

**Medical malpractice: Beyond the discovery “three step”
Putting a case in context for the jury requires finding background information
that supports your theory of liability and your expert witnesses**

BY BRUCE G. FAGEL

The traditional and time-honored method of discovery in all medical-malpractice cases involves three separate steps: First, obtaining the complete medical records on the plaintiff from all doctors and hospitals involved in the care; second, sending those records to a medical expert, who hopefully provides a favorable opinion on negligence and causation; and, third, taking depositions of defendant doctors and nurse employees of defendant hospital to find out what they meant in the medical records they authored.

Since the defendants control the factual side of the case with their entries in the medical records and their interpretation of what those entries mean – and with experts who can explain why the defendant was not negligent and/or not the cause of the injury or death – the defense is almost assured of a jury verdict in their favor.

Further, medical-malpractice cases always involve a specific patient, without any evidence of prior incidents or prior litigation. What should be the most important document in any medical-malpractice case – the report of the hospital committee that investigated the incident – is absolutely immune from discovery. This leaves the injured plaintiff with secondary sources of evidence – the medical records and depositions of the defendants.

But when the case gets to trial, the jury always wants to know the full context of the case. Was this injury or death an isolated incident or does it represent only a piece of a larger puzzle?

Demonstrating that the instant case is just a piece of a larger puzzle might evoke the jurors' concern for patient safety, including their own. To develop this kind of evidence requires that the plaintiff's attorney conduct discovery that is well beyond the traditional “three step” of records, depositions, and experts.

Hospital discovery

All hospitals have written policies and procedures for each department of the hospital, from the kitchen to the Intensive Care Unit, and everything in between. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires all of the nation's 6,000 hospitals that they accredit to have written policies and procedures for each hospital department. JCAHO does not tell the hospitals what specifically must be in those policies, only that they have such policies. As a result, there is wide variation between hospitals regarding what is actually in each

policy, and which situations or procedures have a written policy.

These policies are usually contained in large three-ring binders in each of the hospital departments, and there may be considerable overlap between different departments that often share responsibility for a patient, such as L&D and the nursery or between Surgery and the PACU. These policies require periodic review and revision, and there is usually a separate hospital policy about the requirements for such review and revision, and these are often different between different hospitals. The number or size of such hospital policies and procedures bears little relationship to the size of the hospital, and a small hospital may have more volumes of policies than a much larger hospital.

Each written policy should provide information about who wrote the policy and to whom it applies; they often reference outside literature that supports the policy. However, the name of the policy for a specific situation is often different in different hospitals, and since a request for production of a document should be as specific as possible, an initial request should be made for the table of contents and/or index of all written hospital policies and procedures from all departments that are relevant to the case. After a review of such an index, a specific request can then be made for all relevant documents, without drawing an objection for being overboard, or “a fishing expedition.”

In addition to providing critical information about whether the hospital violated its own policies in the care provided to the plaintiff, they will provide the names of the individuals responsible for drafting the policy. Such individuals are more likely to admit at deposition that a specific nurse violated a specific policy in relation to the plaintiff’s care, and while such an admission may not prove a violation of the standard of care, it can go a long way for a jury, and it becomes very difficult for an insurance claims’ rep to ignore.

Many hospitals are part of a larger chain of hospitals (Sutter, CHW, Kaiser, HCA, etc) and there has been a growing effort by such chains to have specific written policies that are designed to apply to all hospitals in the group. However, this is not an automatic and uniform policy and sometimes a policy that is designed to apply to all hospitals in the group has not been adopted in a specific hospital, and therefore would not be produced in response to a request to the defendant hospital. But if the corporate group that owns and operates the hospital is also a defendant, discovery can be directed to the corporate owner for policies that were designed to apply to all hospitals in the group.

When a specific hospital fails to implement a policy that was designed for the entire group of hospitals, a jury can more easily understand that the standard of care comes from the corporate owner and the failure to implement the policy by a specific hospital would meet the definition of a violation of the standard of care.

After all relevant hospital policies from both the specific hospital and, where applicable, the corporate owner, have been obtained, depositions should be taken of those individuals who were involved in the development of such policies.

The hospital defendant may attempt to claim that such discovery would be subject to Evidence Code section 1157, which prohibits discovery of the records or proceedings of any organized hospital committee that has “the responsibility of evaluation and improvement of the quality of care rendered in the hospital.” But there is a clear distinction between a “mortality and morbidity committee” that reviews the care of a specific patient incident for the purpose of improving the quality of care rendered in the hospital, and a committee that drafts basic policies of operation for the hospital, before any incident.

In any motion to compel the production of information, in response to a section 1157 objection, about the composition of the committee or any records of discussions, the fact that the product of such committees are published, discoverable written policies is in sharp contrast to any reports of committees that review care in the hospital.

Every time a hospital committee drafts a new policy or revises an existing policy, the purpose and content of such policy or revision must be communicated to all of the relevant nursing staff, and depending on the policy, to the relevant medical staff also. To effect this communication and teaching, every hospital must have an education manager to perform such “in service” education. In smaller hospitals this job may be shared with another function and in larger hospitals there may be multiple individuals who serve this function.

After obtaining the relevant hospital policies, the deposition of the hospital education manager should be taken to determine what was done to communicate the purpose and specifics of each relevant policy. Often, the involved hospital nurses have never read the relevant hospital policy and/or do not understand the policy. The involved nurse will not want to admit that the policy was violated in the care of the plaintiff, but the person responsible for teaching the nurses will either have to say that they never properly educated the nurse and/or that the nurse violated the policy. Either way, the jury will see evidence of negligence beyond the specific case before them.

Every hospital has a Director of Nurses, who is responsible for the actions of all nurses in the hospital, and a charge nurse for each unit of the hospital, who is responsible for the actions of the nurses in their unit. In larger hospitals, the charge nurse will have no patient care responsibility and function only as an administrator with responsibility to see that nurses follow written policies. These nurses must obviously be knowledgeable about such policies, but sometimes they are as unfamiliar with the relevant policies as the patient care nurse.

The charge nurse is rarely involved in the patient’s care, and almost never is identifiable from the medical records. The deposition of the Director of Nurses and any relevant charge nurses will also allow the plaintiff’s care to be placed in a context, and will often expose a larger problem in the hospital that would cause a jury to be concerned about basic safety issues involving all patients.

Physician discovery

While information about prior lawsuits and judgments would be of great interest to a jury deciding the actions of a specific physician, such evidence is usually not relevant or admissible. However, any information about a doctor's background and training is both relevant and admissible in any malpractice case.

All physicians have graduated medical school and taken some residency training. Most have completed a residency and are board certified in at least one area of specialization. At deposition, defendant physicians can testify about their vast experience with the procedure at issue in the case and there is no way to disprove their assertion. But every physician is required by the Medical Board to take at least 25 hours of continuing medical education every year, and to maintain the documentation for such education for at least five years.

Since much of modern medicine did not exist when many physicians took their training, many aspects of care that may be relevant to a specific medical-malpractice case may have been learned by physicians after the completion of their formal training. This would include many surgical procedures such as laparoscopic surgeries, gastric bypass surgeries and many diagnostic procedures. Some physicians learn these new techniques in weekend courses with little verification of competence. Therefore, a request should be made for all documents that show the specific continuing medical education courses taken by the defendant physician during the five years before the incident.

While the hospital is charged with the responsibility for granting specific hospital privileges to physicians, the documentation for anything other than a list of privileges is usually subject to an objection under Evidence Code section 1157, but CME courses are not part of any hospital process or review and therefore not subject to any section 1157 privilege claim.

All physicians who apply for privileges to practice in a hospital setting must submit an application that must be approved and reapproved every two years. But because the committee that reviews such applications is covered by Evidence Code section 1157, it is almost impossible to obtain those documents. However, all physicians have multiple relations with health insurance carriers and other entities involved in health care, all of which require applications that are not protected.

Also, the application of a physician for liability insurance coverage should not be considered as covered by the immunity of the Evidence Code, and such documents are maintained by the insurance company. At a minimum, these documents should provide more information about any prior lawsuits, settlements, or other actions than would be obtained from a deposition or interrogatories about prior medical-malpractice cases.

Also, most physicians who are self employed, rather than an employee of a large medical practice group, or Kaiser, will need to have contracts with health plans that allow the health plans to list the physician as part of the health plan for coverage purposes for any patient who has health insurance. These contracts are usually based on applications which must include sufficient information about the physician's background for the health plan to make a decision

about listing that physician as covered under the health plan.

While physicians may claim that they no longer have the application, they must know the name of each health plan with which they have a contract, and those entities must maintain information about the individual physicians, including any reports from the National Practitioner Data Bank, which includes all reports of settlement, regardless of the amount or circumstances. The California Medical Board requires a report for any settlement greater than \$30,000 but the NPDB has no bottom limit for reporting. Larger groups of physicians, such as the Permanente Medical Group, which employs and provides physicians for all Kaiser Foundation Hospitals, usually have clinical practice guidelines for various medical issues or conditions. Even in hospitals where the physicians are “independent contractors,” there may be clinical practice guidelines that apply to the physicians as well as nurses. In all relevant cases, a request should be made for all clinical practice guidelines that may exist on specific subjects that are relevant to the plaintiff’s care. While the defense may claim that such guidelines are not the standard of care, it is very difficult for any defense expert to ignore or refute specific care recommendations in the clinical practice guidelines for a specific hospital or medical group.

Discovery from the state

Under California Health & Safety Code section 1279.1, which was enacted in 2007, all hospitals in California are required to report certain “adverse events” to the State Dept. of Health Care Services no later than five days after the event was detected. The Department then conducts an investigation of the event at the hospital and can fine the hospital between \$25,000 and \$100,000 depending on the severity of the event and the history of prior such events. Between Jan. 1, 2009, and Jan. 1, 2015, the state must make any reports of investigations “readily available to the public,” and by Jan. 1, 2015, these reports will be posted on the Department’s Web site. While many of the 28 specific adverse events may not be applicable to a specific medical-malpractice case, the last category is “an adverse event or series of adverse events that cause the death or serious disability of a patient.”

Most medical-malpractice cases would easily fit into this category, but hospitals only report the obvious events of wrong site surgery, or a retained foreign body, and some do not even report these obvious adverse events. As early as possible in any medical-malpractice case, which may be a notice of intent to sue under section 364 of the Code of Civil Procedure, the hospital should be put on notice that the incident falls within the definition of section 1279.1 (b) (7), and a request should be made for the report of any investigation.

If the hospital did not, or does not file a report in response to being placed on notice by the plaintiff's attorney, the deposition of the person most responsible or knowledgeable about such section 1279.1 reports should be taken to determine why such a report was not made. Often, this person is either the Hospital Risk Manager or Director of Nurses, who will sometimes admit that a report should have been sent, but they never knew about the event.

The main advantage of any such section 1279.1 report is that it is based on an early investigation of the event at the hospital, and will often identify individuals who were interviewed in the investigation, and many of the witnesses who were not directly involved in the patient's medical care, such as supervisors. The report will black out the name of the individual, but will identify by title, and that is sufficient to ask the hospital to provide the name and any such witness for deposition. At deposition, some witnesses will deny the statements made to the investigator. This may be used for impeachment at deposition, and thus at trial, but the report itself and the conclusion and/or fine are all hearsay and thus cannot be directly used at trial. However, as an important discovery tool, it can lead to the discovery of admissible evidence. The fact that a hospital was fined by the California Dept. of Health Services cannot be placed before any jury and in those cases where it has been attempted at trial, such an attempt has always failed.

Discovery on the Internet

All medical-malpractice cases should start on the Internet, before any medical records are obtained and before any other discovery from the hospital. At a minimum, the Internet contains much information about the basic medical issues in any case, including anatomy, physiology, treatment options, survival statistics, and other information that can provide a focus for the case. The Internet cannot answer the critical questions of negligence and causation. Even when there are specific Web sites that purport to discuss standard of care or causation issues, all such information is hearsay and therefore inadmissible.

In addition to information about some of the medical issues involved in the case, the Internet can provide much information about the defendant hospital, medical group, and/or individual doctor. Most hospitals and major medical groups have Web sites that provide information about the services they offer to the public and the relationships which they have with each other. Larger groups like Kaiser or hospital chains like Sutter or CHW also have educational materials and medical information either on their Web site or through links. Kaiser has its own medical journal, which is accessible through either the Internet or by subscription. Even individual physicians have Web sites that are used for advertisement purposes and some of the representations made on their Web sites can be used against them in a specific case.

What is generally not available on the Internet, except through Web sites like Pubmed or specific medical journals, is the vast amount of articles that constitutes the "medical literature." Most of the individual Web sites on specific medical topics are developed by specific hospital departments or educational groups that seek to provide medical information to the public.

Pubmed, which is the official Web site of the National Institutes of Health, does provide access

to all of the articles in the medical literature, but there may be thousands of articles on a particular topic and it can be difficult to find a specific article that may be both relevant and useful to your case.

Whenever the medical literature becomes an issue in a medical-malpractice case, it is far better to have the plaintiff's expert find and use the relevant literature that supports their opinion, rather than the attorney attempting to provide the research for the expert.

Effective use of such discovery

In addition to providing a larger context for the negligence of any specific case, evidence about the violation of a specific relevant hospital policy can be used to corroborate the testimony of any expert on standard of care. It can also make it difficult for a defense expert to claim that the standard of care was met, even though a specific written hospital policy was violated. Jurors can more easily understand and focus on a specific written hospital policy and compare the wording to the actions or inactions of the nurses in the case, rather than the over inclusive opinions by the hospital's experts that the standard of care was met. Faced with an obvious violation of a hospital policy, a defense expert is left trying to explain why the violation of a written hospital policy is not negligence.

The overall purpose of all hospital policies, and any specific relevant policy, is the protection and safety of a patient. Any time the plaintiff's case can expose an issue of public safety beyond the injury to the specific plaintiff, the jury will more likely respond favorably to the plaintiff's theory of liability.

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