When To Consult a Forensic Expert *and* **Malpractice & Being Sued for It – PART 2**

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Malpractice and Being Sued for it

Have I mentioned that ***I'm not a lawyer***, and none of this should be construed as "legal advice"? In fact, although I describe my understanding of some legal concepts and won't knowingly mislead you, don't rely "legally" on anything I say!

Being sued is a crappy process, whether you win or lose. (*Do* rely on that.)

"Malpractice" is a civil matter (a civil "tort"), not a criminal one. You do not go to jail for malpractice in the U.S. If you lose, everything is resolved with money. On the other hand, all adverse malpractice verdicts—*and settlements "out of court"* (but not cases that are dismissed by a court)—are reported to the National Practitioner Data Bank and the Texas Medical Board, and usually must be reported when applying for or renewing clinical licenses and hospital privileges.

Most malpractice cases are governed by state law. The states all have similar statutes and definitions regarding malpractice itself, although rules about statutes of limitations, thresholds for filing, litigation procedures, and limits on damages vary. Some, such as those involving federal hospitals or other federal institutions, or acts occurring on/in federal reservations such as military bases, federal prisons, VA facilities or embassies, are filed in federal court.

Have adequate malpractice coverage. *Do not* "go bare," even in a defendant-friendly state such as Texas.[1] Be sure any "claims-made"[2] malpractice policy has a sufficient "tail" to cover the statute of limitations. (I do not recommend "claims-made" policies, especially if you work with minors.)

Note that employed physicians are usually covered by their employers' policies, *but you should determine for yourself whether or not you believe that coverage is adequate*. Common circumstances in which you may *not* be covered include "moonlighting," otherwise practicing outside your employment/training setting, and performing acts that aren't covered by your malpractice insurance policy (such as committing fraud or other criminal acts, or having sex with your patients—a criminal act in Texas). In addition, some clinical acts considered "discretionary" by an employer may not be covered by an employer's policy. If in doubt about the adequacy of an employer's coverage for you, consider an additional policy that kicks in only if the employer's is insufficient; they're fairly inexpensive (but note that you still will not be covered for non-malpractice acts such as fraud or sex with patients).

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[1] Texas law exempts or restricts many kinds of assets from being awarded to malpractice plaintiffs, including one's primary residence, primary automobile, and some other items. *Consult a lawyer before you rely on this in financial or legal decisions.*

[2] "Claims-made" policies cover only events which occur during the active policy period AND *for which a claim is made during the active policy period* (or within a "tail" allowed by the policy contract). Claims-made policies are inferior to (and should be cheaper than) "occurrence" policies, in which any eligible event that takes place while the policy is in force is covered *regardless of whether or not the policy is still in force when the claim is made*.

Have a malpractice-experienced lawyer. If you are sued, your lawyer will probably be one retained by your malpractice carrier on your behalf and experienced in malpractice litigation. Although that attorney is officially "your" lawyer, it's occasionally a good idea to have a personal lawyer (at your expense) monitor the malpractice lawyer's work, especially if the latter (or your insurance carrier) also represents other defendants in the same case.

Have a thick skin. Lawsuit filings and procedures can sound pretty nasty. Much of that is posturing; try not to take it personally.

What Events Give Rise to Malpractice Lawsuits?

In psychiatry, the most common answer is simple: *Suicides*. The great majority of psychiatric malpractice cases involve alleged wrongful death by suicide. Relative few involve suicide attempts without death, death during seclusion or restraint, and violence toward others (including injury from other patients). Even fewer lawsuits are filed based on allegations of negligent prescribing, side- or adverse effects of medications (including tardive dyskinesia & metabolic syndrome), ECT, unwarranted seclusion or restraint, breach of confidentiality/privilege, or wrongful commitment.

The point of the above is to highlight the fact that although issues of confidentiality, medication consent, adverse drug effects, restraint, etc., are clinically and forensically important, *their numbers pale in the face of suicide when it comes to a psychiatrist's risk of being sued*.

Psychiatrists are sued less often, on average, than most other specialists. Nevertheless, it is not at all unusual for a psychiatrist to be sued once or twice during a career.

In my experience, 90-95% of malpractice cases actually filed against psychiatrists are, one way or another, resolved without a trial. Statistics for all physicians (not just psychiatrists) indicate that about half of all pre-trial settlements are under $50,000. (Note that psychiatric cases very often involve the death of a patient, making that an underestimate for psychiatrists.) Most cases against physicians that eventually go to trial are decided in favor of the physician.

The Standard of Care

Malpractice lawsuits hinge on four things (see The Elements of Malpractice, below). The first two are related to whether or not the defendant clinician and/or facility (hospital, clinic, jail) followed the applicable "standard of care" (SOC). If you can show that you met the SOC (or if the plaintiff—the person who's suing you—can't show that you "more likely than not" fell below the standard), the malpractice lawsuit goes away.

The SOC is usually defined by state statute[3] as something like "that care expected to be rendered by reasonable physicians of like specialty in a similar situation." *This is a formal, legal definition*. Do not confuse legal terms like "standard of care" and "malpractice" with what you may hear in informal conversations with colleagues or at cocktail parties. (Do people still have those?)

[3] Most malpractice cases are heard in state courts. Those that involve federal facilities, such as the VA, military bases or federal prisons, or civil rights, are heard in federal courts.

Note: This definition does not mean that a large group of docs who practice poor care can define their own standard. For example, lots of psychiatrists prescribe, and hospitals use, q15-minute monitoring for high suicide risk, but that is almost always below the SOC.

- The SOC is an *adequacy* standard, not one of "excellence." A doctor or hospital does not have to give exemplary care unless he/she/it represents to the patient that the care given will be exemplary. (Be careful about advertising "the best therapy in town.")

- The SOC generally *is not* defined by such things as "practice guidelines," hospital policies & procedures, and textbooks.[4] Those may be *consistent with* the SOC, or represent *examples* of it, but they do not generally define it. (However, they may influence jury decisions about whether or not the SOC has been met.)

- Phrases such as "best practices" "evidence-based" do not describe a standard of care (though they may create a patient expectation if a hospital or clinician advertises that it always uses best practices or evidence-based treatment).

- The SOC is not usually geographic. In most jurisdictions (not all), *patients in small-town hospitals are entitled to the same level of adequate care as those in a university medical center*. Private hospitals, state hospitals, university hospitals, etc., all must meet the same SOC for a particular situation, assuming all are licensed in the same way. Short of institutional permits and licensing board restrictions, all physicians have the same license to practice medicine regardless of location or specialty. *We are not licensed separately for "small-town medicine" vs. "medical center medicine," or for psychiatry vs. primary care or neurosurgery*.

- The SOC for specialty practices and procedures is not generally tied to the practitioner or facility, but *to the situation or procedure itself*. It is very important to understand that (absent an emergency) heart-lung transplants performed in East Podunk General Hospital must meet the same adequacy standard as those performed in a university medical center. Similarly, *non-psychiatric physicians who choose to diagnose and treat depression (for example) must, generally speaking, meet the same diagnosis, treatment, and risk management standards as fully-trained psychiatrists.* Similarly, *psychiatrists who choose to treat their patients' diabetes must meet the same diabetes standards as primary care physicians*.

  The point is that *the patient is entitled to trust the physician's implied representation that he or she can diagnose and treat the condition with appropriate competence and safety*. Exception is usually made when it is unreasonable to immediately refer to a specialist (such as in emergencies or when specialty care is truly inaccessible); however, explanations such as "it was too much trouble to refer the patient for specialty care 40 miles away" or "the patient was more comfortable having me be both internist and psychiatrist" are likely to fail if put to an SOC test (e.g., in a malpractice lawsuit).

[4] Facilities and organizations that publish guidelines, procedures, and protocols should be careful to avoid describing them as "standards" or "standards of care." Terms such as "guideline," "expected procedure," or "best practice" are less confusing, and more accurate, if legal issues arise.

The Elements of Malpractice

If you are sued for malpractice, *all* of the following must be *proved* (see below) by the plaintiff:

- That you had a *duty* to the patient or other litigant.
  "Duty" often (but not always) translates to whether or not a doctor-patient relationship existed.

- That you *breached* that duty.
  Breach of duty means that your care *negligently* (see below) fell below the accepted SOC (see above). That's different from a simple accident or making a reasonable, but unsuccessful, clinical judgment after adequate consideration of the alternatives.

- That the patient or other litigant was *damaged*.
  In practice, the damage must be significant enough to justify substantial compensation and the trouble of a lawsuit (which also means substantial compensation to the plaintiff's lawyer).

- That your breach of duty *caused* that damage.
  Your breach of duty may or may not have to be the *main* thing (or the *only* thing) that caused the damage. In some cases, and some jurisdictions, even a small portion of causation is enough to give rise to a substantial—or even entire—damage award. *"Causation" is usually the hardest of the four elements for the plaintiff to prove*.

These elements are sometimes remembered, out of order, as "the four Ds": **D**ereliction of **D**uty **D**irectly causing **D**amage.

What does "proved" mean? The *burden of proof* that the plaintiff must meet to be successful in malpractice cases is a "preponderance of the evidence." (Note that the defendant doesn't have to prove anything; the burden is on the plaintiff.) "Preponderance" means anything more than half (50+ percent certain, "more likely than not"). The plaintiff must prove *each and every one* of the above elements of malpractice to just over 50% certainty (enough to tip the scales of justice, so to speak). That's a low threshold compared to the burden of proof in criminal matters ("beyond reasonable doubt").

"Reasonable medical certainty" is the level of certainty required for expert witness opinions (sometimes called reasonable psychiatric certainty or reasonable medical probability). *That phrase is almost always defined simply as "more likely than not."* It is important to understand that, in most jurisdictions, the "certainty" has little to do with absolute certainty. Further, the legal concept of reasonable medical certainty is specifically *not* the level of clinical certainty needed to make a diagnosis, decide on a treatment, advise a patient, or anything similar.

Malpractice, by definition, involves the legal concept of "s*imple negligence*." Simple negligence (as applied in malpractice cases) refers to a defendant clinician or health care facility negligently (not merely accidentally) failing to meet the SOC. The case may not be "simple," but the level of negligence need not rise to what the law calls "gross negligence" (see below).

Depending on the state or federal jurisdiction in which the case is filed, finding only simple negligence in malpractice may limit payment for damages (the plaintiff's compensation) to some statutory "cap" above the actual costs related to the breach of duty (such as medical costs or lost wages). There are such caps in Texas, which are designed to decrease inappropriately large judgments and discourage frivolous malpractice lawsuits. (Unfortunately, they sometimes discourage *deserving* lawsuits.)

"Gross negligence" goes beyond simple negligence, and offers a way for plaintiffs to cite more serious negligence and increase damage awards far beyond those implied by simple negligence or limited by compensation caps. It refers to things the law calls "reckless indifference," "wanton acts" or something similar. Lawyers may allege gross negligence as a way to get around compensation caps (e.g., to seek "punitive damages") or as a way to pressure the defendant into settling out of court (sometimes even before suit is filed), but it is usually difficult to prove.

Advice for Avoiding Malpractice Lawsuits, or Helping if You Are Sued

Practice well. Lawyers are rarely interested in suing—and juries are rarely interested in punishing—doctors who have documented that they practice well. Physicians who practice, or appear to practice, in a slipshod or uncaring manner are much more vulnerable to being sued (and being sued successfully). "Practicing well" often translates to things like good patient relationships, spending plenty of time with patients, limiting delegation of important care (e.g., to physician extenders, regardless of their licensed privileges), communication with & corroboration from family members (e.g., about suicide risk factors and other symptoms), appropriately complete exams (that don't skip over important topics), and excellent *narrative* documentation of the above (not just short notes, cryptic acronyms, and checklists).

Scrupulously document your patient care, especially your thought and judgment processes. Legible narrative descriptions of your assessments, findings, orders, and judgment process are far better for your defense than checklists, short notes, and rote electronic record entries. When considering diagnoses, admission, treatments, patient monitoring or restriction, and discharge, *write a few sentences about the pros & cons of alternatives and explain your assessment and judgment process*. *"No SI/HI," and other quips that don't explain your judgment process are red flags* for malpractice lawyers and experts. Anyone who advises you with the old saying, "If you don't write it down, they can't hang you with it," is an idiot. (Feel free to quote me.)

Never rely solely on patient reassurances when assessing risk (especially suicide risk). Corroboration from relatives, referral sources, recent physicians and therapists, past medical/psychiatric records, appropriate testing, and good patient observation are extremely important to meeting the psychiatric SOC. If there is no adequate corroborating information, always err on the side of safety—and document same—until more and reliable information is available. (We'll revisit this in the seminar on suicide risk.)

You will rarely lose a malpractice suit because of an accident or simple mistake; you may lose because of a negligent mistake. If your procedures and judgment are reasonable and well documented, the other side will have trouble proving negligence.

Never try to hide things already documented in the record. There are legal, proper, non-destructive ways to amend the record or explain circumstances, both during the ordinary course of care and after an event. Anything else is illegal, unethical, and will very likely be discovered if a lawsuit is filed. That will be extremely embarrassing, and probably extremely expensive.

Listen to your lawyer. If you are sued, drop all pretense of arrogance or superiority from dealings with your lawyer. He or she has done this many, many times (if not, get another lawyer); you haven't.

Do not try to contact any patient or other person who is suing you or threatening to sue, or whose lawyer has contacted you about a malpractice matter. *Do not* discuss the matter with the patient, family, or other litigant, even if he or she starts the conversation. *Do not* speak with any lawyer who contacts you (except your own lawyer) about the patient or case; politely decline or refer the attorney to your lawyer or carrier *without making any comment about the case*. If the person is a current patient, figure out a safe and appropriate way to transfer the person's care to someone else. (Consult your healthcare lawyer or hospital risk manager about this.)

Note: I'm not suggesting that you avoid the patient or family in every case of bad outcome, when you don't have any indication of a future lawsuit or complaint. Some malpractice carriers and risk managers give recommendations about such things as attending a patient's funeral (often good), offering condolences (good) or counseling to the patient's family (*maybe* good), having the patient or family attend a conference about the bad outcome (*maybe* good), and/or continuing to treat the patient (usually good unless the patient has threatened to sue). It's often a delicate, individualized balance, to be human and sympathetic while trying not to say things that imply that you were negligent. Even if you believe you may have been negligent, and perhaps want to unburden yourself in some way, doing it with the patient or his/her family is often inappropriate and usually legally unwise. Is it sometimes good to apologize and be open about our foibles and mistakes? Of course. But I suggest getting competent, objective advice before choosing whether or how to do so, especially in the heat of a recent tragedy.

Notify your malpractice carrier preventively by telephone (I suggest you avoid a written notice) if you have been involved in a bad result (such as a suicide). The carrier may have suggestions for avoiding a lawsuit, and will appreciate the heads-up. Carriers do not, to my knowledge, raise premiums as a result of such notification.

Do not try to defend yourself or negotiate your own settlement.

Don't be arrogant, in either your clinical practice or your testimony. Juries generally like doctors, but they hate arrogant ones. I have found that if members of a jury want to render a particular verdict—for example because they simply want to reward a plaintiff, or like or dislike a defendant—they often look for reason to interpret the evidence accordingly. (If juries appear

too biased in the face of evidence to the contrary, judges can render a "verdict notwithstanding the jury," but this is extremely uncommon.)

Role of the Forensic Psychiatrist in Malpractice Suits

The forensic psychiatrist may be either an expert *consultant* to a plaintiff's or defendant's lawyer, or (more likely) an expert *witness*. The latter *may* testify expert for that attorney on behalf of the lawyer's client.[5] If you are sued, your lawyer will probably retain an expert witness. (An expert opinion is required before a plaintiff's lawyer can file a malpractice suit in Texas, though you may never see that opinion if the case settles early). The other side will hire an expert as well.

The expert is retained by, and is an agent of, the lawyer, and is expected to advocate articulately for his or her opinions. *He or she is not an agent of, nor an advocate for, the litigant.* That's the lawyer's job, and would damage the expert's credibility with the court. The expert will review records, depositions and other materials, and may interview litigants and other persons, do research, etc., in order to form "expert opinions." Those opinions are expected to be honest and objective. If the opinions support the lawyer's case, the lawyer is likely to ask the expert to articulate them in a report and/or testimony. If they *don't* support the lawyer's side of the case—which is fairly common—that lawyer may use them strategically (e.g., to assess the value of the case and the chances of winning), but the expert is unlikely to be asked to testify (or even to write a report).

Forensic experts may or may not participate in some aspect of case strategy (such as pointing out weaknesses in an opposing expert's opinions or discussing how a case is likely to be viewed by a jury); when they do, they are often only "consulting experts" rather than testifying ones (because such involvement is less than objective). In general, the expert focuses on things relevant to the elements of malpractice, and on expressing his or her opinions credibly and articulately.

Forensic work in lawsuits may or may not be considered "practicing medicine," depending on the context of that phrase (and some definitions are quite controversial). No doctor-patient relationship is ever formed, and litigants and other people interviewed are never considered the expert's "patients." They are referred to as "plaintiffs," "evaluees," "examinees," etc., as appropriate. States vary in whether or not out-of-state physicians retained for purely forensic purposes require a local license (i.e., in that state)when they are there simply to testify as a medical expert or perhaps to do a forensic or administrative evaluation (not one associated with clinical diagnosis or treatment). Texas may require experts licensed elsewhere to be "sponsored" by a Texas-licensed physician (a fairly simple process).

Forensic psychiatrists are bound by forensic practice standards and—assuming they belong to professional organizations with ethics guidelines—professional ethics. Those ethics sometimes overlap with clinical guidelines and ethics. The common demand to "do no harm" is irrelevant in this kind of forensic work, since the litigant is not the expert's patient; the expert's duty is one of honesty and objectivity for the court, and within that framework to do acceptable work for the retaining entity (usually a lawyer). There are some duties to the lawyer's client related to doing competent and complete work, but *there is no duty to advocate for the litigant or come to opinions that will benefit his case*.

[5] In the U.S., it is unusual for forensic experts in civil matters to be directly retained by some non-litigating third party or by the court itself. One exception is child custody and other advocacy matters, in which an expert may be retained by, or on behalf of, an attorney for a non-litigant child or other incapacitated individual.

What makes an expert an expert? In short, the judge's impression. Any person with sufficient knowledge and experience to educate the court on a specialized topic can be designated an expert by the judge. In court, no one is an expert until the judge rules that he/she is an expert, and a witness is not an "expert," no matter what his/her credentials, without such a ruling. Judges usually accept physician qualifications and designate them as experts so long as they have reasonable—not necessarily extraordinary—knowledge and experience that is relevant to the case at hand. The process of examining expert qualifications in open court is a form of *voir dire*.

What makes expert opinions valid? How do courts deal with junk science, irrelevant studies, and outright charlatans? Experts are required to establish the validity and reliability of their information and the sources of their opinions. The rules for doing that, such as citing legitimate studies, textbooks (sometimes called "learned treatises") or extensive and relevant clinical experience, are outlined in federal rules (for federal cases) and well-recognized appellate cases (known as "caselaw," often based on US or state Supreme Court decisions), that have established a guide for the lower courts. The most commonly cited are the cases of *Daubert v. Merrill Dow Pharmaceuticals* (the "*Daubert* Rules") and *Kumho Tire Co. v. Carmichael*, but Texas courts often rely on *Robinson* (*E.I. du Pont de Nemours and Co., Inc. v. Robinson*). Federal cases rely on something called Rule702 and Rule 403, parts of the Federal Rules of Evidence.

How are expert witnesses paid? *Ethical expert witnesses are paid for their time, not on any contingency basis* (see below). Payment that is in any way contingent on the outcome of a case is unethical for experts (but not for lawyers), and conflicts with our duty to be honest and objective for the court regardless of who is paying for our time. We bill by the hour or day, and some offer a flat rate for certain routine tasks (such as simple evaluations, but not for working in malpractice cases).

"Friend of the Court." There is a common misconception that some experts or other witnesses may testify as "friends of the court." That phrase means something quite different, and unrelated to the kinds of lawsuits we're discussing. (Look up the definition of *amicus curiae*.)

The Malpractice Litigation Process

One purpose of the law in litigation is to try to *keep the playing field level*, to make the process fair for both sides. The plaintiff has the burden of proving every element of the lawsuit (see above). In close calls or when a plaintiff's evidence doesn't reach a preponderance of the evidence ("more likely than not"), the verdict goes to the defendant.

Let's assume *you* are the defendant, and a patient or patient's relative has sued you for malpractice. The person(s) suing you is/are the *plaintiff(s)*. You are a (civil, not criminal) *defendant*.

- Pre-suit Process. The plaintiff's lawyer will carefully assess the legal merits of the case, including a thorough review of the medical records (often by an forensic expert; sometimes by a nurse), before proceeding. Such attorneys almost always work on a "contingency" basis (see How do the lawyers get paid?, below), and *it is expensive to sue*

for malpractice. Lawyers are reluctant to incur substantial costs (often $50-100,000 or more over the course of a case) unless there is a good chance that that they will be compensated in the end. Most pre-suit malpractice assessments result in no suit being filed.

During this pre-suit period, you may receive a call or other communication from the potential plaintiff's lawyer, either openly asking for notes or records (hospital records are gotten from the facility medical records department) or sneakily suggesting that he/she is just trying to solve a problem without filing suit.

Say nothing, and call your malpractice carrier (or training director if you are in training) immediately. In fact, it's a great idea to notify your carrier whenever you have an untoward event, such as a suicide, without waiting for a lawyer's call. They appreciate the notice, and it will not hurt your reputation with them.

- Statute of Limitations. In Texas, almost all malpractice lawsuits involving adults' care must be filed within two years of discovery of the *damage* (not discovery of the alleged breach of the SOC). Some circumstances create much longer statutes of limitations, such as when the patient is a minor. When that period is up, the statute of limitations is said to have "tolled."

- Pre-filing Hurdles. Many states, including Texas, require plaintiffs' lawyers to show a court that the potential malpractice lawsuit has at least some merit. In Texas, this process is complex, and includes having an independent plaintiff's expert review available records and perhaps do other things, then submit a carefully-detailed report (currently called a "Chapter 74 letter") outlining the alleged duties, breaches of duty, damages, and causation in the potential case. That report is separate from work and reports done after suit is filed. If the court is not convinced that the lawsuit has merit, it cannot be filed. Many potential malpractice cases end here.

- Filing. Once the case has been filed, you'll get some nasty-looking legal papers. Take them seriously, and immediately call your malpractice insurance carrier if you haven't already done so. Forward the papers to your lawyer or the carrier as they request (the papers may go straight to your lawyer). Don't do, or answer, *anything* without their approval. *Let your malpractice lawyer (not your family or business lawyer), hired by your insurance carrier, handle everything on your behalf.*

- Discovery. *Discovery* is a long (months or years) period during which the two sides—plaintiff and defense—exchange records and legal paperwork, take depositions (see below), and joust for position. *Do not* change anything in the record once suit has been noticed or filed (and *never dishonestly change the record in any event*; use proper medical record procedures). Discovery may also include court motions and hearings (such as for "summary judgment," usually a defense motion to make the whole thing go away). Resolution of the lawsuit, either by settlement or court dismissal, may occur at any time.

- Discovery Depositions. Discovery depositions are efforts by both sides to determine what facts and evidence the other side may bring to trial. Potential witnesses, who have

been named in advance as a requirement of the lawsuit process, are subpoenaed by the opposing side to testify about what they know (or, in the case of expert witnesses, what their opinions are). (There are no "surprise witnesses" in real cases; that's just on TV.)

There are two kinds of witnesses, whose roles are quite different: "Expert" and "fact." *Expert witnesses*, and only expert witnesses when the rules are followed scrupulously, are allowed to offer *professional opinions* in court. They are also allowed certain leeway in testifying, such as being allowed to rely on things other people have said ("hearsay," which is not otherwise considered reliable). They appear voluntarily and are usually paid for their time. I've already said that expert witnesses must be vetted by a qualifying process and then approved ("admitted") by the judge at trial (but not for depositions). Everyone else is a "fact" witness.

Fact witnesses are limited to testimony about what they *know* (that is, what they have experienced through their five senses, such as "I saw . . ."; "I heard him say _____ . . ."; "I read _____ in the medical record . . ."; I smelled a rotten smell . . . .") They are not strictly allowed to interpret or offer opinions about what they observed or experienced. In practice, of course, some interpretations and opinions slip through; the opposing side may not object unless that lawyer thinks they are damaging.

You will be subpoenaed and deposed by the plaintiff's lawyer as a fact witness for yourself (unless the case has settled or been dismissed). The process is formal, with a court reporter and perhaps a videographer, in some sort of conference room. It usually lasts two to six hours. It is not remotely like the "depositions" you see on TV. The opposing lawyer will ask you lots of questions, usually politely but sometimes with a lot of pressure. Your lawyer, who will be present to object when necessary, should prepare you well for the deposition. Set aside some preparation time, and plan to take the next day off to unwind. Once again, the case may settle at any time.

- Trial. Few malpractice cases ever get to trial (but both sides must assume that they will and prepare accordingly). Trial is usually with a judge (the "trier of law," who is responsible for enforcing the litigation rules) and a jury (the "trier of fact," who weigh the evidence and determine the "truth" of the matter (see "Facts," below). Occasionally the judge is also the trier of fact and there is no jury (unusual in malpractice cases, and always with the defendant's permission). Trials are very formal, with rules designed to keep the playing field level. They are a bit unpredictable, so lawyers almost always try to resolve cases before trial ("settling out of court"). The verdict in a malpractice trial is a "finding for" one side or the other, not a matter of guilt or innocence. Most malpractice trials last a week or two, but they can be longer. As is the case for depositions, real trials bear little resemblance to those one sees on TV.

- Appeals. If either side in a malpractice case believes the *law* of the case was mishandled by the judge, that side may appeal to the next higher court (an *appellate* court). The *jury* verdict itself (which is based on the *facts*[6] of the case rather than matters of law) is almost

[6] "Facts" in legal matters are not always factual in the common sense. They are plaintiff or defense *renditions* and must be proved in some way before they are accepted in court. One side or the other may "stipulate to" a fact, meaning that it agrees with the other side on that limited item. The eventual jury verdict (or the judge's, if he/she is the trier of fact (or "factfinder" in the case) is a "finding of fact" that decides which side's version of the overall case is "true" for legal purposes.

never appealed—appellate courts don't like to substitute their judgment for that of a jury. *It is the actions of the judge, and his/her application of the law during the litigation process, that are appealed, not the "facts."* (Thus, every appeal is, by definition, based on a "technicality.")

The case is not really over until either the losing side accepts a verdict or (less often) the appeals are exhausted (either by the appellate court refusing to hear the case or one side wins at the highest level, such as a state Supreme Court). Matters of state law cannot be appealed to federal courts or the U.S. Supreme Court unless a federal issue, such as a matter of federal law or federal constitutionality, is involved.

How do the lawyers get paid? You probably already know that plaintiffs' lawyers almost always take their cases on *contingency*. That means that their eventual payment is contingent on the outcome of the case. They don't paid unless the plaintiff wins (just as it says on bus benches and in those irritating daytime TV ads). Their fee is a percentage—often capped by statute—of whatever is recovered at trial or in a settlement.

It's a bit more complicated than that. They may also be entitled to charge their expenses (which can be substantial) over and above any judgment or settlement. The successful plaintiff receives his or her share after a careful accounting of the proceeds. The unsuccessful plaintiff, and his/her lawyer, receive nothing. There are other ways—uncommon or too complex to describe here—to finance a plaintiff's case in addition to relying on simple contingency and, from time to time, a malpractice plaintiff funds his/her own lawsuit (such as when no lawyer will take the case on contingency and/or the plaintiff has the money to finance it).

Malpractice defense lawyers are almost always paid by the hour, by the defendant or—more likely—the defendant's insurance carrier.

Discerning readers will note that large facilities and insurance companies can afford to drag cases out, demand more depositions than necessary, file lots of motions, etc., in order to place financial burdens on (especially small) plaintiffs' law firms. That financial advantage can be used to force plaintiffs to settle for less than the case is "worth," or to discourage malpractice filings in the first place. Even when the plaintiff has a good and deserving case, the case value, coupled with the compensation caps in place in many states, prevents many plaintiffs' lawyers from proceeding, or even taking the case. In cases that are likely to result in very large judgments or settlements, plaintiffs' lawyers may contract with larger firms to defray those expenses (and increase the chance of willing or settling well), or even sell portions of a hoped-for recovery to investors at a discount (called "factoring" the case).

A Few Words About "Settling"

Resolving cases before trial is usually a good thing for all concerned. Lawyers know this, and much of their work is in determining the "value" of the case to each side (such as the extent of alleged damage, the strength of alleged causative connections, the costs of proceeding, and the probability that one's side would win at trial). Trials are a "roll of the dice," even when a defendant's or plaintiff's case seems convincing. Trials are also expensive (usually for the loser), though you, as a defendant insured by a malpractice carrier, don't have to foot the bill.

Malpractice insurance contracts often have clauses that guarantee the physician's right to a trial (i.e., to refuse to settle without a trial). ("I want my day in court!") You *can* have your day in court, but it's important to read the fine print. Many malpractice insurance policies say

that one has the right to refuse to settle, but also that if the plaintiff accepts the insurance company's settlement offer, and you refuse, *the insurance carrier may refuse to cover you for more than the amount it would have cost them to settle the case*. That is, they will continue to pay the costs of litigation but if the plaintiff would have accepted $100,000 and a jury awards $200,000, you may be responsible for the difference.

Some physician-defendants believe very small settlements don't have to be reported to the National Practitioner Data Bank (NPDB, see below). That's not true. *All settlements, trial judgments, malpractice payouts, etc., are reported to the NPDB, no matter how small.*

Your lawyer should advise you about the pros and cons of a particular settlement offer, and should act in *your* best interest rather than that of the insurance carrier or other defendants (but be a little cautious when your lawyer is also defending other defendants in the case).

The National Practitioner Data Bank (NPDB).

The NPDB is a federal government service that makes certain adverse information about physicians and other clinicians available to authorized recipients. "Adverse information" includes malpractice judgments and settlements, criminal convictions, most medical licensure actions, loss of hospital/clinic privileges and other serious medical staff or clinical employer censure (except censure for delinquent medical records), adverse ethics actions by some professional organizations, and resignations during pending investigations of the above. "Authorized recipients" of the information in an NPDB file include licensing boards, hospital credentialing committees, and some other groups, but not plaintiffs' attorneys (in most instances) or the general public.

Licensing boards and facility credentialing committees regularly query the NPDB before awarding or renewing licenses or privileges. A physician can view his or her own NPDB record, and file an application to amend it.

For more information, Google the National Practitioner Data Bank and download their PDF information booklet.

Licensing Board Actions

Some of the above also applies to licensing board issues. If a Licensing Board (such as the Texas Medical Board [TMB]) notifies you of Board allegations against you, *retain a **Board-experienced** lawyer, and take his/her advice*. (This is not a job for your family or business attorney, and not something to defend on your own.)

Want Further Info?

Trainees and clinicians are welcome to call my office (830-596-0062) or email me at reidw@reidpsychiatry.com. You may also find my website useful (300+ searchable pages at *www.psychandlaw.org*). Remember, *I'm not a lawyer and will not knowingly give you legal advice*. (Never call a shrink when you really need a lawyer!)