INSIDE THE MINDS

Representing Plaintiffs in Medical Malpractice Cases

Leading Lawyers on Building a Strong Case and Implementing Successful Litigation Strategies

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Current Trends in Malpractice Litigation

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Introduction

While the basic tenet of a malpractice case has remained the same—the need to prove duty, breach, proximate cause, and damages—the complexion of these cases has changed dramatically. Today, the plaintiff's lawyer considering such a case must have the financial wherewithal to compete with the insurance companies, must be familiar with all forms of alternative dispute resolution (ADR), and must above all select his cases carefully. To win today, I teach that you must have "negligence plus," along with a good plaintiff. In this chapter, I will offer my observations on trends in medical malpractice litigation gained from thirty years of practice, teaching, and trying cases.

Decline in Case Filings over the Past Five Years

One trend that I have recently observed in the medical malpractice area is that the number of cases filed nationwide and state-by-state has dramatically declined over the last three to five years. Although nothing suggests that the incidence of malpractice has declined, there has certainly been a decrease in the number of lawsuits. One reason for this trend may be that lawyers have become increasingly unwilling to take malpractice cases that are not "clear winners" these days for a number of reasons.

Most experienced malpractice lawyers have become increasingly selective regarding the cases they take on. For example, while a lawyer may have been willing to take on a $50,000 to $100,000 case ten years ago, the economics of doing so today are far more challenging, since you can anticipate that almost every case will be aggressively defended and that insurance companies—particularly those run by physicians—are less likely to settle. Higher costs and the likelihood of a trial in most cases where the evidence is in equipoise make the economics of prosecuting these cases unappealing to counsel and, ultimately, to the victim.

Plaintiff's lawyers are gun shy and rightly so. My experience is that all but the best cases result in trial. State caps, along with the demonization of malpractice litigation by certain politicians and insurance companies, have created a sobering mood among plaintiffs' lawyers and the public. These factors, combined with the general skepticism of lawyers and the thick skin we seem to have developed to another's plight, are additional reasons cases have been more difficult to win—and are additional reasons for the decline in filings.

Before accepting any case, the lawyer must evaluate the venue: Are there caps? Are cases being won in that court at trial? Is there a large lien asserted by a private health insurance company? Medicare? Medicaid? Are the client's damages real—demonstrable—serious and permanent?

Can a good case be settled—or won? Of course. But strict selectivity and creative strategy are required to achieve victory.

Alternative Dispute Resolution: The Norm for Settling Cases

There has been an explosion in the use of private mediation to resolve medical malpractice cases over the past fifteen years. These sessions are often part of a court program—some mandatory, some not—but the best and most effective use of mediation is the parties' agreement on a private mediator—typically a retired judge whom the lawyers and the carriers like and respect and who the lawyers know has a good track record of success. The parties agree to share the costs of the process to try to hammer out a settlement. In my experience, it is almost unheard of these days for lawyers to settle these cases in direct discussion. Many carriers now do not even involve their counsel in negotiations. They evaluate claims themselves and make their own decisions. Establishing credibility with the carrier—and the mediator—is a critical component of achieving success. Winning a few huge verdicts helps, as well.

Saying You Are Sorry

A notable pre-litigation trend in this area is the "I'm sorry" programs. These programs—almost always utilized by institutional defendants, such as hospitals—have seen some success in getting cases settled sooner rather than later, and without the need for a lawsuit. Programs differ by institution, but the common theme is that a hospital risk manager will approach a patient of a family member they know is the victim of wrongdoing in their hospital, explain what happened, often apologize, and then try to come up with some way to resolve the case before litigation begins. Such practices vary by state and institution, and some are more effective than others are.

Some Veterans Administration hospitals have good programs that have reduced the number of lawsuits and, in many instances, quite fairly. The better

programs allow the family to bring counsel and are off the record, open, and honest. These meetings can diffuse anger, make the family comfortable, and result in a just outcome. I have not much "I'm sorry" in the non-government and non-academic hospitals, but the current administration is a proponent of this effort as part of its overall agenda to reduce health care costs.

Most states now have laws that allow a doctor or hospital to say, "I'm sorry" for whatever medical mishap occurred without that apology later coming up in court. Unfortunately, the vast majority of our clients report that after the injury, they could never find or contact the physician, let alone hear one apologize.

For a general discussion on this topic, see *The Sorry Works Coalition: Making the Case for Full Disclosure,* 32 JOURNAL ON QUALITY AND PATIENT SAFETY, No. 6, 344 (June 2006).

Impact of Medical Malpractice Legislation on Plaintiffs' Rights to Sue

Although no state has entirely foreclosed a patient's right to sue for medical malpractice, state legislators have continually abridged these rights. In Virginia, for example, families can no longer sue their obstetrician for causing hypoxic brain damage and cerebral palsy so long as the doctor registers with the state's "no fault" program, which is akin to a workers' compensation program.

Other states have whittled down the right to sue for malpractice by shortening statutes of limitations or imposing stringent requirements on expert witnesses, for example. However, the most significant legislative impact for the injured plaintiff comes from caps, or limits—sometimes on the entire case (Virginia) or an element of the case, such as non-economic damages (Maryland). The stated goals of these bills are always the same: by decreasing awards, you decrease doctors' premiums, and if premiums do not come down, doctors will be forced out of practice. No study has empirically proved that caps result in lower premiums. Doctors in Virginia still complain that their premiums are too high, even though entire cases are capped at $2 million, but they complain more loudly now that they are being forced out of business by third-party payers. In Washington, D.C., where there are no caps, the number of doctors has been steadily increasing.

When the District was faced with the question of reducing premiums, it took a reasoned and learned approach in crafting legislation. The City Council's study found that reducing premiums was more a function of insurance company math and the stock market than caps. Our bill, the Medical Malpractice Proceedings Act of 2006, tightened up the increases carriers could charge, made the medical society more active in rooting out bad doctors, and promoted early resolution of cases. Caps were not imposed. So far, it seems to be working and should act as a model for other jurisdictions.

Common Medical Malpractice Cases

The most common malpractice lawsuits involve the areas of neurosurgery, emergency department medicine, obstetrics and gynecology, and delayed diagnosis of cancer. Neurosurgical cases are common because when a neurosurgeon makes a mistake, the results are typically dramatic, substantial, and devastating. If a pediatrician makes a mistake and does not diagnose an ear infection two days earlier, there are typically no damages. However, when a neurosurgeon makes an error while operating on the brain or spine, the consequences can be devastating—and patients who are the victims of such malpractice tend to go to lawyers for legal help.

A side note about neurosurgical malpractice bears mentioning. You may find it extremely hard to obtain an expert witness. This is because the neurosurgical association—the American Association of Neurological Surgeons (AANS)—monitors the courtroom testimony of its members who testify for the plaintiffs in court against other neurosurgeons. If the AANS does not like what it hears, it brings the physician up on charges. Talk about a chilling effect!

Emergency room (ER) malpractice cases have always been prevalent, and they generally follow the same format—i.e., an inadequate patient evaluation or history or physical was conducted in the emergency department; a critical diagnosis was missed; and the patient was sent home, where he suffered a heart attack or stroke that could have been avoided if the attending physician had ordered a test to uncover the true reason the patient came to the ER. Failures to diagnose the underlying insidious and imminently dangerous cause of chest pain or a headache are two of the most common ER cases. All too often, a middle-aged man shows up

complaining of "some pain" in the upper abdomen and gets sent home with an antacid—and without an EKG. Or the fifty-year-old woman arrives at 4 a.m. complaining of the "worst headache of my life"—and gets sent home without a CT scan. Yes, this still happens.

The number of malpractice cases against obstetricians has gone down—in my opinion, partly as a result of better care delivered in response to litigation—but again, they generally follow the same format. In some cases, there is an improper prenatal care (i.e., a doctor fails to perceive that the fetus is not growing enough or is growing too much, or there is some other problem during pregnancy that if addressed properly would yield a better outcome for the mother and the baby). More common cases, however, are those involving failure to properly manage the labor and delivery by allowing the labor to go on too long, not adequately reviewing the mother's clinical course, or not monitoring or properly interpreting the fetal monitoring tracings, or when the attending nurses and doctors fail to communicate. Unfortunately, cases involving children with cerebral palsy from bad care continue to occur with some regularity, and they, of course, present the largest exposure risk for physicians and insurance companies—as well as the most significant challenges for the family.

With cancer survival rates thankfully increasing, largely through the benefits of early detection, the failure to detect—whether by not recommending a screening colonoscopy to a fifty-year-old or by misreading a mass on a mammogram—is a common setting for litigation. Each state law is different with respect to how much damage one needs to prove (i.e., "loss of a chance" or "more likely than not will die from the delay"). With the advent of testing to determine whether someone is carrying a cancer gene—cases are being brought for the failure to recommend such testing. *Downey v. Dunnington,* 895 N.E.2d 271 (Ill. App. 2008).

Cases we are seeing more often involve large corporate pharmacies. When a prescription is filled at a large chain pharmacy, its pharmacists are obliged to check to determine whether the medicine you have been prescribed is contraindicated or dangerous in combination with the other medicines you may be taking. Essentially, every time pharmacists are asked to fill a new prescription for an individual who has a history with that pharmacy, their

computer software will pull up a history of all of the drugs the individual is already taking, and if the new drug is contraindicated, that fact will be flagged by the computer program. Unfortunately, those types of warnings and safety mechanisms are not followed as often as they should be. Therefore, we have seen a number of cases over the last few years where the pharmacist was strongly advised by the computer software not to fill a particular prescription, but did so anyway—with a terrible outcome.

Increasingly commonplace are medication errors committed at hospitals, as well—i.e., either too much or too little of a patient's medication is administered. Hopefully, computerized medical records will help reduce those types of errors.

Prevailing in Challenging Times

I have found that the most challenging medical malpractice cases are those that are the most complicated from a medical perspective because, ultimately, the success of a plaintiff's case will depend on the lawyer's ability to make a jury understand what happened. For instance, obstetrical or neurosurgery cases that present extremely complex issues, such as microsurgery or interpreting subtle fetal monitoring tracings, tend to be challenging. Unless you can point out clearly what the doctor did wrong—and get a juror to understand how that just should not happen—many jurors are inclined to give physicians a break either because they do not understand the medicine involved, or they assume that the doctor tried his best. Conversely, if a case involves a fifty-seven-year-old overweight man who shows up in the emergency department with chest pain after playing basketball, a jury is unlikely to excuse the attending physician from failing to do an EKG. Simple cases where the injury is temporal to the act, preventable, and permanent tend to be settled.

Put differently, the cases we settle or win at trial are by and large those where there is a severe, demonstrable injury. We can show the jury what happened because of the malpractice—in other words, how the patient's life has been changed for the worse. In these cases, we also look for "malpractice plus" and tend to decline those where the quality of the wrongdoing is soft.

The typical burden of proof for the plaintiff in a malpractice case is "by a preponderance of the evidence." To make a *prima facie* case, we must technically have evidence that is "ever so slightly stronger" than the defendant's. To actually win, however, or get an insurance company to settle, in my experience, the evidence of malpractice has to be quite clear and egregious; the injuries suffered by the patient have to be serious; and there must be significant financial exposure for either the defendant or the insurance company or both to motivate the parties to settle.

Unfortunately, jurors in medical malpractice cases have become much less sympathetic and empathetic to plaintiffs over the last ten years for a variety of reasons. Lack of sympathy or empathy can be particularly devastating in wrongful death cases, particularly where the decedent was not a high-wage earner or supporting a family. In these cases, even when malpractice is committed, the jury may be frugal because they feel their award will benefit no one.

In addition, jurors are constantly reading or hearing about horrible events that are happening around the world—i.e., people are suffering from the results of natural disasters; our servicemen are coming back from war with severe injuries. Consequently, many jurors have become hardened to the trauma suffered by other individuals, and in hard economic times, they are also less willing to be generous to others in the form of verdicts. The general feeling seems to be, "My life is not that great, but I am dealing with it—and the plaintiff should deal with her situation, as well." Therefore, in wrongful death cases, it is easier to get a substantial settlement if there was someone who was financially dependent on the person who died.

Emotional Distress Cases

Over the years, there has been a gradual expansion of the right of to sue for negligent infliction of emotional distress.

In an important case decided in 2011, the D.C. Court of Appeals sitting *en banc* rejected the requirement that a plaintiff must be in the "zone of danger" created by the harm to bring a claim for negligent infliction of emotional distress. In *Hedgepeth v. Whitman Walker Clinic*, 22 A.3d 789 (D.C. App. 2011), the plaintiff was told that he was HIV positive when, in fact, he was not.

After hearing the news, he became severely clinically depressed and suffered repercussions in his employment and personal life until he was informed by another clinic of the mistaken diagnosis. Essentially, his entire life was turned upside-down. He sued for malpractice, but he lost the case at the trial level because court did not place him within the "zone of physical danger." In its *en banc* decision, albeit a narrow one, the court held that while the "zone of danger" could still be the appropriate rule in certain cases, it need be in all cases. Factors that will determine the test used include the relationship between the parties, policy considerations, and verifiable injuries.

Another evolving legal area involves holding hospitals responsible for physicians who have typically been considered "private docs." Common arguments seen in these cases are that the hospital has a "non-delegable duty" to the patient or that Medicare or Medicaid regulations impose such liability. A more fertile ground may be the "negligent credentialing" case. Here, the theory of liability is that the hospital knew or should have known that the physician was trouble and never should have let him operate to begin with. *See Darling v. Charleston Community Hospital,* 211 N.E.2d 253 (Ill. 1965) (the first case to establish this tort).

Preliminary Steps in Mounting an Effective Medical Malpractice Case

The first step in mounting an effective medical malpractice case is to establish a solid factual foundation regarding what happened. First, you should talk to the client and his family about what happened. Then you must obtain the complete medical record regarding the incident, as well as the non-related medical records of your client. After neatly organizing and date-stamping the records, someone who is qualified to read and understand a chart should delve into every page to find out what actually happened. In most cases, we utilize the services of a trained critical care nurse or licensed legal nurse consultant—someone who understands where information may be hidden in medical records and how to review and interpret subtleties. Such a review will determine, for example, when steroids for brain swelling were ordered versus administered or how much was supposed to be given versus how much was actually given.

As your review proceeds, your investigative strategies will vary, depending on the type of malpractice matter you are dealing with. In a case involving

an emergency department, an ER physician should review the case if possible; a case involving an obstetrician should be reviewed by an obstetrician. You have to know your case before you talk to your proposed expert. You need to be an advocate for your case and often must fight off a pro doctor bias of the reviewer. As stated earlier, in our practice, we have found that in wrongful death cases, our reviewer must be able to clearly and unequivocally point to very bad medicine before we consider taking the case, since these cases are often harder to win than those where we can demonstrate the result of the malpractice in court. At some point, all of us lose someone in our lives and grieve. Jurors are no different. But almost none of us loses limbs and ends up with prostheses. I have connected with jurors when I can let them touch and feel what my client is going through.

That is not to say that death cases should not be brought—they just, in my opinion, present unique challenges.

During and after your review of the medical records, there are a number of critical issues that a plaintiff's lawyer needs to understand and keep in mind. First, does your client have any skeletons in her closet? Preferably, you want to represent a client who is a good and likeable individual and who does not have much baggage. Jurors want to do good things for good people, and defense lawyers and insurance companies know that. Your client needs to make a good impression at her deposition so that defense counsel tells the carrier people will like her. A good rule is that if you do not like your client, a jury will not like her, either. The same analysis holds true for the defendant. If you are fortunate enough to be up against an unlikable defendant, it will be easier to win your case.

Your preliminary investigation must also determine whether there are any dispositive defenses that are available in the case. For example, from the plaintiff's perspective, did the malpractice take place so long ago that litigation is barred by the statute of limitations? Is there some type of immunity in this case that would be provided to the doctors? In most states there are "Good Samaritan" rules immunizing a physician who provides emergency care as a volunteer without the expectation of getting paid. Many states encourage private physicians to donate time at free clinics, and in return immunize them—but probably not the employer—from liability. Notice requirements vary from state to state, as well as under the Federal Tort Claims Act. Any one of these issues can quickly derail even the best case, if not considered.

A major concern in these cases that has arisen over the last five years involves Medicare and Medicaid liens. These liens need to be determined, protected, and dealt with as early as possible in your case. For example, if your client has $500,000 in medical bills incurred as a result of malpractice and paid by Medicare or Medicaid, you and your client are likely liable to repay those sums—or some portion thereof—out of a settlement or verdict. These liens also make these cases more difficult to settle. If you have a case with an offer of $1 million to settle, and your fee is one-third, what will your client net if there is a $500,000 Medicaid lien? Therefore, understanding at the outset how these liens can work to deter settlement needs to be part of the plaintiff's lawyer's thinking and planning. You will often need to know how to negotiate and to get the government to modify its liens to get the case resolved.

Strategies for Demonstrating the Client's Doctor Was Negligent

The best opportunity to demonstrate that the client's doctor was negligent is at the defendant's deposition. Therefore, a good malpractice lawyer will approach a deposition of the defendant as if it is a prize fight. Essentially, your goal should be to strengthen your case by getting the defendant to admit as many times as possible that he or she committed some error. Some attorneys have good enough skills to be able to get critical admissions routinely, but most of us need a great deal of preparation to accomplish the goal.

I will do a thorough background check of the defendant before I go into the deposition. I will find and read any earlier testimony he has given, read his relevant publications, Google her, and use lawyer listservs to get information. I will be polite in my questioning so long as the witness is responsive. I will try to use as much logic as I can to force admissions, and I will know the medicine cold.

To adequately depose the defendant or any of his experts, you need to become thoroughly familiar with the most up-to-date medical literature in relation to the issues in the case. For instance, if you have an obstetrical malpractice case, the key question may be whether the doctor should have given a drug to delay the onset of labor. In doing your research, you may read in the *New England Journal of Medicine* that three years before the client's

baby was born, the American College of Obstetricians and Gynecologists came out with rules and guidelines that clearly put your client in a group of patients that should have been treated in a certain way—i.e., if a woman in labor exhibits certain symptoms, she should be given a particular medicine. If you are familiar with that guideline and you can establish that the defendant is a member of the American College of Obstetrics and Gynecologists and did not administer that medicine, you have gone far in establishing a clear breach of the standard of care—and that is the type of critical evidence that jurors want to see. Jurors want to know whether a rule has been violated because they expect that a professional will follow the rules—and if they see that someone is not following a rule that is clearly written in a medical journal, they will have a much easier time with respect to finding fault. Consequently, being able to impeach and attack the defendant and his experts based on the prevailing medical literature is a critical strategy for winning a case. In fact, I will often walk out of a good deposition knowing that the case is over. Simply put, if you are prepared for the deposition, you may be able to take the defendant down, and those cases will generally settle quickly.

Proving the Client Suffered Injury as a Result of a Doctor's Actions

To determine your client suffered an injury because of a doctor's actions, the jury must be able to see and feel evidence of that injury. It can be difficult to empathize with someone if you have not suffered the same misfortune. Therefore, as the plaintiff's lawyer, you must first establish empathy for your client's condition, and then you need to figure out the best way to demonstrate the injury.

For example, in wrongful death cases, I read and make the lawyers in my office read Elizabeth Kübler-Ross' book, *On Death and Dying*, before we do our pretrial prep of the family. It is important to be sensitive to the stages of grief a person goes through when a family member dies; without some knowledge in that area, you might not know what types of questions to ask the plaintiff. Once you are able to communicate effectively with a client regarding her emotional state, you need to think of a way to ask those questions in a public setting—i.e., before a jury. Because most people are private and because trials are anything but, I try to allow the widow or

children to see a few days of trial before they testify, to get comfortable. I will ask to approach the witness and have a conversation at trial. I will talk about things she remembered from earlier happy days—and publish a picture or two to the jury. I will ask about a story I know the jury will like—in one case my client serenaded his wife right out of a scene from *Don Quixote*. Go over this testimony in the office on two consecutive weekends before trial. Take copious notes at the first meeting; outline them, and use the outline for the second.

In many cases, we will create a "day in the life" film for a client who has suffered a medical injury. A film crew will be hired to go to the house of an adult and videotape daily difficulties—whether bathing, eating, moving, or talking. Those tapes can be shown to the jury to give them an opportunity to see what living with this condition entails. This powerful evidence can become the underpinning for the rest of your damages testimony.

We have had several cases over the years where the defendant has fought bitterly to keep the plaintiff himself out of the courtroom. If the plaintiff was in a vegetative state, the defendant would argue that the jury should not be allowed to see him for fear of prejudicing his case from undue sympathy. Fortunately, we have never lost on that issue; in fact, we find that bringing a severely injured plaintiff to court is generally quite effective. Some years ago, we brought an older client who was paralyzed from the neck down but still had some mental function into court on a gurney and let the jury sit with him for a few minutes as his wife combed his hair. This experience was difficult for everybody involved. We won the case convincingly in part because we gave the jury an opportunity to see what life was like for our clients.

At another trial, we represented a former professional basketball player who lost a leg because of undiagnosed and untreated diabetes. His prosthesis weighed seventy-five pounds. We asked permission to have him remove it in court and pass it around to the jury. I remember their faces when they struggled to lift it. The jury liked our client and our case, and fortunately they decided in our favor. However, it was a risky move that could have backfired if they had thought we were insensitive or overreaching. The latter is a concern in every case. Do not oversell your client's injuries—portray them realistically. Overstating anything at trial risks losing credibility—the kiss of death in a courtroom.

Finally, if a case involves the difference in efficacy of one test versus another—i.e., between a CAT scan and an x-ray, we want the jury to see what an x-ray or CAT scan looks like so that they will know and understand why one is so much more exact than the other.

Helpful Resources for Malpractice Litigation

To prevail, it is essential to have top legal skills and law firm resources at your disposal. Your office needs to be proficient in legal and medical research—such as MEDLINE resources. If you plan to do this work regularly, it would be smart to hire or contract with a qualified nurse or physician's assistant to work in your office to review your clients' medical records.

It is also critical from a plaintiff's perspective that you have enough money to be able to go toe-to-toe with the hospital or insurance company on the defendant's side; if you do not, your client will not end up getting the representation he or she deserves. You do not want to get outspent in this type of case and wind up making the decision to use expert X instead of Y because Y is too expensive.

Lawyers who engage in medical malpractice litigation should familiarize themselves with the local jury instructions; that is the best way to easily understand what the law is in medical malpractice cases in a particular jurisdiction. In addition, they should have advanced trial skills necessary to compete with the lawyers who defend doctors and hospitals. Many of our opponents have tried more than 200 cases in their careers. There is truly no room for a novice first-timer trying a plaintiff's medical malpractice case. I suggest you engage experienced co-counsel for your first few cases.

Expanding Roles of Experts

Two types of damages experts have become popular in medical malpractice cases. First, there are life expectancy experts, who are often not physicians; rather, they are epidemiologists or statisticians who will come to court—typically for the defense—and try to testify that based on their statistical analysis, the plaintiff/patient will not live past age thirty, for example. They have never met the plaintiff. The underlying basis for these statistical opinions has been rejected by some courts. We prefer to rely on medical testimony unique to the patient.

Experts in genetic testing are also now commonly used in medical malpractice litigation. With the knowledge today that many diseases and conditions may be familial in origin, if you are representing the plaintiff, it is critical to rule out the possibility that your client's problems are genetically caused. This issue typically arises in cases involving children who have severe injuries that become evident at birth or in the first or second year of life, and the question arises as to whether the injury is a labor-induced problem or the result of some type of metabolic or genetic problem. Similarly, this issue can arise in cases concerning the management of cancer or other illnesses, where it is found that the client may have an increased risk of developing a particular cancer. For example, if a woman has a history of breast cancer in her family, does her physician have a duty to draw blood when she is having her first mammogram to determine whether she is at increased genetic risk? The law remains unsettled with respect to this issue. *See Downey*, *supra.*

Preparing Clients for Malpractice Litigation

One of the basic misconceptions that many clients have in these cases stems from reading or hearing about huge verdicts. The possibility of winning such a settlement is generally unrealistic, and we explain why.
We always prepare our clients by telling them that malpractice litigation will be a difficult experience. First, they will have to give a deposition; and while that process will not be enjoyable, we let the client know that we will be there with them, and we will prepare them well enough that they will have a sense of everything that will be asked so that there will be no surprises. Fortunately, they have to give a deposition only once, and that is the most difficult part of the case for them until trial.

Next, we prepare the client to anticipate the defenses. No matter how bad the client's injury may seem to the client, the other side will almost always find a way to defend a case, whether on negligence, cause, or damages.

Consequently, we prepare our clients to accept that litigation will not be easy and that they probably will not receive the settlements they think they deserve—if only because doctors do not carry $40 million in insurance. Rather, we explain the realities of coverage and coverage limitations. If you

are dealing with a case where it will cost $10 million to take care of an injured child, but the doctor involved has only $2 million in coverage, you need to discuss this problem, along with your strategy, at the outset in practical terms. Clients should not hear this for the first time at mediation. Particularly in wrongful death cases, clients need to keep in mind that litigation tends to prevent families from having closure. They may not want to go through the litigation process, but they often use it as a way of holding onto their loved one. Therefore, we talk about those issues in very frank terms, and we find that doing so is therapeutic. Ultimately, we prepare clients for trial by telling them that if there is a legitimate way that their case can be settled for an amount that may not meet their original expectations, but is reasonable under the circumstances, then that will be a better result than having to sit through three weeks of listening to someone disparage them and what they have gone through in a bitterly fought trial—and in a situation where they could lose.

Future Trends and Issues in Medical Malpractice Litigation

Looking ahead, I think we will continue to see a combination of caps and other impingements on the right to sue for full compensation. The limits on what people can collect will continue to lower the number of malpractice cases that are being filed and reduce the amounts that plaintiffs will receive. It is also likely that early resolution of cases through effective "I am sorry" programs will become increasingly popular and effective over the next five to ten years.

I do not think that the new health care legislation—if it is survives a Supreme Court challenge—will force implementation of what has been discussed as health courts or separate courts for medical malpractice litigation; nor do I think that there will be a nationwide cap on malpractice cases as a result of the new health care law. I think doctors' premiums will not rise that much in the future and that insurance companies will become increasingly more aggressive in their defense of malpractice cases.

My advice to other lawyers in this practice area is to be as selective as possible in taking on medical malpractice cases. The mantra in our office is that there is no such thing as an easy case. In fact, if you think a case is easy, do not take it because these cases are never easy. Rather, you should take only those cases

with the largest potential settlement amounts, the most significant damages, and the clearest malpractice. If you start spreading yourself too thin, you will find that even cases you think are easy will be aggressively defended, and that will keep you from spending time on more clear-cut cases.

I still believe people need to hold physicians and hospitals accountable for their actions, and there have been solid studies that show the positive effects of medical malpractice litigation on the delivery of quality of care in the United States and European countries. There will always be emotional arguments advanced mainly by insurance companies that malpractice litigation has driven doctors out of business, but the truth is that premiums are only marginally affected by payouts and that health care has become better, not worse, because of legal accountability. Entire medical society standards and protocols have changed because of malpractice litigation.

For example, twenty years ago, the doctors who were sued most often were anesthesiologists, whether because they administered too much anesthesia or they did not monitor their equipment properly—and sometimes patients did not wake up. Fortunately, the American Society of Anesthesiology decided to do something about that situation. To their credit, they promulgated rules—not just protocols or guidelines—that made clear what you have to do to work as an anesthesiologist at a hospital. As a result, anesthesiologists are now at the bottom of the list of doctors who are sued, and their insurance premiums have gone way down. Similar benefits have been realized by neurologists.

Conclusion

Judges find medical malpractice cases among the most interesting on their dockets. The lawyers on both sides are typically at the top of their games—the issues are fascinating and the stakes high. It is easier to succeed in this field if you have an interest in medicine. I read the *New England Journal of Medicine* every week and keep special topic files on recurrent medical issues. It is only with a good command of the medicine that you can go toe-to-toe with an expert or a defendant at deposition or trial.

Although the field seems saturated with lawyers and subject to all sorts of attacks, it is tremendously fulfilling. We have been lucky to have had wonderful clients who faced the indignities in their lives with strength and grace. It is hard not to learn from those examples.

Key Takeaways

- Establish a solid factual foundation regarding what happened in a medical malpractice case by talking to the client and his family, and obtain the complete medical records regarding the incident and your client. Have someone who is qualified analyze every page of those records.
- Determine at the outset whether the client is an upstanding citizen with demonstrable injuries, and whether any dispositive defenses are available in the case.
- Understand how Medicare or Medicaid payment liens can work to deter settlement. Know how to negotiate and get the government to modify those liens because a lien may be a problem in trying to get the case resolved.
- Prior to a deposition, always conduct a thorough background check of the defendant, and become thoroughly familiar with the most up-to-date medical literature in relation to the issues in the case. Prepare the client for the realities of litigation.
- Establish empathy for your client's condition, and then figure out the best way to demonstrate what that condition entails. It may be a good idea to bring the client or a film to the courtroom for the jury to appreciate the extent of the client's injuries.

Bruce J. Klores is a fellow of both the American College of Trial Lawyers and the International Academy of Trial Lawyers. His firm prosecutes serious medical malpractice cases nationwide. He is a past president of the DC Trial Lawyers Association and the recipient of its Lawyer of the Year Award. He is a former adjunct professor of law and is a frequent writer and presenter on medical malpractice and trial techniques. He has been listed in Best Lawyers in America for more than fifteen years.

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Dedication: *I would like to dedicate the chapter to my wife, Irene, and my twenty-two-year-old twins, Molly and Steven*

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