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THE OBJECTIVE ANALYSIS OF THE MEDICAL NEGLIGENCE CASE ©

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… CALL TO THE POST

An upset client sits in your office and describes the circumstances of medical care which have resulted in severe injury to a loved family member. The client wants to know whether the family should pursue the matter. Whether you should undertake this representation is a complex analysis, but if you read further, I'll tell you how I analyze cases.[2] How to evaluate a medical negligence case is not unlike handicapping an horse race. The attorney may know the players, know the facts, but whether you should put your money down on this one, to predict whether your client will win, place or show, requires

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[2] Elliott B. Oppenheim, A *Trial Lawyer's Guide to the Medical Record*, 84 ILL. BAR J. 637 (1996) (discussing how to order and analyze the medical records).

some experience and expertise. This article hopes to provide the attorney with what he needs to know to make these important decisions by the use of an objective standard in the analysis of medical negligence cases.

Fortunately, however, the analysis of a medical negligence can be more scientific than horse racing and the results should be more predictable. But beware, this sport is not for every pocketbook! Sometimes what seems to represent a best case, can go sour.

My analysis follows the tort elements: the duty, the departure from the standard of care, causation, and damages. But there is an important weighted element here. Never lose track of the point that medical negligence litigation includes only a fraction of the typical medical "quality" factor. A practitioner may deliver non-quality care but it may not represent negligent medical care to a degree worth pursuing. Bad things happen under the best of circumstances and even in the best of hands under optimum conditions. While medicine is a science, biologic systems do not respond the way aircraft engines respond. Human beings, are, well, human.

So how do you differentiate a bad result from negligent medical care which would then provide the basis for a successful litigation? To fully analyze a medical negligence case in terms of whether to take the case, one must include other factors: the overall contour of the case, the plaintiff, the defendant. At the end of this article you will find how I account for these variables in a weighted scoring analysis which provides some objectivity.

Finally, I always begin an analysis from the conclusion: damages. If there are limited damages, then, in general, the case is not worth pursuing and there ends the analysis. Cases cost so much to pursue that unless the case is very easy with admitted liability and where the defense expresses a legitimate willingness to settle, then the case is unfeasible. Typically, if tried to conclusion, the attorney can expect to spend about $10,000 per expert, rack up court reporter fees of about $1,000 per deposition, and

expend 500 hours pre-trial once the case is filed and you engage in discovery; twice that number if the case goes to trial. I haven't included other expenses: paralegals, research, secretarial, travel but these may easily reach $10,000. The threshhold dollar figure I generally consider is a recovery of $150,000. More about damages and these economic realities at the end of the article.

LEGAL ISSUES:

The analysis of any medical negligence case must begin at the legal threshold. Have a quick look at the legal deal breakers, the sorts of issues the defense will raise instead of a responsive Answer — all affirmative defenses. Do not forget the *Feres Doctrine*,[3] if your client is or has been in the service virtually any medical care no matter what reason will be viewed as incident to military service...barred. To the degree that any conduct occurred while the claimant was on active duty or in some way part of military services, *Feres* may bar any claim. Unfortunate, but true …

MEDICAL ISSUES:[4]

Duty

The analysis here must begin with the physician-patient relationship. If no physician-patient relationship then there is no duty to treat. The public finds it horrifying that a provider is free to walk away from a person having a cardiac arrest but, unless the physician has a duty to respond, there is no duty to do anything. In the emergency situation, where life quickly ebbs, when a practitioner intervenes he does have a duty to do so in a competent manner; but if he chooses to take his kids to the movies rather than

[3] Feres v. United States, 340 U.S. 135 (1950). Congress may … and this is a long shot … modify this immunity under the FTCA, but don't hold your breath.

[4] As a general overview, remember that there are only two forms of medical negligence: "sins of omission" — where the provider failed to do something which is called into question; or, "sins of commission" — where the practitioner DID something, now called into question. Sins of commission are much easier cases since a defense is more difficult. E.g: "So, you cut _____? How do you explain that?" The "judgement escape route" is much less readily available in commission cases.

to stop at an auto accident, he is free to do so.

When a physician works in the emergency department setting, he must respond and he must, under 42 U.S.C. §1395dd, provide at a minimum a screening examination consistent with his facilities capabilities.

[5] Whenever you see medical care which has taken place in the emergency setting consider the EMTALA analysis.

Once a physician-patient relationship has been formed and the physician has a duty to treat, to inappropriately withdraw, withhold, or terminate treatment may violate the standard of care. Has care been interrupted? If so, what were the circumstances? This breach of the duty is an important factor to include in your analysis.

[5] 42 U.S.C. § 1395dd(b)(1)(A),(B). see Elliott B. Oppenheim, EMTALA: *Its First Decade - A Retrospective Analysis of 42 U.S.C. §1395dd* 10 (Terra Firma 1996). Order phone: 800-416-1192.

Breach of the Duty

This step is vital to any claim since, if no duty was breached, then there is no tortious conduct. Look for discreet breaches, florid breaches. In general you must plan to try each medical negligence case and if you can't get jurors' blood to boil over callous and indifferent care, then you will lose. If you find that you are slicing thin hairs, you are in the gray zone of judgment.

Here's an example. Recently a case involved a doctor who performed an hysterectomy on a 25 year old where the doctor knew from laparoscopy that the organs were absolutely normal. There was no indication for surgery … other than the physician's greed.

Here's another example of an egregious departure from the standard of care. A respiratory therapist noted that a patient's endotrachael tube was loose and that it had slipped out 6 cm. The respiratory therapist blindly slid the tube into the oropharynx, the patient sustained a cardiorespiratory arrest and as a consequence experienced catastrophic brain damage. Jurors understand that "you can't do that!" All the therapist had to do was to remove the tube and bag the patient. There was no contraindication to this safer course of action.

In contrast, here's an example of a case where there was a fuzzy departure from the standard of care: A 15 year old athlete sustained a knee injury and the surgeon selected one technique for repair but, the plaintiff alleged, another technique should have been used. The results were terrible. The techniques the orthopedist selected is in common usage … as was the alternative technique. This choice of procedure represents legitimate choices in medical judgment and these do not represent negligence.

Causation

Unless the defendant's conduct caused some real world harm, the tort analysis

falters and it is often at this stage that the defense may side-rail a case or substantially limit the defendant's liability. What I look for is a nice clean line of causation. The most obvious “clean line” is where a departure directly causes something horrific: death; loss of limb; mental or physical impairment which a juror would immediately attribute to the departure from the standard of care.

An elderly man was in good condition, walked daily but was in a nursing home following flu. He was fed through a gastrostomy tube. An LPN inappropriately removed the tube and when she attempted to insert it again, the tube entered the abdomen. The LPN then proceeded to fill up the abdomen with feeding solution and the patient suffered about three days. When this condition was surgically corrected, the surgeon removed fourteen liters of pus, feeding solution, and fluid from the man’s abdomen. While this episode injured this man, the plaintiff was not able to easily develop sufficient expert testimony to connect the departure from the standard of care to the downhill spiral which ultimately lead to the man’s death. The plaintiff was compensated for pain and suffering between the time the nurse pulled the tube to the date the patient recovered fully from surgery, six to eight weeks, but the settlement did not include the general weakening of the man’s overall condition which lead to death.

Other events may cut off liability so be sure to examine the causation line for each defendant you include. Beware of “junk science” since it can result in no recovery. In general, if your case must rely upon novel theories of medical care or of causation, you do not have a winner.

A woman received birth control pills and then came down with a lipid disorder which her treating physician attributed to the birth control pills. No other physician would support this theory and, if such a theory were valid, no other cases were reported in the literature. The plaintiff would have been litigating a “case of first impression” and in medical negligence, this is dangerous.

In another case, a high-school student fell down in gym class while playing basketball. He ultimately developed reflex sympathetic dystrophy and was essentially completely disabled. RSD is not well accepted and its existence is debatable among reasonable authorities. Further, most jurors would have an hard time accepting a total disability based upon banging the knee in gym class.

[6]

Damages

Tort law requires real world damages. California courts provide ample decisions to learn about the outer limits where courts will permit recovery. The California Supreme Court, in *Ochoa v. Superior Court*

[7] allowed parents to recover where they experienced extreme mental and emotional distress upon seeing their son's illness and witnessing their son's "tragic" death while the child was in custody in a juvenile detention center.

The Court analyzed:

> … [I]t is common to visit a loved one in a hospital and to be distressed by the loved one's pain and suffering, it is highly uncommon to witness the apparent neglect of the patient's immediate medical needs by medical personnel.
>
> [8]

Courts use a standard of "reasonable forseeability" to determine whether a defendant should be liable for his conduct.

[9]

In *Hegyes v. Unjian Enterprises*,

[10] the California appellate court did not find a duty to the plaintiff where, after a woman

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[6] In contrast, in another case, where a stock clerk lacerated her palm with a box knife and developed RSD, that case settled in six figures. A jury would understand that line of causation.
[7] 703 P.2d 1 (Cal. 1985).
[8] *Id.* at 5.
[9] *Id.* at 25
[10] 234 Cal. App. 3d 1103 (Cal.App. 1991).

sustained an injury in a motor vehicle accident for which the defendant was liable, the plaintiff's unborn child sustained injury when a lumbo-peritoneal shunt was compromised.

[11] The California court also pointed out that the tort analysis must proceed in a sequential manner: duty, breach of the duty, causation, and damages. If any step fails, the tort claim fails. Duty is the "initial obstacle."

[12]

In *Molien v. Kaiser Foundation Hospitals*,

[13] the court granted recovery where a woman contracted syphilis … but the diagnosis was wrong; she never had syphilis. The plaintiff's loss of consortium claim stemmed from the emotional state induced in his wife by her belief that she had syphilis. This case stands for the premise that physical injuries are not required for recovery. Where the injury complained of is forseeable, not remote and unexpected, then the court will permit recovery.

[14]

In *Transamerica v. Doe*,

[15] the Arizona appellate court did not provide recovery where the plaintiff was merely exposed to blood infected with the human immunodeficiency virus. No bodily injury; no recovery. With similar reasoning the California Court of Appeals decided *Macy's California v. Superior Court*,

[16] where a shopper allegedly pricked her finger in a pocket in a jacket which she returned to the Macy's store. She feared contracting AIDS[17] "or another serious or lethal

[11] *Id.* at 1108-09.
[12] *Id.* at 1111.
[13] 158 Cal. Rptr. 107, 108 (Cal.App. 1979).
[14] *Id.* at 120.
[15] 840 P.2d 288 (Ariz. App. 1992).
[16] 41 Cal. App. 4th 744 (Cal.App. 1995).
[17] The AIDS cases represent the outside of the envelope in what courts are willing to consider in terms of compensation for damages. The rule is a simple one: reality. If the threat of exposure is "real" and significant,

disease."[18] This appellate tribunal reversed the Superior Court's holding, concluding that "without more" than a needle stick, this plaintiff was not entitled to seek emotional distress damages.

[19]

In *Doe v. Noe*,

[20] a patient sued a surgeon alleging that his failure to disclose to her his positive AIDS status exposed her to the risk of acquiring AIDS. The appellate court ruled that health care providers have a duty to disclose their HIV status

[21] but refused to allow claims for battery,

[22] informed consent, loss of consortium, or conspiracy.

[23] Finally, the appellate court affirmed the trial court's dismissal of the claim for negligent infliction of emotional distress.

[24]

In *Doe v. Northwestern University*,

[25] six plaintiffs sued the University for emotional harm when they were exposed to HIV through a dental student who participated in their treatment. There was no trauma; no known invasion or violation of the plaintiffs' bodies. Claims predicated upon the fear of contracting AIDS, without more, apparently do not survive. The court reasoned that "even a foreseeable fear of deadly disease may not be compensable if the feared

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courts will permit the case to move forward.

[18] *Id. at* 746.

[19] *see also,* Osborn v. Irwin Memorial Blood Bank, 5 Cal. App. 4th 234 (Cal.App.1992) (deciding that a young man and his family could recover where he did contract AIDS from transfused blood. The family wanted to harvest his own blood for use in surgery but Irwin's receptionist stated that harvested blood could not be "earmarked." This was the first case in the nation where a blood bank was "found liable in connection with transmission of the acquired immune deficiency syndrome (AIDS) virus by a blood transfusion.") *Id. at* 246.

[20] 690 N.E.2d 1012 (Ill.App. 1997).

[21] *Id.* at 1018.

[22] *Id.* at 1021.

[23] *Id.* at 1022.

[24] *Id.*.

[25] 682 N.E.2d 145 (Ill.App.1997).

contingency is too unlikely"

[26] and such broad recovery would reward ignorance and hysteria.

[27] The court held that patients should be compensated for a real-world fear of "actual exposure" to AIDS, but fear alone, without more, was not enough.

[28]

Texas uses the "actual exposure" standard to an agent before it will permit recovery. In *Drury v. Baptist Memorial Hospital,*

[29] a surgical patient harvested blood from friends for her surgery but during surgery she received one unit of direct donor blood (her friend) and one from a blood bank.

[30] The blood bank blood tested negative for HIV so that this patient's exposure likelihood was remote; she subsequently tested negative for HIV.

[31] The court held that the defendant was negligent in its administration of the blood and was liable for damages since it violated various sections of the Deceptive Trade Practices-Consumer Protection Act: false, misleading and deceptive acts.

[32]

The appellate court saw the claim as a medical negligence claim and the "sole distinctive feature in her claim is the type of injury she claims to have suffered, mental anguish arising from the fear of contracting HIV, and eventually AIDS, as a result of receiving banked blood."

[33] This court was presented with a very narrow question: May a patient be compensated solely on the basis of fear? While her body had been entered there was conclusive proof that she received AIDS-free blood. So what was the harm; a pinprick?

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[26] *Id.* at 151.
[27] *Id.*
[28] *Id.* at 152.
[29] 933 S.W.2d 668 (Tex. App. 1996).
[30] *Id.* at 670.
[31] *Id.* at 671.
[32] *Id.*
[33] *Id.* at 673.

The Texas court analyzed that the fear must be a "reasonable" fear, "that … [the damages] finds its origin in actual exposure to a substance or condition capable of causing the feared disease or malady."

[34] Presumably the court would have found a reasonable basis of the fear if the actual blood transfused had been AIDS tainted; but it was not. Direct exposure to the disease causing agent is the "indispensable requisite" to recovery.

[35] "A few jurisdictions do not require actual exposure to the disease causing agent. It is sufficient, they say, if the fear is a reasonable one, with the question of reasonableness being left to the trier of fact."

[36]

… AND THEY'RE OFF!

Although what I have described above represents simple tort law and is sufficient for the "basic" case, unfortunately few cases are "basic" and before you decide to accept a medical negligence case, there is more to the brew. This is where science and art converge.

The Supermarket Clerk Test

[37]

This category reflects how the case will play in Peoria. To make the next point I am forced to mix metaphors, baseball for horse racing, but I like cases which represent "slow pitches down the middle of the plate." By this I mean cases which pass the "supermarket clerk test."

In this test, place yourself in the position of the supermarket clerk, your average juror, and, on a busy afternoon, while you present to her your groceries on a busy Friday

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[34] *Id.* at 673-74.
[35] *Id.* at 674.
[36] *Id.*. see Faya v. Almaraz, 620 A.2d 327, 339 n.10 (Md. 1993); Castro v. New York Life Ins. Co., 588 N.Y.S.2d 695, 697 n.11 (Sup. Ct. 1991).
[37] The author acknowledges attorney Leonard Schroeter of Seattle, WA who provided the nucleus of this idea in 1980-81 when the author worked in Mr. Schroeter's law firm.

afternoon, she must become so distracted with your rendition of the facts of the case that she listens to you, becomes enraged and exclaims, "That's outrageous. Even I know you can't do that!"

If you must engage in a complicated scenario with added facts and educate the supermarket clerk with complicated scientific theory, you have lost. Juries are skeptical, give the benefit of the doubt to health care professionals, and if you can't make their blood boil, you can't win at trial. Look for callous, indifferent, inhumane conduct where all the practitioner had to do was "act like a *mensch*" to help the patient; these are excellent fact scenarios for the plaintiff. The jury must feel that a very great injustice was done to this patient for you to win at trial.

Your Client

How much of a media darling, in the jurors' eyes, would be your client? You watch the news; will your client play in Peoria? It goes without saying that who your client is as a person and with all of his life's accumulated detritus will determine how this case will play to a jury. This sometimes requires real artistry but the truth is always your ally. It is when you do not know the truth that trouble will brew.

In a recent case, a patient sought compensation for a wrongful hysterectomy and a large part of her damages stemmed from a dashed career in modeling due to post-hysterectomy pain, dysparunia, and from her desire to have more children. The defense conceded liability but as the efforts to settle bubbled away, we became aware of some important truths: the husband had a vasectomy allegedly as a temporary birth control method. This position was untenable. Second, and most destructive to her case was the fact that she had been raped as a teenager. She hadn't disclosed this rape to her doctor who performed the hysterectomy. While only the plaintiff knew this fact, it was impossible not to settle this case at a substantial discount as soon as possible.

The variations on this theme are many. Always maintain lines of communication

with your client and encourage them to share their "secrets." For this reason, it is imperative to "get to know" your client outside the office and to make it an habit to frequently meet with our clients so that you have an impression as to really "who they are" outside of that first client interview.

[38] If you do not like the client, you may be sure that neither will the jury. But this is only a factor in the analysis and with some polishing and spin-control, some behavior modifications, even the most difficult client may present a convincing case.

[39] Remember this, you don't need a perfect client to win, just an honest, well-behaved client.

In one case the client had been sitting in a car with some other friends when he was blown away by rival gang gunfire. He was transported to a local hospital in ample time but treatment was delayed so that he hemorrhaged to death in the E.R.. The fact that he had been engaged in drug dealing and had been convicted on various felonies made him an unappetizing client but this was not admissible since it had no relevance to the act of medical negligence; the case settled in the low six figures.

[38] ELLIOTT B. OPPENHEIM, THE MEDICAL RECORD AS EVIDENCE §6-1 (Lexis 1998) [hereinafter THE MEDICAL RECORD AS EVIDENCE]

[39] I delve into these interview skills in great detail in THE MEDICAL RECORD AS EVIDENCE §§ 6-2-6-4.

The Defendant

As with the plaintiff, how would your defendants play on 60 MINUTES? One of the main obstacles to the successful conclusion of any medical negligence action is the defendant's stature. Health care professionals wear the white coat into the courtroom so "who" the health care professional "is" becomes as much a part of his medical negligence insurance policy as his team of well heeled attorneys with unlimited budgets for his defense.

It is said that at trial, the doctor wins 9:1. It is before trial, then, where cases may be settled with the vulnerable defendant. In New York, Dr. Orentreich[40] is such a vulnerable defendant who has been involved in perpetual litigation.[41]

If you have a vulnerable defendant, one with numerous suits, for instance, he may not want another lawsuit and may consent to settle. Further, the defendant with a significant disciplinary or criminal history is vulnerable and he may want a quick settlement.

"Drugs, sex, and rock 'n roll" cases involve the vulnerable defendant, and, even with limited damages, may be easily settled. Since the facts speak for themselves in terms of medical negligence standards, the medical profession usually jumps on the band-wagon as experts, and the departure from the standard of care is so egregious that the case falls of its own weight. For the defense, the case won't pass their supermarket clerk analysis. Doctors who prey on patients or who over or mis-prescribe; doctors who leap

[40] Thanks to Attorney Judy Keenan, KEENAN@lawyer1.com (Judy A. Keenan), for calling this vulnerable defendant to the author's attention in her communication to the ATLA medical negligence website.

[41] Newman v. Orentreich, 580 N.E.2d 410 (1991); Richardson v. Orentreich, 477 N.E.2d 210 (1985); Newman v. Orentreich, 1991 N.Y. App. Div. LEXIS 5149 (1991); Hoffson v. Orentreich, 1991 N.Y. App. Div. LEXIS 4031(1991); Newman v. Orentreich, 169 A.D.2d 546 (1991); Hoffson v. Orentreich, 168 A.D.2d 243 (1990); Newman v. Orentreich, 1990 N.Y. App. Div. LEXIS 7644 (1990); Hoffson v. Orentreich, 1990 N.Y. App. Div. LEXIS 3180 (1990); Reboa v. Orentreich, 1988 N.Y. App. Div. LEXIS 55 (1988); Reboa v. Orentreich, 1987 N.Y. App. Div. LEXIS 42629 (1987); Orr v. Orentreich Med. Group, 1987 N.Y. App. Div. LEXIS 41299 (1987); Orr v. Orentreich Med. Group, 128 A.D.2d 469 (1987); Richardson v. Orentreich, 99 A.D.2d 688 (1984); Richardson v. Orentreich, 97 A.D.2d 9 (1983); Stander v. Orentreich, 627 N.Y.S.2d 879 (1995).

over the bounds which are set by common human decency are vulnerable defendants.[42]

Medical Record Analysis

Another factor, one of the most important and frequently overlooked factors in the analysis, are the medical records. Medical records create a presumption the jurors' eyes. What do the defendant's medical records look like? Will a jury accord the records respect or disdain? Cases which may be made in the defendant's own records, are the strongest cases. In general, a case which relies upon favorable testimony from the defendant to support your client's version of the facts, without support from the medical records, is a loser.

If the records look as if they were done by a barnyard animal, then the jury will be impressed with the defendant's slovenly approach to his medical care. The converse is true. Beautiful, well-organized, methodic medical records which tell a jury that this doctor should be believed are also hard to overcome. It is almost impossible for a jury to ignore the impression created by medical records.

If there is fraud in the medical records by way of alteration, destruction, or "spin" through deception, then your case has become much stronger.[43] When you can find spoliation, this will tend to remove the doctor's white coat and may make the case indefensible.[44]

Important Medical Factors:

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[42] See Haley v. Medical Disciplinary Board, 818 P.2d 1062 (Wash. 1991) (disciplining a physician where he initiated sexual contact with a sixteen year old girl after the physician-patient relationship concluded. The Washington Supreme Court held that a physician's conduct is subject to regulation where the conduct "relates to" the practice of medicine.) and see Nghiem v. State of Washington, 869 P.2d 1086 (Wa.App. 1994)(providing another florid example of a vulnerable defendant).

[43] THE MEDICAL RECORD AS EVIDENCE ch.4.

[44] THE MEDICAL RECORD AS EVIDENCE §4-19(c). (discussing Moskovitz v. Mt. Sinai Med. Ctr., 635 N.E.2d 331 (1994) where a physician sealed his fate by altering his records). see also ELLIOTT B. OPPENHEIM, BEFORE AND AFTER: SPOLIATION OF EVIDENCE IN MEDICAL NEGLIGENCE LITIGATION (Terra Firma 1996) (written as the LL.M. Health Law thesis at Loyola University Chicago, School of Law) Call: 800-416-1192 to order.

As a general rule, it is difficult to litigate cases in which there is a serious underlying medical condition. Causation becomes a major litigation issue.

To illustrate:

(1) A woman fell from a ladder and sustained a complicated proximal humerus fracture. It is very difficult to litigate negligence in this context since her underlying condition includes a terrible prognosis under the best of circumstances.

(2) A patient in deep diabetic coma, found after perhaps two days, sustained brain damage. It is almost impossible to link causation since this condition, itself, creates a terrible prognosis.

- Beware of these complicated medical condition cases even when there is a discrete departure from the standard of care.

BEWARE OF THE MEDICAL "TWO-STEP":

It is not unusual for the medical facts to require a "two step" analysis to "get" to the departure from the standard of care. These cases are very difficult.

To illustrate:

In an obstetric case, the plaintiff alleges that the (1) defendant should have done something differently. The departure from the standard of care is not a major STOP sign type of departure. (2) Had the defendant done something differently, then the result would have been different.

More specifically, in an obstetric case where the mother had a set of twins, the providers did not perform biophysical profiles, did not measure amniotic fluid volumes, although they did do some ultrasounds. Then, about three weeks after the last ultrasound, which results weren't perfect but weren't alarming, the mother presented in labor and lost the twins. One twin was dead at birth; the other died about a year later.

Here, the defendant "approximated" the standard of care — didn't floridly violate some obvious indicator — and the twins died. The plaintiff argued: should have performed biophysical profiles … but the standard of care allows for ultrasounds every three to four weeks. "How were we to know what was about to happen?," the defendants argued.

This type of case relies upon a soft departure from the standard of care and then requires the defendants to do something more. Such cases are very hard to win or even to settle.

GENERAL OBSERVATIONS:

Based upon thirty years of case analysis, some general bright lines emerge:

KNOW THE JURY VERDICTS AND SETTLEMENTS:

One of the first tasks in a case analysis, apart from the medical liability analysis, is to thoroughly research the jury verdicts and settlements in similar cases within the jurisdiction. It is a harsh reality, but the costs of a medical negligence case is so high and the risk so great even in very good cases, that the "bottom line" analysis — case value — must drive the intellectual decision whether to take a case from the "get go."

Recently, this author failed to engage in such analysis and discovered that two dead babies in South Dakota were worth $75,000. In an arbitration presided over by a federal Magistrate, his Honor stated, "Do you realize that there has never been a verdict in this state's history in excess of $100,000 for a child. In South Dakota, survivors are compensated for lost economic benefit to the parents … and that's it."

What would we have done differently had we known that fact going into the case? I suspect that we would not have taken the case … spending about $25,000. In addition, the

State of South Dakota had a subrogation claim of $300,000 on one of the babies who died after a year long struggle. The State shared in proportion to the amount recovered with respect to it subrogation claim and paid its proportion of attorney fees. The bottom-line was that the family received about $30,000, for two dead babies!

TOUGH CASES:

Even where liability is a "walk," where the case involves an esoteric area of medicine or a very high risk area, such cases become very difficult to litigate. The reason is that in obscure areas, it is hard to identify and to document the standard of care. For instance, if only three surgeons in the world perform a certain operation, they, in their practices, form the standard of care. In addition, in general, expert witnesses would be impossible to find. High risk medical care is very difficult to litigate.

For instance, it is difficult to criticize a trauma team for inadequate blood replacement, where the patient sustained a gunshot wound to the abdomen. Medicine is practiced prospectively and, yes, it is obvious that the patient didn't get enough blood — but "in the OR it sure looked different at the time."[45]

AUTOPSY:

In general, it is almost impossible to "run uphill" against the weight of an autopsy. Pathologists are the Supreme Court[46] in medicine and, as a general premise, the attorney must fit the autopsy results into the case theory. More, specifically, where autopsy findings are incompatible with the case theory, this presents a "check mat" in most cases.

On the other hand, suppose the autopsy is deficient; incomplete; unsupported by the

[45] The surgeon's testimony …
[46] A medical joke: Internists know everything and do nothing; surgeons know nothing and do everything; pathologists know everything and do everything … but they are just a little bit late.

fact or the autopsy is silent on an important matter but these defects help the plaintiff's case theory, then there is "room to dance." In a recent murder defense, the medical examiner's autopsy was incomplete and did not present a logical path from the incident to death. The autopsy was conclusory; patient died from the trauma. But the pathologist was unable to show, precisely, how the trauma caused the death … some eight years later.

The pathologist faltered. There was no direct line which caused death and, in fact, the pathologist had to admit that the medical examiner was unable to pinpoint a cause of death other than through an empiric analysis.[47]

PERMENANCY:

Watch out for these cases: great case; damages are not permanent…patient all better. Where you try the case, you may get a resounding liability finding, but little to no money. The patient who has undergone an excruciating ordeal but who appears "all better" with no significant future medical expenses, may not raise a sufficient sympathy factor for a jury to "write much of a check."

Recently, I consulted with a very experienced attorney on a plastic surgery case in which a patient underwent a panniculectomy. In this case, a plastic surgeon removed a 56 pound pannus and then the patient went on to have a massive wound infection … which the surgeon ignored. Then, two months later, when another surgeon operated on her, he found two sponges the original surgeon left in the wound when the original surgeon performed a debridement some months after the initial surgery.

[47] Pathologists must conform to *Daubert* principles and an empiric observation doesn't cut it. In this case, the patient had been on a ventilator and was brain dead for eight years … then died. But there was no telltale anatomic evidence. Yes, the patient heart stopped, but why? "This is often the case with cephalomalacia … they just die," opined the pathologist." But was it the case here with this man? The pathologist was unable to be more precise in the detection of the précis mechanism leading to death: "maybe arrhythmia, cerebral insufficiency" … what caused death?

This woman really suffered: four months with massive pus drainage: 4,000 cc's at one time; visiting nurses twice a day doing dressing changes. At trial (in this state defense counsel insists upon trying everything), the jury found that the physician was liable for malpractice and awarded $5,000. Parenthetically, the attorney had already settled against two other defendants for a significant amount but apparently the jury didn't feel that the doctor, himself, injured her very much.

General rule: In a case where the patient is "all better," unless there are great photographs and / or video to illustrate the "ordeal" the jury may fall short in the award. Be careful about the case expenses in such a litigation.

A WARNING ABOUT EMPIRICAL ANALYSIS:

Sound case theories must be based in sound science and medicine. The empirical analysis pitfall is a trap experienced trial lawyers avoid. An empirical analysis is one which centers upon "the obvious."

For instance, a man dies. Moments prior to the MI, the patient received a medicine. Therefore, the medicine caused the death; therefore, to give that medicine departed from the standard of care. Therefore, the case is a "good" (valid) medical negligence case.

Trial lawyers frequently decide upon a medical case theory, selecting it from their lay "common sense" background rather than developing a scientifically based, medically sound theory. They then shop the case out for expert witness opinions based upon their medical case theory.

In jurisdictions where it is possible to plunge well into the course of litigation without a sound case liability, causation, and damage theory, it is possible to do much damage. Attorneys should resist such empiric case theories, as tempting as they may appear.

SETTLEMENT:

One thing I have learned in doing many cases is that you may be able to settle a case prior to trial, but always prepare as if you are going to try the case. When you have a vulnerable defendant, a well demarcated departure from the standard of care, good causation, and sufficient damages, favorable medical records, you may be able to settle without filing suit.[48] If a case has this settlement potential, then you may take it even though the damages are not great but you must hold the "departure from the standard of care" trump card. Without it, you have no case.

THE *coMEDco, INC.*™ FORMULA

Many attorneys become frustrated when they have a medical negligence case sitting on their desk since they have no objective "feel" for the analysis. If numbers are applied to the above factors, seven categories in all, then there is an objective standard on whether to take the case:

Duty = 10 (20)[49]
Departure =10 (20)
Causation =10 (20)
Conduct =10
Damages = 10
Plaintiff = 10
Defendant =10

Total Maximum = 70 (100)

You could assign 10 points to each category so that your ideal case, the absolute perfect case, would rate 70, ten in each category. As noted above, though, this is a sequential analysis so if your case finds no duty, stop the analysis. If there is a duty, then you assign a full ten points. The same is true at the departure step and at causation. If you

[48] In two cases, Mr. Alan Hall of Edmonds, Washington was successful. No discovery was done and both cases were resolved without litigation.
[49] These numbers reflect the weighted analysis.

have a 10 for damages but the other factors are weak, then you would consider whether you have a loser.

To take these relative factors into account, I double the points for Duty, Departure, and for Causation and this has the neat effect of adding to 100 points. Keep in mind, that the average case could total 20 (duty), 10 (departure), 15 (causation), 10 (conduct), 5 (damages), 5 (plaintiff), 5 (defendant) = 80. A case which totals 80+ is very good. One would seriously question taking a case less than 70.

A Great Case:

For instance, to illustrate: 40 year old man goes to the E.R. and has terrific chest pain after Thanksgiving dinner. He is seen by a nurse who telephones the doctor. The doctor tells the nurse to send him home with antacids and diagnoses over the phone "dyspepsia." The man dies from a massive myocardial infarction six hours later and could have been saved by a percutaneous angioplasty. Further, had he been seen by the doctor, an EKG would have been positive and the man had a terrible cardiovascular history. The medical records don't exist; the hospital has a bad track record in JCAHO surveys and has been cited for sloppy E.R. policies and procedures.

THE *coMEDco, Inc.*™ ANALYSIS

1.Duty = 20- the doctor was an E.R. doc who wanted to eat his dinner rather come to see the patient.
2.Departure = 20- this is terrible medical care (against BOTH the doctor and the hospital)
3.Causation = 20 - autopsy disclosed a tight LAD which occluded
4.Conduct = 10- this would enrage any juror. Note further that this care would trigger EMTALA.
5.Damages = 10- the decedent was a middle-aged fellow supporting a family
6.Plaintiff = 10- Baseball coach and devoted father. Non-smoker; not diabetic- would have lived; no negative impeachment materials
7.Defendant - 10 - hospital has been cited for E.R. docs not in the facility; doctor has several egregious malpractice suits.

This case is an obvious winner but let's now suppose that the doctor was not an E.R. doc but a family doctor called at home and that the patient didn't want to come to the E.R., that the hospital was "AAA" gold, the doc pristine, the medical records ideal:

The *coMEDco, Inc.*™ Analysis:

8.Duty: 10- here the doctor may have had a duty to respond; maybe not.
9.Departure: 10 - if no duty, then no departure. But- if some duty, then to not see the patient or to send him to the E.R. would be problematic … but maybe not egregious if the patient refused treatment or refused to go to the E.R.
10.Causation: 10- this was the man's third serious episode and maybe his longevity was in serious doubt. The defense will argue that death was inevitable … and jurors will believe it.
11.Conduct: 5- this doesn't exactly make your blood boil
12.Damages: 4- irregular wage earner, kids grown, wife works.
13.Plaintiff: 5- smoker / diabetic / alcoholic who didn't take of himself; DUI a year ago
14.Defendant: 3- (this scale reflects the plaintiff's analysis so positive points are given for "bad" conduct or impeachment fodder- good medical records reduce the score).

Total= 47

This analysis adds up to 47 which is predictive of an inability to settle and suggests that much work would need to be done to "massage" facts and to get your experts to "help" in their testimony. This sort of case will be tried because the plaintiff will want too much money to settle and the defense will vigorously and righteously defend their client since, so far as they are concerned, he did nothing wrong, the plaintiff contributed to his own demise.

… THE FINISH LINE

Having been involved in thousands of cases over nearly thirty years, it appears to me

that there is no such thing as a perfect medical negligence case. Every case has problems and every case, no matter how good, can be ruined. The standard is stiff; the juries are skeptical and the statistics are terrible: defendants win 9:1 at trial. For these reasons, case selection in medical negligence litigation is everything since you can't make a silk purse out of a sow's ear. I often tell clients that I am their investment counselor and the question they really are asking is whether they should invest in this case or place money into another form of investment, probably more secure.

This scale is no substitute for experience and sometimes a lawyer may take a case to prove a point, because he feels he can out think or out maneuver the defendants, for the experience of learning about these cases, or because there is a good departure from the standard of care and the client wants to proceed even in the face of low damages. Never substitute this analysis technique for your client's goals and for your professional sense of what is right.

That being said, the analysis of whether to take a medical negligence case is susceptible to a quasi-scientific formula consisting of seven predictable and knowable factors. It is important for a lawyer to employ reliable experts who can perform the medical analysis required in steps 1-3. Remember that almost any successful case will pass the supermarket clerk test and cases which are a slow pitch down the middle of the plate, above 80, should finish as a "win." In general, though, you can't make a silk purse out of a sow's ear. If a case tallies less than 70, it is marginal.

This scale is also useful to determine which cases to take over others and how to best apportion valuable financial and human resources within a law firm. My recommendations are conservative and others may view this analysis regime as too rigid. **THE ANALYTIC PROCESS IS ABOUT WHETHER YOU CAN WIN AT TRIAL; IF YOU DON'T FEEL YOU CAN WIN AT TRIAL, THEN DON'T TAKE THE CASE. THE DEFENSE WILL SENSE THIS "TRIAL UNWILLINGNESS" AND GUESS WHERE YOUR CASE WILL HEAD …?**

coMEDco, Inc.™ and
Elliott B. Oppenheim, MD/JD/LLM HEALTH LAW Disclaimer

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Re: *coMEDco, Inc.*™ General Services

DATE: August 2004

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- ***Elliott B. Oppenheim, MD/JD/LLM HEALTH LAW*** offers a unique combination of education, training, and experience devoted to case evaluation and trial consultation for medical negligence litigation and nursing home litigation. In addition, he works in areas of health care criminal defense, health care licensure and hospital credential issues. Experienced — 29 years — in all aspects of medical negligence litigation: obstetrics, cardiovascular, perinatology, cancer, brain injury.

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- ***coMEDco, Inc.™*** will refer you to **well-qualified experts** who will testify at trial if they find a departure from the standard of care. I will work with the expert witness to make sure that you will get the testimony you need for your client's case.

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Abbreviated CV

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Former Physician in ***Family Practice**/ Emergency Medicine***

Formerly **Board Certified in Family Practice by the AMERICAN BOARD OF FAMILY PRACTICE

ELLIOTT B. OPPENHEIM, MD/JD/LL.M. HEALTH LAW DOES NOT PRACTICE LAW OR MEDICINE

- **Education**

1965 **Pennsbury High School**, Yardley, Pennsylvania

1969 **B.A**. **Occidental College**, Los Angeles, California 9/65-6/69

1973 **M.D**. **University of California, Irvine, School of Medicine**
Irvine, California 9/69-6/73 [with Clinical Clerkships at Oxford University (thoracic surgery) Harvard University (general surgery), Stanford University (cardiovascular surgery)]

1973-1974 **University of Washington** affiliated hospital -
7/73-6/74 **Providence Hospital**, Seattle, WA Surgical Internship (PGY-1)

1974-1975 **University of British Columbia**, Vancouver, BC, Canada
7/74-2/75 Vancouver General Hospital Surgical Residency - (6 months)

1995 **J.D.** **Michigan State University College of Law; E. Lansing, MI**
8/92-6/95 [formerly Detroit College of Law, Detroit, MI]
Recipient: Jurisprudence Prize in Constitutional Law

1993-summer school **University of Washington, School of Law**
Seattle, Washington

1995-summer school **Wayne State University, School of Law**-
Detroit, Michigan

1996 LL.M. HEALTH LAW **Loyola University School of Law**,
Chicago, Illinois

- *Thesis*: ***BEFORE AND AFTER:* Spoliation of Evidence in Medical Negligence Litigation**
- **Supervising Editor- Journal of the National Association of Administrative Law Judges**
- Note, *Calvin v. Chater: The Right to Subpoena the Physician in SSA Cases; Conflict in the Circuits over the Interpretation of 20 C.F.R. 404.950(d)(1)*, 15 J. NAT. ASSOC. ADMIN. L. JUDGES 143 (1996).

- **CURRENT**

CEO/President- coMEDco, Inc. - a *national* corporation specializing in *medical-legal analysis*, expert referral, medical and legal litigation related research including evidentiary problems, research support, discovery, and trial consultation in advocacy techniques and strategy.

- **MEDICINE**

Family Practice and Emergency Medicine- 18 years active practice (1974-1992); *formerly* BOARD CERTIFIED **American Board of Family Practice**, Diplomate No. 18445; ACLS, APLS, ATLS Certifications; Former Member ACEP, AAFP, AMA. Formerly licensed in California and Washington.

SIGNIFICANT MEDICAL-LEGAL CONSULTATION PROJECTS

1. *State v. Johnson*, No. 97-1-01564-9 SEA, SUP. CT. WA. (King Co., WA) (1997) - criminal defense of plastic surgeon charged with multiple felony counts of inappropriate conduct with patients. Convicted on only one misdemeanor count. (in consultation with Ms. Julie Spector, Attorney at Law of Seattle, WA).

2. *Cherukuri v. Shalala,* 175 F.3d 446, *(6th Cir. 1999)*- achieved dismissal of charges in defense of physician accused of violation of EMTALA. The doctor was fined $100,000! (in consultation with Mr. Chad Perry, Attorney at Law, Paintsville, KY) before the Departmental Appeals Board, Washington, DC - wrote both EMTALA appeal before DAB and the brief for United States Court of Appeals for the Sixth Circuit). ("We respectfully suggest that the Board should review cases like this one closely and should not simply pass them on to a federal appellate court without providing a reasoned disposition of the objections raised by the parties." 175 F.3d 446, 455).
3. *Annon. v. Annon.*, Dallas, TX (confidentiality agreement) (1999): $3.85 million recovered in medical negligence case concerning brain injury. Permissible details upon request. (in consultation with Ms. Alicia Slaughter, Attorney at Law, Dallas, TX).
4. *State v. Hudson*, Sedgewick Co. Dist. Ct. No. 00CR1399 (Wichita, KS) (2001) – criminal defense of man charged with child abuse / first-degree murder- acquittal on all charges. (in consultation with Mr. L.J.Leatherman, Topeka, KS).
5. State v. Ocaño, Pima Co., Tucson, AZ (Tucson, AZ) (2003)- defendant accused of CSC with 3 year old- acquittal. (in consultation with Mr. Jeff Buchella, Tucson, AZ).

Recent Medical or Law Publications

- *Nursing Home Litigation: A Primer for Trial Lawyers*, 6(2) J.MED.L. 81 (2002).
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- *The Law of Evidence and the Medical Record,* 2(2) J.MED.L. 167 (1999).
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- The *Medical Record: A New Mexico Lawyer's Litigation Guide*, 4(2) BAR J. (NM) 15 (Summer 1998)
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- *A Doctor's Perspective on what the Law Should be for End-Of Life Issues*, 2(1) J.MED.L. 11 (1997).
- EMTALA: *Its First Decade; A Retrospective Analysis of 42 U.S.C. § 1395dd*, 43(4) MED. TRIAL TECH. Q. 77 (1997). Listed: http://www.uplaw.net/articles.htm.
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- Note, *Calvin v. Chater: The Right to Subpoena the Physician in SSA Cases; Conflict in the Circuits over the Interpretation of 20 C.F.R. 404.950(d)(1)*, 15 J. NAT. ASSOC. ADMIN. L. JUDGES 143 (1996).
- Honorable Mention- National Writing Contest of International Association of Defense Counsel (1995) for *Physicians Against Their own Patients: What Happened to the Privilege?* 63(2) DEF. COUNSEL J. 254 (1996).

- *The Trial Lawyer's EMTALA Manual*, 11(4) PROF. NEG. L.REP. 73 (1996).
- *EXAMINING MEDICAL RECORDS: How to Know What is Said When you Read What the Doctor Wrote*, 82 ABA J. 88 (1996).
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PRESENTATIONS / TALKS:

- Brain Fingerprinting: Is it *Daubert*-Proof? 02 May 2001 – Harvard Medical School, Department of Psychiatry, Forensic Research Group; Cambridge, MA.
- Prescribing Psychologists Registry, Psychopharmacology- Los Angeles, CA - 14 hours; 2-3 March 2003.
- The Law of Prescribing Medicines, New Mexico Psychologists- Las Cruces, NM, 10 November 2002.

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- Lexis Law Publishing: R_x Law & Medicine Report, Quarterly (1998-2002).
- Leader Publishing / New York Law Journal Publishing: Medical Malpractice Law & Strategy, Monthly (1997- present).

***coMEDco, Inc.**™ *Briefly Stated* MONOGRAPHS

***EMTALA: *Its First Decade - A Retrospective Analysis of 42 U.S.C. § 1395dd* ©** (Terra Firma, Santa Fe, NM 1996) (ISBN# 1-930263-00-7) 65 pages, 250 footnotes.

***BEFORE AND AFTER: *Spoliation Of Evidence In Medical Negligence Litigation* ©** (Terra Firma, Santa Fe, NM 1996)(ISBN# 1-930263- 03-1) 175 pages; 600+ footnotes

***The Law of Evidence and the Medical Record©** (Terra Firma, Santa Fe, NM 1997) (ISBN# 1-930263-01-5) 115+ pages; 325+ footnotes

*** SCIENTIFIC EVIDENCE IN PERSONAL INJURY LITIGATION: *DAUBERT*'S GHOST©** (ISBN# 1-930263-04-X) 240 pages; 900+ footnotes.

*Books/ Treatises / Chapters

MOTOR VEHICLE LITIGATION: 1500 pages (Litigation One Irvine, CA 2003) coming soon... Discussing the medical legal interface in this area of law.

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THE MEDICAL RECORD AS EVIDENCE, 900 pages, (Lexis Law Pub. Co., Charlottesville, VA 1998) (2003 supplement) (ISBN# 1-55834-889-1) *The definitive work in the field of medical evidence*. To order direct from Lexis Law Publishing: 800-562-1197; item # 66063; listed: in Evidence Law at: http://www.law.seattleu.edu/information/startingpoints/evidence.html.

in David W. Louisell & Harold Williams, *Evidence and Spoliation in Medical Records*, ch. 36, MEDICAL MALPRACTICE (Matthew Bender 2003) ISBN: 0820513709; 100 pages.

Vers. 1/1/04

coMEDco, Inc.™ FAQ's- MEDICAL NEGLIGENCE

→ INITIAL ANALYSIS:

The most important step in any case is the fundamental analysis. Does the case have merit? Can the "case" win, in court, given average jurors, with an average judge?

This fundamental "knee jerk" analysis consists of an initial case overview and an identification of a basic case theory according to the requirements of tort law: standard of care; departure from the standard of care; proximate (legal) causation; damages. Obviously, if the case does not contain these elements, there is no point in moving ahead. This review includes the elements for you, as the attorney, to decide whether you want to take the case.

In essence, in the economic area, ***coMEDco, Inc.™*** functions as your client's (and your) investment counselor: "Can we win? Should my client invest time and money in this case?"

- Consultation Contract: If it would benefit your client, we can work together through the pendency of litigation. ***coMEDco, Inc.™*** offers a realistic contract which includes all services.

→ COMPREHENSIVE ANALYSIS:

If the case has merit, the next step is an in-depth "game plan" analysis where all medical records are obtained and reviewed in-depth. This results in a detailed written report which forms the fundamental case overview and an approach to winning, whether by settlement or trial.

This analysis identifies case strengths and … weaknesses … vulnerabilities. In addition, according to the tort element model, this in depth analysis identifies defendants, excludes persons and / or entities who are not responsible, and then identifies what expert witnesses will be needed. In addition, if the attorney wishes, it is possible to run database inquires on all defendants to determine licensure actions as well as other actions which may affect credibility. At this point in the case, it may also be useful to run verdict searches and engage in a database investigation of the defendant(s).

At this point, a predicted case budget emerges which would include all expert witnesses and the general litigation costs. In general, one must budget about $10,000 / expert witness if a case does go to trial.

Note: This analysis is written in legal format which, you, as the attorney, may "copy and paste" into a complaint.

→ DISCOVERY:

Unless a lawyer has medical training, it would be unlikely that the attorney would be able to craft medical admissions, interrogatories, and deposition questions which will demonstrate to the defense that "they can run, but they can't hide." If this segment of the litigation is well orchestrated and performed, cases generally settle at some point prior to trial. Elliott B. Oppenheim, MD/JD/LL.M. HEALTH LAW will prepare these materials. Why send a lawyer to do a doctor's job?

→ EXPERT WITNESSES:

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If a case does not settle and the case does move to trial, Elliott B. Oppenheim, MD/JD/LL.M. HEALTH LAW will participate in creating demonstrative evidence, preparing all medical witnesses, writing direct and cross-examination questions.

At all phases, Elliott B. Oppenheim, MD/JD/LL.M. HEALTH LAW, upon request, is available to attend important negotiations, discovery depositions and other meetings, including trial. Backed by nearly thirty years of experience in medical negligence litigation, it makes a significant difference at all phases to the defense when the plaintiff works with Elliott B. Oppenheim, MD/JD/LL.M. HEALTH LAW and ***coMEDco, Inc.™***.

NATIONAL REFERENCES:

Mr. Alan Hall, Attorney at Law 425-774-9566 (Edmonds, Washington) Mr. Paul Levin, Attorney at Law 860-249-7226 (Hartford, Connecticut)	Mr. David Pheils, Attorney at Law 800-874-3177 (Perrysburg, Ohio) Mr. Stephen W. Bruccoleri, Attorney at Law (215) 563-4440 (Philadelphia, Pennsylvania)
Mr. Peter M. Zavaletta, Attorney at Law (956) 546-5567 (Brownsville, Texas)	Ms. Anne Pedersen, Attorney at Law (215) 790-7300 (Philadelphia, Pennsylvania)
Mr. John M. Ohman, Attorney at Law 208-522-8606 (Idaho Falls, ID)	Mr. Greg Smith, Attorney at Law 503-581-4463 (Portland, OR)

- Additional civil medical negligence references upon request.
- References in criminal litigation cases, upon request.

References ***coMEDco, Inc.***™

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   How to evaluate a medical record, written for practicing attorneys. Detect medical issues, assist you in making a more efficient presentation to medical experts; know when the doctor has doctored the doctor's record. **$15**

2. **THE *coMEDco, Inc.*™ WAY: OBJECTIVE ANALYSIS OF THE MEDICAL NEGLIGENCE CASE** © This is the "how to" guide in case analysis. Tells you how to identify cases which are a "slow pitch down the middle of the plate."

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