MEDICAL MALPRACTICE PRIMER

Prepared by the Medical Malpractice Subcommittee of

the American Pediatric Surgical Association's Wellness Committee

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DISCLAIMER

Medical negligence, also known as medical malpractice, is a complex area of the law, embracing both complicated legal and medical concepts and principles. The goal of this primer is to introduce the readership to the broader legal landscape of medical negligence law. Appropriate legal review, analysis, advice, and when needed, representation is paramount when engaged in a potential or actual legal dispute. There is no substitute for appropriate legal advice from knowledgeable counsel.

This primer reflects the work-product of those who, in good faith, toiled in its production. It is intended to provide a background overview of the legal concepts, terminology, and stereotypic litigation process of a medical negligence claim. The law varies, sometimes greatly, from jurisdiction to jurisdiction, particularly at the state level. The generalizations set forth in this primer may not be applicable to all legal settings, venues, and jurisdictions.

This primer does not reflect the views or opinions of any individual, law firm or legal or medical organization, society, or institution.

CHAPTER I: INTRODUCTION

Research findings of the American Medical Association AMA's Division of Economic and Health Policy Research suggest that approximately one-third of physicians face or will face a medical malpractice lawsuit. As would be anticipated, the likelihood of being sued increases with increasing physician age and time-in-practice. *See https://www.ama-assn.org/practice-management/sustainability/1-3-physicians-has-been-sued-age-55-1-2-hit-suit* (accessed Aug. 19, 2022); *see also* Guardado JR (2016). *AMA Policy Research Perspectives: Medical Liability Claim Frequency Among U.S. Physicians*.

Medical malpractice litigation is often contentious. The merits of the case may be fiercely questioned and contested. The litigation process, which may be protracted and emotionally traumatic, can be heavily distracting and psychologically draining. An objective analysis of a case can be overshadowed by anger, remorse, despair, isolation, and self-doubt. The end-result can be extreme bitterness and skepticism for the fairness of the legal system and institutional support structures during such a trying process.

Allegations of professional negligence cut to the core of the physician's credo: "First, Do No Harm." In fact, the "harm" alleged in medical negligence lawsuits may be significant, catastrophic, or fatal. The harsh reality is that the harm is alleged, at least by the patient, is purported to be directly attributable to healthcare provider conduct. The core allegation is a deviation from "accepted standards of medical care" which in some manner caused an injury.

Further, substantial economic damages may be claimed in a medical negligence case—often rising into the millions or tens-of-millions of dollars in some instances. An injury to a newborn or infant, for example, can produce a life time of expensive

medical and other care—at great projected cost—particularly when calculated over the course of an economic horizon lasting decades. These damages may greatly exceed the available insurance coverage of the healthcare provider, and lead to perceived or actual economic and professional peril.

In 2022, the American Pediatric Surgical Association's Wellness Committee tasked the Medical Negligence Subcommittee, Chaired by Dr. Steven Stylianos, to incorporate into the subcommittee's educational agenda a "primer" outlining the language of litigation and the procedural and substantive concepts of medical negligence litigation, in particular. Dr. Mark Hoffman, a member of that subcommittee, as both a pediatric surgeon and practicing lawyer, with the support of Dr. Stylianos and Dr. Sarah Walker, produced this document as a resource and reference. The purpose of this primer is to educate our colleagues on a subject that at some point their respective careers may be helpful to understand.

CHAPTER II: THE VOCABULARY OF MEDICAL MALPRACTICE LITIGATION

The following is a basic overview of the terminology oftentimes encountered in medical malpractice litigation and lawsuits in general.

Plaintiff

The plaintiff is the individual, individuals, or entities (*e.g.,* corporations, businesses, associations) who are bringing the lawsuit or legal action and commencing the litigation. The terms "plaintiff" and "complainant" are oftentimes used interchangeably. There can be more than one plaintiff in a lawsuit.

In medical negligence lawsuits involving injuries to a living individual, the plaintiff is generally the patient. If the patient has died, the lawsuit is brought on behalf of the estate of the patient by the legal representative of the estate. If the patient is a minor, the lawsuit may be brought be "the parents and natural guardians" of the minor, or some other legal representative of the child (*e.g.,* a guardian *ad litem* potentially appointed by the court). If the patient is incapacitated and not competent to bring suit, the plaintiff may be an "attorney-in-fact" under a power of attorney, or a guardian of the person and estate appointed by the court.

If the patient has died without a will (intestate), the plaintiff will be the administrator of the estate. The administrator is appointed by the state upon application by an individual or group of individuals (co-administrators), and is generally the parent, spouse, or child of the decedent (the person who died).

If the patient has died with a will (testate), the plaintiff is the executor of the estate as named in the will.

As noted, patients who are deemed incompetent by a court by reason of incapacity to act on their own behalf may have a guardian appointed by the court. The guardian may then commence a lawsuit for the benefit of the incapacitated person. In the case of children, the parents generally bring suit on behalf of their injured child in their capacity of "parents and natural guardians" of the child.

In the caption to a case, the plaintiff is identified on the left-hand side of the "v." (versus). For example, in the caption "John Doe v. Dr. Jane Smith, Smith Surgical Practice, P.C., and Plainville General Hospital," John Doe is the plaintiff.

Defendant

The defendant is the individual(s), entities, and/or health care facilities who are the target of the lawsuit. The defendant may be a physician, nurse, physician-extender, ancillary healthcare provider, practice group, hospital or some combination of them.

The employer of an individual defendant is often named in the lawsuit on the legal principle that the employer is legally liable for the actions of its employees when those employees are acting within the scope of their employment. The hospital at which the alleged negligence occurred may also be named in the lawsuit under the legal theory that the individual providers are agents of the hospital. Practice groups and hospitals may be liable for the conduct of a subordinate or affiliated healthcare provider under a variety of legal theories.

In the caption to a case, the defendant or defendants appear on the right-hand side of the "v." For example, in the caption "John Doe v. Dr. Jane Smith, Smith Surgical Practice, P.C., and Plainville General Hospital," Dr. Jane Smith, Smith Surgical Practice, P.C., and Plainville General Hospital are the defendants.

Parties and Claims

The "parties" to a lawsuit are collectively, the plaintiff(s) and the defendant(s). The plaintiff brings a claim or claims against the defendant or defendants which are, in a medical negligence lawsuit, based upon allegations of medical negligence or other legal theories (*e.g.*, lack of informed consent, battery, recklessness).

The defendant may also assert a claim against another defendant in the lawsuit, a so-called "cross-claim," or even against the plaintiff, a so-called "counter-claim." The latter rarely occurs but may arise in suits which are deemed particularly frivolous.

A defendant may also bring a so-called "third-party claim" against individuals or entities that the plaintiff has not named in the lawsuit but whom the defendant believes is responsible for the plaintiff's injuries. These individuals or entities then become a "third-party defendants." When that occurs, the defendant bringing the third-party claims is generally asserting that some other individual or entity who was not named as a defendant by the plaintiff either shares in the responsibility for, or is responsible for the plaintiff's injuries.

In general, the vast majority of lawsuits are litigated between plaintiffs and the originally name defendants.

Tort Law ("Torts")

Tort law is a branch of "civil litigation" (as opposed to, *e.g.*, criminal law). Broadly speaking, a tort is a civil wrong that occurs between two or more individuals or entities for which some form of relief may be granted. The claims are not based upon a formal contractual relationship. In other words, the nature of the relationship giving rise to the litigation is one imposed by legal duties and obligations that the law recognizes.

The "doctor-patient" relationship is an excellent example of this relationship. The duties and obligations of the doctor with respect to the patient are imposed by law, rather than set forth in a contractual agreement.

Negligence is one such tort. There are others, such as defamation, false light, premises liability, product liability, as examples. The fundamental premise underscored by tort law is that the plaintiff has experienced an injury at the hands of the defendant, and is therefore seeking money damages as compensation for the injury.

The tort of negligence, including medical negligence (also known as medical malpractice) is based on those duties and obligations imposed by law on healthcare providers based upon the relationship with the patient.

Different healthcare providers have different duties: The duties of a nurse are not the same as those of a doctor; the duty of a doctor, likewise is unique to the doctor and the specialty; and the duties of a hospital differ from other healthcare providers. These relationship are generally fiduciary in nature: The holder of the duties and obligations must act for the benefit of the patient and not be guided by self-interest or self-dealing.

At core, the duty imposed by law upon a healthcare provider (*e.g.,* physicians, nurses, physician-extenders, healthcare facilities) is to act within the confines of the relevant and applicable "generally accepted standards of care."

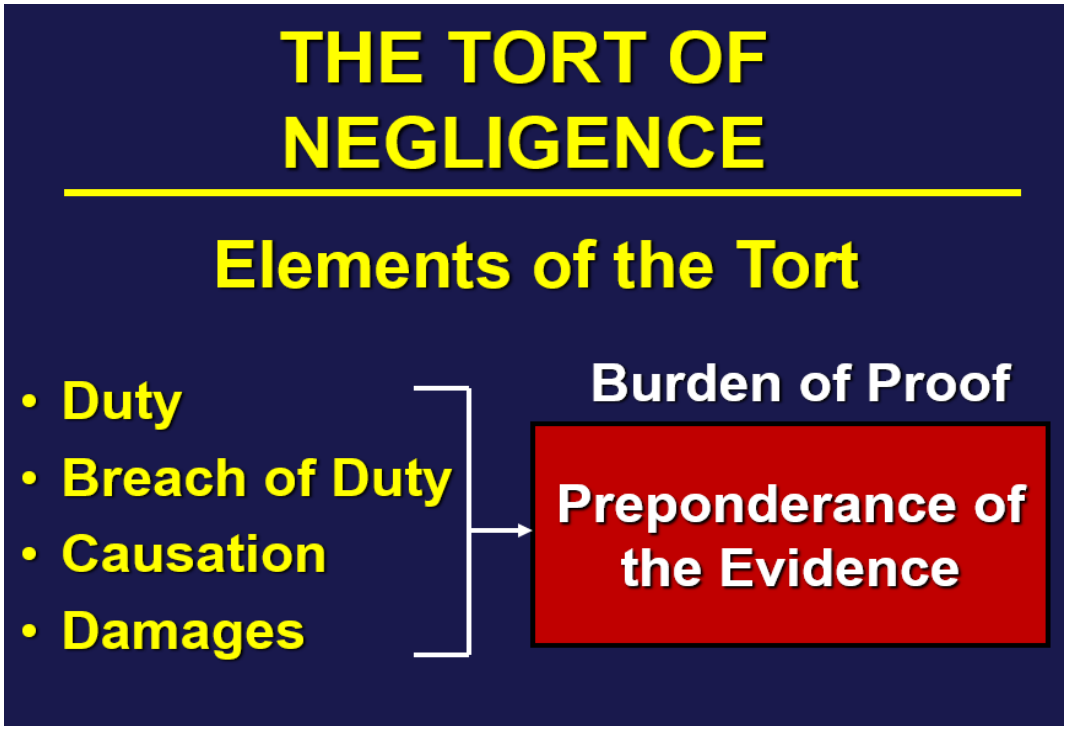
Different standards of care exist for different healthcare providers (*e.g.,* physicians, nurses, physician-extenders, healthcare facilities). The general concept of "standard of care," however, crosses specialty, subspecialty, and professional boundaries, and condenses down to what a reasonable and prudent healthcare provider should do under the circumstances presented by the particular patient or the patient's particular condition or circumstances.

A tort can be thought of as a social "contract" between parties where the terms and conditions of the "contract" are imported by law (to act within the "accepted standards of care") rather than by the mutual agreement of the parties. The law imposes certain standards of conduct (duties and obligations) on one party with respect to another party.

The individual or entity that commits the tort or is the "wrongdoer" is known as a "tortfeasor."

Elements of the Tort of Negligence

Figure 1. The Tort of Negligence



A tort is comprised of various elements. With respect to the tort of negligence, including medical negligence, the four elements of the tort are as follows:

1. **Duty**

The existence of a duty is based upon the relationship between the healthcare provider (*e.g.*, physicians, nurses, physician-extenders, healthcare facilities) with the patient. In medicine, the duty is to provide medical care and treatment to a patient within "generally accepted standards of care." A physician, nurse, physician-

extender (*e.g.,* physician assistant or nurse practitioner), and healthcare facilities must all provide care within the applicable standards to their particular role—that is their duty under the law. Except in exceptional or unusual circumstances, the duty element of a medical malpractice claim is rarely contested.

Duty is therefore intricately linked to the legal concept of "standard of care."

2. Breach of Duty

The concept of breach of duty flows directly from the definition of duty. It is the failure on the part of a healthcare provider to provide care within the accepted standards. Breach of duty is, in broad terms, a deviation from generally accepted standards of care. That standard is then defined by the particular healthcare provider's role in the patient care process.

Breach of duty can generally be conceived as an action which should not have been taken by the healthcare provider in the care of the patient; or as the flip side, inaction by the healthcare provider with respect to the patient under circumstances where action should have been taken. The action or inaction comprise deviations from accepted standards of care—and therefore are negligent.

The standard of care is often contested in medical malpractice litigation, and underscores the role of medical experts in the

litigation process. The parameters of the standard of care are generally defined through expert opinions and testimony.

3. Causation

Causation is the link that must be demonstrated by the plaintiff between the deviation or deviations from generally accepted standards of care and the alleged injury and damages flowing from the deviation or deviations. Causation addresses the following question: Did the alleged deviation from accepted standards of care *cause* the complained of injury.

This legal standard for causation varies among and between different jurisdictions, but as a general matter, follows a few common lines. The "but for" standard for causation requires "proof" (generally "more likely than not") that the injury would not have otherwise occurred "but for" the healthcare provider's deviation from accepted standards of care.

The "substantial factor" standard is considered a looser causation standard, and requires "proof" that the deviation from accepted standards of care was a "substantial factor" in causing the injury. The deviation does not have to be the only factor, but it cannot be an attenuated or ethereal factor or overly disconnected in nature.

Some jurisdictions permit an "increased risk of harm" standard. Under this standard, the likelihood of the injury was increased in risk by the conduct of the defendant. A classic example involves cancer progression cases in which there is no claim that the

defendant caused the cancer—only that the defendant's conduct increased the risk that the cancer would progress. These are generally known as "delay in diagnosis" cases.

Causation is often a flashpoint in medical malpractice litigation and may be heavily contested.

4. Damages

This is the final element of a medical negligence claim. Damages is the legal determination of the injuries (economic and non-economic damages) sustained by the plaintiff that were caused by (attributable to) the negligent conduct of the defendant(s). Causation and damages are therefore intricately linked together.

Damages fall within two broad categories: (a) Economic damages (*e.g.*, past medical costs, cost of future medical care, loss of earnings and future earning capacity, incidental expenses); and (b) non-economic damages (*e.g.*, pain and suffering, disfigurement, humiliation, loss of life's pleasures).

Economic damages are generally considered "liquidated" damages; that is, they are damages that can be assigned a concrete monetary value. Projected loss of earnings and past and projected further medical expenses resulting from the alleged negligence are examples. These damages are frequently calculated by experts in life care planning, rehabilitation and physical medicine, and forensic economics.

Non-economic damages are generally left to the discretion of the jury, and are often the subject of tort reform and damages "caps" in some jurisdictions. For example, in some jurisdictions, there may be a "cap" on jury awards for an item of damages such as "pain and suffering."

A third category of damages sometimes present in a medical negligence claim are so-called "derivative" damages. Loss of marital consortium is an example. While there is generally no direct injury to the spouse of the injured plaintiff, there may be "derivative" injury to the spouse caused by the plaintiff's injuries and the effects on the marital relationship.

In theory, damages in a medical negligence case are awarded to "compensate" the plaintiff for the economic losses and non-economic damages when the defendant has been found, as a threshold matter, to have breached the standard of care and caused the plaintiff's injuries. These types of damages are referred to a "compensatory damages." Compensatory damages are fall within the legal concept of awarding damages to place the plaintiff back in the "*ex ante*" position; *i.e.*, the status quo of the plaintiff before the negligent conduct and injuries occurred. In reality, catastrophic injuries are not reversible, and monetary damages do not accomplish that goal.

Punitive damages are another form of damages that may be claimed in a medical negligence case. While rarely awarded, punitive damages are oftentimes requested by the plaintiff when the conduct of the healthcare provider is perceived to be willful,

wanton, or in reckless disregard for the safety and well-being of the patient.

Punitive damages are dual-purposed, and are awarded to both punish the defendant and deter the defendant (and others) from engaging in such conduct in the future. Conduct giving rise to punitive damages is either intentional in nature or perceived to be so reckless as to warrant punishment. In some jurisdictions, the level of proof for claims of punitive liability of a healthcare provider to a plaintiff is higher—so-called "clear and convincing" evidence.

While compensatory damages generally fall within the ambit of professional liability insurance coverage, an award of punitive damages generally does not. As a matter of public policy, healthcare providers cannot insure for conduct that is willful and wanton, and professional liability insurers will rarely, if ever, cover an award for punitive damages. Such damages leave the healthcare provider personally exposed for the financial effects of a punitive damages award.

Informed Consent

An informed consent claim against a healthcare provider is grounded in the concept that the patient is owed a duty to be provided with sufficient information regarding a procedure or other aspect of medical care to make an informed decision about undergoing the procedure or care.

There are two general standards of informed consent: The “reasonable patient” standard and the “reasonable physician” or “objective medical community” standard.

The “reasonable patient” standard incorporates what a reasonable patient would want to know in order to make an informed decision to undergo a procedure or other aspect of medical care. The “reasonable physician” standard incorporates what a reasonable physician would state to a patient in order to obtain informed decision from a patient to undergo a procedure or other aspect of medical care.

In many jurisdictions, informed consent is defined by statute. For example, the in the Commonwealth of Pennsylvania, a state in which the “reasonable patient” standard applies, statutory provisions give an excellent comprehensive template for informed consent. The duty regarding informed consent is defined by the *Medical Care Availability and Reduction of Error (MCARE) Act*, *40 P.S. §1303.504* (2002) as follows:

> (a) Duty of physicians.--Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:
>
> (1) Performing surgery, including the related administration of anesthesia.
>
> (2) Administering radiation or chemotherapy.
>
> (3) Administering a blood transfusion.
>
> (4) Inserting a surgical device or appliance.

(5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner.

(b) Description of procedure.--Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure. The physician shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide.

(c) Expert testimony.--Expert testimony is required to determine whether the procedure constituted the type of procedure set forth in subsection (a) and to identify the risks of that procedure, the alternatives to that procedure and the risks of these alternatives.

(d) Liability.—

(1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient's decision whether to undergo a procedure set forth in subsection (a).

(2) A physician may be held liable for failure to seek a patient's informed consent if the physician knowingly misrepresents to the patient his or her professional credentials, training or experience.

Kentucky, for example, follows a “reasonable physician” standard as defined by *Kentucky Revised Statute 304.40-320 (1976)*:

> In any action brought for treating, examining, or operating on a claimant wherein the claimant's informed consent is an element, the claimant's informed consent shall be deemed to have been given where:
>
> (1) The action of the health care provider in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with the accepted standard of medical or dental practice among members of the profession with similar training and experience; and
>
> (2) A reasonable individual, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedure and medically or dentally acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other health care providers who perform similar treatments or procedures;
>
> (3) In an emergency situation where consent of the patient cannot reasonably be obtained before providing health care services, there is no requirement that a health care provider obtain a previous consent.

It is best to consult with counsel in order to know the parameters of informed consent in the applicable jurisdiction.

Statutes of Limitation and Repose

The statute of limitations serves as a time-bar to a potential plaintiff's ability to bring a legal action. The statute of limitations is a requirement of timeliness in bringing an action by the injured party, and differs from jurisdiction to jurisdiction. The statute of limitations may, at times, be used as a defense in a lawsuit.

The operation of a statute of limitations is subject to a number of factors, including the age of the plaintiff (minor) and whether there were attempts by the tortfeasor to conceal evidence of responsibility. In some jurisdictions, the statute of limitations for a lawsuit on behalf of a minor may be tolled until the age of majority (*e.g.,* 18 years of age). This can extend the statute of limitations out for several years. Some statutes of limitations begin to run only when the injured party discovers or reasonably should have discovered the injury—the so-called "discovery rule."

A statute of repose focuses on extinguishing a right of action against an injuring party and may be based simply on elapsed time from an event, even if the potential cause of action cannot reasonably be discovered until a later date.

Professional Liability Insurance (Malpractice Insurance)

Similar to other categories of insurance coverage (*e.g.,* home owner's, motor vehicle, general liability, business loss), professional liability insurance is a vehicle

by which risk of a potential loss is shifted from the insured (the purchaser or holder of the insurance coverage) to the insurer (the entity issuing the policy).

Medical malpractice insurance covers claims for medical negligence. This type of insurance can be purchased on the open insurance market from insurance companies who sell or specialize in such policies; or be comprised of self-created funds designated to pay out medical negligence claims; or some combination of the two.

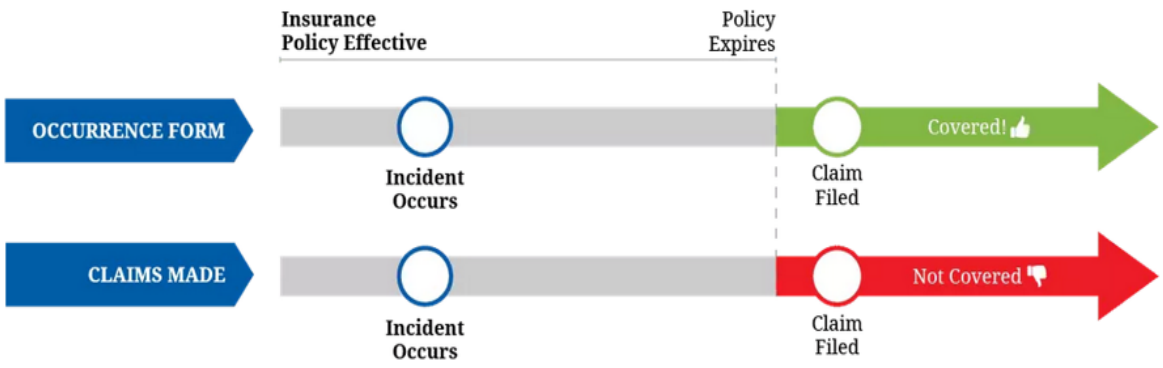
A malpractice insurance policy generally has limits of coverage. Insurance coverage may be layered, in that a certain upper limit of coverage may be set above which another insurance policy assumes the coverage—so-called excess coverage, which may be purchased above an initial pillar of coverage depending upon the protection being sought.

There are generally two types of professional liability insurance policies: Occurrence and claims-made.

An occurrence policy offers lifetime coverage for incidents that occur during the policy period, irrespective of when the claim is actually reported.

A claims-made policy provides coverage for claims that occur—and are reported—within the specific time period set forth by the insurance policy.

Figure 2: Occurrence versus Claims Made Coverage



from: *Message Magazine Insurance Plus* (2023) *at*
https://www.massageliabilityinsurancegroup.com/occurrence-form-policy/

Tail coverage, or extended reporting period (ERP) coverage, may be purchased after a policy has been terminated. The "tail" endorsement extends the reporting time limits of claims-made coverage.

As a general matter, tail coverage should be purchased, even following retirement, to extend for that period of time after which any claims that could have arisen during the claims-made coverage period have expired.

Insurance is a complex area of the law, involving issues regarding the duties and obligations of the insurer and the insured, and the interpretation of language within the insurance contract.

Other items within a professional liability coverage include whether consent is required from the policy holder to settle a medical negligence lawsuit, the aggregate coverage per year or other period (*e.g.*, coverage per claim and aggregate coverage per year), and any exclusions within the policy.

Comparative and Contributory Negligence

In the case of medical malpractice litigation, comparative and contributory negligence refer to allegations of negligent conduct by the plaintiff that may offset or abrogate the claims against the healthcare provider.

Duties and obligations inherent in the healthcare provider-patient relationship are a two-way street, and allegations by the defendant(s) with respect to the conduct of the plaintiff are not uncommon. The conduct for a plaintiff (patient) centers on what a reasonable, or reasonably prudent, patient should have done under the circumstances involved in the care.

Comparative and contributory negligence generally affect the issue of causation: Perhaps a delay in seeking medical attention is an alleged cause of the injury, or the patient failed to schedule a recommended test that was critical to a diagnosis, or the patient failed to follow medical instructions and delayed in taking appropriate actions.

Comparative and contributory negligence, if proven by the defendant by a preponderance of the evidence, can reduce the monetary recovery or bar any recovery by the plaintiff altogether depending on the law of the particular jurisdiction.

A jury may be asked to allocate responsibility for the injuries and damages in the verdict: How much is attributable to the defendant, if any, and how much is attributable to the plaintiff, if any.

Comparative negligence can also be allocated between defendants in instances where more than one defendant is alleged to have caused the plaintiff's injuries. This is usually performed on a percentage basis as determined by the jury based upon the evidence presented during the trial.

Employee-Employer, Ostensible (Apparent) Agency, and Independent Contractor Doctrines

These legal doctrines deal with the relationship between a defendant and another party to the litigation—generally another defendant.

An employer is legally responsible for the wrongful acts of an employee if such acts occur within the scope of the employment relationship and in the course of duties performed which are part of the employment relationship. A bread company, for example, can be held liable for the actions of its employee delivery-driver if the driver is negligent in the operation of the delivery truck during the delivery of bread. Liability attaches to the company even if the company has made every effort to hire safe drivers, train the drivers to follow the rules of the road, and was nowhere near the scene of the accident.

The name for this legal doctrine is *respondeat superior*. The employer-employee relationship is a form of agency—where the "agent" is acting on behalf of and within the scope of the relationship with the "principal." The principal shares legal responsibility for the acts of its agent.

"Ostensible" or "apparent" agency arises when a plaintiff seeks to hold an apparent principal liable for the negligent conduct of an apparent agent. Under those circumstances, there is no formal employer-employee relationship between the apparent principal and agent—only a reasonable perception by an injured third-

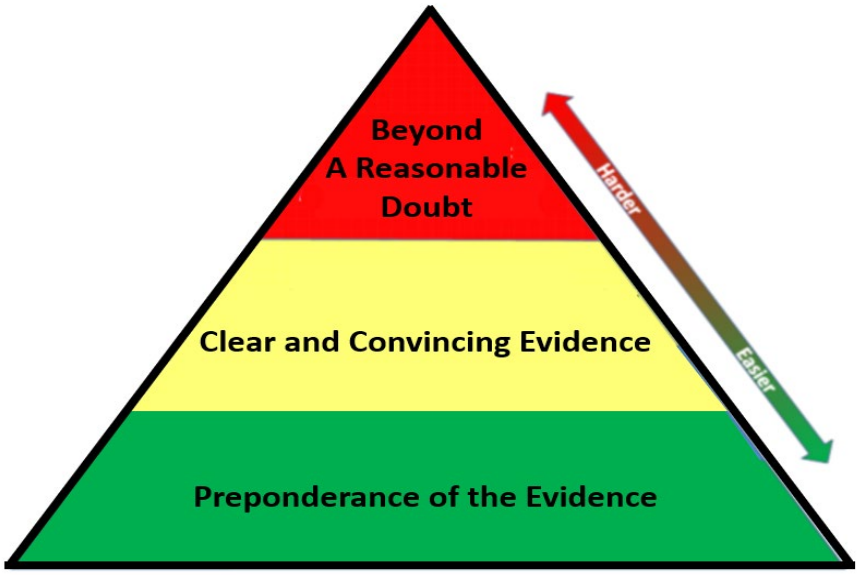
party that the principal employees the agent. The common context of apparent or ostensible agency occurs when a plaintiff sues a physician and hospital, and seeks to hold the hospital liable for the conduct of the physician *even though the physician is not employed by the hospital*. The driver of these claims usually relates to insurance coverage—the plaintiff is looking to the hospitals level of insurance coverage to cover the damages for which the physician is responsible.

An independent contractor is an independent worker who is not an employee of the entity engaging the contractor. In the professional setting, the independent contract has professional autonomy and flexibility and is employed by an entity separate and apart from the one engaging the services of the contractor. A common example may be the relationship between a physician and a hospital in the hospital's emergency department. The hospital may contract with a separate and independent emergency room group to provide these services.

Burden of Proof and Preponderance of the Evidence

The burden of proof refers to the evidentiary burden which must be met by the party attempting to prove its claim. In medical malpractice cases, proof of each and every element (duty, breach of duty, causation, and damages) of the tort claim falls to the plaintiff, and each element must be proven by a "preponderance of the evidence." Simplistically, the preponderance of the evidence is a "more likely than not" standard of proof.

Figure 3: Basic Burdens of Proof



To illustrate the preponderance of the evidence standard, judges often illustrate the burden as follows: If all the evidence for and against the given claim is placed on a balance scale, and the scale tips ever so slightly in favor of the plaintiff, then the plaintiff has met the burden of proof. If the scale remains evenly balanced (does not tip in any direction) or tips towards the defendant in any degree, then the plaintiff has failed to meet the burden.

It should be noted that there are different burdens of proof depending upon the type of claim or case. The preponderance of the evidence standard is applicable in civil litigation. It should not be confused with the ”beyond a reasonable doubt” standard applicable to criminal cases. Preponderance of the evidence is a lower standard of proof.

An intermediate standard known as “clear and convincing” evidence fall between the two standards, and is sometimes applicable to proof involving claims for punitive damages.

Standard of Care

Standard of care is a legal concept that describes what a reasonable, or reasonably prudent, healthcare provider *should* do under the conditions and circumstances of the patient. The concept has crept into medical terminology.

Standard of care is the duty owed to the patient by a healthcare provider, and the benchmark by which a breach of duty ("deviation from the accepted standard of care") is measured.

Standard of care as a legal concept that is absolute in quality. It is not subject to the use of medical judgment, although medical judgment that falls within the accepted standard of care may play a role. The standard of care does not reflect a choice between alternative therapies unless those alternatives each falls within accepted standards of care (sometimes then referred to as "two schools of thought" doctrine). The law considers the standard of care to be a "black-and-white" concept that can be articulated with certainty.

The standard of care does not vary from physician-to-physician, or hospital-to-hospital, or state-to-state—it is not dependent upon locality—the standard of care is considered universal.

At core, the standard of care states what a reasonable physician *should* do under the circumstances: Utilize the appropriate knowledge and skill that is possessed and exercised by others practicing in the field, and keep informed of and apply contemporary developments in the medical field. Standards of care can and do change over time.

The concept of standard of care can be confusing. From a legal perspective, the standard of care is monolithic and is, to a large degree, circumscribed and inflexible. Sources of the standard of care are include practice guidelines, consensus statements, textbooks, medical literature, statements by professional organizations and societies, and "conventional wisdom." The ultimate source of the standard of care with respect to medical malpractice litigation and trials is the medical expert.

During medical malpractice litigation, the standard of care is generally defined (and refuted) by expert witnesses. The fundamental issue is whether the defendant healthcare provider met the generally accepted standard during the care of the patient. This is often a heavily contested issue and the subject of competing expert testimony.

Jurisdiction and Venue

With respect to medical malpractice cases, jurisdiction refers to the court system which has the authority to adjudicate a particular case and which has authority over the parties in terms of binding rulings and trial. The question often becomes whether the court in which the case was filed has "jurisdiction" over the defendants in the case.

At the trial level, jurisdictions include the state court systems of each state and territory, and the federal court system. Most medical negligence cases are filed within a state court system. Federal jurisdiction may occur when the plaintiff the defendants hail from different states (so-called "diversity of citizenship"), or when a federal issue is posed in the litigation (so-called "federal question jurisdiction").

Federally employed healthcare providers and facilities are also sued in federal court.

Court systems are generally divided into two tiers: The trial court level and the appellate court levels. The latter may include an intermediate appellate court with a higher level appellate court above. The intermediate appellate court hears "appeals" from the trial court, and the highest appellate court hears appeals from the intermediate appellate court, or occasionally, directly from the trial court.

Venue refers to the actual locale within the jurisdiction in which the case will be heard. In the state court system, it refers to the county within the state in which the case was filed, litigated, and will be tried. Some states have venue rules which require that medical negligence cases be filed within the county in which the negligent actions are alleged to have occurred. Other states have broader venue rules.

"Forum shopping" by plaintiffs occurs when plaintiffs seek to file a case in a venue that is perceived, historically, to be more "plaintiff-friendly" in terms of trial outcomes. This can occur in states with broader venue rules.

Pleadings and Service of Process

The pleadings contain those initial documents that commence lawsuit and respond to the allegations set forth in the lawsuit: The Complaint and the Answer to the Complaint. The Complaint identifies the nature of the litigation (medical negligence), the names and addresses of the plaintiff and the defendant(s), the name and address of the plaintiff's lawyer, the court in which the lawsuit has been filed and an associated docket number identifier, statements regarding the allegations of negligence, a general statement of the damages, and the relief sought from the defendants.

Jurisdictions follow two patterns of pleading with respect to the Complaint. "Fact pleading" jurisdictions require substantial detail regarding the alleged facts giving rise to the claims of negligence that are set forth in the Complaint. "Notice pleading" jurisdictions require far less factual detail as to the events giving rise to the allegations of negligence and damages claimed.

Once the Complaint is filed by the plaintiff, it is then "served" on each defendant in the case. This is called "service of process," and is accomplished by a "process server" or some other mechanism defined by the rules of the jurisdiction in which the case is filed. Service of process meets the threshold constitutional right of "notice and opportunity to be heard."

Once the Complaint is duly served, the litigation can commence. Each defendant files an "Answer" to the Complaint, which is a responsive pleading to the allegations stated in the Complaint. Some allegations may be "admitted"—most are "denied" with proof of each allegation demanded.

Discovery

Discovery is the process by which each side to a lawsuit gathers information in order to prepare their respective cases. This is the longest phase of the litigation.

The discovery process is guided by the rules of civil procedure. The tools of discovery available to the parties include: (a) Requests for the production of documents (*e.g.*, medical records, tax and financial records, hospital policies and procedures, billing records, etc.); (b) Requests for "things" (*e.g.*, pathology slides, operative pictures, copies of log books, etc.; (c) interrogatories, or written

questions from one party to another (*e.g.*, professional liability insurance information, identities of witnesses, official names of various corporate entities, descriptions of events, etc.); (d) depositions, or face-to-face questioning by a lawyer of a party or a witness; (e) subpoenas, or requests for discovery (*e.g.*, documents, things, or depositions) from non-parties to the lawsuit (*e.g.*, other medical records of the plaintiff); (f) requests to inspect a premises (rare in medical negligence cases); and (g) requests for admissions, in which a party is asked to "admit" or "deny" a stated proposition of fact in writing.

The most powerful and widely used discovery tool in a medical negligence case is the deposition. A deposition is a face-to-face encounter with the opposing lawyer during which a broad range of questions may be asked, and documents shown to the witness for explanation. A deposition is taken under oath, and a stenographic record or transcript of the deposition is created by a court reporter. The deposition may also be videotaped. Deposition testimony is afforded broad use at trial.

Depositions may be read or shown at trial in either small portions or in their entirety, and are often the subject of pretrial motion practice and objections by the opposing party in terms of what the jury is permitted to hear and see.

Any item that is deemed appropriate for discovery by the procedural or evidentiary rules or other sources of the law within the jurisdiction is described as being "discoverable" or "within the scope of permissible discovery." Whether certain information or documents are discoverable may be contested, and lead to motions to the court to either protect materials from being discovered (request for a "protective order") or to compel production of the requested materials (motion to compel).

Expert Witness

Medical malpractice cases are complex in nature and involve complicated precepts of medicine. A medical negligence case can rarely can be litigated without utilizing experts in the field.

In some jurisdictions, expert review and support of a case is a required predicate before a medical malpractice case can be put into suit. Some jurisdictions require Affidavits of Merit or Certificates of Merit around the time the lawsuit is initiated. These documents state that the case has been reviewed by an appropriate expert and has or potentially has merit.

Experts are called upon to offer opinions on most aspects of the litigation: Standard of care, causation, and damages. Experts, from both a practical and legal matter, must possess the requisite knowledge, skill, education, training, and experience to offer opinions at trial.

Different jurisdictions have different standards applicable as to whether a given expert is qualified to offer a given set of expert opinions. Experts, at a minimum, must generally have the requisite credentials to pass muster with the judge before the expert is able to offer opinions to the jury on such topics as standard of care, causation, and damages. Rarely, an expert will be precluded from offering opinions at trial based upon defects in credentials or quality of opinions.

Typical thresholds as to what constitutes the requisite credentials vary by jurisdiction, but may include such issues as: (a) Is the expert board certified in the same or similar specialty or subspecialty as the defendant; (b) is the expert currently engaged in the practice of clinical or academic medicine; (c) do the expert's opinions meet the standards for the admissibility; *i.e.,* are the opinions

derived from the use of a valid scientific or generally accepted methodology; and (d) do the opinions assist the jurors in deciding facts that are in issue in the case?

The ability of an expert to testify at trial based upon these and other factors can be challenged by the opposing party by way of pretrial motions to preclude. All or some of the opinions may be successfully precluded.

As a general matter, an expert witness is permitted to testify on the ultimate issues of whether the healthcare provider deviated from accepted standards of care (negligence), or whether the deviation caused injuries and damages (causation and damages). More than one category of expert is generally employed by both the plaintiff and defendant.

Fact Witness

Fact witnesses have a more direct relationship to the litigation generally based upon what these witnesses may have observed or the to which they are privy. The standard for "fact witness" testimony is whether the witness has "personal knowledge" of the incident or events.

Examples of fact witnesses are non-party treating physicians (either before or after the incident giving rise to the lawsuit), family members of the plaintiff, other non-party healthcare providers who participated in the care or witnessed events, and general witnesses with personal knowledge of what they saw or heard or other facts relevant to the lawsuit *e.g.*, hospital administrators familiar with hospital policies or procedures).

Evidence

Evidence can be documentary (medical records, financial records, hospital policies and procedures); so-called "things" (pathology slides, explanted medical devices, medical equipment); recordings (conversations and statements, videotaped surveillance, static or dynamic radiology studies); statements in learned treatises; testimony; and other statements. Rules of evidence in general, and rulings by judges, determine what evidence is "admissible" at trial and what evidence will not be presented at trial. The law generally presumes that all relevant testimony is admissible within certain parameters defined by the rules.

The admissibility of evidence may be a contested issue by way of pretrial motions to preclude items. Relevant evidence is any evidence that tends to make a fact in issue either more true or less true—a very broad standard. The most common types of evidence precluded are "hearsay statements" ("he said she said" in which "she" is not available to be cross-examined about the truth of the statement that "she said"), documents whose authenticity is questionable, and evidence which is felt to be irrelevant to any fact in issue or claim or defense.

The parties attempt to limit their opponents case at trial by motions to precluded certain evidence and expert opinions.

Procedural Rules (Rules of Civil Procedure)

As the name of the rules implies, procedural rules are those rules which define how cases are litigated—specifically, they outline each and every step required to put a case into suit, proceed with the litigation, serve discovery documents on the plaintiff and defendant, engage in the discovery process, produce expert reports, engage in motion practice, and proceed to trial.

These rules of civil procedure are all-encompassing and provide lawyers with the fundamental roadmap of litigation from a procedural perspective.

Separate rules generally exist within a given jurisdiction for appellate procedure—how to take an appeal from a judicial ruling or verdict.

Evidentiary Rules (Rules of Evidence)

These are the rules which guide the admissibility of evidence, particularly at trial. Most jurisdictions (state courts and federal court) have rules of evidence that are codified into specifically named topics such as privileges, hearsay and hearsay exceptions, the admissibility of business records, the admissibility of other documents, the competency of fact and expert witnesses to testify, and the criteria for their testimony. Evidentiary rules can also be found in case law and statutory law within a given jurisdiction.

Applicable Law

The applicable law is the substantive (as opposed to procedural law) that applies to the facts of the case and a determination of the elements of the claims. This includes the law with respect to the applicable causation standards and damages that are recoverable within a given jurisdiction.

Not all jurisdictions share the same standards for either causation or damages. Some jurisdictions put a global "cap" on recoverable damages or a "cap" on non-

economic damages. Some jurisdictions apply a "but for" standard for causation while others apply a "substantial factor" or other causation standard.

The applicable law is derived from the law of the jurisdiction in which the case has been brought, and may be found in the following sources:

1. **Statutes**

   Statutes are passed by the legislative body of the jurisdiction. Much of the tort reform regarding "caps" on damages, standards for expert witnesses and expert witness testimony, and thresholds requirements for placing a medical negligence case into suit, requisite insurance coverage for healthcare providers, the preservation of medical records, and so forth appear in statutes and regulations. Rules of procedure and evidence may also appear in statutes.

2. **Administrative Codes**

   Administrative codes are rules and regulations promulgated by administrative agencies (*e.g.*, Board of Medicine, Board of Nursing, Department of Health) under the authority of the legislature. Examples include codes pertaining to hospital services, the maintenance of medical records, patients' general rights, the policies and procedures which hospitals must have in place, and others.

3. **Case Law**

   Case law is judicially derived law generally from appellate court opinions. Case law creates "precedent" in an attempt to provide uniformity in the application of the law. It is also referred to as "common law," to distinguish it as judicially created law.

Case law is traditionally described in the format "Plaintiff v. Defendants" with a citation to a court reporter—the place where the case has been reported. The jurisdiction, specific level of the court (trial, intermediate appellate, highest court of the jurisdiction), and year of the case also appears. This is known as the case's "caption," and is unique for each case.

Case law may be classified as "good law" or law that is no longer applicable and has been overruled by a subsequent opinion.

Privileged and Protected Communications

The law recognizes the "privileged" nature of various communications: Doctor-Patient, Priest-Penitent, Attorney-Client, Husband-Wife, and others. Once a patient places medical care and state of health into issue via a medical negligence lawsuit, the right to privacy and the sacrosanct nature of Doctor-Patient communications is, as a general matter, waived, or at a minimum, attenuated.

Privilege also attaches to various "peer review" settings, such as the proceedings of peer review committee meetings and peer review communications. Minutes and analyses from these meetings is generally not "discoverable" in the usual course of a lawsuit, and are protected from discovery—usually by statute (so-called "peer review statute").

This is not true of all jurisdictions, however, and should be carefully understood in advance. Discussions of cases outside of the peer-review setting are also, as a general matter, discoverable and not subject to privilege protection.

Trier of Fact

In a jury trial, the trier of fact is the jury. The jury hears all the facts that are presented in the case by the parties, and is then instructed by the judge by way of jury instructions (also known as the "jury charge") on the law that should be applied to the facts.

The jurors decide those fact that they choose believe and the testimony that they believe was credible. Juries are generally free to decide what evidence will be factored into their verdict, and what weight should be afforded to that evidence.

Jurors render a verdict based upon the of the law that is told to them by the judge and the evidence they choose to find credible and persuasive.

Trier of the Law

The judge decides all issues of law in the case and at trial. This includes the admissibility of witness testimony and evidence to be presented to the jury during the trial.

The judge issues "rulings" and "orders" which inform the lawyers about, among other things, the admissibility of certain evidence, the preclusion of evidence or testimony, and the potential parameters of witness testimony, especially expert witness testimony.

The rulings and orders generally flow from pretrial motion practice by the lawyers. A motion is simply a request from a party for ruling or order by the court.

Pre-Trial Motions

Motions are simply a request by a party for a certain ruling or order or other action by the judge. The latter requested action is generally referred to as "relief"—what the party is requesting that the judge do. Motions can occur throughout the course of a medical malpractice case. When a motion is filed during the pretrial period regarding issues at trial, it is referred to as a motion *in limine*.

Motions seek may seek to end the litigation altogether based upon the facts and applicable law developed during discovery: A so-called motion for "summary judgment." Motions may also seek the dismissal of a party or a particular claim in the case: A motion "to dismiss."

Motions can seek to shield witnesses from testifying or documents from discovery: A motion for a "protective order." Motions have standards with respect to whether they will be granted or denied by the judge, and judges are given broad latitude (discretion) in their rulings.

Jury Selection, *Voir Dire*, and Jury Trial

The right to a trial by jury is a bedrock principle of American law. Procedures for jury selection vary between jurisdictions, but involve the screening of potential jurors (known as the "jury *venire*") for potential and actual sources of bias, or disqualifying attitudes, or relationships with the parties by way of juror *voir dire*

(from the French, meaning “to speak the truth”)—the opportunity for the judge and lawyers to ask, or have the jurors asked, questions.

The *voir dire* process is designed to uncover any juror knowledge about the case, any preconceived biases about medical negligence cases in general or the parties in particular, any relationships to the parties, any prior litigation experience, and any general experience with medical problems similar to those that will be the subject matter of the case.

The ultimate goal of jury selection is a jury that can be fair and impartial to both sides, and who can decide the case based upon the fact presented at trial and the law which is applicable. Ideally, the “playing field” with respect to the jury should be level at the beginning of the trial.

During jury selection, jurors may be stricken “for cause”—*e.g.,* the physician-defendant is their personal physician. Each side also has a certain number of “preemptory challenges” which can be exercised. A preemptory challenge can be exercised by a party without explanation except for certain forbidden circumstances (*e.g.*, racial motivation).

Once a jury is empaneled, the jury will sit throughout the trial to hear the evidence. They then are instructed on the law at the end of the case, and thereafter deliberate and render a verdict.

Bench Trial

A bench trial is a non-jury trial carried out before a judge. These rarely occur in medical negligence cases. In that instance, the judge is both the trier of fact and the trier of the law.

Claims against federal healthcare employees are generally non-jury trials.

Opening Statements

Opening statements at trial provide an opportunity for each side to present the facts of the case in a concise and non-argumentative manner. Each side discusses the nature of the case, what evidence and witnesses will be presented, what the standard of care is, what causal relationship exists between the failure to meet the accepted standard of care, and the injuries and damages being claimed. The opening statements are a preview of their respective cases presented by the attorneys.

Opening statements do not contain argument or editorial commentary. These statements are supposed to be a roadmap to what each party intends to prove and the general manner in which each intends to prove it.

Closing Arguments

Closing argument is the opportunity for each party to argue its case based strictly upon the evidence admitted and presented to the jury during the trial. The parties

have broader latitude to make an argument as to why that party should prevail and receive a verdict in their favor.

Each party generally summarizes the evidence and testimony in a light most favorable to their case, makes an argument as to why they should receive a verdict in their favor and against the opposing party. Both the strength of their case and the weakness of their opponent's case is highlighted and argued.

Jury Instructions ("Points for Charge")

Jury instructions or jury charge or points for charge, as the name implies, are instructions given by the judge to the jurors—generally at the beginning and end of the trial in various formats. The jury instructions are a statement of the law within the jurisdiction that is to be applied to the evidence in the case. Jury instructions are stated in plain language for the jurors to understand, and yet, contain the legal concepts upon which the jury will decide the outcome of the case.

A jury verdict is the application of law, as set forth in the jury instructions, to the facts that have been presented as evidence in the case.

In most cases, the judge provides preliminary instructions to the jury at the beginning of the trial, before opening statements and evidence presentation, regarding various procedural aspects of the trial—which party presents evidence first, what evidence is, what experts are, and instructions of keeping an open mind until all of the evidence has been presented by both sides.

The roles of the jurors (triers of the facts) and the judge (trier of the law) is often explained in preliminary jury instructions. Jurors are also provided with a general

overview of the allegations in this case, how the case will proceed, the nature of evidentiary objections and rulings made during the trial, the role of the lawyers and witnesses (fact and expert witnesses), and a general overview of legal concepts (*e.g.,* burden of proof, preponderance of the evidence).

The jurors are also instructed to keep an open mind during the trial, not to discuss the case with anyone, not to interact with the lawyers and the parties, and not to research any of the issues raised during the trial.

At the close of the evidence, after both sides have put on their respective cases, the jurors are instructed on the applicable law. These instructions include the general law on standard of care, causation, recoverable damages, witness credibility, and if applicable, comparative or contributory negligence.

In cases with more than one potentially liable defendants, the jury is also instructed on the allocation of "causal negligence" between the party-defendants—in other words, what percentage of the total damages, if any, is each defendant liable for in the case. The Verdict Sheet is reviewed so that the questions being asked of the jury are clear.

Post-Trial Motions and Appeals

Posttrial motions and appeals generally arise from one or both party's dissatisfaction with the trial outcome or some aspect of the outcome. Such motions are based upon a party's claims, by way of examples, that: (a) The judge made an incorrect evidentiary ruling; *i.e.*, evidence was precluded that should have been admitted or evidence that was admitted should have been precluded, and why; (b) the verdict was not supported by the evidence presented (a claim that the verdict was "against the weight of the evidence"); (c) there was an error in the jury

instructions; (d) the amount of monetary damages awarded way too low (plaintiff's motion); (e) the amount of monetary damages awarded was too high (defense motion); (f) other errors of procedural or evidentiary law were committed by the judge. In general, these motions request a new trial.

Settlement

A settlement is a mutual agreement between the plaintiff and defendant or defendants to resolve the dispute that forms the basis of the lawsuit for an agreed amount of money. A settlement where the plaintiff settles with all of the defendants is referred to as a "global" settlement, which ends the litigation altogether.

Portions of a lawsuit can also be settled. For example, a plaintiff can settle with some, but not all of the defendants, with the case proceeding against the non-settling defendants.

Settlement culminates in the execution of a "release"—a contractual document with ends all or a portion of the litigation for the payment of a sum of money. When only one or some of the defendants settle, the plaintiff and settling parties may enter into a "joint tortfeasor release," which settles a portion but not all of the case.

Cases can settle at any time, including before litigation is even initiated or after a jury verdict is rendered and during post-trial (appellate) proceedings.

Cases with particularly strong liability may settle before litigation is commenced.

Alternative Dispute Resolution

Alternative dispute resolution is a method of taking, or attempting to take, the litigation out of the court system and place it into private avenues for dispute resolution. Such mechanisms for alternative dispute resolution include mediation and arbitration.

Arbitration can be binding or non-binding. Mediation is generally non-binding, and is often used as a guide to settlement or to provide parameters for the settlement value of a case.

There are many professional mediators and arbitrators who offer alternative dispute resolution services.

CHAPTER III: THE LITIGATION PROCESS

A medical malpractice case, also referred to as a medical malpractice "action," begins in advance of the litigation. In the usual course of events, some type of "incident" has produced an adverse outcome for the patient. This is generally the sentinel event upon which litigation is based.

The fact that an incident or bad outcome occurs, obviously does not mean that a healthcare provider was negligent, or even that the adverse outcome was caused by anything the healthcare provider did or failed to do. Such events may fall under the general rubric of "complications"—and complications occur even when the care was fully and strictly provided within accepted standards.

Nonetheless, many patients seek out legal review of the medical care because of the nature of an outcome and an inability to differentiate between a complication and the result of negligent care. Oftentimes, the patient or relative seeking legal counsel on behalf of the patient simply perceives that "something must have been done wrong" for such an outcome to occur. It is a common perception when there is a catastrophic injury, particularly where a good outcome was expected.

The fact that plaintiff's lawyers handle cases on a contingency fee basis, meaning that there is no payment for any medico-legal review or services unless there is a recovery (settlement or verdict), means that patients have a low threshold for requesting legal analysis. The review is cost-free, and can be sequentially sought from many lawyers and law firms in the face of a negative medico-legal review.

Contingency fee agreements can vary widely from law firm to law firm—from 25% to upwards of 40% or higher for cases that are perceived to be particularly risky and which will necessitate an investment of time, energy, and resources that may not be recovered. Initial expert review of a case, and ongoing involvement of experts throughout the litigation, can be a considerable expense in litigation.

Medical malpractice litigation follows a stereotypical process and is guided in its format by procedural rules. Once a medical malpractice case is accepted by a law firm, and initial support garnered from medical experts, the steps in the litigation follow an orderly process.

The Complaint

The complaint is the legal document that commences the law suit. It is filed in a court of competent jurisdiction, and sets forth the following: (a) The names of the plaintiff and the identity of plaintiff's counsel; (b) the identity or identities of the defendant or defendants; (c) a general statement of why the court has jurisdiction over the matter, including why venue within that jurisdiction is proper; (d) at a minimum, a skeletal recitation of the facts or circumstances giving rise to the lawsuit; (e) allegations of negligence (and potentially other claims such as lack of informed consent); and (f) a claim for damages and relief.

The format of the complaint is a series of numbered paragraphs which contains a short statement of fact or allegation.

Once the complaint is filed, it is "served" on each defendant named in the lawsuit. The complaint is entered on the court's docket. The docket contains a listing of all subsequent filings, rulings, orders, and other materials placed before or issued by

the court in the case. The docket can generally be searched by computer, and documents on the docket freely accessed.

Confidential information is generally redacted by the parties with respect to any documents docketed and accessible to others.

Answer to the Complaint

The defendants in the lawsuit contact their professional liability carriers regarding the initiation of the lawsuit. Counsel is then assigned to the defendants by the carrier. Defense counsel will then enter their appearance on behalf of the defendant, and prepare a responsive pleading, or answer, to the complaint.

The answer to the complaint is correspondingly responsive to each statement of fact or allegation in the complaint. As a general matter, the allegations in the denied.

Expert Support, Analysis, and Reports

Expert opinions and testimony are at the core of medical malpractice litigation, and are used in both the prosecution and defense of the claims. Plaintiff's reports are generally served after the close of discovery. Defense expert reports are responsive to the plaintiff's expert's claims and the claims in the case in general. The plaintiff may choose to serve rebuttal reports.

Preliminary expert opinions are generally sought at the outset of the litigation and before the case is placed into suit. Opinions, and subsequent reports, cover the full spectrum of claims in the case: Standard of care, causation, and damages.

Pretrial Litigation and Discovery

In many jurisdictions, following the pleadings and entry of defense counsel, the court may convene a case management conference to issue deadlines for discovery, service of expert reports, pretrial motion practice, and trial readiness of the case. A Case Management Order then follows.

Discovery involves both "paper discovery" and depositions. Paper discovery includes requests for the production of documents and things, interrogatories, requests for admissions, and depositions of both parties and fact witnesses.

Following the close of discovery, expert reports are served. In some jurisdictions, expert witnesses can also be deposed once their reports are served.

Pretrial Proceedings

Once discovery is over and expert reports have been served, the case is generally deemed "trial-ready." The court may convene a pretrial conference to select a trial date, discuss pending legal issues, set deadlines for pretrial motion practice (motions *in limine*), and to discuss the prospects for resolving the case (settlement).

Some judges choose to be "hands-on" with facilitating a potential settlement. Others leave settlement up to the parties, or simply suggest alternative dispute resolution. Some court systems provide avenues for pretrial alternative dispute resolution by way of court appointed mediators.

Trial

Trial in a medical negligence action follows a generally prescribed orderly process with respect to the judge and jury. The initial step is jury selection, which involves the selection of a jury from a larger panel of potential jurors. The overall goal is to select a jury that will be fair and impartial to both sides and who will decide the case based upon the evidence presented and the law as explained to them by the judge.

Once a jury is empaneled and preliminary instructions are provided to them by the judge, the parties present their respective opening statements which serve as a roadmap for what each side intends to prove and the general manner in which the proof will be presented. Opening statements are not argumentative—they are factual in nature and statements of intention with respect to evidence and testimony. The opening statements are not evidence.

Following opening statements, the presentation of evidence begins through the testimony of witnesses and documents introduced into evidence or used during the testimony.

The plaintiff presents a "case-in-chief"—testimony which generally includes the plaintiff or family or both, fact witnesses, documentary evidence admitted through witnesses, and expert testimony. At the close of plaintiff's case, the plaintiff "rests" and the defendant puts on the defense "case-in-chief" with testimony by the defendant, fact witnesses, and expert witnesses. The defense then "rests." The plaintiff has the opportunity, if elected, to offer rebuttal testimony.

Closing arguments are then offered by each party. The judge then provides the jury with the applicable jury instructions on the law upon which they are to base their

verdict: The law on negligence, causation, damages, witness credibility, and extraneous considerations. The judge will also explain the jury verdict sheet, and instruct the jurors to select a foreman and deliberative respectfully with one another. The jury may send out questions during deliberations to the judge, which may or may not warrant an answer depending upon their nature.

The jury them returns a verdict for one side or the other.

Post-Trial Proceedings

Post-trial proceeding generally involve some form of appellate processes by one or both sides. Issues on appeal may include perceived errors by the court in admitting or precluding certain evidence, rulings of law by the judge that are perceived as being a error of law, issues with the jury instructions or jury deliberations, or the amount of the verdict.

Initial review of appellate issues may occur at the trial court level by way of post-trial motions addressed to the trial judge, or at the intermediate appellate court level. These appeals are generally permitted as a matter of right, and can take several months for rulings. Appeals to the highest court of a jurisdiction are generally heard on a discretionary basis.

CHAPTER IV: PRACTICAL CONSIDERATIONS

Acceptance of Service

Service of process is a fundamental tenet of jurisprudence under the general rubric that a defendant should be provided with "notice and an opportunity to be heard." Service of process is the method by which the defendant receives notice—a copy of the complaint and a summons or some other accompanying advisory that you have been sued in a court of law.

Service manner in which service of process may be effectuated is set forth by the procedural rules in which the lawsuit has been filed. Personal service may be effectuated by, by way of some potentially applicable examples: (a) delivering a copy of the summons and of the complaint to the individual personally; (b) leaving a copy of the summons and complaint at the individual's home or usual place of residence with someone of suitable age living there; (c) delivering a copy of the summons and complaint to an authorized agent; and (d) various methods of delivery by mail and publication if necessary.

Attempts to "duck" service are generally futile and inadvisable.

Once served, the defendant should contact his or her medical liability insurance carrier for further instructions as to assigning counsel and providing a defense.

Conversations With Others

As a practical matter, a defendant in a lawsuit should be circumspect and cautious about discussing any aspect of the lawsuit with anyone beyond legal counsel. The best assumption is that anything that is said by the defendant may be discoverable and could potentially be discovered, and additionally could be used at trial.

While seemingly draconian and isolating, a defendant must take appropriate protections. Even the most inadvertent or seemingly innocent comments or statements my prove harmful to the defense of a case. These should be discussed with counsel.

Be Careful What You Post

The internet and various professional societies, organizations, and informal professional groups provide a forum for discussing cases, patient care issues, litigation, and medical care in general. This is not the place to discuss the facts of a case which has spawned litigation, or the merits of a case, or the care provided by others in the case, or any other aspect of a case. Even if posted under cover of anonymity.

Be Careful What You Email or Text

Email messages, other messages on various messaging platforms, and text messages are all discoverable to the extent that they discuss, describe, mention, relate to, pertain to, or otherwise could be construed as involving the case or the medical care provided.

Do Not Destroy Anything

The general rule should be to preserve everything and destroy nothing that may be pertinent or related to the case. Do not destroy any documents or things that could be construed as related to the case.

Any personal notes or memoranda, electronic communications, drafts of any case reports regarding the case—anything—must be maintained and brought to counsel's attention. Destruction of materials may lead to an "adverse inference" jury instruction at trial—the proposition that the document or item was destroyed because it was harmful to the defendant's case.

CHAPTER VI: CONCLUSION

Medical malpractice litigation is both emotionally and professionally trying. It can call into question the very core of a healthcare provider's self-confidence, belief in the medical system, and attitudes towards patients, patient care, principles of justice, and the court system in general.

Litigation is highly adversarial and pits a patient and physician healthcare provider against one another as a sequel to the "doctor-patient" relationship. The event giving rise to the litigation may simply be a bad outcome or complication of medical care that otherwise strictly fell within accepted standards.

An important caveat to remember: The most knowledgeable expert in the case is the defendant. Not only is the defendant an expert in the field, but the defendant has the greatest knowledge of what, how, and why the event giving rise to the litigation occurred. As a general matter, a defendant should be and remain active with counsel in the defense of the case.

Knowledge of the basic structure of a medical negligence lawsuit will provide the conceptual framework to assist a defendant-healthcare provider in navigating the litigation.

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Dr. Stylianos is the Rudolph N Schullinger Professor of Surgery and Pediatrics and Chief of the Division of Pediatric Surgery at Columbia University. He is currently the Surgeon-in-Chief of the Morgan Stanley Children's Hospital/New York Presbyterian.

A graduate of Rutgers University and the New York University School of Medicine, Dr. Stylianos completed his general surgical training at Columbia-Presbyterian Medical Center (now NYP/Columbia University Irving Medical Center). He subsequently spent two years as the Trauma Fellow at the Kiwanis Pediatric Trauma Institute in Boston, and then completed his formal pediatric surgery training at Boston Children's Hospital. Dr. Stylianos joined the faculty of Columbia University Vagelos College of Physicians and Surgeons and the Children's Hospital of New York in 1992.

Dr. Stylianos has served as Chairman of the Trauma Committee for the American Pediatric Surgical Association (APSA) from 1997-2002 and authored the APSA position paper supporting all measures to reduce the toll of firearm violence in children. He also served as the Co-Principal Investigator of the U.S. Department of Health, Maternal and Child Health Bureau's grant to APSA “Partnership for Development and Dissemination of Outcomes Measures for Injured Children.”

Currently, Dr. Stylianos is an elected member of the Board of Governors of the American Pediatric Surgical Association, a site verification officer of the American College of Surgeons Committee on Trauma and serves on the American Pediatric Surgical Association Foundation's Board of Directors as Treasurer. He is also Editor-in-Chief of the Journal of Pediatric Surgery Case Reports, Associate Editor of the Journal of Pediatric Surgery and served on the Executive Board as a founding member of the Pediatric Trauma Society. Dr Stylianos received the prestigious American Pediatric Surgical Nurses Association's 2016 Champions Award and the American Trauma Society's 2016 NY State Trauma Medical Director of Distinction.

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Dr. Hoffman is a partner at the Philadelphia law firm of Ross Feller Casey, LLP, where he handles medical malpractice, medical device, and pharmaceutical product litigation. He has also provided personal counsel and defense to physicians sued for medical malpractice.

Dr. Hoffman received his undergraduate degree from Amherst College, an M.D. degree from Columbia University's Vegalos College of Physicians & Surgeons, J.D. and Master of Bioethics degrees from the University of Pennsylvania's Carey Law School and Perelman School of Medicine, an LL.M. in Trial Advocacy from Temple University Beasley School of Law, and an M.B.A. from Drexel University's LeBow College of Business.

Dr. Hoffman trained in general surgery at Harvard University's Beth Israel-Deaconess Medical Center, in pediatric surgery at the Children's Hospital of Boston and the University of Toronto's Hospital for Sick Children under Dr. Robert M. Filler, and in solid organ transplantation surgery at Cambridge University in England under the transplant pioneer, Sir Roy Calne.

Before attending law school, Dr. Hoffman was a liver and kidney transplant surgeon and general pediatric surgeon at Tufts University and the Kiwanis Trauma Institute in Boston, Massachusetts. He was a member of the Medical Corps in the U.S. Army Reserves from 1988 to 2002 with service at the Walter Reed Army Medical Center and the National Naval Medicine Center in Bethesda, Maryland. Dr. Hoffman served as an Assistant Professor of Surgery at the University of Pennsylvania School of Medicine and as an attending surgeon at the Children's Hospital of Philadelphia.

Dr. Hoffman is a Fellow of the American College of Surgeons, the Royal College of Physicians and Surgeons of Canada, and the American Academy of Pediatrics. He is a member of the American College of Obstetrics & Gynecology, the American Society of Transplant Surgeons, the American Pediatric Surgical Association, and the Canadian Association of Pediatric Surgeons. He is a member of the Pennsylvania, New Jersey, New York, and Massachusetts bars.

Dr. Sarah K. Walker

Sarah Walker, M.D. is a pediatric surgeon at Texas Tech University Health Sciences Center in El Paso, Texas. She is the rising program director for the general surgery residency program. She also serves as the El Paso Children's Hospital Pediatric NSQIP Champion. Dr. Walker is the co-chair of the EPCH NICU Surgical QAPI committee.

Dr. Walker graduated from Birmingham-Southern College with her B.S. in Biology with minors in Art History and Chemistry. She attended the University of South Alabama College of Medicine, receiving her M.D. She completed General Surgery residency at the University of Louisville in Louisville, Kentucky. During her time there, she was the Kosair Charities Pediatric Surgery Research Fellow under Dr. Cindy Downard.

Following that, Dr. Walker completed her Surgical Critical Care fellowship with concentration in Pediatric Surgical patients at the Medical College of Wisconsin in Milwaukee Wisconsin. There, she also completed a research fellowship in outcomes research. Dr. Walker then completed a pediatric surgical fellowship at the University of Iowa in Iowa City.

Dr. Walker is a member of APSA and serves on the Wellness and Practice Committees, and as the liaison between the two. She is also a Member of the AAP and serves on the Trainee and Early Career committee. Dr. Walker is a member of the ACS and South Texas Chapter of ACS. Locally she is a member of the El Paso County Medical Society where she serves as the Secretary