

MEDICAL MALPRACTICE IN LOUISIANA: NOT JUST FOR BEGINNERS

Authors

**Franklin D. Beahm
A. Rebecca Heiman
Beahm & Green
145 Robert E. Lee Boulevard
Suite 408
New Orleans, LA**

**Jeffrey A. Mitchell
The Cochran Firm - New Orleans
Phillips & Mitchell
1580 LL&E Tower
909 Poydras Street
New Orleans, LA**

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I. INTRODUCTION INTO THE ACT

A. Historical Reflection

In 1975, the Louisiana Legislature passed the Louisiana Medical Malpractice Act (the “MMA”), which is found at La. R.S. 40:1299.41 et. seq. and the Malpractice Liability for State Services Act, (the “MLSSA”), which is found in La. R.S. 40:1299.37 et. seq. Under these provisions, medical malpractice claims are divided into two categories: (i) claims against private healthcare providers and (ii) claims against public or state healthcare providers. Claims against private healthcare providers are governed by the MMA, while claims against public or state healthcare providers are governed by the MLSSA.

Both acts place a cap of \$500,000 on a victim’s recovery. This cap applies to each claim, not to each claimant. Thus, if a person dies and leaves five children, the total amount recoverable is \$500,000 which must be divided between the five children. Each child may not recover \$500,000. Lost wages are included in this cap. The only element of damage which may be recovered by a malpractice victim above and beyond the cap are the future medical expenses. The MMA defines future medical expenses to include past medical expenses. The past medical expenses are recoverable in a lump sum at trial. However, the MMA states that future medical expenses may be paid as they become due. In other words, future medical expenses are not recoverable in a lump sum at trial.

As part of the MMA, the legislature created the Louisiana Patient’s Compensation Fund

(the “PCF”), to administer and pay medical malpractice claims.

B. Current Legislation (2005)

The 2005 legislative session produced few changes to the MMA and MLSSA. However, a couple of changes are worth noting.

For instance, Act No. 127 amended Sections 1299.47 and 1299.39.1 respectively. One change made by the legislature was to change the period of time from sixty (60) days to ninety (90) days that the filing of a request for review shall suspend the running of prescription following notice (by certified mail) that a health care provider is not a qualified health care provider. Now, if the Division of Administration or the PCF notify the claimant that the health care provider named in the request for review is not qualified, the claimant has ninety (90) days to institute the lawsuit in district court. Act 127 also removed the 180 day period for the panel to decide the case. The panel must now render its decision within 30 days after they review the evidence. Finally, the PCF must now provide notification by certified mail return receipt instead of regular mail. However, if the certified mail is unclaimed or returned, then regular mailing is deemed sufficient.

II. DISSECTING THE MMA IN VIEW OF ITS EVOLUTION

A. Constitutionality

The constitutionality of both the MMA and MLLSA have been challenged repeatedly without success.

Arguments Used to Justify the Cap

1. Constitutional test whether MMA's provisions are reasonably related to furthering general social interests. See *Butler v. Flint Goodrich Hospital*, 607 So.2d 517 (La. 1992), *cert. denied*, 113 S. Ct. 2338.
 - a. To reduce or stabilize medical malpractice insurance rates.
 - b. To assure the availability of affordable medical services to the public.

2. Existence of a medical malpractice insurance crisis was widely acknowledged when MMA of 1975 was passed. See *50 Tulane Law Review* 655.
 - a. MMA was a legislative response to the "perceived crisis".
 - b. Problem of uninsured physicians, unable or unwilling to buy insurance.
 - c. Earlier decades had seen both increased access to medical care through various government programs as well as a liberalization of tort liability doctrines. See *Williams v. Kushner*, 549 So.2d 294 (La. 1989) (Dixon, Chief Justice dissenting).
 - d. Improved technology made more complex procedures possible, but also increased the risk of adverse results. See *Id.*
 - e. End of 60's increase in both the number of medical malpractice claims and the amounts paid in such cases (by settlement or judgment). See *Id.*
 - f. The early 1970s saw continued increases in the number of medical

malpractice claims and, as inflation took hold, in the amounts being paid under such policies. See Id.

g. Some insurers decided to cease offering medical malpractice insurance, while others decided to raise malpractice premiums. See Id.

h. Continued increases in malpractice insurance premiums were seen as a threat to hospital and medical providers' ability to furnish affordable, high quality health care without the fear of substantial personal liability. See Id.

1. In order to prevent hospital closures, significant restriction of physician practices, and substantial rapid increases in health care costs, control of medical malpractice insurance premiums was determined to be necessary.

2. MMA was created in response to the need to control medical malpractice insurance premiums.

3. Considered a reasonable but imperfect balance between the rights of victims and those of health care providers. *Butler v. Flint Goodrich Hospital*, 607 So.2d 517 (La. 1992), *cert. denied*, 113 S. Ct. 2338.

a. Three Benefits:

1. Greater likelihood that the offending physician or other health care provider has malpractice insurance;

a) Participation in LA's medical malpractice insurance

plan is voluntary, but the plan does make insurance available to “qualified risks” unable to obtain private insurance. *Butler v. Flint Goodrich Hospital*, 607 So.2d 517, 521 (La. 1992), *cert. denied*, 113 S. Ct. 2338.

- b) Greater assurance of collection from a solvent fund;
- c) Payment of all medical care and related benefits.

b. Quid pro quo

1. Discrimination in the Act against those with excessive injuries vs. reasonable alternative remedy for compensating victims.

2. Louisiana Constitution Art. 1 § 3 of 1974: "No person shall be denied the equal protection of the laws. No law shall discriminate against a person because of race or religious ideas, beliefs, or affiliations. No law shall **arbitrarily, capriciously, or unreasonably** discriminate against a person because of birth, age, sex, culture, physical condition, or political ideas or affiliations..."

- a) Although this statute distinguishes between malpractice victims based upon extent of their injuries, the Supreme Court of Louisiana has determined that the discrimination created by MMA is

not arbitrary, capricious, nor unreasonable. See *Williams v. Kushner*, 549 So.2d 294 (La. 1989) (Dixon, Chief Justice dissenting).

- b) Therefore, the current view is that it does not violate Art. 1 § 3.

Recent Constitutional Attack

In *Taylor v. J. Clement, M.D.* 807 So.2d 909 (La. App. 3rd Cir. 3/09/05), a new attack was made on the constitutionality of the MMA using the argument that the cap is unconstitutional today because it has never been increased for inflation.

1. MMA was created in 1975 in response to medical malpractice insurance “crisis”. The legislature was attempting to control rapidly increasing medical malpractice insurance premiums.
2. MMA established a \$500,000 limit in 1975. With inflation the \$500,000 limit set in 1975 is worth only \$160,000 in 2005. See *Taylor v. J. Clement, M.D., LPCF*, 807 So.2d 909 (La. App. 3 Cir. 3/9/05).
3. If the cap were adjusted to reflect inflation it would have to be increased to around \$1,707,250. See Consumer Price Index, 2003.
4. The dollar continues to be worth less each year, placing lower “caps” on victims each year while the non-existence of any limitation on insurers allows continued increases in their premiums and profits. See *Susan Arrington v. Galen-Med, Inc. et al.*, Original Brief of Appellant, Susan Arrington, et al. (October 7, 2004) p. 24

Introduction to Medical Review Panels in Louisiana

- A. Statutory Definitions
 3. Patient
 - A. La. R.S. 40:1299.41 A(3).
 - B. Derouen v. State ex Rel. Dept. of Health can Hospitals, App.

3 Cir. 1999, 98-1201 (La. App. 3 Cir. 2/3/99), 736 So.2d 890. Plaintiff who alleged a blood sample was drawn for purpose of performing testing for HIV was a “patient” who was receiving “health care” for purposes of Malpractice Liability.

4. Malpractice

A. La. R.S. 40:1299.41 A(8)

B. Physician Standard of Care

LeBlanc v. Barry, 790 So. 2d 75, (La. App. 3 Cir. 02/28/01), 2001 La. App. 3 Cir. Lexis 383. The Court held in order for a Plaintiff to satisfy his burden of proof in a malpractice action based on the negligence of a physician, the plaintiff must prove:

- (1) the applicable standard of care;
- (2) the breach of the standard; and
- (3) the substandard care caused an injury the plaintiff otherwise would not have suffered.

The test to determine the causal connection between the doctor’s negligence and the injury is whether the plaintiff proved through medical testimony it is more probable than not the injuries were caused by the substandard of care.

3. Health Care

C. La. R.S. 40:1299.41 A(9)

D. Patin v. The Administrators of the Tulane Educational Fund, 770 So.2d 816 (La. App. 4 Cir. 08/16/00).

As with all limiting laws, the Medical Malpractice Act is strictly construed against

coverage. In this instance, the Court held the transfer of blood from Touro Infirmary to Tulane did not fall within the Malpractice Act because there was no health care provider patient relationship between Touro Infirmary and Plaintiff. The Court rejected Touro's argument which asserted the plaintiff's claim fell within the Malpractice Act of the State of Louisiana as it had an implicit contract with Mr. Patin because Tulane sought blood from Touro on behalf of Mr. Patin.

- E. George vs. Our Lady of Lourdes Regional Medical Center, Inc., 774 So.2d 350 (La. App. Cir. 12/06/00).

Plaintiff fell down the steps of the mobile unit after donating blood. The Third Circuit Court of Appeal held the plaintiff's claim did not fall within the medical malpractice act and stated:

To constitute malpractice, health care or professional services must be rendered to a patient. (Citations omitted.) Ms. George's sole remedy against Medical Center is based on the general law of negligence and not on the special tort of malpractice. Id. at 352.

- 5. Qualified Health Care Provider
 - A. La. R.S. 40:1299.42A
 - B. Jones v. Crow, 633 So.2d 247 (La. App. 1 Cir. 1993). To qualify under the Medical Malpractice Act, health care provider must file type of proof of financial responsibility described in the statute and pay the Patient's Compensation Fund surcharge levied on the provider. For self-insureds, qualification under the Act is effective upon acceptance of proof of financial responsibility and receipt of payment of

surcharge; for health care providers other than self-insured, qualification is effective at the time that the malpractice insurer accepts payment of the surcharge.

B. Burden of Proof in Malpractice Cases

1. La. R.S. 9:2794

2. LeBlanc v. St. Paul Fire and Marine Ins. Co., 3 Cir.

2000, 99-2008, 772 So.2d 133 (La. App. 3 Cir. 9/6/00). Plaintiffs in medical malpractice actions must establish their claim by a preponderance of the evidence.

3. Malpractice Must be Proximate Cause of Injury

Williams v. Dauterive Hospital, 771 So.2d 763 (La. App. 3 Cir. 10/11/00)

A patient was taken to the hospital after he fell off the back of pick up truck and hit his head on the concrete pavement. The Court held the emergency room physician's breach of the standard of care was not the proximate cause or result of the patient's injury and subsequent death, as the ER physician's failure to timely intervene would not have affected the management or the outcome of the patient's situation as no operation was going to save the patient's life.

C. Filing of a Medical Malpractice Claim

3. Administrative Review

3. La. R.S. 40:1299.47A(1)

4. Bolden v. Dunaway, 727 So.2d 597 (La. App. 1 Cir. 12/28/98).

All claims against health care providers for malpractice must first go through the

Medical Malpractice Act procedure, regardless of whether the claimant is a patient or a non-patient. The court ruled that plaintiff husband's claim for emotional distress was also a claim against a healthcare provider for malpractice and therefore subject to the Act, though plaintiff husband was not a patient.

1. One Panel for State and Private Claims

3. La R.S. 40:1299.49:

The following provisions shall apply when, for the same injury to or death of a patient, a malpractice claim alleges liability of both a state health care provider under the provisions of this Part and a health care provider under the provisions of Part XXI-A of this Chapter:

(1) Unless all parties have agreed otherwise, only one medical review panel shall be convened in such instance to review the claims under this Part and Part XXI-A of this Chapter.

(2) The panel shall consist of a single attorney chairperson and three health care providers who hold unlimited licenses to practice their profession in Louisiana.

(3) The panel shall be considered a joint medical review panel, and its actions shall be deemed to have the same force and effect as if a separate medical review panel had been convened under each of the respective Parts.

(4) The panel shall be governed by the law applicable under both Parts. In the event of a procedural conflict between the provisions of the Parts, the provisions of R.S. 40:1299.47 shall govern.

2. \$100 Filing Fee Must be Paid Per Named Qualified Defendant

3. La. R.S. 40:1299.47 A(1)(c):

A claimant shall have forty-five days from the mailing date of the confirmation of receipt of the request for review in accordance with Subparagraph (3)(a) of this Subsection to pay to the board a filing fee in the amount of one hundred dollars per named defendant qualified under this Part.

(d) Such filing fee may be waived only upon receipt of one of the following:

(i) An affidavit of a physician holding a valid and unrestricted license to practice his specialty in the state of his residence certifying that adequate medical records have been obtained and reviewed and that the allegations of malpractice against each defendant health care provider named in the claim constitute a claim of a breach of the applicable standard of care as to each named defendant health care provider.

(ii) An in forma pauperis ruling issued in accordance with Louisiana Code of Civil Procedure Article 5181 et seq. by a district court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process.

(e) Failure to comply with the provisions of Subparagraph (c) or (d) of this Paragraph within the specified time frame shall render the request for review of a malpractice claim invalid and without effect. Such an invalid request for review of a malpractice claim shall not suspend the time within which suit must be instituted in Subparagraph (2)(a) of this Subsection.

(f) All funds generated by such filing fees shall be private monies and shall be applied to the costs of the Patient's Compensation Fund Oversight Board incurred in the administration of claims.

(g) The filing fee of one hundred dollars per named defendant qualified under this Part shall be applicable in the event that a claimant identifies additional qualified health care providers as defendants. The filing fee applicable to each identified qualified health care provider shall be due forty-five days from the mailing date of the confirmation of receipt of the request for review for the additional named defendants in accordance with R.S. 40:1299.47(A)(3)(a).

D. Qualified Healthcare Provider Status

1. Establishing Status

A. La. R.S. 40:1299.42E(1)

B. St. Paul v. Eusea, 775 So.2d 32 (La. App. 1 Cir. 12/29/00).

A physician can become a "qualified health care provider" whose liability for

malpractice is limited to \$100,000, even if the physician fails to file as proof of financial responsibility every policy of malpractice insurance covering the provider.

- C. Goins v. Texas State Optical, Inc., 463 So.2d 743 (La. App. 4 Cir. 1985).

Certificates of enrollment from Commissioner of Insurance certifying enrollment under Medical Malpractice Act were prima facie evidence of their contents, and it was up to plaintiffs in medical malpractice suit to rebut this evidence of defendants' qualification as health care providers under Act which entitled defendants to medical review panel determination prior to filing of lawsuit against them.

2. Maintaining Status

- A. La. R.S. 40:1299.45A(1)
- B. Jones v. Crow, 633 So.2d 247 (La. App. 1 Cir. 1993).

As long as health care provider remains qualified under the Act, the health care provider and his insurer are liable for malpractice only to the extent provided for in the act.

C. Death of Physician

Prior to his death, a physician was insured through a commercial carrier and was a qualified member of the Patient's Compensation Fund. Upon his death, as was the usual procedure, a portion of the underlying carrier's premium and the PFC surcharge was refunded to the estate of the decedent. Plaintiff then contended the deceased physician was no longer a qualified health care provided and was not accorded the

protections of LSA-R.S. 40:1299.41 et seq. The First Circuit Court of Appeal in *Dunn v. Bryant*, 701 So. 2d 696 (La.App. 1 Cir. 09/19/97), found the decedent, Dr. Bryant, and his estate were protected by the Patient's Compensation Fund under LSA-R.S. 40:1299.41 et. seq.

3. Miscellaneous Jurisprudence

A. Insurance and PCF Coverages Coextensive

The Physician had a claims made policy and paid a PCF surcharge over the time during which medical malpractice occurred, but had let the policy lapse and did not pay the PCF surcharge for the time during which the claim was actually made. The First Circuit held the provision of a claims made policy requiring a claim be made within the policy period was without effect if it reduces the prescriptive period against the insurer to less than a year and, therefore, the policy period was extended by operation of law thereby extending the PCF coverage and allowing the doctor to be considered qualified. *Bennett v. Krupkin*, 819 So. 2d 338 (La. 2002).

B. Failure to Disclose Proper Procedures Actually Performed by Physician

Tucker v. Lain, 798 So.2d 1041 (La. App. 4 Cir. 09/05/01). In a medical malpractice action involving alleged negligence in the delivery of a child, the physician/defendant, a self insured physician who paid surcharges to the PCF was qualified even though she failed to disclose to the PCF she delivered babies rather than merely practicing gynecology (thereby allowing her to pay a lower surcharge to the PCF.)

_____ C. Collection of an Improper Surcharge

In Bennett v. Krupkin, 814 So. 2d 681 (La.App. 1 Cir. 03/28/02)

(La. 2002), the First Circuit stated that with regard to the collection of surcharges, the statutes are clear that where proof of financial responsibility is established through an insurance policy, the insurer has the responsibility to collect the proper annual surcharge. The insurer must then remit the surcharge to the Fund within 45 days of payment of the premium. If the insurer fails to remit the appropriate surcharge, the Fund may assess a penalty and collect attorney's fees against the insurer or pursue legal remedies against the insurer. However, there is no provision in the Act authorizing the termination or restriction of the insured health care provider's qualification if an improper surcharge is collected by the insurer.

E. Request for Medical Review Panel

1. Must be Filed with the Division of Administration

A. La R.S. 40:1299.47 A(2)(a)

B. Jurisprudence

The patient initially filed her medical malpractice claim under the "public" malpractice act, La. R.S.

[40:1299.39/research/buttonTFLink?_m=d83d7bee5db9230f39829ae5f715067a&_xfercite=%3ccite%20cc%3d%22USA%22%3e%3c%21%5bCDATA%5b692%20So.%202d%](#)

et seq. After notification from the agency that administered the act the physician was a qualified provider under the "private" malpractice act, La. R.S. 40:1299.41

[/research/buttonTFLink?_m=d83d7bee5db9230f39829ae5f715067a&_xfercite=%3ccite](#)

[%20cc%3d%22USA%22%3e%3c%21%5bCDATA%5b692%20So.%202d%et seq., she waited 16 months before filing her claim with the correct agency. The physician filed a rule to dissolve the medical review panel in district court, contending the claim had prescribed. The court held the patient would be afforded the suspension of prescription under the public act, even though the physician was a qualified provider under the private act. The patient's claim under the public act was timely. The liberative prescriptive period was suspended pursuant to La. R.S. 40:1299.39A\(2\)\(a\)/research/buttonTFLink?_m=d83d7bee5db9230f39829ae5f715067a&_xfercite=%3ccite cc%3d%22USA%22%3e%3c%21%5bCDATA%5b692 So. 2d% until 60 days after the patient received notice the provider was not qualified under the public act. At that point, she had eight months to toll prescription again by filing her claim under the correct act. Her claim under the private act, filed 16 months later, was untimely. Bordelon v. Kaplan, 692 So.2d 581 \(La. App. 3 Cir. 03/05/97\).](#)

1. As La. R.S. 40:1299.47(A)(2)(a) provides a claim is deemed filed on the date it is received by the PCF, when a medical malpractice claim is sent either to the PCF or to the Division of Administration, prescription is suspended. Patty v. Christis Health Northern Louisiana, 794 So.2d 124 (La.App. 2 Cir. 08/22/01); Holmes v. Lee, 795 So.2d 1232 (La.App. 2 Cir. 09/28/01).
 2. Time Deemed Filed - La. R.S. 40:1299.47A(2)(b)
 3. Waiver of Medical Review Panel
- B. La. R.S. 40:1299.47B(1)(c)

- C. Barraza v. Scheppegrell, App. 5 Cir.
1988, 525 So.2d 1187.

Health care provider who fails to file exception of prematurity prior to filing answer waives right to review of malpractice claims by medical review panel.

B. Prematurity of Suit Prior to Medical Review Panel

3. La. R.S. 40:1299.47B(1)(a)(i)
2. Martin v. Comm-Care Corp., 859 So. 2d 217 (La. App. 2 Cir. 0/16/03).

Decedent was admitted to a nursing home in January 1997 and remained in the nursing home until March 2000. He died in May 2000. Plaintiffs alleged that while in the nursing home's care, the decedent receive inadequate medical care. Plaintiffs filed suit against the nursing home in February 2001, but did not serve the nursing home until June 2001. Plaintiffs did not request a medical review panel until November 2001. The appellate court affirmed the trial court's grant of the exception of prescription.

Selection of the Medical Review Panel

B. Attorney Chairman

1. Joint Selection - La. R.S. 40:1299.47C
2. Strike List
 - A. La. R.S. 40:1299.47C
 - B. Kimmons v. Sherman, 771 So.2d 665 (La.App. 1 Cir. 03/31/00).

By requesting list of attorneys' names within 90 days of receiving notice from

PCF that plaintiffs were required to appoint attorney chairman for medical review panel, plaintiffs in medical malpractice action prevented dismissal of claim for failure to appoint attorney chairman.

C. Health Care Providers

2. Plaintiff's Nominee - La. R.S. 40:1299.47C(3)(a)
3. Defendant's Nominee - La. R.S. 40:1299.47C(3)(b)
4. Third Nominee - La. R.S. 40:1299.47C(3)(d)
5. Multiple Plaintiffs or Defendants - La. R.S. 40:1299.47C(3)(h)
6. Failure of Plaintiff or Defendant to Nominate
 - A. Warning by Attorney Chairman - La. R.S. 40:1299.47C(3)(c)
 - B. Nomination by Attorney Chairman - La. R.S. 40:1299.47C(3)(d)
6. Failure of Two Healthcare Provider Panelists to Nominate Third Member - La. R.S. 40:1299.47C(3)(e)
6. Qualifications of Physician Nominees - La. R.S. 40:1299.47C(3)(f)
7. Excusing Panel Members from Service - La R.S. 40:1299.47C(3)(i)
8. Who May be a Panelist Based on Defendants
 - A. La R.S. 40:1299.47(C)(3)(j)
 - B. Jurisprudence
 1. In re Medical Review Panel for Claim of White, 655 So. 2d

(La. App. 4 Cir. 05/16/95).

Where there are multiple defendants who include a hospital, plaintiffs may name a physician from one of the specialities of the defendant physicians but were not required to do so.

2. Francis v. Mowad 523 So. 2d 863 (La. App. 5 Cir. 1988).

Plaintiff alleged defendant-podiatrist was negligent in treating her foot condition, and a medical review panel proceeding was instituted. Plaintiff nominated an orthopedic surgeon as a member of the medical review panel. Defendant objected. The court of appeal agreed with the trial court that an orthopedic surgeon is not within the same class and speciality of practice, as required by La. R.S. 40:1299.47 C(3)(j).

C. Conflict of Interest by Panel Member

I. La. R.S. 40:1299.47(C)(7)

II. Jurisprudence

A. Whitt v. McBride, 651 So. 2d 427 (La. App. 3 Cir 03/01/95).

Member of medical review panel does not have to be viewed as similar to a judge. The statute only mandates conflicts of interest be disclosed in writing to the parties but does not specify automatic disqualification from service on the medical review panel. Determination is left to discretion of the trial court.

B. Landry v. Martinez, 415 So. 2d 965 (La. App. 3 Cir 1982).

Doctor could not sit as medical review panelist where one of his partners had

served as medical consultant to the medical malpractice claimant and would probably continue to do so.

Duties of the Members of the Medical Review Panel

B. Attorney Chairman

1. General Duties - La R.S. 40:1299.

2. Specific Duties -

B. Advise Panel Members on Legal Issues - La. R.S.
40:1299.47D(5)

B. Send Copy of Panel Opinion to All Parties - La R.S.
40:1299.47D(6)

C. Oath of Office - La. R.S. 40:1299.47J

B. Nominated Members

2. Oath of Office - La. R.S. 40:1299.47C(5)

3. Determination of Fault

A. La. R.S. 40:1299.47G

A. Maxwell v. Soileau, 561 So. 2d 1378

(La. App. 2 Cir. 1990).

The sole duty of the medical review panel is to express its expert opinion. No findings are made by the panel as to damages, and the findings of the panel are not binding on the litigants.

3. Possible Panel Opinions - La. R.S. 40:1299.47G

McCallister v. Zeichner, 664 So.2d 848 (La. App. 3 Cir. 12/06/95).

Under statute, medical review panel must render opinion with written reasons. Opinion is not complete without such reasons, and panel has not fulfilled its statutory duty.

Life of Medical Review Panel

- A. One Year From Appointment of Attorney Chairman - La. R.S.
40:1299.47B(1)(b)
- B. 180 Days from Appointment of Final Panel Member - La. R.S.
40:1299.47G
- C. 90 Days After Notification of All Parties of Dissolution or after Court-Ordered Extension
 - 1. La. R.S. 40:1299.47B(3)
 - 2. LeBlanc v. Lakeside Hospital, 732 So.2d 576 (La.App. 5 Cir. 03/10/99).

Medical review panel automatically dissolves upon the expiration of any court-ordered extension.

- D. Extending the Life of the Medical Review Panel
 - 2. La. R.S. 40:1299.47B(1)(b)
 - 3. In re Medical Review Panel ex rel. Chiasson, 749 So.2d 796 (La.App. 5 Cir. 11/30/99).

Trial court acted within its discretion in determining that hospital did not show

cause for extending life of medical review panel in medical malpractice action as no explanation for panel's delay in ruling was provided, and no hearing was requested.

Prescription Associated with Medical Review Panels

- A. Interruption of Prescription During Panel Proceedings
 - 2. Statutory Law - La. R.S. 40:1299.47A(2)(a)
 - 3. Jurisprudence
 - B. Guitreau v. Kucharchuk, 763 So.575 (La. 2000).

The Court held when the ninety-day period of suspension after the decision of the medical review panel is completed, plaintiffs in medical malpractice actions are entitled to the period of time, under LSA-R.S. 9:5628, which remains unused at the time the request for a medical review panel is filed. Once a medical malpractice claim is submitted to the medical review panel, the prescriptive period is temporarily discontinued. Prescription then commences to run again ninety days after the plaintiff has received notice of the panel's decision. Thus, when the ninety day period expires, the period of suspension terminates and prescription commences to run again; once prescription begins to run again, counting begins at the point at which the suspension period originally began.

- C. Baum v. Nash, 702 So. 2d 765 (La. App. 3 Cir. 10/9/97).

Filing a claim for a medical review panel suspends prescription as to non-named solidary obligors "to the same extent that it is suspended for those named in the request by the panel."

- D. Commencement of the medical review panel proceedings

will serve to suspend prescription. A written inquiry as to the status of a health care provider under the PCF, including allegations of malpractice by the healthcare provider for whom the qualification information is being sought, may serve to suspend prescription. In re Medical Review Panel Leday, 706 So. 2d 985 (La. 1998), the Louisiana Supreme Court interpreted a letter which outlined the complaints of medical malpractice as a timely request for review and overruled the exception of prescription. The case was remanded to the Medical Review Panel for further proceedings.

A. Failure of Panel to Render a Decision and Prescription

1. 180 Day Rule - La. R.S. 40:1299.47 K
2. Bankston v. Alexandria Neurosurgical Clinic, 583 So.2d 1148 (La. App. 3 Cir. 1991).

Medical review panel's failure to render formal opinion did not deprive district court and court of appeal of jurisdiction over medical malpractice claim, where panel had been dissolved without necessity of obtaining court order of dissolution upon its failure to issue written opinion within extension of time granted for rendering of opinion. Once panel was dissolved, no procedural bar prevented patient from filing suit in district court, and it was incumbent upon patient to file suit to preserve her rights as dissolution of panel affected suspension of prescription with respect to defendants.

3. One Year Rule Takes Precedence

Metrejean v. Long, 732 So.2d 1240. (La.App. 3 Cir. 03/31/99). Once 12-month period expires for medical review panel to render expert opinion, patient may file suit, even if the 180-day period for rendering opinion after selection of last panel member happens to extend beyond the one-year period.

C. Panel Renders a Late Decision -180 Day Rule -

La. R.S. 40:1299.47L

D. Filing with Wrong State Agency

Bordelon v. Kaplan, 692 So.2d 581 (La.App. 3 Cir. 03/05/97). Filing of medical malpractice claim in the wrong or improper agency suspends, rather than interrupts, liberative prescriptive period, and at termination of period of suspension, prescription commences to run again.

C. Prescription in Hepatitis C Cases

In Williams v. Jackson parish Hospital, La. 2001, 798 So.2d 921, the Louisiana Supreme Court, apparently overruling their recent decision in Boutte, held pre-1982 claims in strict liability arising out of a defective blood transfusion are not traditional medical malpractice claims and, therefore, not governed by the Medical Malpractice Prescription Statute (La. R.S. 9:5628), but were governed by the General Tort Prescriptive Statute (La. C.C. Art. 3492.) The patient's strict liability claims were not prescribed, although her malpractice claims were.

F. PCF's Right to Raise Prescription

If a qualified healthcare defendant pays less than \$100,000.00, the PCF may raise an exception of prescription, but the PCF cannot raise the issue of prescription if the defendant pays more than \$100,000.00. Miller v. Southern Baptist Hospital, La. 2001, 806 So.2d 10.

G. Premature Suit DOES NOT Interrupt Prescription

2. The Louisiana Supreme Court in LeBreton v. Rabito, 714 So. 2d 1226

(La. 1998) overruled the case of Hernandez v. Lafayette Bone and Joint Clinic, 467 So. 2d 113 (La. App. 3 Cir. 1985) in holding:

[T]he specific statutory provision providing for the suspension of prescription in a context of medical malpractice should have been applied alone, not complimentary to the more general codal articles which addresses interruption of prescription.

After discussing the purpose behind liberative prescription, the Court contrasted the general Civil Code Articles of Prescription dealing with interruption as compared to the Medical Malpractice Act for qualified health care providers which suspends the running of prescription during the pendency of medical review panel proceedings. The Court, believing the statutes were in conflict, and in order to "harmonize" the law, held special rules (here the Medical Malpractice Act) will always outweigh the general rules otherwise the special legislative provisions will be canceled out by the application of general laws. In such a conflict, the Court goes on to point out the purpose behind suspension of liberative prescription, is to accord plaintiffs an equal playing field during the pendency of the Medical Review Panel Proceedings.

2. In Schulingkamp v. Ochsner Clinic, 813 So. 2d 524 (La. App. 5 Cir. 03/13/02).

The plaintiff filed suit, then entered a consent judgment dismissing one of the defendants without prejudice because the claim was premature, but keeping other defendants in the suit. A medical review panel was not filed against the dismissed defendant until eight years later. The plaintiff argued the pending suit against the other defendants interrupted prescription against the dismissed defendant. Citing Lebreton v. Rabito for the proposition it was inappropriate to apply La. C.C. Art. 3463 (which interrupts prescription as long as the suit remained against the remaining obligors), the Court held the claim against the dismissed defendant was prescribed. The Court noted the later, more specific statute, the Medical Malpractice Act, applies and, because the plaintiff did not file the malpractice claim within one year, the claim was prescribed.

3. In Wesco v. Columbia Lakeland Medical Center, 862 So.2d 997 (La App. 4 Cir. 09/10/03).

The plaintiff filed a premature suit and a Medical Review Panel Claim which was dismissed after two years for failure of the plaintiff to select an attorney chairman. The defendant then had the suit dismissed as premature. When the plaintiff filed a second PCF claim within one year of the dismissal of the suit, but not within one year of the first PCF claim, the defendant filed an Exception of Prescription. The court held the premature suit did not suspend prescription and the plaintiff's claim was prescribed.

H. Wrongful Death Claim and Suspension of Prescription

Brown v. Our Lady of the Lake, 803 So.2d 1135 (La.App. 1 Cir. 12/28/01).

A mother and son filed a Medical Review Panel Complaint alleging treatment the mother received was negligent, but the mother died during the pendency of the Medical Review Panel and the complaint was not amended to allege the mother's death. Within ninety days of the Panel opinion, but more than one year after the mother's death, the son filed a wrongful death and survival action. The Court held the wrongful death claim was prescribed as it was not filed within one year of the death and the Medical Review Panel proceeding did not suspend prescription on the wrongful death claim because no notice of the death was given.

I. Burden of Proof Regarding Prescription

In Campo v. Correa, 838 So. 2d 501 (La. 2002), the Louisiana Supreme Court held a medical malpractice petition should not be found to be prescribed on its face if: It is brought within one year of the date of discovery; the facts alleged with particularity in the petition show the patient was unaware of malpractice prior to the alleged date of discovery; and the delay in filing suit was not due to willful, negligent, or unreasonable action of the patient. Therefore, as long as the plaintiff asserts the malpractice was not discovered until less than one year prior to filing the petition, the defendant retains the burden of showing the claim is prescribed.

J. Participating in Medical Review Panel of a Prescribed Action

In Tuazon v. Eisenhardt, 725 So. 2d 553 (La. App. 5 Cir. 12/16/98), the court upheld the long-standing rule of solidary obligations interrupting prescription as to other solidary obligors finding, once prescription is accrued, it cannot be interrupted. Finding the original complaint filed on June 29, 1995 was beyond the date of prescription, the

court concluded the proceedings did not serve to suspend the tolling of the prescriptive period as same was untimely. Regardless of the fact the hospital chose to proceed through the medical review panel proceedings, its choice did not serve to suspend the running of prescription.

K. Constructive Knowledge

In Harold v. Martinez, 715 So.2d 660 (La. App. 2 Cir. 06/24/98), the court of appeal indicated the only necessary ingredient to begin the running of prescription is "constructive knowledge." It is not required an attorney or another health care provider inform of the possibility of a malpractice action before prescription begins to run.

L. Amending Date of Alleged Malpractice and Prescription

In In Re: Medical Review Panel of David Wempren, 726 So.2d 477 (La. App. 5 Cir. 01/26/99), Plaintiff's counsel filed a request for medical review panel within one year of the complained of event. However, in the complaint, the wrong date was set forth as to when the offending event occurred. More than a year after the event in question, plaintiff's counsel amended the original complaint and the hospital filed an exception of prescription which was denied by the trial court. The trial court and the Fifth Circuit Court of Appeal relied upon Louisiana Civil Code of Procedure Article 1153 to find adequate and timely notice to the named defendants of the event in question and the amending petition related back to the original filing of the complaint for medical review panel proceedings. Accordingly, the court affirmed the denial of the exception of prescription.

M. Contra Non Valentum

Collum v. E.A. Conway Medical Center, 763 So.2d 808 (La. App. 2 Cir. 06/21/00). Plaintiff argued her claim fell under the third category of *contra non valentem* because her ignorance of a potential cause of action was in some way "induced" by the defendants when they allegedly neglected to inform her of their actions. The court rejected plaintiff's argument, stating the Louisiana Supreme Court has specifically limited application of this third category to instances where a physician's conduct rose "to the level of concealment, misrepresentation, fraud or ill practices."

Plaintiff also argued the three-year prescriptive period should be interrupted because the alleged malpractice falls under the "continuing tort" doctrine. The Court of Appeal rejected plaintiff's argument in citing prescription runs on a continuing tort from the "cessation of the wrongful conduct that causes of damages where the cause of injury is a continuous one given rise to the successive damages," Collum So.2d at 811. In Crump v. Sabine River Authority, 737 So. 2d 720 (La. 1999). The Court clarified stating a continual tort is occasioned by unlawful acts, not "the continuation of the ill effects of an original, wrongful act." Id at 728. In this instance, the Court found plaintiff was merely suffering the continuation ill effects of the original act same is not a continuing tort.

Submission of Evidence to Medical Review Panel

- X. Written Evidence - La. R.S. 40:1299.47D(1)
- Y. Other Attachments to Submission of Evidence - La. R.S. 40:1299.47D(2)
- Z. Requirements of Claims for a Medical Review Panel - La. R.S. 40:1299.39 E(2)

Filing Suit After Panel Renders Opinion

A. In Favor of Defendants - Bond Required

La. R.S. 40:1299.47 I(2)(c)

In a medical malpractice suit filed by the claimant in which a unanimous opinion was rendered in favor of the defendant health care provider as provided in the expert opinion stated in Paragraph (G)(2) of this Section, the claimant who proceeds to file such a suit shall be required to post a cash or surety bond, approved by the court, in the amount of all costs of the medical review panel. Upon the conclusion of the medical malpractice suit, the court shall order that the cash or surety bond be forfeited to the defendant health care provider for reimbursement of the costs of the medical review panel, unless a final judgment is rendered finding the defendant liable to the claimant for any damages. If a final judgment is rendered finding the defendant liable to the claimant for any damages, the court shall order that the defendant health care provider reimburse the claimant an amount equal to the cost of obtaining the cash or surety bond posted by the claimant.

B. In Favor of Claimant - Bond Required

La. R.S. 40:1299.47 I(2)(d)

In the event a medical review panel renders a unanimous opinion in favor of the claimant as provided in the expert opinions stated in Paragraphs (G)(1) and (4) of this Section, and the claimant has not timely submitted an in forma pauperis ruling to the panel's attorney chairman, and thereafter the defendant health care provider failed to settle the claim with the claimant resulting in the claimant filing a malpractice suit in a

court of competent jurisdiction and proper venue against the defendant health care provider based on the same claim which was the subject of the unanimously adverse medical review panel opinion against the defendant health care provider, the defendant health care provider shall be required to post a cash or surety bond, approved by the court, in the amount of all costs of the medical review panel. Upon the conclusion of the medical malpractice suit, the court shall order that the cash or surety bond be forfeited to the claimant for reimbursement of the costs of the medical review panel, unless a final judgment is rendered finding that the defendant health care provider has no liability for damages to the claimant. If a final judgment is rendered finding that the defendant health care provider has no liability for damages to the claimant, the court shall order that the claimant reimburse the defendant health care provider an amount equal to the cost of obtaining the cash or surety bond posted by the defendant health care provider.

III. EVALUATION OF A MEDICAL NEGLIGENCE CASE

A. Assessing the Case – The Initial Evaluation

“Medical malpractice cases are won or lost in the screening process.” Although many of us medical malpractice lawyers like to assume our great trial skills are responsible for our success, the majority of our wins began and ended during a thorough screening process. There are many factors which determine whether you have a provable medical malpractice case which is worth the time, effort and money it takes to successfully pursue these cases.

First, just because a bad outcome was experienced by the patient does not automatically mean that medical malpractice occurred. Complications are frequently

experienced by patients which leave the patient in a much worse state of health than in which they otherwise would have been. Most complications are not considered to be malpractice, but rather an unfortunate and unintended accepted risk of a procedure.

In determining whether a patient has a medical malpractice case, it is important to make a very important distinction. Knowing that a patient was the victim of medical malpractice and proving it are two very separate things. It does not matter how passionate a patient feels about the medical errors committed upon them if it cannot be proven in a court of law.

Proving a medical malpractice case can be a very challenging and complex task. First, it requires the experience and help of a highly qualified medical malpractice attorney. Next, it requires documentation of the events surrounding the malpractice as they occurred. Third, it requires a complete and accurate medical record which specifically demonstrates the malpractice. Fourth, it requires that the claim is not beyond the statute of limitations. Finally, it requires the retention of top consulting and testifying medical expert witnesses.

Louisiana, like most other states generally requires that in order for a plaintiff to prevail in a medical malpractice suit, he must demonstrate what the standard of care is, a breach of the standard of care and causation of damages from that breach. This standard of proof usually requires expert testimony. Expert testimony is not required where the physician does an obviously careless act, such as fracturing a leg during examination, amputating the wrong arm, dropping a knife, scalpel, or acid on a patient or leaving a sponge in a patient's body, from which a lay person can infer negligence.

Pfiffner v. Correa, 94-0924 (La. 10/17/94), 643 So.2d 1228.

Since the majority of cases will require expert testimony to meet the burden of proof at trial, it is critically important to have the case reviewed by one or more expert physicians prior to agreeing to undertake the representation of the plaintiff. The evaluation process begins with obtaining the medical records.

B. Gathering and Reviewing the Medical Records

Obtaining a copy of the complete medical records is more difficult than it sounds. However, without an accurate copy of these vital records, a patient has virtually no chance of proving a medical malpractice case.

In trying to obtain a complete and accurate copy of the medical chart, there are a couple of important facts to keep in mind. First, a patient must make a written request to the involved health care provider in order to receive a copy of their records. In March, 2003, a new federal law, the Health Insurance Portability and Accountability Act, (HIPPA), became effective. Medical records requests are now governed by the provisions of HIPPA. The complete requirements and implications of HIPPA are beyond the scope of this seminar. However, in general, HIPPA requires that a specific type of medical authorization with specific language be utilized to obtain a patient's medical records. The medical authorizations of the past are no longer accepted by health care providers. Moreover, stiff fines and penalties can be levied against any health care provider who provides confidential medical information on a patient without complying with HIPPA.

With the exception of care rendered to a patient in the hospital, each health care

provider keeps separate records on the patient for the care they rendered to the patient. All records from a patient's hospitalization are kept by the medical records department of the hospital. In order to obtain a copy of these records, a HIPPA compliant written request must be made through the medical records department.

When making a request for such hospital records, it is important for the patient, family member or nurse paralegal to review the original chart first. This way, the copies can be checked to make sure that all of the records were in fact copied.

When making a request for records from either the hospital or a physician's office, attention should not be called to the fact that the records are being sought for a potential medical malpractice claim. Most patients will tell the provider that the records are being sought for a second opinion physician or to make sure that future medical providers are accurately informed about past medical history.

When a patient sees a physician in the physician's office and not the hospital, the records must be obtained from the physician's office. The hospital does not keep physician office notes or records. The physicians also usually do not keep any part of the hospital records in their chart, (with the exception of the operative report or other few pages). Thus, a patient must get records from both locations.

Most hospitals and physician offices become keenly aware of requests for patient records that are made by an attorney. In fact, some hospitals have a policy of routing attorney requests for records through their risk management department so that a risk manager can review the records first.

For these reasons, and the potential fear of record alteration or loss of records, it

is very important that the first request for records come from the patient or his family. Later, after the claim has been filed, the attorney can get a certified copy of the records which can then be compared to the ones obtained by the patient.

Keep in mind that certain types of records are not kept in the formal medical record and must be specifically requested separately. For instance, the fetal heart monitor strips used to monitor babies in the womb are usually not part of the formal record and must be requested separately. These records are often the critical records to determine whether malpractice occurred. They are also the first records to get lost or misplaced.

Finally, it should be mentioned that records are not always immediately available. Hospital records generally will not be made available until approximately 30 days after discharge.

B. The Need for Expert Consultation and Review

In order to properly screen for a viable medical malpractice case, a consulting medical expert must be retained to review the medical records involved in the patient's care. Consulting medical experts are different than testifying experts in that they will review the case, provide an opinion as to whether malpractice may be proven, but they will not testify.

In Louisiana, the identity of consulting medical experts is generally not discoverable by the defense. Thus, some local physicians are willing to anonymously review medical charts to determine if malpractice was committed. However, just because a local physician is willing to review charts without the medical community

knowing this fact, does not ensure that a local physician will be completely objective in the review.

If the local physician knows the doctor involved or is his friend, he may not be as likely to give a completely unbiased opinion on the chart review. Thus, it is always advisable to have an out of town physician review the case at some point before the case is accepted.

Some attorneys like to use nurses to screen the cases for merit. However, this attorney prefers to use physicians, particularly physicians in the same specialty as the physician who is alleged to have committed malpractice, to screen his cases. This approach provides a more thorough and accurate understanding of the issues in the case.

This is why it is important to retain an experienced medical malpractice lawyer who has resources to have the case properly screened for merit. Since the standard of medical care is not written in some book, it is important to use physicians who practice in the same specialty as the defendant doctor to analyze the medical/legal issues in the case.

Consulting experts are not cheap. Most charge by the hour for their review time. Some Louisiana attorneys will not retain consulting physicians and will simply submit the case to the medical review panel for their opinion. However, since approximately 97% of the medical review panels are won by the physicians, it is hard to tell whether the case truly lacked merit. Moreover, the consulting expert can help the attorney prepare the submission of evidence to the medical review panel so that important and

sometimes subtle medical issues are not overlooked.

The consulting medical expert can also assist the attorney in preparing for the deposition of the defendant doctor. Again, thorough preparation can help determine all of the issues in the case at an earlier stage. It is always better for the patient and their families to know as early as possible if the case cannot be proven in a court of law. Consulting medical experts often provide the much needed closure and medical explanation that the family never got in the first place which prompted their suspicion.

B. Establishing Potential Areas of Liability

The initial screening physicians usually provide the potential areas of liability in the case. However, the physician should not be the only individual with input on this aspect. Often, medicine and the decisions made in medicine seem to conflict with logic and common sense. For example, just because some physicians deem it acceptable to perform flexible sigmoidoscopy to screen for colon cancer, does not mean that the patient should have only this test without knowing that only one-third of his colon is being viewed by the sigmoidoscope. Common sense tells us that the patient should be told that the only way to be one-hundred percent certain is to undergo a colonoscopy. If his insurance does not pay for a colonoscopy, he should be offered the option to undergo this test at his expense.

Another concern in establishing a theory of liability is the complexity of the medical issues involved. Even if the case medically presents a clear deviation from the standard of care, the issues must lend themselves to explanation to a lay person jury. If it cannot be explained in simple terms, it will be difficult to overcome a jury's natural

tendency to give the physician the benefit of the doubt in a close case.

B. The Initial Client Conference

There are many things you need to do to prepare to meet with your lawyer. In a medical malpractice case, it is important to gather all of the written documentation supporting your claim. Without the proper documentation, it will be difficult for the attorney to evaluate the merits and value of the case. Moreover, during the first meeting, the lawyer will likely ask many questions which can be answered by existing.

In medical malpractice claims, the most important records to get from the client during the initial meeting are the medical records involving the treatment. You will also want to obtain a copy of the client's driver's license number and social security number. If the case involves lost wages or time missed from work, documentation supporting a potential wage loss claim should be obtained, including, without limitation, tax returns for the past three years, W-2 forms, pay check stubs or other earnings records.

Other documentation to inquire about may include a journal or diary which contemporaneously documented the treatment as it occurred. If the claim involves imaging studies like x-rays or MRI's, the client should also bring the films to the meeting. Most lawyers also like a written summary or chronology outlining the claim against the healthcare provider. Include the names and addresses of all healthcare providers the patient claims were negligent.

IV. **HANDLING OF A MEDICAL MALPRACTICE CASE**

X. Burden of Proof

La. R.S. 9:2794 specifically sets forth the burden of proof in a malpractice case.

It provides:

The plaintiff shall have the burden of proving:

- (1) The degree of knowledge or skill possessed or the degree of care ordinarily exercised by physicians, dentists, optometrists, or chiropractic physicians licensed to practice in the state of Louisiana and actively practicing in a similar community or locale and under similar circumstances; and where the defendant practices in a particular specialty and where the alleged acts of medical negligence raise issues peculiar to the particular medical specialty involved, then the plaintiff has the burden of proving the degree of care ordinarily practiced by physicians, dentists, optometrists, or chiropractic physicians within the involved medical specialty.
- (2) That the defendant either lacked this degree of knowledge or skill or failed to use reasonable care and diligence, along with his best judgment in the application of that skill.
- (3) That as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

* * * * *

- C. In medical malpractice actions the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the negligence of the physician, dentist, optometrist, or chiropractic

physician. The jury shall be further instructed that injury alone does not raise a presumption of the physician's, dentist's optometrist's or chiropractic physician's negligence. The provisions of this Section shall not apply to situations where the doctrine of res ipsa loquitur is found by the court to be applicable.

In a medical malpractice action, opinions of expert witnesses who are members of the medical profession and who are qualified to testify on the subject are necessary to determine whether or not physicians possessed the requisite degree of knowledge or skill, or failed to exercise reasonable care and diligence. Frasier v. Department of Health and Human Resources, 500 So.2d 858 (La. App. 1st Cir. 1986); Steinbach v. Barfield, 428 So.2d 915 (La. App. 1st Cir. 1983).

B. Proximate Cause

La. R.S. 9:2794 noted above also sets forth that, like most other civil cases, the plaintiff has the burden of proving the proximate cause of his injuries. The difference between a medical malpractice case and other civil cases on the issue of proximate cause arises when the underlying healthcare provider pays \$100,000 to settle the case and thereby admits fault. If fault is admitted by this payment, what, if any, damages must a plaintiff prove were proximately caused by the admitted negligence?

This issue has been the subject of much litigation and debate. The law has changed on this issue several times. The current pronouncement on this issue is stated in Graham v. Willis-Knighton Medical Center, 97-0188, (La. 9/9/97), 699 So.2d 365, 372, where the supreme court explained:

[T]he legislative intent of "liability" in Section 1299.44 C(5) was that the

payment of \$100,000 in settlement establishes proof of liability for the malpractice and for damages of at least \$100,000 resulting from the malpractice, which is a very significant benefit to the medical malpractice victim. However, at the trial against the Fund, the plaintiff has the burden of proving that the admitted malpractice caused damages in excess of \$100,000.

Thus, the payment of \$100,000 only admits fault which proximately caused damages of at least \$100,000. Plaintiff, at trial, still must prove by a preponderance of the evidence that he sustained damages by the admitted malpractice in an amount above \$100,000 in order to recover additional sums.

When fault is admitted through the payment of \$100,000 by the underlying healthcare provider and general damages clearly exceed the statutory cap of \$500,000, and now, when there is no issue of third party fault, summary judgment may be an appropriate mechanism to force a quick resolution to the case. Courts have granted summary judgments in the past on this issue. See e.g. Bramlet v. The Louisiana Patient's Compensation Fund, 1998-1728 (La. 11/6/98), 722 So.2d 984; In re Medical Review Panel Proceedings Reidling v. Smith, 2002-0778 (La. App. 4th Cir. 9/18/02), 828 So.2d 656.

1. Filing A Request to Convene a Medical Review Panel

The MLSSA statute requires that “all malpractice claims against the state, its agencies, or other persons covered by this Part, ..., shall be reviewed by a state medical review panel established as provided in this Section, to be administered by the commissioner of administration,” Subsection (b) of that part states:

The request for review of the claim under this Section shall be deemed filed on the date of receipt of the complaint stamped and certified by the

commissioner, or on the date of mailing of the complaint if mailed to the commissioner by certified or registered mail.

Prior to August 17, 1997, the request to convene a medical review panel against a private healthcare provider was required to be filed with the Louisiana Patient's Compensation Fund, (the "PCF"). However, by Act 664 of 1997, the legislature amended part of the MMA, La. R.S. 40:1299.47 A(2)(a), to state in pertinent part:

"Filing a request for review of a malpractice claim as required by this Section with any agency or entity other than the division of administration shall not suspend or interrupt the running of prescription"

Unfortunately, under section 40:1299.47 A(2)(b), the language continued to provide:

"The request for review of the claim under this Section shall be deemed filed on the date of receipt of the complaint stamped and certified by the board or on the date of mailing of the complaint if mailed to the board by certified or registered mail."

The reference to the "board" in A(2)(b) is a reference to the PCF. Thus, an inconsistency existed in that one part of the MMA required the filing of a request for review with the PCF and another part of the same act provided that prescription would only be interrupted by filing the claim with the Division of Administration. This forced prudent attorneys to utilize a dual filing procedure and file a request for review with both agencies.

In 2002, HB 69 of the 2002 1st Extraordinary Session (Act 86), the legislature fixed this inconsistency by amending R.S. 1299.47 A(2)(b) to now provide:

The request for review of a malpractice claim under this Section shall be deemed filed on the date of receipt of the request stamped and certified by the division of administration or on the date of mailing of the request if mailed to the division of administration by certified or registered mail. Upon receipt of the request, the division of administration shall forward a copy of the request to the board within five days of receipt.

Accordingly, both Acts now require that a request for review of a medical malpractice claim be filed with the Division of Administration.

One other point is worth mentioning about the procedural requirement of filing a request for review. The request for review is deemed “filed” on the date it is mailed, not received, if it is mailed by certified or registered mail. A request filed by any other method (including Federal Express Mail), is not deemed filed until received by the Division of Administration. This can be a very significant provision when battling a prescription deadline. If filed by certified or registered mail, the attorney should obtain a certificate of mailing from the post office or have the post office physically post mark the date on the receipt. (This will require that the request for review be hand delivered to the post office). This is the only conclusive proof of the date of mailing, and thus, the date of filing, should a dispute arise.

b. Where to File the Request For Review

As of June 16, 2002, the proper address to file a claim with the Division of Administration is:

Louisiana Commissioner of Administration
Attention: Medical Review Panel
P.O. Box 44336
Baton Rouge, Louisiana 70804-4336

Their new physical address (as of January 2003), is:

1201 N. 3rd Street
7th Floor, Suite 7-210
Baton Rouge, Louisiana 70802

The phone number is (225) 342-7000.

b. What Format or Allegations Should the Request For Review

Contain

In 2003, the Louisiana Legislature again amended 40:1299.47 to include several new and important requirements with respect to filing a request for review. First, the statute now provides a listing of items that the request for review shall contain. This includes:

- (i) a request for the formation of a medical review panel;
- (ii) the name of the patient
- (iii) the names of the claimants
- (iv) the names of the defendant health care providers
- (v) the dates of the alleged malpractice
- (vi) a brief description of the alleged malpractice as to each named defendant health care provider
- (vii) a brief description of the alleged injuries.

In addition to this information, the 2003 amendment also requires:

A claimant shall have forty-five days from the mailing date of the confirmation of receipt of the request for review in accordance with R.S. 40:1299.47(A)(3)(a) to pay to the board a filing fee in the amount of one hundred dollars per named defendant qualified under this Part.

This statute allows for the waiver of that fee for an in forma pauperis case or where an affidavit of a physician holding a valid and unrestricted license to practice his specialty in the state of his residence certifying that adequate medical records have been obtained and reviewed and that the allegations of malpractice against each defendant health care provider named in the claim constitute a claim of a breach of the applicable standard of care as to each named defendant.

One other point is worth mentioning about the procedural requirement of filing a request for review. The request for review is deemed “filed” on the date it is mailed, not received, if it is mailed by certified or registered mail. A request filed by any other method (including Federal Express Mail), is not deemed filed until received by the Division of Administration. This can be a very significant provision when battling a prescription deadline. If filed by certified or registered mail, the attorney should obtain a certificate of mailing from the post office or have the post office physically post mark the date on the receipt. (This will require that the request for review be hand delivered to the post office). This is the only conclusive proof of the date of mailing, and thus, the date of filing, should a dispute arise.

2. Formation of The Medical Review Panel

Once a timely request for review is received by the Division of Administration, it is forwarded to the PCF (in private cases) within 5 days. The PCF then has 15 days to confirm that filing has been received and to confirm whether the defendant is qualified or not. The PCF also notifies all defendants of the complaint and forwards a copy of the complaint to the Louisiana Supreme Court. [1299.47(A)(3)] The medical review panel is made up of three physicians and an attorney chairman. The attorney chairman is selected by the parties. Two physician members are selected by the parties (one each) and the third physician member is selected by the first two members.

In the letter acknowledging receipt of the filing of the request and acknowledgment of the qualification under the MMA, the PCF also requests that the parties coordinate their efforts to select an attorney chairman. Although there is no

specific statutory deadline by which the attorney chairman must be selected, Section 1299.47A(2)(c), provides that the board shall dismiss a claim ninety days after giving notice by certified mail to the claimant that action has not been taken by the claimant to secure appointment of an attorney chairman within two years from the date the request for review was filed.

The attorney chairman is usually selected by mutual agreement of the parties. However, if the parties cannot agree on the attorney chairman, then a striking process is to be utilized. [1299.47C]. Once the attorney chairman is selected, he will contact the parties acknowledging his appointment and request that the claimant furnish the name of a physician (in the same specialty as the defendant), to serve as the claimant's medical review panel member. The plaintiff has 30 days to make this selection from the date of certification of his filing by the board. [1299.47C(3)(a)]. Defendant has fifteen days thereafter to make his choice of the second physician member of the medical review panel [1299.47C(3)(b)]. If plaintiff or defendant fail to make their selection timely, the attorney chairman shall notify them to make the selection within 5 days and if no selection is forthcoming, he shall make the selection himself.[1299.47C(3)(c) and (d)]

Once the two panel members have been selected, they have 15 days within which to select the third and final physician member of the medical review panel. Again, if no selection is forthcoming from the two physicians, the attorney chairman makes the selection [1299.47(c)(3)(d) and (e)]. Once the panel is formed, the attorney chairman notifies the parties within five days by certified mail. The panel remains in effect until they render an opinion. However, if the review panel fails to render an opinion within

twelve months after its formation, and no order is obtained from the district court extending the life of the panel, the claimant may institute a lawsuit in district court. [1299.47(B)(1)(b)]. However, once the life of the panel has expired without an order extending it, the panel is dissolved as a matter of law and cannot be revived. See e.g. LeBlanc v. Lakeside Hospital, 98-909 (La. App. 5th Cir. 3/10/99), 732 So.2d 576.

In LeBlanc, plaintiff sought review of her claim on May 3, 1996. The attorney chairman was selected on July 3, 1996. The medical review panel was formed on September 9, 1996. On June 9, 1997, one defendant obtained an order from the court extending the life of the review panel to January 3, 1998. No decision was rendered by the January 3, 1998, deadline and no extension was filed before that date. On January 20, 1998, seventeen days after the January 3 deadline, another defendant obtained an order from the district court extending the life of the review panel. Plaintiff filed suit alleging that the review panel had dissolved as a matter of law, which would allow her to proceed in state district court. The defendants filed an exception of prematurity arguing that the panel had been extended by the Judge on January 20, 1998.

The court held:

“upon dissolution of the panel, there is no longer a procedural bar preventing the claimant from filing suit in district court; indeed, it is incumbent upon the claimant to take such action to preserve her rights against the defendants because dissolution of the panel after expiration of the court-ordered extension of time affects the suspension of prescription with respect to the defendants.”

Accordingly, the court found that the January 3, 1998, date passed without application for an additional extension and thus, it dissolved automatically by operation of law. It concluded that the trial court did not have the power to extend the life of the

review panel, which had already been dissolved by operation of law. Id. at 578.

The attorney chairman sets a reasonable schedule for submission of evidence, but must allow sufficient time for the parties to make full and adequate presentations of related facts and authorities within ninety days following the selection of the panel.[1299.47C(2)]. The Panel must render a decision within 180 days of the selection of the last panel member and within 30 days of “reviewing all evidence”.[1299.47G]. Once the parties have received notification by certified mail of the issuance of the opinion of the medical review panel, the claimant has 90 days to file suit in district court. [1299.47A(2)(a)]. Courts interpreting this provision have held that in addition to the 90 days, the claimant is entitled to the remainder of the one-year prescriptive period that was unused at the time their request for review was filed. See e.g. Guitreau v. Kucharchuk, 1999-2570 (La. 5/16/00), 763 So.2d 575.

2. Prescription

La. R.S. 9:5628 specifically sets forth the prescriptive period applicable to actions for medical malpractice:

- A. No action for damages for injury or death against any physician, chiropractor, nurse, licensed midwife practitioner, dentist, psychologist, optometrist, hospital or nursing home duly licensed under the laws of this state, or community blood center or tissue bank as defined in R.S. 40:1299.41(A), whether based upon tort, breach of contract, or otherwise, arising out of patient care shall be brought unless filed within one year from the date of the alleged act, omission, or neglect, or within one year

from the date of discovery of the alleged act, omission, or neglect; however, even as to claims filed within one year from the date of such discovery, in all events such claims shall be filed at the latest within a period of three years from the date of the alleged act, omission, or neglect.

B. The provisions of the Section shall apply to all persons whether or not infirm or under disability of any kind and including minors and interdicts.

C. The provision of this Section shall apply to all healthcare providers listed herein or defined in R.S. 40:1299.41 regardless of whether the healthcare provider avails itself of the protections and provisions of R.S. 40:1299.41 et. seq. by fulfilling the requirements necessary to qualify as listed in R.S. 40:1299.42 and 1299.44.

Courts interpreting this provision have uniformly held that the one year prescriptive period commences to run on the date that the injured party either knew, or should have known of the facts on which to base a cause of action. Cruse v. Louisiana State University Medical Center, 34,779 (La. App. 2nd Cir. 6/20/01), 792 So.2d 798; Triss v. Carey, 2000-0608 (La. App. 4th Cir. 2/07/01), 781 So.2d 613. This is the “discovery” rule of Contra Non Valentem. The Louisiana Supreme Court recently further refined this rule and determined that *“Mere notice of a wrongful act will not suffice to commence the running of the prescriptive period; rather, in order for the prescriptive period to commence, the plaintiff must be able to state a cause of action, including both a wrongful act and resultant damages.”* Guitreau v. Kucharchuk, 2000, 99-2570 (La.

5/16/00), 763 So.2d 575.

With respect to the three year limitation, the Louisiana Supreme Court has repeatedly determined that R.S. 9:5628 is a prescriptive statute with one qualification, that is, that the Contra Non Valentem type exception to prescription embodied in the discovery rule is expressly made inapplicable after three years from the act, omission or neglect. See *Whitnell v. Silverman*, 95-0112 (La. 12/06/96), 686 So.2d 23; *In re Medical Review Panel of Moses*, 2000-2643 (La. 5/25/01), 788 So.2d 1173. In fact, in *In re Medical Review Panel of Moses*, the supreme court determined that the failure to remove sutures, which was not discovered until after three years, could not form the basis of a valid claim because it was prescribed. In so doing, the court noted that the failure to remove the stitches was a single breach of duty and not a continuing tort. However, the court left open the question as to whether the continuing tort doctrine could ever be invoked to enlarge the three year repose period of 5628.

Discovery Tools in Medical Negligence Cases

A. Using the Deposition as a Key Discovery Tool

Perhaps the single most important deposition taken in a medical malpractice case is that of the defendant doctor. Cases can be won or lost in this deposition. Therefore, it is imperative that the attorney prepare himself on the medicine and the theory of the case before this deposition is taken. Moreover, the earlier the deposition can be taken, the better. Often, early in the case the defense has not solidified its theory of defense. A thorough deposition of the defendant can take away many of the common defenses.

Different lawyers have different styles and approaches to taking the deposition of the defendant doctor. As with most testimony, it is important to listen and follow up with the responses of the defendant. When multiple defendants are involved, a frequent issue arises regarding the plaintiff attorney's ability to ask co-defendants about breaches of the standard of care by other defendants. In Marchetta v. CPC of Louisiana, Inc., 99-CA-0485, La. App. 4th Cir. 3/11/2000), 759 So.2d 151, the court reiterated a previous ruling that a medical malpractice plaintiff may rely on the testimony of a defendant physician or a defense expert to establish the standard of care. See also, Taplin v. Lupin, 97-1058 (La App. 4th Cir. 10/1/97), 700 So.2d 1160; Giventer v. Rementeria, No. 1577/92 (Richmond County Sup. Ct., N.Y. May 30. 1999).

1. Interrogatories

Prior to 2003, there was disagreement as to whether interrogatories could be propounded in a medical malpractice case in Louisiana during the medical review panel stage. In 2003, the Louisiana Legislature legislatively overruled the Louisiana Supreme Court's pronouncement in Perritt v. Dona, 849 So.2d 56, 2002-2601 (La. 7/2/03) (La. Jul 02, 2003) (NO. 2002-CC-2601, 2002-CC-2603), and specifically provided for the use of interrogatories by any party during the panel stage of a medical malpractice action. La. R.S. 40:1299.47 D(2) now states:

The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, interrogatories, affidavits and reports of medical experts, and any other form of evidence allowable by the medical review panel.

B. Discovery and Use of Medical Evidence

Developing medical evidence in discovery begins with an examination of the

medical record. From there, medical evidence is usually developed through the defendant doctor's deposition, the medical review panel and expert witnesses.

24. Use of The Medical Record

No matter how devastating a medical record appears to damage the defense, the medical evidence is only as good as it is presented at trial. Blowing up the record for viewing by the jury is a common approach in medical malpractice cases, but should not be the endpoint of your preparation of the exhibit at trial. Often, an enlarged record becomes more difficult to read or distorted. One great technique to combat this problem is to have the record scanned onto a poster board and then enhanced by adding typewritten and highlighted graphics in a box pointing to the area of the record it purports to interpret. Thus, the jury can see that the integrity of the record is maintained, but can easily read and focus on the area of the document about which you are making your point.

Bates stamping the record before admitting it into evidence is also a must. Not only does it help the jury to quickly follow along or identify a key document in the jury room, it is also essential for creating a comprehensive and detailed record for appeal purposes. It also avoids the "fumbling" for pages since your preparation will involve using those page numbers to quickly identify what you need in a voluminous record.

Record exhibits which are enlarged should be numbered on the back to avoid the annoying flipping during the trial while you are trying to make a good point to the jury. The exhibits, to the extent possible, should also be premarked before trial so that time is not wasted marking the exhibit during the testimony. Usually, before trial the defense

and plaintiff can sit down and agree about the admissible exhibits making it possible to prepare an exhibit book with the actual exhibit numbers which will be used at trial.

Expert Witnesses

A. Determining the Qualification of the Experts You Need

The majority of medical malpractice cases turn on the testimony of the medical expert witnesses. Thus, your choice of the right expert likely will make the difference in winning or losing the case.

Although there is certainly a large market of out of town "hired guns" to testify, these type of experts usually do far more harm than good to the case. Thus, it is essential that an experience medical malpractice attorney with access to top, well-credentialed experts be retained.

Generally, the type of expert to be retained must be a physician who practices in the same specialty as the accused doctor. Louisiana law recognizes however, that many medical specialties overlap. Therefore, in Louisiana, it is well established that when medical disciplines overlap, it is appropriate to allow a specialist in one area to give expert testimony as to the standard of care applicable to performing a particular procedure common to both disciplines. Campbell v. Hospital Service District No. 1, 33,874, p. 12 (La. App. 2d Cir. 10/4/2000), 768 So. 2d 803, 811 (allowing cardiologist to testify regarding the standard of care applicable to an emergency room physician treating a patient suffering a heart attack); Hunter v. Bossier Medical Center, 31,026, pp. 14-15 (La. App. 2d Cir. 9/25/98), 718 So. 2d 636, 644 (allowing general surgeon to testify as expert about back surgery performed by an orthopedic surgeon); Ricker v.

Hebert, 94-1743, pp. 3-4 (La. App. 1st Cir. 5/5/95), 655 So. 2d 493, 495 (allowing two oral surgeons to testify regarding the standard of care applicable to an ear, nose, and throat specialist who performed a procedure common to both disciplines). See also Levya v. Iberia General Hospital, 94-0795, pp. 6-7 (La. 10/17/94), 643 So. 2d 1236, 1239 (allowing an obstetrician/gynecologist to testify regarding a surgical procedure that was performed by a general surgeon because the procedure was routinely performed by the specialist as well as the general surgeon). Indeed, in Hunter, the Second Circuit noted that the expert, a general surgeon, had served on the medical review panel in the case, as well as testifying at trial regarding the standard of care applicable to a back surgery performed by an orthopedic surgeon. The Second Circuit upheld the admissibility of the general surgeon's testimony because the particular surgery at issue was performed by physicians whose medical disciplines overlapped. Hunter, 718 So. 2d at 644.

Most experienced malpractice lawyers prefer to retain a medical expert who has an academic, or teaching background and clinical or hands-on experience with patients. After all, it is the expert's job to explain the medicine to the jury and why this particular doctor provided inadequate care under the circumstances. If the expert has a teaching background, then he is used to teaching students and others about medicine and is usually good at drawing powerful illustrations for the jury.

Experts with only teaching backgrounds will be subject to criticism at trial because of the lack of day to day experience "in the trenches." An expert who only practices medicine, but never teaches it may find it difficult to explain the difficult

concepts of medicine to a jury. If the expert cannot explain the medicine in easy to understand terms to the jury, his resume is irrelevant.

Most physicians will not testify against other physicians in the same state in which they practice. Thus, most testifying experts are from out of state. However, actively practicing and teaching physicians are very busy with their own schedules and usually charge a small fortune to be involved in medical malpractice cases. It will also require the expenditure of more money to travel out of state for the defense to take the deposition of a testifying expert.

Many experienced medical malpractice attorneys will not agree to take a case until they have a qualified medical expert who is willing to come to court to testify that malpractice was committed. This is true even if a consulting expert has previously indicated that malpractice was involved in the patient's care. The reason for this rule is simple. Until a qualified medical expert is willing to provide sworn testimony in court, the case is not provable.

Many times consulting and testifying experts disagree about the merits of a case. Since the consulting expert either cannot or will not testify, the case cannot proceed until the ultimate testifying medical expert agrees that a case exists. The earlier in the process that a testifying medical expert can be retained, the better.

B. Finding Your Expert Witnesses

Knowing that you need a top well credentialed testifying expert and finding one are two different things. There are a number of resources available to help find the right expert.

1. The Medical Literature

Many attorneys review the pertinent medical literature to find physicians who have studied and written about the particular medical topic about which they are seeking testimony. It is certainly impressive for the jury to hear how your expert has been published and accepted as an expert on the subject by his peers. However, getting these physicians to agree to testify, especially for the patient, is no easy task. Sometimes, it is helpful to have the consulting physician make contact with such a physician to help explain the case. If the expert agrees to review the case, you may want to meet him to determine whether he will make a good witness. Some of the most well-qualified physicians make the worst witnesses. It does no good for the case if the physician is tops in his field, but cannot explain the medicine to the jury in an understandable manner.

C. Medical Expert Services

Some attorneys employ the services of a professional company to help them locate a testifying physician. These services charge anywhere from \$750.00 to \$1,500 just to find the expert. You must then pay the expert to review the case to determine whether he is willing to testify in the case. The attorney must exercise caution when using these services to avoid getting an expert who is a professional witness for plaintiffs. There are some reputable services who provide high quality witnesses. The challenge is to get a physician that has not testified in hundreds of cases, and therefore used up his credibility with the jury.

D. Subsequent Treating Physicians

Many lawyers start their review of the case by contacting and meeting with the subsequent treating physicians. Although it is difficult to get these doctors to testify against the defendant doctor, especially if the subsequent treating physician is located in the same state or community as the defendant doctor, such testimony can be devastating to the defense. Subsequent treating physicians have more credibility because they cannot be accused of testifying for pecuniary gain.

Friends and Word of Mouth

Some lawyers like to find their testifying expert witnesses by obtaining recommendations from friends and colleagues. Many organizations like the Association of Trial Lawyers and the Louisiana Association of Trial Lawyers have email list servers which are used to exchange information about expert witnesses. Again, be careful utilizing these sources. The same hired guns tend to get recycled over and over. Physician friends are often helpful to steer you toward a colleague that is willing to testify in the right case.

Regardless of the source of your testifying expert, be sure that he is well qualified and does not testify in medical malpractice cases for a living. Credibility is the most important asset in the case. A hired gun can lose that credibility for the whole case. Make the right investment of time and money to secure the best available expert in every case.

Trial of a Medical Malpractice Case

A. Order of Evidence/Witnesses/Proof

The order of evidence, witnesses and proof is usually presented in chronological

fashion so as not to confuse the jury. If the facts or issues of a particular case dictate that an order other than the chronological sequence of events is necessary, that presentation should be simple and easy to understand. Thought should also be given as to how to reestablish the chronological sequence of events after presenting evidence out of sequence. For instance, the attorney may want to stress the expected testimony of a witness who comes in at the end of the chronological sequence. If the case dictates, this can be done effectively. However, once the point is made, resume with the chronological presentation and when the time period approaches for this witness, explain that you have already covered that expected testimony.

One effective deviation from a straight chronological approach in an opening statement may be to emphasize, for example, that every expert that will testify will agree on this critical point. Only the defendant disputes it. In this fashion, summarizing blocks of testimony on particular issues can be argued to the jury making the chronology more effective as you go through it later. Topic sentences and summarized conclusions are effective ways to argue in an opening statement without breaching the rule against argument in an opening.

The order of the witnesses is a critical trial decision. Should you call the defendant in your case in chief? Should the plaintiff be first or last? Where do the experts fit into the testimonial scheme? The answer to each of those questions is it depends. Generally, unless you have a deposition of the defendant in which he makes critical admissions about which he cannot credibly change his testimony, it is not wise to call the defendant in your case. After all, you want a simple and clean presentation of

the evidence to the jury. The defense will do everything possible to interrupt this flow and confuse the jury.

The order of plaintiff's testimony is usually governed by the credibility and strength of the plaintiff. First or last are common periods for that testimony. Expert witnesses may also go first or last depending on their abilities. Unfortunately, because of timing, expert witnesses have to testify when they are available. If it took longer than expected to pick the jury or examine a witness, the timing of his testimony could be affected. Often, a plaintiff does not have the luxury of calling their expert at the precise time in the case suited for his testimony.

You must not only expect the unexpected in a trial, you must plan for it. Be ready with other witnesses or depositions which can be used if a problem occurs with the timing of the testimony of a key witness. Approximate the direct and cross examination time of each witness (building in a fudge factor), to help determine when witnesses will testify. Create several different orders in which the witnesses will testify taking into account that the case is either behind or ahead of schedule according to the way it was planned. Number the exhibits, both demonstrative and evidentiary which will be used during trial. There is nothing more ineffective than to attempt to make a critical point while fumbling with documents or exhibits. Assume that you will be so engrossed with the witness examination that the exhibits and demonstrative aids must be useable by an idiot. Numbering on the back of demonstrative charts is an effective method to accomplish this task.

Test the order and method of presenting the evidence on a lay person. If a

spouse (or better yet, a child) can understand the order and issues of your case, you have succeeded. Test it on family and friends. One of the key mistakes lawyers make is to get so close to the case and know the issues so well that they assume that everyone must understand it the way they do.

Use the Record Effectively at Trial

No matter how devastating a record appears to damage the defense, a record is only as good as it is presented at trial. Blowing up the record for viewing by the jury is a common approach in medical malpractice cases, but should not be the endpoint of your preparation of the exhibit at trial. Often, an enlarged record becomes more difficult to read or distorted. One great technique to combat this problem is to have the record scanned onto a poster board and then enhanced by adding typewritten and highlighted graphics in a box pointing to the area of the record it purports to interpret. Thus, the jury can see that the integrity of the record is maintained, but can easily read and focus on the area of the document about which you are making your point.

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not wasted marking the exhibit during the testimony. Usually, before trial the defense and plaintiff can sit down and agree about the admissible exhibits making it possible to prepare an exhibit book with the actual exhibit numbers which will be used at trial.

Defenses and Closing Argument

As noted above, the defenses of victim and third party fault are alive and well. This holds true even if the third party is not a qualified healthcare provider. However, one way to combat these defenses is through closing argument.

As with the other parts of a medical malpractice case, closing argument is a culmination of events and requires preparation even before the trial begins. In this writer's opinion, medical malpractice cases are rarely won or lost in closing. By the time of closing argument, most jurors have already made up their minds. If you are looking to win the case on closing, your case has serious problems. However, that does not mean that you should not give your closing as if the whole case depended on it. If it sways one vote, it is worth it.

It is always effective during trial to use a large flip chart (on an easel) to emphasize points to the jury. First, it prompts the jurors to write notes (which they are now allowed to do), regarding the points you want to make with the witnesses. Second, it is a great way to summarize the evidence in a credible fashion during closing argument. It is more persuasive to show the jury what was said rather than tell them and hope they remember it the way you tell it.

Another effective technique is to prepare a chart (usually done before trial) on the

conflicting opinions rendered by the defense witnesses regarding the key points in the case. Because of time constraints, this can be prepared from the deposition testimony which you have elicited during trial. When the jury sees graphically just how contradictory the defense's own witnesses have been, it can be very powerful.

Reemphasize the points made with your nice enlarged exhibits. You can even use erasable markers during the testimony to make points on the blow-up for use in closing.

Blow-up or use the verdict form and tell the jurors what you want them to do. Jury forms can be confusing. They need to know exactly how to fill out the form to avoid any unintentional results or an inconsistent verdict. Emphasize how the plaintiff will receive less in recovery if third party or victim fault is found. Tell them the consequences of filling the form out as the defense will instruct them to do.

Do not overreach. It is annoying to jurors when lawyers grossly exaggerate the evidence or ask for unrealistic dollars. Trials are all about credibility. Do not lose your credibility with the jury, the court, or opposing counsel by overreaching in your closing argument.

Always save time for rebuttal. Rebuttal is important because, as the plaintiff, you get the last word. There may be points which you do not want the defense to address in his closing argument. Save those points for rebuttal. Also, make sure to listen carefully to the defendant's closing for key opportunities to demonstrate his exaggerations, etc during rebuttal. Try to end the case on a positive thought and not a sympathetic one.

The Jury Charges

This subject can form the basis of an entire paper on its own. The charges and verdict form must be in the correct legal format. Moreover, the verdict form must be presented in a fashion that does not confuse the jurors. Thus, with respect to the trial, the verdict form is the most important element.

The jury charges are probably more important for the record on any potential appeal than to the jury. Again, by the time the charges are given to the jury, they are tired and ready to get to the deliberations. Charge reading by the judge usually takes at least an hour and can be very boring to the jury.

However, the important jury charges should be emphasized from the very beginning of the case. The burden of proof is a good example. Emphasize what you told them in voir dire, that is, that to prevail the plaintiff only needs to prove his case by a preponderance of the evidence - i.e. that something is more likely so than not. You do not have to prove your case beyond a reasonable doubt or to a certainty.

Another key jury charge you need in the charge conference and which needs to be pointed out to the jury is the loss of a chance charge. Virtually every medical malpractice case involves an issue that a chance of a better recovery was lost by the defendant's conduct.

Frequently, the defense has more experts at trial than the plaintiff. This is usually because it has the benefit of the medical review panel opinion and members. Stress the charge that states that it is not the number of witnesses which is determinative, but the quality of the opinion. Emphasize that the jurors are free to disregard the opinions of the medical review panel if they do not find them credible.

Make sure the record is made with respect to your objections during the charge conference. Frequently, judges will conduct the charge conference in chambers without a court reporter. If it looks like the judge is not allowing the appropriate instructions, ask for the conference to be on the record. The court of appeal cannot fix something that is not contained in the record.

Do not argue and object to every defense charge. Yes they hurt. But, if you argue on every minor charge, you have no credibility to argue on charges that truly do not belong in the case. Pick your battles on charges wisely. If you lose on an important charge which will be read to the jury, address it in closing.

V. SETTLEMENT OF A MEDICAL MALPRACTICE CASE

X. PCF v. Underlying Doctors

For those who have practiced in this area for years, it is understood that there is ongoing issues between the PCF and the underlying healthcare providers. One of those issues involves the lack of communication between those parties. The PCF is frequently not kept in the loop by the underlying healthcare provider regarding the case and its status. In fact, the PCF has experienced the problem of receiving its first notice about the status of a case in the form of a judgment following a trial on the merits.

The best settlement for all parties is one that is global and disposes of all issues. The only way to accomplish this goal is to get the involvement of the PCF before the underlying healthcare provider pays any settlement. If the underlying healthcare provider wants to discuss paying less than 100K (and admit fault), then his attorney needs to get the PCF involved in a mediation or other settlement posture. After all, if the case is settled globally with all parties for an acceptable sum, then the plaintiff does not care if the underlying healthcare provider pays 100 or 90. However, that 10k does

mean something to the insurer and physician or hospital.

Frequently, the PCF will need information like the depositions, panel opinion, and other discovery to educate itself on its potential exposure. When substantial future medical care is involved, a life care plan may also be appropriate information to develop and share with the PCF. Remember, the PCF has no legal duty to pay future medical expenses in a lump sum settlement. Since they currently pay more than \$1million a month in future medical care to claimants, they are often receptive to paying those future medical expenses in a lump sum if a large enough discount is provided.

Summary Judgment Strategies

In medical malpractice cases, the most common use of the summary judgment motion occurs after the medical review panel decision and shortly after the filing of the claim in district court. Whichever side wins the medical review panel (usually the defense), files the motion to flush out the opposing side's expert or to escape liability in the event no expert is forthcoming. Up until recently, courts disagreed as to whether expert opinion in the form of an affidavit could be considered in support of a motion for summary judgment. However, the Louisiana Supreme Court answered this question in Independent Fire Insurance Company v. Sunbeam Corporation, 99-2257 (La. 2/29/00), 755 So2d 226. In Independent Fire, the court held that assuming that an expert's opinion evidence would be admissible at trial (under Daubert v. Merrell Dow Pharms. Inc., 509 U.S. 579, 113 S.Ct. 2786 (1993)), a judge must consider it for purposes of a motion for summary judgment.

However, the courts of appeal have not uniformly interpreted Independent Fire in

the same fashion. For instance, in Simmons v. Berry, 1998-0660 (La. App. 1st Cir. 12/22/00), 779 So.2d 910, the court held that an uncertified copy of the opinion of the medical review panel was not admissible evidence which could be relied upon to support a motion for summary judgment. The Simmons court held that in order for the panel opinion to be admissible evidence for consideration in a motion for summary judgment, the opinion of the medical review panelist must be put in the form of an affidavit which meets the form of Daubert. Other circuits have allowed the introduction of an “uncertified” copy of the medical review panel opinion. See e.g. Hinson v. Glen Oak Retirement Home, 34,281 (La. App. 2nd Cir. 12/15/00) (Defendant files MSJ, attaches panel opinion and his own affidavit; court deems evidence sufficient for grant of MSJ.); Venable v. Dr. “X” and Dr. “Y”, 95-1634 (La. App. 3rd Cir. 4/03/96), 671 So.2d 1249, ((Defendant’s summary judgment evidence consisted of opinion of medical review panel and affidavit from one of its members and an unpublished opinion of court; held sufficient to support MSJ); Richoux v. Tulane Medical Center, 617 So.2d 13 (La. App. 4th Cir. 1993) (sworn testimony of one physician and uncertified opinion of medical review panel sufficient to support grant of summary judgment).

Summary judgment can be a useful tool to set up a settlement on liability and/or causation and damages.

Structured Settlements

In Louisiana, structured settlements in medical malpractice cases is a rare occurrence. The primary reason behind this fact is the PCF’s ability to pay future medical expenses as they become due instead of in a lump sum. Remember, the

medical malpractice act does not provide for a lump sum award of future medical expenses by the court or juries. The PCF has the option to pay the future medical expenses as they accrue or in a lump sum.

Obviously, in those instances in which the PCF is willing to entertain a lump sum settlement of their future medical expense exposure, the patient must be willing to take substantially less than what their projected future expense will be. If the patient is willing to give a big discount to the PCF to settle the future medical expenses in a lump sum, how can the attorney ensure that the patient's future medical needs will be met with less money than projected?

The answer lies in establishing a special needs trust. There are only a few medical malpractice attorneys in this state who have been successful in negotiating a fair settlement of the patient's future medical expenses with the PCF while ensuring that their clients are taken care of for the rest of their lives. A special needs trust is complicated and regulated by special rules. Most medical malpractice attorneys employ the use of an expert attorney who specializes in setting up these trusts.

If you are considering a lump sum settlement of the future medical expenses with the PCF it is important to get such an expert involved early. One of the special needs trusts rules prohibits disbursement of the settlement funds directly to the plaintiff's attorney through his trust account. The checks must be made separately to the special needs trust. There is also specific rules for limiting the plaintiff's assets. All of these rules are designed to preserve the patient's eligibility for Medicare and Medicaid as collateral sources to fund the future medical care.

Expertise is required on both the part of the plaintiff's attorney in attempting to

establish what the patient's future medical expenses will be as well as negotiating with the PCF. Once the settlement is completed, the plaintiff's attorney will then need the assistance of an expert in establishing the special needs trust.

Settlement Strategies

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24. Medical secondary payer

B. In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –

- (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
- (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

B. In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to

have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

Repayment required

(ii) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(iii) Primary Plan

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or

services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment other information is received, the Secretary may charge the amount of the reimbursement until reimbursement is made (at a rate determined) by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii)

Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise, to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United

States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

B. Multiple Party Settlements

Coleman v. Deno, (La. App. 4th Cir. 2002), 832 So.2d 1016

We conclude that La. R.S. 40:1299.42(D)(5) does not require that credit can be given only to the defendants who are found liable . . .

In the present case the larger settlement was in the amount of \$25,000. This is the amount that is calculated for the \$100,000 credit to the Fund for the settlement with Charity. The Fund is entitled to an additional credit of \$10,000 for the second settlement with JoEllen Smith Hospital for a total of \$110,000 for the medical malpractice settled claims.

With respect to the credit for Dr. Deno's liability, any amount due up to the cap in excess of the total liability of the qualified health care providers must be paid by the Fund. La. R.S. 40:1299.42(B)(3)(a).

To reiterate, the Fund is entitled to a credit of \$100,00 for the settlement with Charity Hospital and a credit of \$10,00 for the settlement with JoEllen Smith Hospital, as well as credit for another \$100,000 for the liability portion to be paid by De. Deno.

Multiple Recoveries

In Conerly, et al v. State of Louisiana, et al., 714 So.2d 709 (La. 7/8/98) the Louisiana Supreme Court held wrongful death and survival actions are governed under the provisions of Medical Liability for State Services Act (MLSSA) - LSA-R.S. 40:1299.39. Because this statute reduces claimants' rights, any ambiguities of the statute must be strictly construed. Ruiz v. Oniate, 97-2412 (La. 5/19/98; 713 So.2d 442. Nevertheless, the Court will only strictly construe laws in the absence of definite legislative intent to be accomplished by the specific statute in question. If the law is clear and unambiguous no further interpretation should be applied in the absence of absurd consequences. Reflecting on the legislative intent from the enactment, and through its many revisions, the Court found the legislature was attempting to reconcile

MLSSA (LSA-R.S. 40:1299.39) with the Medical Malpractice Act (LSA-R.S. 40:1299.40 et seq. – i.e. the private practitioners) the latter of which only allows the recovery in the total amount of \$100,000 against a doctor and a \$400,000 limit from the PCF for injuries to or death of a patient. More particularly, LSA-R.S. 40:1299.39(D) 97-0871 (La. 7/8/98); 714 So.2d 709 states a party may recover under the public act to the same extent as one may recover under the private act. The Court noted the purpose behind the enactment of MLSSA was to insure an adequate supply of physicians and other professionals to provide healthcare services on behalf of the state and to make an attempt to protect the “public fisc” by limiting the liability of the state to \$500,000. In concluding, the Court ruled in a claim involving malpractice against the state which causes a death of a patient, a plaintiff may bring both a survival action and a wrongful death claim, but is only allowed to recover a maximum sum of \$500,000 combined.

Liability of the Patient’s Compensation Fund

A. Bankruptcy of Defendant’s Insurance Company

Cesar v. Barry, 772 So.2d 331 (La. App. 3rd Cir. 2000). This case is an outshoot of the bankruptcy liquidation of Physicians National Risk Retention Group. After being placed in receivership, plaintiffs and Physicians National Risk Retention Group entered into the settlement agreement for the underlying \$100,000. The settlement was approved by the bankruptcy court. The district court approved the settlement and liability was triggered under LSA-R.S. 40:1299.44. The insurer being in liquidation however, plaintiff only received the pro rata distribution of the insurer’s assets which was estimated to be approximately 30% (i.e. \$30,000.00). The Fund perfected this

appeal arguing the liability was not triggered insofar as plaintiff's did not actually received \$100,000. Relying on the 4th Circuit Court of Appeals opinion in Morgan vs. United States Corporation of New Orleans, 697 So.2d 307 (La. 4th Cir. 1997), the 3rd Circuit stated:

“The PCF cannot create an issue of material fact by introducing the affidavit of the malpracticing physician recanting his admission of liability and substituting for that admission a scenario removing any causative relationship between his fault and the harm suffered.”

The Court granted the plaintiff's Motion for Summary Judgment noting plaintiff had proved damages in excess of \$500,000 for the death of a wife of seventeen years and the PCF had failed to establish the existence of a genuine issue of material fact.

Settlement Terminates Issue of Liability as to the PCF

Judalet v. Kusalavage, 762 So.2d 1128 (La. App. 3rd Cir. 2000). This case involves a premature rupture of a mother's amniotic sac resulting in premature birth of a child and the child's acquisition of a bacterial infection with permanent complications. Dr. Kusalavage tendered \$100,000 in settlement under LSA R.S. 40:1299.41 et seq. The plaintiff moved for summary judgment for the balance of the \$500,000 cap against the Patient's Compensation Fund. In opposition to the plaintiff's motion for summary judgment, the Patient's Compensation Fund argued through expert testimony the fetus was not born prematurely. The trial court rendered a judgment in favor of plaintiff holding the fetus prematurity was a component part of the doctor's admission of liability.

The PCF then contented Dr. Kusalavage admitted only to the artificial rupturing of the membranes, not to the permanent infirmities resulting from her premature birth. Calling the PCF's argument “feeble,” the 3rd Circuit confirmed the district court's

summary judgment in favor of plaintiff stating it was extremely improbable a physician would pay \$100,000 merely for the premature birth of a fetus absent any implications. The Court also pointed out treating physicians of the infant testified harm had resulted from the premature birth and extensive medical problems flowing therefrom included respiratory failure, Streptococcus Sepsis, intra ventricular hemorrhages, seizure disorder, ventriculus shunt surgeries, brain damage, global development delays, and life long physical and cognitive disabilities.

The Court instructed once a malpractice victim settles with a health care provider or its insurer for \$100,000, the liability of the health care provider has been admitted or established. Settlement for a health care provider's maximum liability of \$100,000 activates liability of the PCF and precludes it from contesting the health care provider's liability. La. R.S. 40:1299.42(B)(3). Thus, liability is admitted and settlement terminated the issue of liability in relation to the PCF as payment by one health care provider of the maximum amount of his liability statutorily establishes the plaintiff is a victim of the health care provider's malpractice. Once payment by one health care provider has triggered the statutory admission of liability, the Fund cannot contest the admission. The only issue between the victim and the Fund thereafter is the amount of damages sustained by the victim as a result of the admitted malpractice. The Court here found there were no genuine issues of material facts or issues of causation and damages flowing from the admitted malpractice.

In Thomas v. Insurance Corp. of America, 93-1856 (La. 2/28/94), 633 So. 2d136, the Louisiana Supreme Court interpreted La. R.S. 40:1299.42(D)(5) to allow \$ 100,000

credit for one settlement and then a dollar-for-dollar amount for the second settlement.

The Supreme Court stated:

The scheme for medical malpractice claims, as set up by the Legislature and interpreted in the jurisprudence, does not contemplate that litigation be required against each and every negligent health care provider. It surely permits the health care providers to effect settlements, which our judicial system favors. However, if the Fund were permitted a maximum credit for even a "nuisance value" settlement, the claimant would not likely compromise with any malpractice defendant who did not offer to pay its maximum, \$ 100,000 liability. On the other hand, the defendants' incentive for settlement arguably is also lessened, if only one \$ 100,000 credit is allowed for multiple defense settlements. And equally as important, since the Medical Malpractice Act prevents the claimant from recovering more than \$ 500,000 plus interest and cost for all malpractice claims for injuries to or death of a patient, an interpretation of the statute that only a single, \$ 100,000 credit to the Fund is authorized may well prompt violation of this basic limitation on the claimant's recovery. Should multiple settlements total more than \$ 100,000 and damages reach or exceed the Fund's maximum exposure of \$ 400,000, the claimant would recover more than \$ 500,000, despite the prohibition of Section 40:1299.42(B)(1).

Accordingly, in the case of multiple settlements, a single settlement between a defendant and/or his insurer and the plaintiff for a sum of \$ 100,000, or less than \$ 100,000 but more than any other of multiple settlements, shall reduce by \$ 100,000 any judgment in favor of the plaintiff to be paid by the Patient's Compensation Fund. Each other settlement shall reduce the amount due by the Fund by the amount of that settlement.

Coleman v. Deno, 832 So. 2d 1016, 1033 (La. Ct. App., 2002)

In Russo v. Vasquez, 648 So. 2d 879 (La. 1995), the Supreme Court addressed the issue of whether a settlement agreement between the plaintiff and a health care provider and his insurer for less than \$100,000.00 triggered the statutory admission of liability. In Russo, the insurer agreed to pay the claimant \$95,000.00 in cash in exchange for a \$5,000.00 discount. Plaintiffs asserted that this settlement constituted a \$100,000.00 settlement sufficient to trigger the LPCF's liability for excess damages and

preclude the PLF from contesting the qualified health care provider's liability. The trial court agreed and held that the settlement at issue constituted a \$ 100,000.00 settlement by assuming that when the insurer's actual payment of \$95,875.62 is added to the reasonably anticipated cost of a jury trial, \$6,099.26, the settlement amount exceeds \$100,000.00. The Louisiana Supreme Court disagreed stating:

La. R.S. 40:1299.44(C)(5) provides that a trial court, in determining whether to approve a settlement, is required to consider the liability of a health care provider as admitted and established only where the insurer has paid its policy limits of \$100,000.00. Because the record in this case clearly indicates that the insurer only paid \$95,872.65, the trial court's conclusion is incorrect. Russo at 884.

When a victim of medical malpractice agrees to settle his claim against a qualified health care provider for the policy limits of \$100,000, and demands excess damages from the PCF, he must closely follow the procedure of La. R.S. 40:1299.44(C). Horil v. Scheinhorn, 95-0967 (La. 11/27/95), 663 So. 2d 697. This procedure requires the malpractice claimant to file a petition seeking approval of an agreed settlement and demanding excess damages from the PCF. La. R.S. 40:1299.44(C)(1). In approving the settlement, the trial court shall consider the liability of the health care provider as admitted and established where his insurer has paid the policy limits of \$100,000. La. R.S. 40:1299.44(C)(5). An approved settlement precludes the PCF from contesting the health care provider's liability. Stuka v. Fleming, 561 So. 2d 1371 (La. 1990), cert. denied, 498 U.S. 982, 111 S. Ct. 513, 112 L. Ed. 2d 525 (1990).

Under the statutory scheme of La. R.S. 40:1299.44(C), the malpractice claimant obtains the benefit of having liability established for purposes of obtaining excess damages, up to the statutory cap, from the PCF. Implicit in the trial court's approval of

the settlement was a statutory admission of liability on the part of Dr. Singletary. See La. R.S. 40:1299.44(C)(5). As provided in La. C.C.P. art. 1915(B), in the absence of designation as a final judgment by the trial court after an express determination that there is no just reason for delay, any order or decision which adjudicates fewer than all the claims, rights, or liabilities of fewer than all the parties shall not terminate the action, shall not constitute a final judgment, and may be revised at any time prior to rendition of a judgment which adjudicates all the claims, rights, and liabilities of all the parties. To the extent that the trial court's judgment approving the settlement resulted in a determination of Dr. Singletary's liability, the judgment is a partial judgment subject to revision as provided by La. C.C.P. art. 1915(B). Posey v. Singletary, 855 So. 2d 853, 858-859 (La. Ct. App., 2003).

VI. **PROFESSIONALISM**

Recent Examples of Unprofessionalism

- 24) Plaintiff's attorney designates a vocational rehabilitation expert to defense counsel. Defense counsel expresses his desire to depose this expert. Plaintiff's counsel agrees to call expert to get dates for deposition. Defendant then unilaterally sets deposition of expert, subpoenas the expert for a date not cleared or discussed with plaintiff's counsel. Plaintiff's counsel attempts to call, write and explain to defense counsel that they had agreed to seek mutual dates and that expert would be out of town for the unilaterally set date. Defense counsel refuses to cancel deposition, shows up at designated time, does a process verbal and files a

motion for contempt against expert. Defense personally serves expert with Order to show cause (in an out of town court) seeking to personally cause the expert trouble. Court of course denies motion.

After two other similar failed attempts, parties finally agree to date for expert deposition. Defense is told weeks ahead of time to have a check for \$300 before the deposition. Defendant shows up at deposition with no check, and refuses to agree that expert will be paid or is entitled to payment. Plaintiff's attorney says deposition will not go forward with out at least an agreement (on the record) to pay the expert. Defendant does yet another process verbal, files contempt motion and serves expert personally. Court again denies motion admonishing defendant that expert is entitled to be paid. Deposition finally goes forward.

- 25) Defense counsel sets deposition of plaintiff's treating physician. Treating physician calls plaintiff's counsel a few days before scheduled deposition and cancels deposition. The next day, physician calls defense counsel and says deposition is back on. Neither physician nor defense counsel notifies plaintiff's counsel that deposition is back on. Defendant shows up at deposition, calls plaintiff's counsel. Both lawyers agree to cancel deposition until future date. Defendant hangs up phone with plaintiff's counsel and proceeds to take an ex parte twelve page statement from plaintiff's treating physician without the plaintiff counsel's knowledge or consent.

- 24) Plaintiff files lawsuit and does not ask for a jury. Defendant asks for jury. Defense counsel serves plaintiff's counsel with cover letter enclosing a pleading for payment of the jury bond. In the cover letter, defense counsel says that she is enclosing the posting of the jury bond pleading "which we filed today." Two days before trial, and in opposition to a motion in limine, defense counsel states that plaintiff should know that this is a bench trial, not a jury trial. Plaintiff counsel calls defense counsel who explains that she never filed the bond, (allegedly because the clerk refused to accept the pleading) and that the case would proceed as a bench trial because it was plaintiff's obligation to check the record to see if the bond had in fact been filed even though defense represented in writing that it had been filed.
- 25) Defense counsel subpoenas x-ray film from Hospital, which mistakenly gives defense counsel the original films, which defendant knows. Defense never provides or even discloses to plaintiff's counsel that she got the films from the hospital. For the first time at the deposition of plaintiff's treating physician, defense counsel pulls out film and begins to question treating doctor on films he also has never seen. After objections by plaintiff's counsel, defense counsel agrees to copy film and send it to him later (after the deposition is over and the damage is done). At trial, defense counsel then attempts to vigorously cross examine treating physician on fact that he did not have the films (which she had

subpoenaed and not shared) to attack his opinion.

- 26) Plaintiff has injury to hips and back. Defendant seeks IME for both conditions and chooses a neurosurgeon to perform it even though plaintiff's treater is an orthopedic surgeon. As expected, neurosurgeon says in report that he cannot comment on orthopedic hip injury. Defense seeks second IME for hips. Plaintiff opposes this and court grants limited IME on the hips based on defense representation that new IME doctor will only address the hips. After the hearing, defense counsel specifically directs new orthopedic IME doctor to address hips AND back injury. Orthopedic IME doctor does full exam of back, and hips and provides report on back and hips. Defense provides all of back records, x-rays and seeks several reports and updated reports from orthopedic IME on back condition in direct contravention to the court's order and her own specific written representations to the court in her motion to compel IME that she only sought IME for the back.

VII. HOSPITAL CORPORATE LIABILITY AND INSTITUTION NEGLIGENCE

A. Intentional Torts

Fuentes v. Doctors Hospital of Jefferson, 4 Cir. 2001, 802 So.2d 865. Patient's claims against an ultrasound technician in a hospital who took inappropriate sexual liberties with the patient following the performance of an ultrasound was an intentional tort which is not covered under the Medical Malpractice Act. The patient's claim against the hospital for negligent hiring was not covered as it did not involve patient care. Only

the claims against the hospital stating the presence of a third person during the examination were required fell under the Medical Malpractice Act.

Test to Determine Coverage under Medical Malpractice Act

The Louisiana Supreme Court, in overruling the 4th Circuit's holding patient dumping allegations against a physician were not governed by the Medical Malpractice Act, uses the following factors to determine whether allegations fall under the Medical Malpractice Act:

- X. Whether the wrong was treatment related;
- Y. Whether expert evidence is needed to determine if the standard of care was breached;
- Z. Whether the act or omission involved assessing the patient's condition;
- AA. Whether the incident occurred in the context of a physician/patient relationship; and whether it was within the scope of activities the hospital was licensed to perform; and
- BB. Whether the injury would not have occurred if the patient had not sought treatment.

Nursing Home Coverage Under the MMA

In Pender v. Natchitoches Parish Hospital, App. 3 Cir. 2001, a nursing home patient, left unrestrained in a wheelchair, fell and died after she struck her head. The Court held the nursing home Residents' Bill of Rights creates a cause of action for violations of nursing home residents' rights, the enforcement of which does not require adherence to the Medical Malpractice Act. Furthermore, the Court noted the petition

was not rooted in medical malpractice as the fall from a wheelchair was not related to any specific treatment and did not meet the criteria set forth in *Coleman v. Deno* for determining a claim falls under the MMA.

Withdrawal of Life Support

In *Causey v. St. Francis Medical Center*, 719 So.2d 1072 (2nd Cir. 1998), the decision to discontinue life support procedures on a comatose patient whose family objected to the discontinuation was found to be an issue falling under the medical malpractice act, and the matter must be submitted to a medical review panel before suit may be filed. After the family refused to grant permission to withdraw life support, the physician turned to the hospital's Morals and Ethics Board which agreed with the withdrawal. The Morals and Ethics Board is covered under the Medical Malpractice Act as it is a board of the hospital.

LeJeune Claims

Trahan v. McManus, 728 So.2d 1273 (La. 1999). Plaintiffs were the parents of a decedent attempting to recover 2315.6 damages for mental anguish and emotional distress resulting from their son's injury and death. The two issues before the Louisiana Supreme Court were whether the claim fell within the medical malpractice act and whether "by-stander damages" (also known as Lejuene damages) are recoverable when the event at issue was an act or omission by a health care provider the Louisiana Supreme Court held:

The fact damages recoverable under article 2315.6 are limited to mental anguish damages and to specifically required facts and circumstances does not serve to remove article 2315.6 claims from the applicability of the Medical Malpractice Act, as long as the mental anguish arises from the injury to or death of a patient caused by the negligence of a qualified

health care provider. Id. at 1277.

The Louisiana Supreme Court reiterated tort damage for medical malpractice falls under article 2315, et seq., and it is not the quality of the claimant, but the context within which the claim arises through medical care and treatment provided to a patient. The medical malpractice act does not create a cause of action for negligent medical care as same is created under article 2315, et seq. The Medical Malpractice Act only provides the procedural mechanism for the presentation of such claims. The Louisiana Supreme Court in this case states:

The requirements of Article 2315.6, when read together, suggest a need for temporal proximity between the tortious event, the victim's observable harm and the plaintiff's mental distress arising from and an awareness of the harm caused by the event. Id. at 1279.

EMTALA Claims

Spradlin v. Acadia-St. Landry Medical Foundation, 758 So.2d 116 (La. 2000).

The Supreme Court held EMTALA claims must also be submitted for review to a medical review panel and explained although the courts have construed EMTALA as creating a federal cause of action separate and distinct from, and not duplicative of, state malpractice cause of action, medical malpractice claims and "dumping" claims often overlap. Since EMTALA only preempts state law to the extent state law "directly conflicts" with federal law, the only issue is whether imposing a mandatory pre-suit medical review panel requirement "directly conflicts" with EMTALA. As dual compliance was not physically impossible, there was no actual conflict. Also, state law "actually conflicts" with federal law "where state law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress." Plaintiffs in this matter, demanded

damages under EMTALA based on defendant's alleged breach of its duty to properly stabilize or to appropriately transfer Mrs. Spradlin; if plaintiffs prove a violation of the requirements of EMTALA (which does not distinguish between intentional and unintentional conduct), they will be entitled to recover the appropriate damages.

The facts recited in plaintiffs' petition do not state a claim under EMTALA based on failure to perform a medical screening examination (or based on disparate treatment in that examination, as opposed to pay patients); therefore, whether there was any negligence in the diagnosis and treatment by the emergency room doctor prior to the decision to transfer is a matter to be addressed in the separate medical malpractice action.

Plaintiffs also alleged in this action conduct by defendant's employees fell below the professional standard of care and constituted medical malpractice. The Court held this claim must be submitted first to a medical review panel before plaintiffs can file the claim in district court. It recognized that requiring separate suits based on related claims growing out of the same transaction or occurrence appears to be judicially inefficient and may produce inconsistent results; however, the court in the EMTALA action (which must be filed within two years) may consider whether it is appropriate under the particular facts and circumstances to grant a motion to stay the action, while urging expeditious action in the medical review panel proceeding. Thus plaintiffs were entitled to recover damages on both claims, whether in one or two trials, despite the fact the law requires exhaustion of an administrative remedy in one action which is not applicable to the other.

Federal Nursing Home Regulation Do Not Give Rise to a Cause of Action

In Satterwhite v. Reilly, App. 2 Cir. 2002, 817 So. 2d 407, the Court held federal regulations establishing requirements for a nursing home to participate in Medicare and Medicaid and which provide a nursing home director is responsible for “implementation of resident care policies” and “the coordination of medical care in the facility” do not impose a tort duty on a nursing home’s director, do not grant a private cause of action against a medical director, and do not establish a standard of care for the medical director. Furthermore, the Court held the regulations do not establish a standard of care for a treating physician.

VIII. **HOT TOPICS AND POTPOURRI**

- X. Convening of Panel - La. R.S. 40:1299.47E
- Y. Additional Information Requested by Panel - La. R.S. 40:1299.47F.
- Z. Costs of the Medical Review Panel
 - 3. Attorney Chairman - La. R.S. 40:1299.47I(1)(b)
 - 4. Physician Members - La. R.S. 40:1299.47I(1)(a)
 - 5. Who pays for the Panel
 - B. If the Defendant Wins - La. R.S. 40:1299.47I(2)(a)
 - C. If the Claimant Wins - La. R.S. 40:1299.47I(2)(b)
 - D. If There is a Material Issue of Fact - La. R.S. 40:1299.47I(3)
- AA. Admission of Panel Opinion in Subsequent Lawsuit - La. R.S. 40:1299.47H
- BB. Accrual of Legal Interest - La. R.S. 40:1299.47M
- CC. Limitation of Recovery by Qualified Health Care Providers - La. R.S. 40:1299.42B(2)

DD. Settlement with Claimant Demanding Additional Money from PCF - La.
R.S. 40:1299.44C