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Judicial Diagnosis

Sleep Disorders and a Physician's Responsibility

John Bello, JD

When persons affected by sleep disorders, like sleep apnea or narcolepsy, get behind the wheel of a car, they may be endangering not just themselves, but their passengers, other drivers, and pedestrians. Because of this danger, many state legislatures mandate that physicians report patients who have ailments that cause them to lose consciousness to the state division of motor vehicles. The State of Rhode Island does not have such a statute on the books. But even without a statutory mandate to report patients with sleep disorders to the division of motor vehicles, doctors in Rhode Island may still face potential tort liability when treating patients with sleep disorders.

When a physician treats a patient, the physician is normally responsible only to the patient. In fact, rules for confidentiality preclude any sharing of medical information, or personal information disclosed during a visit. A third party, however, may enter the picture. That third party can be a specific person, or a generalized "public." In certain situations a special relationship exists between the third-party plaintiff and the physician; for example, when the clinician has reason to know that a patient is likely to harm an identified person, a person not identified, or a generalized "public," the clinician may be expected to breach confidentiality. In short, the clinician has a responsibility to that third party.

In order to protect the public, courts across the United States have struggled with the issue of clinicians' responsibility to people other than their patients. Obviously a patient can sue his/her doctor. The question is: can a non-patient - a third party - sue that physician? Some courts have said yes; others no. Because there is no clear consensus on how these third party plaintiff actions should be ruled and because the issue has not been litigated in a Rhode Island court, it is unclear how a similar case would be resolved in the Ocean State.

In some cases, when third party plaintiffs have sued physicians, arguing that the physicians had a "special relationship" with the third party, the courts have found that there was not a special relationship and that there was also not a sufficient link between the two parties to give rise to a cause of action.¹ For example, in New York a patient susceptible to blackouts killed another while driving. The patient had been living in a health care institution under the medical direction of a physician, who discharged the patient. The court found no "special relationship," because the doctor, although the director of the institution, was not the patient's primary treating physician. Thus he had no duty to warn the patient of the dangers of driving. The doctor was not held liable. Courts have also found that if the disorder is obvious and the patient has suffered from it for some time, the physician is not responsible for warning the patient of obvious dangers. In Kansas a patient who had been suffering from a sleep disorder knew of the potential dangers of driving, yet that patient drove, and seriously injured two bicyclists. The bicyclists sued the physician. A Kansas court determined that the doctor did not have a duty to warn this patient because it would be a redundancy and accomplish nothing.²

Other cases, though, have held physicians liable to third party plaintiffs. Those courts have determined that there is a duty from the physician to the driving public when the physician knows or reasonably should know that a patient's ability to drive is affected.³ In *Gooden v. Tips*, 651 S.W.2d 364 (1983), the court found that a physician who prescribed specific drugs either knew - or should have known - their potential im-

pact on the driver's ability to drive: "the doctor was under a duty to take whatever steps were reasonable under the circumstances to reduce the likelihood of injury to other motorists." "Thus the harm resulting to the plaintiffs "...was in the general field of danger which should reasonably have been foreseen by the doctor when he administered the drug."

Furthermore, courts that have held physicians liable to third party plaintiffs have for the most part determined that the physician's duty to warn is satisfied by warning the patient. In *Pate v. Threlkel*, the court reasoned that the burden on a physician to warn others of a patient's condition would place too heavy a burden on the physician.⁴ The standard of care applied in these cases is the same that has historically been applied to medical malpractice claims, where physicians are held liable if their actions do not satisfy the standard of care established by expert testimony. For instance, a patient with a history of seizures had a seizure, which led to a car accident. The court found the patient's doctor negligent and liable to an injured third party plaintiff because the clinician failed to employ recognized procedures to determine the cause of the patient's seizures.⁵ If a physician satisfies this threshold level of care, s/he will probably not be held liable for his/her actions.

A third party need not necessarily be a stranger to the patient. For example, consider a minor child, injured while driving with a parent who suffers from a disorder that causes him/her to lose consciousness. That child might plausibly be considered a reasonably foreseeable plaintiff, one who should be afforded a special relationship status.

For Rhode Island courts, this area of tort law is an issue of "first impression" (not yet litigated). Even without Rhode Island case law, however, Rhode Island physicians who meet or exceed the standard of care established for the questioned treatment and warn patients with sleep disorders about the potential dangers of driving may be able to shelter themselves from liability.

This advice, though, is based on case law in other jurisdictions. Only when cases have been litigated in Rhode Island will there be solid precedent; and only then will the standard for physician responsibility to third parties be clear in Rhode Island.

REFERENCES

1. *Purdy v. Public Administrator*, 72 N.Y.2d 1, 9-10 (1988).
2. *Calwell v. Hassan*, 260 Kan. 769, 776 (1996).
3. *Gooden v. Tips*, 651 S.W.2d 364 (1983).Id. at 370.
4. *Pate v. Threlkel*, 661 So.2d 278, 282 (Fla. 1995).
5. *Freese v. Lemmon*, 210 N.W.2d 576, 579 (1973).

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Rhode Island Monthly
Vital Statistics Report
Provisional Occurrence Data
from the
Division of Vital Records

Underlying Cause of Death	Reporting Period			
	March 2001	12 Months Ending with March 2001		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	296	3,073	293.1	4,353.5**
Malignant Neoplasms	190	2,372	226.3	6,624.0
Cerebrovascular Diseases	46	496	47.3	690.0
Injuries (Accident/Suicide/Homicide)	33	376	35.9	6,996.5
COPD	41	498	47.5	480.0

Vital Events	Reporting Period		
	September 2001	12 Months Ending with September 2001	
	Number	Number	Rates
Live Births	1234	13,302	12.7*
Deaths	780	10,191	9.7*
Infant Deaths	(12)	(99)	7.4#
Neonatal deaths	(12)	(85)	6.4#
Marriages	1,129	8,603	8.2*
Divorces	120	3,341	3.2*
Induced Terminations	411	5,466	410.9#
Spontaneous Fetal Deaths	105	993	74.7#
Under 20 weeks gestation	(94)	(914)	68.7#
20+ weeks gestation	(11)	(79)	5.9#

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.

(b) Rates per 100,000 estimated population of 1,048,319

(c) Years of Potential Life Lost (YPLL)

Note: Totals represent vital events which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.

* Rates per 1,000 estimated population # Rates per 1,000 live births
** Excludes two deaths of unknown age.

– A Physician's Lexicon –

Humor Me, Dear Galen



To most primitives, a person became ill only when some malevolent, supernatural force had descended upon him. It is to the credit of the ancient Greeks that they brought illnesses down to a secular level, ascribing them to some internal derangement or imbalance involving the body's fluid humors. [*Humor* is a Greek word meaning moisture; and, later, a Latin word, *umor*, meaning wetness, as in the word humidity.] Rational medicine, both Western and Arabic, was captive to this humoral theory of disease for over two millennia. Indeed, until the 19th Century, the theory was staunchly advocated to the exclusion of alternate systems of belief in virtually all European medical schools.

These four humors were yellow bile, blood, phlegm, and black bile; and, since each humor possessed certain singular attributes, an excess of each was readily identifiable. Thus, persons with too much blood were said to be sanguine [Latin, *sanguineus*, of blood], courageous, outspoken, often apoplectic. Those with too much yellow

bile were choleric [Greek, *cholos*, meaning bile], passionate, prone to bursts of rage, perhaps jaundiced. Those with an excess of phlegm [Greek, *phlegmos*, meaning inflammatory swelling] were said to be cold, dull, slow to anger, phlegmatic. And finally, those burdened with an excess of black bile [in Greek, *melancholia*] were atrabilious, subject to spells of profound sadness, and also given to rare episodes of anger [but only when they were *splenetic*, the spleen being the alleged origin of black bile].

Therapy for disease consisted of any medical intervention which might rectify the excess of one or another humor. A sanguineous person, hence, was bled repeatedly. Other therapies might include cathartics [rhubarbs, mercurials, jalaps, salts], agents such as paragoric or laudanum to retard bowel evacuation; and emetic medications to promote vomiting.

Medicine increasingly doubted the validity of the humoral theory of disease; yet until the advent of the cellular theory of disease in the 19th Century, there was

little to replace these old Galenic formulations; and so they were advocated but without enthusiasm. Playwrights in Britain and France used the rapidly discredited theory as a basis for their comic efforts; and gradually the word humor became a synonym for travesty and satire. When Shakespeare at the beginning of the 17th Century talked of "a humorous sadness," he was referring to melancholy. A century later, when Addison wrote: "In all thy humors whether grave or mellow, Thou'rt such a touchy, testy, pleasant fellow; Hast so much wit, and mirth and spleen about thee," he was using the word, humor, in both meanings. But by the 20th Century, the word was employed unambiguously to convey the sense of comedy. "Men will confess to treason, murder, arson, false teeth, or a wig," said Colby, "How many of them will own up to a lack of humour?"

– Stanley M. Aronson, MD, MPH

THE RHODE ISLAND MEDICAL JOURNAL

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NINETY YEARS AGO

[FEBRUARY, 1912]

Listing the names of the 218 members and friends who had contributed to the new Medical Library Building, the Journal called on the 100+ non-contributing members to join the campaign.

"In Superior Sanitary Quality of Rhode Island Oysters," Frederic P. Gorham, a Sanitary Expert on the Rhode Island Shellfish Commission, defended the state's oysters. The federal Board of Food and Drug Inspection had ruled that oysters "sown in sewage-polluted water, or...fattened by 'floating' or 'drinking' in sewage-polluted waters" could not leave a state, under Interstate Trade rules; and Dr. Wiley from the Board had found certain Rhode Island oysters "polluted with sewage." The author argued that the danger of sewage-polluted oysters lay in their potential for disease, specifically typhoid. Yet oysters taken directly from beds (even the polluted beds of Rhode Island) had led to no cases of typhoid. [He conceded that floating posed a danger, but Rhode Island fishermen did not "float" their oysters.] Also, the author cited the observation of Dr. Chapin: "Very few oysters are eaten by laboring people, but at present laboring people furnish fully their share of typhoid fever."

Ellen A. Stone, MD, a member of the Committee on Midwifery of the American Association for the Study and Prevention of Infant Mortality, personally interviewed all 40 midwives in Rhode Island. In "The Midwives of Rhode Island," she summarized the results. Half the midwives lived in Providence. Most were Italian (23), followed by Hebrew, Portuguese, American, and English (3 midwives each). They delivered "an immense number of infants": 3 delivered 150 babies each, five delivered over 100 babies. Providence midwives delivered 4788 babies, or 42% of the total births in the city in 1910. Dr. Stone found the midwives' education, training, equipment, and personal cleanliness "far from ideal": 22 could not read sufficiently to fill out the birth certificates; 19 could show no equipment. Although all 40 "professed to scrub their hands well before making vaginal examinations" and 29 used bichloride solution, only 2 understood its significance. Dr. Stone reported folk practices: dressing the umbilical cord with snuff; giving a mixture of molasses and a child's urine to an infant as a physic; and binding the umbilical cord so its cut end pointed upward "to insure no 'bed-wetting' as the child grew older." The Rhode Island legislature was considering whether to recognize midwives. Dr. Stone urged: "Cannot Rhode Island extend her obstetrical charities by out-patient services for the poor and proper semi-charity hospital accommodations for those in moderate circumstances, and then, having secured for all women at confinement the means of obtaining proper obstetrical skill, gradually abolish the midwives till they are no more?"

Frank E. Peckham, MD, in "Post-Operative Roentgenization in Cancer," explained that surgeons discounted this treatment: "...patients come for such treatment, not because they have been sent by the surgeon, but because they have heard of some else being benefited." He abstracted comments from a supportive editorial in *JAMA*; e.g., "The doubters of the curative powers of the x-ray are not found in the ranks of those who know the agent."

FIFTY YEARS AGO

[FEBRUARY, 1952]

In "Acne Conglobata Treated with Aureomycin," Bencil L. Schiff, MD, and Arthur B. Kern, MD, described a 45 year-old male, who at age 18 had developed lesions on his face, followed by lesions on his neck, scrotum, gravias, thighs. He had had numerous hospitalizations. He worked until age 38, when the pain and stiffness in his hips forced him to stop. The profuse prurulent and bloody discharge had led to 2 divorces. After a regimen of aureomycin (500 mg 4 times/day for 9 months, then 1 gram daily for 4 months, then a mixture of Kutapressin and aureomycin), the patient had been "converted from a socially unacceptable semi-invalid to one who is able to carry on his usual duties."

An Editorial "Hat for Health" ridiculed the Congressional Record notation of a recent report from "Hat Life," the organ of the hat workers' association. A Congressman from Fairfield, Connecticut, "the hat center of the world," had submitted the report. Briefly, 100 ear, nose and throat specialists were asked the question: "In your opinion, does a hatless man particularly invite sinus trouble?" Of 22 respondents, 15 answered "yes." The editorial cautioned, "Wait until bureaucratic medicine is in the saddle." To promote health, the government might make hat-wearing compulsory.

TWENTY FIVE YEARS AGO

[FEBRUARY, 1977]

In a Message from the Dean, Stanley M. Aronson, MD, reported on "Internships obtained by Brown University Medical Students, Class of 1977:" 11 students went to New York programs; 10 stayed in Rhode Island; 13 enrolled in Family Medicine, up from 4 for each of the two previous years.

In "Tuberculin Dual Testing: A New England Pilot Study," Ralph A. Redding, MD, FRCP, Francis Segarra, MD, FACCP, and Fredy Roland, MD, concluded that the "technique can be useful in reducing doubtful interpretation to less than 2% of cases." They had tested 1018 Memorial Hospital employees, on a voluntary basis.

Peter B. Reilly, MD, and Lauren B. Cohen, BA, from Harvard Medical School, had presented "Lithium as an Anti-Depressant: Discoveries through Clinical Observations" at the Annual Research Day Program, The Miriam Hospital. The Journal reprinted their talk.

James P. Cooney, Jr., PhD, CEO, RI Health Services Research, Inc. [SEARCH] contributed "Cost Containment and Quality of Care: Are They Both Possible?" Likening the two to Scylla and Charybis, he nevertheless concluded: "The old dictum of the greater good for the greatest number with the funds available is still valid."

An Editorial called for the repeal of the Delaney Amendment. "The recent banning of saccharin by the FDA because it caused bladder cancer in rats is ridiculous." Although saccharin had been available for 80 years, physicians had attributed no case of bladder cancer to it.