

THE ANATOMY OF A MICHIGAN MEDICAL MALPRACTICE CASE

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Overview – Civil Versus Criminal Cases

Litigation is new territory for most people, particularly with personal injury and medical malpractice claims. The following is an attempt to provide a general outline of how cases progress, the facts and the law the attorney must weigh, and why this process is often so protracted. Also included are some, but by no means all, of the technical hurdles that must be addressed along the way.

Medical malpractice cases are civil cases, which differ from criminal cases. In a civil case, the plaintiff is the patient. If the patient is deceased, the plaintiff is the personal representative of the deceased's estate. The defendants are the doctors, hospitals, and other health care providers that the plaintiff claims negligently caused injury to the patient. The only recovery available is money damages for the noneconomic injuries of pain, suffering, and disabilities, and the economic losses due to medical bills and lost wages.

This is in contrast to a criminal case, where the plaintiff is the government, and the defendant is a citizen alleged to have violated a criminal statute. If found guilty, the criminal defendant could go to prison. In medical malpractice cases, the worst that can happen to the defendant is they either settle the case or pay the jury verdict. Civil cases are only about money to compensate the injured

patient; the defendant will not go to jail or lose their medical license, although egregious or repeated malpractice can impact a physician's license or hospital privileges.

Medical malpractice cases are a unique type of civil case in which the plaintiff is required to have significant substantiation for the allegations made against the defendants at the time the case is filed. This includes pre suit reviews by expert physicians and signed affidavits by these experts detailing the manner in which the case is meritorious. If one does not have experts in the identical specialties as the defendants who have reviewed all of the medical records, agree that there was malpractice, that the improper care caused the patient injury, and, finally, are willing to sign an affidavit (sworn statement under oath) stating such, the case cannot be filed. Usually the plaintiff will have to retain an expert from another state, as most Michigan physicians will not testify against a fellow Michigan physician. This adds substantial expense to the initial review and overall cost of the litigation. The initial review and evaluation of a potential claim, well before one gets to the filing, is a critical and essential part of any Michigan medical malpractice claim.

Whether to Take a Potential Case?

Michigan's Tort Reform Legislation Produced Near De Facto Economic Immunity for Doctors and Hospitals

Today, experienced lawyers agree to pursue about 1 case for every 30 new potential clients interviewed. Twenty years ago, attorneys would usually pursue 1 out of every 10 new clients interviewed. Since 1986, the number of new medical malpractice filings has dropped by 80%.¹ Compensation to injured patients fell by 60% between 1991 and 2006, and these continue to fall as fewer cases are being filed.² Michigan ranks 7th in the nation for the lowest average settlement per injury at \$181,198; the national average is \$334,559.³ Why the drastic change?

In the last 38 years, Michigan has had 4 rounds with what is traditionally called "tort reform." Tort reform refers to the legislation that made it more difficult to bring a claim for medical negligence. Michigan medical malpractice laws were amended in 1975, 1986, 1994, and again in 2012. The politician's justification for these changes was that it would reduce the cost of health care, thereby making health care more available. While this has always been a nice political sound bite with appeal to the average citizen, none of these promises have materialized in 38 years. In fact, there has been no reduction in the cost of health

¹ T. Berg, Medical Malpractice Reform Analysis, *Michigan Medical Law Report*, Fall 2007, Vol. 3, No. 3; and Michigan Lawyers Weekly, July 2007.

² Berg.

³ Kaiser Family Foundation, State Health Facts.

<http://www.statehealthfacts.org/comparemaptable.jsp?ind=437&cat=8&sort=a&gsa=2>

care and little reduction in medical malpractice insurance premiums.⁴ The unspoken goal of the medical malpractice insurance companies who pushed this legislation and supported the sponsoring politicians has been a huge success by anyone's yardstick. Insurance company payouts are down by 60%, and their doctor's premiums only went down 19%. Where did the 40% difference go? Instead of tort reform, this legislation should be called "Economic Immunity for Michigan Medical Malpractice Insurance Companies."

To appreciate why an attorney cannot take your case even when there may have been negligent care requires a basic understanding of the business of malpractice litigation. Virtually 100% of cases taken by a plaintiff's attorney are based on a contingency fee agreement. This is usually a 1/3rd (33.3%) fee on the recovery after deduction of the out of pocket costs of litigation. Few clients can afford to pay their attorney an hourly rate.⁵ Therefore, an initial consideration is whether the case has the potential value and merit to compensate the attorney and their staff for working on a case for 2-4 years.

In addition to the attorney fee, the elephant in the room is the often ignored cost of litigation. With the 1994 legislation, the plaintiff is required to have a separate expert for nearly every defendant. If the defendants include a general surgeon, a thoracic surgeon, and a vascular surgeon, which is often the case with a cardiac surgery case, the plaintiff would have to have retained all 3 as experts who support the claim before the case can be filed. If a cardiac nurse and cardiac tech were involved, one would need to have 5 experts before the case is started. This could easily cost \$25,000 just to get the case started. After the case is in court, these experts have to review witnesses' depositions and then give their own depositions.⁶ The cost of deposing experts for both parties (as many as 25 experts in this example as the defendants would also have 5 or more experts to match the plaintiff's experts) can add another \$40,000 to \$70,000 in litigation costs and this is before one gets to trial. With other costs

⁴ Per the latest report of the Michigan Insurance Commissioner at the end of 2009, annual average premium discounts averaged 19.8% for the 5 years of 2003 to 2007, including an average discount in 2007 of 24.9%. Ken Ross, Evaluation of the Michigan Medical Professional Liability Insurance Market, State of Michigan, Office of Financial and Insurance Regulation, October 2009.

⁵ As part of Michigan's tort reform, the Michigan Supreme Court amended the Michigan General Court Rules 8.121 (MCR) effective July 9, 1981 limiting the maximum contingency fee an attorney could charge in a personal injury case to one-third of the recovery after costs. Before this, an attorney could economically justify taking a case of less value by charging a greater percentage of the recovery, as attorneys can do in other civil matters. Like caps on noneconomic recoveries, attorney fees have also been capped adding to the "economic immunity" effect.

⁶ Depositions are a process where the attorneys questions defendants, witnesses, and experts under oath and before a court reporter who transcribes the questions and answers. This process occurs after the case is filed and before trial. It is called "discovery" as each side is entitled to discover what the potential witness will testify to at the time of trial. A short medical witness deposition might be 2 hours; a long one could go 5-6 hours. The expert witness charges for preparation time and for the time spent giving a deposition, often after demanding payment in advance.

for preparation, it is not unusual for a case like the above to require \$70,000 - \$100,000 in cost before the case gets to trial. If the case is tried, the costs can easily exceed \$150,000.

Although Michigan's Attorney Canons of Ethics make the client responsible for all litigation costs, few clients have the money to pay for these expenses and the attorney is permitted to advance the costs.⁷ Attorneys who tell their clients that they are not responsible for the costs either do not know the law, or falsely tell the clients this so as not to scare them away from pursuing a claim. As a practical matter, if there is no recovery, the attorneys frequently end up eating the costs, as most clients do not have the assets or money to repay their attorneys.

The cost of litigation and the limitations on monetary damages that can be recovered, described below, requires the attorney to make a careful and calculated business decision on whether the case can be economically pursued. Many clients come to the lawyer angry about their treatment and are really asking if they can sue "for the principle of the thing" or "so this won't happen to someone else." No experienced lawyer will take on a medical malpractice case on principle, or to make a point. A medical malpractice case has all the elements of an investment. Investigation, medical-legal analysis, and hiring and deposing dozens of experts costs a lot of money. If the top value of the case is the lower cap (see caps on noneconomic damages below) or \$468,000, and the cost of litigation is \$100,000, the attorney is investing 2-4 years of work, \$100,000 of their money, to get their money back (without interest) to make a fee of about \$100,000 or about \$30,000 for each year working on the case. When factoring in the risk of losing everything, most would agree this is not a good investment. Consequently, most attorneys will not take a case valued in the \$400,000 range. The effect; 80% fewer cases are now filed – economic immunity.

Screening of Potential Cases

The above analysis does not include the time and cost of interviewing clients and looking at the 29 cases to find the 1 that can be pursued. This takes time, staff, expertise, and often the cost of obtaining medical records. However, to find that case that has merit and the potential for recovery, the screening process must be methodical and thorough. Each case is different. The following is the process we use and the legal and medical factors the attorney must consider:

Investigation Stage I – Initial Interview. Often we have a nurse perform the

⁷ Michigan Rules of Professional Responsibility (MRPC) 1.8(e)(1) A lawyer shall not provide financial assistance to a client in connection with pending or contemplated litigation, except that a lawyer may advance court costs and expenses of litigation, the repayment of which shall ultimately be the responsibility of the client.

initial interview. It has been our experience that this is the most efficient process to screen cases. Experienced attorneys recognize that nurses are patient advocates and more knowledgeable about the medicine involved in each case and, consequently, better able to ask the key questions at the initial client contact. In addition to the increased quality and efficiency of the initial nurse interview, there is a practical consideration. For attorneys handling these cases, the work is very labor intensive. To prepare these cases for trial, there are pleadings and motions to be researched and drafted to bring before a judge who will hear oral argument in court. Depositions of witnesses must be taken, experts must be consulted, and, finally, the actual trial of cases, are a few of the many time-consuming tasks of working on these cases. Since we agree to investigate only about 1 in 30 cases interviewed, if the attorney were to interview all the new prospective clients, there would be little time to prepare the cases that are in court.

Investigation Stage II — Initial Evaluation. Usually within a week after the interview, the nurse prepares a detailed memo outlining the pertinent medical information and issues. The lead attorney then meets with the nurses, a paralegal, and often another attorney. At that time, we discuss the merits of the potential case, medical and legal issues, and medical and legal research that may have to be done before a decision can be made. We then make a decision whether the case has sufficient legal and medical merit to justify going to the next step, which is to get the medical records. A decision to further investigate the case could take 3 to 4 weeks, or more depending on the facts, medicine, and complexity of the case.

Investigation Stage III — Gathering the Medical Records. Obtaining all of the pertinent medical records is critical to evaluating such claims. While the client's recollection of events is important, the medical records are the foundation of any claim. We cannot proceed beyond this point until we have all (a complete copy) of the medical records for the care in question and often some of the subsequent treatment records.

Some cases require that we get x-rays, digital studies, pathology slides, or other studies that are not part of what is traditionally the medical record. This can be a tedious process that can take weeks and sometimes months.

If the case has questionable merit, we often tell the patient that we will look at the records if they obtain a copy. For patients who encounter resistance from their physician or hospital, the law clearly states that you are entitled to copies:

- Except as otherwise provided by law or regulation, a patient or his or her authorized representative has the right to examine or obtain the patient's medical record.⁸

⁸ MCL 333.26265(5)(1)

- Upon receipt of a request under this subsection, a health care provider or health facility shall, as promptly as required under the circumstances, but not later than 30 days after receipt of the request or if the medical record is not maintained or accessible on-site not later than 60 days after receipt of the request.⁹
- Some clients worry that they will be asked why they want the records. A health care provider or health facility that receives a request for a medical record under section 5 shall not inquire as to the purpose of the request.¹⁰The cost that can be charged is also regulated by Michigan statutes, although payment can be demanded in advance. (a) An initial fee of \$20.00 per request for a copy of the record. (b) Paper copies as follows: (i) One dollar per page for the first 20 pages. (ii) Fifty cents per page for pages 21 through 50. (iii) Twenty cents for pages 51 and over. (c) If the medical record is in some form or medium other than paper, the actual cost of preparing a duplicate.¹¹
- The above price was set in 2004 and is adjusted every two years. In 2017 the charges are: initial fee \$23.71; \$1.19 per page for first 20 pages; 0.60 cents for pages 21-50; and 0.23 cents per page for all pages after 51.

Realistically, this does not routinely happen within 30-60 days, but it helps to have the law at hand.

However, once we do receive the medical records, to insure that we have a complete copy, a nurse organizes and reviews what has been produced. It is not unusual, whether intentional or a clerical error, that the nurse finds critical pages missing. That requires that we request additional records, and this consumes more time. Again, this is a critical step, as an incomplete record will often result in an incomplete and faulty analysis of the case. Once we are assured that we have a complete set of the records, a nurse will review and analyze the records in an attempt to determine if the client's concerns about the care have merit. With the same people who originally met, another meeting is held. We again discuss the legal and medical merits to determine if we should go to the next step.

Investigation Stage IV — Analysis of the Medical Records and the Legal and Medical Merits of the Case. If at the second meeting we determine there is likely legal and medical merit to the case, the nurse will then be asked to prepare a chronological summary of the medical care, the issues that need to be addressed, and research any medical literature that may help in this determination. Depending on the complexity of case, this summary will vary from 5 to 30 pages. Assuming this analysis and summary still indicates the probability of legal and medical merit, a decision is then made as to which experts the records should be sent. If we go to the next step without this

⁹ MCL 333.26265(5)(2)

¹⁰ MCL 333.26267(7)

¹¹ MCL 333.26269(9)(1)

analysis, considerable time and money are likely to be wasted, for the client and the attorneys.

Investigation Stage V — Experts' Reviews. Medical malpractice cases are expert dependent. One cannot pursue such cases without the appropriate experts. If one does not have expert testimony to support the claims, the court is required to dismiss the case. After April 1994, and the so-called Tort Reform changes to the law, experts who may qualify to give an opinion has been significantly narrowed. If the defendant is a specialist, the expert must also specialize in the same practice area. If the defendant specialist is board certified in the specialty, the expert must likewise be board certified in the same specialty. This requires extensive background checks on the potential defendants and the experts to whom we send the case. If there is more than one potential defendant in a case, and of different specialties, an expert must be obtained for each. By way of example, a doctor in internal medicine usually cannot testify against a nurse, an OB/GYN cannot testify against a nurse midwife, nor can a general surgeon testify against an orthopedic surgeon. The more potential defendants, the more experts that will be required. In many cases, we also need experts to discuss complications a patient suffered, other medical problems a patient has that may have an impact on the issues, or the feasibility of alternative treatments.

Expert witnesses are very expensive. The vast majority of litigation cost in a medical malpractice case is for experts. Today, it is not unusual for an expert physician to charge \$500 per hour hundreds of dollars per hour. The hours and money quickly adds up for their time when initially reviewing the records, preparing for depositions, reviewing the defendant's experts' depositions, and for preparing and appearing at trial. Though trial, it is not shocking to see a total bill from one expert between \$25,000 - \$50,000. For this reason, the potential recovery (the damages in the case) must be balanced against the cost of pursuing the case. It makes no sense for the client or the attorney to pursue a case if the total costs will approach or exceed the anticipated settlement value or jury verdict. In addition, there are no guaranteed successful medical malpractice cases. For many reasons, the best of cases can be lost. The risk of losing versus the probability of winning must be balanced against the cost of the litigation and the potential recovery.

Assuming the case reaches this point, the records are then sent to an expert. We attempt to send the records to the most critical experts first. In most cases, we will minimally need 3-4 experts. We do not send the records to all the experts at one time, but to the pivotal experts first. We have found that this saves considerable time, as well as money. If the pivotal expert cannot support the case, it makes little sense to go to the secondary experts. For example, in a birth injury case, the defendants may include the OB/GYN, a nurse, a neonatologist, a resident physician, and an anesthesiologist. The OB/GYN's actions are often the key to the care. If the expert finds nothing deficient in that care, the rest of the case is likely to fail and, therefore, a waste of time

and money to send to the other experts.

The experts we consult are actively practicing in their area of specialization, as they are required to spend at least 50% of their time in the active clinical practice to serve as an expert witness. However, because they have full-time employment, the review of the medical records is often done at night or on the weekends. Although we try to only work with those who are reasonably prompt, this review process is seldom accomplished in less than 3 to 4 weeks. Some clients anticipate a response within days after the records are sent; this seldom, if ever, happens.

The time it takes to investigate each case will differ. Some cases can take 6 months to review, others can take as long as 2 years, depending on the complexity of the case, whether we can get the records promptly, availability of experts, and a multitude of other legal and medical issues.

Legal Considerations

Many clients feel that because they have had a bad or unexpected outcome, the doctors and health care providers should be responsible. That is not the law. When a patient files a lawsuit, they have a heavy burden of proof at the time of trial. The defendant has no obligation to prove they acted appropriately; the patient-plaintiff has the burden of proving the merits of the case. The plaintiff's burden of proof has 3 elements, and all 3 must be proven to the jury's satisfaction to win.

If the patient-plaintiff fails to prove any 1 of the 3, the plaintiff's case will be dismissed. This burden of proof includes the following elements:

- (1) The patient/plaintiff must first prove that the defendant doctors, nurses, and/or hospital were negligent, or that they failed to act in accordance with the acceptable standard of care. The standard of care in Michigan is defined as doing what the physician or nurse "... of ordinary learning, judgment or skill" would have done or not done under the same or similar circumstance.¹² The standard is not what someone else would have done, what ideally should have been done, but what the "ordinary" physician or nurse would have done; this is sometimes referred to as the "average" health care person of the same specialty. Some think the law is what the "reasonably prudent" physician or nurse would have done; that is not the law in Michigan and there is a difference.¹³

¹² Mich Standard Jury Instruction 30.01 Professional Negligence and/or Malpractice.

¹³ US Supreme Court Justice Oliver Wendell Holmes summarized it best: "What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not." *Texas Pacific RR co. v. Bemymer*, 189 U.S. 468, 470 (1903).

The standard is further limited by the state of the art existing at the time of the alleged malpractice.¹⁴ If the treatment was in 2009 and new medical discoveries in 2012 would have changed the results, these later discoveries could not be used; the test is the state of medicine at the time the care was provided.

As mentioned, the only way one can prove the standard of care is by expert testimony. The jury is not permitted to speculate whether the care was appropriate; they must listen to the expert's testimony. If the plaintiff's expert testifies that the care was contrary to the standard of acceptable care, and the defendant's experts testify it was acceptable, then the jury must decide which expert's explanation is more believable.

The fact that one expert would have used a different method of treatment or would make a different diagnosis is not the test, but what the ordinary physician would do. Testimony from an expert as to "what I would have done" is not even admissible.¹⁵

In some situations, there may be one or more acceptable alternative treatments or diagnosis, all within the standard of care. So again, the fact that an individual physician may have made a different diagnosis or used different treatment is not the standard of care, but what the ordinary or average physician would have done.

- (2) The plaintiff must prove that the defendant's negligence was "a" proximate cause of the injury suffered. The definition of "proximate cause is that which, in a natural and continuous sequence, unbroken by new and independent causes, produces the injury." Proximate cause is often hotly disputed in medical cases. Unlike an auto case where the driver was healthy when rear-ended, and sustained a broken arm, and the cause of the injury is obvious, in medical cases many patients come to the hospital because they already have a medical problem. The plaintiff's experts must separate injuries from what would have occurred anyway because of the underlying medical condition and from expected and accepted complications from the treatment. Therefore, many medical cases are defended on proximate cause, even when the negligence, or violation of the standard of care, is reasonably clear.

An example of this is a case I defended when I represented hospitals earlier in my career. With a fractured hip on a patient who had been in an auto accident, the doctors put the wrong leg in traction — it was 2

¹⁴ MCL 600.2912a, Effective April 1, 1994.

¹⁵ *Sirrila v. Barrios*, 398 Mich 576, 248 NW2d 171 (1976) and *Patelczyk v. Olson*, 95 Mich App 281; 289 NW2d 910 (1980).

weeks before they discovered their mistake. Our defense was the immobilization of the opposite hip actually immobilized the fractured hip, the fracture healed properly and, luckily, in proper alignment. There was clearly negligence, but there was no proximate cause or injury due to the negligence. The plaintiff lost.

There is also a quantitative element to proximate cause. The plaintiff must show that, but for the defendant's negligence, there was a greater than 50% probability that the injury would not have happened. If a patient is seen in the ER with chest pain, is not properly treated, and the patient dies, the family must show that with proper treatment the prognosis for survival, if treated in the ER, was greater than 50%. If the experts testify that the chance of survival was only 49% with proper treatment, the plaintiff's case fails on this element. Saying the results would have "possibly" been different with better care is not enough. The quantitative test for proximate cause often uses the terms, "more likely than not, more probable than not, or greater than 50%."

This greater than 50% threshold has been vigorously debated in our courts for the last few years. It is most problematic in cases of misdiagnosis. When there is a misdiagnosis (and failure to treat), the patient must prove that the change in prognosis from the time of the misdiagnosis to the diagnosis and treatment changed more than 50%. The case that caused all the controversy in 2002 was a breast cancer case. There was a failure to diagnose a breast lesion. At the time, with proper treatment, the prognosis was about 85% for a good outcome. By the time the diagnosis was made, the prognosis had fallen to about 65%. Even if the 20% lost chance resulted in death, the court held this was insufficient change to meet the greater than 50% test.¹⁶

The above test was modified in recent years. Instead of using the "subtraction calculation" to arrive at the change in chance of recovery (85% - 65% = 20% change) the Supreme Court has held that a "percentage calculation" is appropriate as that is how change is calculated in the sciences. Therefore, if the chance of avoiding injury was 20% with treatment and this chance fell to 5% without treatment, the change would be 75%, or greater than 50%.¹⁷

Needless to say, the law on proximate cause can be confusing and is often grounds for appeal even if one wins at the trial level. The plaintiff must also prove all elements of damages. If you cannot

¹⁶ *Fulton v. William Beaumont Hosp.*, 253 Mich App 70; 655 NW2d 569 (2002).

¹⁷ *O'Neal v St. John Hospital*, 487 Mich 485; 791 NW2d 853 (2010). It is debatable whether this case is the law, and if so, if it will remain the law. There are 7 Michigan Supreme Court Justices; each wrote a separate opinion in this case. There was not a consensus of opinion.

work, need medical care, have incurred or will incur medical bills in the future, that must be proven through expert testimony. In the absence of an expert testimony, the jury will not be permitted to speculate as to what damages were suffered, past or future.

Expert's Opinions Must Be Based on Current Science as Published in Peer Reviewed Medical Journals

Clients often call us based on a statement by a subsequent treating physician that they interpreted as saying the proposed defendant committed malpractice or that their care caused an injury – such as, “I wouldn’t have done that.” They sometimes have read an internet posting that leads them to believe their care was substandard or caused an injury. Or they conclude the care caused the injury (and therefore negligent) based solely on the timing of events; A happened, B followed A, C occurred due to B, and; therefore, A caused C. While these may ultimately prove to be correct, these are never enough to prove a case in a court of law. All expert opinions must be based on reliable, and usually published, scientific evidence.

Since 1993, courts carefully scrutinize expert’s opinions before permitting the expert to testify, or offer their opinions. If not based on reliable and generally accepted science in the relevant area, they will not be permitted to testify. The leading case in the area of medical science is *Daubert v Merrill Dow Pharmaceuticals*, 509 US 579 (1993). In the 1980’s, Bendectin was a big seller to pregnant women for morning sickness and nausea. After a number of the mothers who had used Bendectin gave birth to children with birth defects, the news and public consensus quickly spread that Bendectin caused birth defects. The lawsuits soon followed.

When the cases reached trial, the science was put on trial. The patients had 8 well-credentialed experts who concluded there was a connection; Dow had 1 expert. However, Dow had 30 scientific, published studies with over 130 patients that showed no relationship. The patient’s only science was some animal studies and chemical analysis. Notwithstanding the credentials of the patient’s experts and their willingness to testify under oath that they believed there was a cause and effect relationship, the trial court did not permit them to testify. Without expert testimony, the case was dismissed. The case was appealed to US Supreme Court; they affirmed the trial court. This case is now cited as the basis for keeping “junk science” out of the courtroom.

Shortly after the *Daubert* decision, the Michigan legislature codified the *Daubert* tests in a statute, Michigan Compiled Laws 600.2955. The criteria the court now examines before any expert can offer an opinion on any of the 3 elements the plaintiff must prove (standard of care, proximate cause or damages) are as follows:

An otherwise qualified expert is not admissible unless the court determines that the opinion is reliable... and shall consider all of the following factors:

(a) Whether the opinion and its basis have been subjected to scientific testing and replication.

(b) Whether the opinion and its basis have been subjected to peer review publication.

(c) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent with those standards.

(d) The known or potential error rate of the opinion and its basis.

(e) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this subdivision, “relevant expert community” means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market.

(f) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered.

(g) Whether the opinion or methodology is relied upon by experts outside of the context of litigation.

Recent decisions from the Michigan Supreme Court have put heavy emphasis on there being published peer reviewed literature (medical journals – (b) in the above list).¹⁸ Their analysis has been: no literature means no science and with no science the expert will not be permitted to testify – the case is dismissed.

While this may seem like more information than one needs to know, “Ignorance of the law is no excuse” and a bad investment of time and money. If a patient gets to trial after 2-3 years of work and spending thousands of dollars only to see their expert struck and the case thereafter quickly dismissed, no one will be happy, including their attorneys.

Noneconomic Damages Are Capped

There are basically two types of damages in a med mal claim: noneconomic

¹⁸ *Edry v. Adelman*, 486 Mich 634; 786 NW2d 567 (2010) and *Elher v. Misra*, 499 Mich 1; 878 NW2d 790 (2016).

and economic losses. Noneconomic damages include elements such as pain, suffering, loss of enjoyment of life, loss of society and companionship, and loss of a loved one in a death case. Economic damages include losses that can be specifically calculated such as lost wages, medical bills, cost of home care, and replacement costs for services one can no longer perform.

No longer are huge verdicts for pain and suffering recoverable – there are caps on noneconomic damages.¹⁹ The jury is not told that there are caps on their award, but after a jury's verdict, the judge makes a determination which cap applies and reduces the award if it exceeds the present applicable level. There are 2 different levels of caps. The lower cap is presently \$476,600; the higher is \$851,000.

.²⁰ The higher cap only applies if the plaintiff is hemiplegic (paralysis of one-half of the body) paraplegic (paralysis of both legs) or quadriplegic (paralysis of all four limbs) resulting in a total permanent functional loss of 1 or more limbs caused by injury to the brain or the spinal cord. If read carefully, this last sentence would make amputation of the wrong leg a lower cap case – neither the brain or spinal could would be involved. In addition, it is only one leg; therefore not meeting the definition of hemiplegic, paraplegic, or quadriplegic.

This definition has not been directly tested by an appellate court decision since its enactment in 1994, but given our present court's strict, literal interpretation of statutes, total and permanent are likely to mean just that.

What is more problematic is what "functional loss" means. If one can move one's legs, but not walk without assistance, is that a functional loss? We would argue that it is, but we have a very conservative Supreme Court.

The higher cap also applies if the plaintiff has permanently impaired cognitive capacity rendering him or her incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living. Note that death is not an exception to the lower cap. This means that even if a patient dies as the result of medical malpractice, the noneconomic damages may be limited to the lower cap, depending on the specific circumstances related to the patient's condition prior to death.

Lastly, the higher cap applies when there has been permanent loss of or damage to a reproductive organ resulting in the inability to procreate.

It is also important to note that the cap applies to all plaintiffs against all defendants - it is not a per person cap, nor can we obtain additional

¹⁹ MCL 600.1483, Effective April 1, 1994.

²⁰ The original noneconomic caps started at \$280,000 and \$500,000 in 1994. These caps are increased yearly by the State Treasury of Michigan using the Detroit Consumer Index. In 2013, the increase was 2.0%. At this rate, it would take until about 2030 for the lower cap to reach \$560,000 and the upper cap to reach \$1,000,000.

noneconomic damages by adding additional defendants. One cap per case is the rule.

Caps on noneconomic damages are not only serious limitations on your ability to be compensated for your injuries, but can cause serious problems at trial if the jury decides that they will allocate most of your award to noneconomic injuries, and do not give the economic losses their due consideration. Because they do not know about caps on noneconomic damages, the jury may decide that they do not want to spend the time and effort to calculate the anticipated yearly economic damages for medical expenses and lost wages, and simply award a large amount for "pain and suffering" with the anticipation that this will compensate for the future medical bills and lost income. Unfortunately, the judge will have to reduce the non-economic (pain and suffering) award to the cap level, leaving the plaintiff with little or no recovery for their economic losses.

The best example was a case where a newborn was severely burned when a nurse used an electrical cautery device while the infant was in an incubator. When the electrical cautery was exposed to the oxygen, there was an explosion. Negligence was admitted. Unfortunately, the jury awarded most of the damages for pain and suffering. After the verdict, the judge reduced the award to the noneconomic cap eliminating 90% of the jury's award.

The point is that with Michigan's present law, there is far more involved in getting to a satisfactory recovery than just proving the case.

Statute of Limitations

There is a time limit when cases must be filed; this called the statute of limitations. There are multiple exceptions, but the general rule is the case should be filed 2 years from the date of the alleged negligence.

If the claim involves a wrongful death, the time may be longer, and there are a couple of alternatives to calculating the limitations period within which one must file the claim. One can use the above rule of 2 years from the date of the alleged improper care. An alternative is the case must be filed 2 years from the issuing of the LOA (Letters of Authority) from the Probate Court appointing the Personal Representative, but never longer than 5 years from the negligent act. Because the rule using LOA is not a statute of limitations, but what the law calls a savings provision, both the filing of the NOI, and waiting 182 days, and filing the complaint must be done within 2 years from the issuing of the LOA.

The statute of repose also applies to wrongful death claims in that no claim can be filed beyond 6 years from the date of first negligence. *Burton v Macha*, 303 Mich App 419; 846 NW2d 419 (2014).

Minors under the age of 8 years of age at the time of the malpractice have until their 10th birthday to start their case.

There is also an exception for cases where it would be difficult for the patient to know there was medical negligence. This exception is called the "discovery rule." The patient has 6 months from the date "the claim was or should have been discovered." Many patients have heard of this rule, and are under the misperception that they have 6 months from the time someone told them there had been malpractice. The law puts a more difficult test on when a patient should have discovered the negligent care.

The law defining the "discovery rule" states that a patient may file a medical malpractice action within 6 months from the time the patient should have discovered the "possible cause of action" but never more than 6 years from the original date of negligence. This possible cause of action standard has been defined by our Supreme Court to mean, "Once a claimant is aware of an injury and its possible cause, the plaintiff is aware of a possible cause of action."²¹ This is a very broad and subjective test, and one that the patient must prove before the jury ever considers the merits of the case. Because the patient and their attorney must invest large sums of money on gathering records and hiring experts before the jury ever decides this issue, many attorneys do not take cases based on the discovery statute unless the date and the event of discovery is undisputable.

A claim not filed within the applicable statute of limitations time period is forever barred.

The statute of limitations also has a practical limitation. Because of the extensive preparation required to file such cases, most attorneys are reluctant to even look at a case unless there are at least 4 to 5 months left until the case has to be filed. If the attorney goes through the above process, which can easily take 4 to 5 months, and decides the case does not meet the above criteria to pursue the case, clients will be upset if the attorney declines the case with only weeks left on the statute of limitations.

Notice of Intent to File a Claim (NOI)

In 1994, part of the medical legislation included another hurdle before one could file a case. Now, one is required to file what is called a NOI (Notice of Intent to File a Claim). This is very similar to the complaint that is filed to start the case. We must send this NOI (a detailed explanation of the allegations of negligence, what each health care provider did that was negligent, specifically how that caused the injury, and the damages that resulted) to every party that may be later named in the case. We often name everyone that looks as though they

²¹ *Solowy v Oakwood Hospital*, 454 Mich 214; 561 NW2d 843 (1997), citing *Moll v. Abbott Laboratories*, 444 Mich 1 at 23-24; 506 NW2d 816 (1993).

may be involved, as they cannot be named as parties later if they are not in the NOI. Therefore, you may see names in the NOI that are unfamiliar or people that we did not originally discuss as defendants.

The court's interpretation of this statute has required that we be very specific in our statements of the claim. For that reason, unless there is insufficient time, we try to do this after we have had the case reviewed by our experts. Often this NOI can be 15 to 30 pages. The original purpose of the NOI was to see if the case could be settled without the cost and time of litigation. While the intentions may have been good, this seldom happens. There are too many disputed issues that can only be sorted out with cross-examination and experts testifying, and this only happens once the case is filed.

What the NOI does, however, in most cases, is to provide additional time for the filing of the formal complaint – it tolls the applicable statute of limitations.²² The NOI must be sent before a case can be filed. After the NOI is sent, we must wait 182 days (6 months) before we can file suit. If the NOI is filed within 6 months before the 2-year time period for filing the complaint, the NOI tolls (stops) the running of this time period (6 months) then it starts running again after the 6-month waiting period expires. This often results in cases not being filed until 2 1/2 years or more after the alleged negligent care. If the NOI can be prepared and sent 18 months before the 2-year statute of limitations, then the waiting period can expire before the 2 years and the case can be filed earlier. If this sounds confusing, you are in good company and is another example of how the law in this area has made these cases a logistical nightmare.

Affidavits of Merit (AOM)

Although the above NOI period may initially sound like a waste of time, there are a number of important details being finalized in preparation for filing the lawsuit at the end of the 6-month wait. One of these is what is referred to as the Affidavit of Merit (AOM).

Another aspect of the 1994 medical malpractice legislation was the AOM. Every case filed in Michigan must be accompanied by an affidavit signed by a physician who qualifies as an expert, who has reviewed all of the pertinent medical records, who attests that the defendant violated the standard of care, and who confirms that the substandard conduct caused a particular injury. These are the 3 elements for which the patient has the burden of proof as described above under Legal Considerations.

²² The tolling does not apply to cases where the 2 years from issuing the letters of authority are used to calculate the statute of limitations, nor to cases where the 6 year on discover may be applicable. To be safe, with the 10-year statute for minors, the NOI should be sent early enough so that the 182 waiting period expires in time to file the formal complaint before the child's 10th birthday.

The AOM has been the focus of many Appellate Court decisions in the last few years. The requirements for this pleading are specific and unforgiving. There must be an affidavit for each defendant named. If a defendant is a specialist, the affidavit must be signed by a specialist. If the defendant is certified by a nationally recognized board of specialists, the expert must have the same certification. Even if the expert and defendant have identical qualifications, there are other factors that must be checked, such as whether the expert performs the same procedures, treats the same conditions, or uses the same medical devices as was involved in the case at issue. In a case with multiple defendants, this process can consume much of the 6 months after the NOI is sent. This AOM must be filed with the complaint when commencing the formal action.

Filing of the Complaint to Trial – The Pre-Trial Discovery Period

Medical malpractice cases, with rare exceptions, must be filed in the county where the medical care was provided. Although this may seem logical and even convenient for the patient, it is also an advantage for the defendants as the case will be heard by a judge and jury who will likely know or be familiar with doctors and hospital.

The period of time after the case is filed, and before trial, is called the period for "discovery." This means literally that each party is permitted, within the bounds permitted by MCR (Michigan Court Rules) to discover what documents the other party may have, what witnesses the other side may call, to take the depositions of each other's' potential witnesses, and to basically prepare the case for trial. Each court is monitored by the Michigan Supreme Court to insure that cases move in a timely fashion. Years ago, this discovery period may have taken 3 to 4 years. Presently, courts attempt to have the parties ready for trial within 18 months after the filing of the complaint. This time may vary, depending on the court's schedule and special circumstances that each case may present, but 18 months is a good rule of thumb.

During this 18-month preparation time, usually after the doctors, nurses and experts have had their depositions taken, the court will likely order that the parties meet with an independent facilitator to see if the case can be settled. This is called mediation or facilitative mediation. All of the parties and their attorneys are present. The facilitator will then meet individually with each of the parties to see if there is a figure at which the case can be resolved without trial. This process is usually per the agreement of the parties, but is sometime ordered by the court.

In addition to facilitation, every civil case in Michigan must go through a process called case evaluation. This is usually scheduled from 3 to 6 months before trial. The court appoints 3 case evaluators. One is an attorney who customarily represents defendants, one who customarily represents plaintiffs, and one who

is described as a neutral, or who does not do personal injury or medical malpractice litigation. Before the case evaluation date, each party submits a detailed summary of the facts, the testimony, and attaches all the pertinent documents. No witnesses are present. Although all parties are entitled to be present, they seldom attend as only the attorneys can speak. Each argues the merits of their case after which the case evaluators meet for 5 to 15 minutes to decide the value of the case. They put a number on the case based on the presentation, the arguments and their experience as to what the case is worth. This is another attempt to settle the case.

After the case evaluation, the parties have 28 days to accept or reject the case evaluation figure. If both parties accept, the case is settled. If one party rejects the figure, the case goes forward to trial. However, if a party rejects the award, there are consequences if they go to trial and the award as to them is not better by at least 10 percent of the award. The consequences are they will have to pay the other side attorney's fees and costs incurred by the other side from the date of the rejection. Because the cost and time to prepare and try a case can be substantial, the risk is considerable, particularly to the patient who is unlikely wealthy enough to personally afford the cost of litigation. In medical malpractice cases, the costs awarded and assessed against the patient will often be from \$100,000 to as high as \$250,000, and sometimes higher.

For all of the above reasons, the most important decision an attorney makes in a medical malpractice case is whether to take the case, or recommend that the client file a lawsuit. Contrary to the media spin, promoted by the insurance lobby, this is not a "lottery," but a serious business decision.

Settlements and Trials

The estimates are that about 93% of malpractice claims are settled. When tried, the plaintiff loses about 75% of the time.²³ The verdict percentages vary drastically from urban to more rural areas. Most cases have to be filed in the county where the treatment was provided, or the injury occurred. Verdicts tend to reflect the political attitude of the county, as jurors are drawn from the county where the case is filed. At one time, Wayne County (Detroit and surrounding area) was viewed as a jurisdiction favorable to patients with more and larger verdicts; even this has changed in recent years with a decline in the economy. Oakland County has traditionally been conservative, although there have been selective large verdicts. As one moves outside of Southeastern Michigan to smaller counties, the verdicts are infrequent and smaller when awarded. Some of these counties have a reputation of never having had a medical malpractice verdict or numbers that can be counted on one hand.

In Michigan, if the case is tried, the case is presented to 6 jurors (although 7 or

²³ *Juries and Medical Malpractice Claims: Empirical Facts versus Myths*. Neil Vidmar, JD, *Clinical Orthopaedics and Related Research*, February 2009, Volume 467, Issue 2, pp 367-375

8 may be impaneled in the event someone has to leave due to illness or a family emergency). The plaintiff (patient) presents their case first after which the defendant presents their witnesses and experts as to why they did nothing wrong, or if they did, their actions did not cause the patient's injury. Unlike a criminal case, where the verdict must be unanimous, when 5 of the 6 jurors agree on a verdict, the trial is over. After the verdict, in addition to the judge's reducing the noneconomic damages to the applicable cap, there are other reductions made to the jury's verdict.

There are other multiple calculations the trial judge will make before the verdict (the jury's decision) is converted to a judgment (the judge's calculations). The winning party may be awarded statutory costs. There may be case evaluation sanctions, which can be substantial. If the plaintiff prevails, in addition to the adjustment applying the applicable cap, any future damages award will be reduced to present value. Given our present law, future damages will be reduced at 5% annually and compounded. Depending on how far into the future these are awarded, this reduction could reduce future damages by half.

The point: even if the plaintiff wins, the verdicts one hears and reads about is not what the plaintiff will receive, but it will be far less. If they lose, there will be the problem of the defendants asking the plaintiff to pay for trial costs and possibly sanctions. While most plaintiffs are not collectable, this can be an unpleasant experience.

Appeals

The case is not over with the verdict; there are frequently appeals. Those cases appealed are, "typically involving more severe injuries, complex medical or scientific evidence, or expert testimony." All three elements are prevalent in any malpractice claim. In medical malpractice cases where the plaintiff loses, the appeal rate is 12%; where the defendant loses, the appeal rate is 26%. The latter number is as high as 33% where serious injuries are involved.²⁴

As a practical matter, defendants may appeal more verdicts in an attempt to gain leverage in post-verdict settlement discussion. On the other hand, the Michigan Supreme Court has been dominated by a conservative Republican majority for at least 20 years and the anecdotal analysis has been that defendants win far more appeals in Michigan than plaintiffs do.

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²⁴ National Center for State Courts, Caseload Highlights, Lee c. and Waters N., Vol. 16, No. 4, Dec 2009.

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