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Better Healthcare Newsletter from Patrick Malone

Dear Jessica,

A dewy-eyed perspective persists about American health care: miracle-working doctors, community-minded hospitals, and cutting-edge medical devices and drugs.

All of it's true, especially about the selfless motives of many doctors and nurses. But what's also true is that American health care is:

* Error-prone (because of its complexity and other issues)

* Profit-driven

* Fragmented among diverse practitioners who don't communicate well with one another.

Americans spent an estimated $3.65 trillion — 19.4% of the gross domestic product — on health care in 2018. Big Pharma and medical device makers are reporting billions of dollars in annual profits. So, too, are big hospitals, which are getting even bigger, and sprawling into new enterprises like free-standing clinics and centers for specialty care like surgery. Hospitals also are gobbling up doctors

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BY THE NUMBERS

2% to 3%

Percentage of patients harmed by medical negligence who pursue litigation

and their practices to fatten institutions' bottom lines.

But even as medicine marches into big-dollar corporatization, it struggles as never before with its human factors: Medical errors claim the lives of roughly 685 Americans per day — more people than die of respiratory disease, accidents, stroke and Alzheimer's. This means medical errors rank as the No. 3 U.S. cause of death, behind only heart disease and cancer. In just one category of this damage, preventable hospital deaths kill more than 160,000 Americans annually — four times as many lives as were lost to vehicle wrecks in 2017, more than twice the deaths attributable to opioids and drug overdoses that year, and more than the toll of stroke or Alzheimer's disease.

Who can patients rely on when harmed while seeking care in the giant U.S health care system? The answer may surprise you, because this safeguard gets bashed by the medical establishment almost without end.

More people need to know that medical malpractice lawsuits play an invaluable role — in protecting patients, according them justice, and improving the quality and safety of medicine. But unhelpful myths surround this key constitutional safeguard, and it's vital to keep busting the falsehoods that spread about malpractice cases. Let's do so now, with a special tip of the hat to the research amassed by the Center for Justice and Democracy at New York Law School. *

*If you see type of a different color in this newsletter, that's a hyperlink you may click on for more information. The CJ&D study that will be referred to in this newsletter may be accessed by clicking here.

The zombie theory of "defensive medicine" just won't die

There is a lot of myth versus fact surrounding medical malpractice suits. Let's start with probably the biggest and most persistent myth. It's about so-called "defensive medicine." It goes like this:

Because any practitioner can be sued, no matter how high-quality their care, to keep patients happy and to safeguard themselves, doctors order more tests and give more treatments than they

40%

Percentage of of paid medical malpractice claims over a 13-year period attributable to just 2% of doctors.

39

Number of times estimated per week that a surgeon in U.S. leaves a foreign object like a sponge or a towel in a patient's body after an operation.

$17.1 billion

Estimated annual cost of measurable medical errors that harm patients.

QUICK LINKS

Our firm's website

Read an excerpt from Patrick Malone's book:

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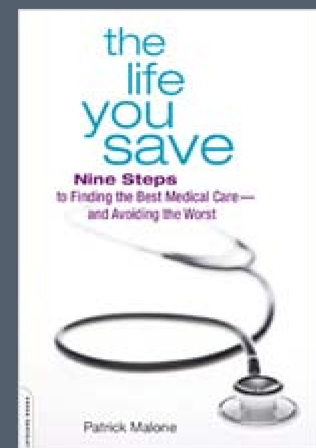

otherwise would need to. If we could curb lawsuits, we could get rid of unnecessary waste and medical treatment would be a lot more affordable.

Well, this is just wrong on multiple levels. But it does contain one core piece of truth. Over testing, over diagnosis, and over treatment in U.S. health care can be blamed for hundreds of billions of dollars in needless costs. But whose fault is it?

Let's start with the fact that all that testing is highly profitable for the people who order the tests and the facilities that provide them. That's "fee-for-service" medicine, a persistent feature of American health care which other countries have eliminated by putting doctors on salary and taking profit out of hospitals. The American way of financing care is thus biased toward more care, with or without legal accountability in the civil justice system when patients get hurt.

Second, the "defensive medicine" argument insults the ethics of health care providers. Don't doctors fundamentally want to do right by their patients? So why would they saddle them with excess costs and procedures? If doctors were charging patients for tests or procedures they don't need, wouldn't they run afoul of fraud laws, insurers, and Uncle Sam (Medicare or Medicaid)?

Third, if you really wanted to know if defensive medicine was a true and significant cause of waste and abuse, you could run a simple experiment: Take one or two big jurisdictions, and eliminate lawsuits, and then measure what happens with the costs of care.

Been there, done that.

As the CJ&D annual "Briefing Book, Medical Malpractice: By the Numbers." notes, with multiple citations of rigorous studies, states where the medical establishment won malpractice damage caps have seen no reduction at all in the growth of health care costs. These states see no reduction in overall spending nor on big ticket items like cesarean sections, testing in coronary artery disease care, or neurological spine surgeries.

Still, among doctors, the canard about medical malpractice and defensive medicine is one of those zombie theories that won't die, even in the face of hard evidence. As the CJ&D study quotes a 2017 study led by a Boston surgeon:

"When AMA-affiliated doctors from a variety of specialties and practice settings were asked, 'Nationally, what do you think are the top reasons for overutilization of resources, if any?' 85% of respondents cited 'fear of malpractice' as the top reason for overtreatment. As the researchers pointed out, 'Perceptions on the prevalence of malpractice suits, however, may be greater than the reality of the problem. Only 2%-3% of patients harmed by negligence pursue litigation, of whom about half receive compensation. Paid claims have declined by nearly 50% in the last decade.'"

LEARN MORE

Read our Patient Safety Blog, which has news and practical advice from the frontlines of medicine for how to become a smarter, healthier patient.

PAST ISSUES

All about vaccines: What you and your family need and why
Coping with crushing medical bills
Some insights into eyesight, and how to take care of our aging eyes
Counting the many ways women are mistreated by the medical system
A grown-up discussion about sexuality for Valentine's Day

You Can Eat This... But Why Would You?

Looking Ahead: Preparing for Long-Term Care

Managing Chronic Pain: It's Complicated

Secure Health Records: A Matter of Privacy and Safety

Standing Tall Against a Fall

More...

Yes, that's right: Tens of millions of Americans receive medical services in any given year, yet only a tiny slice of them sue doctors. If medical personnel — who train for years to understand science and research — dig into the data on malpractice cases, would they panic so much about them?

With malpractice cases, foes exaggerate number, severity, judgments awarded

Psychologists say that irrational fears can bubble up when individuals sense they may lose control, or if they may be somewhat familiar with a cause of their terror but still find it shapeless and menacing. The medical establishment's making of malpractice cases into one of the profession's bogeymen is still hard to fathom. The CJ&D briefing, in its early section headlines, summarizes why:

"Experts agree that when cases are filed, they are not 'frivolous'; few injured patients file claims or lawsuits. The number ('frequency) and size ('severity') of medical malpractice claims, lawsuits and payouts are low. A small number of doctors are responsible for most malpractice payouts …"

Contrary to the fretting about an avalanche of malpractice cases jamming the civil justice system, particularly state courts where such actions usually are filed, "Medical malpractice cases represented only 0.14% of state *civil* caseloads in 2017. This rate is consistent with [National Center for State Courts] data from the previous five years." Even when patients suffer medical harms, or even if they die as a result, malpractice suits don't routinely follow, as the CJ&D briefing says, reporting on research by a team of Johns Hopkins experts:

"Researchers found that a lawsuit was filed on behalf of the patient in 19.9% of harms. In other words, 'approximately 1 in 5 patient harms resulted in a lawsuit.' As the authors explained, 'This is similar to the Harvard Medical Practice Study, which reported an estimated ratio of adverse event to malpractice claim of 7.6:1. Other studies have estimated that as few as 2% to 3% of patients pursue litigation.

These findings all suggest that the vast majority of patient harms never result in a lawsuit.'"

If patients pursue malpractice claims, the cases that go to trial involve individuals with claims of severe harm — and contrary to what medical practitioners may want to think — plaintiffs who prevailed didn't hit financial bonanzas. This is especially true considering the judgments must cover years or even a lifetime of intensive treatment and care, research from the insurer of Harvard medical institutions and their affiliates shows:

"[I]ndemnity payment trends for the 10-year study period [2007-16] were not dramatic. The median payment increased in line with inflation (from $110K in 2007, to $120K in 2016). The average payment, even though distorted by a few atypical payouts, grew on average 3% annually (from $298K to $360K). While that outpaced the consumer price index, it fell below medical inflation, a fair proxy for medical expenses which, along with policy limits, heavily influence payments. Certainly, extraordinary jury awards draw media attention, pique the interest of re-insurers, and can skew the focus of patient safety improvements, but they remain rare. Per 1,000 cases closed, only one or two cases closed with more than $5 million indemnity. Outlier payments (those exceeding $11M) had a minimal impact on overall indemnity trends."

Certain specialists — neurosurgeons, thoracic-cardiovascular surgeons, general surgeons, orthopedic surgeons, and plastic surgeons — may be at higher risk of malpractice claims, studies show.

But for the public, especially patients, politicians, and regulators, there's a big takeaway in the building research on malpractice suits. As Stanford Law School researchers reported recently of their scrutiny of just under a half million malpractice claims, "2% of physicians accounted for about 40% of paid malpractice claims over a 13-year period." These experts, in a Q-and-A about their findings, observed this about malpractice "frequent flyers":

"Physicians often curse malpractice litigation for being random. While it's true that not all medical malpractice claims signal poor-quality care, they are far from random. Repeated claims against a practitioner, in particular, are an important signal of patient safety risk. Regulators and the companies that provide physicians with liability insurance should be paying closer attention to this signal. We're finding that the more we learn about these practitioners, the clearer that imperative becomes."

The alarms have sounded about the few doctors who account for a significant portion of malpractice claims. But what's the response?

When politicians' 'reforms' fail patients

Most Americans take little notice of the details of the medical malpractice system — until the eruption of periodic public policy “crises,” most related to spikes in premiums for insurance aimed at protecting doctors and hospitals from malpractice claims. Insurers, doctors, and hospitals rile up public sentiment with "white coat marches" on state capitols, sprinkled with assertions about how malpractice coverage costs will curtail medical services offered, drive practitioners out of business, and prevent others from wanting to work in a given area.

Prodded by doctors, hospitals, and insurers, politicians race to statehouses, maybe conduct hasty hearings, and many have enacted measures beneficial to a select constituency. Lawmakers in more than half the states have capped malpractice damages that judges and juries may award. (Maryland and Virginia are among these states). As discussed earlier, these caps may curtail damage awards, but they have little effect on health care spending, or the efficiency of the delivery of medical services. Damage caps and other “tort reforms” can add to the nightmares of patients with claims of medical harm, injuries that may leave them with lasting pain, disfigurement, debilitation, and for them and their families, mountains of medical debt and the strong possibility of medical bankruptcy.

Kentucky, like many states that have put up increasing obstacles for patients to pursue malpractice claims, threw out longstanding legal practices, with lawmakers shutting ordinary folks out of the civil justice system. Claimants couldn’t get a lawsuit into court unless they first presented their case to boards made up of local medical experts. These were supposed to volunteer to decide if claims were frivolous or unfounded. But doctors and others with knowledge — maybe even conflicts of interest — couldn’t make time to serve. Long waits became common, even for those who had suffered clear and demonstrable harm.

The highest court in the Bluegrass state infuriated lawmakers and the medical establishment by tossing out Kentucky’s malpractice “reforms,” which jurists decided had broken a fundamental part of the state’s legal system. They found the measures deprived citizens of

their constitutional right to have claims heard in courts in a reasonable amount of time and in a reasonable fashion, as well that politicians couldn't write laws that target just one kind of litigation.

State by state, high courts are taking up and differing in findings as to whether malpractice damage caps are unconstitutional because they abridge plaintiffs' rights for their claims to be decided by courts based on individual circumstance. North Dakota, Oregon, Wisconsin, and Kansas are among states where damage caps have fallen based on constitutional rights claims.

Research, as cited in the CJ&D briefing, also might give the public and politicians reason for pause about "tort reform" targeting malpractice suits, particularly if measures launch from assertions about insurance "crises" damaging doctors and hospitals.

That's because malpractice insurers, as industry reports show, continue "to produce favorable results, with better-than-average profitability for more than a decade…." Meantime, medical malpractice insurance rates remain stable and flat, as "prolonged soft market conditions continue." The premium spikes that occurred in the past — in the 1970s, 1980s, and the early 2000s — aren't occurring now.

And that has led researchers to look skeptically at insurer charges, because, as occurred in Texas in 2003, malpractice insurance premiums hit nosebleed levels without connection in a comparable period to "the frequency of med mal claims, payout per claim, total payouts, defense costs, or jury verdicts."

Instead of looking to court cases as causing soaring malpractice insurance costs, those savvy about the industry may want to turn, instead, to how insurers fare on Wall Street. As attorney Dororshow and insurance expert and reform advocate J. Robert Hunter explained in a study: malpractice "insurance companies make most of their profits, or return on net worth, from investment income." They keep rates low and try to soak up as much cash as they can when the bulls run so they can sock that money into making more on the markets. But if bearish conditions prevail, they rip customers for premiums and slash at coverage. They also cry about malpractice cases to distract from their own problems and to advantage themselves with so-called tort reform.

The current bull market has run for a record decade. If it fizzles, will there be yet more bull flung around about medical malpractice suits and the cost of malpractice insurance?

Lawsuits make institutions accountable and help improve medical care

For patients, accessing and affording safe, efficient, and excellent medical care has become a greater ordeal than ever. That's because of the soaring cost, complexity, and uncertainty of treatments, medical devices, and prescription medications — too many of which prove to be more dangerous than first thought. As they try to navigate the U.S. health care system, patients and their loved ones also find increasing issues with those who are supposed to provide them assistance and safeguards.

This leaves lawsuits as one key protection.

Consider, for example, how colleges and universities — institutions packed with smart people who are supposedly focused on improving the lot of the young — turned a blind eye as staff doctors and coaches sexually abused not just a few but hundreds, even thousands, of young women and men for years.

The Penn State scandal grew over time, involving dozens of victims. The sex abuse at Michigan State and USA Gymnastics victimized more than 300 young women, while the University of Southern California is seeking to settle federal lawsuits over claims of inappropriate conduct by a health service gynecologist and his possible misbehavior with as many as 17,000 coeds. Ohio State University, after an investigation by an outside law firm, has apologized for sexual abuse of at least 177 men who were athletes in the care of a late, pervy team doctor. UCLA is embroiled in a developing scandal over claims involving its staff gynecologist with three cases that have resulted in criminal charges and led to 22 more allegations, plus dozens more women calling to say they want to talk about misbehaviors in their care. Grownups in these cases — notably those with medical responsibilities, including mandated abuse reporting — failed to act and many ignored explosive situations until lawsuits flew.

Media investigations and work by patient safety advocates have shown that medical boards and other organizations that oversee and can discipline doctors too often act like lap kittens rather than tough

watchdogs. Consumer Reports did a deep dig on what it deemed to be one of the nation's better medical licensing boards in California, finding it and others of its kind fail to police the profession in ways that protect patients. The Milwaukee Journal-Sentinel and MedPage Today investigated and found that many doctors who get in trouble for repeatedly malpracticing on patients simply mosey down the road and practice elsewhere. That's because the professional licensing system is a state-by-state patchwork, with a lax and unworkable national reporting system.

In the meantime, the agency that chiefly supervises and accredits hospitals is a supposedly independent consortium run by … hospitals (and with a sketchy oversight role, investigations have found). Hospitals, which also are supposed to protect their patients and themselves by vetting with care any doctors who will get privileges to practice in their hallowed halls, may skimp on that scrutiny, notably if a specialist brings in a lucrative amount of business. They also may decline to be candid with other institutions about problematic practitioners, passing them on to other hospitals for fear of personnel lawsuits. In Dallas, Christopher Duntsch, a doctor trained as a cancer researcher, re-created himself and began to practice as a back surgeon. He mangled surgeries and patients, moving from hospital to hospital, and eluding discipline from the medical establishment (that includes, regrettably, malpractice cases in which parties agreed to settle and keep quiet). Exasperated prosecutors stepped in and filed rare criminal charges against Dunstsch, who since has been nicknamed "Dr. Death" and is now convicted and imprisoned.

Patients also may find themselves ill-served if they hope for protection from bad medicine by federal regulators like those in the Food and Drug Administration. Critics say the agency has become an industry captive, including getting a chunk of its funding from companies it supervises for its oversight activities. The FDA looked the wrong way and opened the path to the opioid and overdose crisis that kills tens of thousands annually now and allowed an estimated 1 million complaints about medical devices to be hidden from the public and patient safety advocates. It doesn't take a rocket scientist to see the wrong, backward way the oversight system works now, with hundreds and thousands of patients needing to file complaints and to sue doctors, hospitals, Big Pharma, and medical device makers before FDA bureaucrats awaken and decide to act.

This all underscores a malpractice reality that must be reinforced for our collective good: The way to reduce malpractice actions isn't to attack the lawsuits but to *reduce medical malpractice*. Putting patients first, improving the practice of medicine, and ridding the profession — pronto — of bad doctors provides the best and most promising way to address malpractice issues, independent research finds.

As much as doctors, hospitals, insurers, Big Pharma, and medical device makers may loathe them, malpractice actions help police and can improve the practice of medicine. Innovation in the field is great and should be encouraged. But with the professional leeway that doctors enjoy, malpractice actions may be one of the few ways to

corral medical cowboys, including those who for decades have subjected women to excessive, needless treatment injury. Who reins in doctors when they over order medications or prescribe drugs off-label, as they can, so that seniors in nursing homes are reduced to "compliant" zombies or babies get dosed up with powerful anti-psychotics?

Those who so much as scan the CJ&D study will see that "never" medical events — errors that "never" are supposed to occur — are far too prevalent and cause tens of billions of dollars of harm: with hospital acquired infections, surgeons flubbing operations and leaving surgical implements in bodies, prescription and procedure orders getting mixed up with disastrous result, and patients misdiagnosed, meaning they go without needed care or get improper treatment. Too many wrongs too often go unnoticed and unacknowledged, even as suffering results.

As those Stanford experts pointed out, good doctors, hospitals, and insurers should be stepping up to protect patients, their profession and institutions, as well as themselves, by dealing with doctors who rack up a sizable portion of malpractice cases as repeat offenders — some who have lost as many as four and five cases. That's not random, nor bad luck. It's bad medicine.

Here's what's further distressing about the Stanford findings: Dubious docs, those with multiple unfavorable judgments, don't quit treating patients. Instead, they shift to settings where they are even less inclined to get assistance or oversight by colleagues. They retreat into solo or small practices. But they keep their medical licenses, and the burden — and risk — rests with their patients to dig up information on their checkered pasts.

So, really, must it be patients' labor to watchdog the quality and safety of their medical services? Sadly, this is too true, notably through malpractice actions. They can be a heavy lift for those who must pursue them. Few Americans ever get into court, save perhaps for jury duty. So many of us may not know that seeking justice in the civil system can be a scary, consuming experience. It doesn't go quick or easy, even with excellent counsel to guide patients through intimidating steps they may be subjected to by representatives for doctors, hospitals, insurers, Big Pharma, and medical device makers. Cases can be expensive, and their legal hurdles can be formidable.

To bust another myth: This all means that malpractice cases aren't taken lightly — they're not trivial or frivolous. Many are settled so patients get the help they need to start to make themselves whole from injuries they have suffered in medical care. Those involving the most severe circumstance and injury may be more likely to go to trial. Patients and loved ones in these cases will seek sizable assistance for what may be an uncertain period, perhaps a lifetime of significant treatment and care. It's also not just about money, experience shows. Patients, some who already were ill or injured, truly want justice after they are medically damaged — they demand public recognition that care givers and companies mistreated them, that

there are consequences for doing so, and that the causes of their harm will be dealt with, so they do not recur. It can take courage to seek these goals, and the medical establishment should not fear righteous claims, right?

Of course, here's hoping that you and yours stay so healthy and well that you have minimal need for medical care, and zero experience with malpractice matters — except for how they have helped to better the quality and safety of medical treatment!

Celebrities savaged by medical errors, too

Rich. Famous. Powerful. Those are three characteristics that many might think would guarantee those who possess them outstanding medical care with exceptional outcomes. It isn't always so. As the Center for Justice and Democracy at New York Law School has pointed out in a recent study, celebrities can be savaged just like ordinary folks by **medical errors that harm and even kill them and their loved ones**.

The group's **study describes 22 cases**, documented by lawsuits and medical board sanctions, to show that, "Celebrity is no safeguard when it comes to medical malpractice," Emily Gottlieb, the report's author and the center's deputy director for law and policy, said in a statement. "As this report illustrates, patients with fame and fortune are just as likely to be horrifically injured or killed by dangerous health providers as the general public."

Gottlieb said the center's list is not comprehensive, and, sadly, needs constant updating due to persistent injuries and deaths involving prominent patients and doctors and hospitals. The center's roster reads like a list of stars on Hollywood's Walk of Fame, recalling cases including those of:

Military personnel barred from claims of medical harm

It's up to Congress now to decide if service members may pursue in the civil justice system claims that they have suffered harms while seeking medical services, a fundamental civil right long denied to military personnel.

That's because U.S. justices, with two notable exceptions, recently declined to **revisit an inequitable, 69-year-old Supreme Court** ruling **involving the Federal Tort Claims Act**. That act governs who can bring a claim for negligence at a military or other government health care facility.

Active duty military personnel cannot bring a medical negligence claim for care at a military facility. This is called the "Feres doctrine," after the Supreme Court decision***, Feres v. United States, 340 U.S. 135 (1950).*** Under the Feres doctrine, members of the United States armed forces are barred from making a claim against the United States for personal injury or death arising

- Julie Andrews and how a “negligent throat procedure” halted the Oscar-winning actress’s singing career
- Dana Carvey and how a “negligent heart surgeon operated on the wrong artery,” causing serious illness and a prolonged recovery for the comedian
- Michael Jackson and how the King of Pop “died of a lethal dose of anesthesia administered by his doctor”
- Prince and how his “Purple Reign” atop music’s best-seller lists ended with his fatal fentanyl abuse after “health providers failed to properly diagnose and treat a prior opioid overdose”
- Joan Rivers and how the legendary comedienne died after “a New York endoscopy center subjected her to numerous unauthorized and unsafe procedures”
- Andy Warhol and how the pop artist and mover-and-shaker of Manhattan night life died after “a gall bladder surgery when hospital personnel essentially drowned him with fluid”

Joanne Doroshow, the center’s executive director, said the group undertook and issued its celebrity study not to fuel star-driven ghoulishness but to underscore that, “the problem of medical negligence is so entrenched and universal that even wealthy celebrities who can afford most comforts in life are not immune from experiencing it.” Further, she added, “Given our celebrity-focused culture, this report might be the best way to catch and hold the public’s attention regarding the serious issue of medical negligence.”

It’s unacceptable that celebrities, who get fawned over by doctors and hospitals and can afford intensive and individualized medical attention and

“incident to service.” Military medical treatment received by a service member, while on active duty, has been held by the courts to be “incident to service,” and, thus not actionable, even if that treatment was for a purely elective procedure, and even if the procedure was performed negligently.

The doctrine may have been meant to help preserve military discipline and order. But it is applied to settings far from battlefields and involving situations affecting ordinary life, not combat.

Walter Daniel, a grieving husband and former Coast Guard officer, petitioned justices to reconsider the Feres doctrine and how it has barred him from legal recourse in the death of his wife, Navy Lt. Rebekah “Moanie” Daniel. She was a healthy 33-year-old woman and a labor and delivery nurse herself. Shortly after delivery in her low-risk pregnancy, she bled to death at the Naval Hospital Bremerton in Washington State.

He sued the Navy for medical malpractice, with court documents showing its “doctors failed to perform vital tests, to employ an obstetrical balloon — a standard device used to halt postpartum hemorrhage — and to start massive blood transfusions until too late.”

Daniel’s case has been blocked by the fact that his deceased wife was active-duty military at the time she gave birth. If she had been treated in the same hospital by the same doctors and suffered the same tragic outcome, but hadn’t been active duty, her widower’s case would not have been barred by Feres. That doctrine only applies to injuries of active-duty personnel themselves.

Two members of the high court who rarely agree on much wanted to reconsider the Feres doctrine by taking up the Daniels case. Justice Ginsburg did not elaborate why. **Thomas filed a short dissent**:

“I have explained before that ‘Feres was wrongly decided and heartily deserves the widespread, almost universal criticism it has received.’ *Lanus v. United States, 570 U. S. 932, 933 (2013)* (quoting *United States v. Johnson, 481 U. S. 681, 700 (1987) (Scalia, J., dissenting)*). I write again

care, still are subjected to medical error. That should give humbler patients with fewer resources great pause about accessing and affording safe, efficient, and excellent medical care.

to point out the unintended consequences of this Court's refusal to revisit Feres … unfortunate repercussions—denial of relief to military personnel and distortions of other areas of law to compensate—will continue to ripple through our jurisprudence as long as the Court refuses to reconsider Feres. Had Congress itself determined that service members cannot recover for the negligence of the country they serve, the dismissal of their suits 'would (insofar as we are permitted to inquire into such things) be just.' *Johnson, supra, at 703 (Scalia, J., dissenting)*. But it did not. Accordingly, I respectfully dissent from the Court's decision to deny this petition."

The justices leaving the Feres doctrine in place makes it more urgent and important for Congress to act, going beyond what eight lawmakers already have proposed in a bill introduced by California Democratic congresswoman **Rep. Jackie Speier (shown above) — a measure that has won bipartisan backing**. As Stephen I. Vladeck, a University of Texas School of Law professor, **argued in a New York Times Op-Ed**:

"[A] bipartisan group of eight House members [has] **introduced legislation** that would overrule Feres in part, authorizing tort claims against the federal government that, as in the Daniel case, relate to 'medical, dental, or related health care functions' provided by federal employees at federal medical facilities. That's a good start, but it doesn't go nearly far enough. Respecting our troops does not just mean saying the right things; it means ensuring that those who volunteer to defend our country don't surrender the ordinary protections of our laws when they do so. And yet, there are too many ways in which our current laws *do* **treat service members like second-class citizens**, often for no other reason than historical inertia. Because the Feres decision was an interpretation of the tort claims act, Congress can overturn it in its entirety by passing another law. Doing so won't fully close the legal gaps between the men and women in uniform and the rest of us, but it would be a salutary — and long overdue — first step."

While readers might want to check our law firm's **website for more details on who can and cannot sue over malpractice events at military hospitals and clinics**,

concerned parties may wish to let their elected officials know they support Spiers' HR 2422, aka the "Sergeant First Class Richard Stayskal Military Medical Accountability Act of 2019."

When we ask service personnel to take the highest risks and make great sacrifices, we owe them the constitutional right we enjoy as civilians to pursue through the civil justice system appropriate claims of harm — medical malpractice suits that do not challenge the order, discipline, and function of forces on or near combat.

Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you:

- USC, Ohio State, Michigan State, and now, UCLA: How can big universities, with all the supposedly smart folks who head them, be so blind and deaf to student complaints that school personnel may be sexually abusing them? And why do academics keep getting caught up in situations where they appear to or may be covering up wrongdoing against the young? Officials at the University of California Los Angeles find themselves apologizing profusely for failing to disclose that they knew of accusations of inappropriate conduct by a gynecologist on the school's staff while treating patients in university facilities, the Los Angeles Times reported.

- Medical ethicists and patient advocates are raising concerns about a big, costly, and often unsuccessful procedure that "pumps blood out of the body, oxygenates it, and returns it to the body, keeping a person alive for days, weeks or months, even when their heart or lungs don't work," the Kaiser Health News Service reported. Extracorporeal membrane oxygenation or ECMO (eck-moe) is considered an appropriate treatment for some patients on death's door. But hospitals, to maintain their competitive business standing, are battling to get the equipment and staff to provide this therapy, which costs on average half a million dollars per patien

- Praise be: Churches nationwide are leaping in with their congregations' blessing and financial support, putting up small sums to buy up and wipe out one of the huge shames of the American health care system: patients' medical debt. The faithful work with RIP Medical Debt, a nonprofit organization based in Rye, N.Y., that provides the know-how to many kinds of donors to help eliminate bills that can crush patients and their loved ones for a lifetime, the Kaiser Health News service reported.

- Federal regulators have given up the unwarranted secrecy enshrouding their watchdog efforts on the nation's most problematic nursing homes. With prodding from the U.S. senators from Pennsylvania, Democrat Bob Casey (above left) and Republican Pat Toomey (above right), the Centers for Medicare and Medicaid Services (CMS) disclosed its list of hundreds of nursing homes that perform so poorly

they are on the brink of regulators' most dire supervision. The list includes five facilities each in Maryland and Virginia.

- The federal Food and Drug Administration has waded into its potential oversight of a substance that already is becoming wildly popular. The process of figuring government rules for cannabidiol, aka CBD, well could be called Confusion By Design. The New York Times and Washington Post both reported on the parade of dozens of parties, pared from hundreds of aspirants, wanting to influence the FDA's path with the agency's first hearing on CBD. It already is sold in thousands of products on the market now. These include pet foods, soft drinks, bath salts, and oils and solutions that users add to food and rub on themselves. Of great concern to the FDA are the extreme and proliferating claims that vendors are making for unproven health-related benefits of use of CBD, which is a nonintoxicating extract that can be derived from hemp and marijuana.

HERE'S TO A HEALTHY 2019!

Sincerely,

Patrick Malone
Patrick Malone & Associates

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