LAW & MEDICINE

Loss of a Chance

Question: A doctor runs a walk-in clinic to treat acute conditions such as minor trauma and provide services such as flu shots and prescription refills. The clinic staff does not routinely measure blood pressure (BP). A patient who has used the facility for many years comes in and asks for a BP measurement because it was elevated when she had it checked at a recent health fair. It now reads 180/105, but she is asymptomatic. The doctor promptly starts antihypertensive therapy and recommends that she follow up with a primary care physician within 2 weeks. But before she can do so, she sustains a massive stroke. Regarding possible negligence in this hypothetical case, which of the following is correct?

BY S.Y. TAN, M.D., J.D.

A. The doctor is negligent in failing to routinely screen for hypertension.

B. The doctor escapes liability because there is no assurance that earlier diagnosis or therapy would have prevented the stroke.

C. The risk of a stroke in hypertensive patients is less than 50%, so the plaintiff will likely lose the case.

D. The doctor should have immediately hospitalized the patient to give her a better chance of survival.

E. The proximate cause of the injury was the patient's underlying hypertension and complicating stroke rather than delayed diagnosis, which merely increased her theoretical risk.

Answer: A. Routine BP measurements are usually performed with every doctor-patient encounter, with some exceptions, such as in a radiologist's office. Whether screening for hypertension should be part of a walk-in clinic routine will be determined by experts who will define the community standard. However, even if the doctor has breached the standard of care, his or her professional liability requires the plaintiff to show that the negligent act or omission proximately caused the injury. Proof of causation may be problematic when the harm suffered is a natural expectation of the underlying condition, and the doctor's negligence simply deprived the patient of some chance of reducing that risk. In this hypothetical case, hypertension was the underlying condition, and the doctor's omission (we assume that the hypertension was present and detectable if the patient had been screened earlier) can be said to have caused the patient to lose the opportunity to avoid or reduce the odds of sustaining a stroke. This is known as the "loss of a chance" doctrine. The doctor's treatment and referral otherwise met the usual standard of care.

The key issue surrounding the "loss of a chance" doctrine is what level of risk reduction or lost opportunity is necessary to pass the proximate causation threshold. How large a risk of an adverse outcome and how much of a reduction in that risk are required as a matter of law? Some courts assert that the plaintiff must show that the original risk is substantial to begin with, e.g., greater than 50%. Other courts have held that all that is needed is for the plaintiff to show that the defendant's negligence led to a lost opportunity for a better result, irrespective of the degree of loss.

A series of cases from Kansas addresses this controversy. The Kansas Supreme Court initially used the term "appreciable chance" as the yardstick of measure (*Roberson v. Counselman*, 686 P.2d 149, Kan. 1984). A decade later, this was modified to "substantial loss of the chance" (*Delaney v. Cade*, 873 P.2d 175, Kan. 1994). Finally, in its latest deliberation on the subject, the Kansas court held that a 5%-10% chance was enough for liability (*Pipe v. Hamilton*, 56 P.3d 823, Kan. 2002). In that case, gangrene and death set in after surgery for small bowel obstruction, and the doctor did not pursue other tests because the patient had only a 5%-10% chance of survival. In ruling against the defendant, the court stated: "Pipe (plaintiff) contends a 10% chance of survival is more than a trifling matter and is something that Kansas public policy supports as being recognized as substantial. We agree. As a matter of law, a 10% loss of chance cannot be said to be token or de minimis."

Cases alleging delayed diagnosis of cancer frequently pose "loss of a chance" issues. In one case, expert testimony established that the plaintiff would have had a 51% chance of 5-year survival if her lung cancer had been diagnosed in a timely way. The court ruled this met the causation burden, but went on to state that a plaintiff could recover for the loss of any appreciable chance, not just one exceeding 50% (*Boody v. United States*, 706 F.Supp.1458, Kan. 1989). In another ruling concerning the untimely diagnosis of lung cancer, a Washington court held that survival reduction of 14%, from 39% to 25%, was enough to entrust the jury to decide on the issue of proximate causation (*Herskovits v. Group Health Co-op. of Puget Sound*, 664 P.2d 474, Wash. 1983).

A few jurisdictions, however, take the position that the loss of a chance has to be more than 50% (*Grant v. American Nat. Red Cross*, 745 A.2d 316, D.C.App. 2000). In this case, the plaintiff contracted hepatitis C after receiving a blood transfusion. The blood bank did not routinely screen for alanine aminotransferase levels, but the plaintiff lost the case after conceding that the chance of avoiding hepatitis C even with screening was less than 40%. ■

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POLICY & PRACTICE

CPAP Coverage Expanded

Medicare now will pay for continuous positive airway pressure therapy for obstructive sleep apnea diagnosed by home sleep testing, according to the Centers for Medicare and Medicaid Services. Previously, the agency covered CPAP only if obstructive sleep apnea was confirmed by polysomnography in a sleep laboratory. Under the new rules, initial coverage of CPAP is limited to a 12-week period for beneficiaries whose obstructive sleep apnea is diagnosed using clinical evaluation and testing with an unattended home sleep monitoring device. If the beneficiary's condition improves as a result of CPAP during this 12-week period, then coverage will continue, the CMS said.

Consumer-Directed Plans Gain Fans

The number of people enrolling in consumer-directed health plans has increased 25% from last year, according to a survey of nearly 2,800 private insurance enrollees by the Blue Cross and Blue Shield Association. The survey also found that consumers in CDHPs are more cost conscious than are non-CDHP consumers; they are 30% more likely to track their health expenses than are those in more traditional health insurance plans and 27% more likely to ask their doctors about the cost of treatment. "[CDHP] consumers are demonstrating more active engagement in their own health care than are non-CDHP consumers, as evidenced by an increased use of health and wellness programs and better tracking, estimating, and budgeting for health care costs," said Maureen Sullivan, senior vice president for strategic services at BCBSA. The 39 independent Blue Cross and Blue Shield companies serve a total of 4.4 million CDHP enrollees—an increase of 50% from last year.

But PCPs Lack Knowledge on CDHPs

Many primary care physicians said they knew little about how CDHPs work, and also reported limited readiness to advise patients on issues of cost and medical budgeting, a study in the American Journal of Managed Care reported. In the survey of 528 primary care doctors, 40% said they had CDHP enrollees in their practices. Of the physicians surveyed, 43% said they had low knowledge of CDHP cost sharing, and about one-third reported low knowledge of how medical savings accounts function. Overall, physicians with CDHP enrollees in their practices knew more than did physicians without those patients, but one in four of these providers said they knew little about CDHP cost sharing. More than two-thirds said they were ready to advise patients on the costs of office visits, medications, and laboratory tests. But half or fewer said they were ready to discuss the costs of radiologic studies, specialist visits, and hospitalizations.

More Trouble With Health Expenses

About one-third of Americans now say their family has had problems paying medical bills in the past year, up from about a quarter of respondents 2 years ago, according to a survey of more than 1,200 adults by the Kaiser Family Foundation. And nearly one in five Americans (18%) report household problems with medical bills amounting to more than $1,000 in the past year. In addition, almost half of respondents report that someone in their family has recently skipped pills or postponed or reduced medical care. In particular, just over one-third say they or a family member put off or postponed needed care, and 30% admitted to skipping a recommended test or treatment—in both cases, an increase of 7 percentage points from last April. "Health care is now every bit as much an economic issue for the American people as job insecurity, mortgage payments, and credit card debt," said Drew Altman, the foundation's president and CEO.

GAO: FDA Needed Broader Pool

Food and Drug Administration officials might have avoided some conflicts of interest on their scientific advisory committees by expanding recruitment efforts beyond word-of-mouth nominations, according to a report from the Government Accountability Office. The report, released last month, analyzed the recruitment and screening of FDA advisory committee members before the agency changed those processes in 2007. The FDA could have reached out beyond its usual source of experts to retired professionals, university professors, and experts in epidemiology and statistics, the GAO concluded. The evaluation was requested by members of the Senate.

Benefits Seen for National Health ID

A national patient identifier system would improve health care quality and efficiency, according to a study from the RAND Corporation. Because no current national identifier exists, most health systems use a technique known as statistical matching, which retrieves a patient's medical record by searching for attributes such as name, birth date, address, gender, medical record numbers, or Social Security number. Past studies have found that such systems return incomplete medical records about 8% of the time and expose patients to privacy risks because of the large amount of personal information that is out in the open during a search. The RAND researchers estimated the costs of creating a unique patient identification system at $11 billion, but noted that it would return more than that amount in benefits such as the elimination of medical record errors and the reduction of repetitive and unnecessary care. "Establishing a system of unique patient identification numbers would help the nation to enjoy the full benefits of electronic medical records and improve the quality of medical care," said Richard Hillestad, the study's lead author.

—Jane Anderson