No. 25831 -- Catherine H. Reynolds, individually and in her own capacity; and Catherine H. Reynolds, by and through Roy A. Horning, her power of attorney v. City Hospital, Inc., a West Virginia corporation; and C. Dong Park, M.D.

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Starcher, J., dissenting:

This Court has heard oral argument and issued written opinions in this case two times. I dissented from the majority's first opinion in this case because it was wrong. I dissent to this opinion as well because it is just as wrong.

I cannot agree with the majority opinion's discussion of the record in this case. I realize that medical treatment often does not result in a perfect outcome. Patients in hospitals get infections and broken bones do not always mend properly. But the facts in this case have nothing to do with a "bad outcome." The plaintiff in this case, Catherine Reynolds, went into the hospital with lower back pain, and her diagnosis on admission was "falling episodes;" the plan for her treatment was 3 to 5 days of testing. The plaintiff came out of the hospital a month later with a broken shoulder, a broken hip, a urinary tract infection, a loss of 20 pounds and bed sores.

At the time of her hospitalization, Mrs. Reynolds was an 86-year-old self-sufficient woman who lived alone at home, ate without assistance and went to the bathroom just like the rest of us. In January 1994 she walked into the hospital, under her own power, for a few days of testing because of lower back pain she was having that resulted from a "dizzy spell" fall. Mrs. Reynolds was carried out of the hospital a month later on a stretcher to an ambulance that transported her back to her home where she has since been under 24-hour nursing care.

Mrs. Reynolds's attorney introduced evidence showing that the defendant doctor over-prescribed certain drugs for the plaintiff which adversely interacted with other drugs given to the plaintiff. This left the plaintiff in a dazed, heavily medicated state -- so bad that one doctor decided to diagnose the plaintiff with "dementia." Then the hospital failed to follow its own policies concerning the restraint of such dazed patients, and neglected to ensure that the facility was adequately staffed with enough personnel who could tend to the plaintiff's basic needs. The result was that Mrs. Reynolds, who was left sitting in her own feces and urine, tried to get out of bed under her own power. The first time she tried she fell and broke her shoulder. The second time she tried she fell and broke her hip.

When the hospital did take the time to tie Mrs. Reynolds to her bed, it catheterized her and left the catheter in for long periods, resulting in a urinary tract infection. The plaintiff was unable to feed herself, and lost 20 pounds during her month in the hospital. The plaintiff was given a "call" button so she could page a nurse for assistance -- but the button was attached to the bed above the plaintiff's immobilized broken shoulder, out of her reach, so that it was unusable. Incredibly, the whole time that this "treatment" was occurring, the hospital failed to diagnose the fractured lumbar vertebrae that was causing the plaintiff's lower back pain.

The majority opinion examines this case as a dry legal dispute of whether the plaintiff proved by a preponderance of the evidence that the defendants deviated from the standard of care. The interests of justice rise above a mere statement of the law. It's patently obvious that Mrs. Reynolds didn't get proper treatment from the defendants, and in this lawsuit, did not get justice.

The plaintiff, in my reading of the record, *did* prove that the defendants deviated from the standard of care. The attorney representing the defendant hospital conceded to the jury during closing argument that even he thought Mrs. Reynolds received "unacceptable" care.

But the circuit court repeatedly constrained the plaintiff's attorney from fully representing Mrs. Reynolds. The defendants based their entire case on the argument that the average person would not have been injured by their negligence, and that Mrs. Reynolds' injuries occurred because of her frailty due to her age. This is a classic "thin skull" or "eggshell plaintiff" case, and the circuit court should have allowed the plaintiff to argue that even though Mrs. Reynolds was aged, she was still entitled to quality care. It is a basic principle of law that a defendant takes a plaintiff as he finds her. *See, e.g.*, *Howe v. Thompson*, 186 W.Va. 214, 217, 412 S.E.2d 212, 215 (1991). Because Mrs. Reynolds was frail, the defendants should have exercised greater caution in her care; because they failed to exercise even basic caution, the defendants should have been held liable to Mrs. Reynolds for the pain, suffering and humiliation inflicted upon her.

Unfortunately, the repeated mistakes committed by the hospital in this case appear to be a routine occurrence when patients are hospitalized. A recent, frightening report by the Institute of Medicine found, based upon studies of medical errors committed in Colorado and Utah hospitals, that an "adverse event" occurred in 2.9 out of every 100 hospitalizations. A similar study of New York hospitals found an "adverse event" in 3.7 out of every 100 hospitalizations. In the Colorado and Utah study, 8.8% of the adverse events resulted in death to the patient, compared with 13.6% in the New York study. The Institute of Medicine found that:

> In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented.
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> When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors. The results of the New York study suggest the number may be as high as 98,000. Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th leading cause of death. More people die as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (15,516). . . .
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> Every year, over 6,000 Americans die from workplace injuries. Medication errors alone . . . are estimated to account for over 7,000 deaths annually.

Linda T. Kohn, *et al.*, *To Err is Human: Building a Safer Health System*, p. 1 (National Academy Press, 1999).

As citizens, we insist on safety in our everyday lives. Take, for example, the risk of flying in an airplane. Until World War II, airplane accidents were viewed primarily as individually caused, and safety meant telling pilots to "be safe." In the years after the war, airlines, plane manufacturers and the government took a comprehensive approach to safety. Every aspect of civilian aviation was studied, accidents were thoroughly examined, and potentially dangerous situations were reported. In sum, everyone learned from their mistakes. The result was better planes, better pilots and a safer aviation industry for everyone. Between 1967 and 1976, the risk of dying in a domestic jet flight was 1 in 2 million; by the 1990s, the risk had declined to 1 in 8 million. "Using the 1996 fatal accident rate, statistically a passenger would have to fly around the clock for over 438 years before being involved in a fatal crash." *See* "The Aviation Safety System," Aviation Safety Information from the Federal Aviation Administration, www.faa.gov/publicinfo.htm.

Another example of improving safety may be found at work. As a result of recognizing and acknowledging workplace mistakes, and removing unsafe conditions and practices, the American workplace has become considerably safer. State and federal occupational safety and health agencies research working conditions, develop and enforce standards for job health and safety and maintain a system where workplace mistakes are reported, recorded, and studied. The result is that, while U.S. employment has nearly doubled since 1971, the number of workplace fatalities has been cut in half and injury and illness rates have dropped by 40 percent.[1]

Conversely, the health care industry is far behind other industries in improving its safety record. The Institute of Medicine states that "*safety is defined as freedom from accidental injury*." *To Err is Human*, *supra* at 49. After carefully examining how hospitals, doctors and other people in the field of medicine practice their trade, the Institute concluded that "the delivery of health care services may be classified as an industry prone to accidents." In light of the damage that was inflicted on Mrs. Reynolds during her hospital stay, this finding is an understatement.

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[1]A brochure issued by the U.S. Occupational Safety and Health Administration states:

> OSHA's mission is to send every worker home whole and healthy every day. Since Congress created the agency in 1971, workplace fatalities have been cut in half and occupational injury and illness rates have declined 40 percent. At the same time, U.S. employment has nearly doubled from 56 million workers at nearly 3.5 million worksites to 105 million workers at nearly 6.9 million sites.

"OSHA Facts: New Ways of Working," OSHA Vital Facts, Occupational Safety and Health Administration, Department of Labor, www.osha-slc.gov/OSHAFacts/OSHAFacts.html. The same brochure states that there were 6,026 worker fatalities in 1998, "212 fewer than in 1997 -- a 3-percent decline in deaths."

The Court cannot, should not, sanction the kind of "care" that Mrs. Reynolds received from the defendants. She was repeatedly subjected to all-to-common mistakes which had a devastating accumulated effect. The defendants should have been held liable for the humiliation, suffering and pain they inflicted upon this elderly lady. I therefore respectfully dissent a second time.

I am authorized to state that Justice McGraw joins in this opinion.