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THIRD LEADING CAUSE OF DEATH: MEDICAL ERRORS, A PROBLEM COMPOUNDED BY UR AND IMR

By Scott O'Mara

An article in the *San Diego Union Tribune* by Bradley J. Fikes presented a list of the most common factors which caused deaths in the United States in the year 2013. The three leading causes topping this list were (1) heart disease; (2) cancer; and, surprisingly, (3) *medical error*.

Regarding the latter, Mr. Fikes cited a study completed at Johns Hopkins University which summarized the most common errors which have led to patient deaths in this country. First and second on this list, respectively, are (1) misdiagnosis of diseases and (2) prescription of the wrong dosage of medications. The factors contributing to these errors by health care providers are cited to be miscommunication, poor training and sheer overwork

As of 2013, the number of error-caused deaths was estimated to be about 250,000 annually — far exceeding the 1999 estimate of 44,000 to 98,000 per year. Although the Centers for Disease Control and Prevention claim that estimates vary widely, Scripps Health geneticist-cardiologist Eric Topol called the current estimate "very reasonable".

The contemporary protocols legislated for California injured workers to obtain medical care only compound this problem. It does not take great sophistication for any observer to recognize the failure of the present Workers' Compensation system to provide to California injured workers *on a timely basis* the care and treatment they need to cure or relieve the effects of their work injuries — *a right which has been guaranteed to them by legislative mandate*.

The changes which have occurred in the California Workers' Compensation system as a result of Senate Bill 899 (effective 4/19/04) and Senate Bill 863 (effective 1/1/13) have not only made the system much more complex, increasing the difficulty for injured workers to obtain needed medical treatment; they also have created an environment which is much more conducive to medical error — whether unintentional or, perhaps, even intentional — because of the nature of the Utilization Review (UR) and Independent Medical Review (IMR) processes.

As many readers are aware, the UR process constitutes a review system which allows the employer or self-insured administrator to shift decision-making regarding the appropriateness and necessity of recommended medical care from the treating doctor who knows and understands the patient, to a physician within the employer's selective medical provider network — *i.e.*, a doctor who not only never sees the injured worker, but also has economic ties to the employer.

In addition, it has been established that in some situations UR doctors have not received from the employer all the appropriate medical documentation needed for them to form a fair and accurate opinion as to the employee's actual need for the recommended care. Moreover, regardless of the education, training and experience that Utilization Review doctors may have, the fact that they never see the injured workers deprives them of the opportunity to weigh and measure each individual patient's unique situation and make a full and complete independent decision as to that person's specific medical needs.

It is important to remember that *doctors are trained to interact with their patients and verify their subjective complaints with test results, or arrange for additional testing if necessary*. However, UR doctors do not have the opportunity to do this when making their medical decisions. In effect, the UR process is a "catch and release" protocol which encourages doctor to simply review medical records and then issue a report — and then move on to the next injured worker's file.

As many readers also are aware, there is pending legislation — Senate Bill 563, sponsored by Sen. Pan — to halt the current practice of rewarding specific Utilization Review and treating doctors with an economic enhancement based upon the carrier's profiling of the benefit they receive from these doctors. It is important to remember that doctors on an employer/carrier's medical provider network list are subject to unilateral removal if they fail to meet economic profiling standards relative to costs.

The Independent Medical Review process has similarly failed to serve the needs of California injured workers. In the case of IMR, however, not only do the doctors not see their patients; they also are protected by a veil of secrecy which makes it virtually impossible to challenge their decisions, which are deemed final for a period of one year. As a result, IMR doctors cannot be held accountable for their decisions.

In all likelihood, the problems and deficiencies in the current Workers' Compensation system in California will contribute to an increased number of medical errors and have a

corresponding impact on the top ten causes of death in this state. Hopefully, the newly-released study from Johns Hopkins will awaken UR and IMR doctors not only to their legal responsibilities as set forth in the California Constitution, but also their social responsibilities as medical providers. In addition, employers and insurers need to be alert for the causes of medical errors, and more aware as to the considerable economic burden associated with these errors. Otherwise, medical errors and all their unwanted by-products will continue to increase because of the inescapable failure of the mandatory legislated protocols of Utilization Review and Independent Medical Review.

NOT JUST A FOOTBALL PROBLEM: WORKPLACE CONCUSSIONS ON THE RISE

By Scott O'Mara

Concussions sustained by football players have been a major issue in the news the last few years. Much less well-known is the fact that non-fatal concussions have also been on the rise in the workplace. Statistics indicated a 54.5% increase between 2011 and 2014, with reported concussions rising from 7,190 to 11,110 during that period.

With all the publicity on this subject, it is important for readers to understand what suffering a concussion truly means. The easiest way to visualize the process of sustaining a concussion is to imagine the brain is like jello which is bounced around inside the skull when the head sustains a violent impact. In the case of injured workers, this impact could be the result of a vehicular accident, a fight, an object striking the head (such as a ladder falling), or some other event causing trauma to the head. Unfortunately, when such trauma occurs, it is not always immediately detectable by the more traditional diagnostic methodologies, such as MRI (magnetic resonance imaging) and CT (computed tomography) scans.

However, a post-concussive head syndrome diagnosis can often be made by medical professionals who have unique knowledge regarding this type of injury. One such specialty is neuropsychology, whose practitioners have the specific training and experience regarding the mechanism of injury related to concussions to enable them to identify the subjective complaints which suggest that the head has experienced a traumatic event. If a post-concussive head syndrome is recognized in its early stages so the patient can receive proper care and treatment for this condition, the rate of recovery

is much better than in this case when the impact of a concussion is not apparent until considerable time has passed.

Some of the symptoms which can be a byproduct of concussions include a change in cognitive abilities, issues with balance, ringing in the ears, hearing loss and nausea. This mild form of brain injury — "mild" in the sense that it is not fatal, and its presence is generally not pronounced — is sometimes missed by doctors who lack the specialization to recognize concussions, as their training and experience is not in that area.

A pending piece of legislation, Assembly Bill 2086, would expand health care related to concussions by re-establishing neuropsychology as a Qualified Medical Evaluator designation — a QME designation which had been eliminated in 2015. This would open the door for concussion victims to be evaluated by medical professionals with the proper background to make adequate decisions regarding their injury conditions. This inevitably will result in quicker diagnostic work-ups in many cases, thereby enabling many injured workers to return to their pre-injury level of function — and their jobs — sooner.

AB 2086 is a much-needed move forward, and will help to deal with the most difficult aspect of treating concussions — *i.e.*, obtaining a proper diagnosis early on.

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