Volume I, Chapter 4

Elements of Triage: Effective Case Screening of Medical Malpractice Claims

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Objectives

• Upon completion of the chapter, the reader will be able to:
• Define the process of “triaging” medical malpractice cases under investigation
• Discuss how effective triage contributes to building your business
• Name at least five elements to consider when screening every medical malpractice case
• Define the three types of damages and give examples of each
• Explain the difference between negligence and “known complication”
• Name where jury instruction guides can be obtained for each state.
Legal nurse consultants (LNCs) pride themselves on producing excellent work products. Medical record summaries are created, research on assigned topics is completed, and experts to review and testify on a given topic are identified in the time frame requested. What many LNCs fail to recognize is how their work product fits into the larger picture of the investigation and litigation of a claim. Many LNCs wonder why they do not get repeat business from an attorney who just months before told them their work product was fine. Understanding how the LNC’s work fits into the larger picture of claims management will make the LNC’s work product more valuable to the attorney and provide the attorney with new insights and strategies in the successful pursuit or defense of potential or actual claims. This chapter will make clear the thought process that LNCs need to understand to produce a product more valuable than completion of singular assignments or tasks. It will explain the critical thinking and analytical concepts necessary to analyze case facts in the context of the legal framework of medical negligence.

Analysis of a medical malpractice claim is as much about medicine as well as law. Blending the talents of the lawyer who understands the law and the advocacy system with those of an LNC, who is schooled in scientific and medical concepts and has a basic understanding of how the disciplines of law and medicine fit together, makes for a more successful endeavor for the attorney and increased satisfaction for the LNC.
When discussing a new assignment regarding an actual or potential medical malpractice case with an attorney, regardless of whether working for the plaintiff or defense, inquire about the elements of triage which are discussed in detail in this chapter. Complete information about the elements of the case will assist the LNC in producing a work product that will be truly helpful to the case. For example, after becoming familiar with the facts and other elements of a case, the LNC may suggest additional or alternative projects from the one assigned that would be more useful and help the attorney to be successful in pursuing or defending a claim.

Not all attorneys handling medical malpractice consider it their area of specialty and even those who do, do not always understand the subtleties of the science and medicine pertinent to the case. The LNC should discuss the analysis of the elements and in particular those missing or difficult elements. It might even be the case that analysis of the elements brings up new or different areas of inquiry or research that the attorney had not considered. The LNC who points out issues with the potential to blindside the attorney will be making a valued contribution. No attorney wants to be unprepared.

While the decision to proceed or defer a potential claim and how to conduct that endeavor ultimately rests with the attorney, giving the attorney warning of potential pitfalls likely to be encountered is a valuable service. Sometimes a lawyer may be eager to pursue a case believing it has the potential for a large settlement or verdict because the client is very injured or because the story has “great jury appeal.” After reviewing the case and carefully considering the elements, a knowledgeable LNC may realize that further pursuit of that claim would be difficult at best. The lawyer may not want to hear this at first, but with tact and diplomacy, the LNC’s professional analysis and opinion
will ultimately be valued. Although the information may not be what the attorney wanted
to hear, the attorney will be appreciative as long as the basis for a “less than optimistic”
outlook for the potential success of the claim is explained and is based on sound analysis
and judgment. The lawyer will see this contribution as more valuable than summarizing
records on a case with little chance for success of pursuit or defense.

Elements of Triage

- Liability/negligence
- Damages
- Causation
- Statute of limitations
- Contributory/comparative negligence
- Economics
- Conflict of interest
- The defendants
- The client
- Other considerations and case types

Each item will be explained with an example given to illustrate the element.

*Liability/Negligence*

Negligence on the part of a HCP (Health Care Professional) requires four
elements be proved. They are: Duty, Breach of Duty, Damages and Causation. The last
two elements will be discussed in detail later in this chapter.
Duty on the part of a HCP is dependent upon the existence of a provider-patient relationship (Am Jur, 2002, p. 292). An example of a HCP without such a relationship would be a HCP testifying as an expert regarding the mental health of one the parties in a divorce claim based upon review of past records.

Breach of Duty is the second component. It is often referred to as liability or negligence. Although states have worded this concept variously, the basic premise is that HCPs have a duty to adhere to the applicable standard of care. They are not required to deliver the highest degree of care possible and they are entitled to exercise individual judgment. They are required to exercise that degree of reasonable skill and care expected of a reasonable competent practitioner in similar circumstances (Am Jur, 2002, pp.296-297). Breach of duty/ liability, must be proven through expert testimony that sets forth the applicable standard and the specifics of the deviation from that standard.

The plaintiff’s attorney will first hear of the potential case from facts gleaned from the potential client in an interview. The plaintiff should be engaged in a thorough discussion of what the health care provider (HCP) did wrong. The presence of an LNC at this interview can be quite beneficial. Know from the outset that most patients seeking the advice of an attorney regarding a potential claim believe that compensation depends on the degree of injury suffered and the fact that it happened during the course of health care. Many people believe that if they had an infection, allergic reaction or unexpected unpleasant side effect, they are due compensation. Do not believe that all the elements of a successful claim are present merely because someone is sick or injured. This does not constitute liability (Eisberg 1990).
Some clients believe that there is compensation due them if the doctor was rude or late or didn’t return calls. This likewise does not constitute liability. They also believe that a subsequent treating physician’s utterance of “we never do that here” or “this never should have happened” is a defacto statement that there is liability. It is not. The first may only indicate that different HCPs do things differently. The second may only be an expression of empathy meaning that the new HCP believes things could have gone alright but for this unexpected complication or adverse event. Neither of these statements is an indictment of prior care.

The investigation of liability should not be confined to what the plaintiff thinks went wrong. Listen to the story and always consider that the patient and family are unlikely to be medically sophisticated and often are unable to state what action or omission caused their problem. Many, if not most, patients and their families cannot state the name of their diagnosis or the purpose of the surgery they underwent. Unless the issue is clear, such as operating on the wrong extremity, listen for clues in the story that may reveal the real facts. Don’t be afraid to make educated guesses or assumptions. Many times, through interview of the potential plaintiff and/or review of the records, it will be discovered that what the plaintiff believes to be negligence is actually acceptable care. However, by using critical thinking, the LNC may discover an entirely different act of negligence, never considered by the potential plaintiff, which could be responsible for causing the plaintiff’s injuries.

An example of this would be the client recently hospitalized for amputation of her leg after an episode of gangrene. She is angry about a postoperative infection in the stump and the treatments she received for it. Starting a claim based on a theory of
infection after a surgery and the difficulties encountered during treatments is not likely going to be successful in terms of liability, the most critical element, because infection is a known complication and not generally considered to constitute liability. But, using critical thinking and analysis the following story emerged. Upon questioning, the caller agreed with the LNC’s assumption that she is diabetic and has been for several years. Gangrene in long-standing diabetics is not unusual or thought to be due to malpractice. In asking more questions the LNC learned that a tiny sore had developed on her big toe a year ago. The wound kept getting bigger and deeper, but did not really hurt. Her doctor never gave her any treatment beyond some ointment but never referred her to a wound care expert or surgeon. She did not know what an A1C was or have regular blood work drawn. She took her insulin or checked her glucose “sometimes when I think I need it.” These facts may support a claim of negligence for failure to properly treat diabetes and related complications ultimately resulting in the amputation. Clearly, to the plaintiff, the amputation is a bigger injury than a stump infection. None of these facts were part of the initial complaint by the patient. The lesson: never assume the client (or the attorney) knows all the facts or understands the medical issues. Just listen, ask and think critically.

Consider the following as these concepts form the basis for negligence. Has the HCP acted outside the accepted standards of practice? Was something done or not done that any reasonable practitioner would have done or not done under the same circumstances? Known or commonly occurring complications or side effects do not typically constitute liability, while failure to recognize and appropriately treat complications may. However, keep in mind that the occurrence of an unusual complication may well suggest a breach of care.
HCPs are allowed wide latitude in their judgment when it comes to choosing treatment in most instances. As long as the treatment chosen was within the bounds of reason, even if the choice does not have a good outcome for the patient, it generally is not negligence. Such an example would be administration of an antibiotic that results in a severe reaction. The patient had no known allergies. Although other antibiotics were available, there was no reason for requiring an alternative. On the other hand, if the prescription was for a medication with known cross reactivity with a known allergy, such a prescription may be considered negligent.

Do not determine liability with the benefit of hindsight. In a case of “failure to diagnose,” remember that the potential defendant did not know what the reviewer knows. A defendant’s liability must be determined based on the information available to the defendant in that time and place and under the circumstances described. A critically thinking LNC will consider the facts available to the HCP at the time. In considering a potential diagnosis, doctors are trained that “when you hear hoof beats, think horses not zebras.” They are also taught that atypical presentations of common diseases are more frequent than typical presentations of rare diseases. These old maxims suggest HCPs will default to the most likely diagnosis as the first working theory of what might be wrong and begin treatment for it. Even if in hindsight the diagnosis and treatment proved to be wrong, it would be hard to make a successful claim of negligent diagnosis if reasonable HCPs seeing those same signs and symptoms could have reached the same diagnosis.

When doing research to document the standard of care, be sure the research matches the period of time relevant to the care delivered. Standards of care change, new imaging techniques are discovered, medication regimens change. Do not use 2008
literature to determine the standard of care for the diagnosis and treatment of a disease or disorder that took place in 2005.

If the initial evaluation of the case makes determining liability difficult because some facts are missing or determining the standard of care would require specialized expert review, assume that liability exists and proceed with the case review to determine if the other elements of negligence are present. It makes no sense to spend time and money to summarize medical records and retain an expert on standard of care if there are other major problems with the case such as an expired statute of limitations. If other elements are present, it may be worthwhile to obtain an expert review on liability.

**Damages**

Damages are divided into three types: special, general, and punitive. Special damages are the out-of-pocket expenses incurred by the plaintiff as a result of the negligence. General damages are injuries on which the law is unable to place a dollar amount such as “pain and suffering.” General damages are sometimes referred to as noneconomic or non-pecuniary damages. Punitive damages, also known as exemplary damages, are monetary compensation exceeding general and special damages intended to punish the defendant, to set an example, and to deter future behavior considered “outrageous.” Most jurisdictions determine whether punitive damages can or cannot be awarded and often set a cap on the amount that can be awarded. Punitive damages are very difficult to prove in medical malpractice cases.

The monetary value of any claim is based on the perceived value of the plaintiff’s injuries. Thoroughly discuss with the plaintiff all potential damages from the alleged negligence. Because damage is one of the four required elements of a negligence claim, if
there are no damages, there is no case, irrespective of the egregiousness of the conduct
(Cardaro, 2000).

Every injury has a theoretical value. The astute LNC will consider the full impact
of any claimed injury and over time will get a feeling for how this translates into the
monetary amount the attorney is considering. Ask the attorney what he thinks his case is
worth. Imagine sitting on a jury and thinking, “How much this should the plaintiff be
awarded?” In assessing damages, determine every way in which the plaintiff’s life has
been changed as a result of the injury. Permanency of an injury and impairment in ability
to work or engage in activities of daily living must all be considered in determining
damages (Cartwright, 1987). Is the injury permanent and/or serious? In cases of death,
consider whether the plaintiff’s life expectancy would have been reduced even if there
had never been any negligence. An injury resulting in a crooked fifth finger in an
arthritic older man is far different from the same injury in a concert pianist.

Some jurisdictions recognize a theory of recovery in medical malpractice cases
for a patient’s loss of chance of survival or loss of chance of a better recovery. Under this
theory, the compensable injury is the lost opportunity to achieve a better result, not the
physical harm caused by the plaintiff’s initial condition. This theory applies when the
patient is suffering from a preexisting injury or illness that is aggravated by the alleged
negligence of the health care provider to the extent that (1) the patient dies, when without
negligence there might have been a substantial chance of survival, or (2) the patient had a
chance of surviving his illness but for the delay in diagnosis. Because of the negligence,
that chance has been lost. This is different from the claim that the patient had a more than
likely expectation of cure that has now been lost due to negligence (Shandell, & Smith, 1999).

Some states, such as Minnesota, do not recognize “loss of a chance.” In Minnesota, expert testimony is required to prove that a plaintiff would have had a greater than 50% chance of survival or less damage at the time of the alleged negligence and that the negligence caused the plaintiff’s chance of survival or permanent injury to drop to less than 50%. The expert testimony requires the phrase “more likely than not,” such as “more likely than not would have avoided the amputation but for the negligence.” In cases where the statistics are known and published, such as cancer cases, there would be no claim for negligence that reduced the plaintiff’s chance of survival from 49 to 0% or from 95 to 51%, but there would be a claim for negligence that reduced the chance of survival from 51 to 49% (Fennell v. Southern Maryland Hospital, 1990). In this last set, the plaintiff went from “more likely than not to survive (51%) to “not likely to survive (49%).” Knowing the law in this regard is essential when doing the analysis on cases with a known mortality statistics. Finding and applying the statistics for the particular disease or illness is equally necessary and may fall to the LNC.

Look carefully at the plaintiff’s health history when assessing damages. Preexisting medical conditions (such as a diagnosis of cancer) or surgeries, medical bills, and disability that would have been encountered even with appropriate care are not elements of damage. Are the plaintiff’s injuries severe enough to warrant further investigation? Can the injuries be seen on x-rays, electrocardiograms (EKGs), magnetic resonance imaging, or other electronic imaging? If the injury is difficult to understand, presenting it to a jury and assigning a monetary value may prove difficult. Cases, in
which the primary injuries cannot be seen by the jurors, such as soft-tissue injuries, mild
head injuries, or mental distress, can pose special problems (Shandell, & Smith, 1999).
Moreover, many jurors have some ache, pain or malady they suffer with every day.
Perhaps they have terrible arthritis or a back full of surgical hardware. If what they deal
with every day makes the plaintiff’s injuries seem trivial, the jury is not likely to award
any sum of money for compensation.
Because the value of a claim in a wrongful death is based in large measure on an
estimate of life expectancy, but for the alleged negligence, unexpected findings at
autopsy can have a major impact on damages and can totally derail a claim. The
discovery of a large bulging aortic aneurysm that could have meant near instant death at
any time or severe undiagnosed multi-vessel coronary artery disease can significantly
impact the damages argument. It will be difficult at best to argue that this person
would have lived 20 years but for the negligence.

Causation

The issue of causation or cause is the main battleground and usually the most
difficult element of medical negligence to understand and prove. In a medical
malpractice case, causation is not ordinarily a common sense thing. Most of the time
causation revolves around medicine, science, physiology, pathology and natural history
of disease and illness (Sloan, 1993). It is this author’s opinion that analysis of causation
is the place where the trained and critically thinking LNC can make the most difference.
The precise definition of cause for each state can be found in the jury instruction
guides for the jurisdiction in question. The jury instruction guides state the precise
language that a judge will read to the jury when instructing them about the information to
consider when rendering a verdict. The question that the jury will be asked to consider is what the attorney will have to prove in court. Jury instruction guides can be found in a local law library or on the Internet.

An example of a jury instruction on causation in Minnesota, as taken from the Civil Jury Instruction Guides (1999) is a “direct cause is a cause that had a substantial part in bringing about the injury/harm.” This means the jury will have to decide if the negligence of defendant plays a substantial part in bringing about the harm to the plaintiff. Also understand that the expert opinion on this cause question must be offered by a qualified medical expert and must be given “to a reasonable degree of medical certainty.” It is not an opinion that hinges on “might have been” or “could have been” or “maybe.” It must be a relatively certain opinion based on the expert’s knowledge, education, training, and experience, and grounded in science and clinical medicine.

To understand causation the LNC must think carefully about the following questions: Did the negligence cause the injury or damage? Could it have been caused by something or anything else? Did the negligence cause all or only part of the plaintiff’s injury? If only part, which part? Is there any reason why the result would or could have been the same absent the negligence? In death cases, could the plaintiff have died of his disease absent any negligence? If so, what are the statistics on morbidity and mortality for that specific condition?

During the course of a case investigation, as new facts are developed the LNC should rethink causation and how the new information or new defense argument fits the existing causation piece. The relationship between liability and cause can become very fuzzy or extremely complicated over the life of a claim. Fuzzy or complicated scientific
issues are hard to difficult to explain to a jury and make for difficult issues for either side. If the scientific or medical basis of the causation argument is difficult for the attorney to grasp even with the assistance of skilled LNC and expert, odds are that an insurance adjuster or a jury won’t understand it either.

The application and importance of science, disease theory and physiology in deciphering cause cannot be understated. Here is a simple example. A plaintiff is claiming that a misfiled or ignored routine mammogram report from 14 months ago resulted in failure to diagnose her breast cancer. At the time of her actual diagnosis she is stage IV with many positive lymph nodes and multiple metastatic lesions in her brain. Common sense implies failure to act on the report was negligent. Common sense and cancer treatment dogma infer that the earlier cancer is diagnosed and treated the better. A common sense cause argument would be: She is now a Stage IV and going to die of her cancer because they missed it. Not necessarily. Science and disease theory infers that breast cancer does not go from curable to Stage IV with multiple positive nodes and visible lesions in the brain over a mere 14 months. Disease theory and statistics hold that she likely already had lesions in her brain and positive lymph nodes and was already at an advanced stage of disease, if not an IV, 14 months earlier. Therefore, it is likely that even 14 months earlier she would have been in need of much of the same treatment and nearly equally likely to die of her disease regardless of what they did with the mammogram report. Therefore, proving that the ignored report and consequent delay caused injury may be next to impossible.

In another example, common sense implies that early and aggressive treatment of septic shock saves lives. Arguments from the defense could be many. They include the
fact that according to the American Association of Critical Care Nurses (Balk, 2000), septic shock is lethal to approximately 20 - 50% of all patients although figures vary by microbe, institution and underlying co-morbidities. The defense might say that the patient’s septic shock was already beyond salvage at the time of presentation. Or that the patient’s underlying disease would have prevented his recovery or shortened his lifespan regardless of the care given for his sepsis. Perhaps the type of microbe involved in the patient’s sepsis is resistant to many antibiotics and difficult to successfully treat at best.

It is the role of the LNC to research, understand and teach on all of these issues to prepare the attorney to better present arguments and defend his or her position. This means delving into the science and physiology of septic shock and the rationale for the recommendations for diagnosis and treatment. Giving an attorney a common sense answer like “earlier treatment is better” is not dealing with causation.

In the fight for causation, beware the autopsy and death certificate. They are very sharp double-edged swords. Worse, sometimes they are wrong (Smith Sehdev, MD 2001). Do not assume that all autopsies are conducted with the precision of a television drama. In this author’s experience, even experienced medical examiners in large cities admit to rarely even glancing at the medical records of a patient who died in the hospital, taking the patient history and recitation of events from the HCP who delivered the care. Moreover, the person doing the autopsy may not be a particularly curious person by nature or someone who thinks outside the box. The cause of death listed and filed with the county may be in direct opposition to what the LNC or attorney think brought about that person’s death. The LNC using critical thinking would consider several questions. How do the facts in the medical record or patient history mesh with the findings at
autopsy? Was anything missed? What was not taken into consideration? Were appropriate samples taken? The LNC may suggest a meeting with the Medical Examiner to fill in any missing information or diplomatically try to discuss the discrepancy. It has been this author’s experience that when presented with an alternative fact scenario taken directly from the medical records, medical examiners may change or amend the autopsy findings and cause of death. Medical examiners also are familiar with court proceedings and often make excellent witnesses.

At the end of a trial, the jury is sent out to deliberate and when they are ready, fill out a form with their conclusions called the Verdict form. Although some of these forms are long with multiple defendants and additional questions, the two basic yes/no questions are:

1. Was the defendant negligent?
2. Did the negligence play a direct or substantial part in bringing about the injury to the plaintiff?

In order to reach any kind of monetary compensation for the plaintiff, the answers to both of those questions have to be yes. Often the answer to the first question regarding negligence is yes and the second question regarding cause is no. Juries have a much easier time understanding and finding negligence than the much more complex concept of causation (Eisberg 1990). Remember that all the plaintiffs in a medical malpractice claim had an illness or injury that brought them to health care in the first place. The defense will do everything they can to remind the jury that the underlying illness or injury can and does sometimes have a bad outcome even in the best of hands. It is the job of the plaintiff to explain why that would not have been the case for the plaintiff and why
recovery without sequela would have been the expected outcome. Therefore, the LNC
must understand the natural history and pathophysiology of the disease or injury as well
as the science of what went wrong. Asking the lawyer to depend on outside medical
experts for this preliminary teaching and thoughtful analytical discussion is expensive
and time consuming. An LNC with a good understanding of and ability to teach on these
issues can be particularly valuable to the lawyer.

Statute of Limitations

Every state has a different statute of limitations (SOL) for medical malpractice
claims. The SOL will be different for minors or when a mentally impaired individual is
involved. Some states have a different SOL for death claims and/or another tied to the
date of the discovery of the injury or negligence. There also may be “notice provisions”
that govern what needs to be done. Claims against the Veterans Administration are
actually claims against the United States and there is a one year notice and special
paperwork to be filed. The medical records and facts of the case will be the determining
factor in setting the statute of limitations, not what the client believes or remembers.
The LNC needs to carefully identify the act of negligence that actually caused the
injury when selecting a tentative SOL. If it was during surgery, count from that date. If
it was some several days before or after, identify that date. If there are multiple
admissions and providers, or care that crosses state lines, be careful and deliberate and
present the relevant facts and dates for the attorney’s consideration in setting the SOL.
Although the LNC is not responsible for officially setting this legal deadline, it
needs to be factored into the analysis (triage) of all new or potential claims. A statute
about to run may not allow enough time for analysis. One that has already expired is
barred from the courts. If a statute runs while an attorney or the LNC is investigating it, the attorney stands a good chance of being sued for legal malpractice. Be alert for the applicable dates in the record and raise a flag for the attorney as soon as possible if a potential problem with a close SOL is discovered. Investigation of a case with a close statute must be a high priority. If the LNC is overcommitted, it may be prudent to decline working on the case rather than risk having the statute run while the file is the LNC’s possession.

Contributory/Comparative Negligence

Some states recognize the doctrine of contributory negligence as a complete bar to a plaintiff’s recovery. If the plaintiff did anything that could be perceived by a jury as having contributed to his own injury, even if the blame is only 1%, recovery is precluded. In other states where the doctrine of comparative negligence is recognized, the jury can assign a percentage of fault to the plaintiff and deduct that amount from any award. In some jurisdictions, the verdict may be reduced to zero if the percentage of fault attributed to the plaintiff is 51% or more.

For this reason, it is imperative that the actions and inactions of the plaintiff/client be taken into consideration in the analysis of the claim. Because there is a distinct possibility that a plaintiff will walk away from the courthouse with nothing because of these doctrines, the attorney must consider the plaintiff’s actions in determining the value of a case. Did the client do anything to cause or aggravate his own illness or injury? Was the plaintiff compliant with the prescribed course of care? Did the plaintiff follow the HCP’s instructions, keep scheduled appointments, inform his provider of new symptoms
or problems, etc.? Was the plaintiff harmed by medication that he continued to take after being instructed to discontinue the medicine (Eisberg, 1990; Cartwright, 1987)?

The following is an example of contributory negligence. A negligent HCP fails to act for over a year on a pap smear report indicating the presence of cervical cancer. This was the 58 year-old patient’s first pap smear in 30 years. Who bears the most responsibility for the advanced stage of cancer at the time of diagnosis? A jury could conclude that much of the fault lies with the patient/plaintiff and therefore fail to award damages based on the doctrine of contributory negligence.

Economics

Medical malpractice suits are difficult and costly. Theoretically, any person can attempt to seek compensation for an injury caused by negligence, regardless of its severity, but most plaintiff attorneys will pursue cases only where damages are significant and permanent, which allows for profit after client compensation and payment of costs of the investigation and litigation (Eisberg, 1990; Sloan 1993).

Almost without exception, attorneys representing plaintiffs in malpractice claims work on a contingency basis. This means that the attorney makes no money unless the claim settles or a verdict is reached and damages are awarded. The contingency fee is a percentage of the settlement or verdict. This fee pays the salaries of the attorney and other office staff plus overhead. Costs on the file are an additional burden. These costs include all aspects of the litigation (e.g., record retrieval, consultant and expert services including the LNC, travel, court reporter, etc.) The plaintiff’s attorney is only reimbursed for these costs if there is a recovery. Plaintiff’s attorneys working on contingency make nothing when a decision is made not to pursue a claim after an investigation has taken place.
Defense attorneys and the insurers and HCPs they represent will incur costs associated with the defense of a claim usually based on an hourly rate plus costs. This makes good triage for both the plaintiff and defense a major economic incentive.

In recent years many states have enacted caps on non-economic damages. This means that no matter how severe the injury, things that are not hard provable costs such as pain, suffering, humiliation and misery, is compensable only to the limit of the cap. To attain a recovery greater than the cap requires proof of special and future damages such as medical costs, wage loss, special needs such as a modified vehicle, companion services or housing. A cap on pain and suffering even in the catastrophically injured can significantly limit the recovery. An example of this would be loss of sight in an elderly person. This is a major injury impacting most aspects of quality of life. However, special medical needs are anticipated to flow from his blindness and his home life will change little. He had no income to loose and his pension remains intact. Although totally blind because of negligence, some attorneys in states with a cap on non-economic damages might find this case potentially too expensive to handle depending on the medicine involved. The potential recovery must always be balanced against the costs of investigation and pursuit.

Other costs to the attorney include travel and depositions. In addition to depositions of the parties, some states require depositions of all experts for both sides as well. With multiple experts required to prove or defend a case on both sides and no limit on where they come from, criss-crossing the country time and again on a single case would not be unusual. In addition to travel, hotel and the cost of the court reporter and
transcripts, there are the daily or hourly fees charged by the medical experts for their time
and participation. All of these things can be very costly.

Most malpractice cases take 3 to 5 years to resolve. The attorney working on
contingency may subsidize a case for a long period of time before receiving any
reimbursement of expenses if ever. In the meantime the cost of maintaining the practice
continues. In a contingency practice, time is money. If a potential case has low to
moderate damages, but the projected number of expensive experts is high and analysis
time-consuming, the plaintiff’s attorney may well be looking at spending more than can
be recovered. This is not good business practice. By employing the “elements of triage”
when asked to work on a plaintiff claim, LNCs can assist the attorney in making an
economically sound decision regarding the investigation and eventual pursuit of the
claim. An understanding of the economics of a contingency practice will help LNCs add
value to their professional services.

Conflict of Interest

Lawyers need to avoid representing clients when doing so would present a
conflict of interest. An example would be representing a physician in his personal and
business matters and simultaneously pursuing a negligence claim against him. Most
lawyers would also decline to handle a claim against their personal physician, a physician
neighbor/acquaintance, or a physician who was about to testify for them on behalf of
another plaintiff even though these situations do not exactly meet the legal definition of
conflict. It is important to identify any possible conflicts of interest as early in the
investigation as possible. The LNC can assist in this effort by identifying all HCPs that
played a role in the care at issue and supplying these names to the attorney for conflict checking.

The Parties

The defendant.

Jurors have a bias toward the health care provider. Most lay persons have a great deal of respect for physicians and other health care providers and believe that everyone makes mistakes. If the defendant is well known and regarded in the community, is charming and empathetic, or highly credentialed, this only adds to the jury’s bias and the difficulty of identifying medical experts for the plaintiff who would be willing to testify against him or her. If the defendant’s area of practice is highly specialized, the pool of potential testifying experts is even smaller and finding an expert might prove next to impossible (Philip, 2007; Eisberg 1990; Vidmar 1998).

The plaintiff.

The LNC should consider the plaintiff’s presentation and demeanor. Is the client likable, articulate, and believable? Does the client evoke sympathy? What are the client’s motives for bringing a lawsuit? Be alert for issues suggesting credibility problems. If the record says one thing and the plaintiff says another, the argument can rapidly disintegrate to a “he said/she said” contest. Such a contest is almost without exception won by the defendant HCP.

Other Considerations and Case Types

Informed consent.

Claims involving only informed consent issues are generally quite difficult for the plaintiff to win. The burden of proof is high and requires a plaintiff to prove that no
reasonable person would have gone along with the treatment, medication, or surgery “if he had only been told” that whatever unfortunate thing has come to pass could possibly have happened. The plaintiff also has to prove, through expert testimony, that the standard of care required the particular risk to be disclosed. As a rule, physicians are not required to disclose every possible complication that can occur or every potential or rare side effect of every drug prescribed. (See Volume I, chapter 7) However, informed consent is sometimes successful when it co-exists with negligence. The LNC’s clinical background and experience will be helpful to the attorney in making good decisions about informed consent cases.

An example of a successful informed consent case follows. A young man has an obstruction in his subclavian artery near the junction of the carotid. It arises from adhesions in the vessel from a childhood trauma. The obstruction is causing ischemic changes in his arm. A vascular surgeon tells him this can be opened with minimal time away from work and minimal risk, using angioplasty. Consent is given and a few weeks later the procedure is done. During the angioplasty, multiple pieces of clot break off and, unable to flow downstream past the obstruction, the debris floods his brain via the nearby carotid. He suffers multiple strokes and permanent significant brain damage. In this case the main claim was negligence in choosing an inappropriate technique. Open surgery would have allowed clamping of the carotid to avoid stroke and opening of the clogged vessel to clean it out fully. The secondary claim was informed consent; the patient was never afforded the opportunity to discuss the more significant risk of the less invasive procedure.

Wrongful life and wrongful birth.
These cases are notoriously difficult to pursue. Many plaintiff attorneys will not even discuss investigating them. The basic injury being claimed is a life that never should have happened. In other words, it puts the parents and attorney in the position of stating they wish their child had never been born or they wish their child had been aborted. It is a social, moral and political hot potato that most attorneys would not want to tackle. This author has only worked on one such case. It involved failure to conduct genetic testing after a first child was born with significant mental retardation. The parents stated that if they had only known that the terrible life their first child suffered was due to a genetic defect they carried, a defect that could have and should have been tested for, they surely would have opted to never have another child. They were only told of the genetic issue after the birth of the second child. Abortion was not an issue.

*Foreign objects.*

A surgeon who leaves an unintended object, such as a clamp or sponge in a patient may be found to be negligent. However, because these objects often don’t cause any symptoms or harm, they are often discovered, incidentally, only many years later and often are just left in place. In this instance there is no damage and therefore no claim. On the other hand, a retained foreign object may cause all manner of pain or illness and require removal. In that instance the statute of limitations may be different depending on when the object was discovered and removed and if that state has a discovery rule. Some states have adopted special statutes for just for discovery of foreign objects versus medical malpractice in general.

*Cooperation of a subsequent treating physician.*
Cooperation or sabotage by a subsequent treating physician can make or break a case especially where the physician is the only observer of a crucial object or event. For example, in a case involving an allegedly botched surgery, the observations of the subsequent surgeon are of crucial importance. The surgeon is the only ostensibly “neutral” person who has seen the site of the original surgery. Jurors will therefore often believe the observations of the subsequent treating physician over the opinions of hired experts for either side.

However, subsequent treating physicians or surgeons often have more expertise than the potential defendant. They are often in position of receiving patients whose care was begun elsewhere and ultimately requires a higher level of expertise or technology or both. Many subsequent treating physicians and surgeons rely on HCPs with lower levels of specialty or experience in surrounding communities for referrals. To testify against these referring physicians or facilities would be cutting of a crucial source of their own business. A good example is a small rural hospital that waited too long to send a critically ill patient on to a tertiary care center. The receiving doctor is not likely to impugne the treatment of the defendant at the rural hospital because it might cause the HCPs at the smaller hospital to feel that their care will be under scrutiny every time they transfer a patient. As a result, the larger hospital and its doctors could see transfers and referrals drop from that facility. Often the only testimony a subsequent treating physician will be willing to give to either side in a malpractice case is a discussion of what they found and what they did, but not offer any opinions regarding prior care. Their input is still often valuable particularly when gathering information about damages or permanent injury. The LNC can assist the attorney by identifying subsequent treating physicians
and gathering information about their specialty or expertise and suggest those the
attorney may want to contact.

Other worries

Long complicated courses of treatment with multiple providers or multiple
facilities all ending with a bad outcome might be impossible to sort out for the plaintiff’s
attorney considering a potential claim. Figuring out who did what wrong and any causal
connection to the injury could be like trying to untangle a spider web. It could also mean
several different statutes of limitations and venues.

Has the case has been rejected by other plaintiff attorneys? Has this person been
looking for a lawyer for months or even years? If the issues were ever investigated and
then turned down by another attorney it is useful to know the reasons behind the decision,
such as inability to find expert support on liability. On the other hand, just because a case
has been rejected by one attorney should not necessarily preclude further investigation,
but this should be a case of “buyers beware” (Eisberg, 1990).

Cases involving private body parts, and functions not typically discussed in public
or in front of “polite company” are also cases the plaintiff attorney needs to carefully
consider prior to pursuing an investigation. If the lawyer is embarrassed or
uncomfortable discussing the facts, he or she will have a potentially difficult time at
depositions and in front of a jury. Even if the lawyer becomes immune to the topic over
time, remember that the jury will not have the same luxury and will hear these things
from the moment the trial begins.
The following examples set forth the facts as gleaned from the plaintiff and/or medical record, followed by the analysis of the claim.

The Disastrous Hysterectomy

A 47-year-old female had a long history of painful uterine fibroid tumors and very heavy periods. She was prescribed iron supplements, but still had trouble maintaining a normal hemoglobin level. Her condition was unmanageable; she wanted no additional children and opted for a hysterectomy. An abdominal approach for the hysterectomy was planned as her surgeon believed there were too many adhesions from prior cesarean sections and other abdominal surgeries. The surgery was completed “without complication” as stated in the operative report. On postoperative day three, the patient was distended and complaining of severe abdominal pain. An ileus was suspected. Laxatives were given and ambulation encouraged. On postoperative day four, the patient was febrile and seemed sicker. An abdominal film was ordered and something beyond an ileus was seen. Additional testing was done and revealed an urinoma. Apparently, during the surgery, the surgeon severed a ureter while trying to free the uterine ligaments from dense adhesions. The patient was returned to surgery for repair of the ureter including stent placement and insertion of a percutaneous nephrostomy tube to drain urine from that kidney while the ureter healed. Days later and still miserable with multiple tubes, the patient was discharged. She was instructed to return six weeks later for the removal of the stent and nephrostomy. Subsequent testing showed the ureter to be functioning well with adequate renal function.
Analysis: This case has problems with liability and economics. The injury to the ureter would be considered a complication in the setting of dense adhesions, not an act of negligence. Even the most careful surgeon could have caused this injury under these circumstances. The fact that the injury went unnoticed at the time of surgery is likewise not likely negligent. The delay in diagnosis of the damaged ureter may also be within the standard of care. Judging the care by what was happening at the time without the benefit of hindsight, an ileus is certainly more common and presents just about the same way for many postsurgical patients. In terms of damages, certainly the patient experienced a less than desirable course, but even prompt recognition in the surgical suite may well have led to the identical course of treatment, albeit a few days sooner. The economics of pursuing a claim based on a few days or even weeks of misery in a patient who was going to be recovering from surgery and out of action for a few weeks anyway does not make sense. The final summary: the patient incurred a known commonly occurring complication not related to an act of negligence and there were no permanent injuries.

The Missed Myocardial Infarction

A 62-year-old man presented to the emergency room of the local hospital with burning chest pain that had developed while he was at work. Upon arrival at the emergency room, the pain had subsided. By history, his cholesterol was “a little high,” but he claimed to be “eating better since he found out.” He also stated that he “used to take blood pressure pills,” but stopped taking them because it was ruining his “married life.” An EKG was done and interpreted as showing only nonspecific changes. No other testing was done. He was discharged with a diagnosis of reflux and symptomatic treatment prescribed. A few days later the pain returned, “worse than ever,” and
continued unabated. He was taken to the emergency room by his wife. An evolving acute myocardial infarction was diagnosed and angioplasty with placement of stents carried out immediately. Three days later, the patient was discharged. Echocardiogram prior to discharge revealed an ejection fraction of 55%. He takes medications for blood pressure, prevention of platelet aggregation and a statin for elevated cholesterol. A retrospective analysis of the EKG done at the first emergency room visit disclosed that the first EKG had been misread and showed evidence of ischemia.

Analysis: This case has good liability, but has problems with causation, damages and even possibly contributory negligence, making the potential for success unlikely. The EKG was misread and accepted standards of care for Acute Coronary Syndrome (ACS) including lab work (troponins and enzymes) were not carried out. At time of the initial emergency room visit, accepted standards of care required admission for evaluation and treatment of the ischemia, evaluation of the extent of disease, likely angiogram and angioplasty and modification of risk factors. These things did not happen. That constitutes liability. However, on cause, even if those things had been done, the course of treatment likely would have been exactly the same and his ejection fraction is still within normal. Therefore, the negligence did not cause the claimed harm. On damages, there are none caused by the negligence. Moreover, it could be said that he is better off with a stent and proper medications, teaching on his disease and life style modifications of exercise and diet. On contributory negligence, the plaintiff’s failure to take his antihypertensive medication as directed may well have contributed to the extent of his cardiac disease.

Delayed Diagnosis of Breast Cancer
A 35-year-old woman was recently diagnosed with breast cancer. She was told by her oncologist that the cancer should have been caught earlier. The patient was shown the missed lesion on a mammogram performed and read as normal 14 months prior to her diagnosis. The patient underwent a lumpectomy and subsequent chemotherapy and radiation. On further questioning, the patient told the attorney that she had a copy of the pathology report and would fax it to the office. The pathology report described the lesion as 2 cm in greatest dimension in the upper outer quadrant of the breast with clear margins. The pathology of the lesion was an infiltrating ductal carcinoma. The sentinel lymph node biopsy was positive with positive estrogen receptors. The patient’s cancer was designated a Stage II.

Analysis: At face value, this case represents likely liability on the part of the radiologist for failing to properly interpret the mammogram. The much more difficult elements to prove in a case such as this are causation and damages. Being successful in this claim would require the plaintiff to prove to a reasonable degree of medical certainty that the delay of 14 months led to a progression of her cancer, and that this delay caused her harm. In other words, except for the negligent delay in diagnosis, her outcome (treatment and prognosis) would have been different and better.

In all cancer cases, the first thing the LNC should do is to look up the statistical survivability of the cancer at all stages and how the specific type of cancer diagnosed normally progresses. If the cancer is not likely to be cured and will progress no matter when it is diagnosed, there is little chance of success in proving a significant difference caused by any delay. If there is a reasonable expectation of significantly longer life or
significantly easier course of treatment, economics will dictate whether or not the claim is worth pursuing.

Fortunately for the plaintiff, a stage II breast cancer is very curable, and the plaintiff is far more likely to survive than not. In other words, even if it is proven that the plaintiff was a stage I 14 months prior to her diagnosis (no lymph node involvement), progressing from a Stage I to Stage II did not change the likelihood that she would survive the cancer. The delay may have reduced the survival odds a bit, but she is still quite curable. If the attorney wishes to consider the damage to be the change from stage I to Stage II, beware that not all states recognize “loss of chance” claims. (In this case, loss of chance would be a downward change in the statistical survivability of the cancer.) In terms of treatment change from stage I to II; even a Stage I cancer would have required surgery and likely radiation. The only change that could be claimed is the need for chemotherapy. And even that could only come into play only with testimony that she would not have had positive lymph nodes 14 months prior to her diagnosis.

The Failed Back Surgery

Mr. Jones had a two-level lumbar fusion with placement of hardware, including two pedicle screws and autologous transplant of bone harvested from his iliac crest. After the surgery and weeks of therapy, Mr. Jones was no better. In fact, in some ways his condition was worse. It was determined that the spinal fusion did not take and was not solid. Mr. Jones required additional surgery to have the hardware removed and the fusion redone. He remained in daily pain and was unable to return to work for a period of several additional months. Mr. Jones and his wife were unable to pay the medical bills and went bankrupt. He was certain that his surgery had been done incorrectly or he would
not have had the postoperative pain and suffering. Before the surgery, Mr. Jones’ doctor assured him that he would be able to return to work 6 weeks after surgery. Mr. Jones said that his diagnosis now is failed back surgery and believed that if he had been told there was a chance that the surgery would not work, he never would have gone through with the spinal fusion and hardware placement.

Analysis: It would seem that this case is a good example of significant general and special damages in pain and suffering, medical bills, and lost wages. Unfortunately, failed fusions are not uncommon and are considered a risk of the procedure. Unless the plaintiff could prove that the fusion failed not by chance, but due to an act of negligence, there is no liability. On the informed consent issue, it is not likely that the attorney would be able to convince a jury that this man would have opted for the misery he was in before the surgery even if he had been told of a small chance that the surgery would not work. In this author’s practice, a recommendation not to pursue the claim would be made.

Failure to Diagnose and Treat Heart Disease

A young mother found herself getting short of breath doing routine things. She was also always tired “to the bone” after an ordinary day. Her doctor told her it was just the burden of working and caring for a young family and suggested more sleep and to have her husband “pitch in more.” Things only got worse. A chronic cough complicated the shortness of breath and her physician diagnosed seasonal allergy. Antihistamines were prescribed. When the symptoms persisted into the winter and worsened, a dust allergy was diagnosed and more antihistamines were prescribed. Two years into this episode, when the young woman could hardly walk the stairs in her own home, her doctor sent her to an allergist. He found no allergies and sent her to a pulmonologist who
was alarmed at her symptoms and their duration and the huge heart he saw on x-ray.

That same day she was diagnosed with end stage idiopathic cardiomyopathy and sent to a major medical center for evaluation for transplant. After six months on an artificial heart, this young mother received a new heart.

Analysis: This is an excellent claim. Symptoms that don’t respond as expected or worsen under treatment require further evaluation. Symptoms of unusual fatigue or new onset shortness of breath in a woman should always raise the suspicion of heart disease.

On cause: Idiopathic cardiomyopathy reverses with treatment in the majority of cases. In the next percentage class, treatment halts the disease’s progress and stabilizes the condition. In a small percentage, the disease progresses despite treatment and transplant is needed. Therefore, medical statistics infer that with treatment, this young woman more likely than not would have avoided transplant and even had her disease reversed with appropriate diagnosis and treatment. The delay in diagnosis caused her to need the transplant.

The damages in this case are also enormous. The cost of her treatment before, during and after her transplant is over a million dollars. Her life expectancy is reduced to the life of the transplant. Her future medical expenses are also large. Non-economic damages, her pain and suffering and the claim of her husband for loss of consortium are likewise huge.

The only worry is the statute of limitations as it relates to cause. If for instance this claim was in a locale with a two year SOL, then some of the care took place outside of that window. If there are no exceptions for this scenario, then that more distant care cannot be considered. If the last documented negligent care within the SOL was near the
time of the actual diagnosis, then causation will be very difficult. It would have to be proved that appropriate treatment on that later date would have given a much better and different outcome. The lesson: Know the SOL and the exceptions in the State the case will be litigated. The first defense a good lawyer will give is that the care complained of is outside the SOL.

Summary

Developing a quality work product often means doing more than was asked. For the LNC, this means expanding from a task-oriented practice to one built on solid analytical and investigative skills. It means going beyond producing a narrative record summary or literature review to applying assessment skills in determining whether the plaintiff/client will prevail. Adding value to the LNC’s service means that the LNC must consider the case facts fully to know what parts of the medical records are important, what information is necessary and important, and what facts or records can be glossed over. The LNC should think critically. Rather than conducting a random literature search on the illness or injury at hand, research those topics likely to be in contention or support your position. It means tactfully pointing out to the attorney things in the record that give rise to real concerns about elements of triage beyond liability.

Many attorneys handling malpractice claims are justifiably proud of their advocacy in the courtroom and believe that if they could just “get their case in front of a jury,” they would be successful. The attorney is and should be an advocate for their client’s position. However, the LNC with unique knowledge and experience can often be
most useful by playing the devil’s advocate and reminding the attorney of the possible
arguments that will face as the case moves forward. Assuming this role takes
assertiveness on the part of the LNC and may take some practice to attain a comfort level.
But the LNC is uniquely qualified to fill this role and doing so will bring greater
satisfaction to the profession of legal nurse consulting.

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1. All of the following are typically considered complications rather than the result of negligence except:

A. An infection in a surgical wound

B. A stroke during a carotid endarterectomy

C. Severe bleeding after lytic therapy for a heart attack
2. In a contingency fee claim, the attorney is paid

A. A percentage of the settlement or verdict

B. A percentage of the calculated value of all special damages

C. Costs plus a percentage of the verdict or settlement

D. A percentage of the calculated value of the time spent on the claim plus costs

3. Determination of the Standard of Care must be based on:

A. What an expert will testify he or she would do in similar circumstances.

B. Care that is reasonable and acceptable to practitioners of the same community.

C. Medical literature that is current and up to date.

D. Accepted standards of care for practitioners of that specialty with similar resources, as practiced at the time of incidents at issue.

4. Contributory negligence might include all except:

A. Smoking

B. Obesity

C. Treated hypertension

D. Missed clinic appointments

5. Special damages are defined as

A. Non pecuniary damages recognized as compensable, but on which the law is unable to place a dollar amount

B. Out-of-pocket expenses incurred by the plaintiff as a result of negligence
C. Exemplary damages awarded to punish the defendant and to deter future “outrageous” behavior

D. Damages awarded when the plaintiff’s life has been changed as a result of the injury