OVERCOMING TYPICAL MEDICAL NEGLIGENCE STRATEGIES AND DEFENSES

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Defendants in medical negligence litigation will employ a number of strategies to try to ensure that your client is denied a just recovery. And they will employ these strategies unabashedly. The strategies include: (1) making up the medicine; (2) hiring experts that are less than honest; (3) attempting to overly narrow the issues; (4) delaying; and (5) playing to jury bias.

Each of these strategies can be overcome. And, in fact, overcoming these defense strategies will increase the value of your case. The first step is to know what the other side is doing.

I. DEFENDANTS MAKE UP MEDICINE

There is no question that defendants will make up medicine in an effort to defend their case. They are aided in that regard by their professional associations and dishonest literature. For example, in 2000, Frank Miller, M.D., set the Ten Goals for the American College of Obstetricians and Gynecologists for the First Decade of the Next Millennium. Goal number seven was to "lead successfully the effort to reduce medico-legal risks for obstetricians/gynecologist."

> We should prioritize the most frequent and costly events that lead to malpractice suits and compile systematically the evidence to identify accurately where the liability risks lie. This scientifically developed evidence can then be used to defend against unwarranted claims and challenge false testimony by expert witnesses and others… [1]

Translated, this was a call to obstetricians to write articles to defend lawsuits, opposed to advancing science or improving patient safety. Obstetricians have met that call.

For example, in the brachial plexus injury arena, a common defense is that the injury could not have been as a result of the defendant's misconduct because it could have occurred as a result of maternal forces of labor. In support of this theory, Gonik and others created a mathematical model to show what the maternal forces of labor were during a delivery[2]. The model was then picked up by other authors spouting the maternal forces of labor defense[3]. There are many reasons to doubt that the modeling has anything remotely comparable to what

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[1] Miller, F., *Ten Goals for The American College of Obstetrics and Gynecology for the First Decade of the Next Millennium*. Obstet and Gynecol, 2000; 95: 1-5.

[2] Gonik B, Zhang N, Grimm, MJ. Defining forces that are associated with shoulder dystocia: The use of a mathematic dynamic computer model. Am J Obstet Gynecol 2003; 188: 1068-1072.
Gonik B, Zhang N, Grimm MJ. *Prediction of brachial plexus stretching during shoulder dystocia using a computer simulation model*. Am J Obstet Gynecol 2003; 189: 1168-1172.
Gonik B, Walker A, Grimm M. *Mathematic modeling of forces associated with shoulder dystocia: A comparison of endogenous and exogenous sources*. Am J Obstet Gynecol 2000; 182-689-691.

[3] Gherman, et al. *Shoulder Dystocia: The Unpreventable Obstetrical Emergency with Empiric Management Guidelines*. Am J Obstet and Gynecol; 2006: 185-657.

occurs in labor and delivery. First, they use the MADYMO software. This software is used to simulate motor vehicle crash situations and to assess injuries sustained by the victims[4]. Second, even though the brachial plexus nerves bear no resemblance to a spring, they were modeled as a spring[5]. Third, the mechanical properties of the brachial plexus nerves were "based on experimental data performed on rabbit tibial nerves". There is no evidence that a brachial plexus nerve in a human baby has any equivalence to a nerve from a rabbit's back leg[6]. Fourth, characteristics of the fetal cervical vertebrae were based on a study of dead goats[7]. Fifth, the shoulder complex "downscaled" with unspecified modification from the MADYMO adult male model[8]. Sixth, the endogenous force was estimated according to the model of a piston. This is inconsistent with biological reality[9]. And the model does not account for the dissipation of force in pelvic soft tissues, lubrication properties, or fetal factors, such as muscle tone[10]. Nonetheless, Gonik and his associates repeatedly made claims about the actual delivery process. For example:

> The real value of our data is… In the realization (by objective determination) that multiple force – related factors can contribute to brachial plexus deformation and possible injury. These include those endogenously generated by uterine contractions and reflect maternal pushing efforts against an obstructed delivery[11].

Gonik told a different story under cross-examination at his November 20, 2001, deposition in *Perlman v. McConnell,* 193 Judicial District Court, Dallas County, Texas, Cause Number 00–09153. There he admitted that the paper he wrote was not intended to be anything other than a mathematical model (page 188), "that the paper was nothing more than a hypothetical model" (page 210), "that he could not testify to anything based on the paper as likely or in a reasonable medical probability" (pages 188 – 189), and that he "had a difficult time translating [the paper] into the human" (page 210). The modeling literature is nothing more than junk science.

Another example frequently cited by the defense in brachial plexus cases is the article by Lerner and Salomon. That article claimed:

> Based on review of the medical literature on the shoulder dystocia and brachial plexus injury the (a) Pub Med and careful scrutiny of the bibliography of over

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[4] Gonik, et al. *Defining forces that are associated with shoulder dystocia: the Use of a Mathematic Dynamic Computer Model*. *supra* note 2 at 1068.
[5] Gonik, et al. *Prediction of brachial plexus stretching during shoulder dystocia suing a computer simulation model*. *supra* note 2 at 1668.
[6] *Id.* at 1169.
[7] *Id.* at 1168
[8] *Id.*
[9] Gonik, Walker, et al., *supra* note 2 at 690.
[10] Gonik, et al., *supra* note 3 at 1072.
[11] Gonik, Zhang, *supra* note 5 at 1176.

> 600 articles on the shoulder dystocia, this paper appears to be the first unambiguous case report of a baby born vaginally without physician traction, and even without the occurrence of shoulder dystocia, that resulted in a permanent brachial plexus injury.[12]

What the article does not point out is that the case report is as a result of a lawsuit in which Dr. Salomon was the defendant. Not surprisingly, Dr. Lerner, a frequent flyer defense expert, was her expert. Those facts were not disclosed. Nor was the fact that the case was settled or that the words "shoulder dystocia" appeared in the medical records. Dr. Lerner was subsequently deposed in a case in which he refused to answer questions about the article[13]. After being compelled to answer questions and being re-deposed, Dr. Lerner showed up with his lawyer and took the Fifth Amendment.[14]

The point is that you need to understand the medical literature in your case before the first deposition is taken. If so, you can often get helpful admissions from the doctors and nurses that injured your clients.

II. EXPERTS THAT ARE LESS THAN HONEST

Oftentimes defendants will hire experts that are less than honest. For these, it is critical that you understand the literature well in advance of taking their depositions. It is further critical that you get all material available regarding the background of these experts when they are identified. Potential sources include prior depositions from the MNIEG website, TrialSmith, AAJ and the various listservers. But beyond that, you need to use your imagination to find and develop information about defense experts. This includes getting pleadings and other materials from lawsuits in which the expert was a party, using the Internet and potentially using an investigator. It is our view that depositions of parties and depositions of experts are not times to simply find out what the defendants and their experts are going to say. They are not times to hide behind the log. Instead, they are times to attempt to finalize the case. The only way that you can do that is by being prepared. Michael Radetsky, M.D., should show the types of things that can be found, but only if you dig for them. Dr. Radetsky is a pediatric infectious disease specialist.

Dr. Radetsky was hired in *Brown v. University of Alabama Health Services Foundation*, in the Circuit Court of Jefferson County Alabama, Civil Action Number CV–210–902148 JLP. His role, as it has often been, was to say that the baby's birth injury was as a result of an infection, opposed to birth asphyxia. He was deposed. He lied. A motion to compel was filed. From the motion:

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[12] Lerner, H, Salamon, E. *Permanent Brachial Plexus Injury Following Vaginal Delivery Without Physician Traction or Shoulder Dystocia*, Am J of Obstet and Gynecol. March 2008.

[13] Deposition of Henry Lerner taken May 7, 2008. *Borunda v. Chotimongkol*., Dst. Ct., Ford Cty., Kansas, Case 04-C-170, p 36-43.

[14] *Id*. Vol. II taken June 5, 2008.

When asked if he currently received pay from any hospital, Dr. Radetsky refused to answer that question, instead claiming that he had a "contract" with Presbyterian Hospital of Albuquerque and a contract with Hospice De La Luz. He further claimed that he was receiving money from Presbyterian–Albuquerque for services he was providing and that if someone came at the time he was working, he could be found at the hospital:

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Q. Currently you don't receive pay from any hospital, correct?
A. Currently I have a contract with Presbyterian Hospital and a contract with Hospice De La Luz.
Q. My question was: Currently you don't receive pay from any hospital; is that correct?
A. I thought I just answered your question.
Q. No, sir, you didn't. You said you had a contract. That doesn't tell me whether or not you're receiving pay from the hospital.
Is it correct that you're not receiving any pay from any hospital?
A. I thought I'd answer your question, sir. Then I don't understand your question.
Q. Well, it's not a very difficult question.
Are you receiving any pay from any hospital?
A. I -- I think I indicated that I have a contract with two different medical institutions here and that's a contract in which I am paid by the two institutions for services.
Q. It's your testimony that you're receiving money from Presbyterian Hospital here in Albuquerque for some service that you're providing?

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A. Yes.
Q. (BY MR. WEISBROD) If someone went to Presbyterian Hospital, would they be able to find any evidence of you working there?
A. I don't understand your question.
Q. (BY MR. WEISBROD) If someone went to Presbyterian Hospital, would they find you working there?
A. Well, if they came at the same time that I was in the hospital, they would find me.

Dr. Radetsky further testified under oath, *inter alia,* that

- he spends significant time "involved in patient care" at Presbyterian–Albuquerque;

- he is "on call 24 hours a day, seven days a week" at the hospital;

- Every doctor in pediatrics at the hospital knows he is on call 24 hours a day, seven days a week and "they call me 24 hours a day."

But his deposition testimony, his refusal to answer questions, and an investigation undertaken of his activities reveal significant discrepancies in Dr. Radetsky's testimony, calling into question his basic assertion that he has a contract with Presbyterian–Albuquerque to perform services there and is compensated for those services. Due to the significant credibility issues raised regarding this question, the Court's intervention was needed to compel Dr. Radetsky to document his relationship with Presbyterian–Albuquerque by, at the very least, producing the contract that he testified exists.

1. <u>Plaintiffs' Investigation Reveals That Dr. Radetsky Lied About his Whereabouts When He Claimed Under Oath to Have Been Working at Presbyterian–Albuquerque.</u>

Plaintiffs' counsel hired Rick Woodward, a private investigator licensed by the State of New Mexico, to conduct an investigation regarding Dr. Radetsky and his whereabouts beginning on Tuesday, November 13, 2012, three days before Dr. Radetsky's deposition was scheduled to be taken in Albuquerque on Friday, November 16, 2012. Mr. Woodward visited Presbyterian–Albuquerque trying to determine if Dr. Radetsky did, in fact, perform services there. Mr. Woodward found that (1) there was no listing for Dr. Radetsky on any of the hospital directories (as shown by photographs of the directories attached to Mr. Woodward's affidavit); and (2) none of the hospital receptionists, including those in the pediatric-related areas, were familiar with Dr. Radetsky. The receptionist in the Pediatric Gastroenterology Unit tried to help Mr. Woodward locate Dr. Radetsky, finding a phone number for him, and calling him and was led to believe he was working at UNM. Mr. Woodward then continued his investigation at the University of New Mexico and found that while Dr. Radetsky is listed as a clinical professor – a voluntary position – he is not employed or paid by UNM Hospital.

Dr. Radetsky's claim to perform services for the hospital is also undermined by his inconsistent testimony regarding claims to have made rounds at Presbyterian- Albuquerque in the days before his deposition was taken. When asked about what he had done the day before, Dr. Radetsky claimed that the day

preceding the deposition (Thursday, November 15, 2012), "Yesterday we had a patient care meeting at the hospice in the morning. I made my hospital rounds. I fielded telephone calls. It was a normal workday for me."

This claim began to unravel when Dr. Radetsky was pressed about what he had done the previous day, and he quickly backed away from his prior testimony:

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Q. Did you go to the Star Cafe yesterday morning, Doctor?
A. I'm sorry?
Q. Did you go to Star Cafe yesterday morning?
A. Yes. I met a doctor at the cafe at some point in the morning.
Q. (BY MR. WEISBROD) How long were you at the Star Cafe yesterday morning?
A. About an hour, hour and a half.
Q. It's the Flying Star Cafe, correct?
A. That's right.

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Q. And then did you say --
A. No, I'm sorry, sir. Wednesday we had our patient care meeting all morning. Yesterday a met a doctor at the Flying Star Cafe in the morning, that's correct.
Q. So your testimony now is that you did not go to the hospice yesterday?
A. That's right. That was on Wednesday when we had our patient care meeting.
Q. Okay. Now, you told me you went to Presbyterian Hospital yesterday. Is that also incorrect?
A. I don't think I went to Presbyterian Hospital yesterday. That was all on Wednesday.
Q. Your testimony is that on Wednesday you went to the hospice and to Presbyterian Hospital?
A. That's correct.

But on Wednesday, unbeknownst to Dr. Radetsky, Mr. Woodward was conducting surveillance of Dr. Radetsky. According to Mr. Woodward, who had Dr. Radetsky under surveillance from 6:30 a.m. to 6:30 p.m., he did not observe Dr. Radetsky going to Presbyterian–Albuquerque or the Hospice at any time on that day. Mr. Woodward concludes in his affidavit that "based on my surveillance of Dr. Radetsky on Wednesday, November 14, 2012, it does not

appear that Dr. Radetsky's testimony concerning going to Hospice De La Luz and Presbyterian Hospital–Albuquerque is true."

2. Other Courts Have Found That Dr. Radetsky has not Been Credible When Testifying, *Inter Alia,* About What He Actually Does for a Living.

This would not be the first time that testimony by Dr. Radetsky has raised serious credibility issues, including questions about how much or how little Dr. Radetsky was actually practicing medicine and performing the pediatric work he claims gives him expertise to testify as an expert in this case. Radetsky (along with his now ex-wife and a trust) brought an arbitration proceeding against their brokers and financial advisors based on trading losses they suffered. After a 22-day arbitration hearing before an NASD panel, the arbitration panel unanimously ruled against Radetsky and the other plaintiffs on all claims. The panel also found Radetsky and the other plaintiffs liable for $50,000.00 in attorney's fees. Radetsky asked the Superior Court of the District of Columbia to vacate the arbitration award, but the court refused. The record in the Superior Court included a document called "Examples of Credibility Issues for Plaintiffs and Their Claim" that detailed numerous incidents where Dr. Radetsky purportedly gave misleading or false testimony. Among other things, this document states that "Dr. Radetsky deceptively sought to portray himself as a pediatrician when in 1998 - 2000 his income was overwhelmingly from testifying as an Expert Witness in defense of doctors in malpractice litigation." This allegation is supported by exhibits indicating that the bulk of Dr. Radetsky's gross income during the relevant time period came not from practicing as a physician but from testifying as an expert witness. A defendant in that case, Gary J. Kopff, has signed an affidavit discussing the proceedings and supporting the contention that Dr. Radetsky primarily receives income from testifying as an expert, not from performing medical services.

These were not just unsupported allegations regarding Dr. Radetsky's credibility – two courts reviewing the record concluded there were credibility issues and included statements about those issues in their decisions. In his order confirming the arbitration award, the Honorable Robert E. Morin specifically notes that "it is clear from the submissions of the parties that there were significant issues concerning the credibility of witnesses, including Dr. Radetsky, which the panel had to resolve and which were material to its determination." In its opinion affirming the Superior Court's order, the District of Columbia Court of Appeals also referenced Radetsky's credibility issues. Given these findings, Mr. Woodward's investigation, and Dr. Radetsky's evasive-at-best answers regarding what should be straightforward questions, the Court should compel Dr. Radetsky to produce proof that, in fact, he does have a contractual relationship with Presbyterian–Albuquerque and is compensated for his medical services by the hospital.

The motion to compel was met with a defense motion to withdraw Dr. Radetsky as an expert. The case then settled.

III. PERSONALIZING THE DEFENDANTS

Typically, defense attorneys will try to personalize the defendants to make them well-intentioned humans who made a mistake. They want to claim that the only issues in the case are whether the doctor was negligent or the nurse was negligent and then present the doctor or the nurse in the most favorable light. Once way to combat this is to develop and focus on systemic errors. Understanding the hospital errors, literature, state and federal guidelines for hospitals, including the Joint Commission Standards, your state's Nurse Practice Act, the Medicaid Conditions for Participation, will help in being able to show that the problems that led to your client's injuries were systemic throughout the organization.

For over 40 years, study after study has confirmed the existence of a medical malpractice epidemic in the United States. Current research demonstrates that just under 200,000 people die every year in hospitals as result of medical mistakes.[15] It is roughly equivalent to two jumbo jets full of passengers colliding in midair each day of the year.[16] In the last four years, approximately twenty percent more people have died in hospitals from medical errors than the total of all U.S. battle deaths from all wars in the history of the United States[17]. This is not simply as a result of medical and nursing mistakes. Instead, it stems from institutional carelessness at many hospitals throughout the country. To be sure, we need to make certain our doctor and nursing negligence cases are strong. But we need to also focus on the institutional liability.

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[15] *HealthGrades, Patient Safety In American Hospitals* 1 (July 2004), available at http://www.Healthgrades.com (last visited February 2, 2006; *see also* Health: Study: Hospital errors cause 195,000 deaths. July 28, 2004, available at http://cnn.com.2004/HEALTH/07/28/health.mistakes.reut/index.html; *see also*, HealthGrades, *HealthGrades Quality Study: Third Annual Patient Safety in American Hospitals Study* (April 2006). See also, Healthgrades: Healthgrades *Quality Study: Fourth Annual Patient Safety in American Hospitals Study* (April 2007).

[16] Kohn, Linda T., *et al., To Err is Human: Building a Safer Health System* Washington D.C.: National Academy Press, 2000 at 1 *citing* Centers for Disease Control and Prevention (National Center for Health Statistics). "Births and Deaths: Preliminary Data for 1998." NATIONAL VITAL STATISTICS REPORTS. 47 (1999): 27. *See also*, Andrews, Lori B., *et al.*, "An alternative strategy for studying adverse events in medical care." 349 THE LANCET 309-313 (1997); Chaundry, Sarwat I., M.D., *et al.,* "Detection of Errors by Attending Physicians on a General Medicine Service' 18 J GEN INTERN MED 595-600 (2003), Schimmel, Elihu M., M.D., "The Hazards of Hospitalization" 60, No. 1 ANNALS OF INTERNAL MEDICINE 100-110 (1964).

[17] American Revolution (4,435); War of 1812 (2,260); Indian Wars (1,000); Mexican War (1,733); Civil War (214,938); Spanish-American War (385); World War I (53,402); World War II (291,557); Korean War (33,741); Viet Nam War (47,410); Gulf War (147); Iraq (2,543 as of February 19, 2007) equals 653,651. *See,* http://www.infoplease.com/ipa/a0004615.html and http://www.antiwar.com/casualties/index.php (last visited February 19, 2007). 195,000 x 4 = 780,000. 780,000 – 653,651 = 126,349. 126,349 ÷ 653,651 = 19.3%.

The total national economic cost, including lost income, lost household production, disability and healthcare costs for these preventable adverse events approaches, if not, exceeds $60 billion per year.[18]

The Agency for Healthcare Research and Quality (AHRQ) became the lead agency for the federal government on quality in healthcare. In order to better track medical errors, the agency developed and released a computer program which included a set of Patient Safety Indicators ("PSI"). These were specifically designed for screening hospital administrative data for incidents of concern related to patient safety.[19] HealthGrades took the Agency's Patient Safety Indicators software and applied it to approximately 37 million Medicare discharges. In 2004, HealthGrades, Inc. released its study: *HealthGrades Quality Study: Patient Safety in American Hospitals*.[20] This was the first study to look at the potentially avoidable mortality and cost impact of patient safety incidents using the PSI's across all U.S. hospitals among the most concentrated at-risk patient population, Medicare patients.[21] The report was shocking. The authors concluded that their data clearly supported the Institute of Medicine's report and the findings from other studies which showed that medical errors and injuries from them are epidemic in the United States.[22] They found that even though there were "shocking and widely publicized" statistics on preventable deaths due to medical errors, there had not been improvements in patient safety since the publication of the Institute of Medicine's report five years earlier. Indeed, they found the previous studies had underestimated the number of deaths caused by preventable medical errors. HealthGrades also looked at some of the economic consequences of the medical errors.[23] The results are staggering. The 16-PSI's studied accounted for $8.54 billion in excess inpatient costs to the Medicare system over the three years studies.[24] They concluded:

> To extrapolate to the nation as a whole, we calculated that Medicare hospital discharges represented 45% of all short-term acute hospital discharges from 2000-2002 period. Using this finding and excluding obstetric patients, we calculated that an extra $19 billion was spent and over 575,000 preventable deaths occurred, as a direct result of the 2.5 million patient safety incidents that occurred in U.S. hospitals from 2000 through 2002.[25]

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[18] *Supra* notes 2 and 3.

[19] *Patient Safety Indicators*, Version 2.1, Revision 1. March 2004. (Agency for Healthcare Research and Quality. Rockville, M.D.).

[20] *HealthGrades Patient Safety In American Hospitals*, *supra* note 1.

[21] *Id*. at 7.

[22] *Id*.

[23] *Id*. at 1.

[24] *Id*. at 6.

[25] *Id*.

These costs are additional costs to the Medicare system as result of preventable errors. They do not account for the other economic and non-economic losses suffered by those hurt by the errors. And they are increasing.

In April 2006, HealthGrades published its *Third Annual Patient Safety in American Hospitals Study*.[26] It found:

> Approximately 1.24 million total patient safety incidents occurred in almost 40 million hospitalizations in the Medicare population. These incidents were associated with $9.3 billion of excess cost during 2002 through 2004. For the second year in a row, patient safety incidents have increased--up from 1.14 and 1.18 million reported in HealthGrades' First and Second Annual Patient Safety in American Hospitals studies, respectively.
>
> Of the 304,702 deaths that occurred among patients who developed one or more patient safety incidents, 250,246 were potentially preventable.
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> Medicare beneficiaries that developed one or more patient safety incidents had a one-in-four chance of dying during the hospitalization during 2002-2004. This rate remains unchanged since our first study released July 2003.[27]

IV. INSTITUTIONAL NEGLIGENCE

Traditionally, when looking at these cases, the issue is whether the physician and/or nurses were negligent. Hospital liability is premised on vicarious liability for the nursing conduct. The problem with that is that jury sympathy will often favor the healthcare provider. And the attribution bias against your client is real. But most importantly, by focusing only on physician and nursing conduct, you are playing into the defense strategy.

JCAHO

Most hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations. This is important financially for the hospital. The Social Security Act §1881(e) and §1865(a) permit for deemed status of hospitals that are accredited by the Joint Commission. This means that they are deemed to meet all of the Medicare Conditions of Participation. It is also important because the Joint Commission sets Accreditation Standards. And an institution's failure to follow the standards can be powerful evidence of institutional negligence.

[26] *HealthGrades Quality Study: Third Annual Patient Safety in American Hospitals Study, supra* note 1.
[27] *Id.* at 3.

Nothing obviously excludes evidence of Joint Commission Standards as a part of an expert's opinions regarding hospital standards of care. In fact, courts in many states often look to the Joint Commission standards as guides for discerning the appropriate standard of care. Though the Joint Commission standards are not identical to the applicable standard of care, they are instructive and may be used as bases of expert opinion of the standards – along with the hospital's own policies and bylaws.[28]

In Oklahoma JCAHO guidelines "provide evidence of the appropriate standard of care even at facilities which are not accredited by JCAHO."[29] In Michigan the JCAHO guidelines may actually establish duty owed.[30] If JCAHO standards are evidence of or expert bases of opinions concerning applicable standard of care, so too are the relevant regulations and statutes, such as the nurse practice act.

While they are not definitive of the standard of care, Joint Commission guidelines, other regulations or statutes are useful bases of expert opinion, helpful to the jury, in describing the applicable standards of care.

JCAHO publishes a Comprehensive Accreditation Manual For Hospitals: *The Official Handbook*.[31] These standards set forth the standards for accreditation in several areas, including: ethics, rights, and responsibilities (R.I.); provision of care (P.C.); medication management (M.M.); improving organizational performance (P.I.); leadership (L.D.); management of the environment of care (E.C.); and management of information (I.M.).

EXAMPLES:

R.I.1.10 and R.I.1.30: Policies, procedures and performance must be in compliance with the organizational ethical code and staff members must be well informed about the content and application of the code to ensure business is conducted in an ethical manner. Care and treatment of patients must be delivered based on patient need, regardless of the organization's financial implication.

R.I.2.90: It is essential that the patient is informed regarding the outcomes of care, including unanticipated outcomes. The licensed independent practitioner or his/her designee must inform the patient, and when appropriate family members regarding any unanticipated outcome.

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[28] *See for example Denton Regional Medical Center v. LaCroix*, 947 S.W.2d 941, 951 (Tex.App.-Fort Worth 1997, pet. denied), citing *Hicks v. Canessa*, 825 S.W.2d 542, 544 (Tex.App.-El Paso 1992, no writ); *Hilzendager v. Methodist Hosp.*, 596 S.W.2d 284, 286 (Tex.Civ.App.-Houston [1st Dist.] 1980, no writ); *Foley v. Bishop Clarkson Mem. Hosp.*, 185 Neb. 89, 173 N.W.2d 881, 884 (1970); *Darling v. Charleston Community Mem. Hosp*., 33 Ill.2d 326, 211 N.E.2d 253, 257 (1965), cert. denied, 383 U.S. 946, 86 S.Ct. 1204, 16 L.Ed.2d 209 (1966).

[29] *Gaines v. Comanche County Medical Hosp.*, 143 P.3d 203, 213 (Okla. 2006).

[30] *Zdrojewski v. Murphy*, 254 Mich.App. 50, 63, 657 N.W.2d 721, 730 (Mich.App. 2002).

[31] *See, e.g.,* www.JCAHO.org.

R.I.2.160: Policies and procedures should address the care of patients to define when pain should be screened, assessed and reassessed, and to provide for communication to patients about effective pain relief.

P.C.2.20, P.C.2.120 and P.C.2.130: The patient assessment and reassessment policies and procedures must be defined in writing. The standards are for performing a thorough initial assessment and reassessment in specified time frames of the patient care needs. Information collected on patients' entry into the emergency department may indicate the need for further assessments. Triage, used to determine the order in which patients will be treated, does not meet the criteria of patient assessment.

P.C.2.150: These standards concern the reassessment of patients to meet their continuing care needs. The assessment and reassessment policies must meet applicable law and regulatory requirements.

P.C.3.230: These standards concern performing tests in a timely manner to determine a patient's health care or treatment needs. Diagnostic tests and procedures require an order. Clinical information regarding the reason for the test is submitted with the order based on organization policy and applicable law and regulation. Testing that requires clinical interpretation must have appropriate information supplied with the order.

ESTABLISHING INSTITUTIONAL LIABILITY

To establish institutional liability, all levels of the organization need to be explored, from the floor nurse to the governing board. To be sure, the hospital will take the position that your case is only about whether or not some nurse was negligent and will resist discovery on institutional issues. However, you must carefully draft the pleadings and be ever vigilant in pursuing discovery.

In many cases, the corporate carelessness arises or is allowed to continue by lack of leadership at all levels in the organization. This lack of leadership is clearly shown by the healthcare industry's lack of compliance with the Joint Commission on Accreditation of Healthcare Organization's Sentinel Event policy. The Joint Commission is the accrediting organization for hospitals in the United States. Its Sentinel Event policy provides that hospitals are supposed to report unexpected bad outcomes. The Joint Commission then conducts an in-depth analysis of the event to determine its "root cause." The concept is that in a non-accusatory way, the Joint Commission can help the hospitals it accredits focus on patient safety and prevent future mistakes. The root-cause analysis looks for system failures in order to provide risk reduction strategies.[32] The Sentinel Event reporting, root-cause analyses and recommendations are shrouded in secrecy and not discoverable in litigation. If patient safety were indeed a concern of the healthcare industry's leadership, one would expect that hospital

[32] *See generally*, Joint Commission on Accreditation of Healthcare Organizations, *2003 Comprehensive Accreditation Manual for Hospitals: The Official Handbook* at SE1-10.

executives would be standing in line to avail themselves of these services. However, the opposite is true. One only need look at the Sentinel Event reporting statistics to see how true.

For example, in the obstetrical arena there is debate about the number of children born with cerebral palsy as result of birth related injury. But, even taking the most conservative estimates, the gross number in the United States of these injuries is in the thousands.[33] Cases considered reviewable under the Joint Commission Sentinel Event Policy are "any prenatal death or major permanent loss of function unrelated to congenital condition in an infant having a birth weight greater than 2500 grams."[34] When such children are born, one would think their cases would be at the top of the list for hospitals to seek root cause analysis. The injury and damages to the child and family are dramatic. Future medical care costs are in the millions, if not tens of millions of dollars. These are the types of injuries responsible hospitals would want to prevent. Of the thousands of children born each year with cerebral palsy from 1996 until July 2004, a total of only seven cases were reported to the Joint Commission under the Sentinel Event Reporting Policy.[35] In July 2004 the Joint Commission published a Sentinel Event Alert. In looking at 40 cases of infant death and the seven cases involving permanent disability which actually were reported in the eight years, the Joint Commission found:

ROOT CAUSES IDENTIFIED

In the 47 cases studied, communication issues topped the list of identified root causes (72 percent), with more than one-half of the organizations (55 percent) citing organization culture as a barrier to effective communication and teamwork, i.e., hierarchy and intimidation, failure to function as a team, and failure to follow the chain-of-communication. Other identified root causes include: staff competency (47 percent), orientation and training process (40 percent), inadequate fetal monitoring (34 percent), unavailable monitoring equipment and/or drugs (30 percent), credentialing/privileging/supervision issues for physicians and nurse midwives (30 percent), staffing issues (25 percent) physician unavailable or delayed (19 percent), and unavailability of prenatal information (11 percent).

RISK REDUCTION STRATEGIES

As required under the Sentinel Event Policy, based on their root cause analyses, organizations develop an action plan citing the steps they will take to reduce the risk of similar future adverse events. The risk reduction strategies identified by these organizations include:

- Revise orientation and training process (70 percent)
- Physician education and counseling (36 percent)

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[33] *See generally*, Volpe, Joseph M.D., *Neurology of the Newborn*, Saunders: Philadelphia, 2001 at 332.

[34] Joint Commission on the Accreditation of Healthcare Organizations, July 21, 2004: *Sentinel Event Issue* #30 at 1.

[35] *Id*.

- Revise communications protocols (36 percent)
- Reinforce chain-of-communications policy (28 percent)
- Revise competency assessment (25 percent)
- Standardize equipment and drug availability (25 percent)
- Conduct team training (25 percent)
- Revise consultation and on-call policies and procedures (23 percent)
- Revise Medical Staff credentialing and privileging process (21 percent)
- Institute changes in the patient assessment policy (21 percent)
- Standardize the evaluation and monitoring process (21 percent)
- Revise the staffing plan and process (17 percent)
- Adopt American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG) guidelines for prenatal care (13 percent)
- Institute mock OB emergency training drills (11 percent)
- Revise the conflict resolution policy (8 percent)
- Revise transfer policies and procedures (4 percent)[36]

Had more of these cases been reported and strategies been adopted, thousands of babies could have been spared the horrific damages they now suffer. The root causes of the injury or death in your case and the hospital's failure to have the risk reduction strategies in place can translate into an independent cause of action for institutional negligence.

STANDARDS

Before filing suit, collect the literature with respect to the medical issues with which you are dealing. But, in addition, collect the standards applicable to the issue at hand.[37] ECRI

[36] *Id*.
[37] *See, e.g.,* 2008 Healthcare Standards, Official Directory (ECRI 2008).

serves as the Healthcare Standards and Guidelines Archive for the World Health Organization. Also, go to the internet. Some helpful sites include:

a. http://www.jointcommission.org

b. http://www.ismp.org (Institute for Safe Medical Practices)

c. http://www.fda.gov

d. http://www.qualityforum.gov (National Quality Forum)

e. http://www.ihi.org (Institute for Healthcare Improvement)

f. http://www.arsbn.org (Arkansas State Board of Nursing)

g. http://www.armedicalboard.org (Arkansas State Medical Board)

h. http://www.sosweb.state.ar.us (Arkansas Medical Practices Acts and Regulations)

ORGANIZATIONAL STRUCTURE

A. STRUCTURE. Malpractice is typically not an isolated medical event. It is instead a culmination of errors that occur at various levels throughout the hospital. It is necessary to understand the organization structure and hierarchy at the hospital in order to determine who the appropriate defendants are and what standards apply. For example, at a large hospital, a typical arrangement is that the emergency department is staffed by contract with an emergency room group of physicians, physician assistants who are employed by the physician group (or the hospital) and nurses and other ancillary personnel employed by the hospital. At a small rural hospital, the emergency department is typically staffed by emergency department or other physicians under contract with the hospital and nurses employed by the hospital.

Whether the hospital is a 40 bed rural hospital or part of a large chain, early discovery efforts should be undertaken to determine the organizational structure of the institution. For example, in a typical obstetrical case, this will include the obstetrical nurse, who may be an employee of the hospital, a pool nurse or agency nurse. It will include the charge nurse, the Nurse Manager of Labor and Delivery, the Nursing Director of Women's Services, the Director of Nursing, the Administrator and the board. It will include the Nursing Education Department. If the Hospital is part of a chain, it may include national policies and procedures or reporting obligations to distant corporate entities. It is important to get a handle on the organizational structure early on. You can then begin to look for the various areas of breakdown, without which your client would not have an injured.

B. DOCUMENTATION WITH RESPECT TO ORGANIZATIONAL STRUCTURE AND DUTIES. To determine the organization structure and also the various duties amongst the

health care providers, several references must be considered early on. Early discovery should include requests for institutional documents:

1. Organizational Chart;
2. Management Services Agreement;
3. Monthly Reporting to Board;
4. Annual Reports to Board;
5. Job Descriptions of everyone involved;
6. Medical staff bylaws;
7. Rules and regulations of medical staff;
8. Contract between emergency department group and hospital;
9. Contract between emergency department physician and hospital;
10. Contract between emergency department physician and emergency department group;
11. Contract between physician assistant and hospital;
12. Contract between physician assistant and emergency department group;
13. Physician personnel file;
14. Physician Assistant personnel file;
15. Nurse personnel file;
16. Supervision agreements between physician and physician assistant; and
17. Hospital policies and procedures.

C. DEPOSITIONS. Take lots of depositions.

V. DELAY – JUSTICE DELAYED IS JUSTICE DENIED

Defendants will invoke every delay strategy they can. Typically, defendants will object to interrogatories, they will object to requests for production. They will not respond to requests for depositions. To counter defendants' propensity for delay, prepare in advance. For example, much information with respect to the defendant hospital's systemic failures is

available on the Internet. Oftentimes you can get the hospital's policies and procedures prior to filing suit. And you can get a lot of information about the institution's structure from the Internet prior to filing suit. Tailor the discovery to your case and carefully draft it so that it is not automatically subject to easy objections. The discovery should be served with the petition, together with notices for depositions and, in most jurisdictions, a motion for a scheduling or a docket control order. When the defendants respond, typically with objections, immediately follow up. Get the documents, literature and background information you will need early on. And then aggressively pursue the depositions.

In the era of the electronic medical record, initially request the audit trail. The key issue is this: An audit trail (an automatically generated accounting of who accessed an electronic record, when, and the actions they took care in such a document's creation, alteration or deletion.) is the only way to authenticate electronic medical records. Electronic data are not tangible – electronic data are invisible bits of data on some electronic storage media such as magnetic disks – and such data can be manipulated on that media. Unlike paper records, detection of an alteration by simple inspection of print-outs of electronic records is impossible. The only way to tell if electronic records have been altered is to get an electronic audit trail that can track changes to the record content. Thus, without a complete audit trail, an electronic medical record is not authenticated as complete and free from alteration, by anyone, and its admissibility as a trustworthy business record of clinical events should be called into question.

The typical response by defense counsel is that no such thing exists or they have no idea what you're talking about. The hospital's IT people, however, will typically know exactly what you're talking about. To comply with the Health Insurance Portability and Accountability Act of 1996[38], together with the federal regulations under each, and together with the Joint Commission Information Management Standards, they will have someone who understands exactly what it means. Assuming that the hospital will not turn over the audit trail, the initial request for production should include requests for the operator's manual and the user guide for the electronic medical record. It should also include a request for the contract with the vendor providing the software for the electronic medical record.

The audit trail will show who entered the electronic record and what changes were made by him. This information will not show up in the printed version of the electronic records that the defendants will produce. If the electronic medical record was created or altered as a part of a risk management investigation, which defendants in most states typically claim is privileged, the audit trail will reflect those changes.

Each specific piece of data in an electronic medical record is a "cell". The manuals and user guide for the electronic medical record typically describe ways to retrieve information from individual cells. Keep in mind that the user retrieving such data for your request must have sufficient security clearance to do so. Otherwise, you'll get a response from the defendant

[38] Public Law 104 – 191, as amended, the HP I TDCH Act; American Recovery and Reinvestment Act of 2009/division a/title XIII – health information technology, HITDCH, SEC. 13001 (Title I the of Division B).

that the information is not obtainable. If all else fails, consider deposing customer support or the person with most knowledge at the vendor or company providing the software.

VI. PLAY TO JURY BIAS

A full discussion of overcoming jury bias is beyond the scope of this paper. Nonetheless, keeping those biases in mind throughout the development of the case is important. Not only are they real and dangerous, defendants will intentionally make an effort to play for them at the time of trial. The defendants will try to portray the institution as being there only to provide help and take care of people. The same is true for the doctors and nurses. Whether the hospital is a non-profit institution or a for-profit institution, make no mistake that it is all about the money. If the hospital is for-profit, obtain the 10K filings. Likewise, if the institution is non-profit, obtain the Form 990. Both are available on the Internet. The motivation for the institutional failures that had to occur at many levels in order to allow your client to be injured or killed is money. Finally, keep in mind three simple axioms:

A. every medical negligence litigation case is a punitive damage case until proven otherwise.

B. In almost every medical malpractice litigation case, there is “dirt“ or “greed”, or both – your job is to keep digging until you get the dirt.

C. Persuade the insurance carrier that you are going to get a punitive damages issue to the jury and persuade the jury that you have a punitive damages case.