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How to Develop an Effective Cross-Examination of an Opposing Medical Expert in a Medical Negligence Case

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I. Introduction

One of the most critical aspects of successfully defending a medical negligence case is the ability to effectively cross-examine the opposing party's medical expert witness. Expert witness testimony is usually necessary to establish a breach of the applicable standard of medical care and proximate causation. Therefore, the outcome of a medical negligence case often turns on the battle of the experts' competing opinions. The ability to effectively cross-examine the opposing medical expert is often a key factor in achieving a successful outcome.

II. Preparation on the medical issues

A thorough understanding of the facts of the case and the medical issues involved is necessary to formulate an appropriate defense strategy and effective cross-examination of an opposing medical expert. The attorney should carefully review all medical records, create accurate time lines and summaries, and extensively research the relevant medical issues. Consider using your medical expert witness to help with your education on the applicable medical issues and direct you to the most relevant and authoritative medical literature on those issues. If you have work product concerns about using your medical trial expert for that purpose, then consider using a consulting medical expert. While not a physician, counsel still needs to have a solid working knowledge of the medical issues and relevant medical literature to be able to battle against the opposing medical expert during cross-examination and to effectively communicate defense themes at trial.

The Internet also contains several excellent Web sites for medical resources, such as *Medline*, the National Institutes of Health (NIH), medical school Web sites, and the Web sites of professional medical societies. These Web sites often have numerous summaries and articles written in plain language for patients and the public. They also have extensive publications, statistics, and diagrams, which not only are reliable but also are often used by medical professionals and can be used as effective weapons for cross-examination. Fee-based subscription services, such as *MDConsult*, can provide access to complete digital copies of leading medical treatises, journals, and patient materials that can be printed or downloaded. These resources not only will help with your medical education but also will be invaluable in developing points for cross-examination and effectively communicating complex medical issues to the court in a clear and concise fashion.

An attorney who is thoroughly prepared will have tactical and strategic advantages over an opponent who has not taken the time to understand the medical issues. Your command of the facts and medical issues may give you the edge you need to win your case. If you are not thoroughly prepared, the opposing medical expert will take you to task at every opportunity and may inflict significant damage on your ability to defend your client.

III. Investigate the opposing medical expert

A comprehensive investigation of an opposing medical expert can provide many helpful points for cross-examination. Federal Rule of Civil Procedure 26(a)(2), regarding disclosures about experts, is a good starting point for your investigation of the opposing expert. The expert's curriculum vitae provides a summary of the education, training, and experience of the expert. Gaps in education and employment history may suggest that the expert has had professional problems. The lack of medical board certifications and recertifications (when required) or the presence of certifications by non-American Medical Association boards can reveal a lack of proper qualifications, which can be used against the expert at trial. Also, the expert's publication list may provide medical literature usable against the expert at trial or co-authors who may have published articles usable against the expert on cross-examination. The expert's case list may also be helpful. If the expert has disclosed sufficient information about the cases in which he or she has testified, you may be able to contact relevant counsel in those cases or review online court docketing systems to gain access to depositions, trial transcripts, and court opinions relevant to the expert.

Internet research on opposing medical experts has now become a critical investigatory tool. Many helpful Internet sites exist that may provide valuable information on an opposing medical expert. Generalized Web searches through *Yahoo!* and *Google* can also yield important information. In some instances, transcripts from court proceedings, news articles, and other valuable information can be found through such generalized searches.

Other valuable Web sites exist to help in the investigation of the opposing medical expert. The expert's medical license and disciplinary history can be investigated by using the Web site for *AIM/Docfinder*. This Web site provides access to a database with the medical licensing and disciplinary boards of several states and links to those boards not included in the database. Board certifications can be checked on the Web site for the American Board of Medical Specialties. Many medical experts are affiliated with academic institutions. A review of their biographical and professional information on the expert's academic site may provide helpful cross-examination material. Such Web sites may have general medical articles written by the expert or the expert's colleagues, which might be used against the expert during cross-examination. Further, you should not overlook the expert's background for possible academic fraud and plagiarism. The number of experts guilty of such misconduct has been on the rise, and newspapers and professional journals may have articles regarding such charges if the charges have been upheld by any academic or disciplinary bodies.

Some medical experts advertise their services through their own personal or professional Web sites, Web sites for commercial expert witness referral services, and Web sites for national and state bar journals. You should also examine any printed advertisements the expert may have published in legal magazines or journals. The mere fact that an expert advertises his services for hire suggests that he is really a professional witness, rather than an active practitioner.

Westlaw and *LexisNexis* are also great resources for investigating the opposing medical expert. You can research their activities in reported and unreported cases (both as an expert witness and as a party to litigation), locate other attorneys who may be willing to share information about the expert and their own investigation into the expert's background, and scan various litigation databases with information about the opposing medical expert. Jury verdict databases on *Westlaw* and *LexisNexis* may also provide important information about how the experts have fared in other cases. *Pacer* and other state court docketing systems can also help you locate information about cases in which the expert has been a party or served as an expert witness.

IDEX and *MDX* are commercial sources of information regarding expert witnesses. For a fee, these services will provide you with information about an expert, any litigation history regarding the expert in the service's database, articles about the expert, and any available testimony in the database from depositions or trial transcripts. These services also list other attorneys who have requested information about the expert in the past and who may be willing to share the results of their investigations with you. The Defense Research Institute (DRI) also has extensive databases regarding expert witnesses which may be accessed by members of their organization. Local, state, and civil defense organizations may have similar databases.

An e-mail inquiry to offices of other United States attorneys can be very helpful. Many offices may have information on the expert and may be able to retrieve deposition and trial transcripts of the expert's prior testimony. The insights of other trial attorneys in the USAO system with regard to an expert can be helpful in how you approach the expert at deposition or at trial.

IV. Use discovery to set up your cross-examination at trial

A. Have a preliminary trial plan or list of objectives in place prior to the discovery deposition

Once you have become familiar with the medical and factual issues of the case, you should prepare either a trial plan or a list of the evidentiary points you want to prove at trial. This plan or list of objectives will keep you focused on the medical and factual points that need to be established to help you win your case. The plan or list can be modified as necessary based on any new developments in the case.

This plan will also help you prepare a series of questions to be used against the opposing medical expert at the expert's discovery deposition. While the expert may not agree with your position on the issues, you may be able to secure agreement on certain key elements of the case which will help you undermine the expert's ultimate opinions. It is not unusual for the opposing medical expert not to be fully prepared or knowledgeable about the facts or medical issues in a case at the time of the discovery deposition. The expert may not have thoroughly read all of the depositions and discovery materials prepared prior to the discovery deposition. Your thorough preparation may catch the expert at a disadvantage, and you may be able to secure agreement on key points through the use of short hypothetical questions.

The bottom line is that if you focus on your trial plan and objectives in preparation, you will be in a much better position to attack the opposing medical expert's opinions at the expert's discovery deposition. While you may not want to fully disclose your cross-examination strategies at the discovery deposition, your goal should be to lay the groundwork for an effective cross-examination at trial by using focused questions consistent with your trial plan or objectives.

B. Use the discovery deposition of the opposing medical expert to your advantage

The discovery deposition of the opposing medical expert is the perfect opportunity to begin planting the seeds of your trial cross-examination. You can use the deposition to set up not only bias and prejudice attacks, but also reliability attacks, cross-examination questions regarding medical literature, and to limit the opposing expert's ability to testify on key issues at trial. During the discovery deposition, you will obviously need to cover a variety of subjects based on the Fed. R. Civ. P. 26(a)(2) disclosures regarding the opposing expert. However, you should also be sure to examine the opposing expert on the following matters:

- **Fees, charges, and litigation history**. The opposing expert's rates, total charges, outstanding balances, and litigation history as an expert should be thoroughly explored at the deposition. The opposing expert's history of testifying for plaintiffs and defendants in medical negligence cases, as well as the expert's prior relationships with the plaintiff's counsel, should be examined and covered. You should also explore any other potential areas of bias and prejudice of the opposing expert at the discovery deposition, with the view of using the expert's testimony on those matters at trial.

- **The opposing expert's qualifications and professional experience**. If you have any doubts regarding the opposing expert's employment history, certifications, or other qualifications, then those issues should be explored at the deposition. If your expert has more experience or qualifications than the opposing expert, set up some favorable comparisons for trial by examining the areas where the opposing expert will be weaker than your expert.

- **The expert's factual foundations for his opinions**. You should question the opposing expert about all of the information reviewed and relied upon by the expert, any information the expert is intending to review prior to trial (but has not yet), and any assumptions the expert has made to support his

opinions. If the expert has not reviewed necessary or significant depositions, records, or other evidentiary materials, then you should establish, either directly or indirectly, that he has not reviewed those items of information. If the opposing expert's assumptions are deficient, you may want to ask short hypothetical questions to determine whether his opinions would change if the facts of the case differed from those deficient assumptions. The discovery deposition testimony of the opposing expert on these matters could provide you with significant cross-examination ammunition for trial.

- **Medical literature**. You need to discuss the medical literature reviewed by the expert to form his opinions, any publications he has authored on the subjects involved in the case, any literature reviewed but not included as a basis for his opinions, and the treatises and journals he has in his library or regularly reviews that might discuss issues involved in the case. Excerpts from the treatises and journals in the expert's personal library might provide some cross-examination material for trial and help establish the reliability of those publications under Federal Rules of Evidence 803(18).

C. Using other discovery tools to your advantage

Requests for admissions and answers to interrogatories can also prove to be very helpful in developing cross-examination strategies for trial. If the opposing expert's opinions or testimony is contrary to facts admitted by the plaintiff in other discovery disclosures, then you may be able to undermine the opposing expert's credibility at trial or limit the potential subjects of his testimony.

V. Planning an effective cross-examination

Once discovery is over, you should begin to develop a cross-examination consistent with your trial plan. The aim of the cross-examination of an opposing expert is to help you win your case. When developing your cross-examination, stay focused and develop questioning strategies to bolster the points you want the court to find in your favor at the end of the case. The key to a successful cross-examination of an opposing expert witness is not the length of the examination but whether you are able to make your medical, legal, and factual points in an orderly fashion, without letting the opposing expert control the cross-examination. To achieve this goal, you should follow time-tested cross-examination strategies for success.

First, develop a strategy as to what you want to accomplish on cross-examination and stay focused. This strategy should be based on your trial plan or list of trial objectives. Generally, the cross-examination of the opposing expert will not win your case, but you must make the key evidentiary points important to your case. Do not ramble on irrelevant points; you will diminish your credibility as an advocate. Your questions should not repeatedly restate the opinions expressed by the opposing expert on direct examination, but rather should reflect the points you want to make to win your case.

Second, prepare an outline of those key points and formulate a series of concise leading questions to make each point. Some attorneys prefer to write out their questions completely, while others prefer to use an outline form with a list of points used to formulate the proper questions. No matter which style you prefer, use concise leading questions, appropriately broken down into understandable elements, to prevent the opposing expert from launching into a long narrative response. Generally, if you do not know how the expert will answer a question, then do not ask that question. The point is not to end each question with "isn't that correct?" but to have direct leading questions which require only brief answers in most instances. Some questions, such as those dealing with bias and prejudice, might be somewhat open ended. However, those types of questions should always be structured to allow only for limited answers, and you should already have the answers in the discovery deposition testimony of the opposing expert witness. Keep questions brief and take small steps. If you properly pace the cross-examination, the court should have no trouble seeing the purpose and goal of your questions.

Third, be organized in your cross-examination. You should list in your cross-examination outline each piece of deposition testimony, every exhibit, and every other piece of evidence you need to support each question you intend to ask the opposing expert at trial. Those materials should be readily available for use during the cross-examination. Having to search or fumble around to try to find a passage in a deposition transcript or a necessary exhibit will hurt your credibility as an advocate and will give the opposing expert more time to try to formulate an answer. The experts you most often encounter will be

professional witnesses who testify frequently and serve more as advocates than the legal counsel who hire them. However, they can and do make mistakes trying to recall facts or information in a case. Thus, if you are organized and ask questions in a straightforward leading fashion, the opposing expert will not have the time to try to repair a mistake.

When you anticipate possible lines of impeachment, make sure that you have a clean and unmarked copy of the impeachment material available when, and if, you are required to present it to the opposing expert. If you need to use courtroom technologies to display exhibits or other evidence, be knowledgeable about how to use the equipment or have someone with knowledge assisting you during the cross-examination (if the court allows). Rehearsal with the equipment and your planned use of the exhibits and evidence will give you more confidence and control during the cross-examination.

Fourth, you should know the evidentiary rules and case law regarding impeachment, foundations for exhibits, and the evidentiary issues you anticipate during cross-examination. You should be ready and respond quickly to any likely evidentiary issues or objections raised by opposing counsel. Make your cross-examination flow as smoothly as possible and avoid being sidetracked with unnecessary evidentiary squabbles.

Fifth, structure your cross-examination so it is clear to the court where you are going. A wandering shotgun approach is not the preferred method of cross-examination. The points you intend to make should be organized in an understandable fashion so that the court will be able to follow along and understand not only the points you to intend to establish but also the overall purpose of the cross-examination. Everything you do on cross-examination should move toward the goal of effectively communicating your message to the court.

Sixth, make the opposing expert your expert when possible. When the opposing expert agrees with your client or your expert, use those points of agreement in your favor on cross-examination. If the opposing expert has authored an article which helps your case, point that article out on cross-examination. Should the opposing expert agree that your client is not responsible for certain events or did certain things correctly, use leading questions on cross-examination to emphasize those points as well.

Seventh, be flexible when needed. Like war plans, plans for cross-examination may need to be modified on the fly when unexpected events occur. A surprise answer or evidentiary ruling by the court may require you to make changes in your planned cross-examination of the opposing expert witness. If you have prepared yourself thoroughly for the trial, you will be able to meet those challenges.

Eighth, an experienced lawyer knows that a good cross-examination may not result in a complete or partial repudiation of an opposing expert's opinion. To paraphrase a recent movie, "Take what you can and give nothing back." PIRATES OF THE CARIBBEAN: THE CURSE OF THE BLACK PEARL (Walt Disney Pictures 2003). The opposing expert may stick to his opinions and may be difficult to undermine strictly on the medical or factual issues involved in the case. You must remember that an opposing expert witness is often a highly paid and gifted advocate who may be hard to shake on cross-examination. In those cases, you may need to formulate general questions to make certain key points on cross-examination.

Ninth, recognize that you may not be able to attack the opposing expert's opinions directly because of his level of expertise or the nature of the issues involved in the case. In those situations, you should try to emphasize general themes on cross-examination. Potential cross-examination themes that might be applicable include: that there are two recognized and accepted methods of treatment; that a patient's failure to provide accurate medical history can be unreasonable and constitute negligence; that certain treatments and medications can have side effects; and that it is not always possible to achieve a successful result despite meeting the standard of care. These general themes, combined with a few points specific to your case, may be all a relatively successful cross-examination can achieve. In those situations, use general questions (in a leading form) to set the stage for your medical experts to drive home your essential medical and factual points during their direct examinations.

Tenth, start strong and end strong. Make key points early and often and be sure to finish with a strong closing point. Do not forget to take a brief moment before you finish to make sure that you have covered all of the points you intended to make on cross-examination. At times, you may be tempted to ask one question too many. Avoid that temptation! You need to remember the goals and objectives of your cross-examination and stay true to your trial plan.

Finally, remember that your fact finder in a Federal Tort Claims Act (FTCA) case is a judge. You should know your judge well and know the types of arguments that your judge is likely to find more credible. Be sure to ask other attorneys in your office about techniques and strategies that have worked well for them in past cases involving the judge. If you have some idea about how the judge will likely react to certain strategies and issues, you can structure your cross-examination accordingly.

VI. Specific cross-examination techniques and strategies

Successful cross-examination of an opposing expert often involves several techniques and strategies woven together not only to diminish the credibility of the opposing expert but also to undermine the validity of that expert's opinions. Several techniques exist to accomplish these goals. The following discussion is far from an exhaustive list of what can be done to successfully attack an opposing expert; however, it is important to remember many of these basic techniques because they are frequently used.

A. Attacks based on bias and prejudice

An expert's bias and prejudice can be demonstrated in many ways. Some experts will take only plaintiff-oriented cases or testify only for plaintiffs. Others may have a long history of testifying for a particular law firm and may have received substantial sums from that firm over the years. In some cases, a plaintiff-oriented firm will retain a single expert to review several cases at one time, and the opposing expert may be appearing (or reviewing) as a potential witness in several cases simultaneously or within a close time frame. The expert may also have a bias against the federal government. The expert witness may have had tax problems in the past, been investigated for health care fraud, or may have another well-known bias against the federal government. The expert could also have a personal bias regarding the medical issues or techniques involved, the client medical entity, or clients that are competitors with the expert.

Fees charged by the expert can also demonstrate bias or prejudice. Excessive fees or a substantial pending balance may indicate that the expert will testify as to whatever is necessary to justify his charges or to ensure that he will be paid out of the proceeds of a successful verdict. Moreover, the fact that his charges for expert services comprise a substantial portion of his income, or that he has been paid substantial fees in the past by the plaintiff's firm, can present good material for cross-examination.

B. Attacks based on lack of qualifications and expertise

Even if an opposing expert is technically qualified under § 702 of the Federal Rules of Evidence so as to avoid exclusion as a witness at trial, the expert's qualifications and expertise may still be successfully attacked on cross-examination. If, compared to your expert, the opposing expert has not had much experience with a particular medical treatment or procedure, or has not routinely treated a patient with the plaintiff's medical problems, then you should take the time to point out these facts on cross-examination. This type of attack involves the weight that should be given to the opposing expert's opinions and is a perfectly legitimate line of inquiry. This line of attack allows you to diminish the opposing expert's credentials and bolster your expert's qualifications at the same time. In addition, some medical experts may not have appropriate board certifications, may not have become recertified, or may lack other credentials that are generally recognized as being standard qualifications for the particular medical specialty involved in the case. Also, the expert may routinely refer patients with the specific problem involved in the case to experts in other subspecialties. If your expert is in such a subspecialty field, do not hesitate to develop that fact on cross-examination.

C. Attacks on reliability, relevance, and methodology

Section 702 of the Federal Rules of Evidence requires that expert opinion testimony must be based on sufficient facts or data, be the product of reliable principles and methods, and be the result of applying the principles and methods reliably to the facts of the case. Since FTCA cases are trials to the court, trial judges are often reluctant to exclude expert testimony in advance of trial. If you know the opposing expert's opinions may not meet the foundational tests of § 702, you may want to wait to expose the

deficiencies at trial, rather than through a pretrial motion. That way your opponent will not have the opportunity to try to cure those deficiencies prior to trial via a ruling on a motion to exclude the expert's opinions. In this situation, using the element of surprise at trial may be the better strategic course.

For example, some experts will not have reviewed key depositions and documents, or may have intentionally overlooked such evidence to arrive at their opinions. The factual foundation the expert has used for his opinions may well be suspect, allowing you to frame a "garbage in, garbage out" attack on cross-examination. This situation often occurs when opposing counsel fails to send all of the evidence to the opposing expert, or the opposing expert has relied too heavily on a erroneous or incomplete summary prepared by the plaintiff's counsel. Other experts may simply make mistakes or assumptions which are not based on the evidence in the case. You should make sure to develop a tight cross-examination to exploit these deficiencies because these problems will diminish the expert's credibility and reliability, particularly if your own expert has reviewed everything and weighed all of the evidence carefully. Moreover, an opposing expert's failure to consider a key piece of evidence may establish why he reached the wrong conclusion. Once you demonstrate the deficiency in the opposing expert's analysis, your expert can testify why the omission is critical. When the opposing expert makes a number of such foundational errors, your cross-examination can be effective using the "death by a thousand cuts" technique, where you highlight each error on cross-examination to create a heavy cumulative credibility problem for the opposing expert. In those instances, you will want to establish that if the expert's factual basis for his opinion is in error, then his opinion will naturally be erroneous (this can be set up at the discovery deposition through generalized questions). If the expert argues that his opinion would remain the same no matter what the facts really are, then the expert's prejudice and lack of credibility will suddenly become magnified before the court.

If the opposing expert suggests that your client should have used a particular medical treatment or procedure, but your client used another technique that is also generally accepted, do not hesitate to use statistics or other evidence on cross-examination to make that point. In some situations, you may want to simply highlight the existence of the other schools of thought, techniques, and procedures on cross-examination and let your expert carry the day on the issue during direct examination. In any event, emphasizing problems with the opposing expert's methodology or erroneous application of principles and methods is an important cross-examination technique that should not be overlooked.

D. Attacks using medical literature

The "Learned Treatise" exception to the hearsay rule is another method of cross-examining an opposing expert. Federal Rules of Evidence § 803(18) permits medical literature to be called to the attention of a witness on cross-examination if the literature is established as a reliable authority by the testimony or admission of the witness, by other expert testimony, or by judicial notice. A key aspect of this exception to the hearsay rule is that the reliability of the literature does not have to be established by securing an admission from the opposing expert. You can use the literature on cross-examination on a conditional basis provided your expert (or another qualified witness) can establish the reliability of the literature for the purposes of § 803(18). However, you need to remember to complete the foundation for the literature with your expert witness (or other qualified witness) and move for admission of the statement to avoid a later motion to strike by opposing counsel. While the written statement does not become an exhibit, the statement can become substantive evidence if the foundational requirements are met and the court admits the statement into evidence under § 803(18).

When you decide to use medical literature against the opposing expert, you need to exercise great caution. The literature should come from peer reviewed or well regarded journals and treatises. If the statement comes from the opposing expert, that is even better. In some cases, the statement or literature may come from the opposing expert's colleague or from another medical expert with whom he has co-authored other articles or treatises. Cross-examining the opposing expert with literature written by the opposing expert's mentor in medical school or during residency or fellowship training can also be a very interesting technique.

The statement from the literature you intend to use should be clear and directly relevant to the issues involved in the case. Make sure that the literature does not have points which can be used against your client or expert. In some situations, you may elect to have the opposing expert merely agree to the actual

content of a statement in a book or article and then use your expert later to explain its significance. You should be mindful that the opposing expert is being paid substantial fees to try to win the case for the plaintiff and may be prepared to provide a long and convoluted explanation to try to counter the literature you want to use. Opposing counsel may also have some explanation ready on redirect. You should always be prepared to counter the opposing expert's explanation, whether during your cross-examination or through your own expert later in your case-in-chief.

E. Prior inconsistent statements

An opposing expert may realize after the discovery deposition that you have scored some points and try to change his testimony or express a different opinion at trial to remedy the situation. Federal Rules of Evidence § 613 governs the use of prior inconsistent statements. Once the inconsistent statement is made, then you need to challenge the witness by examining the witness about his trial testimony being inconsistent with his deposition testimony. The extrinsic proof of the inconsistent statement (the deposition testimony) will only be admissible after you have shown the prior inconsistent statement to the witness and your opponent has had the opportunity to interrogate the expert about the statement, if so desired. Fed. R. Evid. 613(b). You should take your time and carefully set the stage for impeachment by a prior inconsistent statement. This type of impeachment can be devastating to an opposing expert witness and you want to maximize the impact when the opportunity arises to use this technique.

In addition, trial testimony inconsistent with prior deposition testimony may also be subject to exclusion under Federal Rule of Civil Procedure 37(c) when the trial testimony is actually a new opinion not previously disclosed as required by Federal Rule of Civil Procedure 26(a)(2). Federal Rule of Civil Procedure 37(c) calls for automatic exclusion unless the failure to disclose prior to trial was "substantially justified or harmless." If several weeks have passed between the deposition and the trial with no new evidence disclosed in the interim, and your opponent failed to supplement the disclosures required by Federal Rule of Civil Procedure 26(a)(2) or as mandated by Rule 26(e) or an order of the court, then you will have a strong basis to exclude the new opinion testimony and to make the opposing expert lose credibility with the court.

VII. Conclusion

The cross-examination of an opposing medical expert in a medical negligence case is one of the most challenging tasks for a trial lawyer. Careful and thorough preparation of the medical issues, coupled with effective investigation and discovery of the opposing expert, will often yield important information which can be used to create an effective cross-examination. The key is to combine various techniques and strategies into a series of evidentiary points and arguments consistent with trial objectives and then to effectively communicate them at trial.❖

ABOUT THE AUTHOR

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Medical Malpractice Defense: The Predictive and Protective Power of Mortality, Survival, and Life Expectancy

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I. Introduction

The defense of medical malpractice presents a significant challenge to Assistant United States Attorneys (AUSAs). A medical malpractice claim consists of proof of: (1) duty (2) breach of the duty (3) causation and (4) damages. Often the breach of the duty and the causation elements present complex medical issues involving multiple specialties and subspecialties of medicine. A considerable amount of time is required to prepare the defense pertaining to the alleged breach of the duty and causation elements. The damages aspect of the medical malpractice case are often not given equal treatment and may not be fully developed. As a result, damage awards can be surprisingly high once the breach of the standard of care and the causation defenses fail.

II. Purpose

The purpose of this article is to underscore the importance of developing the damages aspect of the case. In particular, this article will demonstrate through a case study the power of using fact-based medical-actuarial risk statistics and life expectancy testimony to limit, by thousands if not millions of dollars, economic damages to impairment-specific "years of life lost" in medical-malpractice torts. The important points to remember are that from the moment a case is assigned to an AUSA, the AUSA must: (1) focus as much, if not more, attention on damages; (2) execute a discovery strategy that ensures all aspects of damages are thoroughly investigated; and (3) retain the appropriate experts, including, in appropriate cases, an expert on medical risk appraisal and life expectancy.

III. Presentation of the case*

At 8:30 p.m. in June 2004, a rescue team of a local emergency response crew found a 58-year old white male veteran lying supine and unresponsive, with shallow breathing, on the floor of a restaurant in a U.S. city. Witnesses in the restaurant indicated that the victim had stated at dinner, just prior to collapsing, that "he felt weak and felt that he was going to pass out." The rescue squad began basic cardiopulmonary resuscitation and advanced cardiac life support (ACLS) resuscitation measures. The veteran was transported to the Local Medical Center Emergency Room-Critical Care Area. His electrocardiogram monitor rhythm indicated asystole (lack of heart beat), and, after further ACLS resuscitative measures proved futile, the patient was pronounced dead at 9:19 p.m. The medical examiner was notified; an autopsy was not performed.

The veteran's medical history indicated a cascade of severe metabolic, cardiopulmonary, and vascular risk factors, as well as other clinical risk factors including the following: Ischemic cardiomyopathy with episodes of chronic congestive heart failure (CHF); a history of coronary heart disease (CHD) with

myocardial infarction (MI or heart attack) in 1987, treated with percutaneous transluminal coronary angioplasty (PTCA) without a stent; uncontrolled diabetes mellitus, type II, since about 1999; severe chronic obstructive pulmonary disease; morbid obesity; hyperlipidemia; peripheral vascular arterial disease; mental depression; obstructive sleep apnea; bronchial asthma; ocular myasthenia gravis; sinusitis with post nasal drip; athlete's foot; tinea pedis and onychomycosis (fungal infections of the feet and toe nails); varicose veins with lower extremity venous insufficiency (with varicose vein surgical stripping in 1999); and erectile dysfunction. There were no known allergies or history of alcohol or drug abuse, and he had stopped smoking his usual two and one-half packs of cigarettes per day (50 pack-years) after a heart attack in 1987.

The patient's parents were both diabetic and deceased. His brother and sister had also been diagnosed with diabetes mellitus.

IV. Legal action

An FTCA medical tort was filed against the U.S. Government by the veteran's estate seeking money damages based on alleged medical negligence in failing to perform coronary artery bypass surgery resulting in a wrongful death. The complaint also alleged failure by the Veteran's Administration Medical Center in the veteran's home state to diagnose and treat recurrent coronary artery disease.

V. Medical-actuarial theme

What is the morbid impact of the veteran's major risk factors, medical impairments, and disabilities on the probability of survival, mortality, and life expectancy at a given attained age (58-years) compared and contrasted with an age, sex, and race matched cohort (unexposed to the identical risk of the deceased plaintiff) in the most current U.S. Decennial Tables? The term "probability" - not "certainty" - is used because, as we shall see, the percent annual survival in the life table takes values from 100% to 0.0%, mathematically equivalent to a probability.

Table 1: Medical Risk Profile No. 1; EDRs/1000

Age in Years	50-59	60-69	70-79	80 up
Uncontrolled diabetes mellitus, type II	31.0	38.0	31.0	4.0
Severe, progressive CHD, ischemic cardiomyopathy & CHF	56.6	72.7	72.7	72.7
Chronic obstructive pulmonary disease (COPD)	24.0	24.0	24.0	24.0
Morbid obesity (BMI ≥40)	31.8	31.8	31.8	31.8
Dyslipidemia	15.0	15.0	15.0	15.0
Peripheral vascular disease (PVD)	20.0	20.0	20.0	20.0
Major depression	8.0	8.0	8.0	8.0
Summed Excess Death Rates (EDRs)	186.4	209.5	202.5	175.5
EDR decimal values	0.1864	0.2095	0.2025	0.1755

VI. Major risk factors

Risk is the chance (mathematical proportion) for harm. Major risk factors and comorbidities contribute significantly to excess mortality (actual to expected) expressed as the excess death rate (EDR) per 1000 people over and above the normal expectation in the U.S. Decennial Tables by age, sex, and race in people not burdened by the risk. Each risk factor cumulatively increases the total burden of excess mortality. The summed EDR is an absolute number and, as noted, is usually expressed as extra deaths per 1000 people. It mathematically indicates the observed (actual) total extra mortality burden (qx) - the probability of dying - of a disease, or combination of diseases or risk factors, in an individual, or group of individuals, matched by age, sex, and race with an identical risk pattern, compared to the normal (expected) mortality burden of a group matched by age and sex unexposed to the risk - column q'x - in the

most current U.S. Decennial Life Tables. The EDR (qx - q'x) is converted to a decimal prior to use in a life table for the computation of the life expectancy of the subject-cohort under discussion.

Evaluation of the veteran's complete medical records indicates that he suffered from a multiplicity of severe major medical risk factors: metabolic, cardiopulmonary, vascular, and central nervous system. Each has individually elevated EDRs, starting at age 50 and extending to age 80 and above, as noted on Table 1.

VII. Minor risk factors

Relatively minor risk factors that do not contribute significantly to the veteran's overall excess mortality are not included. Although very troubling, minor risk factors do not reach such a severity level as to cause excess mortality. The following are not considered to be significant additions to his mortality risk profile because of the absence of morbid sequelae: ocular myasthenia gravis, sinusitis with post nasal drip, athlete's feet, tinea pedis and onychomycosis (toenail fungus), varicose veins with lower extremity venous insufficiency (history of varicose vein surgical stripping in 1999), and erectile dysfunction.

VIII. Other risk factors

To be as conservative as possible, obstructive sleep apnea, although a major risk factor, will not be included in the veteran's life expectancy analysis. The apnea-hypopnea indices and data for quantification of severity were not in the available medical records.

IX. Scientific basis of methodology and analysis

Epidemiologic principles and standard actuarial methods provide the scientific framework for accurately measuring the reduced individual life expectancy caused by additional mortality associated with various risk factors, diseases, and disabilities. The scientific basis of life expectancy methodology is rooted in the mathematical interrelationship of impairment-specific EDRs with population data contained in the U.S. Decennial Life Tables for any given attained age, sex, and race. These scientific methods have been well described in publications by medical actuarial professionals and others interested in both the vital statistics of the United States and in the preparation of population-based life tables.

Life expectancy (e°) is defined as the average number of years lived by a group of persons from their starting age until all have died. It is a standard feature in column 7 of the U.S. Decennial Life Tables. A method was published in the Journal of Insurance Medicine in 1992, 1998, and 2005 to adapt this format to a spreadsheet computer program.

X. Absolute risk of dying

As noted in Table 1, the veteran's summed cumulative mortality burden for ages 50-59 years, expressed as the EDR per 1000 people (the probability of dying) for all comorbidities and risk factors combined at attained age 58 years, is extremely high at 186.4 deaths per 1000, compared to the expected (q'x) for normal white males of 0.01231 (12.3 deaths) per 1000, at attained age 58 years, in the U.S. Decennial Tables. (*See* abbreviated Table 2 to attained age 70, Column q'x, Age 58 - row 58 years, below).

XI. Life tables

The life table is a spreadsheet device for displaying the mathematical interrelationships between the rows and columns (column heading symbols are designated in parenthesis) in logical order. Life expectancy methodology is well described in the medical actuarial peer reviewed literature, and, although the table appears formidable because of its size, the arithmetic relations of the variables in each column are relatively simple and repetitive. These arithmetic relationships are briefly summarized below in the key to Table 2 and are ordinarily succinctly described in the glossary and explanation of life table column derivations from A to I in any life expectancy report or spreadsheet workbook.

Life Table methodology summary:

Step 1. Reduces the population (column Ix) each year until it reaches zero (0).

Step 2. Calculates the average population remaining (column Lx) with each advancing year and expresses this as annual person-years of exposure to the risk of dying.

Step 3. Calculates the cumulative (total) person-years of exposure (column Tx) to the risk of dying in any age interval.

Step 4. Calculates the average life expectancy (column ex) for any attained age interval by dividing the total person-years by the number surviving at the beginning of the attained age interval.

Use of other than U. S. Decennial Life Tables:

1. Other annual tables between the decennial ones cannot be used because complete annual data, depending upon the particular table used, are given only to age 85 to 100 years.

2. The annual tables are based on deaths in a single year and, except for census years, on postcensal population estimates rather than on the data from a decennial census, and the annual tables are calculated by abbreviated methods.

3. The expectation of life is defined as the average number of years lived by a large group until all have died.

4. This article stresses the data cut off at age 85-100 in the intercensal-annual or abridged life tables because the accurate calculation of life expectancy requires that the life table calculations be carried out until all entrants have died. Hence, the abridged or annual life tables cannot be used for accurate calculation of life expectancy.

5. Because table preparation is a lengthy process, the latest available Decennial Tables are 1999-2001, published on August 5, 2008.

Table 2	MRP1: "Vincent Veteran" Life Expectancy (e_x) Without Postulated CABG							Life Expectancy
Age x	q'	EDR	Proj. q	l_x	d_x	L_x	T_x	e_x
58	0.01231	0.1864	0.1987	10 00.00	198.71	900.65	4,089.31	4.09
59	0.01366	0.1864	0.2001	801.29	160.31	721.14	3,188.67	3.98
60	0.01503	0.2095	0.2245	640.98	143.92	569.02	2,467.53	3.85
61	0.01641	0.2095	0.2259	497.06	112.29	440.92	1,898.51	3.82
62	0.01788	0.2095	0.2274	384.77	87.49	341.03	1,457.59	3.79
63	0.01947	0.2095	0.2290	297.28	68.07	263.25	1,116.56	3.76
64	0.02118	0.2095	0.2307	229.21	52.88	202.78	853.31	3.72
65	0.02297	0.2095	0.2325	176.34	40.99	155.84	650.54	3.69
66	0.02483	0.2095	0.2343	135.35	31.72	119.49	494.69	3.66
67	0.02689	0.2095	0.2364	103.63	24.50	91.38	375.21	3.62
68	0.02926	0.2095	0.2388	79.13	18.89	69.69	283.83	3.59
69	0.03200	0.2095	0.2415	60.24	14.55	52.97	214.14	3.55
70	0.03509	0.2025	0.2376	45.69	10.86	40.26	161.17	3.53

Key:

Age x: Advancing age groups with each year of attained age in the U. S. Decennial Tables q': Number of people expected to die in any age group

EDR: Excess death rate; calculated as the observed mortality rate (q) minus expected mortality rate (q')

Projected q: The sum of q' plus EDR

Cohort Ix: Designates the number alive at the start and the survivors alive at the start of each subsequent year of attained age

dx: Derived as product of projected q and cohort (Ix)

Lx: The average number exposed to risk during the full year of attained age; L=Cohort (Ix)-(0.5)*(d)

Tx: The sum total of all values of L from the current year through age 109; T=?L

ex: Life expectancy for all attained ages; ex=T/Cohort (Ix)

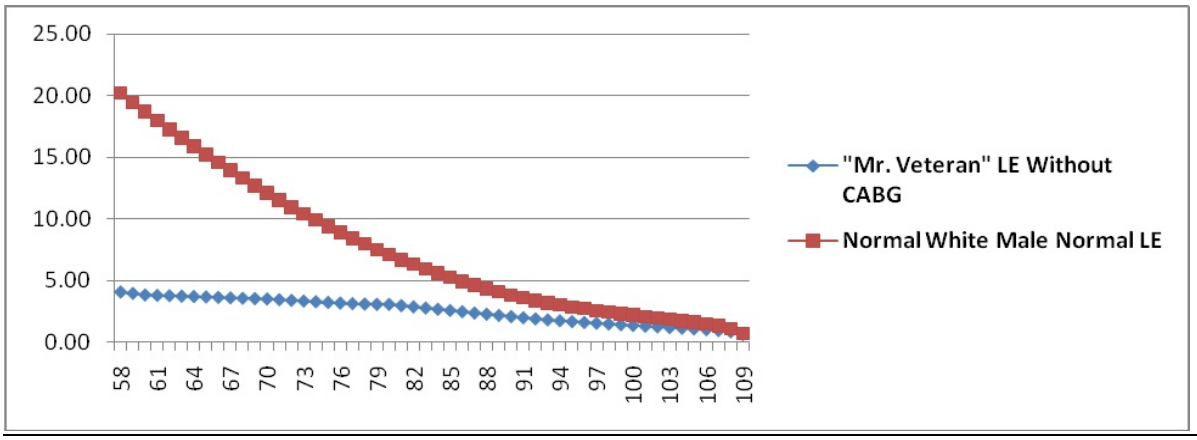
CABG: Coronary artery bypass graft

XII. Life expectancy conclusion at attained age 58 years

The veteran's summed mathematical burden of excess mortality, expressed in his Medical Risk Profile as the total EDR at attained age 58, severely impacts residual life expectancy (ex) which is 4.09 years. In terms of life expectancy, this is understood as the average number of years lived by a group of

58-year old white American males with the identical set of major risk factors as those found in Mr. Veteran until all have died, as compared to normal white American male life expectancy of 22.02 years at attained age 58. Thus, 4.09 years represents the enormous reduction of 79.75% below the normally expected residual life expectancy of 20.20 years in the U.S. Decennial Life Table for a population matched by age, sex, and race. *See* Graph 1.

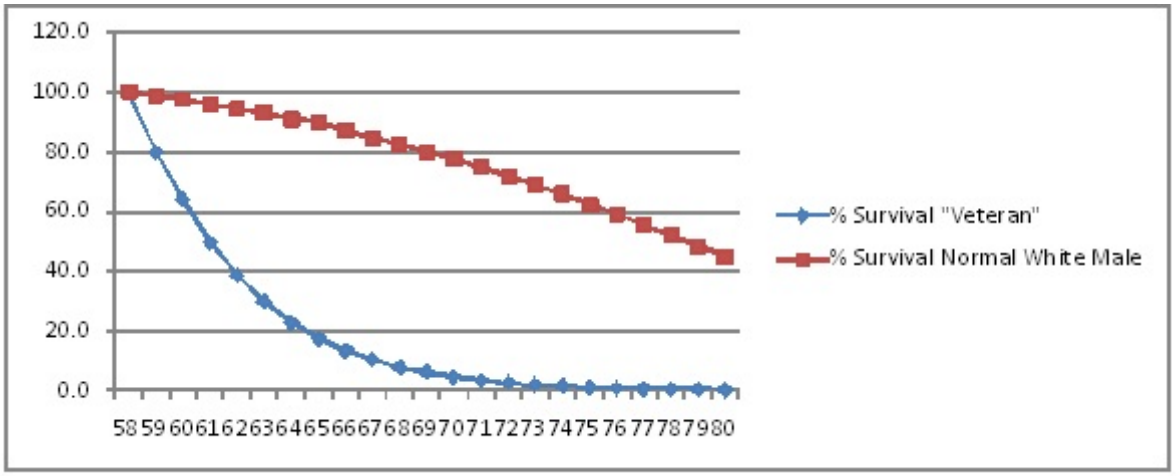
Graph 1: "Mr. Veteran" vs. Normal White Male Comparative Life Expectancy @ Age 58



XIII. Corollary: Comparative probability of survival with advancing age

A brief perusal of Column Ix in the above Life Table 2 indicates that the median age of survival and median age at death of white males with the same risk factors as the veteran, with advancing age, is extremely truncated: between 60 and 61 years of age compared to the normal between age 78 and 79 years (normal white male table not shown). The percent probability of survival of the veteran to age 65 and 70 is only 17.6 and 4.6 percent respectively, versus normal white male survival of 89.0 and 77.5 percent respectively, to the same ages. *See* Graph 2.

Graph 2: Comparative Percent Probability of Observed Versus Expected Survival to Age 80



XIV. Supporting life expectancy expert testimony

An AUSA, by focusing on damages from the inception of the case and retaining a medical expert to testify on life expectancy, can discover the necessary facts that will allow the trier of fact to determine with greater accuracy the amount of damages in a wrongful death case. The AUSA should seek all of the veteran's medical records, disability compensation files, Social Security files, insurance disability files, and other records that provide an accurate assessment of the veteran's medical condition. Using interrogatories, requests for admission, and depositions, the AUSA can narrow the issues for trial and establish the factual predicate for expert testimony on life expectancy. By retaining an expert of life expectancy early in the litigation, the AUSA can obtain the insights of an expert in the field regarding the discovery plan.

XV. Conclusion

For the purposes of successful dispute negotiation and medical malpractice tort resolution, the predictive and protective power of evidence based medical risk assessment and life expectancy is a useful tool for limiting economic damages to "years of life lost." AUSAs should consider, at the outset, retaining an expert on life expectancy. For example, the case study plaintiff would likely rely on the state life table or other data to argue that the decedent would have lived 22 years. Armed with the expert testimony regarding life expectancy, the AUSA, whether during alternative dispute resolution or at trial, would be able to make a strong case, well grounded in fact and law, that the life expectancy of the decedent would have only been approximately 4 years. The difference between 18 years and 4 years in future earnings or other damages can often amount to hundreds of thousands, if not millions, of dollars. The proper preparation of the damages portion of a medical malpractice case begins early, involving an expert in the field that can provide the trier of fact important evidence to make an accurate assessment of damages.❖

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* The case study is not based on a single individual but is a fictional patient used for teaching purposes only. Any similarity between the case study and any actual person is not intended.

Deposition Fees for Treating Physicians: How Much Does the Good Doctor Get?

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I. Introduction

In almost every medical malpractice case there are a number of doctors who have either treated or allegedly mistreated the plaintiff. Some are defendants, but many are just treating physicians, and they are the focus of this article.

The Federal Rules of Civil Procedure (Rules) set up a regimen for the treatment of certain professional or "expert" witnesses. Clearly, the retained expert who prepares and submits a report is not a fact witness and is entitled to receive compensation when he or she is deposed. Fed. R. Civ. P. 26(b)(4)(C)(1). It is equally clear that the neighbor or family member who happens to be a professional is not entitled to their usual hourly fee if they are deposed in the case. They, like all good citizens, are more than happy to give of their time for the furtherance of justice, and to get the standard $40 witness fee, along with the heartfelt thanks of a grateful nation!

II. Hypothetical

Herein lies the rub. What about the doctor who treated the plaintiff but who has not been retained or provided a report under Rule 26(a)(2)(B)? Let's set up a hypothetical and see which witness gets their own fee and which gets the standard witness fee. Plaintiff—let's call him Paul—had surgery at a government hospital and found out a month later that he had an extra sponge in his abdomen which caused an infection and had to be removed. Dr. A did the initial surgery and would be the defendant (save for substitution under the Federal Torts Claim Act). Dr. C found the sponge at the County General Emergency Room, where Paul was sent by Dr. B, his family doctor, when Paul started running a fever. Dr. D is the head of surgery at State University General and a noted expert on lost sponges who has been retained by Paul's attorney to testify against the United States. Andy Architect is a witness who lives next door to Paul and who told Paul to go to the doctor when he noticed Paul's swollen stomach and fever.

Let's set the stage! You are quietly reading the advance sheets in your office on a lovely Friday afternoon when you get assigned this new case. You spring into action and, after interviewing Dr. A and all the government doctors and nurses, decide to depose Paul, Dr. B, Dr. C, and Andy Architect. Now you go down to the admin section in the USAO to grovel and beg for litigation funds. Dr. B charges $1,000 up front for a deposition. Dr. C charges $650 per hour with a 2-hour minimum. Andy wants to be reimbursed for all his lost time redesigning the Armada Room at the Holiday Inn at $225 per hour. Dr. D charges $5,000 per half hour with a 3-hour minimum, payable in advance. Your admin funds have been pretty much depleted by the criminal division. You may be able to get $2,500. Your exposure in the suit is over $1 million. What is an AUSA to do?

III. The Rules

When all else fails (take special note those of you who, like the author, refuse to read directions and spend 3 days building a child's swing set) **read the Rules**. Rule 26(a)(2)(A) requires that parties disclose any expert who is expected to offer evidence under "Rules 702, 703, or 705 of the Federal Rules of Evidence." Those rules are as follows:

> Rule 702. Testimony by Experts
>
> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.
>
> Rule 703. Bases of Opinion Testimony by Experts
>
> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect.
>
> . . .
>
> Rule 705. Disclosure of Facts or Data Underlying Expert Opinion
>
> The expert may testify in terms of opinion or inference and give reasons therefor without first testifying to the underlying facts or data, unless the court requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross examination.

Fed. R. Evid. 702, 703, 705.

In addition, Rule 26(a)(2)(B) requires retained experts to provide written reports. Dr. D has provided a report; you will have to pay his fee to depose him unless you can work out an "I'll pay mine and you pay yours" agreement with opposing counsel. This can eliminate a lot of problems if you have that sort of rapport. If not, you will have to get a contract approved by admin in advance of any work being performed. The "pay up front" plan just does not work with the government, and most of the doctors the author has dealt with agree to bill the United States because they recognize that the government cannot pay until the doctor performs. If you cannot reach an agreement to avoid a demand for advance payment you may have to seek the court's help, because you cannot pay them in advance and it is impractical to promise to bring a check. *See* 31 U.S.C. § 3324; USAM 3-8.600.

IV. The witnesses

Now to Andy Architect. He is a witness and entitled to a witness fee. *See Demar v. United States,* 199 F.R.D. 617, 620 (N.D. Ill. 2001). However, he is not an "expert" under these facts and is entitled only to the standard witness fee, which is currently $40. He is clearly testifying only as a "fact" witness.

What about Dr. B, the family doctor? Now we venture into a gray area. We will assume for sake of discussion that Dr. B is an "expert" on medicine. However, is he or she testifying as an expert or a fact witness? First, we should note that courts have held that a treating physician called as to the treatment rendered may be either. Our Senior Litigation Counsel has gone so far as to suggest that the deposition fee be split and the deponent paid their hourly fee only for the portion that is not fact witness testimony—a result with strong intellectual appeal, but less to recommend it practically. The courts have not addressed this possible split so far. In *Fielden v. CSX Transp. Inc.,* 482 F.3d 866, 869-71 (6th Cir. 2007), the Sixth Circuit held that a treating physician should be disclosed under Rule 26(a)(2), but does not have to file a report if their expected testimony is limited to opinions formed during treatment. Specifically, the court stated: "[A] report is not required when a treating physician testifies within a permissive core on issues pertaining to treatment, based on what he or she learned through actual treatment and from the plaintiff's records up to and including that treatment." *Id.* at 871.

Thus, if Dr. B had only witnessed Paul at the country club in apparent pain that hampered his back swing, he clearly would get only the $40 fee. But that is not usually what doctors testify to in such cases. If, however, Dr. B is to testify only as to his treatment and give no opinion based upon information

acquired after treatment as to causation or extent of injuries beyond that to which a layman could testify, the gray gets hazier. If he is to testify that the pain came from the site of the sponge, or that the fever was secondary to the sponge having been left during the surgery, could a layman testify as to that or is that a medical call? If it is expert testimony under Fed. R. Evid. 702, 703, or 705, then Rule 26(a)(2) and Rule 26(b)(4)(C) apply, and the plaintiff must disclose Dr. B as an expert, after which reasonable payment for deposition testimony and preparation is required.

Now, what about Dr. C? He is the ER doctor who found the sponge and ordered it removed. He will testify that Paul's pain resulted from a foreign object that he saw on an x-ray. Clearly beyond the pale of non-doctors (except maybe some seasoned medical malpractice lawyers who read x-rays pretty well), I would propose that this is likely expert testimony. Although Dr. C is disclosed only as a treating doctor, since he will have to give opinions, he is an "expert" but would not need to provide a report under Rule 26(a)(2)(B).

V. The law

So how does the law treat this? It appears that the law is evolving, with all due apologies to Mr. Darwin from a lawyer practicing 30 miles from the site of the Scopes "monkey" trial. The rigid rule is that fact witnesses get $40 and experts get "reasonable" rates. But, as usual, the devil (and maybe the dollar) is in the details. In *Mock v. Johnson,* 218 F.R.D. 680, 683 (D. Haw. 2003), the magistrate judge in a discrimination case held that the expert psychologist was entitled to a reasonable fee where there was no expert report but the possibility of expert testimony was disclosed. The court opined that the opinions testified to "derive from their highly specialized training." *Id.* at 683.

The *Mock* court reviewed the lines of cases on both sides of the issue and concluded that doctors and similar professionals should be compensated, even without the report requirements of Rule 26. The court cited *Coleman v. Dydula,* 190 F.R.D. 320, 323-24 (W.D.N.Y 1999); *Bovey v. Mitsubishi Motor Mfg. of America Inc.*, 2002 WL 820670 (C.D. Ill. Apr. 3, 2002); and *Haslett v. Texas Instruments, Inc.,* 1999 WL 354227 (N.D. Tex. May 20, 1999), wherein courts concluded that the specialized knowledge of the physician militated to payment of their regular fees. *Mock*, 218 F.R.D. at 682. The court went on to collect the contrary authority, citing *Fisher v. Ford Motor Co.*, 178 F.R.D. 195, 197-98 (N.D. Ohio 1998); *Mangla v. Univ. of Rochester,* 168 F.R.D. 137, 139-40 (W.D.N.Y 1996); *Baker v. Taco Bell Corp.,* 163 F.R.D. 348, 350 (D. Colo. 1995); and *Demar v. United States,* 199 F.R.D. 617, 619-20 (N.D. Ill. 2001), holding that doctors were no more inconvenienced than other fact witness citizens (*e.g.*, our Andy Architect).

Interestingly, none of the courts really discuss how treating doctors, unlike any other profession, come into almost daily contact with workers compensation and personal injury cases, as well as employment plaintiffs. It is so prevalent that the author now deals with many physicians who have a "deposition day" in their calendar every month.

More recent cases have tended to reach the same result as in *Mock*, following the language of Rule 26(b)(4). In *Hoover v. United States,* 2002 WL 1949734 (N.D. Ill. Aug. 22, 2002), a magistrate judge in the same court that decided *Demar,* went the other way and allowed a treating physician to be paid reasonable fees, reasoning that the Rule itself compels the payment of treating doctors. *Id.* at *8. If a witness is disclosed as an expert treating physician, under the *Hoover* analysis the witness is not required to file a report but is entitled to a reasonable fee.

This conclusion comes not from policy but from a direct reading of the Rule. *Id*. Specifically, the *Hoover* court explained that:

> [The contrary view] fails to come to grips with the fact that a treating physician who testifies about the examination, diagnosis, and treatment of a patient necessarily draws upon his or her skill, training and experience as a doctor. And the physician can only do so as an expert under Rule 702 – which makes the treater an expert under Rule 26(a)(2)(A), who is subject to deposition under Rule 26(b)(4)(A) and who, under the terms of Rule 26(b)(4)(C)(i), is entitled to payment of a reasonable fee for the deposition.

Id. at *7.

Two more recent cases, *Weimer v. Honda of America Mfg, Inc.,* 2008 WL 4503562 (S.D Ohio Oct. 1, 2008), and *Snook v. County of Oakland,* 2009 WL 928753 (E.D. Mich. Mar. 31, 2009), both seem to follow the newer trend. In *Weimer*, an employment discrimination case, the plaintiff suffered a head injury, and the doctor was questioned about the plaintiff's blurred vision. The court opined that the opinions solicited were clearly beyond fact witnesses and that since the Rules were changed in 1993, doctors who treated a plaintiff could testify as experts without being so retained and ostensibly without a report, and were therefore entitled to be compensated. *Weimer*, 2008 WL 4503562, at *2.

In *Snook,* the injuries allegedly resulted from a jailhouse incident. The treating doctor, a neurosurgeon, had a hefty up-front fee and hourly rate. The doctor was not listed as a retained expert but apparently was disclosed and provided a report as a witness expected to give "opinion" testimony. *Snook*, 2009 WL 928753, at *3. The *Snook* court cited *Lamere v. New York State Office for the Aging,* 2004 WL 1598778 (N.D.N.Y. June 29, 2004), requiring that deposition fees be paid to a doctor who was not disclosed in any way as an expert. *Id.*

This leave us with three possible scenarios:

1. Expert named pursuant to Rule 26(a)(2)(A) and a report furnished under Rule 26(a)(2)(B):

Clearly, a retained expert must be reimbursed for reasonable fees for preparation and deposition time. Rule 26(b)(4).

2. Expert not named as a retained expert, but disclosed as a treating physician:

The plaintiff would be required by Rule 26(a)(2)(A) to disclose the treating physician as an expert if the doctor is expected to give evidence under Rule 702, 703, or 705 of the Federal Rules of Evidence. This would key the fee provisions of Rule 26(b)(4)(C). If no disclosure is made, then the treating doctor may well be a "fact witness." *But see Lamere*, 2004 WL 1598778.

3. Treating doctor not disclosed under Rule 26(a)(2)(A) and no report provided under Rule 26(a)(2)(B), but initial disclosures under Rule 26(a)(1) list the doctor as a fact witness:

If the treating doctor is not disclosed as giving testimony under Rules 702, 703, or 705, Federal Rules of Evidence, then the witness may be treated as a fact witness (with the caveat that some courts, for example, *Lamere*, may find that failure to disclose under Rule 26(a)(2) may not preclude the court from finding the physician is an expert due a fee if the substance of the testimony is expert opinion).

VI. Conclusion

Some of the cited cases contain lengthy discussions of policy considerations. The views vary from recognition that the doctor with special expertise should be compensated to finding that a treating doctor not disclosed as an expert is just another citizen with fact information crucial to the judicial process. None of the cases found have addressed the policy concern of reduction of the availability of treatment to patients, especially in medically underserved areas, where doctors may become very reticent to accept patients with work-related or tort-related injuries if the doctor fears that he will then be subjected to depositions at the rate of only $40 per day.

There is also the tactical conundrum that a treating doctor not disclosed under Rule 26(a)(2) will be quickly antagonized by the offer of only $40 for the deposition. Doctors work long hours and you are asking them to set aside 1 to 2 hours for a total of $40, scarcely a tank of premium gas for the Porsche! Although one would hope that professionals would not vary their testimony based on a fee, cooperation may well be limited if fair compensation is not paid. Making payment of the fee dependent on the plaintiff's choice of disclosure will likely defer the issue to the last days before trial and cause other strategic concerns, such as delaying any possible settlement in favor of the defense. The wrangling over fees can be just another distraction from the real issues of your case. It appears to the author that the trend is to allow experts to be reimbursed a reasonable fee, even if they are the treating physicians, so long as they are testifying to opinions that require their specialized expertise.❖

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The Confidentiality of Department of Defense Medical Quality Assurance Records: Developments Under 10 U.S.C. § 1102

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I. Introduction

Historically, Congress has exercised an active role in promoting high quality health care within Department of Defense (DOD) health care facilities. In 1986, as part of those efforts, Congress enacted §1102 of Title 10, United States Code. *See* 10 U.S.C. § 1102. Congress intended § 1102 to improve the quality of DOD medical care by promoting the peer review process and thereby encouraging physicians to identify and prevent medical risks. *See* Woodruff, *The Confidentiality of Medical Quality Assurance Record*, ARMY LAWYER, May 1987, at 5 (comprehensively discussing the background and provisions of § 1102).

To promote the DOD peer review process, Congress enacted a comprehensive statutory framework embodying civil immunity provisions, discovery prohibitions, evidentiary rules, a Freedom of Information Act exemption, penalties for disclosure, and an extensive scheme of authorized disclosures. Section 1102 (1) prohibits release and discovery of medical quality assurance (QA) records; (2) precludes testimony about QA records, findings, recommendations, evaluations, opinions, or actions taken regarding QA activities; (3) establishes penalties for willful disclosure of QA records; and (4) provides good faith civil immunity for QA participants.

Prior to enactment of § 1102, the federal common law privilege for self-evaluative materials was applied by some courts to protect peer review reports. The privilege involved a balancing test in which the public interest in encouraging confidential peer review was weighed against the need of the party seeking discovery. *See Bredice v. Doctor's Hospital*, 50 F.R.D. 249 (D.D.C. 1970); *see also Mewborn v. Heckler*, 101 F.R.D. 691 (D.D.C. 1984); *see generally* Note, *The Privilege of Self-Critical Analysis*, 96 HARV. L. REV. 1083 (1983).

Section 1102, which expands on the Veteran's Administration QA statute, state peer review statutes, *see* Woodruff, at 5, and the common law self-evaluative privilege, rests on the congressional determination that peer review among medical professionals promotes high quality health care in DOD health care facilities. The Veteran's Administration QA Confidentiality Statute, 38 U.S.C. §5705 (VA QA Statute), confers confidentiality on quality assurance "records and documents;" the DOD statute extends confidentiality to "proceedings, records, minutes, and reports." The DOD statute also has a broad prohibition against either voluntary or required testimony in judicial or administrative proceedings with respect to any finding, recommendation, evaluation, opinion, or action taken in connection with the QA record. The VA QA Statute requires that QA activities be specified in a regulation, while the DOD statute does not. Although the scope of the DOD statute is broader, it is subject to more exceptions than the VA QA statute. In addition, the DOD statute confers civil immunity on persons who, in good faith, provide or participate in the creation of QA records. The VA QA statute represents a considered legislative choice between competing public concerns – medical staff candor and plaintiff's access to evidence. Section 1102, which embraces the goal of peer review candor at the cost of impairing plaintiff's access to evidence, reflects a congressional judgment that the public interest in improving DOD medical care is best served by encouraging candid and thorough peer review among health care professionals even if, in a particular case, that would preclude plaintiff from obtaining evidence emanating from the peer review process.

Since enactment, § 1102 has to a great degree fulfilled the congressional purpose of establishing an environment of confidentiality surrounding DOD peer review activities. Courts have seized on the clear and specific language of the statute to prohibit disclosure in a variety of circumstances. More importantly, in the area of discovery practice, the plain language of § 1102 has deterred plaintiffs from attempting to pierce the sanctity of the peer review process.

Attorneys involved in QA, claims, and litigation should be aware of the protections § 1102 confers on the DOD peer review process. This article will review judicial interpretations of § 1102 and examine recurrent issues regarding QA records. The article will underscore that § 1102 is a prohibition against disclosure, not a mere evidentiary privilege, and will describe how government attorneys should prove that QA records are protected under § 1102.

II. Case law under § 1102

A. Section 1102 is a prohibition against disclosure, not a privilege

In the first published opinion under § 1102, *In re United States of America*, 864 F.2d 1153 (5th Cir. 1989), the Fifth Circuit Court of Appeals, in a broadly worded reading of § 1102, held that the section prohibits a court from requiring disclosure of QA records even when a government attorney fails to make timely objection to a discovery request for QA records. The decision of the court, which emphasized the clear and specific language of the statute, is the starting point for interpreting § 1102. The decision is also important because of its rejection of waiver under § 1102 and interpretation of § 1102 as a statutory prohibition against disclosure, not a mere privilege.

The § 1102 issue prompting the Fifth Circuit's decision arose in a medical malpractice suit under the Federal Tort Claims Act, 28 U.S.C. §§ 1346(b), 2671-80, when plaintiff served the complaint along with a request for production of QA records, requiring a response within 60 days, and the government failed to object until 78 days after service. The district court, ruling that the government's untimely response waived any objection under § 1102, ordered production of the QA records.

The district court's decision was based on the general rule of waiver that when a party fails to object in a timely manner to interrogatories, productions requests, and other discovery requests, the objections are waived. The district court, treating § 1102 as a privilege, held that the United States waived the protection of § 1102 by failing to raise the objection in a timely manner.

Notwithstanding the court's order, the United States opposed disclosure on the grounds that § 1102 was not subject to waiver and that the district court's order required the attorneys for the United States to perform an unlawful act, that is to disclose QA records in violation of § 1102. The Department of Justice petitioned for a writ of mandamus.

On writ of mandamus, the Fifth Circuit Court of Appeals vacated the district court's order to produce QA records and held that the government attorney's failure to object in a timely manner did not waive the confidentiality of QA records. The court emphasized that Congress prohibited disclosure of QA records and the government has no discretion to release QA records except as specifically provided for in the statute.

The court's decision provides guidance on how § 1102 should be interpreted. The court extensively cited the language of the statute and insisted that the plain language of the statute be given meaning. The court's reliance on the clear and specific language of the statute was central to its rejection of plaintiff's argument that § 1102 allowed for waiver. The court, after looking to the ambiguous prohibition on the disclosure of QA records contained in subsections (a) and (b) and the detailed list of exceptions in section (c), noted that waiver was not one of the exceptions Congress enacted as part of the statute. Because Congress clearly prohibited disclosure and specifically listed permissible disclosure of which waiver was not one, the court concluded that Congress did not intend for waiver to apply under § 1102.

As a matter of statutory interpretation, the court's decision emphasized that the specific and clear language of the statute was the starting point and key to understanding congressional intent underlying § 1102. The court insisted that the plain language of § 1102 be applied to resolve the issue of congressional intent. Legislative history was consulted only to reinforce the plain meaning of the statutory language.

The court's decision is important because of its treatment of the concept of waiver under § 1102. The court rejected plaintiff's attempt to equate § 1102 to a privilege subject to waiver. The court emphasized that the general rule that failure to object waived objections had no applicability to § 1102.

Arising from the court's insistence that plain meaning be given effect, the court noted that none of the § 1102 exceptions even arguably applies to a Federal Tort Claims Act (FTCA) case. In doing so, the court recognized the congressional intent that QA records should never be admitted in any FTCA action. The FTCA action should proceed as if a QA review had never occurred, since § 1102 embodies a statutory prohibition barring disclosure and use of QA records in litigation.

Other courts have followed *In re United States* and interpreted § 1102 as a statutory bar precluding waiver or use in litigation. *See, e.g., Smith ex rel. Smith v. United States*, 193 F.R.D. 201, 205 (D. Del. 2000) ("The court finds that the government is correct in its assessment of 10 U.S.C. 1102, as precluding waiver of the Q.A. privilege."); *Cole v. McNaughton*, 742 F. Supp. 587, 590 (W.D. Ok. 1990) (inadvertent disclosure of medical QA records placed in doctor's public-record file "does not constitute waiver of the confidential and privileged nature of these documents"); *Maynard v. United States*, 133 F.R.D. 107, 108 (D.N.J. 1990) (agreeing "with the reasoning in *In re United States*[]").

As the courts have recognized, § 1102, by its terms, broadly prohibits disclosure. *See, e.g., In re United States*, 864 F.2d at 1153; *Smith*, 193 F.R.D. at 205; *Cole*, 742 F. Supp. at 587; *Maynard*, 133 F.R.D. at 108. Subsection (a) prohibits disclosure of QA records to any person or entity except as provided by the statute. Subsection (b)(1) precludes use of QA records in litigation except as Congress has expressly provided for in the statute. Subsection (e) prohibits a person having possession or access to QA records from disclosing the contents of those records in any manner except as provided by the statute.

Case law demonstrates that government representatives have no authority to waive confidentiality under § 1102. *In re United States*, 864 F.2d at 1153; *accord, Franco v. Dist. Court In and For City and County of Denver*, 641 P.2d 922, 931 (Colo. 1982) (construing Colorado peer review statute: committee members had no authority to waive peer review privilege; prior disclosures were without effect). The implicit assumption underlying waiver arguments is that the government records custodian had an option of disclosing medical QA records. Waiver exists only where there is a choice between two legal courses of action. When there is no choice between courses of action, there can be no waiver. Just as the government attorney in *In re United States* had no discretion to release QA records, other government officials have no authority to release QA records.

Government attorneys in FTCA litigation involving DOD medical care facilities must recognize §1102 as a statutory prohibition barring disclosure or use in litigation and not as a privilege subject to waiver. The § 1102 prohibition against disclosure is analogous to state statutes that have been interpreted as placing an absolute embargo on discovery or use of QA records. *See Emory Clinic v. Houston*, 258 Ga.

434, 369 S.E.2d 913 (Ga. 1988) (construing the Georgia peer review statute); *see also Kappas v. Chestnut Lodge, Inc.*, 709 F.2d 878, 880 (4th Cir. 1983) (construing Maryland peer review statute; rejecting waiver argument without discussion, where peer review committee members disclosed confidential material). As a statutory prohibition barring disclosure or use in litigation, § 1102 is not subject to waiver.

B. Defining "quality assurance records"

Faced with § 1102's clear prohibition against disclosure, plaintiffs have focused their efforts in obtaining QA records on the definition of "quality assurance records." Plaintiffs recognize that if a court finds that the record is a QA record, then disclosure can only be made pursuant to the express exception contained within the statute. The best way of avoiding the clear prohibition against disclosure is to attack the characterization of the record and keep it outside of the protection of § 1102.

Section 1102 defines "quality assurance records" as the "proceedings, records, minutes, and reports that emanate from quality assurance program activities . . . and [that] are produced or compiled by the Department of Defense as part of a medical quality assurance program." 10 U.S.C. § 1102(j)(2). "Medical quality assurance program" is defined as "any activity carried out before, on, or after 'the date of enactment' by or for the Department of Defense to access the quality of medical care . . . ." *Id.* Courts have given the statutory definition of QA record a broad reading consistent with congressional intent. *See, e.g., Cole*, 742 F. Supp. at 590 ("The statutory protection afforded by Title 10, section 1102 . . . applies to all records created before, on, or after the date of enactment, November 14, 1986.")

The term "medical quality assurance" does not include information in a record created and maintained outside a medical QA program, such as a patient's medical records, merely because it was presented during a QA meeting. 10 U.S.C. § 1102(e); *see also* S. Rep. No. 331 (1986). Section 1102 prohibits any person who reviews or participates in QA activities from testifying about QA records or any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records, except as provided in specified exceptions. 10 U.S.C. § 1102(b)(2).

In *Coffey v. United States*, No. S86-1104(G) (S.D. Miss. Apr. 1, 1987) (unpublished), plaintiff asserted that an Air Force Inspector General investigation into the quality of medical care in a particular department of a medical center was not protected by § 1102. Plaintiff also alleged that § 1102 did not protect the identity of participants in the investigation, descriptions of each participant's involvement, the identities of persons interviewed during the investigation, and the findings and conclusions of the investigation. The court rejected plaintiff's narrow construction of § 1102 and held that the Inspector General's investigation into the quality of medical, as well as the other information sought, was protected by § 1102.

The court's opinion recognized the importance of affording broad protection to the peer review process. The peer review process is more than the opinions and recommendations that emanate from a QA committee. The peer review process also includes reviews that are conducted by an inspector general for the purpose of assessing the quality of medical care. The court's decision also recognized that the identity of peer review participants, the extent of their involvement, and the scope of the QA investigation reflect aspects of the peer review process and are entitled to protection.

The definition of "quality assurance records" is broad and includes, as stated above, the "proceedings, records, minutes, and report that emanate from a quality assurance activity." In *Spitzer v. United States*, No. CV 107-72 (S.D. Ga. Dec. 16, 1987) (unpublished), the court dealt with the issue of whether a doctor's written statement to a credentials committee was protected by § 1102. The plaintiff argued that subsection (j)(2) definition of "quality assurance record" only protected information that "emanates from quality assurance committee activities." Under the plaintiff's theory, the doctor's letter to the credential committee was not protected because it was provided to the committee and did not emanate from the committee.

The court rejected the plaintiff's narrow construction of the definition of QA records and held that the letter from the doctor to the credential committee "emanated from" the committee's activities in so far as it was "compiled by the Department of Defense as part of a medical quality assurance program." *Id.* The court recognized that § 1102 protects a broad range of activities that are part of peer review process. Gathering information is an important aspect of any peer review process since the effectiveness of any

peer review activity is directly related to the quality of information provided to the peer review committee.

C. Establishing the confidentiality of quality assurance records

The burden is on the United States to establish the protected status of QA records. To establish the documents as QA records, a declaration should be obtained from an agency official responsible for the QA program. *Goodrich v. Department of Air Force*, 404 F. Supp.2d 48, 51 n.4 (D.D.C. 2005) (rejecting *in camera* review because "Defendant's affidavits sufficiently describe the records sought by Mr. Goodrich, and the Court finds that an *in camera* review is unnecessary."). The declaration should describe the agency's QA program and explain the rationale for QA in terms of improving the quality of health care, the importance of the QA activity in promoting peer review, and how confidentiality enhances full and candid discussions among health care professionals. The declaration should also describe the documents, without disclosing their contents, to demonstrate how the statutory and regulatory terms apply to the documents.

A properly prepared declaration by an agency QA official can often preclude unnecessary litigation. For example, in *Roy v. United States*, No. 88-1376 (D.D.C. June 23, 1989), the plaintiff requested copies of risk management and QA investigations into the quality of medical care provided to plaintiff. The Army opposed release of QA records and provided an affidavit by the Quality Assurance/Risk Management Coordinator listing the documents. The court, relying on the Fifth Circuit Court of Appeals decision in *In re United States*, held that documents generated in the course of the medical peer review process in a military hospital were protected by § 1102. The court looked only to the affidavit of the Quality Assurance/Risk Management Coordinator and found that the plaintiff's request included "documents that Congress has specifically and clearly determined are privileged from disclosure." *Id.* Similarly, the value of a properly prepared agency declaration was demonstrated in *Maynard*, where the court held:

> The documents sought by third[ ]party defendant KMH, have been classified by COL. William Miller, Quality Assurance and Risk Management Officer for Walson Army . . . Hospital, as medical quality assurance reports. The plaintiff has provided no basis to question the classification. Since none of the exceptions to subsection (c) of 10 U.S.C. 1102 apply to the FTCA case, these privileged and confidential records will be protected from disclosure.

Maynard, 133 F.R.D. at 108.

Section 1102, in contrast to the VA QA statute, allows, but does not require, implementing regulations defining "medical quality assurance activities." A variety of reasons exist for extending broader protection to the DOD peer review process than to the VA peer review process. The DOD peer review system must function at locations throughout the world under varying conditions, including deployment. The broad statutory definition of QA records underscores the importance of the agency declaration in defining what is a QA record. Specifically, an agency's interpretation of § 1102 should be given substantial weight since § 1102 is designed to protect the DOD peer review process and military physicians and health care professionals are entrusted with administering the DOD peer review systems. *See Chevron U.S.A. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984) (saying that "considerable weight should be accorded to an [agency's] construction of a statutory scheme it is entrusted to administer").

III. Conclusion

Government attorneys handling medical malpractice litigation arising from DOD health care facilities must recognize that § 1102 is a statutory prohibition barring disclosure in litigation and take the necessary steps to protect DOD QA records from disclosure. Early identification of documents as QA records is critical. Early engagement with agency QA officials will ensure that the proper evidentiary foundation is presented to the court through agency declarations. Because of the nature of the congressional mandate embodied in § 1102, government attorneys have a special responsibility to protect QA records. When they

do so, they establish the conditions to allow military medical professionals to improve health care in DOD medical facilities through peer review as part of the DOD QA program.❖

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I'm Sorry, So Sorry: Litigation and the VA Policy of Admitting Adverse Events to Patients

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I. Introduction

A January 18, 2008 Directive by the Department of Veterans Hospitals (VA) requires the disclosure of "adverse events" to patients. Veteran's Health Administration (VHA) Directive 2008-002. This includes cases where the adverse event "may not be obvious or severe, or where the harm may only be evident in the future." What is an "adverse event?" The directive defines it as "untoward incidents, therapeutic misadventures, iatrogenic injuries [injuries caused by a physician], or other adverse occurrences directly associated with the care provided" by the VA. This requirement of disclosing these events to the patient has obvious (and not so obvious) implications for subsequent litigation that may ensue. This article will discuss the early efforts at developing such a policy at the Lexington, Kentucky, VA Medical Center, the impact of such disclosures on the overall cost to the system, and its impact on subsequent litigation that may be filed under the Federal Tort Claims Act (FTCA).

This new directive is separate and distinct from the long-standing requirement within the VA to report adverse events (and close calls) to quality management and safety activities. VHA Handbook 1050.01. These actions are generally classified as quality assurance measures. The reporting and investigation of such reports has been exempt from discovery as peer review materials. *See generally* FED. R. EVID. 501. Obviously, the VA's policy of disclosures to the *patient* will not enjoy such protection, and the Assistant U.S. Attorney assigned to defend the VA will have to deal with the impact of those disclosures in the defense of the case.

This VA's policy is consistent with a Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission) policy in effect since 2001 that provides that "[p]atients and, when appropriate, their families are informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes." Standard RI 2.90. Thus, the challenge facing U.S. Attorneys in dealing with these disclosures is one shared with the private bar that will be defending private hospitals, doctors, and nurses who may have made disclosures to patients consistent with the Joint Commission policy.

II. The experience at VAMC Lexington

Long before the Department of Veterans Affairs instituted their national policy of full disclosure of adverse events to patients, the VA Medical Center in Lexington, Kentucky, was leading the way in reforming the way it dealt with medical errors and patients. This came about by necessity.

In 1987, after receiving adverse court verdicts in two medical malpractice cases, resulting in $1.5 million in awards, the leadership of the Lexington VA realized that something had to be done. The cases resulting in the $1.5 million loss had been poorly handled from the time of the patients' injuries forward, and this placed the government in a disadvantage with the trial court. The issue of whether proper medical care was provided became overshadowed by whether the VA had acted in a forthright manner thereafter. In bench trials, the trial judge is privy to far more information than the trier of fact would be in a jury trial. The result is that when evidence is produced at a bench trial, the trial judge considers that evidence through a lens ground through countless pretrial motions, each detailing conduct of one party or another (or their counsel). Although this pretrial information, of which the court is fully aware, may not be the basis of an ultimate judgment, it no doubt skews the court one way or the other in considering the evidence properly admitted at trial.

Partially in response to these losses, the VAMC Lexington began a transformation in the way it approached adverse outcomes with patient care. At the time, corporate America was embracing the concept of "risk management" — internal offices and groups designed to deal with corporate conduct that exposed the corporation to potential legal liability. Their purpose was, where possible, to change the way the corporation acted to avoid potential liability and, when litigation was threatened, to coordinate the corporation's response so as to avoid or minimize financial exposure. VAMC Lexington, through its chief of staff, worked with District Counsel in Louisville to establish a "risk management committee," headed by the chief of staff. Medical staff were directed that any untoward outcome in patient care was to be referred to the committee for investigation, and, after a thorough review of the record, the committee would recommend the appropriate course of conduct for the VA as to that potential claim. This process did not replace the long standing "quality assurance" program within the hospital

Previously, legal counsel for Lexington was provided by then District Counsel in Louisville. New counsel was hired to be "out stationed" at Lexington, and a part of her duties was to serve on the risk management committee to review troublesome cases and shepherd those cases to a resolution. The work of the committee commenced. It reviewed cases and made recommendations.

In 1990, the committee was faced with a case where a patient was admitted emergently. The patient was provided the wrong medication and subsequently died. Although the patient was chronically ill, there was little doubt that the error with her medication caused her death. There was just one thing: the family of the patient did not know. The committee decided that it had to remain in the role of caregiver and contact the family. Thus began a policy of disclosure of previously unknown errors to patients or their families that continues to this day. In 1995, the policy expanded system wide when it was included in the VA policy manual, in a section called "Patient Safety," where it provided that in the event patients are injured by accident or negligence:

> the medical center will inform the patient and/or the family, as appropriate, of the event, assure them that medical measures have been implemented, and that additional steps are being taken to minimize disability, death, inconvenience, or financial loss to the patient or family.

The policy also directed that VA counsel advise the medical center director about informing the patient and/or family of their right to file an Application for Compensation and Pension or an administrative tort claim. The policy was further clarified in 2008 by way of VHA Directive 2008-002, referenced above, to require the disclosure of "adverse events" to the patient and/or family.

III. Full disclosure has lowered the total paid for torts

In a 1999 article entitled *Risk Management: Extreme Honesty May be the Best Policy,* in the ANNALS OF INTERNAL MEDICINE, Vol. 131:12, 963-67 (Dec. 21, 1999), VAMC Lexington Chief of Staff, Steve Kraman and VA Staff Attorney Ginny Hamm described the change in the culture at VAMC Lexington and made the case for this "humanistic risk management policy." Did the VAMC Lexington's

policy of full disclosure lead to an increase in the number of claims filed or the amount of money paid on FTCA claims or judgments? Kraman and Hamm note that for the period of 1990 through 1996, VAMC Lexington had 88 malpractice claims. It paid out $190,113 per year for a total of $1,330,790 for the 7 year period. Of the 88 claims, 7 proceeded to federal court and were dismissed on motion prior to trial. One case went to trial and judgment was entered in favor of the VA. Recall that $1.5 million was paid out in judgments in 1987 alone in two cases—more than would be paid out for all *claims* for the entire period of 1990 through 1996.

Moreover, Kraman and Hamm compared the VAMC Lexington with 35 other similarly situated VA facilities east of the Mississippi. In both the total number of claims filed and total payments throughout the period 1990 through 1996, VAMC Lexington ranked in the bottom quarter among those institutions. VAMC Lexington's average settlements were approximately $15,000 per claim, compared with more than $98,000 at other VA institutions. Hillary Rodham Clinton and Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, N. ENGL. J. MED., vol. 354:21, 2205, 2207-08 (2006).

If VAMC Lexington is acknowledging errors to patients (some of whom did not know that an error had occurred), then why was there not a significant increase in claims or payments? Kraman and Hamm conclude:

> We believe this is due in part to the fact that the facility honestly notifies patients of substandard care and offers timely, comprehensive help in filing claims; this diminishes the anger and desire for revenge that often motivate patients' litigation. In our experience, plaintiffs' attorneys, after first confirming the accuracy of the clinical information volunteered by the facility, are willing to negotiate a settlement on the basis of calculable monetary losses rather than on a potential for large judgments that contain a punitive element. This can benefit a facility by limiting settlement costs to reasonable amounts. It also fairly compensates patients who have been injured because of accident or error. This is important because such compensation is deserved but is infrequently offered.

Steve Kraman and Ginny Hamm, *supra* 966.

IV. The U.S. Attorney's experience in defending VAMC Lexington in court

Our office defended VAMC Lexington in the two cases in 1987 that resulted in large judgments, and has continued to represent the agency over the nearly 20 years that it has had in place its "humanistic risk management policy." Overall, it has been a very positive experience. Cases with a serious risk of exposure are typically settled administratively.

The Staff Attorney at VAMC Lexington also serves as a Special Assistant U.S. Attorney. She routinely calls the Civil Chief to discuss pending administrative claims to obtain a second opinion as to how defensible the case would be before the federal courts of our district. They also discuss settlement options. As a result of this level of cooperation, the U.S. Attorney's Office is never caught off guard by a new tort suit. As a SAUSA, the VA attorney also continues in the defense of the case once it is filed in federal court. Although an AUSA will take the lead, the SAUSA appears as co-counsel and will handle some of the discovery depositions, attend hearings and settlement conferences, question witnesses, and argue at trial. This keeps the agency fully informed of the status of litigation, including the strengths and weaknesses that a case reflects as it progresses through discovery. It also speeds the availability of witnesses, as VA counsel can readily gain access for the AUSA when needed.

Having the VA counsel remain engaged in a claim after it goes to litigation also helps to keep the VA "invested" in the claim. That is, through the VA counsel, the agency will continue to be consistently involved in the claim and have agency resources devoted to the defense of that claim. All too frequently, USAOs are served with process in tort claims with no prior interaction from the client agency. Once served, the USAO notifies the agency, which may send a litigation report but beyond that provides little assistance. The agency is passive. Any judgment paid will not affect the agency. Such is not the case with our VAMC Lexington cases. This is probably a key as to why full disclosure has worked so effectively here: medical center personnel investigate care, acknowledge deficiencies to the patient, and attempt to resolve any claim. If the claim goes to litigation, it does not magically go away, but rather the medical

center's personnel continue with the claim until it is resolved in the judicial arena. This allows the institution to mature and learn from its own mistakes.

The majority of the FTCA cases that actually are filed in court are ones where the local risk management committee found no deviation from the standard of care and the VA refused to offer anything to settle the case administratively. The great majority of these cases are resolved by motion practice. In the past decade, only one case that went to trial resulted in a judgment against the United States. In these cases where the risk management committee has found that no error was made that impacted the patient, the VA's policy of full disclosure has no impact on how we, as defense attorneys, handle our cases. The client denies liability and we proceed accordingly.

There are two situations where the policy does create a hurdle in our defense of the VA. The first is a situation where the care of the patient has been reviewed by the local risk management committee and the patient and/or family have been notified, all in compliance with the hospital's policy. When VA counsel attempts to settle the subsequently filed administrative claim, the patient's (and typically counsel's by that point) demand is far too high. Although experience shows that honestly approaching a patient with a full disclosure of some mistake that was made in the course of their medical care will result in a reasoned response and settlement, that does not work with some patients, or more typically, a patient's family. They see the admission of a mistake as the doorway to big money.

In these situations, we have found that the defending AUSA just has to be persistent. We always hire independent experts to review the medical records, regardless of what the risk management committee has concluded. An independent eye often finds evidence undervalued by the committee and upon which a defense can be mounted. Additionally, the risk management committee does not consider the state legal standard as to whether a cause of action for medical malpractice can be established—a deviation from the standard of care that has caused damage to the patient—but only whether an "adverse event" has occurred. Finally, there are many legal defenses peculiar to the FTCA that may be raised pre-motion that will prevent a claimant from going forward with a suit, regardless of any admission by VA personnel. If the plaintiff's claim survives then, at mediation with the Magistrate or private mediator, our consistent efforts to offer a reasonable resolution of the claim are well received by the neutral, who typically is able to convince the plaintiffs to compromise their claims and take a lesser sum in settlement.

The second situation wherein the policy causes problems in the USAO's defense is created by improper implementation by one or more medical care providers at VAMC Lexington. VHA Directive 2008-002 requires communication to the patient and/or family about an adverse event by a clinical team member and should contain "preliminary factual information to the extent it is known, express[] concern for the patient's welfare, and reassure[] the patient or personal representative that steps are being taken to investigate the situation, remedy any injury, and prevent further harm." However, sometimes the clinical team member goes further and opines on medical/legal issues and states to the patient that he has been injured as a result of a medical mistake. They may encourage the patient to bring a claim. Such statements by the clinician are not anticipated by the policy. The policy provides a framework for the clinician to refer these incidents to the Risk Manager or Patient Safety Officer for further investigation. Only after adequate investigation will the institutional leaders (Chief of Staff, Nurse Executive, etc.), in consultation with Regional Counsel, meet with the patient and/or family and make the appropriate disclosures.

Nonetheless, the defending AUSA will have to deal with the statements the clinician made to the patient, regardless of how unauthorized those statements were. The AUSA will be in a position of having to impeach his own witness (perhaps the treating physician he is trying to defend). However, this is just a variation of a commonly encountered problem within an institution as large as a VA medical center—a clinician in one service "trashing" the care the patient received in another service. For example, a primary care physician may tell the patient that radiology incorrectly read a film. These are improper statements for a clinician to make, and the VA's policy requiring disclosure does not endorse the making of such statements. In fact, the policy provides a mechanism for the proper investigation and subsequent disclosure of confirmed adverse events.

V. Admitting liability

Within the Department of Justice, an AUSA handling the defense of a tort case who would like to stipulate to liability must first obtain the approval from the settlement authority—that official who may authorize a settlement based on the total exposure in the case. The U.S. Attorney may settle cases for up to $1 million dollars. Beyond that, the approval of the Deputy Attorney General is required. 28 C.F.R. § 0.168 (2009). Such a stipulation is rare indeed and nothing in the VA policy on the disclosure of adverse events requires such a stipulation. The policy requires the institutional leadership, after a full investigation, to inform the patient or family of an "adverse event" and to apologize with a complete explanation of the facts. In contrast, a "stipulation of liability" is an acknowledgment by counsel that the opposing party need not put on proof on the issue of liability, leaving only the issue of damages for the trier of fact.

Given, apologies and explanations of how adverse outcomes occurred are something that no defense counsel wants to deal with. Obviously, in cases where the agency has apologized and explained an adverse event in the course of a veteran's medical care, "winning" a subsequent trial is highly unlikely. Appropriately compensating the veteran for his or her injury can be the only goal.

VI. Conclusion

Contrary to the natural instincts of any good defense attorney, the use of open disclosure of medical mistakes has been a great thing for VAMC Lexington. Patients have greater confidence in their caregivers because they know that their providers will be honest with them if mistakes are made. The providers know that not only are they allowed to report an adverse event, they are expected to do so. Claims are processed much faster. Fewer cases go to litigation, and overall costs to the system are reduced.

Many times in the course of mediation (when, admittedly, discussions are privileged) the author has followed the VA's lead, looked the plaintiff in the eye and told them how sorry we are that they were injured, explained how it happened, what was done to insure that it did not happen again, and expressed to them our desire to resolve the case through a reasonable settlement. Invariably that helps work through the disdain plaintiffs deal with as lengthy administrative tort claims become lengthy court proceedings. Twenty years of experience at VAMC Lexington demonstrates that doing that as early as you can, rather than later when the realities of discovery force you to, not only is the right thing to do, but also benefits your client agency.❖

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