Lessons from Joseph Brant *c.difficile* class action and settlement

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Overview

1. Background
2. JBMH litigation
3. JBMH settlement
4. Comparator settlements
5. Lessons learned

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1.1 Background

- Canadian health care institutions face number of infectious disease class actions post-SARS
- *e.g.*, TB (*Lakeridge*); pseudomonas (*UHN*)
- *c.difficile* ubiquitous
- Contagious intestinal bacteria produces toxic diarrhea, nausea, vomiting, fever; severe cases -- perforation of bowel, death
- Claims only make sense to degree materially worse than baseline/background *c.difficile*
- Outbreak alone not proof of breach of standard

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1.2 Class actions …

- Facilitate these sorts of claims, where individual damages may be low, uneconomic for lawyer
- Representative plaintiff receives order to represent, for example, all patients during outbreak period
- Notice of class certification goes to class
- If class members fail to opt out, then individual claims determined, for better or worse, in class action
- Necessarily be a common issue phase (standard of care) and an individual issue phase (causation/damages) of the suit

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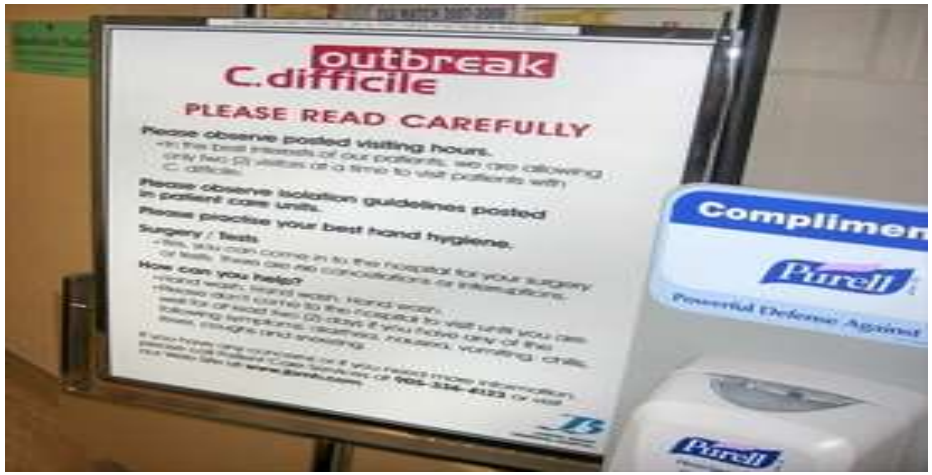
1.3 JBMH facts

- Ontario's worst outbreak of c.diff. superbug
- Outbreak -- May 2006 to December 2007
- Alleged Hospital did not properly clean, maintain, disinfect rooms
- Changed cleaning protocols; invested heavily in infection control



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1.4 JBMH facts

- 223 patients with *c.difficile* in outbreak period
- 91 said to have died
- Elderly most affected
- Diagnosis issues
- Factual causation issues -- nosocomial?
- Legal causation issues

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1.5 JBMH facts

- Made public Spring 2008 on review by expert

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1.6 JBMH facts

- Class counsel made effective use of local media

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2.1 JBMH litigation

- Proposed class action commenced July 9, 2008
- Issued from Hamilton court
- Class action was certified on consent on October 11, 2011
- These cases often certifiable as class actions subject to resolving issues such as class scope, common issues
- Class certification procedural; doesn't mean breach of standard

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2.2 JBMH litigation

- 4 representative patient plaintiffs sued Hospital only
- So how deal with respective treating physicians, might be partially responsible re use of antibiotics?
- What about absent proposed class members?
- What about physicians responsible for infection control practices?
- Involvement of CMPA counsel; entered limitation “tolling agreements”

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2.3 JBMH litigation

- Battle of experts even prior to certification
- Hospital expert says Hospital had appropriate infection control practices in place
- Baseline *c.difficile* always present
- Outbreak start and end date issues
- Causation issue -- have to prove contracted *c.difficile* at Hospital

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3.1 Settlement discussions

- Mediation with well-known mediator failed
- OHIP subrogated claim conundrum -- government effectively suing itself
- Subsequent private negotiations resulted in settlement
- Concern re tag end but large “opt out” claims

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3.2 Settlement collateral issues

- The claims were well in excess of insurance coverage limits; ultimately settled within limits
- Hospital for obvious reasons did not want to sue its own physicians re antibiotic use, so liability discount to recognize physicians not sued

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3.3 Settlement structure

- $9,000,000 all-inclusive
- Patients receive, for up to:
  - **30 day symptoms**: $3K plus $1K total for family members including out-of-pocket expenses
  - **31 to 90 days symptoms**: $10K plus $2K FLA
  - **+91 days symptoms or death**: $15K + $21K FLA

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3.4 Settlement structure

- Additional $714K fund (up to $20K per person) available for class members who suffered symptoms for 91 days or more or who died, if suffered certain additional complications
- In event insufficient funds, claims reduced *pro rata*

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3.5 Settlement fund allocation approx…

- $5.6M for class members
- $715K for OHIP
- $2.3M for class counsel
- $375K for administration and arbitration

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3.6 Settlement notice and approval

- Direct letters and newspaper notice of settlement approval hearing
- Many direct retainers of class counsel
- A few objections and 5 opt outs
- Not make separate claim, mostly withdrawn at settlement approval heard in Brampton
- Court at settlement approval heard from Hospital re post-incident infection control practice improvements

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3.7 JBMH settlement administration

- Marsh Risk – administrator appointed by court
- Reva Devins – arbitrator appointed by court
- Still underway
- How do you find people?
- Elderly, many deceased
- Privacy and representation issues
- Pro rata slows final payout
- Unused monies may be returned to Hospital special purpose fund

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4.1 Comparator settlements

- Quebec: *Deslauriers* = $7K for 3 months *c.difficile*
- Ontario: *Cupido* = $20K for 12 months *c.difficile*
- Nova Scotia: *McNeil* = $3K for salmonella
- Ontario: *Wallaston* = $4K for diarrhea, vomiting and cramps from E coli in water beyond 30 days under Walkerton Plan

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4.2 Comparator settlements

Ontario: *Tiffany Gate* pasta salad bacteria

1-3 symptom days = $1K + $250 FLA

4-9 days = $2K + $500 FLA

10-15 days = $4K + $750 FLA

16-22 days = $6K + $1200 FLA

Over 22 days = $8K + $1500 FLA

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4.3 Comparator settlements

Quebec *c.difficile* class action

- $1 million settlement
- Approximately 70 affected
- General damages = $5K to $10K including 16 deaths
- Per surgery (up to 3) = $4K to $12.5K
- FLA = $7500/spouse + $5000/child

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5.1 Lessons learned -- medical

- Will leave it to experts, 2013 APIC Guide but …
- JBMH now model for *c.difficile* infection control & best practices
- Infectious disease outbreaks likely to occur from time to time even with best practice, thus important to have robust systems in place for:
  - Surveillance of infections, including periodic review by multi-disciplinary team who can analyze trends and reference meaningful comparators
  - Early identification of concerning developments, including ability to alert appropriate persons within the hospital

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5.2 Lessons learned -- medical

- Implementation of as many infection prevention and control best practices as possible
- Frequent updating of infection control policies and associated staff education
- Verifying appropriate precautions are implemented in respect of infected patients
- Antibiotic management
- Creation of a multi-disciplinary outbreak management team as required
- Red flags noted; IC meeting minutes completed, reviewed

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5.3 Lessons learned -- ethical

- Nothing like usual personal injury litigation
- Imperfect justice aspect
- Some claims overvalued others undervalued
- “Scorched earth” v ethical battle
- Fight v settle
- Elderly population
- All funds to patients, families, counsel, mediators, administrators, ultimately paid by Ontario’s taxpayers
- Resource allocation issues

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5.4 Lessons learned -- legal

- Complex questions re:
  - Who involved in litigation and when
  - Standard of care re infection control
  - Factual causation
  - Legal causation
  - Damages by *c.difficile* as opposed to other conditions
  - Sequencing of certification and settlement approval

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5.5 Lessons learned -- legal

- More class action exposure for institutions than physicians, except perhaps infection control physician
- One incident or multiple for insurance purposes?
- Files take new dimensions, out-of-box thinking, precedents of limited value
- Start-to-finish attention to details, different roles of counsel

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5.6 Lessons learned -- legal

- Keep insurer informed from day one
- Representative plaintiffs are tip of iceberg, class of other persons affected
- Keep an eye on individual *c.difficile* complaints
- With class action, greater concern about preserving records and witness memories
- Usually have document preservation memo to staff in place prior to litigation
- Ongoing 2 year limitation issues, tolling agreements will often be necessary, with CMPA counsel

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5.7 Lessons learned -- settlement structure

- Fixed settlement fund or per person payment?
- Take up rate issues
- Who values claims?
- Reversion or non-reversion?
- *Cy-pres* fund?
- Fund for uncashed cheques?

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5.8 Lessons learned -- media

- Assume will be covered by press
- Counsel need to be involved as part of media strategy; risk/benefit analysis of various strategies
  - Pre-emptive press release?
  - Press release/statement in response to inquiries?
  - Website statement, Q and As?
- Assure patient privacy

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Questions?

Thank you for inviting me!

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