I EVALUATING THE 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 prove 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.

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. Since March, 2003, these written requests must be made in a specific format.

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 written request must be made through the medical records department.
When making a request for such hospital records, it is important for the patient or family member 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.

C. The Need for Expert Consultation and Review

In order to determine whether a viable medical malpractice case exists, 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.

D. Establishing Potential Areas of Liability

E. 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.

Premises Cases

Like automobile and medical malpractice claims, documents like accident reports, wage loss information and medical records are important to bring to the meeting with your lawyer. However, it is also important to bring pictures of the particular property you allege was defective and caused your injury. This will assist your lawyer in evaluating the defective nature of the property hazard.

F. Commencing the Action

A. The Statutes and Case Law

Louisiana 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 Medical Malpractice Act, (the “MMA”), La. R.S. 40:1299.41 et. seq, while claims against public or state healthcare providers are governed by the Malpractice Liability for State Services Act, (the “MLSSA”), which is found in La. R.S. 40:1299.37 et. seq. La. R.S. 40:122.39.1 of the MLSSA specifically addresses the procedural requirements for filing a claim of malpractice against a state healthcare provider. The provision of the MMA governing that procedure is found at La. R.S. 40:1299.47.

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.

a. 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
b. **What Format or Allegations Should the Request For Review Contain**

The statutes do not specifically set forth the format or content of a legally valid request for review. There is also a divergence of opinion among practitioners regarding the degree of specificity which should be included in a request for review. Courts which have considered this issue have provided minimal guidance on the contents of a legally valid request for review. See for example: In re Medical Review Panel for claim of Juanita Leday, 1997-3068 (La. 2/13/98), 706 So.2d 985; Coleman v. A.C. Dickerson, D.D.S., 94-25 (La. App. 5th Cir. 5/31/94), 638 So.2d 420; and Apande v. Kudla, 560 So.2d 668 (La. App. 3rd Cir. 1990). These cases allow the request for review to be made in the form of a letter. The Apande court stated that the letter should contain: (i) a brief recitation of the facts surrounding the alleged negligence; (ii) list specific allegations of negligence on the part of defendants (iii) provide the full names and addresses of the defendants; and (iv) contain a prayer for damages. The Coleman court held that although a letter can form a proper request for review, a letter merely requesting information as to whether an individual healthcare provider is qualified is **not** sufficient to suspend prescription. In Leday, the subject letter set forth the name of the patient and involved healthcare providers, the dates of treatment, the allegations of negligence and the problems resulting from that alleged negligence. However, rather than requesting the formation of a medical review panel, the letter stated:

“Please advise whether or not Dr. Darbonne and Dr. Humphrey or Humphries are qualified under the Medical Malpractice Act. I do not know these physicians first names, but they were employed at University Medical Center on August 5, 1993. I also need to know if the University Medical Center is qualified under the Medical Malpractice Act.”
The lower court and appellate court (1st Circuit), held that this letter did not interrupt prescription because “Nowhere in the letter is there even a hint of a ‘request for review of a claim’ under LSA-R.S. 40:1299.39.1 or 40:122.47 (A).” The Louisiana Supreme Court reversed this decision stating:

We interpret the August 1, 1994 letter which outlined the complaints of medical malpractice as a timely request for review. Exception of prescription overruled.

Thus, it appears that the magic language specifically requesting the formation of a medical review panel is not legally necessary to file a valid request for review. However, it is strongly suggested that any letter request specifically request the formation of a medical review panel along with the other elements outlined by the courts in the cases noted above.