the Health Law Section.

Anna Dulaney, a woman from the state of Washington was visiting Boise.[1] She fell from a deck and hurt her back. She was taken to an emergency room, x-rayed and released. A few days later she collapsed in excruciating pain and was taken back to the emergency room. The doctors reviewed the two-day-old x-rays, but ordered no new tests. They again released her, even though she was in such pain that she was unable to walk. Two days later, she returned home to Washington. She drove immediately to the emergency room. An MRI revealed that she had a block in her spine. The delay in treatment allegedly rendered her a paraplegic. She sued, in Idaho, using Idaho law.

Idaho Code § 6-1012, enacted in 1976, sets the standard of care for medical malpractice as a "strict locality standard," that is, the community standard at the time and place of the alleged malpractice as practiced by those of similar training and qualifications to the defendant. The "community" is the area served by the local hospital. Section 6-1013, enacted simultaneously, sets forth exactly how plaintiff's expert is to be qualified.

Mrs. Dulaney's lawyer was able to find two out-of-state experts to testify. Their professional credentials were beyond dispute. They were willing to say, with medical certainty, that the standard on this matter would not likely vary from one emergency room to another and that her care would have been inadequate "in any Emergency Department within the United States of America."[2] Even though Boise, Idaho is part of the United States of America, the woman could not even get past summary judgment because she was unable to satisfy the court that she had established the standard of care at the time and place of her injury.

The strict locality standard, by its very terms, permits the given community to be an island of negligence; if the defendant establishes that he was following community custom, he is exonerated, even if the community custom is out of step with the state and the nation. But the reported Idaho appellate cases indicate that this occurs seldom, if ever. Instead, what happens is that plaintiffs are unable to find a way to establish the standard of care in a given area. Idaho Code § 6-1013 requires the expert to be familiar with the local standard of care at the time of the alleged malpractice. The expert may himself be from the community or may "adequately familiariz[e] himself with the standards and practices of (a particular) such area."[3] Case law establishes that this can be done by various means, including telephoning local area practitioners.[4]

In the case of Mrs. Dulaney, her lawyers asked twenty-two Idaho orthopedists to confirm to her experts that the local standard of care conformed to the national standard. None would speak with them. Her experts were eventually able to speak with three doctors who had experience in Boise. Yet the district court, affirmed by a majority of the Idaho Supreme Court, deemed that they were insufficiently knowledgeable about the relevant standard of care in her case.

The first was an Idaho doctor, board certified in both Emergency Medicine and Internal Medicine, who had practiced internal medicine in Boise, but had not practiced emergency room medicine in Boise. The record did not indicate that he had become familiar with the Boise standard of care for emergency room doctors. On the other hand, the record did not indicate that the standard for emergency room doctors would differ from the standard applicable to an internist, especially in the context of an alleged omission to treat. Nonetheless, his information was insufficient to qualify the expert.

A second doctor was contacted. He lived out of state, but had practiced in Boise. He was asked about neurological tests performed by the defendant orthopedist. But although he had practiced neurology in Boise, he had not practiced orthopedics or emergency room medicine in Boise, nor was he asked about the practices of orthopedic surgeons. The district court was also concerned that he had practiced in Boise two years *before* the year of the plaintiff's injury. His information was insufficient to qualify the expert.[5]

A third medical doctor was contacted, a professor who had not practiced in Idaho but who stated that he was familiar with the standard of care in Boise at the time of the injury. He spoke only anonymously. He and the plaintiff's expert spoke three or four years after the injury. He indicated that he had trained orthopedists who were "presently" practicing in Boise, but he did not state if they were practicing in Boise at the time of the injury. Although he had lectured in Boise, he did not state when. His information was insufficient to familiarize the expert with the local standard of care.

Mrs. Dulaney's experts were therefore unqualified to testify, because they were insufficiently familiar with the standard of care in Boise, Idaho at the time of her injury. Mrs. Dulaney's case was dismissed on summary judgment. She never got to trial and the facts of the case were never publicly aired. This was upheld by the Idaho Supreme Court in what has become a leading opinion in medical malpractice.[6]

This is a troubling result. Anna Dulaney's case is representative of other cases that have passed through the Idaho courts. Certainly *Dulaney* is a cautionary tale for the plaintiffs' bar. A case last fall, *Ramos v. Dixon*, reiterates that the plaintiff's lawyer must oversee every aspect of the information gathering necessary for the plaintiff's case in chief.[7] Conclusory statements of familiarity with the local standard will not suffice. Experts and local doctors must be asked precise questions about how they have become familiar with the local custom. But *Dulaney*, and the approximately forty-five other standard of care cases decided since Idaho Code § 6-1012 and § 6-1013 were enacted, reveal some recurring flaws in the system.

Mrs. Dulaney was neither the first nor the last plaintiff to discover the reluctance of doctors to testify against each other.[8] Nor was she alone in experiencing how the strictures of the statute

compound the medical community's penchant for silence. If the community sets the standard but the community refuses to talk, it is difficult to prove violation of the standard. The facts in *Dulaney* are particularly disturbing. Five medical professionals had stated on the record that the standard of care had been violated. One stated: "What took place was outside the standard of care of modern Emergency medicine practice."[9] The defendants had not refuted the standard of care. Even to a lay reader, Mrs. Dulaney's repeated release from the emergency room seems questionable.[10]

Normally when defendants move for summary judgment, the court construes the record in the light most favorable to the party opposing the motion, drawing all reasonable inferences and conclusions in that party's favor. But, because of the specificity of § 6-1013, the threshold question of I.R.C.P. 56e must be addressed—whether the information in the supporting affidavits is admissible. The burden is on the plaintiff to qualify the expert. Thus, by moving for summary judgment, defendants can force the plaintiff into an early show of proof. The Idaho courts sometimes take this too far. Even within the strictures of § 6-1013, district courts may permissibly make logical, rational inferences, especially pre-trial; they should be encouraged to do so. *Dulaney* is particularly egregious in this regard. The district court was troubled that one local doctor had provided information about the standard two years *before* the injury. But the expert and the local doctor were saying that standard was *higher* than that allegedly met by the defendants. To disallow that information is to assume that the standard went *down* in two years, which is unlikely and implausible. Similarly, the Idaho Supreme Court majority was troubled that the anonymous professor did not specify whether the Boise doctors with whom he was familiar had practiced at the time of the injury or three years later, at the time when he was speaking with the expert. The likelihood of any change in the standard during that three-year window was small, especially in view of the credible assertions of the two experts that the standard of care was in fact *standard* across America. The professor's assertions were in an affidavit submitted as part of a motion for reconsideration of a summary judgment; this was not a situation where a witness on the stand could not remember crucial facts. There was still time, before trial, to garner more precise utterances from the professor or others. The majority's refusal to let the matter proceed to trial seems inflexible, even within the intentionally narrow confines of the statute.

Dulaney is merely one of several disconcerting medical malpractice cases in the Idaho Reports. The courts should rethink their application of the law and should encourage the district courts to make rational and logical inferences. But even so, the courts will be hemmed in by § 6-1-12 and § 6-1013.

Idaho has lived with these statutes for over thirty years—a generation. The time has come for the legislature to revisit and rethink the wisdom of the legislation. It was enacted with the express purpose of lowering liability insurance premiums so that Idaho would become a more attractive state in which to provide health care and thus attract more and better health care providers. The legislators intentionally protected defendant doctors at the expense of plaintiffs, in the name of increasing the public good. The first question is whether the legislation has actually attracted doctors. The law of Idaho is indeed viewed as doctor friendly,[11] especially when coupled with low non-economic and punitive damage caps and short statutes of limitations. On the other hand, despite these measures, recent studies indicate that the number of Idaho doctors is not keeping up with the state's rapidly growing population, especially outside of the Boise area.[12] So, the question remains, whether the "friendly" law is a significant draw to the state. The second question is whether the number and quality of Idaho care providers could be increased at lower cost to patients. The legislature should engage in fact-finding about who is likely to experience malpractice and whether the statutes are significantly reducing compensation to those with legitimate claims. Creative problem solvers across the nation have been writing about the most effective ways to deter medical error so as to benefit all patients. Possibly Idaho's current regime is the best for the state, but if so it should be retained consciously, not through inertia. The time is right for the Idaho legislature to begin the process of discerning the optimal means of increasing the availability of high quality medical care across the state.

About the Author

Monique C. Lillard *is a Professor of Law at the University of Idaho College of Law. She has taught torts for twenty years. She has recently published an article examining medical malpractice. "The Standard of Care for Health Care Providers in Idaho," – Idaho L.Rev – (2008). This topic was slated for discussion at the Idaho Law Review Symposium, "Law and Healthcare: Bridging the Divisions" in Boise on April 11, 2008. The author would be glad to share, upon request, her notes on the insights achieved at that cross-disciplinary session.*

Endnotes

[1] *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 45 P.3d 816 (2002) (Kidwell, J., dissenting).

[2] *Id.* at 171, 45 P.3d at 827.

[3] IDAHO CODE § 6-1013 (2004). He need not be of the same specialty as the defendant, as long as he is familiar with the community practice. *Strode v. Lenzi*, 116 Idaho 214, 216, 775 P.2d 106, 108 (1989).

[4] *See Grover v. Smith*, 137 Idaho 247, 251, 46 P.3d 1105, 1109 (2002).

[5] The Idaho Supreme Court majority did not base its decision on the time difference, but on the doctor's lack of familiarity with the standards applicable to the defendants, given their specialties.

[6] *Dulaney*, 137 Idaho 160, 45 P.3d 816. The facts recited in the previous paragraphs come from the majority and dissenting opinions in this case.

[7] 144 Idaho 32, 156 P.3d 533 (2007).

[8] *See John Banja, Medical Errors and Medical Narcissism* 3 (2005); *Grover v. Smith*, 137 Idaho 247, 46 P.3d 1105 (2002); *Gubler v. Boe*, 120 Idaho 294, 299 n.4, 815 P.2d 1034, 1039 n.4 (1991) (Bistline, J., dissenting). Note that in *Dulaney*, even the out-of-state professor spoke only anonymously. 137 Idaho at 163, 45 P.3d at 819.

[9] *Dulaney*, 137 Idaho at 171, 45 P.3d at 827 (Kidwell, J., dissenting).

[10] The defendants doubtless have explanations and rejoinders to the allegations against them. It is in the public interest, as well as in the parties' interest, to give full and fair airing to all of the facts in open court. That is one of the main purposes of jury trials.

[11] *See, e.g., Tresa Baldas, Localized Pain, National Law Journal*, July 16, 2007, at 1, 17.

[12] *See* MGT OF AMERICA, INC., MEDICAL EDUCATION STUDY FINAL REPORT 1-10 (2007), *available at* http://www.boardofed.idaho.gov/publications/MedEdStudyRptFinal.pdf (considering the expansion of medical education within Idaho).