How I pick the doctors I'll sue

Publish date: AUG 20, 2004

Print

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A conversation with plaintiffs' attorney Bruce Fagel, MD, JD

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When doctors meet a malpractice plaintiffs' attorney, they don't get a warm-fuzzy feeling. When they meet Bruce Fagel, however, they don't know what to think because he's definitely "one of them," but also "one of us."

Before becoming a plaintiffs' attorney, Fagel spent 10 years working as an emergency physician in Chicago and Los Angeles, and he still moves easily between both worlds. He speaks frequently to medical gatherings on malpractice issues, and some of his best friends really are doctors.

Since he began practicing law in Los Angeles in 1982, Fagel has won more than 500 settlements and nearly 50 verdicts in malpractice cases, including many multimillion dollar jury awards. With seven associates in his Beverly Hills office, he specializes in catastrophic injury and delayed diagnosis cases.

In a recent interview with Medical Economics Senior Editor Berkeley Rice, Fagel discussed the economics of malpractice cases, told us how he chooses the cases he pursues, and why he finds litigation more challenging and satisfying than medicine.

I have to ask the obvious question: What made you give up medicine for law?

Fagel: It was burnout, which happens a lot in emergency medicine. After 10 years of it, I just couldn't see working the 24-hour shifts, or the nights, weekends, and holidays for the rest of my life.

So I started law school. I took evening classes for three years while I continued doing emergency medicine during the days.

How did you choose malpractice law, and why did you decide to represent plaintiffs rather than physician-defendants?

Fagel: When I was still in law school, I happened to meet a plaintiffs' attorney—also a former physician—who specialized in medical malpractice. He hired me to review cases and take depositions for him, and I discovered that I really enjoyed it. I found those cases more intellectually challenging and satisfying than medicine. I loved taking a set of medical records and trying to figure out why something happened, and analyzing the causal relationship between the actions and the outcome.

Did any of your former colleagues wonder why you quit medicine to work for "the enemy"?

Fagel: I got a few negative comments, but most of the physicians I have contact with now are ones I hire as medical experts, and they're glad to supplement their income with the fees I pay them.

Tell me how your typical caseload breaks down.

Fagel: About 60-70 percent of our cases involve obstetrical or other catastrophic injuries to children. The rest are surgical incidents that lead to death or permanent injury, or delayed diagnosis cancer or cardiac cases.

Is that because those are the cases you look for, or because they're the ones that come in?

Fagel: Both. Obviously, we look for catastrophic injury cases because they're worth more money in terms of potential recovery. But a lot of them get referred to us because that's what we're known for.

We get about 50 calls a day from people inquiring about possible malpractice claims. Sometimes the patients themselves call us. Or we'll get cases referred to us by nurses or other attorneys.

Of those calls, I'll only request medical records for a few of them, because most don't really involve malpractice, or because the injury wasn't clearly caused by medical negligence.

What goes into the initial case review

How do you review prospective cases?

Fagel: With an average case, I'll first review 500 or more pages of records covering several years and multiple physicians. There'll be internists' notes, surgeons' notes, nurses' notes, progress notes, lab and X-ray reports. I skim through those records to get an idea of what happened, and whether there's clear negligence and causation. Based on that initial review, I'll decide whether the case is worth pursuing. If it is, we'll request additional records and documents like hospital staffing schedules, surgical logs, and policy manuals.

What factors determine whether you decide to take a case?

Fagel: I first try to figure out whether there's a causal connection between what occurred and the injury. In cancer cases, for example, the doctor may have missed a lump, or misinterpreted a mammogram, or not followed up properly. But the real question is whether the delayed diagnosis made a difference in the outcome. With certain types of cancer, for instance, it may not make much difference when you catch them. But with breast cancer, a significant delay in diagnosis can have a substantial effect.

After causation, the next thing I look for are the key issues in the case. Are they clear enough and simple enough for the jury to understand? Jurors probably won't understand all the scientific details and analysis of the case. But they will understand something like a breakdown in communication between doctors, or between doctors and nurses. That's often the cause of a catastrophic injury, rather than clinical negligence.

Jurors generally start out with a presumption of innocence on the part of the doctors. So it's always a tough job trying to convince them that there was negligence, and that it was a substantial factor in causing the injury.

The economics of litigation

What about the cost of your case preparation? Does that affect your decision about taking it on?

Fagel: Of course. Unlike defense attorneys, whose salary and expenses are paid by the insurance companies whether they win or lose, we bear the entire cost of bringing the plaintiff's suit. If we lose, those costs are a total loss for us. If we win, but we recover less than what we spent on the case, that's also a loss. So it's always a real gamble.

What does it cost to prepare a typical case?

Fagel: The initial evaluation, with an outside expert review, can cost $10,000 to $25,000. That includes the cost of ordering the records, which can run from $500 to $1,500 depending on the complexity of the case. If it's a child or an adult with catastrophic injuries, hiring experts to evaluate their damages and future medical costs can run another $10,000 to $20,000.

Then we move to the discovery stage, when we take depositions of the defendants and their experts, and they take depositions of our experts, whose time I have to pay for. That can run $25,000 in a simple case up to $100,000 in a complex case with many experts. And that's all before trial. Going to trial can cost from $150,000 to $300,000 in a catastrophic injury case with several defendants and a dozen experts. Delayed diagnosis trials generally cost less, around $100,000.

Add it all up, and that's close to $450,000 in expenses on the high end. Even on the low end, you're looking at about $150,000.

Why do you need all those medical experts? Isn't your own medical background enough?

Fagel: It's good enough to screen cases initially. But if I take the case, I'll need outside experts to help me prepare it. In a complex birth-injury case, for example, we may retain 10 to 15 different experts: surgeons, obstetricians, perinatologists, neonatologists, pediatric neurologists, nursing experts, and rehabilitation experts. In delayed-diagnosis breast cancer cases, we'll need expert oncologists, radiologists, oncology nurses, pathologists, etc.

What do they charge, and who pays them?

Fagel: I pay them all, regardless of how the case turns out. Their fees average $450 to $500 an hour, but some charge as much as $1,000. Many of them are in academic medical centers, and the rates we pay are better than what they earn in their practice.

Do any experts refuse when you call?

Fagel: Some will only work for the defense, and some simply don't want to do medico-legal work at all. The ones we use generally work for both plaintiffs and defendants, so that they don't get labeled as "hired guns."

Screening "good" cases from "bad" ones

Do you turn some cases down because they don't make economic sense in terms of their cost vs the potential recovery?

Fagel: That depends. We refer some of those cases to other attorneys. But if it's a "good" case, where the negligence and causation are fairly clear, we may still take it on even if it's only worth $100,000 if we think we can get a quick settlement. Then there are some cases I'll take even though they don't make much sense economically. I take them because I think the injury and the negligence were outrageous, and I know I can call the insurer directly and settle the case quickly. I just don't like the idea that someone who's injured as a result of medical negligence can't get reasonable compensation if the case doesn't have enough money in it.

Where we hesitate is when causation or negligence isn't clear, and we know it'll take a major investment in time and money, with no assurance that we'll be able to convince the jury. After all, we're running a business. If we can't win enough to cover our expenses and the cost of our time, we can't afford to stay in business.

How about the plaintiffs? Are some more financially attractive "business prospects" than others?

Fagel: Unfortunately, yes. A 45-year-old attorney at the height of his career represents a much greater potential recovery than a 75-year-old widow living alone on Social Security. That's why plaintiffs' attorneys seek cases involving catastrophic injuries to children, because they'll need 24-hour care for the rest of their lives. Those are the cases that produce the big settlements and verdicts. So does the case of a high-income breadwinner who suffers a fatal cardiac arrest and leaves a wife and several young children without financial support.

Those economic factors are particularly relevant in California and other states that have caps on noneconomic damages. That's why plaintiffs' attorneys in those states have to focus on economic damages like lost income and medical expenses, rather than on noneconomic damages.

Tort reform advocates often point to California's MICRA [Medical Injury Compensation Reform Act of 1975] as a model because it limits noneconomic damages to $250,000. What do you think of a damage cap?

Fagel: I don't think the idea of a cap on noneconomic damages is unreasonable, since it's so difficult to put a dollar value on pain and suffering. What's unreasonable is the fact that MICRA was passed in 1975, and the $250,000 limit wasn't tied to inflation. As a result, each year plaintiffs here are really getting less money. Today that $250,000 is worth less than $75,000 in 1975 dollars. So it's a real problem for plaintiffs with legitimate claims for pain and suffering.

The problem of primary care referrals

What types of cases do you handle that involve primary care doctors?

Fagel: Mostly delayed-diagnosis cancer or cardiac cases. They're typically the result of a breakdown of communication between doctors: The internist refers a patient to a specialist, but doesn't follow up; or the specialist runs some tests, but doesn't report the results to the internist. When that kind of error involves cancer or cardiac arrest, it's something a jury can easily understand.

I just presented a case against an internist and an FP who had seen a patient with atrial fibrillation. Although both doctors considered giving the patient Coumadin [warfarin] to reduce the risk of a stroke, neither one actually prescribed it, thinking that aspirin alone would be sufficient. Sure enough, the patient suffered a stroke two weeks later, and ended up partially paralyzed.

Another problem for family physicians and internists is whether and when they refer to a specialist. That's become more of an issue today, with health plans forcing them to jump through hoops to get approval for referrals. An internist who wants a cardiologist or a pulmonologist to see his patient is faced with a difficult choice: Is he willing to go through all the steps and paperwork required to get approval from the health plan? Or does he simply handle the problem himself? If he does treat the patient for a condition that normally calls for a referral to a specialist, he'll be held to the standard of care for that specialty if something goes wrong.

Why most cases never go to trial

How many of your cases actually go to trial?

Fagel: Very few—maybe 10 percent. The rest usually settle. But you have to prepare every case as though it's going to trial, and the defense has to know that, because otherwise they won't agree to settle.

When cases do end up going to trial, it's usually because the defense refused to settle, or made an offer that was unrealistically low. Usually, by the time we've been through discovery we've developed enough information to convince the defense attorneys and the insurance carrier that if they go to trial it's going to cost them much more than a settlement would.

Another reason they may settle is if their client shows such arrogance in our deposition that they're afraid to let him appear in front of a jury. When you talk to jurors after a trial, it's clear that little things like the doctor's personality are just as important as the medical details and the expert testimony.

For example, I just finished a trial of a complicated obstetrical case involving a woman who developed an infection during delivery, and eventually died from septic shock. Numerous experts testified about the clinical details, but the jury focused mostly on the fact that the obstetrician never came back to see the woman after her delivery. When the obstetrician took the stand, and we questioned him about it, he became very hostile. He might have lost the case anyway, but that behavior certainly didn't help him.

Do you try to take advantage of such character traits during a trial?

Fagel: Absolutely. I'll gladly let a doctor demonstrate his arrogance on the witness stand because I know the effect it'll have on the jury. The same thing happens with medical experts, because they're often pompous. When you question them during cross-examination, they'll get angry, or they'll go off on a long tangent with some complicated explanation that I know will turn off the jury.

"Frivolous" lawsuits are few and far between

Tort reform advocates—including many of our readers—often complain about "frivolous" lawsuits. Are those complaints unreasonable?

Fagel: That depends on what you mean by "frivolous." Contrary to what many doctors think, I won't take a case that's clearly unjustified—not only because it's wrong, but also because it wouldn't make legal or economic sense. First of all, the judge would probably toss the case out. Even if he didn't, the defense wouldn't settle because they'd know it was a weak case. And I wouldn't risk the expense of taking it to trial because I'd know I couldn't win.

Doctors who get sued usually think the suit is frivolous because they're convinced they weren't negligent, and were just trying to do their best for their patient. The real problem is that most doctors don't understand what negligence is.

Negligence simply means that something bad happened that was preventable if reasonable care had been taken. Usually it's not intentional, and not as obvious as operating on the wrong leg. More often, it's the result of miscommunication. For example, say two doctors both assume that the other one is going to do something for the patient, but it never actually gets done, and the patient suffers an injury as a result. Is that negligence? Neither doctor thinks so, but in fact, both were negligent.

Or say the nurse misreads a doctor's handwriting, and gives the patient the wrong medication, or the wrong dosage, and the patient suffers an injury. Is that negligence? The doctor doesn't think so, because he wrote the correct information, so he feels it's not his fault if the nurse misread it. But a jury may call it negligence. In both cases, the patient suffered an injury that shouldn't have happened.

It's my job to see that that patient gets a reasonable compensation for his injury, and I'm proud that I'm able to help him accomplish that.

Bruce Fagel's take on tort reform

The real problems plaguing medical malpractice in the US today aren't the "frivolous lawsuits, greedy lawyers, and runaway juries" that doctors typically blame. So says plaintiffs' attorney Bruce Fagel, MD, the subject of the accompanying interview. "Unfortunately, the solutions usually proposed to fix this supposed crisis are aimed at restricting plaintiffs' claims and limiting payments to them rather than eliminating the underlying causes of medical error that give rise to malpractice cases," he asserts.

Fagel believes that none of the tort reforms currently under consideration by Congress and various state legislatures are likely to reduce medical negligence, patient injuries, or malpractice claims.

Here's more of Fagel on tort reform:

Communication problems. Many complaints filed against physicians are based on their miscommunication with patients, nurses, or other doctors. But even well-intentioned efforts to improve doctors' communication skills run into opposition from the medical profession. For instance, the National Board of Medical Examiners has introduced a one-day exam designed to test doctors' ability to communicate with patients, as well as their clinical skills. Unfortunately, the American Medical Association has opposed the test, and vows to block its implementation.

Healthcare economics. For both doctors and hospitals, the combination of rising expenses and lower reimbursements often leads to efforts to save money by cutting personnel and cutting corners. Unfortunately, the personnel or systems being cut may be part of the safety net required in modern healthcare. For example, it's often the intercession of a nurse or a second physician's opinion that prevents medication errors or medical disasters. Or it's the chance for a second look at a problem, or a conversation with a nurse or colleague that raises the possibility of a potential problem before it occurs.

That's why healthcare needs more redundancy, not less. But the economics of today's healthcare system forces doctors and hospitals to eliminate some of the checks and balances that protect patients from medical and medication errors.

The high cost of hospital care has also led to a dramatic increase in the number and nature of medical and surgical procedures being performed in physicians' offices or outpatient surgical centers. If something goes wrong, however, those facilities don't offer the same level of experienced staff and emergency support that hospitals do.

Accepting responsibility for medical errors. One of the most common causes of malpractice that should be changed—but probably won't be—is the pervasive attitude among doctors, nurses, and hospitals that discourages candor and the acceptance of responsibility when something goes wrong. Whenever someone's negligence may have caused a serious injury or death, the immediate response by all involved is typically a total shutdown of

any open discussion about what went wrong.

When a distraught patient or family member asks the appropriate question, "What happened?" the response they're most likely to receive is, "I don't know."

Healthcare providers may convince themselves that such an answer isn't evasive. But in fact it's quite likely to push the patient and family into a consultation with a plaintiffs' attorney in an attempt to get the answers they feel they're entitled to. In today's healthcare system, the only way to get those answers is often through the legal system.

When doctors are cross-examined in a deposition or during trial, they often try to avoid responsibility for their actions. In fact, some defense attorneys encourage this attitude, instructing their clients not to answer even reasonable questions. As a result, jurors may ultimately be convinced of a doctor's negligence not by the nature of his actions in the case, but by what looks like intentional evasion of responsibility when explaining why something went wrong.

The real value of our jury system in medical malpractice cases has little to do with the jurors' ability to understand the medical facts and issues in the case. In fact, it's widely accepted that they don't understand much of the clinical information presented to them. What they do understand is when a witness is telling the truth. Doctors would do well to remember that.

Berkeley Rice. How I pick the doctors I'll sue. *Medical Economics* Aug. 20, 2004;81:54.

About the Author

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