Defending Medical Malpractice Claims
Leading Lawyers on Navigating Medical Malpractice Developments and Mounting a Successful Defense
Presenting an Effective Malpractice Defense before a Lay Jury

Charles L. Bach Jr.

Partner
Heidell Pittoni Murphy & Bach LLP
Introduction

It is often said that medicine is an art, as well as a science. Certainly there is an art to the trial attorney’s task of defending physicians, and this chapter will address fundamental precepts for preparing the defense to prevail at trial. As the director of a play must consider the impact staging will have on the audience, the trial attorney defending a physician must consider his audience and gear the defense to that audience.

Three Key Steps in Mounting an Effective Medical Malpractice Defense

Our firm’s overall goal in mounting a medical malpractice defense is to demonstrate that the defendant physician’s treatment of the plaintiff was eminently reasonable at the time it was rendered, and/or the patient’s outcome was caused by an underlying medical problem or a complication of that condition. Of course, when we are defending a medical center, we have the same goal: to demonstrate that the treatment rendered at the time of the event met the standard of care.

The seminal case in New York setting forth the standards by which a physician is judged is *Pike v. Honsinger*, 155 N.Y.201, 209, 49 N.E. 760, 762 (1898). This case articulates the physician’s duty to use “reasonable care and diligence” in his treatment of a patient. Another important case is *Nestorovich v. Ricotta*, 97 N.Y.2d 393 (2002), which holds that a medical caregiver may not be liable if he merely chooses between medically acceptable forms of treatment.

It is our goal to demonstrate that our client acted prudently and exercised sound judgment in weighing the risks and benefits of potential treatment plans. Indeed, if the patient’s condition worsened or she did not survive, it was the underlying condition, complications of that condition, and complications of the treatment that are responsible for the poor outcome. Hence, the first step in mounting an effective defense is to thoroughly investigate the facts that were presented to the physician or health care professional at the time of the treatment at issue. This requires an exhaustive interview of the physician and close examination of his office records and hospital chart entries, including all laboratory tests, radiographic studies, and reports from consulting physicians. Once we have
a complete understanding of the factual context in which the plaintiff or
plaintiff’s decedent consulted our client, we are able to identify the critical
areas that must be addressed in mounting our client’s defense.

At the initial stages of the investigation, we identify renowned experts in the
particular medical specialty involved in the claim who are conversant with
the standard of care at the time treatment was rendered. This second step
will require some Internet research, review of medical literature, and close
consultation with our client. Indeed, defense counsel must obtain a
thorough understanding of the plaintiff’s disease process, including any co-
morbidities or risk factors plaintiff presented. This requires intense medical
research using search engines such as Google’s Scholar, Pub Med, and
Uptodate. Many defense firms maintain medical libraries and databases with
curriculae vitae of the leading experts in every specialty.

Once we have an understanding of the standard of care and recognize all of
the accepted treatment alternatives and the downside risks of the treatment at
issue, we are ready to proceed to step three: an exhaustive document
discovery process during which we obtain all of the plaintiff’s medical
records, including health insurance records. We examine the records of each
prior and subsequent treating physician or hospital and produce a timeline of
the plaintiff’s treatment. It is of critical importance that we understand the
context in which our client made treatment decisions and ensure that the
physician was thorough in his approach. We want to establish that when our
client assessed this particular patient, he took a complete history, performed a
thorough examination of the patient, ordered the tests that were indicated at
the time, and came up with a reasonable assessment of the disease process—
i.e., a reasonable differential diagnosis—before recommending a treatment
plan for the condition diagnosed.

Presenting the Case: Key Arguments

At trial, the plaintiff’s lawyer will try to convince a lay jury that her client was
injured by a physician who “may be an excellent doctor, but was negligent on
the day in question.” During jury selection, opposing counsel will often give the
analogy that a person can be an excellent driver 999 days out of 1,000, but the
one day he rushes through a stop sign and injures a person, the good driver is
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negligent and must compensate the plaintiff for injuries. As defense counsel for physicians and medical centers, we need to demonstrate that this is a poor analogy because the patient who consults a physician has an underlying health problem. A physician’s efforts to cure or improve the patient’s condition involve complex matters of professional judgment and are not analogous to a driver who runs a stop sign and hits another driver’s automobile.

We teach our attorneys that our clients do not “injure” their patients. The word “injury” is derived from the Latin injuria, which means “to harm.” Barnhart, CHAMBERS DICTIONARY OF ETYMOLOGY, 529 (2003). Our clients follow the Hippocratic Oath of “First do no harm.” If the patient has gotten sicker despite treatment, this was because of the underlying condition. We thus argue that the patient was not “injured.”

It is our goal to defend our client by educating the jurors and the judge about the nuances of the plaintiff’s disease and treatment options. Claims against physicians ought to be decided by thinking jurors who use their heads, rather than their hearts, in analyzing the facts of the given cases. During trial we use audio and visual equipment to explain the anatomy, the disease process, and our client’s own thinking process at the time treatment was rendered. We retain certified medical illustrators to create trial exhibits that graphically portray the diseased anatomy in question and the surgery our client performed to address the disease. These visual aids enable our client and experts to communicate to jurors in a language they can understand.

Considerations in Creating a Successful Defense Strategy

If we are representing a physician who, for example, is sued for an alleged failure to diagnose cancer in a timely manner, our initial investigation requires interviewing the physician and some of her staff members and analyzing her office records. When the claim is against a medical center and it involves allegedly improper surgery or postoperative monitoring, the initial investigation may be far more time-consuming. In those cases, we interview all of the staff members who were involved in the care and treatment in the operating room, the recovery room, or the intensive care unit. We may also need to inspect a medical device if there is an allegation that the surgeon mishandled a device, and have the device tested to determine whether it was maintained and functioned properly. Other departments may have been involved in the patient’s care. For example, we
may need to obtain pathology slides or radiographic studies, such as CT scans and MRIs so that they can be reviewed by experts in those specialties. Every step of the way, the success of a malpractice defense strategy is measured by the attorney’s understanding of the medicine and the unique factual setting of the plaintiff physician’s interaction with her patient. Ultimately, success is measured by the disposition of the case through a voluntary discontinuance, a favorable settlement, a dismissal on a summary judgment motion, or a defense verdict at trial. These results cannot be achieved unless the attorney masters the underlying medical facts.

**Skills and Resources Needed to Successfully Defend Medical Malpractice Claims**

The primary legal skill needed to defend physicians and medical centers is the ability to identify the material issues (“issue spotting”) in the context of a complex medical situation. The attorney must have a sound working knowledge of the medicine involved; she must be willing to put in long hours to understand the significance of each chart entry; and she must be willing to become an expert in the plaintiff’s disease and the particular medical procedure at issue in the malpractice claim. The defense attorney must then be able to communicate to laypeople the bases for the physician’s judgment calls and demonstrate how each one was reasonable at the time it was made. This means the attorney must understand how to weigh the risks and benefits of each treatment decision her client made.

Frankly, trial attorneys who defend physicians and medical centers do more medical research than legal research. For example, if the case involves the performance of a colonoscopy on a patient with ulcerative colitis, an inflammatory bowel disease, who suffered a perforation of the colon resulting in a colectomy, the defense attorney must become an expert in ulcerative colitis. Defense counsel must understand the medications used to treat ulcerative colitis, the significant complications the disease presents to the patient suffering from it, and why a colonoscopy performed on an ulcerative colitis patient is far more complicated than a routine screening colonoscopy in a healthy adult. The defense attorney must understand why the gastroenterologist performs endoscopic surveillance on his patient’s entire colon to determine how the patient’s disease is responding to the prescribed treatment at the time of the colonoscopy. In addition, the gastroenterologist
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treating an ulcerative colitis patient must be concerned about the increased risk for colon cancer that his patient presents as an inflammatory bowel disease patient. Thus, a colonoscopy in an ulcerative colitis patient is generally performed on at least an annual basis to screen for dysplasia or other precancerous signs and to assess the response of the disease to prescribed medications. In an appropriate case, the defense may be able to argue that the ulcerative colitis patient who suffered a perforated colon necessitating a colectomy is better off without his diseased colon because the patient is cured of colitis and has avoided the risk of colon cancer.

Hopefully, your client will be a primary resource of medical knowledge during the course of litigation. The physician is part of the defense team, helping the trial partner understand the standard of care based on the medical literature, treatment guidelines, and advancements in treatment and whether there is any causal connection between the care and treatment and the plaintiff’s outcome.

Malpractice Investigation Procedures: Preparing the Client to be Interviewed

Physicians may face investigations of their care and treatment of a former patient by a state disciplinary board, a hospital administrative board, or a plaintiff’s attorney in the context of the lawsuit.

In New York, any complaint concerning a physician’s treatment that is made to the New York State Department of Health is referred to its Office of Professional Medical Conduct (OPMC). OPMC has subpoena power over medical records, and New York’s Public Health Law mandates that it investigate every complaint confidentially. See N.Y. PUB. HEALTH LAW § 230(11)(a); Michaelis v. Graziano, 5 N.Y.3d 317 (2005). Hence, the physician is not told who lodged the complaint.1 It may have been brought by a patient, a patient’s family member or legal counsel, or by a former medical colleague. The staff at the OPMC opens a file and assigns an investigator who obtains relevant medical records, including the office records of the target physician—the one whose care is the subject of the complaint. That physician is required to supply a copy of his office chart on request by the

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1 If a patient later testifies at a formal disciplinary hearing, his identity and any written complaint are subject to disclosure to allow the physician to fully cross-examine the patient. The proceedings remain confidential to the public. See McBarnette v. Sobol, 83 N.Y.2d 333 (1994).
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OPMC investigator. Working with a staff physician at the OPMC and the investigator, the agency decides how exhaustive the investigation should be. After the complainant is interviewed and records are obtained, the physician may be called in for an interview, and he has the right to counsel at this interview. Defense attorneys need to prepare their clients for these interviews as if they were preparing for grueling depositions or trials. The physician must be ready to explain in detail his treatment of the patient and how he met the standard of care at the time of treatment. The role of the defense attorney remains behind the scenes during an OPMC investigation. Defense counsel identifies the critical issues, makes a checklist of what must be covered by the physician, and then quietly attends the meeting. Allow the physician client to answer all of the questions and concerns of the investigators.

At the OPMC interview, the defense attorney may make a brief statement to ensure that the investigators learn the important details of the plaintiff’s care and treatment that may not be so apparent from the chart. At this interview, the goal is for the physician to convince the OPMC that the standard of care was met so that the investigation will be closed without any administrative charges. Unlike a trial, the issue of patient outcome is not dispositive: the focus is on whether the physician met the standard of care or is in need of further training. If charges arise, OPMC hearings are held before an administrative judge, an OPMC panel member representing the public at large, and a physician who should practice in the same specialty as your client. These hearings do not follow strict rules of evidence, and they can result in findings that adversely affect your client’s medical license, including its revocation or the placing of the client on probation. To be sure, there is much at stake in representing physicians in disciplinary investigations and proceedings.

Hospital investigations may wind up in disciplinary proceedings by the OPMC. If there is a subsequent private lawsuit, the details extracted during hospital investigations are generally protected from discovery under a “quality assurance” privilege. See N.Y. EDUC. LAW § 6527(3); N.Y. PUB. HEALTH LAW § 2905-m. As in OPMC matters, the physician is expected to cooperate voluntarily and speak freely about her treatment, explaining the outcome without holding back. There is no public role for defense lawyers at, for example, a mortality and morbidity conference where a particular surgery is analyzed after an unanticipated outcome. The same is true of any
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typical hospital board investigation of the physician’s treatment. The goal is always to establish that at the time of the events, the physician’s judgment was sound, and the care was acceptable. A lawyer’s involvement in a hospital investigation may arise if a sanction is about to be imposed, and a physician seeks a hearing under the hospital’s bylaws.

In sharp contrast to these settings is the investigation that is pursued as part of medical malpractice litigation. Before suit is filed, the physician will be placed on notice that she may be sued when she receives a lawyer’s letter requesting copies of her records. In New York, the Public Health Law gives patients the right of access to their treatment records and mandates that physicians release copies of their chart in a timely manner for no more than seventy-five cents per page to copy the records, and then send them to the former patient’s attorney. See N.Y. PUB. HEALTH LAW § 18(2). Once in receipt of such a request, the physician ought to consult counsel to discuss the nature of her care so that efforts can be made early to identify potential medical and legal issues, important witnesses, documents, laboratory results, etc., that need to be obtained and analyzed.

Once the case is in suit, the physician is urged to cooperate with counsel and become part of the defense team. Together, the physician and lawyer must prepare for the battles that medical malpractice litigation entails.

Common Targets of Recent Medical Malpractice Lawsuits

One of the most common medical malpractice lawsuits involves a failure to diagnose cancer or some other life-threatening condition in a timely manner. The mantra “early detection offers a better chance of a cure” is so well known by the public that it puts the defendant physician who did not diagnose breast cancer, for example, in a difficult position when sitting at the defense table. The plaintiff may have died or suffered horrendous complications of the treatment for her cancer, so the physician must explain to a lay jury that he did not order particular tests because they were not clinically indicated. This can be a difficult argument to make in a courtroom because lay jurors tend to use 20/20 hindsight and assume that earlier tests would have pointed the physician to an earlier diagnosis, affording a “better chance for a cure.”
But New York law with respect to causation is construed liberally. Proximate cause is established where the defendant’s conduct was a “substantial factor” in bringing about the injury. *Stewart v. New York City Health & Hosps. Corp.*, 207 A.D.2d 703, 704, 616 N.Y.S.2d 499 (1st Dep’t 1994), lv denied 85 N.Y.2d 809, 651 N.E.2d 920, 628 N.Y.S.2d 52 (1995). “[P]roximate cause is a legal concept which cannot be dissected and measured in terms of percentages,” and it “has proven to be an elusive [concept], incapable of being precisely defined to cover all situations.” *Mortensen v. Memorial Hosp.*, 105 A.D.2d 151, 157, 483 N.Y.S.2d 264 (1st Dep’t 1984); see also *Goldberg v. Horowitz*, 73 A.D.3d 691, 694, 901 N.Y.S.2d 95 (2d Dep’t 2010) (“proximate cause may be found legally sufficient even if (the plaintiff’s) expert is unable to quantify the extent to which the defendant’s act or omission decreased the plaintiff’s chance of a better outcome or increased the injury”).

Also common are claims against obstetricians on behalf of infants who later develop cerebral palsy. These cases involve tremendous monetary exposure to the physician and medical center and are, of course, extraordinarily sympathetic. Frequently, the claim is that the physician should have recognized signs of fetal distress and performed a Caesarean section, rather than allow labor to continue to a natural vaginal delivery. The obstetrician who allowed labor to continue is accused of carelessness resulting in hypoxic brain damage to the baby. By the time this case reaches trial, the infant plaintiff is often wheelchair-bound with significant cognitive deficits. The plaintiff’s attorney argues that that the child would have been “normal” but for the negligent conduct of an obstetrician.

To overcome the challenges obstetrical cases present, we search for an alternative reason the infant is impaired. Often, analysis of the placenta by a skilled obstetrical pathologist will provide facts that indicate the fetus was damaged *in utero* before the events of labor and delivery. Another potential defense is that the infant’s severe neurological deficits are attributable to his extreme prematurity, and the obstetrical team could not extend the pregnancy or avoid the delivery of such a premature baby. An analysis of cranial MRIs by a pediatric neuroradiologist may demonstrate that the child’s brain lesion was not caused by hypoxia during labor and or delivery, but by other factors outside the control of the obstetrician. In a rare case, a geneticist may be able to identify a syndrome that is the cause of the child’s neurological deficits, thereby providing a medical defense for the obstetrician and neonatologist.
Risks of Being Sued for Medical Malpractice

Physicians who perform high-risk procedures on patients with comorbidities or additional risk factors, such as diabetes, obesity, or high blood pressure, are at the highest risk for suit. Insurance premiums paid by a neurosurgeon are exponentially higher than those paid by an internist. A neurosurgeon who operates on the brains and spinal cords of his patients will have patients who suffer brain injuries or death or paralysis. That is the nature of the practice.

As noted, obstetricians/gynecologists are also at high risk for litigation, not only in neurologically impaired infant cases, but also in cases involving alleged failure to diagnose breast cancer, ovarian cancer, cervical cancer, or other types of gynecological cancer. The obstetrician/gynecologist is often the de facto primary care physician for a woman and is expected to field complaints—for example, for a breast lump, select the proper work-up—i.e., a mammogram or ultrasound—and then act accordingly, based on the result of the tests.

Cardiothoracic surgeons operate on the heart. When things go wrong, their patients may die or suffer many untoward complications. We have had cases where patients wound up with amputations of their legs after open-heart surgery because medical complications required the use of vasopressors, which constrict blood supply to the periphery to guarantee better blood supply to the brain, kidneys, and other major organs. This, in turn, leads to ischemia in the outer extremities (fingers, feet, and toes). As a result, these specialists are often sued based on complications of life-saving surgery.

Radiologists are also at risk for suit. In suits against radiologists, we often employ a “Where’s Waldo?” analysis. Looking at a radiographic study cold, a radiologist may not interpret a particular finding as problematic. However, when shown a film by an attorney, the radiologist is looking for a finding to explain the lawyer’s interest in the case. If, for example, a subsequent radiographic study demonstrates the mass that has now been determined to be malignant on biopsy, it is easy to see where “Waldo” was and how a particular shadow on an earlier film should have been identified as a mass that required an earlier work-up. This is classic “outcome bias,” and the defense attorney must be prepared to overcome it.
Finally, a high-risk patient who has diabetes, hypertension, obesity, sleep apnea, or any combination of chronic diseases, is at increased risk for a poor outcome, and his physician is, in turn, at increased risk to be sued.

**Demonstrating that the Client Acted Reasonably**

My primary strategy in demonstrating that a malpractice suit client acted in a reasonable manner involves understanding the medical context in which my client physician rendered treatment. Any interaction of physician and patient is a consultation that can best be described in an organized “SOAP note.” SOAP is an acronym taught in medical school where the “S” stands for the subjective information the patient communicated to the physician at the outset of the office visit. A patient’s medical, surgical, and social history should be carefully taken by the physician, and the pertinent parts should be well documented.

In an office setting, I advise my clients to hand a questionnaire to their patients at the first visit so that each patient fills out in his own hand exactly why he is consulting this physician and writes down all of the information concerning his prior medical and surgical history; family history of cancer, etc.; his social history—whether he smokes, drinks, etc.; the medications he takes; and any allergies he may have. This questionnaire should be made part of the physician’s chart and scanned in and electronically maintained, along with the other medical records, laboratory results, and consultant reports concerning the patient. A good deal of medical malpractice litigation revolves around the question of whether the patient was a poor historian or the physician a poor listener. Trial lawyers refer to this as “the swearing contest,” and the physician who has well-organized, well-documented records will win that contest.

Defense counsel must also demonstrate that her client performed an appropriate “objective” examination of the patient. This is a hands-on examination that can be described by the physician in the “O” part of her SOAP note. An internist will likely have a note describing findings on examination of the patient’s head, eyes, ears, nose, throat, cardiac system, pulmonary system, and extremities. A thorough head-to-toe, hands-on examination can easily be described on one sheet of paper. A spinal surgeon will perform a neurological evaluation and describe the strength of the patient’s leg muscles in evaluating a patient who complains of back pain.
Next comes “A” for assessment: in other words, what are the possible explanations for this patient’s complaints? Once there is a diagnosis, the physician articulates a plan of treatment, and that is documented in the “P” portion of the SOAP note. For example, a patient who came to the office of an orthopedic surgeon with a subjective complaint of lower back pain radiating down the left leg must supply a complete history before being examined. A physician presumes that the patient is feeling pain, but must perform an evaluation to see whether physical findings support a factual basis for that subjective complaint. The physician may then order radiographic studies (nowadays an MRI, as opposed to an x-ray or a myelogram in the old days) and rely on a neuroradiologist’s report and his own review of the MRI images to make a diagnosis concerning the cause of the back pain. If it is a lumbar disc impinging on a nerve root, a laminectomy may become the “P,” the plan of treatment.

In addition to defending the plaintiff’s care and treatment, we like to know something about the plaintiff that may impact the merits of the plaintiff’s claim or the plaintiff’s credibility as a witness. Today, with social networking sites and blogs, we can sometimes discover that the plaintiff is a malingerer, an unreliable historian, or a litigious person if we have carefully searched the Internet.

At the time of trial, we scan in all of the material medical records so that we can project them onto a screen and highlight particularly important parts of the charts, rather than using blow-ups. Today’s jurors are trained to understand things visually, rather than through mere audio presentations. They prefer to see exactly what the records made at the time of events demonstrate and view medical illustrations to understand what the surgery was all about, rather than merely listen to a lawyer’s description of this data.

Choosing a Good Medical Expert and Proving the Physician Did Not Cause Plaintiff’s Damages

The finest medical expert is one who has a great deal of experience in the particular procedure or disease at issue in the case and the ability to communicate in simple terms to a lay jury. Our experts tend to be at the top of their profession, and they know it. However, the best experts relate to a jury as humble individuals who have a particular gift. To obtain these experts, we first speak to our own clients to see who they have heard
lecture at national meetings. We research peer-reviewed medical literature to identify authors of seminal articles on the disease. At the same time, defense counsel must retain an expert who does not have any professional or social ties to the client. The expert should not be retained if, for example, she has co-authored any articles along with your client.

The expert must be able to relate to jurors from all walks of life and teach them the relevant medicine so that the finders of fact understand the plaintiff’s disease process, how the defendant weighed the risks and benefits of various treatment options, and why the defendant chose the option that is now the subject matter of litigation. Jurors can be turned off by physicians who do not make eye contact with them and come across as arrogant, impatient, or disorganized. By searching the medical literature, including PowerPoint presentations available on the Internet and medical center websites, it is not difficult to identify good experts, but it may be difficult to convince them to take the time required to review the documents that are in a case file and then be willing to come to court to testify at trial.

In New York, there are no depositions of experts except in rare circumstances. See N.Y. C.P.L.R. 3101(d). Rather, there is a document prepared by attorneys known as “expert disclosure” that does not identify the expert, but merely summarizes what the expert is likely to testify about at trial and provides some background information, including the date of medical school graduation, the date of internship and residency, and any fellowships and board certifications. Computer software allows both sides to identify the experts and then obtain their medical literature, prior testimony in other cases, and any other information that may be used to challenge their credibility or expertise during trial.

Once they are retained based on their assurance that they can defend the care and treatment at issue, experts are part of the defense team. Experts can point us to relevant peer-reviewed medical literature and specialty guidelines to show us the complication rates for various procedures and to explain the standard of care. For example, we like to call as witnesses medical experts who are members of a national board who give examinations that must be passed to obtain board certification, or experts who are chairs of departments at major medical institutions. These physicians are aware of the standard of care because they teach it daily to their residents.
We can then contrast the defense experts to a plaintiff’s “expert,” who in many cases merely has an office practice, no real publications, no significant teaching appointments, and is being paid an astronomical sum to testify even though he does not have any true expert credentials. We like to demonstrate that the plaintiff’s expert has testified all over the country and offers his services on “find an expert.com.” In addition, if the plaintiff’s expert presents an opinion on causation that we consider to be “junk science,” we challenge the expert by applying to the trial court for a Frye/Daubert hearing where the expert must establish that his hypothesis has a valid scientific basis. See, e.g., Cumberbatch v. Blanchette, 35 A.D.3d 341, 825 N.Y.S.2d 744 (2d Dep’t 2006) (precluding plaintiff’s expert testimony where expert could cite to no relevant scientific data or studies to support his causation theory that fetal distress resulting from the compression of the infant plaintiff’s head due to labor contractions, augmented by Pitocin, resulted in ischemia, which, in turn, resulted in an infarction, and he could cite to no instance when this type of injury had previously occurred in that manner).

Typically, the plaintiff’s attorney is looking for experts who can sound convincing to a lay jury when they testify in support of a plaintiff’s theory of negligence. They often do not care about the contents of an expert’s curriculum vitae. Rather, they want to be sure the expert will “toe the party line” and be an advocate for the plaintiff in front of a jury by refusing to make any concessions when cross-examined by the defense attorney. A common trick of a plaintiff’s expert is to testify as to how he would have treated the plaintiff while couching his testimony in the usual language about the “standard of care.” Such second-guessing is more convincing when there is a strong sympathy factor. However, by obtaining the expert’s prior depositions and trial testimonies in cases pending around the country, the defense can often discredit the plaintiff’s expert as a hired gun who has developed a cottage industry by reviewing cases and testifying against his fellow physicians, shaping his testimony about the standard of care to fit the needs of the case at hand.

**Top Challenges of Defending against a Medical Malpractice Claim**

The biggest hurdle for the defense is the plaintiff’s medical outcome and the need to overcome “outcome bias.” We ask jurors not to judge our clients using a “retrospectoscope.” Rather, we establish the timeline of treatment and ask the jury to pretend they are watching a DVD as the case unfolds. The defense must
prove that at the point in time the physician made his recommendations or performed his surgery, he acted reasonably. If the patient’s outcome was poor, that fact is after-acquired knowledge that cannot be used to judge the physician’s conduct. Once the facts are proved, the DVD is stopped at a particular “frame” or point in time, and the jury is asked to determine whether the physician’s judgment was reasonable at that time, regardless of subsequent events. In this respect, the physician’s contemporaneous records are of paramount importance, and we always point out that the records made at the time of the events are the best evidence of what occurred years before the trial. After all, memories fade, but a computer entry or a written note does not. Today, plaintiffs often want to obtain the metadata behind the computer entry to see when it was actually entered and by whom. This can present a problem in cases involving large medical centers using computer software systems that produce a trail of who knew what, where, and how.

Nevertheless, it can be difficult to overcome the sympathy factor, particularly in cases involving neurologically impaired infants or adults. We have had some success in making pretrial motions to bifurcate medical malpractice cases into two phases: the first liability, and the second damages. We argue that the first phase of the trial should focus on whether the standard of care was met before the jury hears any evidence about the plaintiff’s current predicament, with the usual showing of a “day in the life” video and testimony about millions of dollars in past, present, and future damages, that might render a dispassionate deliberation on the liability issues impossible.

Avoiding Medical Malpractice Claims

To avoid medical malpractice claims, a physician ought to organize his treatment note so that it is legible and so that when it is subpoenaed to court and blown up to four feet by three feet, he would be proud to stand next to it and explain every entry. It does not have to be a lengthy dissertation, but it ought to be a well-organized SOAP note.

In addition to good documentation, it is critically important to have a good bedside manner and build a rapport with the patient and her family. Thus, it is extraordinarily important for the surgeon to see the patient after surgery, talk to the family after surgery, and stay in touch with the family as the patient remains in the hospital. The attending physician who relies on residents to do all of his post-operative work on patients is playing a
dangerous game. The attending physician must take ownership of the case and build a rapport with his patient and the family.

In some hospitals, including the University of Michigan, The Mayo Clinic, and the Harvard Medical Centers, physicians and hospital administrators have been encouraged to hold meetings with family members when a patient experiences an untoward outcome. Patient apology programs have been successful when the family is receptive to hearing the physician describe what occurred in the operating room, what the hospital’s investigation entailed, and when they are placed at ease as to why a particular complication occurred and what the medical center intends to do about it. We are cautiously optimistic that these meetings, when handled properly, will result in less litigation.

We caution our physician and medical center clients not to discuss their treatment with the patient or family members over the telephone. Telephone calls may be taped unbeknownst to the doctor or risk manager, and statements taken out of context may impair the defense that sound medical judgment was employed at the time of the treatment at issue in the litigation.

Conclusion

When defending a physician at trial, the lawyer must turn back the clock to the hour, day, month, and year treatment was rendered. Understand the nuances of plaintiff’s disease and explain to a lay jury how eminently reasonable the physician’s medical or surgical judgment was at the time treatment recommendations were made. Establish the concept of acceptable treatment alternatives, and demonstrate how your client met the standard of care by recommending one of those acceptable alternatives.

In an appropriate case, the defense must challenge plaintiff’s causation theory by demonstrating that there is no peer-reviewed study or accepted medical evidence to link the physician’s treatment to the patient’s outcome. Interview or depose key subsequent treating physicians to expose the fallacy of plaintiff’s theories of causation. Conduct the defense as though you have the burden of proof by being proactive at trial. You must convince the fact finders that objectivity requires they find facts that will exonerate your client. In that respect, justice will be done.
Key Takeaways

- Thoroughly investigate the facts that were presented to the physician or health care professional at the time of the treatment in issue. Interview the physician, and closely examine his office records, hospital chart entries, laboratory tests, radiographic studies, and reports from consulting physicians.

- Identify renowned experts in the particular medical specialty involved in the claim who are conversant with the standard of care at the time treatment was rendered and who can communicate well with a jury. Obtain a thorough understanding of the plaintiff’s disease process, including any co-morbidities.

- Obtain all of the plaintiff’s medical records, including health insurance records. Examine each prior and subsequent treating physician or hospital, and produce a timeline of the plaintiff’s treatment to understand the context in which your client made treatment decisions and ensure he was thorough in his approach.

- Use audio and visual equipment to explain the plaintiff’s anatomy, the disease process, and your client’s thinking process at the time treatment was rendered. Be able to communicate to laypeople the bases for the physician’s judgment calls and demonstrate how each one was reasonable at the time it was made.

- Advise physician clients who wish to avoid malpractice suits to maintain good documentation and a positive relationship with the patient and her family, during and after her hospital stay.

After serving four years as an assistant district attorney in The Bronx, Charles L. Bach Jr. started as an associate at Heidell Pittoni & Moran in June 1981. Since that time he has been defending physicians and staff members of university medical centers at trial, in professional disciplinary proceedings, and on appeal. In 1985, the name of his firm was changed to Heidell Pittoni Murphy & Bach LLP, and as a senior partner with more than thirty years of experience defending physicians, he has recognized the need to effectively communicate complex medical concepts to a lay audience.

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