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## Chapter 9

# Initial Assessment and Medical Research

G. Scott Tyler, M.D. and James C. Dutson, J.D.

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### *Synopsis*

9.1 First Contact with the New Client

9.2 The Intake Interview

9.3 Determination of Negligence

- A. Failure to conform to accepted standards of medical care.
- B. Medical product defective or misused.

9.4 Failure to Inform

9.5 Causation

- A. Was there a cause other than negligence?
- B. Would the results have been the same without negligence?

9.6 The Responsible Entity

- A. Multiple defendants
- B. Hospital liability
  - 1. *Respondeat superior*
  - 2. Independent contractor or actual agent?
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- C. Health maintenance organization (HMO)

9.7 Spoliation

9.8 The Good Samaritan Doctrine

9.9 Statutes of Limitation

Appendix A. Outline of Medical Malpractice Damage and Liability

Appendix B. Recommendations for the Attorney's Personal Office Medical Library

Endnotes

This chapter will discuss client intake and determination of extent of damages, standards of care applicable at the time of the incident, whether breach of these standards occurred, and whether the breach caused the injury (see Appendix A). In much of this, computer-based research is emphasized. Other issues aired are those of informed consent, finding the entity responsible for liability, and how to deal with possible spoliation.

## **9.1 First Contact with the New Client**

To pursue a new case or not is a critical and often difficult decision. Does the attorney turn it down and take the chance of missing out on a good case or does he or she extensively explore a bad case and waste a lot of time? Unless the attorney's plate is already very full, it is probably better to err on the side of at least speaking to the complainant.

The attorney's first contact with the prospective client or his or her family will usually be by phone. Even if another attorney refers the aggrieved party, it is an excellent idea to speak to the prospect by phone as most cases are not worthy of any additional time. If the attorney is returning the prospective client's call, he or she needs to consider doing so in person (unless the attorney has a nurse or other medically experienced paralegal) promptly but at a time when free to listen empathically to what he or she is being told. If it is not possible to return the call by the next working day after it is received, the attorney's secretary should phone with an explanation and a time when the attorney will probably return the call.

The decision to spend more time on the matter is more easily affirmed when it is clear that damages are enough to afford more effort on the attorney's part. Regardless of whether there is liability, monetary loss (lost wages, cost of care, and so on—see Appendix A, item I A) and non-economic damages (pain and suffering, and so forth.—see Appendix A, item I B) must be substantial or there is no reason to go further. Therefore, after letting the caller ventilate on the medical situation that he or she wants so badly to talk about, bridge away to how the incident has affected the victim and family monetarily and emotionally.

If the victim was fully retired, chronically underemployed or disabled before the incident in question, the value of the case may not be great enough to afford further pursuit. However, be aware that the older aggrieved party can have been managing the family fortune from a computer terminal at home. Also, even "geriatric cases" can at times bring high damage awards if the victim is grossly maimed or requires significant medical care. It can be argued that he or she has been robbed of his or her golden years. If the potential plaintiff is a well educated, highly motivated young person that was advancing nicely in his or her career, the value of the case is high.<sup>1</sup>

Ask about the amount of the already billed cost of medical care, both paid by insurance and out-of-pocket. For still-living victims, form some idea of need for future care—full-time medical care facility or nursing at home, ability of the injured party to care for his or her own needs, and so on. Are there further expensive medical procedures and services to be paid? How much of all these needs has come about because of the assumed negligence rather than the result of the person's condition in the absence of negligence?

Although most states allow a jury to consider and award for aggravation of a preexisting condition, such medical causation issues are difficult and confusing for juries and even medical experts. Many medical malpractice cases are litigated and lost on the issue of causation even when liability (standard of care) and damages are well established.

The attorney may want to reach a preliminary conclusion about the emotional aspects of the injury. How much pain and suffering is there? How are family companionship, affection, household duties, and sexual relations (all subsumed under "consortium") affected? Is the victim's ability to experience pleasure diminished due to impairment of normal activities of daily living (hedonic losses)? It is helpful to make a list of activities the victim could do before the malpractice but cannot do now because of the malpractice. How much emotional pain is the potential plaintiff experiencing due to his or her inability to lead a physically active normal life? How much distress, especially in young females, does disfigurement cause?

If another attorney has already reviewed the case in some detail, ask why this attorney turned the case down. Then, with the aid of the caller, try acquiring enough detail on just those few points to check the other attorney's judgment not to carry on with the situation.

When the attorney decides based on damages that there is not a case, he or she should be prepared with the names and phone numbers of a couple of other attorneys to give the caller. Also the attorney should have on hand telephone numbers for the state licensing boards (M.D., D.O., and RN) to give when all the party wants is to teach the medical provider a lesson or to see the same thing does not happen to someone else. If there is a referring party, phone or drop a note to this person regardless of the attorney's initial impression.

When the attorney decides that the damages are possibly enough to warrant further exploration, he or she will concentrate more on the question of negligence or breaches in standards of care. If a few minutes more conversation does not turn up facts against continuing the screening process, it is probably more efficient in the end to interview the victim or family in person.

## **9.2 The Intake Interview**

If the attorney decides to interview the client-to-be in person (which should be done whenever possible), have him or her bring any records, including medical bills, photographs, diaries of the client or the client's family, and so on, in his or her possession. The attorney may wish to delay long enough to have the prospect pick up record copies from the doctor or hospital. Such records will not be complete, but they are very helpful for preliminary assessment—and at small cost and effort. This strategy also avoids the doctors learning that a malpractice attorney is reviewing a case against them, which may put them in a defensive mode early on. The victim or the victim's family should be cautioned to make any notes separate from the records themselves so as to avoid confusion as the originator of notations handwritten on what is to become the legal file. If another lawyer has already gathered records, the attorney will want to get these, of course.

For this initial interview, try to limit the number of interviewees to two, or at most three, individuals. To be totally outnumbered by a room full of family adds unnecessary confusion. Even with three people, have them agree among themselves who will be primary spokesperson for immediate matters and for the attorney to contact in the future with need for additional information—and to relay messages to the rest of the family. If additional family members or friends have more to add, or could be witnesses, they can be contacted separately later by the attorney or staff.

Having outlined and digested the negligence aspects of the potential case through the informants and incomplete records (see Chapter 5 for guidance in reviewing records), it is time to crack open the books and log on to the computer.

### 9.3 Determination of Negligence

Examples, difficult ones, are used to illustrate how medical information on standards of care and other medical issues can be found. These examples are teased from cases on which the authoring medical consultant has worked but with the license to change, combine, or omit identifying information.

Emphasis is placed here on use of the Internet for medical information. There is a nearly endless, ever-increasing amount of medical information on the net including access to medical textbooks. A problem with the net is that for the practice of medical liability law it can be too current—it covers the newest texts not the standards of practice current a couple of years before when the violation of standards occurred. Thus it is still necessary occasionally to have access to hard copy medical texts (see Appendix B). If the law practice is near a medical school library, or there is unlimited access to the library of a large hospital, the attorney can probably get by without owning much hard copy. One trick is to use the Net to purchase used copies of recently superseded text books only at the time they are needed.

Another problem with the Internet textbooks is that they cannot be scanned as readily as hard copy. With hard copy the reader can find the chapter on the subject and scan for what is interesting whereas the same chapter on the net is sectioned off and fractionalized. Contrariwise, the Net highlights the search term selected and the finder can be used for still further refinement of terms sought.

In using specific case examples, on the one hand, it is impossible to anticipate all of the reader's needs in the matter he or she is researching. On the other hand, Internet resources are constantly expanding so it behooves the reader to be ever alert for sources not cited here.<sup>2</sup>

#### **A. Failure to conform to accepted standards of medical care.**

The first theoretical case is that of an attorney colleague who phones about a workers' compensation client of hers. There was a bad outcome of osteopathic manipulation of a pinched low cervical spinal nerve root.

The referring attorney feels that injections given by the osteopathic physician led to clogging of arteries in the same hand in which the nerve was pinched; he had talked to a physician who conjectured that medication had unintentionally been given into the artery. While the theory

seemed unlikely, records, including statements from the claimant, were readily available so the attorney agreed to look at them. Review of the file revealed that, as had been done on three prior occasions, the osteopath had the nurse give an injection in an unrecorded (and unremembered by the claimant) place of an unrecorded amount of Robaxin® (orphenadrine, 3M Pharmaceuticals) followed by injections in or near the midline of the spine of Kenalog® (triamcinolone, Bristol-Myers Squibb Company) and lidocaine. This was followed by osteopathic manipulation treatment. Within the next few hours the hand pain became much worse and the hand turned blue for the first time. Clogging of both arteries at the wrist level was eventually diagnosed but not until death and decay of several fingers had occurred requiring their amputation.

Approach to this matter can be divided into two aspects: anatomic and chemical. Is it physically possible for the healthcare giver to insert a needle from the site of injection into the artery going to the hand? If so, is the medication if injected into a blood vessel of a chemical nature that will initiate blood clotting in the artery?

The first question is one of applied anatomy. Where are injections of medications such as orphenadrine given? By common experience, most people know “shots” are given in the upper arm or the buttocks. But are there other places they can be given? While the objective of this chapter is to show how information can be obtained over the Internet, this first example search emphasizes the need of the attorney to develop a different type of net—a network of contacts with physicians, nurses and other healthcare professionals. There is no place on the Internet, or even in medical textbooks, showing how injections are given. The sole alternative to phoning some knowledgeable professional is to visit the medical library. It took twenty minutes (not including transportation) to find the nursing texts’ code number and to stand at the rack opening indexes more or less at random. It was the sixth book<sup>3</sup> that contained illustrated instructions of “preferred sites” for giving such injections—with no statement that they were never to be given elsewhere.

Thus it was confirmed that there are three places where an orphenadrine injection might be given. Only one of these, an injection into the shoulder (deltoid) muscle on the critical side, is even remotely near the blood vessel to the hand. A close look at and feeling around on the attorney’s own body to find the pulsating “pressure point” (artery) in the

inner aspect of the upper arm shows that a needle inserted into the deltoid must be at least four inches long to pass through bone to get to the artery.

Common experience would be expected to give no clue as to the second type of shots, termed “trigger point injections,” given very near the spine low down in the neck and upper shoulder region. Again this type of basic applied anatomy requires networking or a bit more searching text-books on physical medicine. Once the term is defined (as an injection of an anesthetic and, sometimes of a cortisone, into a localized tender point in a muscle) a look at an anatomy book (see Figure 9.2) reveals there are no blood vessels from the back of the lower neck, where the lidocaine was given, to the arm. For blood or chemicals to get from the neck to the arm they would have to pass to the heart and from there in a diluted state to the whole body. A look at the pharmacology text shows Kenalog is a cortisone; cortisone in its varying forms is used by nearly every conceivable route, including by vein. This clears it of properties that might initiate blood clotting (a really close look reveals that is not used through arteries so its specific effect is unknowable). Lidocaine is also prepared in many forms including that used by vein to slow abnormal heart action. Thus, it is not possible to inject either triamcinolone or lidocaine from the back of the neck into the vessel to the arm nor would they cause clotting if so injected.

Despite such seeming physical impossibility of any intra-arterial injection, the attorney decided to have his consultant cover all bases by looking up chemical information on orphenadrine. A look at the pharmacology text or *PDR* reveals it is a muscle relaxant with no medical indication for it to be injected into blood vessels.

The attorney decided to see if there is anything in the medical literature about intravascular injection of orphenadrine. This was done using the Internet GratefulMed program of the National Library of Medicine that has been superseded by the current Entrez-PubMed system. (See below for details of use of this system.) This confirmed that there has never been a report in the world medical literature since at least 1966 of intravascular orphenadrine injection. If the attorney wishes to check even further, he or she can phone the 3M pharmaceutical company at the 800 or 888 number listed in the first white page section of the *PDR*, ask for a pharmacist and ask if the company is aware of such an occurrence. The company pharmacist will possibly, but not necessarily, fax the attorney an

FDA MEDWATCH form (one is included as the last page in the *PDR*) for the attorney to complete and fax back while the pharmacist is checking the literature and asking around the department. The pharmacist, in this case, will return with the fact that they have never heard of any case of intravascular injection of orphenadrine.

Thus, after this multifaceted search, the attorney had no physical or chemical grounds for pursuing this element of the case.

### **B. Medical product defective or misused.**

The example case for this section is selected because of the medical consultant's frustration over not finding adequate information on the computer. The search was done in mid-1996 using the GratefulMed software connected to the National Library of Medicine by phone. For this book, the search was repeated using the Internet GratefulMed source and other facilities as indicated.

A thirty-four-year-old suffered a second fracture of the larger bone of the leg. The first fracture had required temporary use of a metal plate and screws. This severe injury and the subsequent surgery caused more-than-usual bony overgrowth (callus) at the fracture site. To treat the second fracture in March 1993 the doctor decided to place a long pin (a Synthes™ intramedullary nail) down the relatively soft center of the bone leaving the hard outer bone and covering muscles and skin untouched.

To place the nail the surgeon had to drill out the center of the bone resulting in a hole thirteen inches long. When the drill reached the overgrowth, the operative report states that tissues around it became heated resulting in a skin blister over the old fracture site. Over the next five weeks the skin and muscle, which were originally intact, over the fracture site opened up exposing the metal nail. This demanded another operation to try to cover the wound with transplanted muscle. After prolonged medical care and patient suffering the leg was amputated.

Cooking the patient does not meet standards of medical care. Even a brain surgeon knows that! But how common is such an injury? At the time of the incident was use of the nail part of premarketing testing and FDA certification? If so, was the company sales representative in the operating room? What were the hospital's requirements regarding outsiders in the operating suite? Where (a medical convention, manufacturer sponsored symposium or so forth) did the doctor receive her training in the use of the

reamer and nail? How familiar was the surgeon with the manual for the equipment? Was the surgeon inexperienced with all the equipment or under some other pressure causing him to misuse the reamer? Was the nail used for its intended purpose? Review of the medical literature will answer only some of these questions. (As a multifaceted tutorial exercise this example search will begin with terminology the attorney might pick up from the medical file but that does not correspond to the PubMed's thesaurus (index or "controlled vocabulary") to show how to find effective terminology.)

- To check literature on burns in medullary reaming in the time period of interest, opened **PubMed** ([www.ncbi.nlm.nih.gov/entrez/query.fcgi](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi)) and clicked, in the left upper corner, **Limits**.
- At the bottom of the page, at the **Publication Date**, entered the **To** date as that of the date of the operation.
- Left everything else untouched and near the left upper corner in **Search PubMed** entered intramedullary reaming AND burns.
- Clicked on **Go** and noted there to be only one posting, this in German without an abstract.
- Judging this an unsatisfactory finding, further check seemed necessary.
- In the sidebar to the left clicked on **MeSH Database**.
- In what was then in the **Search MeSH for** entered just burns and clicked on **Go**.
- Noted that there were five subdivisions the last four of which obviously did not apply here.
- Clicked on **1: Burns** to find a plethora of subheadings, only one of which was relevant.
- Checked the box **surgery** and, at the top of the page, on **Go to** brought up **Burns/surgery[MeSH]**.
- Clicked **Search PubMed** to find record of thousands of articles, far too many to work with (note that it is not possible to activate limits of publication dates). Abandoned that approach.
- Checked the accuracy of use of the MeSH vocabulary by backspacing to the German language article and, in the right upper corner, clicking on **Related Articles**. This brought up many refer-

ences, mostly foreign language or without abstracts, until reaching a cadaver study titled “Heat of Intramedullary Reaming.”

- Opened this article to **Citation** and looked at **MAIN MESH HEADINGS** revealing the accepted indexing to be **Fracture Fixation, Intramedullary/\*adverse effects and Heat/\*adverse effects**.
- Went back to **Search** for and very carefully saved and pasted in these two headings. This still showed only the same relevant reference leading to the conclusion that this type of injury must be very unusual. Printed a copy of the abstract.

A check with the Food and Drug Administration, Center for Devices revealed records on two devices, a “universal tibial nail and unreamed tibial nail,” released thirteen months before it was used in the case under discussion. Thus, the device was newly on the market, tending to support the theory that the surgeon might not have been experienced in its use and even that the company representative might have been at hand in the surgical suite. This information adds fuel to the fire.

Frustration with a lack of information in this instance is somewhat relieved by noting that, if PubMed is currently opened with using Limits, there is a little more information now than there was at the time of the original search about overheating with intramedullary reaming.

## 9.4 Failure to Inform

Old common law allowed a patient to bring an action against a doctor for battery, if a doctor operated on that patient without consent (except in emergencies). Most states have abrogated strict liability for battery as a cause of action but have instead retained or developed the doctrine of negligent failure to disclose or inform. The following elements of this theory of lack of informed consent are typically found in most states:<sup>5</sup>

- the existence of a material and reasonably foreseeable risk unknown to the patient,
- a failure of the physician to inform the plaintiff of that risk,
- that disclosure of the risk would have led a reasonable patient in the plaintiff’s position to reject the medical procedure or choose a different course of treatment, and

- a causal connection between the failure to inform the plaintiff of the risk and the injury resulting from the occurrence of the nondisclosed risk.

Informed consent is rarely alleged as a sole theory of liability but as an additional theory (to add fuel to the fire) along with other strong negligence theories. The reason for this is the third element listed above. A plaintiff must not only prove that he or she *subjectively* would not have agreed to the medical procedure or treatment had he or she been properly informed, he or she must also prove *objectively* that no reasonable patient would have consented. The fact is that most reasonable patients agree to whatever their doctors recommend. This should be kept in mind during the initial review of a case. Only the most sympathetic and heavily maimed clients would seem to warrant a medical malpractice case based on informed consent alone. However, most medical malpractice cases have more than one claim of negligence, informed consent often being one.

Some doctors mistakenly believe that simply stating a few worst-case risks obviates the need for more precise information about lesser but more common risks. Some doctors also fail to customize their informed consent to the needs of an individual patient. For example, if a doctor knew that a patient's particular subgroup involved a higher complication rate than the general patient population, then informing that patient of a blended or overall complication rate would be misleading. To illustrate, there can be a 5-percent complication rate of nighttime glare with blepharoplasty overall, but that rate can rise to as high as 40 percent when the particular patient's pupils in a controlled environment measure eight millimeters or greater.

Informed consent need not be in writing. The discussion between the doctor and patient is the informed consent and the writing is merely some evidence of it. Forseeably, this often creates disputes in testimony between the patient and the doctor, which a plaintiff's attorney usually tries to avoid.

As with other claims of negligence, expert testimony should be obtained, and is often required, for such elements of informed consent as the materiality or extent of the risk, the content of the informed consent, and causation.

The obligation to obtain informed consent rests with the health provider who provides the care. Thus it is the surgeon and not the hospital who has the duty to inform the patient of the risks of an operation that the surgeon performs at the hospital. However, the hospital may have duties to inform a patient of risks regarding pre- or postoperative procedures or treatments performed by its employees or agents.

A doctor is not required to inform a patient of every conceivable risk. Rather a patient should be advised of the seriousness of the ailment, the general nature and risks of the proposed treatment, the prospects of success, the risks of failing to undergo the recommended treatment, the availability and risks of alternate treatments, and, when applicable, any experimental aspects of the treatment.

## **9.5 Causation**

### **A. Was there a cause other than negligence?**

A woman in her late forties had a hysterectomy through a traditional lower abdominal incision (an “abdominal hysterectomy” in distinction from vaginal or laparoscopic procedure). The surgeon noted in a “quick surveillance” large amounts of abnormal fibrous webs (adhesions) in the upper abdominal cavity. At the end of surgery the bowel was replaced in the abdomen without further note. In the next five days the patient, who was a nurse, felt the doctors ignored her complaints of pain. She vomited bile and had normal bowel movements. On reoperation on the sixth day a small bowel segment was found kinked between the abdominal wall and the fatty interabdominal apron (the omentum).

At the time the attorney asked for a medical legal opinion a petition for damages had already been drafted. The consultant agreed there was no means by which the bowel could have climbed up by itself into the place it was found and that he knew of no way to check medical literature on the matter. The consultant felt an expert general surgeon to be appropriate and proceeded to locate such a physician.

Several weeks later the attorney reported that the expert had found no violation of standards of care. The attorney had already talked to a couple of other surgeons with the same result. The consultant proceeded to speak with three more friends or prospective experts and could find no one who agreed with the hypothesis that the surgeon had been negligent in failing

to replace the bowel into its normal position; they did not offer another explanation.

The consultant learned (1) that logic does not always apply to medical matters, (2) not to hastily shoot off his mouth about things of which he or she has no proof, (3) not to agree too readily with the attorney who has obviously already made up his mind, and (4) how valuable it is to have one or more friends in all medical specialties of whom one may ask dumb questions.

### **B. Would the results have been the same without negligence?**

A man in his early forties visited the emergency room just before midnight complaining of abdominal pain. A CT of the abdomen was interpreted as negative (the radiologist subsequently acknowledged that the lesion was at the edge of the area studied and he or she simply missed it), and the patient was admitted to the intensive care unit. As instructed, the nurse phoned the family doctor on call who told the nurse he would see the patient in the morning. In the morning the patient's red blood cell indexes had dropped, and the family doctor requested a surgical consultation. Despite the nurse's repeated calls, it took the surgeon three hours to complete ongoing surgeries and to get around to seeing the patient. There was more delay getting the patient scheduled into the operating room. He died on the operating table of his ruptured dissecting abdominal aortic aneurysm.

There is no question of both collective and individual negligence in the misinterpretation of the CT scan and the delay in diagnosis and treatment. The attorney recognizes that the most likely defense, at least regarding the delay, will be that, even if treatment had been prompt, the outcome of this innately very disastrous condition would still have been death.

How readily can this argument be defeated? What is the death rate in persons with dissecting abdominal aortic aneurysms? This is a hortative example of the system learned by trial and error such as a person with limited medical knowledge might use. For an attorney or a paralegal intending for the first time to use the National Library of Medicine (NLM) web site, spending several hours on the following example (including time to "surf" the site away from the actual exercise itself) will be an excellent start, but only a start, on obtaining information on "real" cases he or she is working.

- As in Section 2.3B, open **Entrez PubMed** ([www.ncbi.nlm.nih.gov/entrez/query.fcgi](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi)).
- In the upper left-of-center part of page at **Search PubMed** for enter dissecting abdominal aortic aneurysm.
- Click on **Go**.
- Click near the right upper corner of the page to **Details** to check spelling and see that the system has reasonably translated your entry.
- To the left of the same line as **Details**, open **Limits**.
- In order to confine the search to a time interval eliminating outdated medical knowledge (ten to fifteen years before the questionable action in an actively evolving field such as vascular surgery) and changes in the field subsequent to the surgical event in question, to the left lower in the **Limits** page, enter suitable dates.
- Click on **Go** again to bring up several hundred references (care must be taken to use good English as entering dissecting aortic abdominal aneurysm results in the system dropping the word **aortic** and doubling the number of references).
- Since screening all of these the several hundred references is difficult most of them must be eliminated if possible. So far in the search the factor of death has not been a part. But, what terminology is best in using PubMed? Is it death? Prevalence of death? Mortality rate? Survival rate? Or what?
- To the left of center of the screen, pull down on at **Summary to Citation** and click **Display**.
- Page down on each citation to the **MeSH Terms** and survey them. Within the first handful of citations the term **Fatal Outcome** is listed as a MeSH term—a word or phrase found in the system’s “index.”
- At the top of the page at **dissecting abdominal aortic aneurysm** add AND fatal outcome and click on **Go** to bring up a very manageable number of references. Note that **Citation** has been automatically changed back to **Summary**.
- Page down through the summaries to find an article “Aortic Dissection after Trauma: Case Report and Review of the Literature” that is near but not quite on the mark for needs here. None of the

other articles seem of any interest. So further effort to answer the question is required.

- Go back to the opening PubMed window and enter dissecting abdominal aortic aneurysm.
- Instead of using the MeSH term AND fatal outcome try entering AND mortality, a Text Word, added to dissecting abdominal aortic aneurysm.
- Click **Go** to bring up a sizable number of references.
- Surf through these titles. A chronicle of ten pages is found and opened, reporting on a limited number (to be statistically valid it takes hundreds or thousands of cases, which will never be possible in this condition) of patients. This paper from an outstanding American institution reports a 17-percent fatality rate in acute dissecting abdominal aortic aneurysm cases. This report is not found by search under the MeSH **AND Fatal Outcome**.
- Print a copy of the summary.

Of considerable interest in this search is that the strictly human actions of some persons at the NLM in choice of indexing options have made it necessary to do two entirely different searches—i.e., use of MeSH Term **AND Fatal Outcome** as opposed to the Text Word **AND Mortality**. The source of the problem may lie in the interpretation of meaning of the word mortality, but logic would seem to rule that these would be cross-indexed.

## 9.6 The Responsible Entity

### A. Multiple defendants

There are some that have advocated the shotgun approach: suing everyone involved, hoping some will settle, even for a small amount, whether truly liable or not. The theory is to “shake the tree and see what falls out.” The authors submit that this is not only questionable from a professional and ethical standpoint, but it is usually counterproductive and can even be suicidal for your case.

Rule 11 and good practice requires a thorough investigation, which should include a narrowing of claims and potential defendants, before the suit is filed. There are other beneficial reasons to do so. It is usually advantageous to a plaintiff to simplify a case to its strongest elements as

much as possible, which will make it easier to convince a jury. The fewer the defendants, each of which will have his or her own separate attorney and expert witnesses, the less the logistical problems, expenses, multiple cross-examinations of your witnesses, and jury confusions.

It is difficult enough to convince a jury that one doctor committed malpractice. It is much more difficult to convince a jury that multiple health providers could have made the same mistake. Also if a plaintiff loses in the eyes of a jury regarding peripheral defendants or issues, it tends to weaken the credibility for the entire case. Of course there are many instances when multiple defendants must legitimately be named. For example, the plaintiff must not leave an “empty chair” at which the defense is able to point—a party not cited as a defendant but who the defense may claim is the tort-feasor rather than the defendant in the adverse medical outcome. When unavoidably faced with multiple defendants they may hopefully be played off one against the others, each accusing one or more of their codefendants of poor judgment or skill, thus weakening the general defense.

## **B. Hospital liability**

### **1. *Respondeat superior***

Whenever it is clear that the negligent person was an employer or agent of the hospital, it is better practice to sue the hospital and not the individual. Besides avoiding an extra defense attorney (as discussed above), jurors will have an easier time awarding damages against a corporate entity than, for example, a sympathetic looking nurse. The hospital will be vicariously responsible for the acts of its employees or other agents under the well-established doctrine of *respondeat superior*.

### **2. Independent contractor or actual agent?**

Hospitals typically have written independent contracts or policies with in-house physicians, such as anesthesiologists, radiologists, intensivists, and emergency department doctors. Hospitals also frequently claim independent contractor status for lab or x-ray technicians and similar workers. The law in most states indicates that labeling such people or entities as independent contractors does not necessarily make them such. If the hospital exercises significant control over a person, he or she may be found to be an employee or agent, regardless of any written policy or inde-

pendent contract. Doctors, such as internists, surgeons and various specialists, that have separate offices and mere staff privileges to see their patients at the hospital are usually not agents of the hospital.

### **3. Ostensible agency**

Even if there is not sufficient control by the hospital to rise to the level of actual agency, the hospital could be found responsible for a person's acts under the doctrine of apparent authority or ostensible agency. That can occur when a patient, or the public in general, could reasonably conclude that the person was an agent of the hospital with authority to act for the hospital. This could be based on either intentional or negligent representations by the hospital.

A good example of the factors the courts will apply in determining ostensible agency, is found in an Arizona case.<sup>6</sup> In finding that a radiologist was an agent of the hospital, the court pointed out three factors: (1) the patient had no choice over which radiologist would provide services; (2) the radiologist's service was an inherent function of the hospital; and (3) the hospital provided all facilities, instrumentalities, and administrative services for the radiology department.

### **4. Hospital's own negligence**

All of the above paragraphs are based on a hospital's vicarious liability for the negligent acts of others. In a few less-common cases, however, a hospital could breach its own nondelegable duty or be responsible for its own acts of negligence. Such direct failures could include lack of proper or safe equipment or facilities; lack of policies, procedures, or other guidelines; or failure reasonably to select, review, or retain its medical staff. An expert in hospital administration would usually be required or recommended in such cases.

## **C. Health maintenance organization (HMO)**

The same laws and theories discussed above for hospitals will, in most cases, apply to HMOs. However, besides being a health provider, an HMO is also an insurer. In some instances an HMO will argue that its alleged failure to provide needed medical care is an insurance coverage issue and not a medical malpractice issue. The HMO may further argue federal preemption of the issue under the Federal ERISA statute if it is a large

employer-sponsored plan. Care must be taken when drafting the complaint to keep the allegations in the context of pure medical negligence and away from breach of contract language. It also is essential to keep abreast of ongoing court rulings on HMO matters, such as those of the Supreme Court recently, at the time of this writing, in the Texas cases.

## **9.7 Spoliation**

If a plaintiff can prove that a defendant had intentionally altered a medical record in a defensive way, it can inflame a jury against that defendant. However, though often suspected, spoliation can seldom be proven.

Usually when a hospital receives a request from an attorney for medical records, it will contact the key physicians involved to review the chart before it is produced. Any later additions, deletions, or cross-outs in records are supposed to be clearly indicated as changes, dated and initialed. However, the temptation is great to change the record without showing it was changed.

It is suggested that clients obtain records themselves early on, well before the attorney obtains them. Then the attorney should carefully compare the two copies. It is also suggested that the original chart be inspected at the hospital, to compare it with all prior copies, and to look carefully for inconsistencies in handwriting, ink color, dates, page order, blank spaces, and so on. If a suspicious change is found, a color copy of that record should be requested. If a suspected change is important to the case a document expert could be retained to examine the original document.

## **9.8 The Good Samaritan Doctrine**

Most states apply what is called the good samaritan doctrine, usually by statute. If the defendant healthcare provider rendered aid to a client in an emergency (life-threatening) situation, the plaintiff may have to prove gross negligence. The requirements to qualify as a true good samaritan usually include (1) no preexisting duty to treat the patient, (2) the emergency was not created by the healthcare provider, (3) the healthcare provider's normal job is not to respond to such emergencies, and (4) the aid was rendered gratuitously (in most states).

A few states have also passed a similar statute for obstetric patients. In those states if the doctor has no knowledge of the patient's prenatal care and assists with an emergency delivery, gross negligence would have to

be proved even if the doctor bills for his or her services. Knowledge of prenatal care would have to be more than what he learned from the patient at delivery time. It would include his or her own involvement with the patient prenatally, a view of the actual prenatal records, or a discussion with the prenatal physician.

### 9.9 Statutes of Limitation

Many states have a different statute of limitation for malpractice actions from other types of personal injury actions. There may be even a different statute of limitations for a minor injured by medical malpractice. If a person dies because of medical malpractice, some states determine that the time begins to run from the date of injury and other states start the time from the moment of death. Other states have a different limitation period for injury than for death. Many states apply some or all of the following rules to toll, or delay, the running of the statute of limitation.

- **discovery rule.** A person could not reasonably have discovered the injury sooner.
- **foreign object rule.** Object left inside the patient by the doctor until discovered or removed.
- **continuing treatment rule.** The doctor continued to treat and reassure the patient for a time after the negligence or injury.
- **infancy rule.** The statute does not begin to run until the patient reaches the age of majority, usually eighteen.
- **incapacity or incompetency rule.** The statute does not run during any time the patient is mentally incapacitated or is mentally incompetent.
- **fraudulent concealment rule.** The doctor does not fully inform the patient of facts known to the doctor, which would make a reasonable person suspect malpractice.

Any attorney reviewing a potential medical malpractice case must become fully aware of the laws of the state where the case will be tried (usually where the malpractice occurred) and also fully aware of the facts of the case to be able to determine which statute or tolling rule may apply to that specific case. To fail to do so may cause the attorney to become a de-

pendant in his or her own malpractice lawsuit based on the most common cause of legal malpractice: a missed or mistaken statute of limitation.

## **Appendix A**

### **Outline of Medical Malpractice Damage and Liability**

#### I. DAMAGES

##### A. economic

- loss of income
- medical costs
- cost of continued care

##### B. noneconomic

- pain and suffering
- consortium (if spouse is faithful)
- hedonic
- stress from continuing disability
- disfigurement
- inconvenience
- physical impairment

#### II. LIABILITY

##### A. negligence (failure to meet standards of care by affirmative actions or by acts of omission)

##### 1. below standards of care (to assess standards of care, failure rates of a treatment or operation must be determined through review of medical literature and opinion of experts)

##### a. on part of care giver per se

- “loss of opportunity” or “last clear chance” to make a correct, timely diagnosis, esp. in death cases

- failure to obtain consultation

- failure to adequately treat pain

- failure to obtain informed consent or informed refusal

- failure to inform regarding medically appropriate treatment because treatments not covered by health plan (i.e., undisclosed financial incentive to minimize care)

##### b. product defect

##### c. product misuse

##### 2. failure to inform (as a rule of thumb, if the failure rates of a treatment or operation are less than 0.5 percent the patient

need not be informed of the possible complication, alternative, etc.)

complications not explained

alternatives not explained

misinformation re surgeon's experience with procedure

off-label use of medical devices

negligent misrepresentation

failure to explain genetic tests with implications for their children

3. Failure to acknowledge report(s) of error and to learn from it (them)

B. entity responsible?

healthcare provider

managed health care provider

did referring doctor or institution know healthcare provider was incompetent

corporate or institutional negligence in credentialing

C. spoliation present

D. unfair or deceptive trade practices

E. when medical research involved, was Institutional Review Board properly constituted and protocols followed (including consent, and so on)?

F. especially for psychiatrist and psychologists, was there failure to inform of threatening behavior  
alienation of affection  
creation of false memory

G. battery (touched without consent)

H. refusal to agree to withdraw life support

I. unauthorized disclosure of confidential information

J. missed or unreported child abuse

- K. failure to have translator present (not malpractice but DHHS-OCR requirement for reimbursement by Medicaid, State Children's Health Insurance Program and Ten Assistance to Needy Families program)
- L. mental anguish over fetal loss
- M. broke specific promises (not malpractice but breach of contract)
- N. inference of negligence: failure to dictate note on surgery with poor outcome

### III. CAUSATION

- A. Is there a cause other than negligence including unavoidable treatment of condition (i.e., A leads to worsening of B)?
- B. Would the result have been the same without negligence?
- C. With devices, does FDA clearance of product protect against suit?
- D. With medications does presence of "informed intermediary" protect manufacturer?
- E. Is someone else liable, such as the nurse who is the hospital's agent?

### IV. MITIGATING ISSUES

- A. lifestyle or attitude of plaintiff
  - plaintiff has outlived his or her life expectancy, not earning money, and so on
  - drug abuse, extreme obesity, minority culture, language or religion
  - contributory negligence by plaintiff or parents
  - refusal to accept recommended treatment
  - appearance of family untrustworthy to wisely use award

plaintiff accepted unnecessary risks  
family overwhelmed by additional child (in wrongful conception cases)

- B. qualities of either expert  
has advertised, frequently testified as expert or makes living as expert  
has “problems” at licensing board, DEA, personal malpractice suits, hospital PR
- C. qualities of defendant  
ol’ Doc, so lofty in community to be above reproach  
high-flown academic, beyond question but cold  
acted alone (i.e., individual issues more difficult than if collective)
- D. qualities of plaintiff’s expert  
local doctor appeals to jury’s liking but is prone to late withdrawal or minimization  
expert has no track record to check, does not know rules “of the game” and/or may be disaster on stand
- E. injuries too catastrophic  
“wrong” purpose, e.g., to satisfy family greed of award in wrongful death  
so much brain damage plaintiff not appreciate damages done

## **Appendix B**

### **Recommendations for the Attorney's Personal Office Medical Library**

The level of what the attorney chooses to purchase for his or her library will depend on what investment can be afforded, how convenient it is to get to a medical school, law school, county medical society, or superior courthouse libraries and orientation of the chosen law practice—and on what she or he can borrow from a suite neighbor. It is not necessary to be the first to buy each new edition of any given textbook: the attorney is not interested in the newest trends but in what the state of the art was at the time the unforeseen event took place a year or two before.

#### **Level One**

The *Merck Manual of Diagnosis and Therapy* (Whitehouse Station, NJ: Merck Research Laboratories, 1999)

Comment. A doctor never quotes the *Merck Manual* to another doctor; to do so would be playing the fool. At least until the recent past physicians considered the *Manual* to be trite and trivial. But for the nonphysician the *Merck Manual* is the source of first-attempt for nearly everything in medicine. The *Manual* is available off and on the web but, when it becomes out of date, the company pulls it off the web for months pending publication of the next hard-copy edition. Also, the web version is somewhat difficult to use as it shows only one subsection at a time on a given subject. However, the computer's ability to link to additional subjects can be helpful.

#### **Level Two**

A. *Gray's Anatomy* (Edinburgh; New York: Churchill Livingstone, 1995) is the perpetual, classic reference, but the attorney may find *Anthony's Textbook of Anatomy and Physiology* (St. Louis: Mosby, 2003) easier to read.

Comment. Pick up a used copy. Knowledge of anatomy does change so rapidly that the attorney needs to have the newest edition.

B. A textbook of internal medicine

Comment. The doctor may prefer *Harrison's Principles of Internal Medicine* (NY: McGraw-Hill, 2001) for its detailed presentation. The attorney may find Cecil textbook of medicine (Philadelphia: W.B. Saunders, 2000) more readable.

C. A pharmacologic text

Comment. A pharmacologic text such as Goodman and Gilman's *Pharmacological Basis of Therapeutics* (New York: McGraw-Hill, 2001) discusses drugs as a group more than does the *PDR (Physicians Desk Reference)*; Montvale, NJ: Medical Economics Company) or similar material available on the web. A text also includes older off-patent drugs no longer included in the *PDR*. Especially here, a "used" edition will do quite nicely.

D. A one- and two-year-old *PDR*

Comment. A current *PDR* is not recommended; there are sources on the web with the newest information on drugs. What the attorney needs is the old copy the public library throws out every January showing the latest information at the time the medical misadventure took place.

**Level Three**

A. An orthopedic text such as *Campbell's Operative Orthopaedics* (St. Louis: Mosby, 2003)

B. An obstetrical or gynecological text such as *Williams Obstetrics* (NY: McGraw-Hill, 2001)

**Level Four**

Only if the attorney has no nearby medical library will texts of this level be necessary. Purchase on an as-needed basis is to be considered. Listing is in order of decreasing necessity.

A. Neurology and psychiatric

B. Medical subspecialties: Cardiology and so forth

C. Nursing

D. Emergency or critical-care medicine

E. Pediatrics

F. Radiology and other imaging

G. Surgical subspecialties: cardiac or vascular, urology, plastic, otolaryngology, etc.

H. Pain management such as *Myofascial Pain and Dysfunction* (Philadelphia: Lippincott, Williams & Wilkins, 1998)

I. Anaesthesia