

Healthcare Class Actions: Bad Doctor or Bad System?

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“As is your pathology, so is your medicine” – Sir William Osler

“Quality means doing it right when no one is watching.” – Henry Ford

Atlantic Canada has received national attention over the last two years arising out of two healthcare scandals rooted in failures of pathology. One scandal involved the work of a single pathologist at a regional hospital serving a catchment of 50,000 people in Miramichi, New Brunswick. The other scandal involved the work of an entire pathology department at a university affiliated provincial reference laboratory in St. John's, Newfoundland and Labrador, serving a provincial population of 500,000, and has been called the greatest healthcare scandal in Canada since tainted blood. Each scandal provoked class proceedings and each provoked the authorities to institute commissions of inquiry.

This paper will focus on the strategic issue for plaintiffs of who to sue as party defendant: hospital authority, doctor, or both? The answer may depend on whether the case is primarily a “bad doctor” case or a case of the whole system gone bad. Hospitals are creatures of systems

and obviously the “bad doctor” and “bad system” models exist on a spectrum. These conceptual models are useful in bringing out practice points nonetheless.

A comparison of the Miramichi and Eastern Health cases will help to elucidate the “bad doctor” and “bad system” models.

In 1993 the New Brunswick government decided to close down the two community hospitals servicing the Miramichi area, and build a new regional hospital at Miramichi. The new hospital would be fully departmentalized with diagnostic support services in radiology and laboratory medicine. A CEO was hired and tasked with recruitment of medical staff. He placed advertisements and received a sole application for a staff position in surgical pathology, that of Dr. Menon.

The application was referred to the hospital Credentials Committee. This committee did not have a pathology peer of Dr. Menon on its membership to assist in evaluation of competency, but approved his application for privileges for a one year contract. The hospital CEO ignored the probationary restriction and offered Dr. Menon a position without restriction as to term. The appointment did not go through either the Medical Advisory Committee or the Board of Directors, as required by by-laws. Chronic problems ensued with turnaround time, absenteeism, resistance to quality assurance, minor and major errors in diagnosis, and deficient reports. On the whole, there was an absence of peer review. An early attempt by administration to dismiss Dr. Menon proved abortive when a letter of dismissal was drafted but never signed. A complaint was laid in 2005 but dismissed by the MAC. Administration finally did an end run around the

MAC and complained to the College of Physicians and Surgeons of New Brunswick, resulting in an executive suspension of Dr. Menon's license to practice in February 2007. This College action terminated Dr. Menon's conduct of surgical pathology at Miramichi after a tenure of 12 years.

The resulting public apprehension caused government to refer out 23,998 cases performed by Dr. Menon during his tenure. Of these, 5,286 specimens or 22% of the total reviewed had a partial or complete change in findings. 370 cases had a complete change in findings, and 101 involved cancer. The most common cancer diagnoses would involve breast, prostate, skin and gastrointestinal cancers. About 17,000 patients had their specimens retested and are potential claimants for mental distress damages.

The Miramichi case involves the conduct of surgical pathology by a lone pathologist. By contrast, the Eastern Health case involves the conduct and interpretation of a sensitive and sophisticated immunohistochemical test by the entire academic pathology staff of a provincial reference laboratory affiliated with a university medical school. Testing of hormone receptors in breast cancer specimens is done to determine whether cell nuclei stain positive for these receptors; if so drugs such as tamoxifen can be given to cut the cancer cells off from needed growth factors. Tamoxifen reduces the risk of 10 year recurrence by 50% (odds ratio of 2.0 or double the risk without tamoxifen), other drugs by a greater degree.

Hormone receptor testing (ER/PR testing) began at Eastern Health in 1997 and lamentably, there was no quality assurance in place and the testing was set up for failure from the start. After

many bungled opportunities, in the spring of 2005 the so-called Index case was uncovered. A program of retesting was commenced, and by July 2005 a false negative rate of 67% was found on 38 of 57 retested samples which had originally been tested negative. ER/PR testing was shut down as of August 2005, and Mount Sinai was asked to review all negative ER cases from 1997 to August 2005 in a retrospective study adjusted for cut point. By September 29, 2005 Eastern Health had received 156 retested cases from Mount Sinai, with a 51% false negative rate. The ultimate false negative rate after retesting 1,088 specimens is over 49%.

The action against Eastern Health was certified in an oral judgment¹ delivered at close of hearings and revelations contained in answers to interrogatories precipitated the public inquiry.

The variety, extent and systemic nature of the problems lying at the root of the testing failures have been described by Commissioner Cameron in her report:

The primary causes of the changes in testing results were poor fixation and tissue processing, the absence of optimization of processes, the failure to follow proper procedures in ER/PR testing, and inadequate and/or improper antigen retrieval.... The high rate of conversions was caused by the lack of quality assurance processes in the IHC laboratory that could have prevented the problems or at least have detected them earlier, as well as the failure of pathologists to pay adequate attention to internal controls.

...

Had occurrence reports been filed, this, coupled with Dr. Ejeckam's observations about the tests, as stated in his three 2003 memos, should have triggered a review at that time. Indeed, Dr. Banerjee was of the opinion that Dr. Ejeckam's concerns alone should have triggered an external review in 2003. Even in 1999,

¹ *Doucette v. Eastern Regional Integrated Health Authority*, 2007 NLTD 138 (CanLII).

the problem might have been detected had Ms. Purcell's case been investigated, as Dr. Cook agrees it should have been. ... I am satisfied that for Ms. Deane, and patients like her with invasive lobular carcinoma, the original negative ER test results should have been questioned by both pathologists and oncologists. At a minimum, the ER/PR tests for such patients should have been redone.... Had ER/PR metrics been kept from 1997 to 2005, even on a yearly review it would have been obvious that in certain years the positivity rates were so outside the norm that laboratory staff should, in the normal course of events, have investigated to determine the source of the problems.

...

The procedures and protocols within Eastern Health for ER/PR testing during the period from 1997 to 2005 were so deficient as to be practically non-existent. They were neither reasonable nor appropriate.²

Indeed world renowned expert Dr. Dabbs characterized the situation as a "recipe for disaster" and testified that the lab would have been shut down if inspected to standards prevailing in the United States.³

The class proceeding against Eastern Health is set for mediation with Hon. George Adams, Q.C. at the end of October 2009. The Plaintiff will submit that 678 patients were seriously medically injured. The broad class membership is 3,007 patients, on behalf of whom claims for mental distress and aggravated damages will be advanced. The mental distress claim is based on reasonable contemplation in contract (although a defendant may wish to argue contract should not apply in a public health care system). The aggravated damages claim arises out of the general conviction in Newfoundland and Labrador that Eastern Health got caught in an attempt

² The Hon. Margaret A. Cameron, Commission of Inquiry on Hormone Receptor Testing, Volume 1: Investigation and Findings, pp. 451-453, www.cihrt.nl.ca.

³ Evidence of Dr. Dabbs, September 16, 2008, p. 250

to cover up the extent of the testing failure. The aggravated damages claim is based in breach of fiduciary duty. Despite dissimilarities between the Miramichi and Eastern Health cases, the central theme identified by Commissioner Creaghan in the Miramichi case, namely lack of quality assurance, is the central theme in the Eastern Health debacle as well:

It was self evident from the beginning that the matter of quality assurance and quality control was central to the problem under investigation.⁴

Commissioner Creaghan's prescription for future change is equally applicable to Eastern Health as it is to Miramichi:

In the future, the laboratory ... must be operated under a culture of patient safety, rather than a policy of risk management in a situation where a problem arises.⁵

In the Eastern Health case, in May 2007 the case management judge certified the following class definition, in part:

(a) Patients, including their estates, who underwent ER (estrogen) and PR (progesterone) receptor tests in which their breast tissue samples were tested at the Defendant's hospital during the Class Period;

The case management judge also certified the following common issues:

- (a) did the defendant owe a duty, and if so,
- (b) did the defendant breach that duty, and if so, when and how?

⁴ Commissioner's Report: Commission of Inquiry into Pathology Services at the Miramichi Regional Health Authority, www.miramichicommission.ca, p. 125.

⁵ *Supra*, p. 126.

An obvious rock on which healthcare class actions may founder is the lack of commonality in the various medical acts causing damage to patients. The potential variation in facts and medical interventions from one case to another is almost infinite. The object for a plaintiff desiring certification is to persuade the case management judge that the unifying theme of the case is systemic error, not individual error. The failure of a whole department lends itself to the allegation of corporate and systemic failure. The plaintiff in the Eastern Health case judged that it was not necessary to name individual doctors, and indeed doing so lends ammunition to the case against certification owing to the potential for detracting from corporate and systemic failures. The defendant Eastern Health did not take third party proceedings against the doctors responsible, and the reason may be that to sue so many of its own employees would be disruptive to the corporation and to patient care, and might well cause a crisis of physician retention and recruitment in the province. Whether in the background, negotiations are occurring between the hospital authority and the physician defence organization, has not been publicly disclosed.

In a case such as the Miramichi case, the decision as to who to sue may be less clear. Systemic failures occurred no doubt, but the principal bad actor in the drama is a single doctor. The certification hearing has not yet taken place, but the class definition which will likely be proposed is, in part, as follows:

- (a) Patients, including their estates, whose tissue samples underwent pathology testing reported by pathologist Rajgopal Menon, at the Defendant's hospital during the class period, and whose tissue samples the Defendant subsequently caused to be retested;

The common issues likely to be proposed would be as follows:

- (a) did the First Defendant owe a duty to credential competent medical staff?
- (b) did the First Defendant breach that duty, and if so, when and how?
- (c) did the Second Defendant owe a duty of competence?
- (d) did the Second Defendant breach that duty, and if so, when and how?

There is an obvious thread of identity or commonality to the issues thus framed – competency and the duties of doctors to maintain it and of hospital authorities to require it. The plaintiff case would be that the doctor was not competent, and would not have caused the extensive damage he did cause if he had not been granted privileges, as he ought not to if the credentialing process had adhered to requisite standard.

An example of a bad doctor case which achieved certification is *Bellaire v. Daya*⁶, the Tompkins metroplasty case. Certification was by consent on settlement. In looking at the common issues at para. 19, the key would seem to be that Dr. Daya's negligence was in performing an outmoded procedure, the Tompkins metroplasty, on each class member. The issue appeared to be, was the Tompkins metroplasty procedure negligent *per se*, and was the hospital negligent in allowing Dr. Daya to perform this procedure. There were about 175 people in the class. Both the doctor and the hospital authority were parties to the consent certification, and the common issues were:

- (1) Was Dr. Daya negligent in performing the Tompkins metroplasty on each Class Member?
- (2) Was the Hospital negligent in relation to Dr. Daya's performing the Tompkins metroplasty on each member?

⁶ *Bellaire v. Daya*, 2007 CanLII 53236 (ON S.C.).

The contrast with Miramichi is that in the Miramichi case the allegation is that the doctor was not competent to practice the spectrum of surgical pathology, and the hospital was negligent to credential him. The further allegation is not that the doctor was negligent in relation to each mistaken outcome, but that he owed directly to patients a duty of competency – a duty to possess the skill and knowledge requisite to surgical pathology – and the details of the negligence involved in any particular mistaken diagnosis – the details of how and in what respect the standard of care in making the diagnosis was breached – are irrelevant. This position has a certain logic and perhaps even elegance, and time will tell how it fares.

The Miramichi plaintiff initially elected to sue only the hospital authority, and successfully resisted a motion by the hospital defendant for an order to add Dr. Menon as a defendant.⁷ Soon thereafter, the plaintiff decided to add Dr. Menon as a defendant. Why?

Although pursuit of the hospital authority as sole defendant may help to preserve the focus and commonality of common issues, it can also create complications in the background which militate against possible settlement. Hospital insurers and defence organizations may have settled relationships and practices with the Canadian Medical Protective Association, the physician defence organization, which may be impeded when the principal bad actor is left out of the proceedings. In other words, framing the claim in a manner calculated to maximize chances of certification may undermine the practices which the physician and hospital defence organizations have developed in mutual working relationship to handle settlement in bad doctor cases.

⁷ *Gay v. Regional Health Authority* 7, 2009 NBQB 101 (CanLII).

The suggested practice point for plaintiffs in bad doctor cases is: open good lines of communication with defence counsel and explore the background issues which may bear on settlement before making a final decision on who the party defendants ought to be, considered in the setting of common issues likely to pass scrutiny at certification. There may be a fine balance between maximizing the prospect of certification and maximizing the prospect of settlement; striking the right balance is how good counsel earn their pay.

Appendix of Certification Decisions

New Brunswick:

Outcome

Bryson v. Canada (Attorney General), 2009 NBQB 204 (CanLII) ----- Denied

Newfoundland and Labrador:

Wheadon v. Bayer Inc., 2004 CarswellNfld 105 (T.D.) ----- Certified

Rideout v. Health Labrador Corp., 2005 CarswellNfld 193 (T.D.)----- Certified

Doucette v. Eastern Regional Integrated Health Authority, 2007 NLTD
138 (CanLII) ----- Certified

Ring v. The Queen, 2007 NLTD 146 (CanLII)----- Certified

Ring v. The Queen #2, 2007 NLTD 213 (CanLII)----- Stay lifted

Davis v. Canada (Attorney General), 2007 NLTD 25 (CanLII) ----- Denied

Davis et al. v. Attorney General, 2008 NLCA 49 (CanLII)----- Denied

Sparkes v. Imperial Tobacco Canada Limited, 2008 NLTD 207 (CanLII)----- Denied

Nova Scotia:

None reported