Praise for *The Medical Malpractice Trial*

"Koskoff and McElligott have done what some thought impossible: they have written a clear, direct guide to handling medical malpractice cases. They survey common (and many uncommon) problems that confront plaintiffs' lawyers and explain the options available for solving those problems. Straight talk and good advice from a med. mal. master and his protégé. Anyone thinking of handling a medical malpractice case should read this book."

—Rick Friedman, past president of the Inner Circle of Advocates and coauthor of *Rules of the Road: A Plaintiff Lawyer's Guide to Proving Liability*

"Finally, a guide to the toughest kind of case a lawyer can face in the courtroom—medical malpractice. Based on their years of experience, Mike and Sean teach you how to find an expert, make sense of complex medical issues, and then—through the magic of framing and storytelling—help the jury grant justice. Whether you are trying your first medical malpractice case or have been doing this for years, you need this book in your briefcase."

—Randi McGinn, first woman president of the Inner Circle of Advocates and author of *Changing Laws, Saving Lives: How to Take on Corporate Giants and Win*

"Mike and Sean have written a book that combines the best of two worlds. It provides valuable practical suggestions, and also offers creative insights into the preparation and trial of a medical negligence case. It is an outstanding book."

—Mark Mandell, member of the Inner Circle of Advocates, past president of the AAJ, and author of *Case Framing*

"Finally, a first-rate book that provides invaluable insight and strategies on how to win medical malpractice cases at trial. Mike and Sean explore winning strategies, emphasizing three of the most important things that lead to success (storytelling, education, and empowerment). The book covers the gamut of subjects from taking the case (or not) to judgment. It is well known that in medical malpractice litigation, the defense wins more than they lose. I highly recommend reading this book to shorten those odds significantly."

—Joe Power, Jr., current president of the Inner Circle of Advocates and past president of the Illinois Trial Lawyers Association and Public Justice. He has the largest medical malpractice verdict in Illinois history and has never lost a medical malpractice case at trial.

"*The Medical Malpractice Trial* by Koskoff and McElligott is an excellent resource for both new and experienced trial lawyers looking to try a medical malpractice case. Everything you need to know, from A to Z, is in this treasure trove of information. The book provides many useful strategies for defeating the usual tackle box of defenses raised in medical malpractice cases. I highly recommend this book. It will help you win more cases."

—Brian Panish, member of the inner circle of advocates and managing partner of Panish Shea and Boyle

"As a young plaintiffs' lawyer looking to transition from motor vehicle cases to the arena of medical malpractice, I've found this book to be an invaluable resource. The idea of taking on a medical malpractice case can be a scary prospect for younger members of the bar, but Mike and Sean do an excellent job of providing the reader with the necessary tools to take such a case from intake to conclusion. Just as Mike and Sean have empowered juries to return scores of spectacular verdicts, they will empower you to embrace your next (and perhaps first) medical malpractice case."

—Michael J. Dolan, named to the National Trial Lawyers Top 40 Under 40 for the State of Connecticut, selected as a New England Super Lawyers Rising Star in the area of Personal Injury Law for 2017, and received the 2017 *Connecticut Law Tribune* New Leader in the Law Award

"Is there any need for yet another book by a pair of successful plaintiffs' trial lawyers about how to litigate a medical malpractice case? Don't answer that question before you have read *The Medical Malpractice Trial* by Michael Koskoff and Sean McElligott. Your answer then will surely be a resounding *yes*. This book is an essential addition to your library, offering wise and practical analysis and advice to inform and guide even the most experienced trial lawyer. A highlight of the book is the long, thoughtful section on the standard of care, especially techniques for challenging defenses of 'medical judgment' and 'risk of the procedure,' and proving negligence in cases involving misdiagnosis. The book is worth the price for this section alone. But there is much more. The authors' 'battle plan' for litigating a malpractice case makes it eminently clear why they are so successful in their representation of the victims of medical negligence."

—Steve Wizner, dean of the faculty of the National Board of Trial Advocacy and William O. Douglas clinical professor emeritus at Yale Law School

The Medical Malpractice Trial

Michael Koskoff & Sean McElligott

Trial Guides, LLC

Trial Guides, LLC, Portland, Oregon 97210

Copyright © 2019 by Michael Koskoff and Sean McElligott.

All rights reserved.

TRIAL GUIDES and logo are registered trademarks of
Trial Guides, LLC.

ISBN: 978-1-941007-85-3

These materials, or any parts or portions thereof, may not be reproduced in any form, written or mechanical, or be programmed into any electronic storage or retrieval system, without the express written permission of Trial Guides, LLC, unless such copying is expressly permitted by federal copyright law. Please direct inquiries to:

Trial Guides, LLC
Attn: Permissions
2350 NW York Street
Portland, OR 97210
(800) 309-6845
www.trialguides.com

Managing Editor: Tina Ricks

Production Editor: Travis Kremer

Copyeditor: Patricia Esposito

Cover Design: Alexandra Starkovich

Original Interior Template Design by Laura Lind Design

Interior Layout by Travis Kremer

Printed and bound in the United States of America.

Printed on acid-free paper.

CONTENTS

Introduction 6

Part 1: The Standard of Care

1. Finding the Standard of Care 16
2. The Medical Judgment Defense 35
3. The Risk of the Procedure Defense 48
4. The Misdiagnosis Case 66

Part 2: A Battle Plan for Trial

5. Opening Statement 82
6. Order of Proof 108
7. Trial Technology and Courtroom Optics 127
8. Demonstrative Evidence 139
9. Goals of Closing Argument 149
10. Battle Plan for Final Argument 158

Part 3: Starting the Lawsuit From Intake to Complaint

11. The “Take or No Take” Decision 183
12. Gathering Relevant Information About an Intake 199
13. Practical Considerations about a New Case 210
14. Get an Expert 216
15. The Complaint 228

Part 4: Nuts and Bolts 239

16. Getting and Using Medical Literature 240

17. Defending Your Expert's Deposition. 252

18. Deposing the Defendant's Expert. 267

19. Mediation 274

20. Some Thoughts on the Psychology of Persuasion 293

21. Focus Groups 302

22. Some Thoughts on Framing the Medical Malpractice Case . .308

Conclusion 320

PUBLISHER'S NOTE

This book is intended for practicing attorneys. It does not offer legal advice and does not take the place of consultation with an attorney or other professional with appropriate expertise and experience.

Attorneys are strongly cautioned to evaluate the information, ideas, and opinions set forth in this book in light of their own research, experience, and judgment. Readers should also consult applicable rules, regulations, procedures, cases, and statutes (including those issued after the publication date of this book), and to make independent decisions about whether and how to apply such information, ideas, and opinions to a particular case.

Quotations from cases, pleadings, discovery, and other sources are for illustrative purposes only and may not be suitable for use in litigation in any particular case.

Many of the cases described in this book are actual cases, and the names and other identifying details of participants, litigants, witnesses, and counsel have been fictionalized except where otherwise expressly stated.

All references to the trademarks of third parties are strictly informational and for purposes of commentary. No sponsorship or endorsement by, or affiliation with, the trademark owners is claimed or implied by the author or publisher of this book.

The author and publisher disclaim any liability or responsibility for loss or damage resulting from the use of this book or the information, ideas, or opinions contained in this book.

INTRODUCTION

If you are holding this book, you are probably aware that medical malpractice cases are more difficult to win than other types of personal injury cases. We ask a lot of the medical malpractice juror. We ask the juror to come in off the street and enter a courtroom, perhaps for the first time. After listening to three weeks of evidence, we ask the juror to tell a brain surgeon how to do his job. Can we reasonably expect a juror to do this without some extraordinary advocacy on our part? The answer is no, obviously. But we must find a way to get the juror from point A to point B.

We start every case with certain disadvantages. In an automobile negligence case, a juror feels qualified to judge the actions of a fellow driver from the moment she walks into the courthouse. Many jurors drive every day. The juror has seen good and bad driving and has opinions about which is which. You could say that driving is a neutral battleground. Medicine, however, is not a neutral battleground. It is an away game. The defense represents the physician. The standard of care is not written down, but somehow physicians know it, like a secret handshake. These are the same physicians that the defense represents. The medical malpractice defendant has better access to almost everything: literature, experts, past practice, records, and hospital officials.

These are the special challenges that medical malpractice cases present, and it is no wonder that they are statistically difficult to win. But some lawyers win a large percentage of their medical malpractice cases every year. What are these lawyers doing differently and how can we learn from them? The purpose of this book is to answer this question with an eye toward helping you win more cases.

We approach this task from different perspectives. Michael Koskoff has tried countless high-profile medical malpractice cases to verdict and has achieved a record number of multimillion-dollar verdicts. He has resolved hundreds of other cases on behalf of victims of medical

malpractice. He is a past president of the Inner Circle of Advocates and is recognized nationally as a leading medical malpractice lawyer. Sean McElligott is an experienced trial lawyer who, until recently, focused on automobile and general negligence cases. Using the methods Mike developed, Sean achieved a $10.5 million verdict in his first medical malpractice trial, a $6.5 million verdict in his second medical malpractice trial, and a $12.5 million verdict in his third medical malpractice trial.[1] The premise of this book is that you can do the same thing. If you are a lawyer who has mostly tried motor vehicle and general negligence cases, this book will help you make the transition to winning medical malpractice cases.

This book offers a toolbox of proven patient advocacy techniques. As with any topic on the art of advocacy, there is no one-size-fits-all solution to prove liability in every case. Each trial lawyer applies his or her own experience and creativity in a unique way to the challenges each medical malpractice case presents. More fundamentally, "what works" is a moving target. As society's attitudes toward the medical profession evolve, new methods will begin to work and old methods may lose their luster. As electronic medical records and algorithmic decision-making become the norm in medicine, patient advocacy must adapt accordingly. It is crucial, therefore, for you, as a patient advocate, to have a theoretical structure from which to develop tomorrow's powerful techniques.

The theoretical structure we suggest in this book focuses on empowering the lay juror and simplifying complex medical topics through education. It recognizes that every patient advocate, no matter how experienced, starts out with some inherent disadvantages in a medical malpractice case. It also recognizes, however, that the medical malpractice plaintiff starts with certain advantages in every case. We find that current legal literature has largely failed to explore these inherent advantages, but that current social science research has revealed these

1. He won his next two trials as well with similar verdicts.

advantages beyond a shadow of a doubt. Knowledge of these *advantages* is helpful in settling cases as well as trying them.

One example of an advantage that social science research reveals is that people generally have a strong desire to rationalize in hindsight even the most unexplainable or unpredictable of events (commonly known as the *hindsight bias*).[2] When people construct a story to explain an event, the world feels more understandable, less uncertain, and safer. This is an advantage for the plaintiff because the defense almost always takes the position that the defendant doctors did everything correctly and your client's injury was unavoidable and inevitable. This dynamic is largely absent in an automobile case where jurors can typically apportion the fault between the drivers involved in the traffic accident. In a medical malpractice case, by contrast, the story must explain how the client's injury was the predictable result of the defendant's risky conduct and not simply an "adverse outcome."

But providing a persuasive story is only half the battle in a medical malpractice case. You also have to empower the jury to realize the courage of their convictions. Even if the jury believes the defendant committed malpractice, they may still falter at the critical moment when they are required to judge the physician. That is where empowerment comes in. We empower the jury by educating and motivating them because, as the old saying goes, knowledge is power. There is also an obvious connection between being an educator and having credibility, long acknowledged to be the coin of the realm during trial. If you think back to some of your favorite teachers from high school or college, you probably remember them as dynamic, credible, and perhaps even wise.

The analogy of the teacher instructs us further: We all remember sitting through long, boring classes when we passed the time by watching the clock. As the professor droned on and on, we wondered why the big hand seemed stuck on the five. When we endeavor to assume the

2. Gregory N. Mandel, "Patently Non-Obvious II: Experimental Study on the Hindsight Issue Before the Supreme Court in KSR v. Teleflex," *Yale Journal of Law and Technology* 9, no. 1 (2007).

role of the good teacher, the engaging, interesting, talented teacher in court, we'd better do a good job. You must use all the tools available to you: illustrations, videos, photos, diagrams. Your experts should get up and stand in front of the jury like TED talk speakers. In the end, you will empower the jury. You will be the jury's favorite teacher with all of the credibility you need to win.

In order to prevail in a medical malpractice case, you need to construct a winning story, educate the jury about the medicine involved, and empower the jury to judge the physician. These three things (storytelling, teaching, and empowering) are the holy trinity of the medical malpractice trial. If you achieve all three, you will win your case. Focusing on these three things will also help you simplify your presentation of evidence. If a piece of evidence doesn't tell a story, educate, or empower, get rid of it.

If you understand the need to simultaneously tell a story, educate, and empower a medical malpractice jury, you can easily understand why so few lawyers manage to do it consistently well. The dismal medical malpractice trial statistics reveal a simple truth: too often we fail to take advantage of our natural advantages at trial and fail to empower jurors. If the jury hears a muddled or inconsistent story from us, the defense wins. If the jury doesn't understand the anatomy and medicine involved, the defense wins. If the jury doesn't feel empowered to judge the physician, the defense wins. So we need to tell a story, educate the jury, and empower the jury to win.

Remember that while we are trying to educate and empower the jury, the defense will be trying to do the opposite. In fact, some of the most common defense tactics depend on an impotent, uneducated, and confused jury. For example, in almost every case, the defense will argue that the physician's challenged decision was one of medical judgment. A plaintiff will typically argue that one choice is outside the standard of care (the one that the defendant doctor made) and another is within the standard of care (the one your expert advocates). The defense often tries to create a safe harbor for both choices by claiming that they are both reasonable and that the choice among them is one

of medical judgment, surgical judgment, and so on. The safe harbor will always, almost magically, encompass the key decisions that the defendant doctor made in the patient's care. By the way, when a medical judgment results in your client's death or dismemberment, the defense calls this an "adverse outcome," or a "risk of the procedure," that is, "stuff happens."

If we understand this tactic and why it works, we understand why we play right into the defense's hands when we set up our case as a battle of the experts. "Look, even the experts disagree," the defense argues, proving that reasonable minds may differ and therefore medical judgment is appropriate. In order for the medical-judgment argument to work, the jury must remain impotent and intimidated by the experts. They must cede the power to determine the standard of care to the experts, and never feel qualified to assume responsibility for declaring it themselves. But with a properly educated and empowered jury, experts are merely stepping stones. Nobody, not even the experts in the field, knows more about the case than the juror at the close of the evidence.

If we fail to educate and empower the jurors, we will lose. It's that simple. A juror shows up for jury selection with none of the tools required to judge a physician. If we don't give the jurors the tools, we can't expect them to do the job. Before you can convince jurors that a physician violated a rule of practice, you have to make the jurors feel that they deserve to be part of the discussion. The good news is that people in general enjoy being educated, particularly about the human body. The great trial lawyer Moe Levine used this to his advantage from the moment of his first interaction with a potential juror in voir dire:

> To me it is essential that the jury be provoked into interest in the type of presentation it's going to be because they are going to sit there for days or weeks. They had better know that what's coming is exciting, it's interesting, it has to do with their bodies, and they're going to learn things.[3]

3. Moe Levine, *Moe Levine on Advocacy* (Portland, OR: Trial Guides, 2009).

Moe told the story of a voir dire in a cardiac case, where he told the panel, "You're going to hear things you never knew, because we're going to bring you right up to date. You're going to know what was learned last week, and we're going to have the best specialist in the city here to talk to you about it."[4] After the defense excused a man from the panel, he refused to leave. He wanted to know more about his heart. This is the standard we should aspire to, that a juror should want to stay just for the educational value of our presentation.

As trial lawyers, we are fortunate in that, unlike Moe, we are living in the information age. The availability of medical information online, and people's willingness to use this information when making their own medical decisions, has made our job a little easier. In some ways, that information has also raised the bar. Our teaching must go beyond what jurors could turn up with a simple online search. We must present the jury with the best teaching experts, the best technology, and the best visual presentations. We must show that our way makes sense because it is the safest way.

Our central mission to tell a story, educate, and empower will inform every aspect of a medical malpractice case's preparation and trial, from case selection through closing argument. At the end of a trial, the jurors must feel that, at least as concerns the narrow topic of this particular medical decision, they know more than anyone in the world. The first thing we tell jurors in closing is that they "are now ready to decide the case." They had better be, or we've already lost.

Our mission is crucial, and this book comes at an important time. Medical malpractice defendants have disproportionately benefitted from tort reform efforts. The specter of doctors "moving out of state" because of high insurance premiums is a constant bogeyman. The deplorable win percentage of medical malpractice cases adds fuel to the fire. Studies show that 78 percent of medical malpractice claims result in no payment to the patient. To tort reformers, this statistic confirms that most medical malpractice cases are "frivolous." Indeed, tort reform

4. *Id.*

proponents have used this statistic to justify their measures.[5] Recently, efforts to repeal the Affordable Care Act have included proposals to essentially eliminate medical malpractice claims as we know them.[6] The best way to counter these efforts has been through vivid stories of the devastating effects of medical malpractice framed by talented patient advocates.

At the same time, society's view of doctors is also changing. While people once considered doctors altruistic healers, they now are less naïve about the medical profession as a whole. For example, national debates about the cost of health care have made many people aware of how money and profit can influence medical decision-making. People are also now more willing to question long-held but dangerous practices of the medical profession, including the risks of resident fatigue and poor incentive structures in hospitals. We hear from jury after jury that something needs to be done to make doctors understand that patient safety must come first, above all else, because lives are at stake. So in some ways, we are at a societal tipping point where juries are demanding more accountability from doctors—both in the exam room and in the courtroom.

A CALL TO ARMS

To trial lawyers, the terrible win percentage in medical malpractice cases is a call to arms. We must do a better job selecting, preparing, and trying medical malpractice cases. We must win more. Sir Isaac Newton is often described as the greatest scientist who ever lived. He discovered revolutionary scientific principles that dominated scientific thought for

5. Institute of Medicine (US) Committee on Quality of Health Care in America, *To Err Is Human: Building a Safer Health System*, ed. L.T. Kohn, J.M. Corrigan, and M.S. Donaldson (Washington, DC: National Academies Press, 2000).

6. H.R. 1215: Protecting Access to Care Act of 2017, available at: www.govtrack.us/congress/bills/115/hr1215.

centuries. When asked how he did it, he stated, "If I have seen further, it is by standing on the shoulders of giants." This book describes how the giants of the plaintiffs' medical malpractice bar have been beating the odds in case after case. We hope the book provides a firm set of shoulders to inspire you to see further and win more.

PARTS OF THE BOOK

This book is divided into four parts. Part 1, "The Standard of Care," is designed to introduce you to some basic concepts that come up frequently in medical malpractice cases but are rarely seen in automobile or general negligence cases. We have all heard the old saw that law school is designed to get students to "think like a lawyer." We designed part 1 of this book to help you "think like a medical malpractice lawyer." First, we discuss the concept of the standard of care and explore the best way for you, as a patient advocate, to think about the standard of care. The ensuing chapters address some common issues involved with the standard of care, such as medical judgment, risk of the procedure, and differential diagnosis.

In part 2, "A Battle Plan for Trial," we address the medical malpractice trial. We present a sample battle plan for trying a medical malpractice case that you can adapt to many different kinds of cases. We focus on constructing a winning story, educating the jury about the anatomy and medicine involved in the case, and empowering lay jurors to return a plaintiff's verdict.

In part 3, we talk about how to choose the right medical malpractice case to take on and how to get the case from intake to filing the complaint. One major advantage we have as patient advocates is that we get to choose our cases. Deciding which cases to take, however, can be more challenging in the medical malpractice context than in the automobile context. We discuss some of our accumulated experiences in picking which cases to bring and which cases to avoid.

In part 4, we discuss a curated assortment of some of the nuts-and-bolts issues particular to medical malpractice cases, including how to prepare your expert for deposition and how to find and use medical literature.

This book assumes a certain amount of familiarity with basic concepts of personal injury litigation. We assume that you are a lawyer who has tried motor vehicle cases and are either just beginning to venture into the area of medical malpractice or have been trying them for some time. We believe that the advice and techniques in this book will be helpful for the experienced medical malpractice advocate who is looking for a fresh perspective and approach as a patient advocate. This book is not a comprehensive personal injury litigation manual. Instead, we have tried to distill our specific knowledge about preparing and trying medical malpractice cases into easy-to-understand chapters that you can put into practice right away.

PART ONE

THE STANDARD OF CARE

THE STANDARD OF CARE

You won't get very far into your journey as a patient advocate before you encounter the term *standard of care*. Although every state in the country defines "standard of care" by statute, few people actually understand what it means. In order to succeed as a patient advocate, you need to master the nuances of this often slippery phrase. There is one guarantee in a medical malpractice trial—the defense will twist and distort the standard of care to their own ends. For decades, the concept of standard of care served as a bulwark against any meaningful oversight of the medical profession. Knowledge of the standard of care was historically kept within the medical profession, and few doctors were brave enough to serve as experts for a patient. Even today, the standard of care still serves as a barrier of sorts because it places the necessity of an expert opinion between the jury and its considered judgment of the doctor.

Part 1 explores how talented patient advocates turn the concept of standard of care to the advantage of the patient, and how to master these techniques. You will learn how to think about the standard of care as a patient advocate. You will learn that certain battle lines almost always emerge over the standard of care in a medical malpractice case. The plaintiff will push for the rule that can save the patient. The defense will push for the rule that allows the patient to be harmed. There is always one version of the standard of care that protects the patient and there is always another version that protects the doctor. We will talk about how this battle plays out in the context of several near-universal medical malpractice defenses including the medical-judgment defense, the risk-of-the-procedure defense, and the typical defense in a misdiagnosis case.

1

FINDING THE STANDARD OF CARE

All physicians in the United States are required to comply with the *standard of care* in their treatment of patients. If a physician departs from the standard of care, and the patient suffers harm as a result, the physician has committed medical malpractice. Accordingly, the concept of the standard of care undergirds the entire medical liability system in the United States. Perhaps surprisingly, many of us, doctors included, misunderstand the concept of the standard of care. The purpose of this chapter is to introduce you to the concept of the standard of care and to help you think about the standard of care as a patient advocate.

What is the standard of care? It's easy enough to define in the abstract. It's usually defined as "the level of care, skill, and treatment that, under all the circumstances present, is recognized as acceptable and appropriate by reasonably prudent similar health-care providers practicing in the United States."[1] But the standard of care turns out

1. *See* Conn. Gen. Stat. § 52-184c.

to be an extremely elastic concept when you attempt to apply it to a particular physician treating a particular patient, at a particular point in time. Because the concept of the standard of care is so elastic, defining it and applying it to the facts is a major battleground in every medical malpractice case. You need to learn how to win this particular battle to be successful in a medical malpractice trial. This chapter will help you do just that.

THE STANDARD OF CARE IS A LEGAL CONSTRUCT

The first thing you need to understand is that the standard of care is a legal construct that generally has very little to do with how doctors practice on a day-to-day basis. Many people assume that the standard of care that applies to doctors is written down somewhere. In reality, this is rarely the case. And even where the standard of care is written down, it is often too general to be of use in the treatment of any particular patient. Many people are familiar with Hippocrates and his famous oath: "First, do no harm." Fewer people are aware that Hippocrates created a set of comprehensive written rules for medical procedures in 400 BCE, such as, "treat the disease and not the symptoms" and "never perform surgery just for monetary gain." While some of Hippocrates's rules remain relevant today, the concept of a comprehensive set of written rules that apply to all physicians under all circumstances is not. This makes sense given the hundreds of medical specialties in existence today and the practically infinite series of symptomatic variables that can apply to an individual patient.[2]

2. There are currently twenty-four board-certified medical specialties and close to two hundred subspecialties of practice in the United States: Allergy/Immunology; Anesthesiology (Pediatric Anesthesia, Cardiac Anesthesia, Obstetrical Anesthesia,

But if the standard of care is not written down, where can you find it? The definition tells us that the standard of care exists in the minds

---

Neuro-anesthesia, Critical Care Medicine, and Pain Management); Dermatology (Cutaneous Surgery, Pediatric Dermatology, Dermatopathology); Emergency Medicine (Pediatric, Toxicology, Sports Medicine); Family Medicine (Geriatrics, Adolescent Medicine); General Surgery (Cardiovascular, Vascular, Transplant, Trauma, Colorectal, Pediatric Surgery, Critical Care, Oncology); Neurosurgery (Spine, Tumor, Functional Stereotaxy, Epilepsy); Plastic Surgery (Craniofacial, Microsurgery, Hand, Breast, Oncology); Internal Medicine (Cardiovascular Disease, Endocrinology, Diabetes and Metabolism, Gastroenterology, Hematology, Infectious Disease, Medical Oncology, Nephrology, Rheumatology, Pulmonary Disease); Medical Genetics (Molecular Genetic Pathology); Neurology (Cognitive Disorders, Stroke, Epilepsy, Neuromuscular, Electrophysiology, Sleep Disorders, Neuro-ophthalmology, Neuro-otology, Multiple Sclerosis, Neuro-oncology, Movement Disorders, Neurorehabilitation); Nuclear Medicine; Obstetrics and Gynecology (Gynecological Oncology, Maternal Fetal Medicine, Reproductive Endocrinology); Ophthalmology (Neuro-Ophthalmology) Orthopedic Surgery (Reconstructive, Sports, Spine, Trauma, Oncology, and Pediatrics); Otolaryngology (Head and Neck, Facial Plastic, Pediatric, Otology, Neuro-Otology); Pediatrics (Adolescent Medicine, Pediatric Cardiology, Pediatric Critical Care, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Hematology/Oncology, Pediatric Infectious Diseases, Neonatal/Perinatal Medicine, Pediatric Nephrology, Pediatric Pulmonology, Pediatric Psychology, Pediatric PM&R, Pediatric Rheumatology, Child Neurology, Genetics, General Academic, Pediatric ER, and Behavioral and Development); Physical Medicine and Rehabilitation; Psychiatry (Addiction, Forensics, Adolescent Child, Pain Medicine, and Geriatrics); Preventative Medicine (Medical Toxicology); Radiology-Diagnostic (Musculoskeletal, MRI, Abdominal Imaging—GI or GU, Chest, Pediatrics, Nuclear Medicine, Angiography and Interventional Radiology, Women's Imaging, Neuroradiology); Radiation Oncology; Thoracic Surgery; Urology (Pediatric Urology, Urologic Oncology, Renal Transplantation, Male Infertility, Calculi, Female Urology, Neuro-urology).

of "reasonably prudent similar health-care providers."[3] But, in reality, this is a fiction. Doctors don't actually think in terms of standard of care in their day-to-day practice. Consequently, litigation may be the only time when doctors truly attempt to *recognize* the standard of care that applies to a given situation. In fact, one reason smart experts enjoy working on medical malpractice cases is that they appreciate the unique opportunity to study the standard of care in depth in the context of a particular patient. So the standard of care doesn't exist in the minds of "reasonably prudent similar health-care providers," as the standard jury instructions state.[4] In fact, it barely exists at all outside of court.

If you are used to trying automobile cases, the idea of elastic liability rules disconnected from day-to-day practice may seem strange. In automobile cases, the rules tend to be written down. Also, drivers on the road know the rules and follow them daily. Take the example of the right-of-way rules. Typically, a state will have written traffic laws clearly describing what driver has the right of way. For example, the rule may state that a driver must yield the right of way when making a right turn on a red light, or that a driver must yield the right of way when entering an intersection with a flashing yellow arrow. If the driver fails to yield in these situations, the driver has violated the rule. There is no need to call two expert drivers to the stand to testify about what traffic laws are "recognized as acceptable and appropriate by reasonably prudent similar drivers." But in medical malpractice cases, this is how the liability rules are determined.

But you may be wondering, "How is it that doctors don't write down the standard of care that applies to their own profession?" The answer has to do with how doctors think. Doctors think a lot about how to best treat their own patients. They give some consideration to how their colleagues might treat similar patients differently. But they

3. Conn. Gen. Stat. § 52-184c.

4. *Id.*

give very little thought to what the national minimal standards are in the United States for treating a particular type of patient.

Further, unlike traffic laws, treatment methods are constantly changing based on available technology and scientific understanding. Younger doctors may come out of training with different methods of treating patients. Older doctors may change their ways based on an important journal article or the invention of a new medical device. Good doctors pay close attention to how they individually treat patients, but they don't have much incentive (or time) to try to understand the minimum standards that apply to an entire specialty, particularly as the minimum standards can change on a frequent basis.

In a recent case, we were questioning a defendant doctor about the standard of care when choosing between an end-to-end anastomosis and a side-to-side anastomosis.[5] Unlike a disclosed expert, a defendant doctor is typically not required to express an opinion on the standard of care. This particular doctor was a little more honest than most about his knowledge of (and interest in) the standard of care:

Q: What's an end-to-end anastomosis?

A: An end-to-end anastomosis is when the ends of the bowel are connected head-on, OK? So that's an end-to-end anastomosis.

Q: All right. What is a side-to-side anastomosis?

A: Side-to-side anastomosis is when the bowels are connected side to side.

Q: And what does the standard of care require of a surgeon deciding between performing an end-to-end or side-to-side anastomosis?

---

5. An anastomosis is a surgical connection between two segments of the intestines, used when a portion of intestine has been removed.

A: I have no idea.

Q: You have no idea what the standard of care requires?

A: No. I can tell you how I was trained and what I do, but as far as the standard of care goes, I don't and wouldn't have any thoughts on that.

Q: What was your training?

A: I was trained to do a side by side when operating on the patient's right side because it reduces the chance of the anastomosis narrowing. And that is how I have done it for twenty-five years.

This particular deponent was being honest about the relationship between the medical profession and the standard of care. Basically, doctors have little interest in it outside of litigation. Doctors frequently refer to the standard of care as a "medico-legal" concept, by which they mean it's not truly part of how they practice. Instead, it's something that doctors know they have to deal with if they are dragged into court, and on that basis, they have become reluctantly familiar with the concept.

THE STANDARD OF CARE IS PATIENT-SPECIFIC

Many people assume that the standard of care generally applies to all patients in the same way that a traffic rule generally applies to all drivers. In reality, the standard of care applies to a single patient at a single point in time and rarely can be generalized beyond that. In a recent case, we represented the family of a thirteen-year-old boy who died of

pneumonia after being misdiagnosed in the emergency room. The issue in the case was whether the standard of care required the emergency room doctor to order a chest X-ray.

The patient presented to the emergency room with the following symptoms:

- severe sore throat
- Tylenol-resistant fever of 104 degrees
- difficulty swallowing
- painful breathing
- cough for three days
- swollen tongue
- headache

The plaintiff's expert opined that the standard of care required a chest X-ray because the constellation of symptoms indicated the likely presence of bacterial infection and possibly an infection of the respiratory tract. But if the patient's list of symptoms changed even slightly, the standard-of-care inquiry would change with it. For example, if the fever had been brought down a single degree by the Tylenol, the case potentially changes. Also, if new technology (such as a blood test for pneumonia) were to be developed, this would change the standard-of-care inquiry as well. So when we talk about the standard of care, we are almost always talking about the standard of care as it applies to a single individual patient at a specific moment in time.

THE STANDARD OF CARE IS A BATTLEGROUND

Because the standard of care is unwritten and patient-specific, the definition of the standard of care will be a battleground in every case. Almost every medical malpractice case will involve opposing experts who present competing versions of the standard of care. Accordingly, the liability rule to apply to the defendant's conduct will almost always be in dispute in a medical malpractice case.

Again, we can contrast the medical malpractice case with an automobile case. In an automobile case, parties often agree on the liability rule to be applied because the rules of the road are mostly written down. For example, parties in court will not dispute that the speed limit on a particular road is fifty-five miles per hour. The battleground in an auto case is more likely to be about the facts of what happened. For example, there may be a large dispute about whether the driver was going fifty-five or sixty-five miles per hour. There may be five witnesses who are called to testify about their recollections of the driver's speed. Ultimately, the facts determined in the case mean everything, because everyone knows and easily understands the rules that apply. You might say that the typical automobile case involves *known* rules and *unknown* facts.

The medical malpractice case presents the opposite problem. It involves *known* facts but *unknown* rules. The facts are largely known because the defendants have a professional and legal obligation to document what they did for the patient in the patient's official medical chart. In contrast, drivers have no obligation to document how fast they go on a daily basis. We don't want to overstate this point, because many malpractice cases do have important factual disputes, as we'll discuss further in other chapters. But the main issue in many malpractice cases is as follows: "By what standard should the defendant be judged?" This is probably different from the typical question in an automobile case.

THE STANDARD OF CARE BATTLE FOLLOWS A PATTERN

Because the standard of care is a battleground, each side will present its own version of the standard of care in a medical malpractice case. The competing versions tend to follow a particular pattern that is helpful to the plaintiff. For example, the rule that the plaintiff advocates will be one that would have prevented the harm, had the defendant complied with it. The rule that the defense advocates will be one that presents the harm as inevitable regardless of the treatment. If you look for this pattern in your case, you will probably find it without much difficulty.

We had a recent anesthesia case that is a good example of this pattern. The patient was scheduled for a same-day elective surgical repair of an abdominal hernia. She was a thirty-nine-year-old woman who was morbidly obese, weighing 273 pounds. When the anesthesia team put her under general anesthesia, the team elected to use a laryngeal mask airway (LMA) for airway support instead of an endotracheal tube (ET tube). An LMA has certain advantages over an ET tube, including quicker recovery time after surgery. But the LMA also comes with a major safety risk: it doesn't protect the patient from aspiration of stomach contents into the lungs. By contrast, an ET tube does provide protection from aspiration.

The anesthesiologist gave her drugs for general anesthesia and inserted the LMA. Moments later, the patient aspirated stomach contents into her lungs and was transferred to the intensive care unit. She spent two months in intensive care in a medically induced coma and was left with permanent and severe neurological deficits.

Both the defense expert and the plaintiff's expert agreed that physicians and staff should not use an LMA in a patient who is at "increased risk" for aspiration. They disagreed, however, about what type of patient is at such "increased risk." The defense expert maintained that only non-fasted patients (those with a full stomach) are at increased risk for aspiration. Since

almost all surgical patients are required to fast prior to planned surgery, the defense rule excludes practically nobody. The plaintiff's expert opined that patients who are "morbidly obese" are also at increased risk for aspiration. Accordingly, the plaintiff's expert maintained that anesthesiologists should not use an LMA in morbidly obese patients.

Notice that the disagreement between the experts in the case example above follows the pattern we identified. The defendant's proposed standard of care *would not* have prevented the patient's injury. This is because the patient had fasted and, according to the defense expert, was therefore not at increased risk for aspiration. The plaintiff's proposed standard of care *would* have prevented the patient's injury. This is because the patient was morbidly obese, which placed the patient at increased risk for aspiration.

THE STANDARD OF CARE BATTLE EXTENDS BEYOND THE COURTROOM

Notice that these competing versions of the standard of care have different consequences outside the courtroom. Under the defendant's rule in the case example above, all future morbidly obese patients will be subject to the potentially devastating complication that the plaintiff experienced. Under the plaintiff's rule, morbidly obese patients will be protected. We sometimes say the plaintiff's standard of care protects the patient; the defendant's standard of care protects the doctor. Obviously, the choice between these two standards of care has safety implications for the community. The defendant will always advocate the rule that would allow harm to the plaintiff and that will expose all similar patients to the same risk going forward.

Remember that we want to tell a story, educate, and empower the jury in a medical malpractice trial. So if we are thinking about presenting a certain type of evidence or argument, we should ask what goal (storytelling, education, or empowerment) is served by including it? When we talk about the potential consequences of a particular standard of care in the community, we are mostly in empowerment mode. The doctor is saying that it's perfectly OK to continue a dangerous practice of using an LMA in the morbidly obese. Does the jury agree? The only thing standing between him and another needlessly injured patient is the voice of the jury. We need to tell him what that standard of care is so nobody else gets hurt. If we tell him his standard of care is correct, nothing will change.

UNAVOIDABLE VERSUS PREVENTABLE

You may be wondering how it is that a defendant doctor can stand up in front of a jury and propose a standard of care that allows harm to the plaintiff and similar future patients. The answer is that the defense lives in a world where some patients are just destined to suffer harm despite careful and skillful medical care.

- **Under the defense's version of the standard of care**, the harm to the plaintiff is always *unavoidable* (at least as far as the defendant's conduct is concerned). The plaintiff's injury is always the type that happens *despite* careful and skillful care. The plaintiff is the noise in an otherwise safe system.

- **Under the plaintiff's version of the standard of care**, the harm to the patient is always *preventable*, if only the doctor follows the

standard of care. The plaintiff is like every other patient, and we must keep patients safe.

We talked in the introduction about how the plaintiff has certain inherent advantages in a medical malpractice case. The typical standard-of-care fight described above is one such advantage. We think everyone can be saved. We are the optimists. The defense, by contrast, presents a rather dark view of the world where anyone, at any time, can randomly die because stuff happens. That's a tough sell.

The basic standard-of-care pattern will be present in most medical malpractice cases if you look for it. In this book, we will explore many ways that plaintiffs can benefit from it. We all know that jurors do not like to think of any injury as unavoidable. Even if the injury will never likely happen to a juror, the juror will still have a hard time accepting that an injury is truly unavoidable. This is a story problem for the defense and a story opportunity for us.

As we discussed above, if the standard of care will apply outside the courtroom as well, the jury is empowered. The jury's job is to both *determine* and *declare*: to *determine* what the standard of care is for your client, but also to *declare* what it will be for all future patients in the same situation as your plaintiff.

Emphasizing that the jury will declare the standard of care for future patients serves a few functions for the plaintiff. First, it makes the case more important, and by implication, it makes the jury's role more important. A sense of importance will empower the juror further and ultimately make the jury more willing to judge the conduct of the doctor. Remember that storytelling, education, and empowerment are the holy trinity of the medical malpractice trial. Our legal system vests responsibility for declaring the standard of care in the jury. We don't empanel an expert jury made up of doctors. We ask a lay jury to pass judgment. This is empowering because, in a way, it elevates the jury above the medical profession (and that's where we want them).

Second, establishing the importance of the verdict beyond the trial will help you persuade the jury in difficult liability cases. A plaintiff's

verdict that improves the way doctors practice medicine is more important than a defense verdict that will continue the status quo. Show the jury that the case is important. Tell the jury that their verdict in this case is important and will have an impact on the way doctors practice. The jurors should seize the opportunity to make positive change. With a defense verdict, nothing changes; doctors may continue to harm people like your plaintiff. This means that the defense case always has an inherent empowerment problem. Their position will always require the jury to essentially do nothing and let the status quo prevail.

If you are used to automobile cases, you are familiar with the Reptile approach to trying cases.[6] The Reptile approach emphasizes community safety and specifically how the defendant's negligence endangers members of an entire community. The approach works great in automobile cases because everyone drives or rides in cars. Everyone could potentially suffer the exact harm a person injured in a car has suffered. The Reptile approach can be challenging to use in a medical malpractice case because some of the medical scenarios are rare and a juror is unlikely to ever be in the same situation. One way to use the Reptile method in medical malpractice cases, however, is to emphasize the future implications of the jury's decision on the way doctors practice generally.

THE JURY'S JOB IS TO DETERMINE AND DECLARE

In addition to working these types of themes into your evidentiary presentation, you should frequently inform the jury of its role in both determining and declaring the standard of care. Stress the importance of the task. In closing, tell the jury that, although the case is simple (and

6. David Ball and Don Keenan, *Reptile: The 2009 Manual of the Plaintiff's Revolution* (New York: Balloon Press, 2009).

it must always be simple to them by that point; more on that later), they must not think their role as a jury is any less important. In fact, it's more important. For example, you could say the following to the jury (borrowed in part from Moe Levine):

> As the jury, you're the conscience of the community. You say what's right and what's wrong. You say what is a case, what isn't a case, and what will be a case in the future. We should be able to stand up in a case like this and say confidently—this was not careful and skillful medical treatment. If we can't say that confidently in a case like this, it's hard to imagine when we could ever say it. The harm was clearly preventable if only the hospital had followed [the rule that prevents the harm].

Depending on the particular case's tenor and the defendant's likeability, you can use the battle between the two standards of care to polarize as well. Tell the jury that they have a clear choice between two standards of care: one protects the patient and one protects the doctor. The plaintiff's standard of care protects this patient and all those who are like her. The defendant's standard of care protects no one except Dr. Smith.

THERE IS NO STANDARD OF CARE

Sometimes the defense tries very hard to avoid stating their own version of the standard of care. We call this *The Matrix* defense ("there is no spoon"). Remember that the defense does not have the burden of proving what the standard of care is or whether the defendant complied with the standard of care (a fact the defense loves to point out to the jury at every opportunity). The best scenario for them is that your expert has an opinion, their expert has an opinion, and a bunch of

authors of medical journal articles have their opinions, but there is no agreed-upon standard of care for everyone to follow. The defense will show a sudden interest in the characteristics of the patient that make the patient unique and not subject to the ordinary, prevailing rules. This type of defense can feel incredibly insincere, as the injury in your case may have resulted from exactly the opposite type of conduct—a doctor's failure to treat a patient like an individual. But the defense knows that people want doctors to treat a patient like an individual, so they try to claim this ground.

FORCE THE DEFENSE TO MAKE A STAND

If you allow the defense to take pot shots at your case instead of advancing their own standard of care, you will not be able to give the jury a clear choice between two alternatives. This will leave the jury confused and unmotivated, and you will fail to empower them. Rick Friedman's ground-breaking work on polarization applies fittingly to medical malpractice cases.[7] The first step to effectively polarize a medical malpractice case is to make the defense say what the standard of care is.

In one recent case, our position was that the doctor violated the standard of care by placing an epidural needle two vertebral levels higher than he intended. The defense expert stated that the doctor didn't violate the standard of care because he *intended* to place the epidural in the right spot. This led to a great "reduction to absurdity cross," about the consequences of that standard-of-care opinion. What if the doctor is five levels higher than he intends? What if the doctor puts the needle in the patient's ear?

---

7. We can't stress enough how important it is for every trial lawyer to read Rick Friedman's books. Rick Friedman, *Polarizing the Case: Exposing and Defeating the Malingering Myth* (Portland, OR: Trial Guides, 2007).

You can't test the validity of the defense's version of the standard of care unless you force them to say what it is. Ultimately, this may force them to say there is no standard of care in a given situation. We have seen that argument so many times. It's the ultimate example of the defense's outmoded way of thinking about the medical profession. "I am the doctor. I can do whatever I want. You cannot question me about it. There are no standards under which to judge me." The argument that there is no standard of care is also dismissive of the civil justice system, and by implication, the jury. If there are no standards, why are we all wasting our time with a trial? So for you, the defense taking the no-standard-of-care position can be a best-case scenario. We argue in closing that gone are the days when we blindly trust doctors to do the right thing for our health care. We are entitled to know why the doctor treated the patient this way and whether it makes sense. We are entitled to be educated both as patients and as a jury.

Try to ask the defendant doctor (and his experts) questions that begin as follows: "What does the standard of care require when a doctor . . ." This will help draw out the defense version of the standard of care. In the recent case involving the spinal anesthesia needle, we were sure to get the defense opinion clearly on the record before attempting to impeach it. Somehow the defense expert had made his way through an entire direct examination without actually saying what the standard of care was. In cross, the expert finally stated his position:

Q: And your version of the standard of care is that if an anesthesiologist attempts a spinal epidural L2–L3 and it turns out the anesthesiologist is actually at a different level, that's also within the standard of care, correct?

A: Correct.

Q: And is another way to say that, so long as an anesthesiologist intends to be at L2–L3, the anesthesiologist has complied with the standard of care?

A: That's correct.

[We wrote the answer on a large notepad for the jury.]

Q: OK. All right. Did I transcribe that correctly? As long as the anesthesiologist intends to attempt a combined spinal epidural at L2–L3, he has complied with the standard of care?

A: Correct.

We write key testimony down on a large pad, so the jury can see it (more on that later). Once stated, this opinion was obviously absurd by its own terms. Better yet, we had to drag the opinion from the expert. And once we exposed the opinion as absurd, it became clear to the jury why the expert was reluctant to share it. So make sure the defendant states his version of the standard of care. This is part of your job in educating the jury. The jury has to know what you are selling, but they also need to know what the defense is selling. Ultimately, the jury should have two clear choices when deciding what the standard of care is, and yours will always be the better, safer choice.

THE HYPOTHETICAL FUTURE PATIENT

One useful technique to highlight the distinction between the competing versions of the standard of care is to show the jury that the defendant himself will continue to mistreat future patients unless he is set right about the standard of care. Ask the defendant: "If a patient came into your office tomorrow with the same characteristics as the plaintiff, would you treat that patient the same way?" This is particularly effective where the defendant doctor himself presents expert

testimony at trial because it goes to his credibility. You can also use it with a defense expert.

There really is no bad answer to this line of inquiry. If the doctor says a patient would be treated differently today, then why did the plaintiff receive lesser treatment? Why should the doctor get a free education at the expense of the health of your client? If the defense doctor argues that the standard of care evolved, what were the key studies that came out between the time the plaintiff was treated and the time of trial? Were these studies really so different from what was already out there?

If the doctor states that a hypothetical patient would be treated the same way, this is also helpful. This response adds urgency to the jury's role in declaring the standard of care and enhances their empowerment. Depending on the facts of the case, the doctor's statement may not implicate the jurors' personal safety concerns, since none of the jurors may ever be in an identical medical situation. For example, if we return to the anesthesia case example above, the juror may never be morbidly obese and seeking hernia repair surgery. But the doctor's answer will remind the jury that the doctor's declaration of the standard of care has immediate, real-world implications.

Q: Doctor, you testified on direct examination that you believe it is within the standard of care to use an LMA in a morbidly obese patient?

A: Correct.

Q: And you don't agree that morbidly obese patients are at increased risk for aspiration because of higher gastric pressure and gastroparesis?

A: Not significantly, no.

Q: So if a patient came in to your office tomorrow with the plaintiff's identical symptoms and characteristics, you would treat her the same way?

A: Yes.

Q: You would order that an LMA be used?

A: Yes.

Q: But you would hope for a different result?

[Objection sustained.]

This line of questioning brings the defendant close to a common definition of insanity: Doing the same thing over and over again and expecting different results. The only people who can stop the cycle are the jury.

CAUSATION AND THE STANDARD OF CARE

For the plaintiff, the most important question in every case is this: Could the harm to this patient have been prevented with a different treatment? This is a causation question. But for us, *causation* dictates the standard of care. If we understand that the standard of care is patient-specific, varies depending on the circumstances, and that physicians believe it primarily exists in litigation, we should also understand that we have great flexibility in how we present the proper standard of care that would have prevented this patient's mistreatment. If there is a different treatment that would have saved the

patient, why not give the treatment? Is it too expensive? Too difficult? How much is too much when a human life is at stake?

Causation is also of primary logical importance in considering whether the particular injury is *unavoidable* (the defense's view) or *preventable* (the plaintiff's view). The tighter causation is, the more preventable the injury will appear. As an example, let's say that there is a simple blood test that would have diagnosed a patient with a clotting disorder prior to a surgery. Had the clotting disorder been known, the patient would have survived the surgery. Now let's say that there isn't a surgeon in the country who would have performed the blood test prior to surgery. It's just not done. As a patient advocate, you should be asking yourself, why not? The injury is clearly preventable, if doctors take a reasonable precaution. How common is the disorder? How much does the blood test cost?

If we take the anesthesia case as an example, we can see that causation tells us everything we need to know about the standard of care. First, we look at the patient's harm, in this case aspiration while an LMA was in place. We then ask, "Could a reasonable safeguard have prevented this harm?" Our research tells us that using an ET tube in place of an LMA is very effective at preventing aspiration in the morbidly obese. So then the question becomes, "Why not use the ET tube in morbidly obese patients?" Unless the defense can present compelling reasons for not using the ET tube, this should be the standard of care that the jury declares.

Frequently, we have to convince an expert that something *should* be the standard of care despite the fact that few currently do it (by the way, there is no greater satisfaction as a patient advocate). Again, the standard of care exists primarily in litigation. It makes sense that we would be the ones to finally aggregate enough evidence to actually change the way doctors practice. There is a reason why large hospitals keep their doctors informed about important medical malpractice verdicts. We are often the ones doing the important work of asking what the standard of care should be (as opposed to what it happens to be based on inertia or other nonsubstantive reasons).

TAKEAWAYS

- The standard of care is the most important concept to understand as a patient advocate. The standard of care is an elastic, patient-specific concept that exists almost exclusively in litigation.

- The standard-of-care arguments in medical malpractice cases follow familiar patterns, with the plaintiff's version *preventing* the harm and the defense version *allowing* the harm. This is a narrative advantage in every plaintiff's case.

- The defense will try to avoid saying what their idea of the standard of care is, but it is essential to force them to articulate it so you can polarize the case (our standard of care protects the patient; their standard of care protects the doctor).

- The defense says the injury is *unavoidable*. We say the injury is *preventable*.

- *Causation* dictates the standard of care.

Click the link below to get your copy of *The Medical Malpractice Trial* by Michael Koskoff and Sean McElligott.

CLICK HERE TO ORDER YOUR COPY