Determining When Your Medical Malpractice Case Has Merit

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To accept or reject a medical negligence case: this is the single most important decision you will make when processing a medical negligence case. If you choose unwisely, either a case with good potential will be lost, or an unmeritorious case will tie you up for long periods of time at great expense.

To make an informed decision about accepting a case, you must have the facts, not only those you obtain from your client, but more importantly, those obtained from qualified medical experts after a thorough review of the medical records.

It is not enough to have medical records reviewed by just anyone. Medical records should be screened by those specially capable of understanding and identifying all medical-legal issues. These individuals should be experienced in medical-legal analysis and board-certified in the medical specialty where the alleged negligence occurred. Even better, the medical records can be reviewed in a collaborative setting, where the records are screened by one board-certified physician who then confers with other medical specialists to form consensus opinions.

Lesser levels of analysis including reviews by nurses, retired physicians who are unaware of the latest advances in their fields, uncertified medical generalists, and medical students and residents will often be incomplete, inaccurate, or misleading. It is generally a mistake to rely on opinions or conclusions obtained this way. The medical issues are often complex and do not lend themselves to simple or straightforward analysis.

It has been said that a little knowledge can be dangerous. Nowhere is this more obvious than in medical negligence case analysis. The quality , credibility, and scope of the record analysis will only be as good as the reviewing individual(s). Bottom line: Choose reviewers wisely; pay appropriately. Typical costs for detailed initial case screening average $500 to $1000 depending on the size of medical records, complexity of the case, and the specialty of the reviewing physician.

Cases that are deemed provisionally meritorious should be sent for a second review by medical experts identified by the screening physicians, who are prepared to give oral testimony if called upon. Careful attention should be given to determining who the medical experts should be. Ideally, a physician consultant experienced in medical-legal matters should assist you in the identification of the appropriate medical specialists. This person can "talk shop" with the potential expert and be in a better position to decide whether any given medical expert is the right person for the case. By analogy, you, as an attorney, would be in a much better position than a layperson to

recommend another reputable and successful attorney in a specific legal specialty area. Thus, it makes good sense to establish a relationship with a physician consultant experienced in medical-legal case analysis.

Two objective case analyses are touted by many seasoned medical malpractice litigators as the judicious approach to working up a potential case. When the two reviews are in concordance, you will be on solid footing and well on your way to maximizing your chances for a successful outcome. If there is a discrepancy between the two reviews, then it will be easier for you to understand the weaknesses of your case. The knowledge you attain in this way will help you to decide whether you want to drop, or stay with the case. The costs for the in-depth medical expert record review and analysis should be in the neighborhood of $1000 to $2000 per medical expert; again depending on the volume of records, complexity of the case, and the specialty of the medical expert doing the record review.

Case review is both a science and an art. The physician reviewer must be adroit at dissecting out the critical facts and determining whether or not the appropriate standards of practice were breached. Moreover, the reviewer must decide whether issues of causation clearly reinforce any alleged departures from the standard of care. Attention must also be given to damages. The issues can be quite complex. Are the injuries or disabilities due to malpractice or are they a maloccurrence, an unfortunate bad outcome that could not have been prevented? A few brief examples will illustrate how seemingly meritorious medical malpractice cases end with unequivocal defense verdicts.

CASE 1: When It Turns Out To Be An Accepted Risk Of A Procedure

The plaintiff was a 52 year old woman who suffered from esophageal achalasia, a condition in which the lower esophageal sphincter spasms and fails to relax. It results in difficulty swallowing. She went to a gastroenterologist who recommended pneumatic balloon dilatation or surgical repair (esophagomyotomy). The patient preferred the least invasive procedure and chose dilatation which was performed unsuccessfully three times by the defendant. On the third attempt, the plaintiff's esophagus was perforated. Esophageal perforation was a known risk of balloon dilatation to which plaintiff gave consent before the procedure. She underwent emergent surgical repair and suffered a prolonged hospitalization with serious infectious complications associated with the perforation.

The plaintiff alleged that repeat attempts at dilatation subjected her to increasing risk for perforation. She also alleged that the gastroenterologist was incompetent in the performance of the procedure and was directly responsible for negligently causing her injury. The defendant contended that he had done hundreds of dilatations without one complication, that he did this dilatation no differently than he did the others, that he had obtained

sufficient informed consent from the patient, that the perforation was an accepted risk of the procedure, and that in this instance, the perforation was unexpected, unforseeable, and would have occurred with any other gastroenterologist performing the procedure.

The verdict was 12-0 in favor of the defense. Unexpected complications happen; but they're not always the doctor's fault.

CASE 2: When You Can't Clearly Substantiate Your Theory Of Causation

The plaintiff was a 36 year old women who presented to a hospital for routine removal of her thyroid gland. The surgery went smoothly without complications. However, shortly after surgery in the recovery room she developed a hematoma and suffered a respiratory arrest. She was resusitated and the hematoma was surgically evacuated, but a significant delay in treatment resulted in severe brain damage and the patient is now in a permanent vegetative state.

Counsel for the plaintiff alleged that the nurse in the recovery room failed to call the attending physician when she noticed the hematoma. She also failed to call the doctor when the patient suddenly was unable to speak. The defendant contended that the nurse had been told that a certain amount of bleeding was normal and to be expected. The defendant also contended that the loss of the ability to speak was not accompanied with any other sign of clinical decompensation. The plaintiff's expert testified that the sudden development of the inability to speak suggested a compromised recurrent laryngeal nerve and required emergency intervention. Defense experts testified that the development of the inability to speak could occur in the absence of a developing hematoma and without additional signs or symptoms and did not require urgent intervention under these clinical circumstances.

The verdict was 12-0 in favor of the defense. The burden of proof is on the plaintiff to demonstrate that, more likely than not, the injuries were due to a negligent act. But when, at the time of a clinical decompensation, there is an alternative reasonable explanation for the problem and the jury is convinced of its veracity, you will most probably lose your case.

CASE 3: When You Don't Name The Correct Defendant(s)

The plaintiff was a 17 year old student who fell while playing basketball and sustained a closed head injury with a brief period of unconsciousness. He also sustained clavicle and rib fractures as well as a wrist injury. His friends took him to the nearest emergency room where he was triaged by an intake nurse who astutely documented the extent and magnitude of injuries. The emergency room then contacted the doctor who was on call for the medical

group with whom the plaintiff and his family maintained insurance coverage. The doctor, however, was not told of the head injury. He insisted that the patient receive his evaluation and care at another emergency department. No physician did a hands-on evaluation of the patient at the first emergency department. Upon arrival at the second facility, the patient deteriorated, underwent a CT scan of the head and a subdural hematoma was diagnosed. The second hospital did not have a neurosurgeon on-call, so the patient was transferred back to the first hospital. The delay in diagnosis and definitive management amounted to more than 5 hours. After evacuation of the clot, the patient was left with a moderate hemiparesis and mild cognitive impairment.

The attorney for the plaintiff sued the "gatekeeper" physician for the plaintiff's health plan alleging that he had no reason to request a transfer of the plaintiff to another facility and that this resulted in the prolonged delay in definitive management. He further alleged that the doctor failed to adequately inquire about the specifics of the plaintiff's fall and his neurologic status. The defendant contended that based on what he was told the patient was stable for discharge to another facility that accepted his medical coverage. He claimed that he asked the triage nurse pertinent questions specific to her case presentation.

The verdict was 12-0 in favor of the defense. The jury felt that it was an "insurance decision" and not a "medical decision" as to where the plaintiff should have been treated. By failing to name the first hospital and it's emergency department staff as defendants, the attorney gave the case away. The responsibility for the patient rested not with the gatekeeper but with the first hospital's emergency department. This is because the patient was not satisfactorily evaluated. Any patient with a history of head injury causing a loss of consciousness must be seen by a physician. These patients are considered medically unstable until cleared by a qualified physician. The triage nurse did not bring this case to the doctor's attention. The liability belonged to the first hospital, but they were not named in the lawsuit. The attorney, in working up his case, was not properly informed.

CASE 4: When Your Case Comes Down To The Physician's Word Versus The Plaintiff's Word

Plaintiff minor was a 1 year old with a history of a congenital heart defect who in 1984 underwent open heart surgery to repair the defect. During this surgery he received a blood transfusion contaminated with the AIDS virus. He is expected to live no longer than his sixteenth birthday.

The plaintiff's mother alleged that she spoke to the defendant physician the night before the surgery and demanded that the family be allowed to donate blood for the child. She also said that the defendant told the family that it was too late to donate. The physician defendant claimed under oath that

neither the plaintiff's mother nor any other family member ever requested direct blood donations. There was no documentation either way.

The verdict was 12-0 in favor of the defense. The most probable factor in the jury's decision was their propensity to believe the doctor; the doctor is innocent until "proven" guilty.

CASE 5: When You're Letting It All Ride On An Informed Consent Issue

The plaintiff was a 49 year old women with chronic knee pain who had undergone three previous failed arthroscopic knee surgeries. Because of ongoing pain and disability, her surgeon recommended total knee replacement surgery. She claims that her surgeon did not inform her at the time of obtaining informed consent that a revisional procedure was required shortly after the first procedure. The plaintiff alleges that had she known this, she would have refused the first surgery.

As it were, she suffered irreversible nerve injury. The plaintiff's expert orthopedist questioned the propriety of the total knee replacement, opining that it was an overly aggressive approach to the problem. The defense expert testified that the procedure clearly was a viable option and was within the standard of practice.

The verdict was 12-0 in favor of the defense. The jury felt that even if informed consent was inadequate, there was enough evidence that the procedure was one proper option and the best choice for fully ameliorating the patient's symptoms.

CASE 6: When Your Case Rests On One Easily Defensible Point

The plaintiff was a 42 year old man with a long history of hypertension. He presented to an urgent care center complaining of vomiting for several days. The only recorded vital sign was his temperature. The diagnosis was gastritis and he was prescribed an antacid. The next day he suffered a hemorrhagic stroke. His blood pressure was found to be 280/170, a true hypertensive emergency. He is now a hemiparetic and is completely disabled.

The plaintiff alleged that it is below the standard of care to not take the blood pressure as part of the routine evaluation, or to elicit the patient's history of uncontrolled hypertension. Accordingly, the plaintiff alleged that had the blood pressure been taken, he would have been admitted, his blood pressure emergently treated and the stroke would have been prevented. The defendant contended that it would have been his custom and practice to take a blood pressure regardless of the chief complaint and he believed that he did so but simply failed to record it since it was not significantly elevated. The defense position was that the stoke occurred after the visit to the urgent

care center and could not have been anticipated by the defendant physician whose practice was clearly within the acceptable standards.

The verdict was 12-0 in favor of the defense. The jury had no problem vindicating the defendant who they believed, did nothing wrong.

CASE 7: When You Can't Get Beyond The "Ordinary" Care Standard

The plaintiff was a 54 year old man with a history of a prior small myocardial infarction who, under the supervision of a cardiologist, was rehabilitated to excellent health. All stress treadmills, echocardiograms and electrocardiograms were without abnormalities. Prior to a planned strenuous hiking trip, he underwent a stress treadmill. During this study, he had a sudden drop of blood pressure when his heart rate was near its maximum for the study. The doctor erroneously concluded that this abnormality was spurious and represented no danger. His patient, while hiking one week later, suddenly collapsed and died.

At trial, the plaintiff's expert provided a scientifically correct physiologic explanation for the drop in blood pressure, stating that this represented a drop in cardiac output which was due to left ventricular dysfunction. But the defense retorted that by customary standards, the treadmill results were excellent without any ECG changes. By widely accepted criteria, the patient could be categorized as functional class 1, with no exercise limitations.

The verdict was 12-0 in favor of the defense. The jury justified their decision by saying that the doctor's oversight did not breach the "reasonable" or "ordinary" care standard, even though they were convinced that the sudden drop in blood pressure was, more likely than not, due to serious cardiac dysfunction. This reinforces the jury instruction that physicians do not have to be "perfect" in their practice of medicine; they only have to meet a "reasonable" or "ordinary" care standard.

CASE 8: When Minimal Or No Damages Result In Exoneration Of The Negligent Doctor

The plaintiff was a 42 year old women who told her regular physician that she had noticed a lump in her right breast. Her doctor thought the lump was consistent with benign fibrocystic breast disease and did not order a mammogram, even though she requested one. She returned twice more to the doctor for unrelated complaints. The chart did not document breast complaints, however, the patient was adamant that on both occasions, she told the doctor about the breast mass and asked twice for mammograms. She said that the doctor dismissed her concerns and denied her requests for a mammogram.

Finally, on the fourth visit, 13 months after her initial visit, the doctor acquiesced and ordered a mammogram which revealed a malignancy. She underwent a partial mastectomy and the tumor was characterized as Grade I with no lymph node involvement. At trial, the plaintiff was in excellent health without recurrence and it was the opinion of the defense experts that she was entirely cured.

The verdict was 12-0 in favor of the defense. Although the jury was critical of the doctor's delay in diagnosing the tumor and felt that this was a clear breach in the standard of care, because the plaintiff appeared cured and there was no evidence of metastasis, they were reluctant to damage the respectable doctor's reputation by returning a plaintiff verdict.

CASE 9: When A Delay In Diagnosis And Treatment Doesn't Change The Prognosis

The plaintiff was a 33 year old women who had a new breast mass evaluated by her physician. He did an immediate needle biopsy which was negative and he decided not to order a mammogram. A year later, she was diagnosed with terminal metastatic breast cancer.

The verdict was 12-0 in favor of the defense. Although jurors agreed that the standard of care had been breached in that a negative needle biopsy should be followed by a mammogram or surgical biopsy, they believed the defense expert oncologist who testified that based on the grade and stage of the tumor at the time of the diagnosis one year earlier, the cancer was already terminal. Earlier diagnosis and treatment would not have altered the course of the disease. Thus, the plaintiff's attorney could not successfully establish "causation" and lost the case.

CASE 10: When A Plaintiff's Damages Don't Justify A Plaintiff Verdict

The plaintiff was a 46 year old cab driver who visited an orthopedist with complaints of right knee pain. The physician's exam which focused only on the knee was negative, as was an x-ray of the knee. The doctor was told by his patient that many years earlier, he had a midshaft tibial fracture which required open reduction and internal fixation. However, the physician did not examine the area, nor did he order x-rays of the mid-tibial area. Instead, he referred the patient to a neurologist for evaluation.

The defendant neurologist interviewed the patient but did not conduct a focused neurologic exam postulating instead that the patient's pain was due to meralgia paresthetica- entrapment of a nerve in his thigh. He prescribed anti-inflammatory medication and told the patient that he would improve over time.

The patient was seen weekly for several months without any improvement nor any direct examination of the leg. Ultimately, his pain worsened and he was diagnosed in a local emergency room with advanced tibial osteomyelitis. He underwent debridement and was hospitalized for a two week course of intravenous antibiotics. He eventually healed. His only residual was a gross cosmetic defect in his mid-tibia. This deformity did not prevent him from returning to work.

He sued the neurologist and orthopedist contending that they failed to include in their differential diagnosis the obvious possibility of a tibial complication. With appropriate diagnosis and care, he would have avoided surgery and the grotesque leg defect.

At trial, even the defense attorney conceded that the standard of care had been breached, yet he pointed out that worker's compensation paid for all the medical bills, that sick leave took care of his lost wages, and that the defect did not preclude his returning to work.

The verdict was 12-0 in favor of the defense. The jurors concluded that both doctors were negligent and that their carelessness was a direct proximate cause of the patient's injuries. But when faced with the decision of whether they should penalize the doctors with a reputation-damaging plaintiff verdict, they decided to act in their favor. The doctors were obviously negligent, yet the jury found in their favor. Why? Simply, juries tend to be sympathetic towards physicians, especially when the monetary loss is minimal and the disability minor, such that it hardly interferes with a plaintiff's normal personal and professional life.

To summarize, in addition to the above examples, consider not taking medical negligence cases in the following instances:

1. The medical issues are complex. The more complex the medical issues, the more difficult it will be to convince the jury that the doctor committed malpractice. If a case involves multiple physicians, some of whom committed no negligent acts, it may be exceedingly difficult to separate out the truly negligent care. Jurors may view this kind of lawsuit as an unwarranted attack on everyone. Plus the more doctors who are involved, the more costly the undertaking, in terms of obtaining more medical experts.

2. The patient underwent a medical procedure for cosmetic rather than medical reasons. Jurors often believe that these people are vain and that they assume all the risk of a bad outcome.

3. The plaintiff's condition is such that delayed or misdiagnosis did not result in significant additional injury and would not have changed the prognosis. Jurors often find the "so what" defense compelling enough to excuse negligence.

4. When the defense medical experts include the follow-up care physicians. Their credibility usually exceeds the credibility of the plaintiff's experts.

5. Damages resulting from the injury are too small to justify the time and expense of litigating the claim.

6. The defendant is a well-known and highly respected physician that most reputable medical experts refuse to testify against. It will be very difficult to find an appropriate expert; and even if one is found, because of the defendant's standing in the medical community, it may be more difficult to obtain a judgment against him. Also, if the procedure, treatment, or medical subspecialty is rare, then it will be very difficult finding a medical expert witness to testify.

7. The case hinges only on informed consent or misrepresentation issues. This often pits the health care provider against the plaintiff in terms of credibility and honesty. Furthermore, it will be difficult to convince a jury that the plaintiff would not have agreed to the procedure or treatment if properly informed of its risks.

8. If the issue of causation can not be satisfactorily established. Cases will be lost in these situations even when care was grossly negligent.

9. A plaintiff has exacerbated the damage by not following the physician's instructions. For example, did the plaintiff add to the damage by walking on a leg despite non-weight bearing orders?

10. When a shortened life-expectancy existed anyway from non-related conditions. For example, even though a 40 year old man bled to death on the operating room table due to physician error, this patient had terminal lung cancer and a very short life-expectancy.

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