Exam ID # _____

WIDENER UNIVERSITY SCHOOL OF LAW

HEALTH LAW I FINAL EXAM

Professor Pope **Fall 2011**

GENERAL INSTRUCTIONS:

1. **Read Instructions**: You may read these instructions (the first three pages of this exam packet) ***before*** the official time begins.

2. **Honor Code:** While you are taking this exam, you may not discuss it with anyone.

3. **Competence:** Accepting this examination is a certification that you are capable of completing the examination. Once you have accepted the examination, you will be held responsible for completing the examination.

4. **Exam Packet:** This exam consists of **seventeen (17) pages**, including this cover page. Please make sure that your exam is complete.

5. **Identification:** Write your exam number in three places:

   (1) Write it in the space provided in the upper-right hand corner of this page.
   (2) Write your exam number on the cover of each Bluebook (or your ExamSoft file) that you use for Part Two.
   (3) Write your exam number on the upper-right-hand corner of your envelope.

6. **Anonymity:** The exams are graded anonymously. Do **not** put your name or anything else that may identify you (except for your exam number) on the exam.

7 **Timing:** This exam must be completed within three (3) hours (6:30 – 9:30 p.m.).

8 **Scoring:** There are 180 total points on the exam, approximately one point per minute. The final exam comprises 60% of your overall course grade, 180 of the 300 total course points.

9 **Open Book:** This is an OPEN book exam. You may use **any** written materials, including, but not limited to: any required and recommended materials, any handouts from class, PowerPoint slides, class notes, and your own personal or group outlines. You may not use a computer other than in its ExamSoft mode.

10 **Format:** The exam consists of four parts which count toward your grade in proportion to the amount of time allocated.

PART ONE comprises 15 multiple choice questions worth three points each, for a **combined** total of 45 points. The suggested total completion time is **45 minutes** (3 minutes each).

PART TWO comprises one essay question worth 25 points, and has a suggested completion time of **25 minutes**.

PART THREE comprises one essay question worth 25 points, and has a suggested completion time of **25 minutes**.

PART FOUR comprises one essay question worth 85 points, and has a suggested completion time is **85 minutes**.

11 **Grading:** All exams will receive a raw score from zero to 180. The raw score is meaningful only **relative** to the raw score of other students in the class. Your course letter grade is computed by summing the midterm, final, and quiz scores. There are two separate curves: one for L.L.M and S.J.D. students and one for J.D. students. The applicable mandatory curve in this class permits a maximum average grade of 3.40 for the J.D. students. I will post an explanatory memo and a model answer to TWEN a few weeks after the exam.

12 **L.L.M. and S.J.D. students ONLY:** The timing limits discussed elsewhere do **NOT** apply. I will email a PDF of the exam to L.L.M. and S.J.D. students on Thursday night. They must submit a hard copy of both this exam booklet and their typed exam answers to the law school Registrar before 10:00 p.m. on Tuesday, December 13th. The essay answers must not exceed 2500 words. Please address any questions to the Law School Registrar.

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Circle the Best Answer:** For each question**, circle** the best answer choice on this exam itself.

2. **Ambiguity:** If (and only if) you believe the question is ambiguous, such that there is not one obviously best answer, neatly explain why in a separately marked section of your Bluebook or ExamSoft file. Your objection must (i) identify the ambiguity or problem in the question and (ii) reveal what your answer would be for all possible resolutions of the ambiguity. I do **not** expect this to be necessary.

SPECIAL INSTRUCTIONS FOR PARTS TWO, THREE, & FOUR:

1. **Submission:** Write your **essay** answers in your Bluebook examination booklets or ExamSoft file. I **will not** read any material which appears only on scrap paper.

2. **Legibility:** Write legibly. I will do my best to read your handwriting, but must disregard (and not give you points for) writing that is too small to read or otherwise illegible. **I am serious; write neatly.**

3. **Outlining Your Answer:** I strongly encourage you to use **at least** one-fourth of the allotted time per question to outline your answers on scrap paper **before** beginning to write in your exam booklet or ExamSoft file. Do this because you will be graded not only on the substance of your answer but also on its clarity and conciseness. In other words, organization, precision, and brevity count. If you run out of insightful things to say about the issues raised by the exam question, stop writing until you think of something. Tedious repetition, regurgitations of law unrelated to the facts, or rambling about irrelevant issues **will** negatively affect your grade.

4. **Answer Format:** This is important. **Use headings and subheadings**. Use short single-idea paragraphs (leaving a blank line between paragraphs). Do **not** completely fill the page with text. Leave white space between sections and paragraphs.

5. **Answer Content:** Address **all** relevant issues that arise from and are implicated by the fact pattern and that are responsive to the "call" of the question. Do not just summarize all the facts or all the legal principles relevant to an issue. Instead, **apply** the law you see relevant to the facts you see relevant. Take the issues that you identify and organize them into a coherent structure. Then, within that structure, examine issues and argue for a conclusion.

6. **Citing Cases:** You are welcome but **not** required to cite cases. While it is sometimes helpful to the reader and a way to economize on words, do not cite case names as a complete substitute for legal analysis. For example, do **not** write: "Plaintiff should be able to recover under *A v. B.*" Why? What is the rule in that case? What are the facts in the instant case that satisfy that rule?

7. **Cross-Referencing:** You may reference your own previous analysis (*e.g.* B's claim against C is identical to A's claim against C, because __." But be very clear and precise what you are referencing. As in contract interpretation, ambiguity is construed against the drafter.

8. **Balanced Argument:** Facts rarely perfectly fit rules of law. So, recognize the key weaknesses in your position and make the argument on the other side.

9. **Additional Facts:** If you think that an exam question fairly raises an issue but cannot be answered without additional facts, state clearly those facts (reasonably implied by, suggested by, or at least consistent with, the fact pattern) that you believe to be necessary to answer the question. Do **not** invent facts out of whole cloth.

STOP !

Do NOT turn this page until the proctor signals

PART ONE

15 questions worth three points each = 45 points

Suggested time = three minutes each = 45 minutes

1. **The standard of care for medical professionals:**

   A. In most cases is for courts to determine, in keeping with the principles set out in *Helling v. Carey.*
   B. In most cases is derived from clinical practice guidelines established by committees of nationally recognized expert specialists.
   C. Must always be established by testimony from a medical care provider of the same specialty as the defendant.
   D. None of the above is correct.

2. Dr. Kronstadt served as patient's physician from 1987 to 2006. During this time, Kronstadt tested patient's PSA levels as part of patient's annual physical exams. PSA tests may reveal evidence of prostrate diseases. A normal PSA test is in the 0 to 4 range. Results above 4 may indicate prostrate disease. Patient's PSA test results were 3.8 in July 2001, 5.7 in July 2002, 5.2 in July 2003, 5.86 in July 2004, 4.7 in July 2005, and 7.7 in July 2006. After receiving patient's PSA test results in July 2006, Kronstadt referred patient to an urologist. The urologist diagnosed patient with adenocarcinoma of the prostrate.

   Following this diagnosis, in December 2006, patient obtained all his old PSA test results. On September 14, 2008, patient filed a medical malpractice action against Kronstadt, alleging that Kronstadt violated the applicable standard of care by failing to refer him to an urologist in 2002, 2003, 2004, 2005, and that this failure delayed his diagnosis until after his cancer had spread and his treatment options were limited. The jurisdiction has a three-year statute of repose.

   Is patient's claim barred?

   A. Yes, except as to the lack of referral in 2005, because the lawsuit was filed more than three years after the other negligent acts.
   B. Yes, because the last negligent act was performed more than three years before the filing of the lawsuit.
   C. No, because the lawsuit was filed within three years of patient's discovery of Konstadt's negligence.
   D. No, because the lawsuit was filed within three years of the end of the course of treatment by Kronstadt.

USE THIS FACT PATTERN FOR BOTH PROBLEMS 3 AND 4

Patient was a patient of Doctor. Patient had lab work performed in July 1995, May 1997, and October 1998. Each of these tests revealed that Patient has significantly elevated liver enzyme levels. But Doctor did not notify Patient of these abnormalities. After Patient had begun seeing another physician, in December 2008, Patient was diagnosed with liver cancer. On May 21, 2009, Patient filed a complaint against Doctor for medical malpractice. This jurisdiction has a four-year statute of repose.

3. **Which of the following is true?**

A. The claim is barred by the statute of repose.
B. The claim pertaining to the 1995 and 1997 tests are barred, but the claim relating to the 1998 test are not.
C. The claim is not barred by the statute of repose, because it was filed less than one year after the malpractice was discovered.
D. The claim is not barred by the statute of repose, because of the course of treatment doctrine.

4. What is the latest date on which Jerry could have filed a non-barred lawsuit?

A. July 1999.
B. May 2001.
C. October 2002.
D. December 2012.

5. Julie went to see Dr. Creep because she was having hip pain. During the course of the overall medical examination, Dr. Creep penetrated her vagina with his fingers. He did not inform Julie that he would be performing a vaginal exam. He did not wear gloves. He did not use lubrication. He did not make a note of the vaginal exam in the medical record. Julie has sued Dr. Creep because she thinks that the vaginal exam was purely sexually motivated. But she failed to disclose an expert who would testify in her case-in-chief.

Julie may have a successful cause of action for:

A. Medical malpractice
B. Battery
C. Intentional infliction of emotional distress
D. Breach of contract
E. A and B
F. B and C
G. More than two of the above (A – D)

6. In 2001, Psychiatrist began treating Bruce, a then 38–year–old, mentally ill patient with a history of violence. In May 2002, Psychiatrist ordered that two of Bruce's medications, Zyprexa and Luvox, be discontinued for six weeks to rule out the possibility that Bruce might be developing neuroleptic malignancy syndrome ("NMS"). About two weeks after Bruce stopped taking Zyprexa and Luvox, he began having nightmares, panic attacks, and bouts of heavy sweating. He also started hearing voices telling him to kill. He brutally attacked his Neighbor. Neighbor has sued Psychiatrist, and has obtained an expert witness to opine that, if Bruce had NMS, which the expert believed he did not, the proper procedure would have been to hospitalize him.

What claim might Neighbor successfully assert against Psychiatrist?

A. Medical malpractice
B. Battery
C. Negligence
D. Breach of contract
E. More than one of the above

USE THIS FACT PATTERN FOR BOTH PROBLEMS 7 AND 8

Krissi, a resident of Delaware, suffered from ongoing mental health problems. On the recommendation of her case manager, Krissi consulted with Psychiatrist, a resident of Iowa not licensed in Delaware, through a telepsychiatry research study that he was conducting. Krissi and her case manager expected that Psychiatrist would aid in Krissi's treatment through his expertise. Given the increase in Krissi's angry and aggressive behavior and self-mutilation especially, they were especially eager for recommendations about Krissi's medication.

Psychiatrist was provided with a very recent medical evaluation of Krissi performed by another doctor, which was supplemented by additional information about Krissi from Krissi's treatment team. Krissi also completed a pre-assessment documentation, and participated in a one-time, ninety-minute video-conference session with Psychiatrist in August 2010, in which Psychiatrist performed a psychiatric evaluation of Krissi.

Psychiatrist completed a consultation evaluation that described Krissi and the history of her present illness. The Evaluation also provided a diagnostic impression of Krissi and set forth recommendations for an initial treatment plan. The Evaluation specifically stated that, consistent with the telepsychiatry research protocol, no follow-up services would be provided, and no medication prescriptions would be directly provided. The report further explained that the recommended treatment plan was to be weighed by Krissi's treatment team, for possible implementation. After sending his evaluation, the psychiatrist had no further interaction with plaintiffs, Krissi, or any member of her treatment team. Krissi committed suicide in February 2011.

7. Can Krissi's estate sue Psychiatrist for medical malpractice?

A. Yes, because she and Psychiatrist were probably in a treatment relationship.
B. Yes, even if Psychiatrist was only providing an informal, curbside consult.
C. No, because at the time Krissi committed suicide, any treatment relationship had already been validly terminated.
D. No, because Psychiatrist was only providing an informal, curbside consult.

8. Psychiatrist might be subject to the WHICH of the following regulatory sanctions.

A. Criminal, for practicing in Delaware without a license.
B. Sanctions from the Iowa Medical Board for practicing without a license in Delaware.
C. Both A and B.
D. Neither A nor B, because Psychiatrist was licensed in at least one state.

USE THIS FACT PATTERN FOR BOTH PROBLEMS 9 AND 10

Even if well-performed, a sterilization procedure is not always effective in preventing pregnancy. Plaintiff had a tubal ligation (cutting of fallopian tubes) in October 2008. But in October 2010, she discovered that she was pregnant. She gave birth in June 2011. Plaintiff is now suing the surgeon who performed the sterilization for medical malpractice.

9. Which of the following is probably true?

A. Plaintiff needs an expert to establish the standard of care.
B. Plaintiff can use *res ipsa loquitor*, since she was pregnant after a sterilization procedure.
C. Plaintiff can also sue for breach of contract, given the implicit promise: the whole point of a sterilization procedure was to prevent pregnancy.
D. Both B and C.

10. If this jurisdiction has a one-year statute of limitations and a one-year statute of repose for all claims against a healthcare provider, then:

A. Plaintiff must file by October 2009.
B. Plaintiff must file by October 2010.
C. Plaintiff must file by October 2011.
D. Plaintiff must file by June 2012.

11. In 2005, Madeleine was diagnosed with breast cancer. She had a double mastectomy but declined chemotherapy or radiation treatment. In 2010, Madeleine's condition had deteriorated significantly. She was admitted to the hospital the same day with a diagnosis of metastatic breast cancer with liver and bone metastases. Her cancer had spread to her liver, skull, vertebrae, spleen, lymph nodes, and uterus. Dr. Darr felt Madeleine's condition was grave and she should be admitted to hospice. Dr. Darr ordered palliative care, including medications for pain. He felt that her prognosis was measured in days at the most. Madeline died several days later.

Madeline's husband, Steve, filed a medical malpractice action against Dr. Darr, alleging that Madeline's death was expedited by the over-administration of pain medication. Two experts testified. Dr. Madison testified that Madeleine only had a short time to live and could die at any time, and that the administration of medication could have actually prolonged Madeleine's life. Dr. Tibb opined that Madeleine's death would probably have occurred within the same time frame, regardless of the administration of medication. This is a traditional causation jurisdiction.

A. Steve should survive summary judgment, because a reasonable jury could find it is **possible** that Madeline's death was hastened by over-medication.
B. Steve should survive summary judgment, because a reasonable jury could find that the Dr. Darr deprived Madeline of a chance of surviving longer.
C. Summary judgment should be granted in favor of Dr. Darr, because no reasonable jury could find it is **probable** that Madeline's death was hastened by over-medication.
D. Summary judgment should be granted in favor of Dr. Darr, because no reasonable jury could find **beyond a reasonable doubt** that Madeline's death was hastened by over-medication.

12. In February 2011, Shane presented to Hospital complaining of chest pain and described a history of cardiovascular disease. At Hospital's emergency department, there are protocols for the classification of patients: "one," which mentions chest pain, is reserved for the most severe cases; "two" for less severe; and "three" for the least severe. The urgency and aggressiveness of the treatment of a patient depends on the triage classification. Shane was classified as a category 3 patient and was not seen for some time. Shane's unstable diagnosis was never diagnosed, because she died from a myocardial infarction before being seen by a cardiologist.

A. Hospital has violated its EMTALA screening obligation.
B. Hospital has violated its EMTALA stabilization obligation.
C. Hospital has violated BOTH its screening and stabilization obligations.
D. Hospital has violated NEITHER its screening and stabilization obligations.

13. In August 2011, the Centers for Medicare and Medicaid Services (an agency within the U.S. Department of Health and Human Services) sent the following letter to a Texas hospital:

> After a careful review of the July 2011 survey report, the CMS has determined that Parkland Health and Hospital System no longer meets the requirements for participation in the Medicare program because of deficiencies that represent an immediate and serious threat to patient health and safety. . . . Unless the serious and immediate threat to patient health and safety is removed, your hospital's Medicare agreement will be terminated on September 2, 2011.

This hospital is at risk of losing its:

A. License, and can no longer operate
B. License, but can still legally operate
C. Accreditation, and can no longer operate
D. Accreditation, but can still legally operate
E. Certification, and can no longer operate
F. Certification, but can still legally operate

14. Between January 2011 and June 2011, Dr. Woo, a Pennsylvania physician wrote 127 prescriptions for 7640 tablets of Schedule II and IV controlled substances (an average of 20 prescriptions and 1200 tablets per month) for an Idaho resident without ever conducting a physical examination, without requesting medical records, and without contacting the individual's other treating physicians.

Dr. Woo is probably subject to sanctions from:

A. The Joint Commission.
B. The Delaware Medical Board.
C. The Office of the Inspector General, U.S. Department of Health & Human Services (who brings civil monetary penalties for EMTALA violations)
D. The U.S. Department of Justice (who sometimes enforces the ADA).

15. Neil was admitted to the Butt Rehabilitation Center (BRC) in 2009, suffering from dementia, hypothyroidism, and COPD. He was at risk of falling and had fallen several times at home. At BRC, Neil fell thirteen times, and ultimately died as a result of complications from the falls. His wife, as representative of his estate, filed a malpractice action against BRC. Each of plaintiff's three expert witnesses testified that BRC breached the nationwide standard of care.

If this claim is governed by the laws of Narnia (see Statutory Appendix), then:

A. The trial court should grant summary judgment to defendant, since plaintiff has not established the applicable standard of care.
B. The trial court should grant summary judgment to defendant, since Neil was not in a treatment relationship with BRC.
C. The trial court should deny defendant's motion for summary judgment, because it is up to the jury to set the standard of care.
D. The trial court should deny defendant's motion for summary judgment, because plaintiff has submitted sufficient evidence from which the jury might ascertain the applicable standard of care.

PART TWO

1 essay questions worth 25 points

Suggested time = 25 minutes

Tommy was arrested and taken to the Allegheny County Jail. While in jail, he sustained serious injuries to his face and head. He was taken to UPMC Hospital. When he arrived at the hospital, Tommy was suffering from a life-threatening medical condition. He was in obvious and serious physical distress. He exhibited facial bruising, suffered seizures, and experienced symptoms of withdrawal from Ativan.

Tommy's sister told the hospital of Tommy's medical history and the prescriptions that he had been taking. Nevertheless, the hospital ignored her. Apparently, because he was a prisoner, the hospital did not screen Tommy for prescription drugs, did not inquire about the medications that Tommy had been taking, and did not prescribe him medication for his withdrawal from Ativan. Tommy was returned to the jail. He was found dead the next day.

Evaluate a potential EMTALA claim by Tommy's estate.

PART THREE

1 essay questions worth 25 points

Suggested time = 25 minutes

Wilmington Hospital is a non-profit hospital in Delaware, and a healthcare provider in the Keystone Health Plan's network. In 2005, Wilmington Hospital had contracted with Keystone to provide health care services to beneficiaries of the Keystone Health Plan at agreed-upon reimbursement rates, which rates were typically discounted from Wilmington Hospital's usual and customary rates. Widener University subscribes to the Keystone Health Plan on behalf of its employees.

Since Wilmington Hospital is an "in network" provider in the Keystone Health Plan, Widener employees can get services there with no co-payment or co-insurance fees. Consequently, most Widener employees get their healthcare from Wilmington Hospital. Indeed, between May 2008 and August 2011, Wilmington Hospital provided numerous medical services to the employees of Widener University. But Keystone denied Wilmington Hospital reimbursement for some of that healthcare, explaining that certain services were not covered, certain patients (e.g. some employees' dependents) were not eligible, and/or required pre-certification was not obtained.

In December 2011, Wilmington Hospital filed a complaint against Keystone Health Plan in the Superior Court of Delaware, seeking payment for over $1 million in medical services provided to Widener employees. Wilmington Hospital alleged that Keystone should have, but failed to, to reimburse for this $1 million. It is undisputed that Wilmington Hospital has standing as an assignee[*] of the Widener employees.

Explain Keystone's best response to Wilmington Hospital's action?

[*] An assignee is "a person or entity to whom some right, interest, or property is transferred."

PART FOUR

1 essay question worth 85 points

Suggested time = 85 minutes

The following occurred in the hypothetical U.S. state of Narnia. Possibly, but not necessarily, applicable laws from Narnia are in the Statutory Appendix to this exam. After Mr. Taylor complained of severe abdominal pain, he was taken from his home to a nearby hospital. Dr. Primary, his long-time family physician, ordered a CT scan, which showed that Mr. Taylor's pancreas was enlarged and that a "mass could not be excluded." Based on a needle biopsy that the hospital performed at Dr. Primary's request, a pathologist at the hospital prepared a report stating, "Ductal carcinoma is favored as being the changes noted in the ducts." Dr. Primary told the Taylors about the report and referred Mr. Taylor to Narnia University Hospital (1200 miles away) and, specifically, to Dr. Surgeon, a Narnia University Hospital surgeon. Dr. Primary also wrote to Dr. Surgeon, asking him to "evaluate" Mr. Taylor for "probable ductal carcinoma of the head of the pancreas and for consideration of resective surgery."

When Mr. Taylor called to ask Dr. Surgeon to treat him, he told the doctor that he had "concerns" about the cancer diagnosis and that his father, who was the chief of cardiology at a New Jersey hospital, had described the diagnosis as "pretty weak." Dr. Surgeon agreed to treat Mr. Taylor and asked for his hospital records and biopsy slides. Two Narnia University Hospital pathologists reviewed these materials and provided a written "diagnosis": "Pancreas, head, needle biopsy. Infiltrating grade 2 (of four) adenocarcinoma."

Dr. Surgeon reviewed the pathologists' report before the Taylors arrived at Narnia University Hospital. When the Taylors came to his office, Dr. Surgeon immediately told them that Mr. Taylor had pancreatic cancer, that it was deadly and aggressive, and that he (Dr. Surgeon) could do surgery the next morning. He recommended the so-called "Whipple procedure," which entails removing part of the pancreas and stomach, as well as the duodenum. Dr. Surgeon explained that while drastic, the procedure was virtually risk-free apart from the anesthesia. Mr. Taylor responded by asking the doctor whether he was sure of the diagnosis. Dr. Surgeon said that he had no doubt that Mr. Taylor had cancer because a Narnia University Hospital pathologist, who was one of the best in the world, if not the best, had unequivocally diagnosed him with it.

Despite repeatedly questioning the cancer diagnosis and getting affirmative responses, Mr. Taylor was still unsure. When he got back to his hotel, he emailed Dr. Surgeon, asking if they could verify that he had cancer after they opened him up for surgery but before doing the Whipple. Dr. Surgeon sent back an email that they would do a biopsy of the "mass ... to verify that it's cancer," and that "if they didn't find cancer, they'd just close [Mr. Taylor] up and send [him] home." Dr. Surgeon outlined three possibilities to the Taylors. In the third one, if the biopsy they performed showed no cancer, they would just close him up.

Dr. Surgeon performed the procedure on Mr. Taylor three days later. But Dr. Surgeon did not first perform an intraoperative biopsy of Mr. Taylor's pancreatic tissue to verify that he had cancer. Five days later, Narnia University Hospital pathologists examined the excised pancreatic tissue, and concluded that Mr. Taylor had never had cancer at all. These results were mailed to Mr. Taylor, who received them on November 4, 2010.

Mr. Taylor was annoyed that he had the Whipple "for nothing" and that he was now suffering from some of its side effects (e.g. difficulty emptying the stomach after consumption, inflammation of the pancreas). Mr. Taylor filed a lawsuit on December 8, 2011. Four experts testified.

Dr. Galina testified for the plaintiff. A New Jersey physician, he testified that he had never been to Narnia, that he did not know where Narnia was located, that he did not know how large the hospital was, that he knew no one from Narnia, and that he knew no one who had ever practiced medicine in Narnia. Dr. Galina testified that Surgeon deviated from the standard of care because he failed to ascertain whether the patient definitively had cancer before proceeding with the Whipple.

Dr. Stuart testified for the plaintiff. A Delaware physician, he testified that he was familiar with the standard of care in Narnia. He said that he saw what doctors were doing and the standard of practice from examining the patients' treatment records on referrals from Narnia. Dr. Stuart further testified that he had reviewed over 100 medical charts from Narnia, had testified in three other malpractice cases in Narnia, and "had reviewed statistical information about the medical community in Narnia, which included information about the medical specialists and resources available. Dr. Stuart testified that Surgeon deviated from the standard of care.

Dr. Morris also testified for the plaintiff. A Pennsylvania physician, he testified that insofar as Narnia physicians are trained and examined and have developed the same sets of skills, read the same literature, update their skills, go to the same conferences for continuous education that I do, come to my conferences when I give them in Philadelphia. He testified that the standard of care "does not vary throughout the country." Dr. Morris testified that Surgeon deviated from the standard of care.

Dr. Salby testified for the defendant. A Narnia physician, Salby opined that Surgeon "totally complied" with the standard of care in his treatment of Mr. Taylor. He explained that whether to stop and test tissue samples after opening a patient up for surgery is a "judgment call" and that there is substantial support for the practice of immediately proceeding with the operation without stopping to wait for lab results.

You represent Mr. Taylor. Assess his potential causes of action.

NARNIA STATUTORY APPENDIX

**** Use for Part Four ONLY unless specifically directed. ****

Narnia Code 100

(a) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim.

(b) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred.

Narnia Code 200

(a) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than one year after the injury is discovered or reasonably should have been discovered.

Narnia Code 300

(a) Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.

(b) What constitutes informed consent emanates from what a reasonable person in the patient's position would want to know. What a physician must disclose is contingent on what a reasonable person would need to know to make an informed decision.

Narnia Code 400

(a) In any proceeding against a physician, clinical psychologist, podiatrist, dentist, nurse, hospital or other health care provider to recover damages alleged to have been caused by medical malpractice where the acts or omissions so complained of are alleged to have occurred in Narnia, the standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this State and the testimony of an expert witness, otherwise qualified, as to such standard of care, shall be admitted.

(b) Any physician who is licensed to practice in Narnia shall be presumed to know the statewide standard of care in the specialty or field of medicine in which he is qualified and certified.

(c) An expert witness who is familiar with the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in Narnia.

Narnia Code 500

A plaintiff who cannot establish that probably (more likely than not) she would have suffered the same harm had proper medical treatment been rendered, is entitled to no recovery for the increase in the risk of harm or for the loss of a chance of obtaining a more favorable medical result.