Trial Tip

TIM DOLLAR

COMBATTING THE "RISK OF THE PROCEDURE DEFENSE" IN MEDICAL MALPRACTICE CASES

If you have had the fortune or, perhaps, misfortune of trying a medical malpractice case recently, you very likely have noticed a substantial jury bias favoring the physician or other medical defendant. It almost seems that absent an admission of negligence by the physician or his expert, juries are giving the defendant the benefit of every doubt, however slight. Defense attorneys have been quick to capitalize on this pervasive bias by successfully using what I call the "risk of the procedure defense" to escape responsibility for unexpected injuries which occur during a medical procedure. Faced with explaining the cause of a catastrophic injury which occurred during a procedure, the physician's attorney simply argues that the injury or result was a known risk of the procedure which can and did occur without negligence.

This defense is most effective in situations where the physician was either unaware of the injury at the time he inflicted it, or is the only person with first-hand knowledge as to whether he was careless or not. The defendant's expert typically testifies that the injury is a known risk of the procedure and that there is nothing in the records which shows that proper procedure wasn't followed. This is always followed by the physician's testimony that he used the prescribed procedure or technique as evidenced by his written report. The defendant and his expert then sympathetically bemoan the fact that the plaintiff was just one of the unlucky few who suffer these complications under the best of care.

You are no doubt familiar with these types of cases but here are some examples: A tear of the esophagus during an esophageal dilatation; a surgical nick of the dura during back surgery; a laser burn of the colon during abdominal surgery; injury to the hepatic duct during gall bladder surgery; or a puncture of the eyeball during a retrobulbar block. These are all examples of physician caused injuries which are neither anticipated nor intended. Frequently, the physician is not even aware of the injury for hours or days following the procedure until serious complications develop. The operative report or record is usually devoid of any reference to anything unusual occurring during the procedure, whether by ignorance or intent. When the undesired result occurs, the physician often points to a lengthy consent form in the file which mentions the complication as one of the known risks.

In my humble opinion, this defense is completely bogus. The physician is, in essence, telling the jury that by consenting to a procedure, the patient has given him a license to commit malpractice in the case of known risks. The challenge for us is to expose the absurdity of this defense and appeal to the common sense of jurors who, absent the prevailing bias in today's culture, instinctively know that most of these injuries do, in fact, occur because of a lack of skill, experience, judgment, patience, or care by the physician.

One of the smoke screens that must be dispelled for the jury in these cases is the typical testimony by a physician that a certain untoward injury or result is reported by the medical community to occur in X percentage of cases. Frequently, this type of statement is purportedly backed up by the "reported medical literature." However, I have rarely, if ever, seen reported medical literature which breaks down reported complications by "negligent" vs. "nonnegligent'" causes. I always try to make every defense expert concede that 1) his statistics include negligently caused complications; 2) he has no idea how many of the reported complications were inflicted by a negligent physician; and 3) consenting to a procedure with known risks does not excuse a careless physician. I have never cross-examined an expert who has refused to concede these three points and I believe this approach has been successful in neutralizing the attempt to hide carelessness behind medical statistics.

Cross-examination of an expert witness for the defendant physician can frequently be challenging and may call for consideration of methods which are often thought to be unorthodox. Conventional wisdom usually dictates that cross-examination should involve leading questions only. In my trial advocacy class which I teach at the University of Missouri-Kansas City, I routinely tell students that they should never, ever ask an open-ended question on cross-examination because it allows the witness a second opportunity to explain his opinions. However, in "risk of the

procedure" cases I have departed from my own advice on occasion and achieved some surprisingly favorable results. Thus, my trial tip includes a suggestion for cross-examining the defendant's expert in "risk of the procedure" cases. It involves considerable risk itself because it will challenge the expert with an open-ended question and will further challenge him to explain his answer to the jury. However, I have used this approach in three recent malpractice trials and in each case the expert had such difficulty responding that jurors told me afterwards that it affected the expert's credibility.

As with every good cross-examination, the setup must be precise in leading the witness to the brink. To illustrate the approach, I will use excerpts from the cross-examination of an expert in an esophageal dilatation case. **[Esophageal dilation is a procedure used to slowly dilate a stricture in a patient's esophagus. This is accomplished by slowly advancing a rubber bougie down the patient's esophagus to stretch the lining and improve swallowing. Sometimes, the esophagus, without the knowledge of the doctor, can be torn or lacerated.]** Remember, the expert has already testified that he has reviewed the chart, the depositions and all other records and has concluded that the defendant was not negligent and that this was simply a risk of the procedure:

"Q Now, Doctor, I wanted to ask you some questions about Ms. Smith, the lady who died in this case. We can agree, can we not, Doctor, that Mary Smith died as a result of complications from an esophageal perforation, is that correct?

A Correct.

Q That simply means that a hole was punched in the tube that carried her food and water from her mouth to her stomach, isn't that right?

A Right.

Q Then the food, liquid, and acid that leaked out of the hole into her body killed her?

A Correct.

Q And we can agree that this hole that was punched in the esophagus was done by Dr. Jones during his dilatation procedure?

A Correct.

Q Now, you've testified today that poking a hole in the esophagus during one of these procedures is expected, is that correct?

A Not expected but certainly possible.

Q Do you also agree that sometimes a perforation occurs because the doctor was careless?

A Certainly.

Q But you say in this case that your review of the operative report convinces you that this perforation was not caused by carelessness?

A Correct.

Q Please point out what it is in the operative report that convinces you that Dr. Jones was not negligent.

A The report reflects a normal procedure.

Q So your opinion that there was no negligence is based upon an operative report prepared by the defendant?

A Yes.

Q And because the report reads like a normal report you have concluded that Dr. Jones didn't do anything wrong?

A Yes.

Q So tell me doctor, what would you need to find in this report for you to conclude that there was negligence?

A I simply don't know. But there's no reason to believe from this chart that the procedure was carried out in a negligent or abnormal fashion.

Q So unless a doctor puts in his chart, "I was negligent" you will always conclude he did nothing wrong.

A Well, I mean, I don't know how else you can do it unless there were some nursing notes that indicate that the doctor was behaving in an inappropriate manner.

Q How many times in your whole career, doctor, have you ever seen an operative report in which the operating physician admits he was careless or negligent?

A I can't say that I have ever seen that."

The jury in the above case clearly got the message that unless the defendant blew the whistle on himself, this expert was not going to find negligence. The simple question which asks the expert to specify what he would need to find in the chart to conclude that the defendant was negligent has elicited damaging responses from an expert every time I have used it. I believe this line of questioning illustrates for the jury the fallacy of the "risk of the procedure defense". Telling a jury that a catastrophic outcome was simply a risk of the procedure under circumstances where the defendant controls the flow of information is immediately recognized by the jury as double speak for saying that when you undergo such a procedure, there is a risk that the doctor will be negligent.

Finally, when it comes to tie all of this together in the closing argument, I compare the situation for the jury to a car accident case:

> "Ladies and Gentlemen of the jury, when you decide to travel in a car there is a risk that another driver will run a red light and cause you injury. In other words, there is a risk that another driver will be negligent. In such a case, the driver's assertion that his negligence was simply a risk you undertook when you got into your vehicle would be met with ridicule. Dr. Jones has a license to practice medicine -- not a license to commit malpractice." ■