

**STANDING ON THE SHOULDERS OF GIANTS:
TRIAL TIPS AND TECHNIQUES FOR TRYING
THE MEDICAL MALPRACTICE CASE
(THE PLAINTIFF PERSPECTIVE)**

I. Threshold Considerations - Plaintiff's Rule #1 (The Only Rule) - Evaluate Your Case.

At the outset, though it may already be touched on elsewhere in these materials and in the presentations, this author can't overstate the importance of conducting a rigorous and thorough evaluation of the plaintiff's potential medical malpractice / medical negligence¹ case.

Medical negligence cases are a specialized business, and carry substantial economic risk. Such cases are very time consuming, and are very expensive to develop and carry to verdict. A thorough risk-cost / benefit analysis, to the extent such can be carried out, can only benefit the advocate and the advocate's client.

I recognize there may be no hard and fast rules for conducting a risk-cost / benefit analysis, and that successful attorneys practicing in this highly specialized area can and do differ in their approaches. This author believes that such a skill can be likened to an art, but that several considerations can serve the advocate well.

Consider, at least:

- time limitations (if any) for filing suit or bringing claims
- the nature and extent of liability to be proved and harm alleged
- the number of potential defendants at-fault

¹ The author recognizes the terms "medical malpractice" and "medical negligence" can be used interchangeably, and prefers the term "medical negligence".

- the difficulty of proving a prima facie case of liability
- the difficulty of proving a prima facie case of causation
- the economic costs of obtaining all medical and financial records
- the economic costs of obtaining threshold opinions of qualified experts
- the economic costs of depositions and deposing the opponent's experts
- that you may have to incur travel costs for yourself and/or experts
- the economic costs of researching medical literature
- the jurisdiction and venue
- the economic costs of focus groups and mock trials
- how your client will be perceived by the finder of fact
- the time you will spend on the case (to the detriment of other matters)
- the potential damages (recovery)
- potential claims of comparative or contributory fault

It is a fact that physician, clinic and hospital defendants win more cases at trial than they lose. Statistics seem to vary, but *plaintiffs in medical negligence cases lose 80% - 90% of the time*. It bears repeating. The reasons are numerous, and the following is only as a partial list of reasons this author has identified to explain his belief why plaintiffs are not more successful in medical negligence trials:

- liability is nearly always vigorously disputed
- the psychological principle of accountability bias
- complexity, confusion and ambiguity of medical and scientific issues
- the reality that medicine is an inexact science
- the place of, and generally high regard for, physicians in society
- the reality of conservative juries
- the reality of bias in juries
- jurors that are distrustful of the tort system and plaintiff lawyers
- the availability (or lack) of qualified experts willing to assist the plaintiff

- the reality of well-funded defendant opponents
- the reality of highly experienced opponents
- the reality of sophisticated evaluations by opponents and insurance carriers
- over-estimating the strengths of plaintiff's case
- lack of sympathy as motivator for juries
- the perception of skyrocketing health care costs
- the perception of out-of-control runaway verdicts

There is abundant literature available to the interested advocate on each and every item above, and it is not this author's place to discuss these listed items point-by-point in detail. Rather, they are listed here so that the advocate will be ever-mindful of the reasons why it is vitally important, as a business consideration and as a practical matter, to evaluate one's potential case in a realistic light.

That having been said, the aspiring advocate can take heart. Many years ago a good friend shared with me one of his secrets for a successful practice specializing on behalf of plaintiffs in medical negligence cases. He said "**Take only good cases ... and there are lots of good cases**". It probably helped that my friend (holder of several record verdicts) is an M.D. as well as a J.D., but his words did then, and continue to ring true for this advocate.

II. Threshold Considerations - Plaintiff's Rule #2 - Not All Negligence Is Actionable.

A seasoned medical professional privately shared with me the opinion that every medical file contains evidence of some negligence. While this author personally believes that opinion may prove something of an overstatement, the point here is to be mindful that not all negligence is necessarily actionable.

Case Study #1

You are at your desk. The phone rings and prospective client (“PC”) relates this story:

PC’s 87 year old mother is admitted to hospital for treatment of bacterial pneumonia. At the time of admission, PC tells the nurse that his mother has a past history of angioedema when taking an ACE inhibitor (class of cardiac drug). The nurse notes this in the patient chart under allergies. The patient receives IV antibiotics and supportive care for the pneumonia but develops congestive heart failure. This is treated with digitalis, diuretics and Vasotec (ACE inhibitor). The patient develops an anaphylactic reaction with cardiorespiratory distress and shock. She is successfully treated for the anaphylaxis but dies a day later from the severe pneumonia.

The hospital admitted the medication error to PC at the time. But, the error, while negligence, does not matter as the patient died from sepsis from the bacterial pneumonia.

Case Study #2

A 61 year old male, smoker of one pack a cigarettes a day for more than 20 years, is followed by his internist with annual visits. On an annual exam, the patient reported a persistent, non-productive cough for the past 2 - 3 months, with occasional wheezing. The physician performs the usual annual exam, including auscultation of the lungs, and recommends that the patient stop smoking. No chest x-ray is obtained. The patient is told that if the cough worsens to contact the office.

The patient returns to the office in 2 months reporting that he is unable to quit smoking and asks for a nicotine patch. The patient reported that his coughing remained the same. The patient was given a patch and advised to contact the office if the coughing persisted.

Six weeks later, the patient returns to the office reporting a significant reduction in his smoking and persistence of the cough (now productive), with more frequent wheezing. The physician listened to the lungs and noted some abnormal breath sounds but did not obtain a chest x-ray. The patient was told to stop smoking and return to the office if his cough worsened.

One month later, the patient returns to the office reporting shortness of breath and more coughing. He also reported pain in his bones. The physician orders a chest x-ray and then a bronchoscopy which diagnosed small cell (oat cell) carcinoma.

Lung resection is not an option in small cell carcinoma due to its early metastases so the patient undergoes a course of chemotherapy. It is discovered that the small cell carcinoma has already invaded his bones and brain and the patient ultimately succumbs.

Even though the signs of lung cancer were present (persistent cough, wheezing, shortness of breath and chest pain), the doctor failed to consider lung cancer and failed to make a timely diagnosis. Given the nature of the cancer (small cell carcinoma), the negligence (delay in diagnosis and treatment) is moot. With this type of cancer, by the time the patient has symptoms, the cancer has spread to other parts of the body and the prognosis is extremely poor.

III. Threshold Considerations - Plaintiff's Rule #2 – Not All Negligence Is Actionable (A Further Consideration).

This author believes there is a further and very important consideration to the “Rule” that not all negligence is actionable. However the author must qualify that this consideration is anecdotal.

There is a shared belief among a number of expert advocates representing plaintiffs in medical negligence cases that **in many instances more than ordinary negligence will be required to obtain a favorable verdict**. In other words, some believe that many, if not most juries today are apt to forgive or overlook ordinary negligence on the part of an otherwise earnest and apologetic health care provider.

That being said, the plaintiff's advocate should be prepared for the anecdotal "reality" that he or she may, as a practical matter, face having to prove "gross negligence" in order to win at trial.

IV. The Medical Negligence Trial – Considerations For The Plaintiff's Advocate

It's 8:30 Monday morning and trial is about to begin. You have screened your case, lined up your experts and properly prepared them. You have done a thorough job of discovery, and have obtained and studied the relevant medical literature. You have overcome your opponent's motions for summary judgment. You and your client attended mediation in good faith, and your client is fully informed of the risks and costs of trial. You have conducted a series of focus groups (hopefully early and often), prepared your client, and convinced your spouse or legal partners to let you spend the money that will be required to get through the two week trial. You learned your client's story and how to tell it, and have identified a case theme or themes that will resonate with the jurors. Your exhibits are prepared, pre-trial motions have been heard and ruled upon, and the judge has announced that you, the plaintiff's advocate, may begin jury selection. You take a deep breath and ... jump in.

A. Burden Of Proof (The Mountains You Must Climb)

Any consideration of burden of proof should begin with the applicable law, and the instructions on the law. WPI 105.03 is the starting point.

WPI 105.03

BURDEN OF PROOF—NEGLIGENCE—HEALTH CARE PROVIDER

[In connection with the plaintiff's claims of injury resulting from negligence, the] [The] plaintiff has the burden of proving each of the following propositions:

First, that the defendant failed to follow the applicable standard of care and was therefore negligent;

Second, that the plaintiff was injured;

Third, that the negligence of the defendant was a proximate cause of the injury to the plaintiff.

If you find from your consideration of all of the evidence that each of these propositions has been proved, your verdict should be for the plaintiff. On the other hand, if any of these propositions has not been proved, your verdict should be for the defendant [as to this claim].

The advocate must present expert testimony in order to prove up “negligence” in medical negligence cases.

WPI 105.03 will be given with WPI 21.01.

WPI 21.01

MEANING OF BURDEN OF PROOF—PREPONDERANCE OF THE EVIDENCE

When it is said that a party has the burden of proof on any proposition, or that any proposition must be proved by a preponderance of the evidence, or the expression "if you find" is used, it means that you must be persuaded, considering all the evidence in the case [bearing on the question], that the proposition on which that party has the burden of proof is more probably true than not true.

There you have your starting point; and if the advocate can meet his or her burden of proof on these threshold issues then he or she is on the way to establishing a prima facie case of medical negligence.

B. Proximate Cause (Just When You Thought It Was Safe To Stop Climbing)

Proximate cause considerations are important in medical negligence cases. It is often claimed by opponents that the defendant health care provider was not negligent, and further, that even if he or she was negligent, the negligence was not the proximate cause of the plaintiff's harm.

Again, one turns to the applicable law and instructions. WPI 15.01 defines proximate cause.

WPI 15.01

PROXIMATE CAUSE—DEFINITION

The term "proximate cause" means a cause which in a direct sequence [unbroken by any new independent cause,] produces the [injury] [event] complained of and without which such [injury] [event] would not have happened.

[There may be more than one proximate cause of an [injury] [event].]

As with negligence, the advocate must present expert testimony in order to prove up "causation" in medical negligence cases.

C. Organizing The Case (Presenting The Story)

There are probably as many approaches to organization as there are people in this world. This author urges the advocate to develop the method of organization that works best for him or her.

This advocate believes that organization is an important part of case development. All considerations of organization in my office are designed and implemented with the twin goals of “ease of use” and “ease of access” in mind.

That said, the author believes the more fundamental question meant to be addressed by the sponsors of this seminar is **“How will you present the best story of the case to the ultimate decision maker – the jury?”**

This may be the part of trial where cases are most often won or lost by the advocate. And this advocate believes that the greatest skills a trial lawyer can develop are 1) how to learn the client’s story, and 2) how to tell the client’s story in a way that will have maximum persuasive impact on the jury.

Gerry Spence is quoted as saying “Great trial lawyers tell simple stories”. This author wholeheartedly believes in and endorses that statement. But what does it mean exactly?

Here is where the time, money and energy that you have put into focus groups can pay off. If run correctly, focus groups can help identify, among other things: resonant themes; best evidence; worst evidence; marginal or inconsequential evidence; areas of concern; impressions about evidence; impressions about exhibits, key words, and phrases; and order of proof.

Focus groups are not a panacea. The advocate would be wise err on the side of caution and not place too much reliance on focus group decisions about case value. However, for the purposes listed in the preceding paragraph, the author believes focus groups can show and tell the advocate many things about a case that might not otherwise be seen or heard because of the blinders and biases an advocate can develop from deep within the factual forest of his or her case.

On this, as with all other parts of trial, the advocate can learn from the many authors and commentators that have published key works or presented resourceful seminars with the goal in mind of helping the advocate become better, and win his or her case. This author will share and recommend several of those works and resources in the last section of this paper.

D. Order of Evidence / Witnesses / Proof (The Story Continues)

The author believes that this section and the previous section C contemplate the same subject matter and ask the same essential question. There may be no hard and fast rules with respect to the order of evidence, witnesses and proof, other than this author's belief that such concerns must consider the question "how best to tell the story of the case to maximum persuasive benefit".

The author believes that many cases are lost by plaintiff advocates that might otherwise be won. One reason is that many inexperienced (and experienced) advocates unnecessarily "overtry" cases, piling on evidence when less would be more, calling marginal witnesses that do nothing to materially advance the advocate's cause, conducting unnecessarily overly lengthy direct and cross-examinations of witnesses, and being long-winded about collateral, marginal or weak evidence during opening statement and closing argument.

On this topic, and the related topic of “sponsorship costs of evidence” this author recommends Winning Jury Trials, Trial Tactics and Sponsorship Strategy, Second Edition by Robert H. Klonoff and Paul L. Colby.

E. Use Of Experts (Care And Feeding)

Medical negligence cases are “expert driven” cases. Expert testimony is required to prove and refute negligence, causation, many damages and harms. With such valuable and necessary assets, the advocate is well served to understand principles regarding the care and feeding of his or her experts.

First and foremost, the advocate must locate and retain a qualified expert in the relevant specialty area of practice who is willing to testify to a reasonable degree of medical certainty about the essential elements of the case. This can be easier said than done. However, there are several places the advocate can look to find a good and reputable expert.

Subsequent Treating Physicians

If there is one, a subsequent treating physician can provide powerful testimony for your case. Be mindful that the subsequent treater may wish to avoid involvement, and if this is the case he or she will likely communicate that to the advocate. This author believes the advocate is well-served to respect the subsequent treating physician’s feelings and wishes about involvement. There is no substitute for being respectful, and the advocate may wish to ask the subsequent treater if he or she knows others in the field who might be established experts in the relevant area of practice.

Experts For Hire

More typically, the advocate will look beyond the subsequent treating physician for his or her expert. The advocate may find it is helpful to contact established attorney colleagues with experience in medical negligence cases. Membership in professional trial lawyer organizations such as WSTLA and ATLA can help network the advocate. However, if you do ask a colleague for an expert referral, and he or she provides an expert, then keep in mind that your colleague's reputation is on the line. Your care, feeding and handling of the expert, if done poorly, will reflect back upon your referring colleague too, and likely would be the last referral he or she will make.

One benefit of an expert referred by a colleague is that the expert is likely to be a "known quantity" in that he or she will have experience reviewing and evaluating cases, working with attorneys in such cases, and testifying at deposition and trial. Often, also, such experts will be actively practicing in the community.

If the advocate needs to look further, he or she can contact any of a number of services that offer to locate qualified experts. This author believes there is nothing inherently wrong or unethical about using such services. However, there is typically an added expense for the "finder's fee" that can be significant, in addition to the fees that the expert will charge for his or her services.

Paying The Freight And Sticker Shock

When working with experts in medical negligence cases, it is important to be mindful that experts will want to be paid, and paid well, for their time. **The advocate must be prepared to advance substantial sums** for initial record reviews, verbal and written reports, pre-deposition preparation, travel, incidental expenses, pre-trial preparation and trial testimony.

Working with experts can be a very rewarding part of medical negligence cases. In the end, it is a collaboration. Experts are people too. Some occasionally speak in a different language, and work in an area that the advocate may, at first, know little about. However, as individuals, they tend to respond to the same considerations that we all do. They appreciate an advocate that shows he or she has taken the time to learn about the medicine. They appreciate being provided with all of the relevant materials (well-organized medical records, applicable peer literature, authoritative texts) they will need to conduct a thorough inquiry. They appreciate retaining their objectivity. They appreciate being prepared in advance of depositions so that they can avoid undue embarrassment. They appreciate being paid promptly, and they appreciate the advocate's earnest enthusiasm and belief in his or her case. Caring is contagious, and this author has seen the benefits of that maxim on more than one occasion.

F. The Medical Record And Exhibits As Tools Of The Trade

The Medical Record

The starting point in every medical negligence case is, of course, the medical record. Most often the medical record will be voluminous. This author believes it is important for the advocate to be familiar with the relevant aspects of the medical record.

Our office retains the services of a professional to prepare a records summary and chronology that allows for ready access to the most important medical information in the case. Medical records often arrive in a disorganized manner, and are typically very difficult to read by anyone unfamiliar with medical shorthand and notation. A good records summary and time chronology can help the advocate maintain his or her focus where it needs to be, and avoid being sidetracked by collateral issues.

Illustrative Exhibits

Exhibits for illustrative purposes, when used properly, can be very helpful to the finder-of-fact in developing an understanding in medical negligence cases, and can simplify complicated aspects of testimony. They can also, when used improperly, confuse and unnecessarily complicate issues.

Exhibits can, but need not be, expensive. And more is not necessarily better. Keep in mind the purpose of your exhibit. Conventional wisdom says that each exhibit should illustrate one point. Do you need an exhibit? If so, don't overdo it.

If the answer is "yes" then consider what effort and expense is justified. There are abundant sources and resources for the advocate willing to take the time to prepare his or her own exhibits. Any of a number of good anatomy texts can serve as a starting point. Anatomy texts typically come in two types: cadaver photographs or colorful illustrations. Netter, Grant, McMinn, and A.D.A.M. have served this author well. The Internet (for example "Google Image") can also be a good resource.

Occasionally, the advocate may find that a specialized exhibit is needed. These can be expensive, particularly if custom work is needed, but can also be very persuasive. There are any number of companies that work with attorneys to develop illustrative exhibits based on the medical record and unique facts of the case. Quite often the advocate can find a suitable "stock" illustration that can be helpful to the case.

G. Statutory And Case Law Requirements

The author understands this topic is covered in Part III of the seminar syllabus, and so defers to the presenters and their respective materials.

H. Defenses And Closing Argument (Righteous Indignation)

Defenses

It is an oversimplification, but a not uncommon refrain, that defendant opponents in medical negligence cases will typically assert multiple defenses of the following types:

- We didn't do it (denial).
- If we did do it, it wasn't negligent (denial).
- Even if we did do it, and it was negligent, it didn't cause any harm (denial).
- If there was any harm, it was caused by the plaintiff or someone else or instrumentality and not us (affirmative defense).

The plaintiff's advocate will be well-served to narrow the defenses of his or her opponent in discovery and in pre-trial motions. Medical negligence cases, even in the best of circumstances, can be made complicated, and it is to the advocate's strategic advantage to make the case as simple as possible for the finder-of-fact to understand and comprehend. The more defenses the opponent throws at you, the harder may be your job at trial.

Defenses will typically be either a "denial" or an "affirmative" pleading. The advocate should carefully note each and every defense (both denial and affirmative) set out by the opponent, and through discovery interrogatories and depositions strive to learn every fact and circumstance the opponent is relying on.

The defendant will have the burden of proof with regard to any affirmative defenses asserted. The plaintiff, however, has the burden with respect to his or her prima facie case. In that regard, the advocate will soon find the thorn of "physician judgment" in his or her shoe.

Perhaps the most common (and frustrating) defense an advocate will face in medical negligence cases is the assertion that the alleged negligent act, conduct or omission was within the sound judgment of the physician, and thus, not negligence. The advocate will need to become familiar with WPI 105.08, the “exercise in judgment” instruction and ask many “why” questions during depositions of defendant’s experts when this defense is asserted.

WPI 105.08

EXERCISE OF JUDGMENT

A physician is not liable for selecting one of two or more alternative [courses of treatment] [diagnoses], if, in arriving at the judgment to [follow the particular course of treatment] [make the particular diagnosis], the physician exercised reasonable care and skill within the standard of care the physician was obliged to follow.

Closing Argument

The author believes that closing argument is the time to highlight the strong facts of your case, take issue with the weaknesses in your opponent’s case that the opponent has put in issue, minimize the significance of the opponents strong evidence, and if one can do so authentically, inspire a sense of righteous indignation in the finder-of-fact that will drive a verdict in the advocate’s favor.

Closing argument is not a time to be shy. Rather, the author believes the finder-of-fact will expect and anticipate the advocate to make strong arguments and provide clear guidance on what the advocate is asking for and the reasons why.

For further guidance on developing and making effective closing argument, the author recommends Chapter 12, Closing Argument in Winning Jury Trials, Trial Tactics and Sponsorship Strategy, Second Edition by Robert Klonoff and Paul Colby.

I. The Jury Charges

The author has referenced relevant jury instructions in preceding parts of this paper.

V. Conclusion – Standing On The Shoulders Of Giants – Borrow Or Steal

As said earlier, “Great trial lawyers tell simple stories”. What is the story of your case? How is that story best presented to the ultimate decision maker? Short of actual trial experience, where and how will you learn to try a medical negligence case? There is no substitute for experience. Still, it has also been said “Good trial lawyers borrow, but great trial lawyers steal”. In that regard, and with the caveat that this author in no way considers himself to be a “great” trial lawyer, he nevertheless wishes to conclude with a list of resources he has either borrowed or stolen from that have been notably helpful in his personal and professional development. In no particular order, they are:

- David Ball on Damages, by David Ball
- How to Do Your Own Focus Groups, by David Ball
- Theater Tips and Strategies For Jury Trials, by David Ball
- Facts Can’t Speak For Themselves, by Eric Oliver
- Winning Medical Negligence Cases, by William Trine and Paul Luvera
- Winning Jury Trials, Trial Tactics and Sponsorship Strategy, Second Edition by Robert Klonoff and Paul Colby
- Acting-In, Practical Applications of Psychodramatic Methods, Third Edition by Adam Blatner, MD
- Cross-Examination: Science and Techniques, Second Edition by Larry Pozner and Roger Dodd
- Anything in the DVD and videotape Trial Skills series by Gerry Spence

The author wishes you, the plaintiff's advocate, will have the best of success.

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