

# Afraid of getting sued? A plaintiff attorney offers counsel (but no sympathy)

🔴 Lawyer Lewis Laska has chronicled medical malpractice settlements and verdicts for more than 25 years. Here, he crosses the aisle to share insights.

**Janelle Yates**  
Senior Editor

**N**o surprise that the lawyer who wrote *Sue the Doctor and Win!* has a divergent view of the medical liability “crisis,” compared with the way ObGyns usually see it.

Lewis Laska, JD, PhD, shares ObGyns’ concerns about the effect of malpractice on women and their children. But he doesn’t agree that the number of lawsuits is increasing, or that the dollar value of jury verdicts is rising beyond what might be expected with “normal” inflation, or that most malpractice cases are generated by “greedy” lawyers.

Instead, he asserts that most liability cases arise from poor care, that ObGyns and other physicians often do themselves more harm than good when responding to a poor outcome, and that all doctors could learn a lot by considering the viewpoint of their nemesis, the trial attorney.

OBG MANAGEMENT decided to explore Dr. Laska’s intriguing proposition to view medical malpractice through an alternative lens and take advantage of his considerable experience as an attorney and medical malpractice expert. In a Q&A session, we asked about some of his assertions and inquired specifically about the ways he believes physicians draw avoidable medicolegal trouble.

Dr. Laska is a legal consultant and editor of *Medical Malpractice Verdicts, Settlements & Experts*, a monthly compendium of malpractice cases from around the country ([www.verdictslaska.com](http://www.verdictslaska.com)) and the sole source of malpractice case summaries in the “Medical Verdicts” section of OBG MANAGEMENT (page 54).

**IN THIS  
ARTICLE**

**Is the number  
of lawsuits rising?**  
page 36

**Origins of cerebral  
palsy remain a bone  
of contention**  
page 38

**Why do patients sue?**  
page 39

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CONTINUED ON PAGE 36



**OBG MANAGEMENT:** Let's focus first on the fundamental disagreements between malpractice attorneys and physicians. In your opinion, what are the most common misconceptions among ObGyns about malpractice litigation? That is, what do doctors just not "get" about the reasons they get sued?

**LEWIS LASKA:** They think that lawyers are always looking for ways to sue doctors; in reality, it's just the opposite. For every lawsuit filed, as many as 100 are turned down. There are a lot of angry people out there, and trial lawyers do a lot of filtering.

Doctors also have the attitude that malpractice lawsuits are caused by lawyers rather than by anything that the doctor did or failed to do. In other words, physicians seem to think that health-care safety would improve if only there were no lawyers—and they overlook the obvious: that somebody (a nurse or doctor) did something wrong.

The most common misconception among ObGyns is that there is nothing they can do to avoid being sued. In reality, however, there is much that can be done. If ObGyns participated in drills to manage shoulder dystocia and common emergencies, and honed their skills and those of labor and delivery nurses so that their responses to these so-called complications were improved, they wouldn't get sued so often.

ObGyns also fail to manage gestational diabetes aggressively, a clearly avoidable "complication." Finally, if ObGyns were more responsive to questions from their patients, and acted more kindly, patients wouldn't be so eager to sue them.

"If ObGyns were more responsive to questions from their patients, and acted more kindly, patients wouldn't be so eager to sue them"

LEWIS LASKA, JD, PhD

### Is the number of lawsuits rising?

**OBG MANAGEMENT:** How many malpractice cases are filed each year in the United States?

**LASKA:** No one except the insurance companies knows how many malpractice cases are filed—and they aren't telling. There is no central source in this country in which lawsuit filings are tallied, although some years ago the Physician Insurers Association of America cited an estimate of 30,000.

Nor is there clear agreement about what constitutes a malpractice "case." Does it include a fall from a hospital bed? A fall from an ObGyn's examining table?

It also is important, in addressing this question, to point out that a lawsuit is not the same thing as a claim. The latter may involve a patient simply complaining about poor treatment, bad office staff, and so on. Although a lawsuit is certainly a claim, a claim is not a lawsuit—and there are many, many more claims than lawsuits.

**OBG MANAGEMENT:** Is the number of malpractice lawsuits increasing?

**LASKA:** The most recent data that address this question are from the year 2006 and come from the National Practitioner Data Bank (NPDB). There were 15,843 medical malpractice payment reports received that year. That figure is 8.3% less than the number received in 2005, which showed a 2.2% decrease from 2004.<sup>1</sup>

Anecdotal data provide additional evidence that the number of malpractice lawsuits is dropping. For example, *Massachusetts Lawyers Weekly* reported that 485 lawsuits were filed in 2008, compared with 708 in 2000. And *Pennsylvania Lawyers Weekly* noted that 1,602 lawsuits were filed in 2008, compared with 1,641 in 2007 and 2,732 in 2002.

As for the number of lawsuits filed each year, I think the 30,000 figure is about right. According to the NPDB, the average delay between an incident that leads to payment and the payment itself is 4.88 years—and that delay actually increased by 80% from 2005 to 2006.<sup>1</sup> If we assume that 30,000 cases are filed each year, and that it takes about 5 years for a case to close, that means about 15,843

BLAIR KELLY FOR OBG MANAGEMENT

## Origins of cerebral palsy remain a bone of contention

**OBG MANAGEMENT:** In your book, you make frequent reference to ACOG Technical Bulletin #163, which no longer exists, but which was modified slightly and rearticulated in the 2003 publication, *Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology*, as you also note.<sup>4</sup>

The 2003 report was authored by both ACOG and the American Academy of Pediatrics (AAP). In a press release issued at the time of publication, ACOG noted that newborn encephalopathy and cerebral palsy (CP) are “associated with significant mortality rates and long-term morbidity and have been central in the assignment of blame in obstetric litigation.”

In the 2003 report, ACOG and the AAP essentially concluded that the majority of newborn brain injury cases do not occur during labor and delivery, but are attributable to events that occur before labor begins.

What do you make of their stance on the matter?

**LASKA:** First published in 1992, Technical Bulletin #163 set a very high standard for when intrapartum asphyxia could provide a “plausible link” to CP. Criteria included:

- umbilical cord pH <7 (i.e., acidosis)

- an Apgar score of 0 to 3 that persists for more than 5 minutes
- later documentation of neonatal neurologic problems, such as seizures
- dysfunction in any or all of the newborn’s cardiovascular, gastrointestinal, hematologic, pulmonary, or renal systems.

These criteria applied only to term newborns who did not have an obvious, or, at least, diagnosable, congenital anomaly. The actual diagnosis of “the problem” caused by “the incident” was hypoxic-ischemic encephalopathy (HIE).

The main thrust of Technical Bulletin #163 was challenged in the medical literature as early as 1995, by Goodlin, who argued that the practical effect would be that few cases of CP would be judged to be the result of perinatal asphyxia.<sup>5</sup> Two other articles by Korst described cases in which it was clear that the newborn had experienced an acute intrapartum event such as uterine rupture or a prolapsed cord, yet only one met the ACOG criteria for HIE. Korst’s later study of 47 newborns found that only 10 met all four criteria.<sup>6</sup>

The 2003 international consensus statement is similar to Technical Bulletin #163, but actually supports some of the theories in plaintiffs’

recoveries in these cases, mentioning (as #163 does not), a “sudden, rapid and sustained deterioration of the fetal heart rate pattern, usually following the sentinel event, even where the pattern was previously normal.” This statement actually endorses electronic fetal monitoring, which is commonly disparaged in litigation in the United States, despite its use in 80% of labors in this country.

An international consensus statement published in 1999 also requires “early imaging evidence of acute cerebral abnormality.”<sup>7</sup> This means that CP can (and must) be confirmed by neuroimaging —another battleground issue in litigation in the United States.

Even your own journal recently asked who or what test can conclusively eliminate intrapartum asphyxia as a medically probable cause of cerebral palsy.<sup>8</sup> In reply, the article stated, “The answers are disheartening.” The article went on to explain that “only 14.5% of CP cases are associated with intrapartum asphyxia.” Let’s see. That would mean 14.5% of 6,400 cases of CP—or 928 needlessly brain-damaged infants each year.

My personal view is that the percentage of CP cases caused by an intrapartum event is higher than currently thought.

payments each year, since it is a cumulative number for about 5 years’ worth of cases.

**OBG MANAGEMENT:** What about the dollar amount of jury verdicts? Has that been increasing in recent years?

**LASKA:** My impression is that any increase in the amount of dollars awarded simply reflects medical inflation—namely, the increase in the cost of medical care. This is especially true when the lawsuit involves future medical care, as in the case of a baby injured by health-care negligence.

Accurate dollar data are very hard to find. According to the NPDB, obstetrics-related cases generated 8.7% of all payments reported in 2006, and also were responsible for the highest median payment: \$333,334.<sup>1</sup>

When discussing dollar data, it is important to avoid the use of averages because a few very high outcomes distort this figure—and most of these amounts are lowered on appeal or settled for much less on appeal. The better figure is the median, which I cited above.

## Why are so many cases settled?

**OBG MANAGEMENT:** In your book, you note the following:

In 1994, it was reported by *American Medical News*, the AMA's weekly newspaper, that of every 100 birth-injury lawsuits filed, 47 were dropped by the plaintiffs or dismissed by the court prior to trial. Of the remaining 53 cases, 40 (three quarters) were settled by monetary payment. That leaves 13 cases. Of these, the doctor won 78%. In other words, plaintiffs won only three of the 13 that went to trial. This means that only 3% of birth injury cases result in a plaintiff's verdict.<sup>2</sup>

Are these figures still relatively accurate?

**LASKA:** Yes, so far as I can tell.

**OBG MANAGEMENT:** Why do you think so many cases (40%) are settled by monetary payment? Is there blatant negligence in those cases? Or is the insurance company simply reluctant to bear the burden of cost of seeing the case all the way to trial?

**LASKA:** Sorry, but this is a false dichotomy. Insurance companies never settle unless there is provable liability. The notion that an insurance company would settle a big injury case with marginal liability is simply a cultural myth of medicine.

## Why do patients sue?

**OBG MANAGEMENT:** In your book, you say many injured patients sue just to find out what really went wrong because the doctor has not been communicative about all the events that transpired. If physicians were more straightforward about adverse outcomes and the reasons for them, do you think fewer patients would sue?

**LASKA:** Yes, I think there would be fewer suits, lower settlements, and greater trust. Doctors should stop demanding "tort reform" and look more closely at themselves.

If my book seems too toxic for ObGyns, another option is *Medical Errors and Medical Narcissism* by John D. Banja. He argues that physicians are self-obsessed, wanting to be seen as "perfect." And when they do wrong, they follow a path driven by narcissism. Shock

and concern are followed by rationalization, avoidance, and minimization.

By the way, most people would like doctors to communicate with them the way physicians communicate with patients (and one another) on television. Jurors are sometimes stunned to learn that the doctor being sued did not communicate with nurses about the problem as it arose, and then disappeared without talking to the injured patient.

**OBG MANAGEMENT:** You say that about one in eight patients who sustain injury in the hospital actually sues. Why do you think that figure is so low?

**LASKA:** The injuries sustained are not so severe that a lawyer can be convinced to take the case, or the patient simply does not know that she was injured by negligence.

Because it takes so much money to press a health-care liability case, the injury has to be severe to justify it. Here's an example: The obstetrician cuts the baby's face during a cesarean delivery. The parents are outraged, but if the baby heals nicely, there really isn't much of a case that will bring enough money from a jury to justify a lawsuit.

**OBG MANAGEMENT:** In your book, you claim that juries are moved not by sympathy, but by anger. Could you elaborate?

**LASKA:** When a physician is sued, and, in response, points the finger at someone else, who points the finger right back, juries conclude that the team simply was not working together. And the refusal of anyone on that team to accept responsibility makes the jury angry. Doctors may call it "system breakdown," but juries consider it malpractice—or, the term I now use, "health-care liability."

Another reason juries get angry is the rude and condescending behavior that physicians sometimes exhibit in videotaped testimony. Sometimes doctors make fools of themselves in these videotapes by contradicting themselves, contradicting the medical records, contradicting the testimony of nurses, and so on. This kind of behavior will torpedo a case and lead to a higher verdict than it would have in the days before videotaping, when the deposition was merely read to the jury.

"Insurance companies never settle unless there is provable liability"

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CONTINUED ON PAGE 40

## How do lawyers try these cases?

**OBG MANAGEMENT:** Has the way in which lawyers try cases changed?

**LASKA:** Most medical liability cases now end up in the hands of legal “specialists,” who have experience in a particular area. In addition, lawyers now share information better than in the past. ObGyns and other doctors don’t understand that health-care victims’ lawyers are working together as never before and learning to overcome the many defenses—some very tenuous—that are raised in a doctor’s defense.

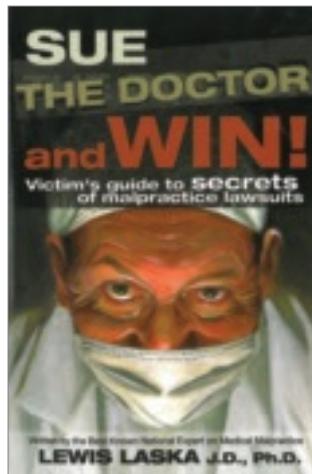
A recent Tennessee case is an example. In *Olinger v. University Medical Center*, the defendant ObGyn (and his experts) testified that shoulder dystocia is a “sudden emergency” because it occurs in only 3% of deliveries.<sup>3</sup> They also asserted that 90% of the time, shoulder dystocia is relieved by initial maneuvers, such as McRoberts’ maneuver.

In this case, because the doctor had delivered 4,000 babies and had encountered shoulder dystocia only 100 times, and because the legal case represented the first time initial maneuvers had failed to resolve the dystocia, the defense argued that the occurrence was a true “sudden emergency,” allowing the jury to be so instructed on that issue.

The doctor won his case—fine. But now that it is established in Tennessee law and Tennessee medicine that shoulder dystocia that cannot be resolved with “initial maneuvers” is a medical emergency, you can bet that victims’ lawyers are going to find ways to demonstrate that a particular case is one in which the doctor did not know how to deal with this particular “sudden emergency.” In short, the Olinger case provides a roadmap for how to win (or turn down) a shoulder dystocia case.

**OBG MANAGEMENT:** What do you think about proposals set forth to resolve the malpractice crisis?

**LASKA:** In the 1970s, physicians advocated



malpractice review panels to end the so-called crisis. These panels fell from favor because they did not work. Now, the idea *du jour* is the establishment of special “malpractice courts.”

What will be the result? A cadre of superspecialists will develop who handle nothing but malpractice court cases. The typical lawyer will refer cases to one of these superspecialists (as they usually do now), and it will become easier to prove the standard of care nationwide. After all, why should the handling of a

case involving shoulder dystocia be different in Phoenix than it is in Nashville?

Doctors, be careful what you wish for. Special malpractice courts are the first step toward national standards of care.

**OBG MANAGEMENT:** A final question: Who buys your book, *Sue the Doctor and Win!*, as far as you are able to gauge?

**LASKA:** The primary buyers have been MD/JDs, probably because they all wanted to write such a book. Nurse consultants have also been buying it, as well as “puppy” lawyers at malpractice firms.

By the way, the book has sold poorly. Everybody thinks they already know all they need to know about malpractice. That includes doctors and victim’s lawyers. ☹

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