

**MEDICAL MALPRACTICE LITIGATION: PLAINTIFF’S PERSPECTIVE**

Philip C. Henry, Esquire  
Henry Spiegel Milling LLP  
Suite 2450  
950 East Paces Ferry Road  
Atlanta, GA 30326  
(404) 832-8000

**TABLE OF CONTENTS**

Case Selection and Choice of Defendants..... 1  
Statute of Limitations Issues.....7  
Affidavits and Experts.....10  
Discovery Issues.....12  
Settlement Issues.....13  
Statements of Apology.....14  
Conclusion..... 15

## **MEDICAL MALPRACTICE LITIGATION: PLAINTIFF'S PERSPECTIVE**

This paper will provide an overview of the plaintiff's perspective on several issues that arise in medical malpractice litigation. It will begin by discussing our selection process for medical malpractice cases and some of the reasoning behind our choice of defendants and expert witnesses for different stages of litigation. The paper will then address discovery issues involving the medical records and a summary of our general goals and obligations in pursuing a settlement. The paper will also highlight some of the ways in which the tort reform legislation passed in 2005 has changed our approach to some of these issues.

### **Case Selection and Choice of Defendants**

Proper case selection is particularly important in the medical malpractice context due to the complex issues and the time and expense required to successfully pursue cases. The proper screening of potential medical cases is often time consuming and expensive, but the failure to thoroughly screen cases will inevitably lead to even greater expense, stress, and frustration over having taken a case that should not have been taken and likely cannot be won. This is especially true because health care defendants virtually never settle a case for "defense costs" or a nominal amount to make the case go away. We must evaluate every potential case with the mindset that it will go to trial. It is therefore not surprising that we end up taking very few cases.

The recent tort reform provisions make case selection even more crucial. Examples include the caps on non-economic damages, the more stringent standards applicable to expert testimony, the heightened burden of proof in emergency room cases (the plaintiff must now prove gross negligence by clear and convincing evidence), and the arguable elimination of joint and several liability. More than ever before, health care defendants are taking complete advantage of the new laws and aggressively defending almost all cases through trial.

The screening of a medical case requires a detailed gathering of the facts, an assessment of the applicable statute of limitations and statute of repose, a medical and legal analysis, and the exercise of sound judgment based on our own experiences and the experiences of others. The screening process generally involves an initial phone call with a potential client or referring attorney, a client interview, an in house review of the medical records, and an expert review. The process is more an act of de-selection than selection. The case is probably not worth pursuing unless questions can be answered to the attorney's satisfaction at each step of the way.

The expert review is critical. The reviewing expert should be someone who is respected, knowledgeable and fair. The role of the reviewing expert should be to give an honest and accurate assessment of the issues. Getting the case reviewed by someone who will always tell you that there was malpractice will only result in spending time and money on losing cases for clients with unreasonable expectations. By getting a fair and knowledgeable assessment at the outset, a plaintiff's attorney can properly determine whether to proceed further.

The reviewing expert needs to answer two questions: (1) was there a deviation from the standard of care; and (2) did the deviation cause or contribute to cause an injury? In some cases we have to consult two or more experts to obtain answers to these questions. For example, a radiologist may be able to tell us whether a cancer was missed on a film, but we may need to consult with an oncologist or surgeon as to whether the delay in diagnosis caused any real injury.

In discussing the case with the expert, we listen intently to his or her analysis. We ask questions to determine the strengths and weaknesses of the case. We also try to understand what mental and physical process any potential defending physician went through in making his or her assessment and treatment decisions. If we can understand why the physician made the error, it is likely a jury will too.

When making a final determination on whether to accept a possible case, there are numerous practical questions to consider even if it appears that liability and causation are reasonably clear. Many attorneys actually begin the selection process by focusing on damages, and this is particularly true in the aftermath of the cap on non-economic damages. The theory is that if damages are not significant, the case cannot be effectively and economically pursued and should be rejected. The threshold amount of damages necessary to pursue a case will vary among attorneys. If the damages do not meet the individual attorney's threshold, considerations of liability and causation will not influence an attorney to accept a case.

The minimum threshold of damages not only varies among attorneys, but on a case to case basis. A "one size fits all" analysis of the amount of damages necessary to pursue a case is not useful. An analysis must be made of the amount of time and expense required to pursue a case. For instance, a case in which liability would be significantly disputed or serious causation issues exist will likely warrant a higher threshold of damages than a case with clear liability and little question regarding causation. There are numerous other factors, such as the number of defendants or the number of experts required, which may impact the damage threshold. Simply stated, an analysis must be made as to whether the damages suffered by a potential client are significant enough to warrant the time and expense necessary to effectively pursue a medical malpractice case. In light of the caps on non-economic damages and the heightened standards for emergency room cases, the reality is that even more people with meritorious cases will not be able to pursue their claims in light of the significant expenses involved.

From a practical standpoint, we also consider potential reimbursement issues early in the case selection process. It is important to obtain the medical bills as soon as possible to ascertain the source of the payment. This will assist not only in assessing potential economic damages

that are not subject to the cap, but will also provide some insight into the reasonableness of the pursuit of the claim. We must consider the financial impact of a reimbursement claim by Medicare, Medicaid, insurance companies, self-funded ERISA plans and others. We have several cases where the plaintiffs incurred more than \$1 million in medical expenses, and the insurance companies have asserted a reimbursement claim. We have encountered situations where these reimbursement claims or similar amounts owed to Medicare or Medicaid made the acceptance of a settlement offer virtually meaningless for our clients. While reimbursement may not be the ultimate issue in determining whether to take the case, it is important to consider these issues early because they can certainly impact upon the financial feasibility of resolving claims.

The type of defendant in a potential case is also important. Cases involving corporate or institutional entities, such as a hospital or HMO, generally will result in a more significant damage award than cases against an individual doctor. Our experience has taught us that juries may be more likely to forgive a likeable medical provider than to award significant damages unless the facts or results (or, more likely, both) are egregious. Identifying and developing theories of liability against an institutional defendant will almost certainly benefit the amount of a recovery received by settlement or at trial.

Institutional defendants are also treated differently under the tort reform cap on non-economic damages. There is a \$350,000 cap on all non-economic damages in any medical malpractice action involving one or more "healthcare providers". The cap is \$700,000 if the case involves the malpractice of a medical facility and a healthcare provider. The cap is \$1,050,000 if the case involves the malpractice of two medical facilities and a healthcare provider, although the situations where this would occur are relatively rare.

In cases against hospitals or other health care institutions, those cases involving a “system” breakdown are better cases than ones involving bad medicine. For example, we prefer a case with an abnormal test result that never finds its way into the system over a case involving a nurse who receives an abnormal laboratory result but for some reason fails to appreciate its significance. Clearly, the breakdown of the system that is designed and implemented to provide information important to the wellbeing of patients is inherently a better case than one involving human error that will be attached to a given individual.

One other note regarding the choice of defendants: in the pre-tort reform days, good plaintiff’s attorneys knew that it was almost never beneficial to use the “shotgun” approach of naming all physicians, health care providers, and institutions involved in the patient’s care with the aim of ferreting out the non-culpable parties during discovery. This approach generally only resulted in a substantial amount of work and a significant loss of credibility for the plaintiff and, potentially, the plaintiff’s experts. The only time a shotgun approach was warranted was when it could not be avoided because the facts were unclear, and there was an imminent statute of limitations deadline.

The recent tort reform provision requiring the jury to consider the fault of non-parties may change that. Under O.C.G.A. § 51-12-33(c), the trier of fact shall consider the fault of all persons or entities who contributed to the alleged injury or damages, regardless of whether the person or entity was, or could have been, named as a party to the suit. Plaintiffs’ attorneys will not want to give the defense any opportunity to aggressively blame non-parties who are not present to defend themselves. For the same reason, plaintiffs will be less likely to settle with less than all defendants.

## **Statute of Limitations Issues**

We must consider two separate statutes in determining whether a potential medical malpractice case can be timely filed. First, the statute of limitations bars actions filed more than two years after the date of an injury or death. Second, the statute of repose provides that a physician cannot be sued for negligence that occurred more than five years prior to the date of filing. With respect to the statute of limitations, the negligent act and injury often occur on the same date so that the beginning of the statute of limitations is clear. The issue becomes more complicated in some misdiagnosis cases.

### **1. The general rule in misdiagnosis cases**

In cases involving a misdiagnosis that resulted in a failure to properly treat a condition, the injury generally occurs at the time of the misdiagnosis because the patient continues to experience pain, suffering, or economic loss from the time of the misdiagnosis until the problem is properly diagnosed. Under these circumstances, the misdiagnosis itself is the injury and not the subsequent discovery of the correct diagnosis. As a result, the general rule is that the limitation period begins on the date of the misdiagnosis.

### **2. The subsequent injury exception in misdiagnosis cases**

The Court of Appeals created a limited exception for cases where a misdiagnosis results in the development of a new and different injury than the injury that existed at the time of the misdiagnosis. Because the new injury is often difficult or impossible to date exactly, the statute of limitations runs from the date the new injury is discovered. The subsequent injury exception applies only if the plaintiff developed a truly new and distinct injury and the plaintiff was asymptomatic for a period of time after the misdiagnosis. Examples of cases applying the subsequent injury exception include: (a) a localized precancerous growth in the breast at the time

of misdiagnosis develops into metastatic cancer of the breast and lymph nodes; (b) optic nerve disease develops into neovascular glaucoma; and (c) a fracture worsens into a severe vertebral compression causing failure of spinal ligaments and destabilization of the spine.

### **3. The statute of limitations is strictly interpreted**

The Supreme Court strictly interprets the statute of limitations. In at least two situations the Supreme Court has reversed attempts by the Court of Appeals to expand the limitation period to give patients more time to file a lawsuit. First, the Supreme Court has held that the continuous treatment doctrine does not extend the statute. The continuous treatment doctrine, which applies in some other states, operates to change the trigger date for the statute of limitations from the date of the injury to the date that the patient's treatment for the condition terminates. It basically means that the negligent act continues as long as the patient is under the physician's care. In 2002, the Supreme Court held that the doctrine cannot apply in Georgia because our statute of limitations starts to run at the time of the patient's injury, not the occurrence of the negligent act.

The Supreme Court's next action occurred in 2007 in the interesting case of Kaminer v. Canas, 282 Ga. 830 (2007). Derek Canas was born with a rare heart defect in 1984. When he was two months old, he underwent surgery at The Medical College of Georgia Hospital and received blood transfusions. He later treated with Dr. Kaminer, a pediatric cardiologist, beginning in 1991 and Dr. Al-Jabi, a pediatrician, beginning in 1993. Although Canas displayed signs of pediatric AIDS that worsened over time, neither physician diagnosed that condition. Instead, they both attributed his symptoms to the heart condition. In 2001, Canas was finally tested for HIV and diagnosed with AIDS. It was undisputed that his condition was the result of the blood transfusions he received in 1984.



In 2001, Canas sued Dr. Kaminer and Dr. Al-Jabi. The physicians had initially misdiagnosed his condition more than five years before he filed suit, but they had continued their failure to diagnose his worsening condition within two years of the action. Based on the statute of repose, the trial court granted summary judgment to the physicians on all claims for medical malpractice where the alleged negligence occurred more than five years before filing. It denied summary judgment on all claims where the injury occurred within two years from the date of filing and the negligence that caused the injury occurred within five years of filing.

The Court of Appeals agreed with the trial court. The Court reasoned that if a patient like Canas has a significant change in the signs and symptoms of his condition such that the standard of care would require the doctor to reevaluate his original diagnosis, it can be considered a new misdiagnosis. It further reasoned that if there is a new misdiagnosis, the injury that results cannot be deemed to have occurred any earlier than the date of the new negligence.

In October 2007, the Supreme Court reversed. The Court held that Canas was injured, and the statute of limitations began to run, on the date that Dr. Kaminer and Dr. Al-Jabi first failed to diagnose the AIDS condition in 1991 and 1993 respectively. The injury was that Canas continued to suffer from an undiagnosed and untreated condition that slowly progressed. The Court rejected Canas' contention that when he developed additional or increased symptoms of his misdiagnosed condition, he was in effect re-injured, and the statute of limitations recommenced. The Court determined that although the physicians' subsequent failures to recognize that Canas' additional or increased symptoms were indicative of AIDS may constitute new negligent acts, they did not inflict any new injury on him. The Court also rejected Canas' contention that the subsequent injury exception applied because he was never asymptomatic for a period of time following the misdiagnosis. The Canas case is good example of the complexity of

the statute of limitations analysis we sometimes face in determining whether to accept or file a malpractice case.

### **Affidavits and Experts**

The Plaintiff's attorney needs an expert witness to fulfill three separate roles: (1) to review the case; (2) to sign the affidavit; and (3) to testify at deposition and/or trial. There may be good reasons not to use the same expert for all of these roles.

In many cases we like to have a physician who will never testify in the case sign the affidavit. The benefit of this strategy is that it avoids having the testifying expert cross-examined based on an affidavit given before any discovery was obtained and before many of the facts were known. If we anticipate the affidavit expert may testify in the case, we always include language in the affidavit stating that the expert may form other opinions based upon additional facts, and that the affidavit is given solely for the purpose of complying with the affidavit statute and is not intended to encompass all of the opinions held by the expert.

An example of this potential problem is where an expert signs an affidavit filed with the complaint that does not contain criticisms of a defendant added after discovery. The expert may then criticize the subsequently added defendant in his discovery deposition. In these cases we routinely file a motion in limine to prevent defense counsel from suggesting at trial that the expert's credibility is suspect because he was not critical of the subsequently added defendant in the filing affidavit or because his affidavit may not include every criticism of every defendant that he intends to offer a trial. Courts routinely grant our motion, finding that permitting a witness to be cross-examined with an affidavit that by definition is incomplete and was prepared solely to comply with a statutory filing requirement is an inappropriate use of the affidavit.

Expert witnesses are another area covered by tort reform. O.C.G.A. § 24-9-67.1 imposes a number of conditions that an expert witness must meet in order to testify in any civil action and sets forth special standards for expert opinions in professional malpractice actions. The special standards apply to experts who sign the filing affidavits and testify at trial.

One section of the statute has generated several recent appellate cases. It provides that even if an expert is “otherwise qualified as to the acceptable standard of conduct of the professional whose conduct is an issue,” the opinions of the expert will only be admissible in a malpractice action if the expert:

(c)(2) ... had actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given as the result of having been regularly engaged in:

(A) The active practice of such area of specialty of his or her profession for at least three of the last five years, with sufficient frequency to establish an appropriate level of knowledge, as determined by the judge, in performing the procedure, diagnosing the condition, or rendering the treatment which is alleged to have been performed or rendered negligently by the defendant whose conduct is at issue.

In one case, the Court of Appeals held that the requirement that the expert have “actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given” does not mean that the plaintiff’s expert must practice in the same specialty as the defendant doctor. In other cases, the Court has affirmed the dismissal of lawsuits where the filing affidavit did not plainly show the physician’s activities in at least three of the five years preceding the negligence or the frequency with which the physician had performed the procedure, diagnosed the condition or rendered the treatment at issue.

O.C.G.A. § 24-9-67.1(c)(2)(a) grants trial courts the authority to determine whether an expert is properly qualified, and authorizes trial courts to hold pretrial hearings to make that

determination. After such a hearing, a trial court's finding regarding an expert's qualification will only be reversed on appeal if the trial court abused its discretion. As a result, we are now even more careful in the selection of our experts and the content of our affidavits.

### **Discovery Issues**

Discovery issues in health care cases can actually begin during the case screening process. An appropriate screening requires a review of all necessary medical records. Georgia law provides that upon written request from the patient "or a person authorized to have access to the patient's record under a health care power of attorney for such patient," a health care provider "shall furnish a complete and current copy of that record" unless such a disclosure "will be detrimental to the physical or mental health of the patient." O.C.G.A. § 31-33-2(a)(2),(c). The records "shall be furnished within a reasonable period of time..." O.C.G.A. § 31-33-2-(b).

Despite this clear statutory language we have sometimes encountered difficulty obtaining a complete copy of the medical record. Various health care providers, most often hospitals, have responded that the record cannot be released promptly because it is "incomplete" or "offsite." This response can raise a red flag to an attorney screening a case.

Additionally, in cases where the patient is deceased, it is sometimes difficult to obtain records where there is no estate. It should not be. Under O.C.G.A. § 31-33-2(a)(2), if the patient is deceased, a request for records "may be made by a person authorized immediately prior to the decedent's death to have access to the patient's record under a health care power of attorney for such patient; the executor, temporary executor, administrator or temporary administrator for the decedent's estate; or any survivor, as defined in Code Sections 51-4-2, 51-4-4, and 51-4-5." In almost every conceivable case our client will fall under one of those categories.

The medical record, including x-rays, pathology slides, fetal monitor strips, etc., is generally the crucial piece of evidence in medical malpractice cases. A premium is placed on cases where the plaintiff's attorney discovers that the health care provider lost part of the medical record, altered the record or did not document what happened accurately. Cases are also enhanced where the health care facility does not follow its own policies. Healthcare providers can avoid the inference of wrongdoing by having clear policies, making sure that employees follow those policies, and ensuring that employees accurately document events and appropriately maintain all records relating to medical treatment, especially treatment that involves an unfortunate outcome. Providers have nothing to gain by losing or altering the record.

### **Settlement Issues**

Sometimes plaintiff's attorneys reject settlement offers that on their face seem reasonable given the injury involved. Such a rejection likely is not driven by any greed of the attorney or client, but rather by more practical issues.

Our ultimate responsibility in every case is to provide effective representation for our clients. Our primary goal in settlement is to make certain that any recovery is meaningful to our clients. This means we must obtain an amount of money, after expenses, attorney's fees, and any reimbursement obligations to health insurance companies, Medicare or Medicaid are met, that will positively impact our client's lives. Examples of such positive impacts include a paralyzed client's ability to purchase a specialized van and home health care to enable her to leave a nursing home, a widow's ability to pay off her mortgage, or a young girl in a persistent vegetative state's ability to obtain the quality around-the-clock health care she will need throughout her life.

We have had cases where the clients were obligated to reimburse hundreds of thousands of dollars to Medicaid and Medicare. The rejection of a seemingly reasonable settlement offer in such cases is because our hands, and the client's hands, are tied by these "behind the scenes" obligations. For a meaningful resolution of such cases, it is essential that the defense have a realistic understanding of these obligations and the underlying basis for the monetary amounts we demand in settlement.

### **Statements of Apology**

One last area of medical malpractice litigation that has been impacted by tort reform is worth mentioning. In the past, the plaintiff's case was easier when the health care provider admitted to the patient that he or she had made a mistake or was at fault for the outcome. Plaintiffs were able to use those statements as "admissions against interest" to help prove that a breach of the standard of care occurred. One tort reform provision now enables health care providers to apologize to patients and their families for unfortunate outcomes without fear of having those statements used as admissions during subsequent litigation. O.C.G.A. § 24-3-37.1(c) provides as follows:

In any claim in a civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider... to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence and shall not constitute an admission of liability or any admission against interest.

The Georgia Court of Appeals has interpreted this statute to encompass statements of fault. In Airasian v. Shaak, 2008 WL 324740 (Ga. App. February 7, 2008), Dr. Shaak removed a significant portion of Mr. Airasian's colon. Dr. Shaak later performed an emergency surgery

after he discovered that a large portion of the remaining colon was necrotic. Mr. Airasian subsequently filed a malpractice action, alleging that his colon died because Dr. Shaak failed to provide adequate blood flow to the surgery site and failed to monitor his condition after surgery. The jury found in favor of Dr. Shaak.

On appeal, Mr. Airasian alleged that the trial court was wrong in deciding not to admit statements made by Dr. Shaak at the time of the second surgery. Mr. Airasian said he should have been allowed to present evidence of (1) his wife's observations that Dr. Shaak appeared "white as his jacket" and "quite upset" after the second surgery, and (2) Dr. Shaak's statement to the wife immediately after the second surgery: "This was my fault." The Court of Appeals agreed with the trial court that these observations and statements "clearly" fell within the plain meaning of O.C.G.A. § 24-3-37.1(c) and were inadmissible.

### **Conclusion**

Although the rewarding nature of medical malpractice cases has not changed, the impact of tort reform and medical reimbursement claims has greatly complicated the process. Nevertheless, medical malpractice cases still present an opportunity for plaintiffs' attorneys to significantly change their clients' lives for the better. With commitment to the practice, careful case screening, creative damages presentations, and credible, dynamic expert witnesses, attorneys can overcome these recent complications and achieve significant results.