An Overview of the Medical Malpractice Legal Process

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Presented By: Bruce Wapen, MD, FACEP
Emergency Physician / Emergency Medicine Expert
969-G Edgewater Blvd #807
Foster City, CA 94404
(650) 577-8635
Speaker

Bruce Wapen, MD, FACEP, is a board certified emergency physician. Prior to retiring in January 2014, he practiced emergency medicine full time for 37 years in general, acute care, hospital-based Emergency Departments. He is licensed to practice medicine in the States of California, Washington, and Idaho and has been a clinical instructor in emergency medicine for the Stanford University School of Medicine, University of California at Davis School of Medicine, Samuel Merritt College Physician Assistant training program, and the United States Army Medical Corp at Letterman Army Medical Center. He has served as a forensic consultant in cases involving the Emergency Department for the past 19 years and has qualified as an expert witness in emergency medicine at trials in the States of California, Alaska, Idaho, Arizona, New Mexico and Nevada. He has given a series of talks at seminars sponsored by the Society of Forensic Engineers and Scientists regarding his forensic involvement in malpractice litigation arising from various Emergency Departments across the country.
Learning Objectives

1. Describe how and why a healthcare practitioner may get sued for malpractice.

2. Discuss patient care that may lead to allegations of malpractice.

3. Explain how a healthcare professional can become a medical expert.
Causes of Medical Malpractice Suits: Error by Commission

- A medical error is made by one of two mechanisms: by commission or by omission.

- Errors of commission are made when the medical provider does something which is considered to be below the “standard of care.”

- The standard of care is generally defined as: That care which would be expected of a practitioner of the same or similar training under the same or similar circumstances. ¹
Causes of Medical Malpractice Suits:  
Error by Commission (cont’d)

• Example: A 28-year-old male is camping at night. While striking a rock with the back of a hatchet, he feels a sudden, sharp pain in his left eye associated with decreased vision in that eye. He drives himself to a nearby hospital. The Emergency Department (ED) physician thinks she sees a foreign body (FB) embedded in the cornea and lifts a flap of cornea to remove it. Fluid exudes from under the flap, and the anterior chamber flattens out. An ophthalmologist is consulted, and global penetration is diagnosed when a FB is identified lodged in the retina (the corneal flap was merely the entrance wound). Surgery is performed, but normal vision cannot be restored. Manipulation of the corneal flap would be an act of commission that may or may not be an error which may or may not be below the standard of care.
Causes of Medical Malpractice Suits: Error by Omission

• Errors of omission are made when the medical provider fails to do something that should have been done in order to meet the standard of care.

• Example: A 52-year-old female presents to the ED at 6:00 PM complaining of the rapid onset of burning epigastric pain that radiates into her lower chest. She has a history of gastro-esophageal reflux disease (GERD) and is taking an H2 blocker. No EKG or lab testing is done. She is diagnosed with an exacerbation of GERD and discharged with a prescription for a proton pump inhibiter (PPI). She is found dead in bed the next morning. An autopsy reveals evidence of an acute myocardial infarction (AMI) which is greater than 12-hours old. Failure to perform diagnostic testing to look for evidence of an AMI would be an act of omission that may or may not be an error which may or may not be below the standard of care.
In order for a medical malpractice suit to be considered, four components of the suit need to be present. These components are:

1. Duty
2. Breach of Duty
3. Damages
4. Causation
The Four Components of a Suit:
#1 - Duty

• The patient and the medical providers must have established a relationship in which the patient is seeking medical care, and the providers agree to provide that care. This would normally involve the signing of a patient/provider agreement and the understanding that the providers will charge for services rendered.

• It is understood that a person who signs-in to be seen by medical providers on-duty in an ED is seeking medical care and that the physician, as well as the nursing and ancillary staff, have agreed to accept that duty to provide medical care. “Duty,” then, is not usually a contested issue in medical malpractice cases arising from the ED since everyone being seen has already agreed to be seen by the providers, and those providers have accepted that duty.
The Four Components of a Suit: 
#2 - Breach of Duty

• Breach of duty occurs when an error of omission or commission is made that is below the standard of care. The standard of care changes as evidence based medical practice changes, which makes the standard of care a moving target. Textbooks will rarely define some test or treatment as being the standard of care, and published guidelines are consensus opinion statements from experts on various committees tasked with defining current best practice parameters but do not constitute the standard of care. Ultimately, the standard of care is determined by a jury at the time of trial on the basis of the opinions of experts retained by each side in the case, and those opinions are often 180-degrees apart. How can that be?
The Four Components of a Suit: #2 - Breach of Duty (cont’d)

- Consider this:

- A consensus statement from the American Society of Thoracic Radiology (indorsed by the American College of Obstetrics & Gynecology) - Clinical practice guidelines for evaluation of suspected PE in pregnancy: Do a VQ scan if pulmonary imaging is necessary.³

- Guidelines from an evidence-based group out of UC San Francisco on the same issue recommend: Do a CT angiogram if pulmonary imaging in pregnancy is necessary, not a VQ scan.

- Obviously, opinions regarding best practice may differ, and it would be argued that either testing approach is within the standard of care.
The Four Components of a Suit: #2 - Breach of Duty (cont’d)

- But what about this:

- The Centers for Medicare and Medicaid Services (CMS) rule 253 states that a pregnancy test must be done and the results noted in the chart on every 14 to 50-year-old female who presents to the ED with a chief complaint of ABD pain. Sounds like a federally mandated standard of care to me, at least in those women with federally funded health insurance. You can see where you would be hard-pressed to explain your “error of omission” to a jury if the patient were pregnant and she had an adverse event related to the pregnancy that you failed to diagnose because you didn’t do the mandated pregnancy test.

- With nationally recognized board certification, standards of care tend to be national; but some states support the notion of “community” standards, and written policies or protocols that are in place in the ED where you work may constitute a “local” standard of care.
The Four Components of a Suit:
#2 - Breach of Duty (cont’d)

• There are as many ways to make a mistake as there are decisions to be made regarding patient management, but a 2007 article looking at “Unanticipated death after discharge home from the Emergency Department” identified four types of cases that seemed to be most problematic from the standpoint of death as a harmful endpoint:

• An atypical presentation of an unusual problem.

• Patients with chronic disease who have decompensated.

• Unexplained, abnormal vital signs at the time of discharge.

• Patients with mental disability or who have underlying psychiatric disease.
The Four Components of a Suit: #2 - Breach of Duty (cont’d)

• In addition, there are cognitive errors (biases) that lead to breach of duty; and there are “red flag” events that get missed, often with serious consequences.²⁻⁷

• One such cognitive error is “anchoring bias.” For instance, a patient without co-morbidities presents to an ED with a severe sore throat but has, in addition, a 1-week history of weakness, thirst, and excessive urination. The nurse practitioner (NP) looks at the throat, diagnoses strep throat, treats that problem, and discharges the patient who then dies at home of diabetic ketoacidosis (DKA). The provider “anchored” on the obvious diagnosis of strep throat to the exclusion of considering other or additional diagnoses suggested in the history of the present illness.
"Red Flag" events or findings, that are not appreciated as such, constitute another huge source of medical error. The common presentation of low back pain may constitute an epidural abscess if that patient also has a fever (Did you notice that abnormal vital sign, doctor?) or is an IV drug user. Or what about missing an early cauda equina syndrome because you didn’t ask about bladder or bowel incontinence, either of which would be a red flag event in the setting of back pain?
The Four Components of a Suit: #3 - Damages

• Assuming that the providers have established a duty to treat and that an error was made that breached that duty (care that fell below the standard of care), there must be some harm that was caused by the error. That harm is referred to as the “damages.” The damages may be difficult to quantify, as in the case of pain and suffering; or they may be more concrete, as in the case of the loss of use of an arm which results in lost wages that can be quantified in addition to the pain and suffering, all of which will figure into the damages for which compensation is being sought.

• Lawyers divide damages into three general categories:
  1- Non-economic: pain & suffering and loss of consortium
  2- Economic: medical expenses and lost wages
  3- Punitive: monetary payment for egregious behavior
The Four Components of a Suit: #4 - Causation

• Assuming that the providers had a duty to treat, that an error was made that breached that duty (fell below the standard of care), and that damages occurred, there still had to be causation between the breach of duty and the damages. In legal terms, the error had to be the “proximate cause” of the harm.

• For example: An elderly male presents to an ED with a cough. He is seen by a certified physician assistant (PA-C). The chest x-ray shows an infiltrate compatible with pneumonia. He is treated with an antibiotic, but the discharge instructions do not specify that he must have a follow-up chest x-ray done in a few weeks either by his primary care physician or back in the ED. A year later, he is diagnosed with lung cancer in the same region as the previously seen infiltrate, and he succumbs to that cancer. The poorly done discharge instructions may be seen as a breach of duty, but was there causation between that breach and the damage, which was the patient’s demise?
Notification

- The medical records need to be looked at by a medically savvy lawyer. The patient can request the records and give them to the lawyer, or the lawyer can request the records via a HIPA compliant form.

- If a lawyer requests the records, the Risk Management Department of the hospital will be on alert, but the medical provider may not be notified as no claim is yet being filed.

- However, when a lawyer determines that a lawsuit should be initiated, a “Notice of Intent to Sue” will be mailed out which will name the parties to be sued. In California it’s California Code of Civil Procedure Section 364: “90-day notice of Intent to Sue.” In Section 340.5, it is stipulated that the lawsuit must be filed within one year from the time of the injury. In cases where the injury was not discovered immediately, there is a three year time limit from the date that the injured party should have known about the injury.
The Lawyers

- The injured party is called the plaintiff, and the lawyer representing the plaintiff is plaintiff’s attorney. The lawyer usually works on a contingency fee basis but may require money up-front from the plaintiff to launch a case.

- The parties being sued are the defendants. There may be several of them (e.g. the ambulance company, the hospital, the ED physician, consulting physicians, physician extenders, and nursing & ancillary staff). Each may have separate defense counsel; although employees of the hospital, such as nurses, usually fall under the hospital’s umbrella and are represented by the hospital’s defense attorney. The defense attorneys are retained by the defendants’ medical malpractice insurance carriers.
The Experts

• The attorneys for plaintiff and defense will each retain one or more experts. At this level, the function of an expert is to decide if the standard of care was met and, if it were not met, to decide if the medical error was the proximate cause of the damages. There may also need to be actuarial and accounting experts to estimate the dollar value of the damages.

• Subsequently, the experts’ role is to explain their findings and opinions to the lawyers, judge and jury.

• The expert is not supposed to be an advocate for one side or the other, just an advocate for the truth.\(^8\)
The Experts (cont’d)

• Laws regarding the qualifications required to be an expert vary from state-to-state. In some states, only another emergency physician may render opinion about the medical care provided by a defendant emergency physician. However, in more than half of the states, practitioners from other specialties can opine about the care provided by an emergency physician in the ED.

• The American College of Emergency Physicians (ACEP) offers the following guidelines for physicians wanting to qualify as an expert in the specialty of emergency medicine:⁹

1- Be currently licensed in a state, territory, or area constituting legal jurisdiction of the United States as a doctor of medicine or osteopathic medicine.
The Experts (cont’d)

2- Be certified by a recognized certifying body in emergency medicine.

3- Be in the active clinical practice of emergency medicine for three years immediately preceding the date of the event giving rise to the case.

4- Abide by nine additional guidelines which may best be summarized by the ACEP Policy Statement: “An expert witness clearly has an ethical responsibility to be objective, truthful, and impartial when evaluating a case on the basis of generally accepted standards of practice.”
The Experts (cont’d)

• The lawyer who retains an expert may request a document regarding that expert’s opinions.

• One such document, called an affidavit of merit, is required by many states before a suit may even be filed. Plaintiff’s expert will need to compose this document based on a review of the medical records.

• A more comprehensive opinion report may be requested of an expert after additional information has been “discovered” via subpoena of records, medical literature research, and/or questioning of parties involved in the suit. Information obtained during the discovery process, in addition to the expert’s training & experience, provides the rationale behind expert opinion.
The Experts (cont’d)

• To be of substance in civil law, the expert’s opinion has to be true “more likely than not.” In other words, it has to have a greater than 50% likelihood of being true.

• In an opinion report, this is often stated as: “Based on a reasonable degree of medical certainty and on a more probable than not basis, my opinion is that X met the standard of care or that X fell below the standard of care in emergency medicine for the following reasons:” (opinions enumerated).

• Without this statistical advantage, an expert’s opinion regarding standard of care and/or causation may be discounted.
Deposition

- Deposition is the process by which a person is questioned by a lawyer while that person is under oath to tell the truth, at penalty of perjury.

- In a medical malpractice suit, the following people will commonly be deposed: the defendants, percipients (those with knowledge of the event such as the plaintiff’s family and friends and those medical providers who were involved in the care of the patient but are not being sued), experts, and the plaintiff.

- One attorney will schedule and pay for a deposition and will be the principal (lead) interrogator at that deposition, but all of the attorneys involved in the case will be present and each of them may ask questions.
Deposition (cont’d)

• Depending on the complexity of the case and the number of issues that need to be probed, a deposition may be brief or go on for many hours. The entire proceeding is recorded verbatim by a Certified Shorthand Reporter (CSR) and may also be videotaped.

• Some of the questions posed to the deponent will be “objected” to by opposing counsel (the lawyer representing the other side). However, unless advised not to answer a specific question for legal reasons, the deponent must answer every question. Later, the judge will determine if the question and answer being contested may stand or should be stricken (not permitted to be presented at trial).

• Once a deposition has been taken, the deponent will be held to his or her statements and may not tell a different story to the jury at trial. If new information becomes available and an expert wishes to amend statements already made at deposition, it will be necessary for that expert to be deposed a second time.
Settlement

• Fewer than 10% of medical malpractice suits go to trial. The rest get dismissed or settled.

• After hearing the testimony of the defendant and the defense experts, plaintiff and/or plaintiff’s attorney may come to the conclusion that the case does not have merit and may decide to drop the case.

• If the case has merit, the plaintiff and defense attorneys get together and negotiate a settlement. This is why you carry medical malpractice insurance. That insurance is intended to pay for the settled amount.

• If a settlement cannot be reached, the case proceeds to trial.
Trial

• Trial is the process whereby a case is presented to a judge and jury. The previously deposed persons will be put on the witness stand and, again under oath to tell the truth, be asked many of the same questions that they were asked at deposition. Alternatively, some cases are decided by “binding arbitration” and no jury is involved. This is how Kaiser Permanente has its cases adjudicated.

• At trial, one attorney will ask a series of “direct” questions after which opposing counsel will “cross examine” the witness. Following that, it may be necessary to clear up points made on “cross” with “re-direct” questioning, following which may come “re-cross” questions.

• The initial phase of this questioning is the point at which the court decides to accept or reject “expert” status for a witness who claims to be an expert.
• As in a deposition, one lawyer may object to another lawyer’s question, and the judge will decide if the question gets to be answered by the witness; however, at trial that decision is made in real time. The judge will either “sustain” the objection, and the question will be dropped without being answered; or the judge will “overrule” the objection, in which case the question must be answered.

• Experts for the defense will testify that the defendant provided care that was within the “standard of care” and/or that there was no “proximate causation” between the adverse event and the care provided. Plaintiff’s experts will provide diametrically opposite opinions.

• After hearing all of the witnesses give testimony, the jury is given legal instructions by the judge on the proper way to proceed in its deliberations. The jurors must then decide whom to believe and must come to a verdict as to whether the defendant was negligent.
This is why the jury is called the “trier of fact.”

Since the jury is medically naïve, it may be difficult for the members to fully understand the medical issues and the scientific evidence that gets presented. Therefore, in deciding which opinions to trust, the jury may be swayed more by the apparent credibility of a witness than by the hard, scientific evidence presented by that witness.

A trial is theater, or as Greg Henry, MD likes to say, “Trial is show business for ugly people.”
Consequences

- If the case is settled or loses at trial, the defendant’s medical malpractice insurance compensates the plaintiff and pays all legal fees. The medical damage cannot be undone, but the money may help relieve the plaintiff’s mental, physical and/or financial burden.

- If the defendant is found not negligent at trial, the defendant’s insurance pays the defense team’s legal fees; but plaintiff’s attorney does not get paid. The average case is estimated to cost a plaintiff’s attorney about $100,000.

- The defendant pays a price that is difficult to quantify but is measured in anxiety, depression, loss of self esteem & self assurance, and may engender suicidal ideation or action.

- In other words, regardless of the judicial and monetary outcome of the case, you lose the moment you are named as a defendant.
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The End!

Questions?

References to follow . . .
References


2- Supreme Court of Michigan affirms that guidelines can not be substituted for the opinions of experts regarding standard of care: Jilek v. Stockson, 289 Mich.App 291; 796 NW2d (2010)


4- Sklar DP, et. al., “Unanticipated death after discharge home from the emergency department,” Annals of Emergency Medicine, 2007 June;49(6):735-45

5- Bouncebacks! Emergency Department Cases: ED Returns by Michael B. Weinstock, Ryan Longstreth, Hudson Meredith & Gregory L. Henry (June 2006)
References (cont’d)

6- Bouncebacks! Medical and Legal by Michael B. Weinstock, Kevin M. Klauer, Gregory L. Henry & Hudson Meredith (October 2011)

7- Avoiding Common Errors in the Emergency Department by Amal Mattu, Arjun S. Chanmugam, Stuart P. Swadron & Carrie Tibbles (May 2010)


Thank you for attending!

Bruce Wapen, MD