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A Plaintiff's Lawyer Looks at the Morass

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I. INTRODUCTION

"*Primum Non Nocere*" when freely translated means "First, no harm to the patient." It has been a first principle of *medical* practice through the years and to this axiom might well be added: "Let the harm done to a patient *not be aggravated* by a lawyer." It is tragic enough when a lawyer's potential client has been permanently injured or incapacitated or is the survivor of an individual who has met an untimely and unnecessary death at the hands of a medical practitioner or hospital, but the tragedy is compounded when the lawyer inflicts further psychic trauma or economic loss on such a client by ill-advised or ill-timed pursuit of medical negligence litigation. This is a seldom discussed (and rarely admitted) problem in the presently over-heated discussion over medical malpractice litigation. It is time that the legal profession, particularly trial lawyers, fully realize the magnitude of the impact of medical negligence on the patient or his survivors and the *double impact* that the lawyer can create and inflict on them by ill-advised involvement in malpractice litigation.

Although lawyers are supposedly trained in the mental discipline of fact-situation analysis which does not permit *emotional* reaction to the *seeming* abuse of an individual by medical science and its practitioners, many times when faced by a paraplegic, a widow, a physically wrecked person or a sufferer from undiagnosed terminal disease, they react by recommending remedial litigation. Medical negligence, with its ensuing damage to life and limb, does exist and on too broad a scale. And when it truly is present, the victim should seek redress and fair compensation. Successful pursuit of such claims mitigates the harm already suffered by offering some financial redress. It also supports a growing demand for the upgrading of medical practice and more careful application of the healing arts. However, the mediocrity of medical practitioners does not justify the mediocrity of legal practitioners. For a lawyer to *react* to rather than *analyze* a medical horror story, to tell the victim

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that he is entitled to redress in the courts, and to set in motion a financial expenditure to build a case without merit is as unforgivable as is the self-proclaimed omnipotence of a careless physician. An attorney cannot justify expending thousands of dollars to pursue an alleged medical negligence claim only to find himself faced with no expert testimony, a directed verdict at the close of plaintiff's case, or the realization that the case cannot be proven. For a lawyer to permit this to occur is as much malpractice as the alleged claim being pursued. The lawyer has no right to spend his client's funds under the pretext of preparing a case when he has not analyzed the medical facts, acquired expert evaluation and had access to competent, professional testimony which will support the case.

Even though technically medical negligence may have been committed, the attorney cannot justify the filing of a case in the absence of provable *substantial damages* or death resulting from the malpractice. To bring a case, where the chances of proving the medical facts is no better than 50-50 in favor of the client, and where there are no substantial damages or death resulting from the negligence, is professionally unforgivable. This type of "nuisance claim" has justifiably aroused the indignation of the medical profession. It does nothing but place economic strain on the lawyer himself for him to expend his time and office overhead in behalf of a case that has little pecuniary value to the client or himself which proximately results from a claim of negligence by the physician.

There is no room in the legal system for nuisance lawsuits nor for "shake-down" claims' pursuit. There is no justification for suits against other professionals that are not meritorious and that have not caused great financial personal loss to the claimant. As there is no room for mediocrity in medicine, where human life and well-being is involved, there is also no room for mediocrity in pursuing alleged malpractice claims.

The remainder of this article will set out suggested procedures that the attorney should follow to ensure that the claim which is being pursued has merit.

II. APPROACHING A POTENTIAL CASE

A. The Client's History

When a client with a potential medical negligence claim first enters a law office, he should be asked to bring with him a compendium of events that have led to the alleged claim. All treating physicians, places of treatment, and known medical facts should be

outlined by him before coming to the lawyer's office or at the first consultation. Following this, there should be penetrating inquiry as to the client's previous medical history: Have there been other hospitalizations within an arbitrarily set period of ten years? Who has been the family physician? What chronic physical maladies does the client suffer from aside from the problems attributable to the alleged claim now being presented? What injuries or other trauma has the client sustained in the course of his employment, military service or elsewhere? What medication, either sold over the counter or by a prescription, is the client presently taking? What brought the client to the particular physician or hospital whose treatment led to the claim now being presented? What information was imparted to the client as to the nature of the medical technique, procedure or treatment which led to the claim? Was the situation necessitating treatment an emergency or did it involve elective care? What has the client been told, and by whom, as to the prognosis of his present medical problem or ongoing condition? What additional consultations has he sought, both medically and legally, prior to coming to the attorney's office?

The foregoing queries are basic in evaluating the "whole man" from a medical standpoint up to, at the time of and subsequent to the alleged commission of medical negligence upon him. If the client has been a walking medical textbook of problems, it may be extremely difficult, if not impossible, to pinpoint responsibility for the condition which now leads him to the lawyer's office. In addition, if he has a propensity towards neurosis as to his health, this might play a commanding role in the development of a possible case arising from the particular incident which brought him to the lawyer's office.

The evaluation of the client himself is also of paramount importance. What kind of an impression will he make at deposition when opposing counsel is evaluating him as a witness? What kind of an attitude does he project? The "saleability" of the client must be weighed should the case eventually be brought before a jury. A strong case may be greatly diluted by a client's relationship to a jury, judge and opposing counsel. Accordingly, inquiries into the client's background, his work history and relationship with his family become part of the ultimate determination of whether the attorney should accept the case.

B. Records

After the initial screening interview with the client, it is mandatory to obtain all hospitalization records pertaining to the claim in

question, and any hospitalization records for at least ten years prior to the incident. Pathological conditions and the comments of attending physicians in such prior records often give an insight into the client and his general medical profile.

It is wise to obtain hospital records prior to seeking records of a target physician because his comments concerning the care and the condition of the patient will already have been noted in the hospital records. Once these are obtained in *complete form*, then the records of the potential defendant physician, together with those of all consulting or prior treating physicians must be obtained. In these days of acute consciousness of malpractice claims, upon receipt of a letter from an attorney requesting a patient's records physicians often react by immediately calling insurance carriers, personal attorneys or other physicians. They are gripped by fear. Notwithstanding this, it is absolutely imperative that the patient's personal records be obtained. Although the law varies from place to place on the right to obtain such records, there are techniques which can or should be employed to effectuate the voluntary or involuntary turnover of records by physicians concerned.

In *Cannel v. The Medical & Surgical Clinic*,[1] an Illinois appellate case, the court, after considering opinions from other jurisdictions on the subject, adopted the concept that the fiduciary qualities of the physician-patient relationship required the disclosure of medical data to a patient or his agent on request. The physician's records themselves need not be turned over to a patient, but the information contained therein must be given, *i.e.*, by photocopy. In *Cannel*, a complaint was filed by the attorney for a petitioner seeking workmen's compensation benefits because the medical records of the company doctor attending the petitioner were not voluntarily disclosed upon written request to him. The clinic where the physician practiced refused to release any information about the petitioner without the consent of his employer, who had retained the physician and clinic to attend the petitioner following the job-related injuries. The trial court dismissed the petition. In the subsequent appeal, the court held that the patient had the right to obtain such information. The clinic's position had been that it would only release the information when required to do so by subpoena. The court did not accept this argument and instead recognized that a patient need not "engage in legal proceedings to obtain a loftier status" in his quest for medical information. Where suit

1. 21 Ill. App. 3d 383, 315 N.E.2d 278 (1974). *See also* Emmett v. Eastern Dispensary & Casualty, 396 F.2d 931 (D.C. Cir. 1967); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *In re* Culbertson's Will, 57 Misc. 2d 391, 292 N.Y.S.2d 806 (Sur. Ct. 1968).

is filed, another technique to get and preserve records can be utilized.[2]

C. Medical Research

As the first step after accepting a case for review, the lawyer should thoroughly research medical authorities on the nature of the alleged claim. Without such research, he cannot know what the standards of practice are nor where the commission of the error in care and treatment likely occurred. Generally speaking, lawyers are not physicians nor do they have training in medicine or biochemistry. Nevertheless, they can educate themselves sufficiently to understand the fundamental relationships of body systems to one another, the effect of trauma on such systems, or the result of a loss of function of such systems. After a search of authority and after some evidence of the medical soundness of the claim begins to appear, the lawyer should present the facts together with all medical records to a physician in the appropriate specialty for his evaluation. It is imperative that an attorney involving himself in medical litigation have access to a physician who will privately evaluate a potential claim without being compromised. A lawyer who does not have such access probably should not engage in malpractice litigation. The time and expense that can be saved by having *original* evaluation close to the attorney's own town is considerable. If the case has merit on initial evaluation, then what is necessary is acquiring testimony from medical practitioners looking toward ultimate trial of the claim. If the case does not have value, there is no reason to waste the financial resources of the client nor the time and office overhead of the attorney in pursuing claim evaluations at distant geographic locations.

Assuming that the initial research and evaluation shows a potentially valid claim, the lawyer must then read extensively in the particular area of medicine concerned and become conversant with its terminology and problems. If the attorney cannot communicate knowledgeably with the medical community which he is confronting, he has little hope of success. He not only will fail to understand the nature of the medical problem in the case, but he will also fail to impress his adversaries with his knowledge and his ability to see the claim through to completion. The knowledge he acquires will also aid in evaluation of future cases involving similar problems and in taking depositions from potential defendant physicians and other treating or attending physicians.

2. Strodel, *Preservation of Physician's Records in Original Form—The "Reach and Snatch Technique,"* in 2 EXAMINATION OF MEDICAL EXPERTS 509 (M. Bender ed. 1973).

III. BUILDING A CASE—BASIC TECHNIQUES

A. Interrogatories

After basic medical evaluation has been obtained and research accomplished, interrogatories should be sent to each defendant physician which will elicit information to be used as a basis for deposition interrogation. This is an excellent opportunity to acquire information as to a physician's background and qualifications, his area of specialization and the medical authorities recognized by him in the particular field, and to obtain general responses to preliminary questions which will provide a basis for detailed examination at deposition. With few exceptions, a defendant physician's deposition should not be taken without first having probed for basic knowledge through the use of interrogatories. Inquiry into his knowledge of the authorities on which he relies can be used in cross-examining him at deposition and at trial. The defendant physician's updating of his own skills and his extent of experience are also exposed by this technique. If he has done any writing on the medical subjects involved, this information is ascertainable together with information as to any prior similar litigation in which he may have been involved as a defendant or as a witness. Prior involvement in litigation on similar subject matter may produce court testimony or deposition transcripts from which the physician can be examined in the present case. Additionally, hospital staff positions the physician has held and reasons for leaving them, along with other similar information, provide interesting insight into the nature of the physician himself. Such information can also lead to personnel files from former hospitals which may contain opinions of professional competency or information of personality defects or basic medical training failures of the physician involved.

B. Depositions

As the case progresses, depositions of the defendant physician and expert witnesses for both plaintiff and defendant become the very crux of the case's ultimate success. Most insurance carriers writing medical negligence coverage will not offer meaningful settlement of the case until an expert witness has been produced by the plaintiff whose testimony amply shows that a prima facie case can be made in court, which ultimately will go to a jury for verdict. Proper preparation of the expert witness to be utilized for this purpose is critical. Especially important is his background and prior experience or involvement in testifying in medical-legal situations. It is felt that obtaining an expert witness with a limited amount of experience in giving testimony generally or specifically

on behalf of physician defendants, lends extensive credibility to the use of this expert in the case at hand. His testimony must be both scientific and convincing, and he must pinpoint solid medical reasons why the defendant has deviated from recognized standards of care and skill. It is elementary that failure of a plaintiff to show by testimony that the defendant has deviated from these recognized standards is fatal to the case and grounds for a direct verdict.[3] Therefore, it is essential that the plaintiff's expert be properly prepared.

Additionally, a case can be won or lost for settlement purposes or at trial when the defendant physician's deposition is taken. However, not only is the defendant physician "on trial," but so too is the trial lawyer. His correct pronunciation of medical terminology and his knowledgeable use of it will impress the defendant with the breadth of knowledge, research and skill that the trial lawyer has acquired before meeting him face to face at deposition. The defendant physician will be quick to find out if the lawyer is lacking in medical knowledge of the subject, use of terminology or sharpness of questioning. The capable physician can turn the deposition around and destroy the plaintiff's case by evading the lawyer's questions or counter-attacking with exceptions to the points being raised. Once the defendant physician ascertains that the lawyer is both knowledgeable and well-read, he will become uneasy and more defensive, or so intense that he slips at a crucial point and makes an admission which is damaging to his position. Normally, it is this deposition that is the first confrontation between the plaintiff's attorney and the defendant physician. If the attorney is well-prepared, this can produce a psychological advantage for him when discussion of settlement occurs at a later date and a physician is called upon to consent to such settlement under the terms of his liability insurance policy. Few physicians wish to face the ordeal of a court trial, particularly when an attorney has done his homework and the physician knows that a case can be presented against him and reach a jury for determination. Furthermore, good examination by the lawyer at the deposition can lead the particular witness to point the finger of responsibility at another defendant or potential defendant in an effort to excuse his own misconduct.

C. Requests to Admit

Acquiring information by interrogatories and depositions in many cases sets the scene for the use of Requests to Admit Facts.

3. Annot., 81 A.L.R.2d 597 (1962).

While depositions, interrogatories and pleadings *are not* evidentiary, Requests to Admit Facts, under most state procedural rules, and also in the federal system, are. This means that any fact admitted in response to a Request to Admit negates the necessity of proving that fact at trial.[4] This can save considerable time and expense at trial and enable the attorney to concentrate on the basic proofs of the case.

IV. HANDLING THE CLIENT

The approach of the attorney toward a new client with an alleged malpractice claim should be extremely conservative. He should express concerned interest in the client's problem but should take the overall view that there may not be a provable claim. The client must be initially advised that the attorney has only agreed to evaluate the case and give an opinion as to whether it should be pursued. He should be told that the lawyer will not take the case until there has been a thorough examination and evaluation which shows that a provable case exists. The client must be told that the attorney must be reimbursed for any economic expenses arising from the initial evaluation. He should know that the attorney reserves the right to decline the case if, after evaluation, it is his professional judgment that the case should not be brought.

Initially, medical authorizations must be signed by the client. In addition, it is wise to put the client under a contingent fee contract which summarizes all of the things that have been discussed at the initial interview and contains a clause permitting the attorney to withdraw in the event he ascertains no legal merit in the client's cause. The contract should also contain the expense reimbursement obligation statement.

The client should be advised as to the approximate cost of ascertaining the merits of the case and should be told that the attorney is receiving no fee for making the evaluation. It must be emphasized that medical negligence cases are difficult to prove and costly to handle. The client should also be told that the attorney must rely upon physician evaluation of the facts and circumstances presented by the client's cause.

The attorney should be aware that many prospective claimants fear that they will forfeit medical care and attention as a result of pursuing medical negligence claims. These fears must be alleviated by stressing that truly meritorious claims should be compen-

4. Princess Pat. Ltd. v. National Carloading Corp., 223 F.2d 916 (7th Cir. 1955); Sieb's Hatcheries v. Lindley, 13 F.R.D. 113 (1952); FED. R. CIV. P. 36.

sated and that there are many practitioners who will accept a patient on face value. In the same vein, the client should be told that a physician is not an insurer of his practice, that he is only accountable for negligence in the context of professional standards and that the purpose of litigation is compensation, not vindication.

Attorneys are traditionally notoriously poor in communicating with clients. Because of the time involved in accumulating records and evaluations and doing research in these cases, the client should be told initially that he will not hear from the attorney until the attorney's work product is completed and there is something to tell the client. An estimate of the time in which this will be accomplished (at least 30 to 60 days) should be given at the first opportunity. It should be pointed out that silence by the client, while the investigation is being pursued, is likewise important.

A straightforward approach to the client initially will help ease the impact of an evaluation which indicates that the case has no merit. The client should never be promised anything beyond a reasonable and fair evaluation because such evaluation can and often does result in a determination that no claim exists. A candid approach at the initial interview is crucial to the future relationship between the client and attorney. It makes the client feel that the attorney will treat him fairly as far as the expense money is concerned and it makes it clear to the client that he has only been promised a professional "answer" as to the nature of his claim not a "result."

V. THE VIEW FROM OLYMPUS

Sometimes it is pleasant to climb the mountain peak and look down upon the panorama of the scene below. It perhaps creates a false sense of "wisdom" in the climber, but nevertheless serves a useful purpose in leaving the scene of battle and becoming a bit philosophical. With this in mind, the following conclusionary comments are made.

It is suggested that the term "malpractice" be used sparingly in dealings with the medical community. The word itself triggers animosity, generates paranoia, and causes rebellion in the mind of the medical practitioner because of the tremendous emotionalism generated by current national conflict over the problem. The term "medical negligence" should be used whenever possible. Enlightened physicians can accept the idea that a negligent act might occur, but they rarely will accept the idea that a "mal" or "bad" professional performance has occurred.

A jury should initially be advised in *all cases* of medical negligence that no claim is being made that a defendant physician is

a "bad" doctor and that he is not about to lose his license if found accountable in the lawsuit. It should be made clear that this is a civil action seeking compensation only for an error committed on a particular patient at a particular time, that nothing more is involved than *professional accountability* for a negligent act at a given time, and that the defendant physician, in fact, is a "good" physician, but made a mistake. Laymen jurors give the physician the benefit of the doubt before holding him legally accountable. This is evidenced by statistical proof that 80 per cent of cases tried against physicians across the United States have resulted in physician victories.[5] The layman may be jealous of the socio-economic status of a physician, but he also feels that the physician stands between him and death or serious illness. For this reason, medical negligence cases must not be approached in a prosecutorial manner or with an attitude of ill-will.

When a lawyer brings an action for medical negligence, he ventures into the arena of the physician. Broad medical knowledge acquired in a personal injury practice is important but in no way prepares the lawyer to engage in medical-legal litigation. The professional pressures and emotionalism of medical negligence litigation is different than any other field of tort law. It is unusual for a negligence trial lawyer, representing plaintiffs in medical negligence claims, to enjoy any kind of relationship with the medical community that is not suspect or characterized by antagonism since the lawyer engaging in such a practice is an economic and personal threat to the medical practitioner.

No lawyer should lightly sue another professional. As indicated at the beginning of this article, a lawyer who proceeds on emotional reaction cannot survive economically or psychologically. He is a professional failure if he does not exercise the cool, objective reasoning expected and required of him in handling such claims. A poor medical result is not the same as professional negligence.

The lawyer who establishes a reputation in both the legal and the medical community of being careful in the analysis of the cases he brings will be feared and respected and will well serve his clients' causes. Equally important, he will contribute substantially to the upgrading of medical practice in the area in which he lives. It is the professional and personal reputation of the lawyer that ultimately has much to do with his success and the establishment of his credibility as a professional in this field.

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5. DEP'T OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 10 (Jan. 1973).