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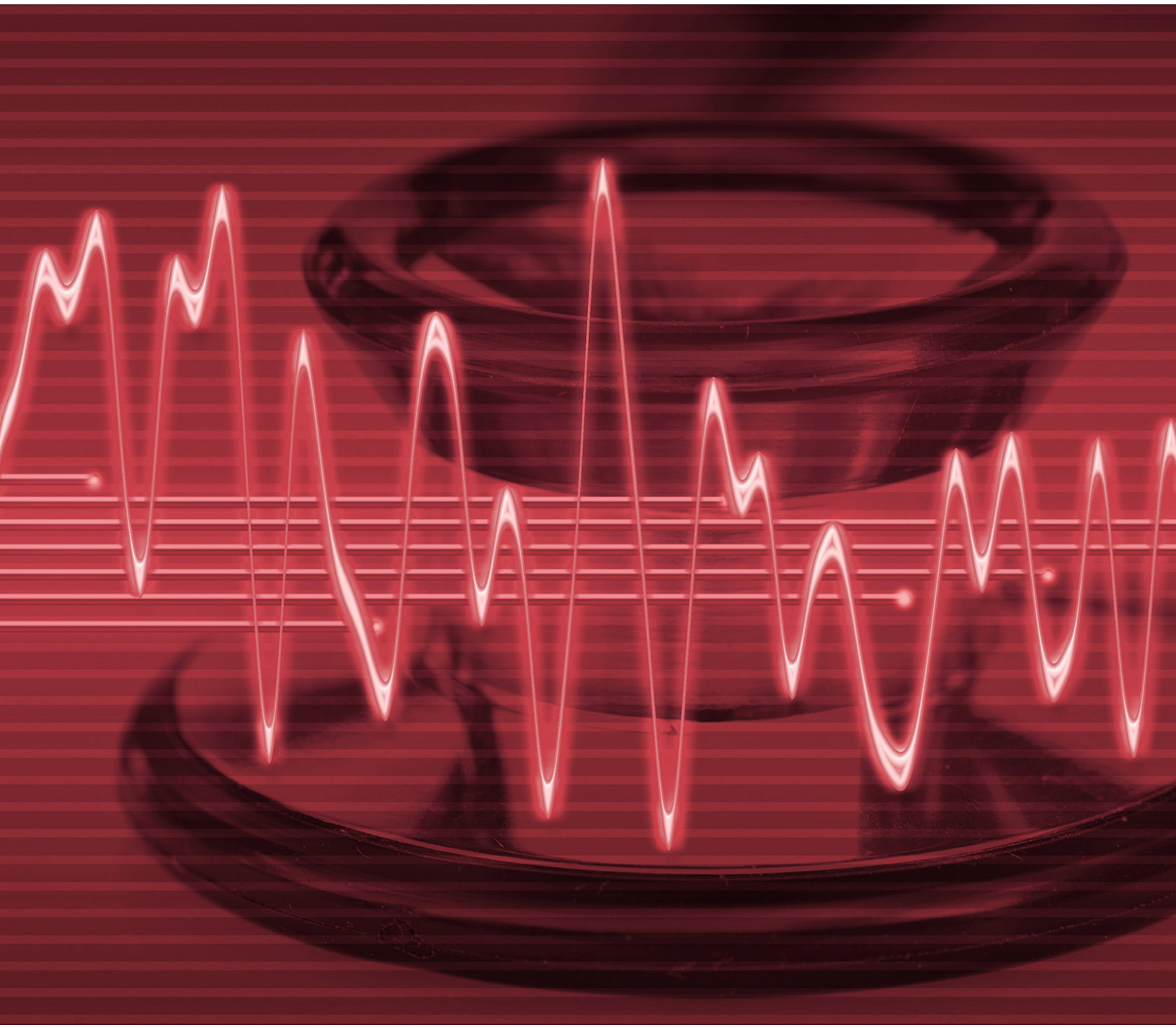
WINTER 2024 / MEDICAL MALPRACTICE EDITION



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A LETTER
from the President

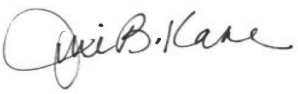
Friends,

I hope each of you had a restful and grateful Thanksgiving weekend with friends and family. As we are approaching the end of the year, I anticipate your remaining holidays are filled with joy and excitement of a wonderful 2025. AIEG is positioned for an exceptional year in 2025, and your leadership team is working hard every day to make sure we are offering you the very best opportunities we can. Along with me, your president-elect Wes Ball, your treasurer Julian Gomez, and your general counsel Larry Coben, our exceptional AIEG staff are working nonstop on behalf of the organization and our various practice areas.

Our AIEGVoice this quarter, dedicated to our members who practice in the field of medical negligence, shares information that will be eye-opening to the majority of us. Our medical negligence cases face similar challenges as our traditional product liability cases: industry-controlled experts, electronically stored information designed to protect patients' data frequently concealing the same from the patients' lawyers, and complex records that require specialists to sort and understand. Our medical malpractice committee hopes this issue of the AIEGVoice will help reveal some ways to deal with these issues.

You will be incredibly impressed with the articles in this quarter's magazine. Articles about two specific types of cases deliver practice tips which will be useful across the field. Laparoscopic cholecystectomies are performed every single day, and I thank Kent and Adrian for sharing their unique perspective with us. Laparoscopy is the 'safe' way to perform the surgery — until complications arise. Special thanks to Andy Campbell for sharing his lessons learned from a recent pathology case. Last, but certainly not least, the technology article provided by Complete Legal touches on ways to uncover key medical evidence in digital imaging, audit trails, and electronic health records.

Thanks for all each of you do to help and protect others in your communities. Working together, our AIEG membership is stronger than any of us can be individually. Thank you for your support of AIEG, and as always, reach out to me at julie@colson.com or 305-632-1780 for any reason. Meanwhile, please keep up the great work you each do protecting public safety. Best to all for wonderful holidays and an exceptional 2025.



Julie Braman Kane
AIEG President 2023-25

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/UPCOMING CLE EVENTS

2025 AIEG PARALEGAL SEMINAR

San Antonio
TEXAS

Feb. 27 - Mar. 1
La Cantera Resort & Spa

Please call the host hotel at 1-210-558-6500 to reserve a room in the AIEG room block by January 27, 2025. Please reference event name and the group code, AIB2625A.

As the 2025 AIEG Paralegal Seminar is hastily approaching, we hope that your paralegals are registered and ready to learn, network, and have a wonderful time in the unique city of San Antonio, Texas. These seminars provide unmatched opportunities for our members' legal staff year after year, and this upcoming seminar is promised to be no exception.

Registration and agenda are available on the AIEG website.

**PLEASE NOTE: Registration cancellations within 10 days of the event will not be refunded.*

2025 AIEG SPRING SEMINAR

NEW ORLEANS
LOUISIANA

April 2-4
Hotel Monteleone

Please call the host hotel at (504) 523-3341 or by calling our Group Reservations number at (800) 217-2033.
Indicate you are with Attorneys Information Exchange Group (not AIEG).
Room block deadline: March 3

Registration is open on the AIEG website.

Agenda TBA.

**PLEASE NOTE: Registration cancellations within 10 days of the event will not be refunded.*

2025 AIEG FALL CONFERENCE

BOSTON
MASSACHUSETTS

OCTOBER 22-24
The Langham Boston

Please call the host hotel at (617) 451-1992 or our Group Reservations number at (800791-7761.
Room block deadline: September 30

Registration is open on the AIEG website.

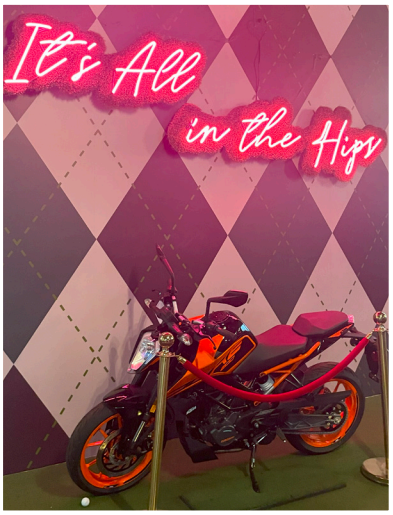
Agenda TBA.

**PLEASE NOTE: Registration cancellations within 10 days of the event will not be refunded.*

/Photos from the 2024 AIEG Fall Conference

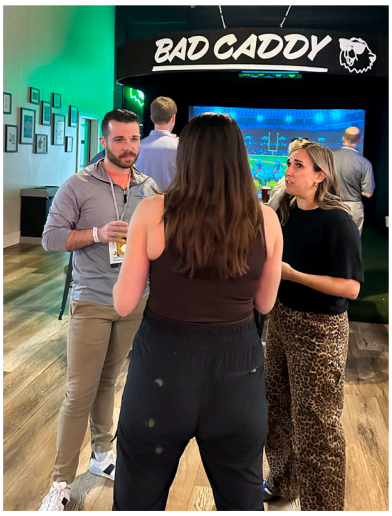
Salt Lake City, UT


Black Hats
Society


It's All
in the Hips

/Photos from the 2024 AIEG Fall Conference

Salt Lake City, UT - *continued*




D CADDY


BAD CADDY


It's All
in the Hip

/Photos from the 2024 AIEG Fall Conference

Salt Lake City, UT - *continued*


Julian
TREASURER
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The
GRAND
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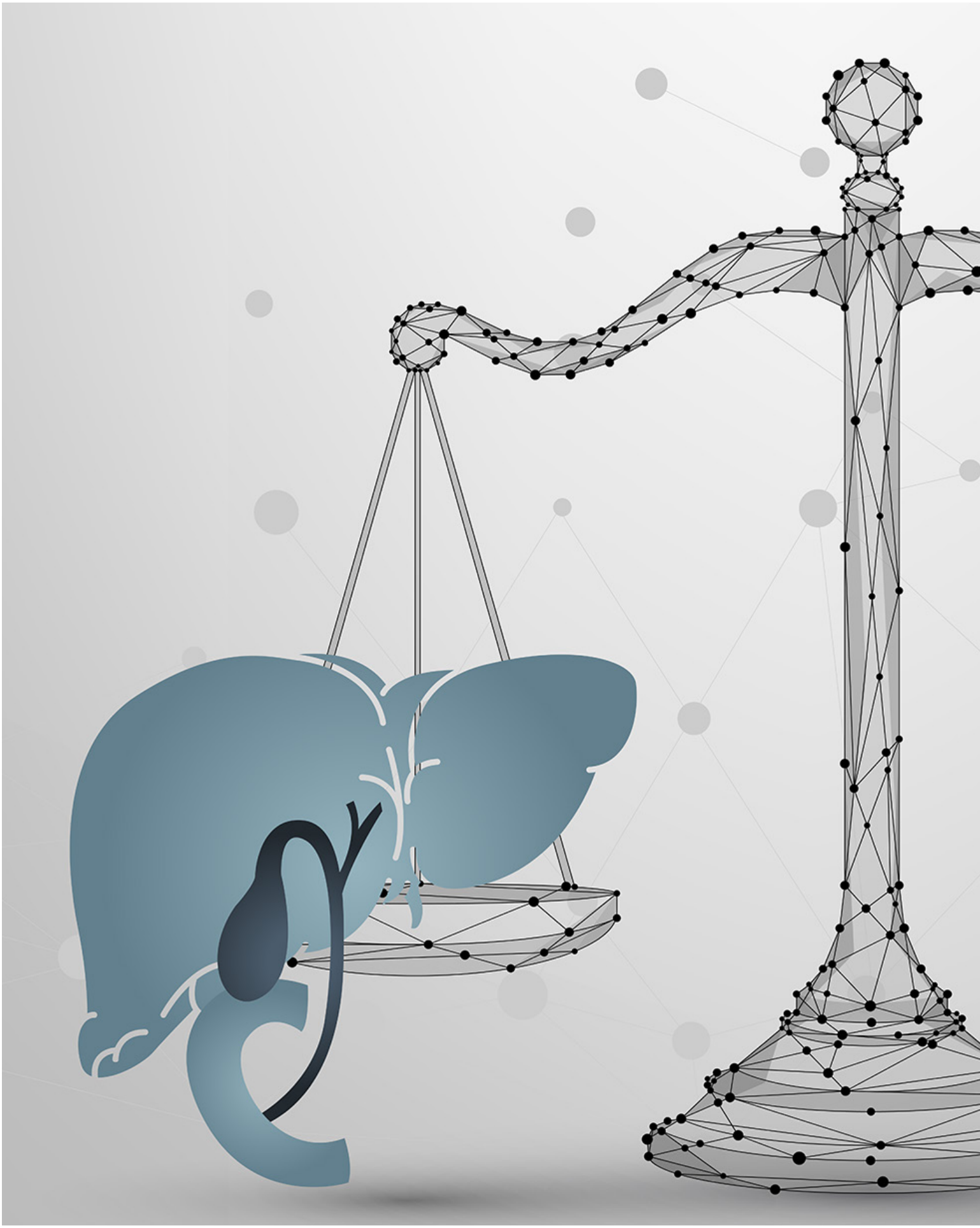
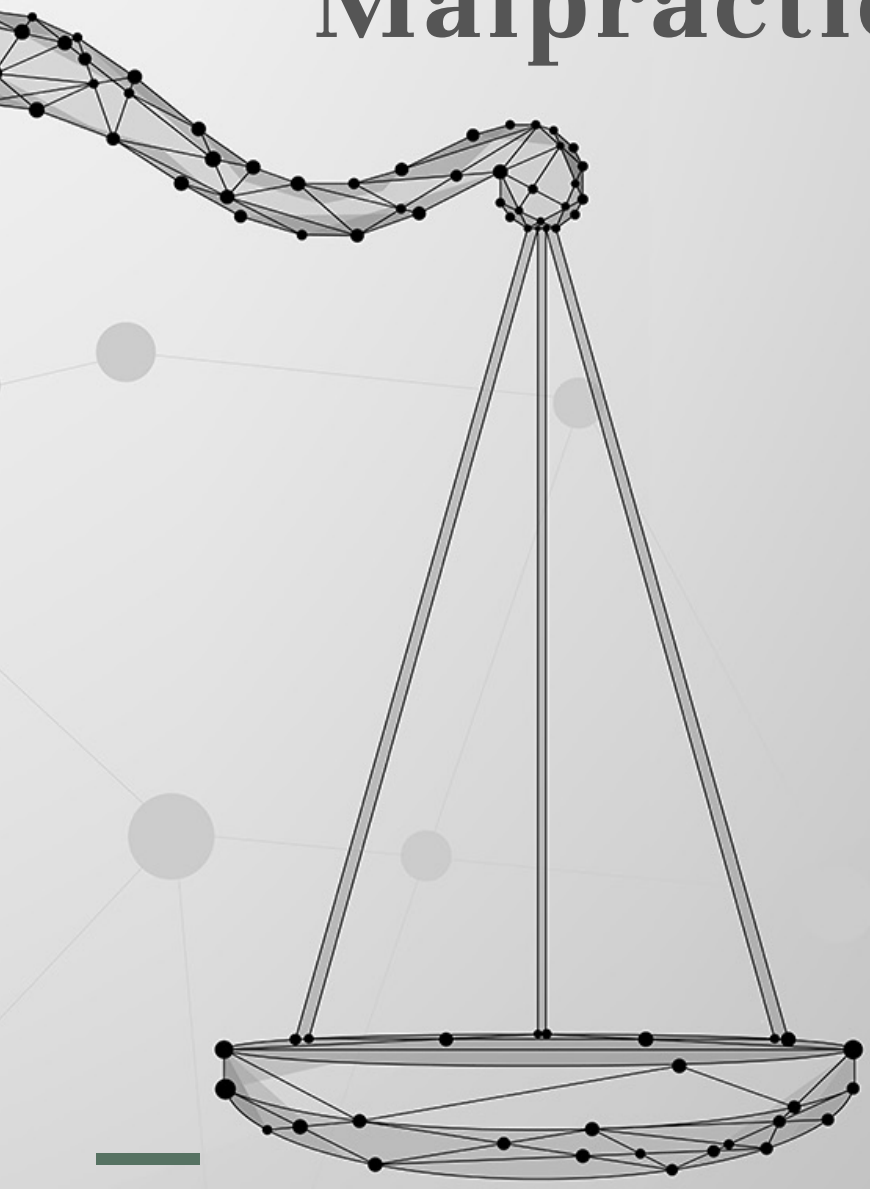
MEDICAL MALPRACTICE ISSUE



Litigating Laparoscopic Cholecystectomy Malpractice Cases



Adrian Vega
Kent Buckingham

Biliary injury is the greatest problem besetting one of the greatest advances in biliary operation during this century, the laparoscopic cholecystectomy. The key to this problem is not in complicated repairs at tertiary centers but in prevention. Prevention requires commitment to perform meticulous dissection so that only structures that have been unequivocally and conclusively identified are divided.[1]

This quote is from an article written by Steven Strasberg, MD in 1995. And it remains true to this day. Laparoscopic cholecystectomy has become the gold standard for treating symptomatic gallbladder disease, due to its minimally invasive nature and quicker recovery times compared to traditional open surgery. However, like any surgical procedure, complications can arise, and in some cases, these complications may lead to serious consequences for the patient.

Until the end of the 1980s, this surgery was done as an "open" procedure, requiring a six-inch incision, a three- to four-day hospital stay, followed by a three- to six-week convalescence. In 1989, the world of gallbladder surgery underwent a revolution with the introduction of laparoscopic cholecystectomy. Laparoscopic Cholecystectomy is a fiber optic surgery, and sometimes robotic surgery, performed through the abdominal cavity wall. Developed in the United States by Dr. Eddie Joe Reddick, the procedure was enthusiastically embraced by both the surgical community and the public, because it resulted in less postoperative pain, shorter hospital stays, and more rapid return to normal activity when compared to the open procedure.

Currently, 90 percent of cholecystectomies are done laparoscopically, and the procedure is the most common one performed in a general surgery practice. Yet, the benefits of the procedure have been attained against the backdrop of an alarmingly increased number of iatrogenic injuries, or those inadvertently induced by the surgeon. While many errors can arise during laparoscopic cholecystectomy, the focus of this article is on the most devastating complication — iatrogenic injury to the bile duct system.

For trial lawyers representing plaintiffs in Laparoscopic Cholecystectomy malpractice cases, understanding both the technical aspects of the procedure and the legal framework for proving medical negligence is crucial. This article outlines key issues to consider when litigating laparoscopic cholecystectomy malpractice cases, from understanding the procedure to identifying potential breaches of the standard of care.

The Anatomy

To understand the mechanism of bile duct injury, it is necessary to be familiar with the anatomy of the biliary structures. The liver is a large organ in the upper right part of the abdomen. One of its primary functions is to produce bile. Bile, which is a combination of digestive enzymes and waste products, plays an important role in the digestion of fats in the intestinal tract. The bile is delivered from the liver to the intestines through a series of ductal structures. Collectively, the gallbladder and these ducts are called the biliary system.

From the liver, the bile initially passes into the Right and Left Hepatic Ducts. These then coalesce into one duct called the Common Hepatic Duct. Merging into this duct is the Cystic Duct, coming from the gallbladder. After this merger, the duct is then called the Common Bile Duct, which feeds on down to the small intestine. It is important to remember that the Common Hepatic Duct and the Common Bile Duct are truly the same ductal structure. It just changes names upon the merger of the Cystic Duct coming from the gallbladder. Similar to the way a street changes names when it crosses a major thoroughfare.

The gallbladder itself is a pear-shaped sac that lies on the undersurface of the liver. It connects to the biliary ductal system through the Cystic Duct. The gallbladder serves as a storage shed ... its primary job is to collect and concentrate bile, which is secreted continuously by the liver, until the bile is needed to aid in digestion.

After fatty food is eaten, the gallbladder contracts and sends its stored bile into the small intestine by way of the Cystic Duct into the Common Bile Duct. When digestion of the meal is completed, the gallbladder

relaxes and once again begins to store bile. The bile sent down to the small intestines is then recirculated in the digestive tract by being absorbed in the intestine and returned to the liver in the bloodstream.

Gallstones are formed when the components of bile (particularly cholesterol and bilirubin) solidify and form crystals. These stones can range from the size of a grain of sand to the size of a golf ball. The gallbladder may contain anywhere from one stone to hundreds.

The consequences of gallstones may be severe, ranging from brief episodes of biliary pain to potentially life-threatening complications. It is thought that gallstone pain results from a blockage of the Cystic Duct by a stone. If stones become lodged in this duct and block the flow of bile for several hours, they can cause acute cholecystitis, an inflammation of the gallbladder. Blockage of the Cystic Duct is a common complication caused by gallstones.

Occasionally a gallstone can move through the Cystic Duct from the gallbladder and slip into the Common Bile Duct. The stone can then potentially lodge at the outlet of the Common Bile Duct (a condition known as choledocholithiasis) and block the flow of bile completely. If this occurs, the bile accumulates in the blood stream, causing the patient to become yellow or jaundiced. If this blockage is associated with infection of the bile, a life-threatening condition known as cholangitis (inflammation of the bile ducts) results. A prolonged blockage of any of the biliary ducts can cause severe damage to the gallbladder, liver, or pancreas.

Once a patient with gallstones begins having pain in the upper abdomen for which there is no more likely explanation, elective cholecystectomy is indicated. An urgent cholecystectomy is performed if the patient is experiencing more severe gallbladder problems, such as acute cholecystitis, choledocholithiasis, and cholangitis.

Understanding the Procedure: Laparoscopic Cholecystectomy Overview

Laparoscopic cholecystectomy is performed using video-telescopic visualization of the gallbladder and surrounding vital structures. The patient is placed under general anesthesia. One of the common techniques for performing this procedure is begun by making a small incision near the navel and inserting a needle into the abdominal cavity. The cavity is then inflated with carbon dioxide gas. This distention allows for easier viewing and creates a workspace for the surgery to be performed. The needle is then removed, and a sharp, hollow metal cylinder called a trocar is inserted into the now insufflated abdominal cavity. A laparoscope is then placed through the trocar.

The laparoscope is equipped with a camera that allows a magnified view of the inside of the abdominal cavity to be projected onto video monitors located on either side of the operating table. Once the laparoscope is in place, the abdomen is examined to ensure no injuries resulted from the placement of the trocar. Additional trocars can then be placed into the abdomen through small incisions under direct observation through the laparoscope. It is through these ports that various surgical instruments are inserted for manipulation and dissection. The surgeon then watches the monitor and performs the operation by manipulating the inserted surgical instruments.

In the typical procedure, the end of the gallbladder is pulled upward toward the diaphragm. This allows the Cystic Duct, the Cystic Artery, and the Common Bile Duct to be seen. Once these structures have been clearly identified and dissected away from the surrounding tissue, the Cystic Duct is sealed with a clip placed near its junction with the gallbladder. The surgeon then places two more clips near the point where the Cystic Duct joins the Common Bile Duct. The Cystic Duct is cut and separated between the clips. The Cystic Artery, which provides the main blood

supply to the gallbladder, is then divided in the same way.

In performing this procedure, the surgeon must be meticulous, for the cardinal rule of cholecystectomy is that no anatomic structures are clipped or cut until the surgeon is unequivocally certain that they have been properly identified.[2]

Once the ducts have been divided, the gallbladder is separated from the liver bed and the gallbladder neck is pulled through the port at the navel. The neck is then cut open and the stones and bile are expressed. The deflated gallbladder is then removed through the incision near the navel. The abdominal cavity is irrigated to prevent any irritation from spilled bile. The instruments are removed, and the carbon dioxide is allowed to escape. The half-inch incisions are then closed with small sutures, if necessary, and bandaged. The procedure should last between 40 and 60 minutes.

Early on in the procedure, if there is any doubt as to the identification of the biliary structures, the surgeon may perform an intraoperative cholangiogram. This procedure may also be done if it is suspected that a stone has lodged in the common duct. Cholangiography is also especially helpful in detecting any unusual anatomy — a typical defense raised by the surgeon.

To perform a cholangiogram, a small incision (a *ductotomy*) is made in the Cystic Duct just below the clip placed at the junction of the Cystic Duct and the gallbladder. The cut is made before the placement of any of the remaining clips and before any division of the structures. A catheter is then slipped into the Cystic Duct and a radiopaque contrast solution — which shows up clearly as a light area on the X-ray — is injected into the biliary duct system.

The injected material is then monitored with a device called a fluoroscope as it travels through the biliary ducts, and the surgeon obtains an image similar to a real-time X-ray. Failure of the various ducts to fill with the contrast solution should alert the surgeon to a problem requiring immediate attention before continuing with any cutting of the biliary system.

Many surgeons perform cholangiograms routinely, and some have described the procedure as creating a "safety zone."[3] It has been a matter of great controversy among biliary surgeons whether a cholangiogram is the standard of care during gallbladder surgery. The consensus at this time appears to be that cholangiogram is not required by the standard of care; however, a surgeon should not hesitate to perform it if there is any question as to the identity of the biliary anatomy. Cholangiography is also useful in detecting unrecognized iatrogenic injury to the bile duct at a time when it can most easily be effectively repaired.

Those who argue against routine cholangiograms say the procedure may actually increase the chance of ductal injury as a confused surgeon may mistake the Common Bile Duct for the Cystic Duct and cut into the Common Bile Duct for catheter placement. This has occurred; however, the subsequent cholangiogram, if properly read, will show the injury and allow immediate repair during the primary procedure.

An additional problem may arise if the cholangiogram is performed and simply misread. This occurred in the first case handled by the author, where the defendant physician, in the face of severe inflammation, properly decided to perform a cholangiogram. The physician then failed to appreciate that the ductal structures were not filling with the contrast material due to her improper placement of a clip on the Common Bile Duct itself.

Common Complications in Laparoscopic Cholecystectomy

Several potential complications may occur during or after a laparoscopic cholecystectomy, some of which

may be due to substandard care. Common issues include:

- Vascular Injury: Damage to blood vessels, such as the hepatic artery or portal vein, can result in significant bleeding, leading to shock or even death. Vascular injuries are often associated with poor technique in the insertion of the trocars.
- Bowel Injury: Accidental perforation or injury to the small or large intestine can occur, especially if the surgeon's view is obstructed during the insertion of the trocars.
- Postoperative Complications: These may include infections, abscess formation, or the formation of adhesions, which could require additional surgeries.

But the most common, serious problem that occurs is the transection (cutting across) of the Common Bile or Common Hepatic Duct. As recognized in the medical literature, this injury may result in the unfortunate patient becoming a "biliary cripple."[4] The recurrent strictures or narrowing of the bile duct due to scar tissue formation may require multiple operations, accompanied by an increased risk of secondary biliary cirrhosis and liver failure. A surgical dictum — "the only cardinal sin in biliary tract surgery is injury to the Common Bile Duct" — is premised on the devastating effects of this type of injury.[5]

This is one of the driving forces behind laparoscopic cholecystectomy litigation as patients, due to no fault of their own, incur enormous medical bills — hundreds of thousands of dollars —as a result of the injury. The future medical expenses easily surpass that if the liver becomes so cirrhotic as to require a liver transplant.

Typically, injury to the bile duct occurs when the surgeon cuts the Common Bile Duct, mistaking it for the Cystic Duct and thereby violating the cardinal axiom of biliary surgery that every structure be clearly identified before cutting. A similar duct injury is known to occur with the open procedure but not with the same frequency or extent of ductal damage as seen with laparoscopic cholecystectomy. Injuries may also be caused by compromising the blood supply to the duct during the dissection process, causing an ischemic stricture — a constriction or narrowing of the duct usually due to scarring.

Injury may also occur when part of the bile duct is pinched due to an improper application of the clips to the Cystic Duct. This may lead to partial or complete severance of the bile duct and also predispose the bile duct to stricture formation.

Depending on where the Common Bile Duct is injured, effecting a lasting repair can be an impossible task. The "higher" the transection occurs on the biliary tree, the worse the prognosis. The height of the injury is usually referenced by using the *Bismuth scale*, which gauges an injury based on its location in relationship to the confluence of the Right and Left Hepatic ducts. The lower the Bismuth number, the greater the chance of good repair and full recovery.

Unfortunately, bile duct injuries occurring during laparoscopic cholecystectomy are usually ranked high on the Bismuth scale, creating a poor prognosis for a good outcome. These injuries are associated with an increased risk of failure of the repair.

The standard operation to repair a high bile duct injury is the Roux-en-Y hepaticojejunostomy. In this procedure, a part of the small intestine, the jejunum, is looped up and adjoined to the hepatic ducts, allowing the flow of bile from the liver directly into the intestine. In a large number of cases, particularly when the injury is high on the Bismuth scale, strictures (scar tissue) occur at the point of attachment of the ducts into the intestine. This can result in a failure of the Roux-en-Y procedure and require additional operations to open up the ducts. Eventually, these strictures may cause such a stagnant flow of bile and increased biliary pressure that the liver

itself becomes cirrhotic, necessitating a liver transplant.

Although beyond the scope of this article, it should be noted that attempted repair with a Roux-en-Y hepaticojejunostomy by the primary surgeon (the surgeon who performed the cholecystectomy) can itself give rise to a cause of action. There is typically only one good chance at effecting a repair with a Roux-en-Y hepaticojejunostomy as subsequent attempted repairs, if needed, are much more likely to fail due to stricture formation. It has been shown that attempts by the primary surgeon to perform Roux-en-Y hepaticojejunostomy have a success rate of only 21 percent while Roux-en-Y hepaticojejunostomies performed at tertiary centers have a 95 percent success at effecting repair.[6] The likely reason for this boils down to experience … primary surgeons are not performing Roux-en-Y hepaticojejunostomies very frequently in their practice whereas the biliary specialists at tertiary facilities may be doing them on a weekly basis.

The fundamental cause of iatrogenic injury to the Common Bile Duct during laparoscopic cholecystectomy is anatomic misidentification by the surgeon, because he or she failed to take the steps necessary to clearly see the biliary structures. This may be caused by acute inflammation or chronic scarring, both of which are present in most reported bile duct injury cases.[7] Excessive bleeding or large amounts of fat may also impair the surgeon's view. Excessive cauterization or blind placement of hemostatic clamps in an attempt to control the bleeding has also contributed to a large number of iatrogenic injuries.

Another possible reason for iatrogenic injury, typically asserted as a defense in laparoscopic cholecystectomy cases, is that of anomalous anatomy. The surgeon and defense experts will claim that the Cystic Duct and Common Bile Duct were in such an unusual relationship anatomically that it was not a breach of the standard of care for the surgeon to have misidentified and cut the Common Bile Duct. This can be rebutted by showing that there is no "normal anatomy" of the biliary tract. A common pattern of several anatomic variants exists, and it is the surgeon's responsibility to recognize these normal variations when they occur.[8] Further, the operative report may not discuss any anomalous anatomy giving rise to the argument that the defense is being created out of whole cloth.

Injury prevention

It has been noted that it is "far better to prevent a duct injury than to repair an avoidable injury."[9] There are a number of strategies that, if incorporated, would allow a surgeon to prevent iatrogenic injury. From the author's experience in laparoscopic cholecystectomy malpractice cases, the defendant physician usually could have averted catastrophic injury to the patient had these techniques been adopted.

First and foremost, the procedure should only be performed by experienced, well-trained surgeons. Even the experienced surgeon should be ready to convert to an open procedure (laparotomy) if there is any question as to identification of the biliary anatomy, if the case is too difficult due to inflammation, or if the view is obscured by excessive bleeding. While the surgeon's ego may dictate plowing ahead laparoscopically, conversion to an open technique is not considered a negative outcome but rather good surgical judgment with a successful outcome for the patient. Indeed, the American College of Surgeons' *Statement on Laparoscopic Cholecystectomy* sets forth its requirement that laparoscopic cholecystectomy only be performed by surgeons who are qualified to perform an open cholecystectomy.[10]

There are numerous surgical approaches that can be employed to prevent iatrogenic injury. These include performing an intraoperative cholangiogram as discussed above. However, the key to avoiding bile duct injury lies in the technique utilized by the surgeon to conclusively identify the Cystic Duct.

In the early days of Laparoscopic Cholecystectomy, surgeons utilized the Infundibular Approach for identification of the Cystic Duct. This approach is still used by many older surgeons who did not receive training in Laparoscopic Cholecystectomy during their residencies. The infundibular approach to identifying the Cystic Duct during a cholecystectomy is a technique that involves focusing on the gallbladder infundibulum, which is at the base of the gallbladder that connects to the Cystic Duct.

Steps of the Infundibular Approach:

- Expose the Gallbladder: The gallbladder is retracted to expose its neck and the infundibular area where the Cystic Duct joins the gallbladder. The surgeon works to dissect the gallbladder neck and the infundibulum, avoiding any unnecessary manipulation of the Cystic Duct at first.
- Identify the Cystic Duct: The Cystic Duct enters the infundibulum from the side. It is typically identified by gently lifting the gallbladder and dissecting around the junction where the Cystic Duct and the gallbladder meet. The Cystic Duct may be visualized as a small, tubular structure that is usually slightly tortuous.
- Clip and Cut the Cystic Duct: Once the Cystic Duct is clearly identified and isolated, it is clipped and divided. If necessary, the cystic artery is also clipped and divided in the same manner, completing the dissection for removal of the gallbladder.

However, in 1995, Steven Strasberg, MD (whose quote was cited at the beginning of this article) published a seminal paper in the field of cholecystectomy in which he espoused a new technique for Cystic Duct identification ... the *Critical View of Safety (CVS)*.[1] The Critical View of Safety is a technique which offers a much safer and accurate identification of the Cystic Duct and cystic artery, reducing the risk of bile duct injury. This approach is designed to minimize the chances of damaging major structures like the Common Bile Duct.

The Critical View of Safety (CVS) approach involves the following key steps:

- *Dissection of Calot's Triangle*: Calot's Triangle is the anatomical space formed by the Cystic Duct, cystic artery, and the liver bed. The goal is to clearly identify and separate these structures. The surgeon must ensure that the Cystic Duct is fully separated from surrounding tissues, particularly from the Common Bile Duct and hepatic artery.
- *Clear Identification of Three Key Structures*: Cystic Duct: The duct leading from the gallbladder to the Common Bile Duct. Cystic Artery: The artery supplying blood to the gallbladder, typically found close to the Cystic Duct. Common Bile Duct: The duct that carries bile from the liver and gallbladder into the duodenum.
- *Complete Separation:* The critical view is achieved when the Cystic Duct and Cystic Artery are clearly separated from all surrounding structures.
- *Two and Only Two Structures*: The CVS requires that there are exactly two structures (the Cystic Duct and Cystic Artery) that are isolated in the Calot's Triangle, with no other structures (such as the Common Bile Duct) being mistaken for the Cystic Duct.
- *Visualization:* The Cystic Duct should be clearly identifiable with its course and relationship to the gallbladder. The Cystic Artery should also be easily identifiable.

If there is any doubt about the identity of the Cystic Duct or artery, the surgeon should not hesitate to extend the dissection or even convert to an open procedure for better visualization.

Benefits of the Critical View of Safety

Prevention of Bile Duct Injury: The most significant

benefit of the CVS approach is the reduction of the risk of bile duct injury.

Minimizing Complications: CVS helps in preventing other complications such as bleeding from improper identification of the cystic artery.

Improved Surgical Outcomes: Studies have shown that the CVS approach improves the safety of laparoscopic cholecystectomy and helps achieve better long-term outcomes.

Most experienced surgeons and surgical societies now recommend the CVS approach as the standard technique for identifying the Cystic Duct and Cystic Artery during laparoscopic cholecystectomy. There is an emphasis during surgical residencies on training physicians to recognize the importance of the CVS approach, especially in complex or difficult cases.

Discovery

In addition to the usual discovery conducted in every medical malpractice case, plaintiff attorneys bringing these cases should cover two other areas. First, some physicians record the complete procedure. Attorneys should obtain the recording through a request for production immediately.

The recording can be immensely useful for experts to analyze and pinpoint the negligent act or omission. The recording, when viewed with the experts, may also serve as a starting point for the attorney learning about the procedure. Additionally, it can be used during the deposition of the defendant to establish the exact moment at which the bile duct injury occurred. Finally, the recording may also be edited for a trial exhibit. On occasion, the recording made during the procedure is erased once the defendant becomes aware of the injury he or she has caused. This action not only gives rise to damaging cross-examination but may also create the independent cause of action of spoliation of evidence in jurisdictions where that tort is recognized.

The second area to develop during discovery is the training that the defendant obtained to perform laparoscopic cholecystectomies. Although virtually every surgical residency now offers formal training in this area, many surgeons who completed their residencies before the mid-1990s did not learn the technique in a formal setting. Most of these surgeons attended a “quickie” weekend course in the procedure, often promoted and produced by the manufacturers of the laparoscopic instruments.

Considerations for the Trial Lawyer

Injuries to the anatomy can occur in other types of cases as well. For example, bowel and bladder injuries can occur in medical procedures, ranging from colonoscopies to oophorectomies. It is incumbent on the trial lawyer to know and understand the most common defense: “risk of the procedure.” It is true your client, more likely than not, signed consent forms typical in any such procedure (which of course the trial lawyer will verify). Accordingly, the timeline of events must be seriously considered with a keen eye toward the trajectory of the patient following the procedure and, importantly, when any such injury was identified.

There are, in fact, situations where a surgeon may injure the patient and immediately recognize and repair the injury. If the repair was performed correctly, the patient may go on to recover without additional injury. However, there are instances where the repair itself was performed incorrectly, leading to additional complications for the patient. A lawyer must consider whether the failed repair is worthy of battling the “risk of the procedure” defense.

More common, however, are situations whereby the healthcare provider does not immediately recognize the injury. The failure to timely recognize and treat iatrogenic injury must be the focus of your case. It has

been the experience of the authors that any such injuries frequently present with a common pattern: A loved one undergoes a procedure and, following the procedure, they complain of pain, are told the pain is normal, and things would get better. The patient's belly is distended but the patient is told they had been insufflated with gas for the procedure and the tenderness and distension would subside. The pain does not subside and hours after the procedure, the patient does not pass gas or urinate. The providers have the patient attempt to stand up or walk. Meanwhile, the patient's white blood cell count slowly elevates and the nurses begin noting diaphoresis, tenderness to palpation, and decreased bowel sounds. The patient may slowly begin to exhibit signs of respiratory distress and, critically, sepsis. The nurses continue to monitor the patient while the physician orders consults and, hopefully a CT scan of the abdomen. The CT scan, more often than not, will show "free air," which should be a tell-tale sign of an abdominal perforation caused during the procedure. As a rule, free air should be considered an iatrogenic injury until proven otherwise. It is incumbent on the trial lawyer to consider the hospital's defense: The patient was insufflated with gas during the procedure, and the patient's symptoms are merely the result of the insufflated gas yet to disperse. Your timeline, however, should dismantle the defense, as any insufflation should diminish with time. A patient with free air at 36-hours post operation, presenting with an irregular heart rate, diminished bowel sounds, pain, tenderness to palpation, or other vital sign irregularities should be considered in their totality when the trial lawyer screens the case. In some cases, it can take as little as 72 hours for the patient to crash and develop fecal peritonitis from a bowel or bladder injury. In other instances, it took over five days of patient deterioration before an exploratory laparotomy was performed.

In a separate experience, following a routine colonoscopy, a patient presented with a distended abdomen following the procedure. She remained in the post-anesthesia care unit ("PACU") for her outpatient procedure but reported pain. Within hours, despite being told to walk it off to pass the gas, the patient was in respiratory distress. This patient's pain progressed along with her abdominal distension. A CT scan was ordered but never performed. The patient's daughter testified that her mother's stomach continued to grow until it looked like a basketball. That afternoon, merely hours after what was to be an outpatient colonoscopy, the patient died. The cause of death was attributed to tension pneumoperitoneum, a life-threatening condition that occurs when air builds up in the abdominal cavity due to an iatrogenic injury. This patient suffocated to death as the buildup of air put immense pressure on her lungs which made it impossible for her to breathe in to fill her lungs with air. The key to this case was thorough discovery. A subpoena to the Office of the Medical Investigators revealed full-body imaging that corroborated the daughter's damning testimony.

The consequences of the delay in diagnosing and treating iatrogenic injuries are often catastrophic. In most scenarios, a patient will undergo an open exploratory laparotomy to repair the injury. Whether or not the patient remains stable thereafter often relies on the degree of sepsis, fecal peritonitis, or patient deterioration. In most cases, if the patient survives, it has been the experience of the authors that multiple open surgeries will be required to treat the infection, including removal of any fistula that may grow from the infection. A month-long hospital course, sometimes with open wounds, is not unheard of. Most patients report lifestyle changes, decreased mobility, and an aging effect impacting their overall health and well-being.

It is critical for the trial lawyer to assess the patient's post-operative care trajectory. Over time, the patient should continue to get better, not worse. A deep dive into the nurses' notes often reveals the details of the patient's downward trajectory. In our various case files, nurses have reported flowsheet findings stating "toxic appearance", "patient appears ill", or "patient feels like she

is going to die." While each case is different, recognizing patterns and understanding the totality of facts giving rise to when a reasonable person knew, or should have known, that an iatrogenic injury ought to be on the top of the differential diagnosis is the key to building a case based on delayed diagnosis and treatment.

Conclusion

Laparoscopic cholecystectomy and iatrogenic malpractice cases can be complex, requiring a thorough understanding of both the medical procedure and the standards of care. For trial lawyers, success in these cases hinges on the ability to identify breaches in the standard of care, establish causation through expert testimony, and effectively counter any defenses raised by the opposing side. A patient who experiences this injury can be faced with a life of pain, loss of quality of life, ongoing surgical interventions, and enormous medical expenses. An attorney who is called on to assist a client who has suffered such a catastrophic injury should remember the words of Dr. George Grey Turner, who over half a century ago, wrote, "Injuries to the main ducts are nearly always the result of misadventures during operations and are therefore a serious reproach to the surgical profession. They cannot be regarded as just an ordinary risk."[11]

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1. Steven M. Strasberg et al., *An Analysis of the Problem of biliary Injury During Laparoscopic Cholecystectomy*, 180 J. AM. C. SURGEONS 101, 125 (1995).
2. *Id.*; *see* A.R. Moossa et al., *Iatrogenic Injury to the Bile Duct: Who, How, Where?* 125 ARCHIVES OF SURGERY 1028, 1029 (1990).
3. K. Ido et al., *Confirmation of a "Safety Zone" by Intraoperative Cholangiography During Laparoscopic Cholecystectomy*, 10 SURGICAL ENDOSCOPY 798 (1996).
4. Jonathan M. Sackier et al., *The Role of Cholangiography in Laparoscopic Cholecystectomy*, 126 ARCHIVES OF SURGERY 1021, 1023 (1991).
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10. *Statement on Laparoscopic Cholecystectomy*, 75 BULL.AM.C. SURGEONS 23 (1990).
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Lessons Learned from a Recent Pathology Case

Andy Campbell

Recently, our Firm had the opportunity to represent the family of Chrissy Marris in a wrongful death delayed diagnosis case filed against various medical providers. The case was absolutely tragic, as Chrissy endured perhaps the worst pain and suffering we have ever seen after her diagnosis of cervical cancer. Chrissy's cancer metastasized to her sciatic notch, resulting in significant compression on her left sciatic nerve. Despite massive amounts of opioids and other narcotic pain medication, Chrissy suffered from intractable pain, along with other horrible complications from the cancer. Chrissy died in February 2021 at the age of 30.

In February 2019, when Chrissy was 28 years old, she underwent a PAP smear, which is a screening test for cervical cancer or pre-cancer. The PAP smear was sent to a local pathology laboratory where a cytotechnologist reviewed the cells. A cytotechnologist is trained to see and identify abnormal cells on a PAP smear. If the cytotechnologist sees any abnormal cells, the standard of care requires that the PAP smear be sent to a pathologist for diagnosis. However, if there are not any abnormal cells, the cytotechnologist is permitted to report the PAP smear as normal/negative and send a report to the patient's clinician.

The cytotechnologist who reviewed Chrissy's February 2019 PAP smear interpreted the slide as normal/negative and sent a report with that interpretation to Chrissy's clinician. Nine months later, Chrissy was diagnosed with squamous cell carcinoma, an aggressive cervical cancer. Despite significant treatment, including chemotherapy and radiation, Chrissy died a little over a year after her diagnosis.

In the ensuing litigation, Plaintiffs alleged that the cytotechnologist, an employee of a pathology laboratory, did not see or identify the abnormal cells present on Chrissy's February 2019 PAP smear, which led to a nine-month delay in diagnosing her cervical

cancer. Plaintiffs alleged that the delay in diagnosis allowed Chrissy's cancer to grow and spread to surrounding tissues, which significantly decreased her ability to beat the disease.

Plaintiff's Due Diligence — An Expert Blind Review

To determine whether the pathology lab's cytotechnologist violated the standard of care in the interpretation of Chrissy's February 2019 PAP smear, we contacted Martha Pitman, M.D., a cytopathologist at Massachusetts General Hospital and professor of pathology at Harvard Medical School. During our first phone call with Dr. Pitman, she quickly instructed us not to tell her anything about the case, the outcome of the patient, or which side we represented, as that information could lead to an outcome or hindsight bias. Instead, Dr. Pitman requested that we send the PAP smear slide at issue ("litigation slide") to her office at Mass General Hospital. Dr. Pitman's assistant mixed the litigation slide with nine other "distractor" slides, then presented the 10-slide set to Dr. Pitman for her interpretation. Dr. Pitman diagnosed Chrissy Marris's PAP smear slide as abnormal and opined that the pathology lab's failure to visualize and identify the abnormal cells on Chrissy's PAP smear was a violation of the standard of care.

The Defense Strikes Back

In her deposition, Dr. Pitman made multiple admissions that the defendant sought to use to support its attempt to introduce otherwise inadmissible blind review evidence. For example, Dr. Pitman testified that a larger sample size of PAP smear reviewers creates a more accurate interpretation of a slide due to the inherent subjectivity in the interpretation of pathology slides. The defense used this testimony as an excuse to orchestrate two blind reviews of its own with multiple non-testifying experts.

Defendant disclosed that 10 cytotechnologists, who were not employed by the defendant pathology lab, reviewed Chrissy's litigation slide with nine distractor slides. The participating cytotechnologists took notes as to their interpretations of each of the 10 slides, and those notes were provided to the defense attorneys after the review. According to the defense disclosures, 7 out of 10 cytotechnologists involved in the blind reviews interpreted Chrissy's slide as normal/negative, just as the original cytotechnologist did in February 2019. These cytotechnologists were identified by name but were not designated as testifying expert witnesses by the defense. Instead, the defense intended to present the 10 cytotechnologists involved in the blind reviews as fact witnesses.

The defense then designated John Newby, M.D., as a testifying expert pathologist. Dr. Newby performed his own blind review and opined that Chrissy's litigation slide was normal/negative. Further, Dr. Newby was provided the notes and interpretations of the 10 cytotechnologists involved in the blind reviews and, indeed, relied on the results of the two blind reviews orchestrated by the defense to support his opinions that the interpreting cytotechnologist did not violate the standard of care when she interpreted Chrissy's February 2019 PAP smear as normal/negative.

In his deposition, Dr. Newby testified that he was not present for, nor had any involvement in, the two blind reviews orchestrated by the defense. Additionally, Dr. Newby testified that he did not know, nor had any information about, the qualifications of the cytotechnologists involved in the two blind reviews that he relied on to support his opinions. Dr. Newby was unaware whether any of the cytotechnologists involved in the blind reviews were actually certified to interpret PAP smears, whether the cytotechnologists had ever been subject to remedial training by an employer due to incorrect interpretations of PAP smears, or whether any of the cytotechnologists had ever failed any annual proficiency tests required by federal law. Finally, Dr. Newby admitted that in his nearly 40 years as a practicing pathologist, he had never used blind reviews

to diagnose PAP smears and had never been involved in a blind review prior to this case.

Calling Defendant's Bluff

Plaintiffs filed multiple motions to strike the blind reviews and Dr. Newby's reliance on such. The grounds to exclude the evidence were numerous and included reliance on inadmissible hearsay, the cumulative nature of the opinions, confusion of the issues as to the standard of care, which is not based on a "majority wins" approach, and blind reviews are not ordinarily used by healthcare providers to diagnose PAP smears. Plaintiffs also filed a *Daubert* motion, asserting that Dr. Newby's reliance on the interpretations of 10 cytotechnologists, of which he did not personally know and had never reviewed their qualifications, was not a reliable principle or method.

To be clear, Plaintiffs did not challenge Dr. Newby's own personal blind review. As will be discussed further herein, we believe it is perfectly appropriate for expert witnesses to testify about a blind review that he or she personally conducted. In fact, we believe that such blind reviews should be encouraged and readily used when appropriate. Plaintiffs' objection was focused solely on Dr. Newby's reliance upon the notes, findings, and interpretations of other "experts."

The Chrissy Marris case resolved prior to the Court hearing Plaintiffs' motions to strike the blind reviews and exclude Dr. Newby's testimony based on *Daubert*. Defendant argued that the testimony of Plaintiffs' own expert, Dr. Pitman, made the admission of such evidence critical for the jury to hear as it supported the defense's position that the interpreting cytotechnologist complied with the standard of care. Plaintiffs' response was that, while Dr. Pitman was a world-renowned pathologist, her testimony did not determine the admissibility of evidence in a court of law.

Plaintiffs were confident that the trial judge would rule in their favor and exclude the blind review evidence. However, we also had to consider the risk that if the judge did permit the blind review evidence, our chances of prevailing at trial decreased significantly. Any jury hearing that 7 out of 10 cytotechnologists determined the PAP smear was normal/negative would likely view such evidence as highly persuasive. Although we likely had a built-in appellate issue if the trial judge admitted the blind review evidence, a defense verdict at trial certainly would not be ideal for us, and, most importantly, our clients.

Case Studies on Blind Reviews

Plaintiffs primarily relied on three cases in requesting the Court to strike the blind reviews. First, expert reliance on blind reviews conducted by other individuals was examined in *Webster v. Ctr. for Diagnostic Imaging, Inc.*, 2018 WL 2136451, in the U.S. District Court for the Southern District of Indiana, Indianapolis Division. In *Webster*, an expert radiologist for the defense used a blind review "in order to determine whether the standard of care was met by the reviewing radiologist in a case." The expert, Dr. Mehta, organized two blind reviews of a radiology scan, and, because a majority of the radiologists did not find cancer on the radiology scan at issue, Dr. Mehta testified that the defendant radiologist did not fall below the standard of care.

The *Webster* plaintiffs filed a Motion to Exclude, arguing that Dr. Mehta's testimony was "classic hearsay" being offered for the truth of what is asserted and did not fall under any exception to the hearsay rule. The plaintiffs also argued that Dr. Mehta's testimony did not pass muster under *Daubert* because the findings of a majority in a blind review does not establish the standard of care. Finally, the plaintiffs argued that the testimony should be excluded under Federal Rule of Evidence 403 because the probative value of the testimony was far outweighed by its potential to unfairly prejudice the plaintiffs, confuse the issues, and mislead the jury.

The Court found that, "[D]espite Defendants' claims, Dr. Mehta's testimony on the results of the blind panels is clearly being offered to prove the truth of the matter asserted by the results — namely whether the 2014 scan showed the return of Ms. Webster's cancer and, relatedly, whether a breach of the standard of care occurred in this case." As such, the Court found that Dr. Mehta's testimony regarding the blind reviews was inadmissible hearsay.

Additionally, the Court noted that the Defendants "failed to identify a single case in which Dr. Metha's method has been used by a court. This makes it highly unlikely that Dr. Mehta's methodology suffices under Rule 702, even if it were not hearsay. Put simply, Defendants have not come close to meeting their burden of demonstrating that Dr. Mehta's testimony would satisfy the *Daubert* standard."

Finally, the Court expressed significant concern that Dr. Mehta's testimony regarding the blind review failed "to allow opposing counsel to cross-examine the twelve physicians whose opinions comprise the blind panel results. In other words, the blind panel creates an inability to cross-examine the individuals upon whom Defendants would have the jury rely in determining whether the standard of care was met. This would eliminate the primary means of undermining the credibility of a witness whose testimony is false or inaccurate and therefore improperly undercuts the right of cross-examination."

As such, the Court struck Dr. Mehta's report and testimony as inadmissible hearsay, not based on reliable principles, and denied the plaintiffs their right of cross-examination.

The Supreme Court of Florida also looked at a similar issue in *Linn v. Fossum*, 946 So.2d 1032 (2006). In *Linn*, the defense presented Dr. Dana Weaver-Osterholtz as an expert urologist. Dr. Weaver-Osterholtz testified that she reached her opinions in the case based on a "brief conference with several other urologists whom she regarded as representative of the general urologic community." The other urologists were not witnesses at the trial, which resulted in a verdict for the defendant physician.

The Court in *Linn* held that an expert is not permitted to testify regarding a reliance on consultations with colleagues or other experts in reaching his or her opinion. The Court's reasoning found that "referring to consultations with other experts creates the danger of bolstering the credibility of the testifying expert's opinion without providing the opposing party the ability to effectively cross-examine the expert as to the basis for the opinion. Allowing the expert to testify on direct examination that he or she relied on consultations with other experts creates 'too much of a possibility of an inference being drawn that these experts agreed' with the testifying expert."

Finally, the Supreme Court of Arkansas examined this issue in *Williamson v. Elrod*, 348 Ark. 307. In *Williamson*, the Court stated that "If 'majority' was the standard, it would require a poll of physicians practicing in a community."

Lessons Learned from the Marris Case

Traditionally, blind reviews are most often performed in radiology and pathology cases in which the defendant healthcare provider missed a significant finding on a CT scan, MRI, PAP smear, or other similar test. Based on our involvement in the Marris case and heavily researching the blind review issue, we strongly encourage other lawyers handling these types of cases to follow these pieces of advice when contacting an expert in radiology and pathology cases:

1. Do not disclose which party you represent;
2. Do not disclose the outcome of the patient;
3. Do provide the expert with the information that the interpreting clinician had at the time, such as a patient history and physical, PAP smear requisition form, radiology clinical history, or other similar reports; and,

4. If possible, send "distractor" slides or radiology films with the litigation slide or film. As plaintiff lawyers, we very rarely, if ever, will have access to such, but perhaps the expert's assistant or colleague can make such arrangements. If the expert only has one slide or radiology image to look at, and that expert knows that such is the subject of litigation, the defense could argue that the expert went on a treasure hunt to find what was missed by the initial clinician.

While precedent strongly suggests that an expert relying on the blind reviews of other individuals will likely not be admissible, such evidence can be very powerful for settlement purposes. If considering this approach, we recommend the following strategies:

1. Always disclose the identities of the individuals involved in the blind review(s) relied upon by the expert. Anonymous blind reviews will almost certainly be excluded due to depriving a party of their right of cross-examination;
2. Always disclose ample information, such as updated C.V.'s, about the qualifications of the individuals involved in the blind review(s). An expert relying on the findings of individuals without knowledge of their qualifications will likely be excluded for reliability concerns;
3. Get admissions from defense witnesses and experts that support admission of blind review evidence.

While blind reviews, whether performed by an individual expert or a group of individuals, can be highly effective in demonstrating a violation of the standard of care in radiology and pathology cases, blind reviews can also be used in nearly every medical malpractice case. Take, for example, a classic failure to diagnose case at the emergency department where a patient is sent home without proper workup for a serious condition such as a heart attack or stroke, then the patient dies hours later. Often times, these cases can become a "battle of the experts," with 12 laypersons on the jury left wondering which expert to believe.

In such a scenario, a blind review could be the difference in the jury leaning your way. Contact an expert and, without disclosing which side you represent, ask the expert to review the relevant medical records that do not include the patient's ultimate outcome. If the expert identifies any breach in the standard of care, then you will have an unbiased expert opinion. Contrast that with the defense expert who has testified 95 percent of the time on behalf of defendant health care providers, who has worked with the defense attorneys on numerous occasions, and was made aware of all aspects of the case in the initial phone call with defense counsel.

Conclusion

Blind reviews, while especially persuasive in radiology and pathology cases, are highly effective methods of showing violations of the standards of care in nearly all medical malpractice cases. Although blind reviews performed by several non-testifying experts relied upon by a single testifying expert presents numerous admissibility challenges, an individual expert performing his or her own personal blind review should be readily utilized by plaintiff attorneys when the facts of the case warrant such. This shields your expert from attacks of bias and puts your client in the best possible position to prevail in the case.

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settlements & verdicts

/GENERAL

Failure to Equip — Mack Granite Dump Truck

Mack Trucks settled a failure to equip case involving a 2019 Mack Granite Dump Truck. On August 9, 2020 the plaintiff, Lewis Reese, was operating a 2020 Nissan Kicks, traveling northbound on a two-lane highway. He was stopped with his left turn signal activated, in preparation to turn left. Defendant, Jancsi Woodward, was traveling in the northbound lane of travel and struck Mr. Reese from behind. The Nissan that Mr. Reese was driving was pushed into the opposing southbound lane of travel and struck a third vehicle traveling in the opposite direction. Mack equipped the 2019 Mack Anthem and Pinnacle dump trucks with the Bendix Wingman Fusion System but chose not to include the Bendix Winman Fusion system on the Mack Granite model. The crash would have been significantly mitigated with a collision mitigation system, consisting of forward collision warning, automatic emergency braking, and active brake assist, reducing the severity of the plaintiff's injuries. *Reese v. Mack Trucks, Inc.* AIEG members Jaime Jackson and paralegal Emma Parnham represented the plaintiff. Plaintiff Expert: Shawn Harrington (accident reconstruction and testing). Remaining experts and defense experts were not disclosed prior to settlement.

Inadequate Safety Program — Liquified Petroleum Gas

TIMS South Texas, LLC, and AmeriGas Propane, LP, settled a propane explosion case involving liquified petroleum gas. On November 4, 2020, an explosion due to a gas leak occurred at a residence in Crystal City, Zavala County, Texas, where the plaintiffs, Santos Vera and Laura Vera, resided and were present at the time. Defendant TIMS supplied propane gas service to the plaintiffs at the residence. Defendant AmeriGas acted as a wholesaler and sold the propane to TIMS. The gas leak, which caused an explosion, was undetectable due to the defendants failing to ensure that proper odorization procedures were in place. As a result, the plaintiffs suffered severe burns, disfigurement, severe bodily injuries, pain, and other damages. *Vera v. TIMS South Texas, LLC, et.al*. AIEG member, Miguel Chapa, along with Orlando Lopez, represented the plaintiffs. Plaintiff Experts: William Aycock (mobile device

forensics), Elizabeth Buc (metallurgical engineering), Paul Carper (mechanical engineering), Tim Dunn (chemical engineering), Christine Foran (chemist), Lila Laux (human factors), Thomas Sing (fire cause and origin), Dale Berry (prosthetics), Andrea Bradford (vocational specialist), Rodney Chan (burn reconstructive surgery), Keith Fairchild (economist), Kevin Foster (burn surgeon), Janyna Mercardo (neuropsychology), and Ruth Rimmer (life care planner). Defense Experts: Eric Benstock (mechanical engineering), Charles Brown and Richard Gilbert (forensic engineering), Ruston Hunt (engineering), Scott Davis (failure analysis), Shawn Sapp (forensic engineering), John Schumacher (chemical engineering), Jeffrey Tucker (entomology), Jayson Aydelotte (critical care), Douglas Cooper (neuropsychology), Thomas King (vocational rehabilitation counselor), Jonathan Scott (prosthetist), Joanna Vasquez (family nursing), David Meyer (oil and gas), Alfred Martinez, Jr. (fire investigator), Mark Hergenrether and Dave Heldenbrand (professional engineer), and Richard Baron (forensic metallurgist).

Negligence

Ozark Central Ambulance District settled a failure to follow policies and procedures when transporting, failure to wear proper footwear case. On November 6, 2021, Betty Sachs was at her residence located in Bland, Missouri. The residence is a one-story home with entrances in the front, side, and back. The back entryway requires going up or down a single step to access the home. Sachs fell while at the residence. The defendant, Ozark, was contacted and it dispatched an EMS team, consisting of defendants Hegel and Aufderheide, to the residence. After securing her to a stretcher, they decided to carry her through the back entryway. While doing so, the defendant, Aufderheide, tripped and fell, dropping the stretcher they were carrying and causing her to fall to the ground where she incurred significant injuries. She was transported to the hospital. It was determined that she was suffering from multiple injuries including a left displaced femoral neck fracture, left frontotemporal hematomas, left temporal ecchymosis, and delirium. *Sachs v. Hegel/ Aufderheide/Ozark Central Ambulance District*. AIEG

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member, Rob Palmer, along with Nathaniel Scearcy represented the plaintiff. Plaintiff and defense experts were not disclosed prior to settlement.

/PCFFF

Post Collision Fuel Fed Fire — Freightliner M2

Daimler Truck North America and Penske Truck Leasing settled a post collision fuel fed fire case involving a 2014 Freightliner M2. Plaintiff Dasean Scott was the driver and operator of the Freightliner Penske truck, which was leased and rented by defendant Penske. The Freightliner was cut off by another vehicle and traveled onto the shoulder where it contacted the jersey barrier, passenger side leading. The unprotected passenger side fuel tank was punctured by the sharp edge of the passenger side cab-entry steps, which were driven back and inboard when the truck impacted the jersey barrier. The Freightliner fuel tank was punctured following the impact. The truck rolled onto its driver's side where highly flammable diffuse diesel vapors were released and exposed to countless ignition sources, including the hot exhaust and the sparks generated by the truck's metal scraping the concrete. A fire erupted and fully engulfed the Freightliner, catastrophically burning the plaintiff on over more than 40 percent of his body. Despite being put on notice of potential litigation, Penske spoliated the Freightliner truck. *Scott v. Penske/Daimler Trucks North America*. AIEG members Chris Stucky, Austin Osborn, Anthony Baratta, Jaime Jackson and paralegal Emma Parnham represented the plaintiff. Plaintiff Experts: Shawn Harrington (accident reconstruction), Brian Herbst (heavy truck fuel system design/guarding), Michael Schulz (fire cause and origin), Ruth Rimmer (burn injury life care plan), and Sigrid Blome-Eberwin and Roselle Crombie (burn injury). Defense Experts: Douglas Stahl (heavy truck fuel system design), Kerry Parrott (fire cause and origin), Kevan Granat (accident–reconstruction), Douglas E. Young (human factors), Michael Dickinson (accident reconstruction/fuel system design), David M. Anderson (fire cause and origin), Jeffrey Anderson (burn injuries), and Maryanne Cline (life care planning).

Post Collision Fuel Fed Fire — Jeep Cherokee XJ

FCA US LLC settled a post collision fuel fed fire case involving a 1996 Jeep Cherokee XJ. On January 28, 2019, Silvia Arriola was driving her 1996 Jeep Cherokee XJ when she was struck from behind

while stopped at a red light. As a result of the rear impact, the rear-mounted fuel tank in the subject vehicle ruptured and allowed gasoline to leak. The gasoline quickly ignited and engulfed the entirety of the subject vehicle in flames. Ms. Arriola was unable to escape her vehicle and subsequently burned to death. *Quilcat/Arriola v. FCA US LLC*. AIEG members Jonathan Negretti and Dylan McGurk represented the plaintiff. Plaintiff Experts: Mark Arndt and Charles Dickerson (accident reconstruction), Neil Hannemann (automotive engineering), Russ Hunt (mechanical engineering), and Mendel Singer (statistician). Defense Experts: Jon Olson (economics), Eric Boelhouwer (human factors), Jarrod Carter (product liability), Mark Flemming (mechanical engineering), Marilyn Huestis (toxicology), Kristin Lennox (engineering), and Jack Ridenour (automotive mechanics).

/ ROOF CRUSH

Roof Crush, Roadway Safety — Ford F-150

Ford settled an improper design, construction, and maintenance of a highway, roof structure integrity case involving a 2001 Ford F-250. On July 23, 2022, the Plaintiff, Amber Hall-January, was operating the subject vehicle in Douglas County, Missouri going eastbound in the right-hand lane. The plaintiff lost control of the subject vehicle due to loose, improperly angled or soft asphalt, and a drop off on Highway AA from recent repair and resurface activities of defendant MHTC. The subject vehicle crossed the road and overturned a half roll onto grass and dirt on the other side of the road. The roof of the subject vehicle collapsed as a result. *Hall-January v. Ford/Missouri Highways & Transportation Commission/ MHTC*. AIEG members Rob Palmer and Eric Jensen represented the plaintiff. Plaintiff Experts: Brian Herbst (design), David Altman (life care planning), Jonathan Eisenstat (forensic pathology), Paul Lewis (biomechanics), Ralph Scott (economist), and Michelle Beah (accident reconstruction). Defense Experts: Christopher Eikey and Ram Krishnaswami (mechanical engineering), Donald Tandy, Jr. and Mark Fleming (engineering), Mark Sochor (biomechanics), and Michale Mullins (toxicology).

Leveraging eDiscovery in the Pursuit of Justice in Medical Malpractice

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Background Overview: In the digital age, electronic discovery (eDiscovery) has become a critical tool in medical malpractice litigation. As healthcare providers increasingly rely on electronic health records (EHRs) and digital communication, effectively managing and analyzing electronic evidence is paramount. This article explores how eDiscovery can be leveraged to uncover crucial evidence, establish timelines, and identify patterns that substantiate malpractice claims. We'll examine the eDiscovery process, its challenges, and best practices for plaintiff attorneys seeking justice for their clients.

As the complexity of medical malpractice litigation continues to grow, the importance of effectively managing electronic evidence has never been greater. Complete Legal offers unparalleled expertise in navigating the intricate processes of eDiscovery, providing plaintiff attorneys with the tools and support necessary to uncover critical evidence and build compelling cases. From identifying and preserving electronic health record-related electronically stored information (ESI) to analyzing digital communications, Complete Legal's comprehensive eDiscovery services empower legal teams to address the challenges and seize the opportunities digital evidence presents. By partnering with Complete Legal, attorneys can confidently tackle the complexities of medical malpractice cases, ensuring they are fully equipped to pursue justice for their clients.

Applying eDiscovery in Medical Malpractice Litigation: A Strategic Approach

Medical malpractice cases often involve intricate evidence and complex medical records. For attorneys experienced in this field, the challenge is not in understanding malpractice itself but in effectively utilizing eDiscovery tools to extract, preserve, and present digital evidence to strengthen their case. Seasoned plaintiff attorneys can leverage eDiscovery to uncover vital digital evidence in medical malpractice cases.

Misdiagnosis and Delayed Diagnosis: Leveraging Digital Timelines

Misdiagnosis or delayed diagnosis often results in serious, preventable harm. Experienced attorneys can use eDiscovery to create a comprehensive timeline by analyzing electronic health records (EHRs), diagnostic logs, and communications between healthcare providers. This analysis can reveal lapses in diagnostic procedures or failure to follow up on test results — key evidence in proving negligence.

Surgical Errors: Analyzing Digital Communications and Procedural Logs

In cases involving surgical errors, eDiscovery is essential for retrieving and analyzing pre- and post-operative digital records, including notes, checklists, and internal communications among surgical teams. Attorneys can use these records to identify deviations from standard procedures or gaps in communication that may have contributed to the error, providing a solid foundation for demonstrating negligence.

Medication Errors: Tracing Digital Prescriptions and Pharmacy Logs

Medication errors often leave a clear digital trail that can be crucial in establishing fault. eDiscovery tools can be used to trace communication between prescribing physicians and pharmacies, review electronic prescription records, and identify any discrepancies in medication management. This enables attorneys to pinpoint where the breakdown occurred, linking the error directly to the harm suffered by the patient.

Birth Injuries and Anesthesia Errors: The Role of Electronic Monitoring Data

In complex cases involving birth injuries or anesthesia errors, eDiscovery allows attorneys to delve into electronic monitoring data, digital imaging, and audit trails from medical equipment. This data can be analyzed to identify equipment malfunctions, improper monitoring, or delayed responses that could prove critical in establishing causation and liability.

The Increasing Role of eDiscovery

As healthcare providers continue to rely on electronic systems to manage patient information, the volume and complexity of electronic evidence have grown significantly. eDiscovery gives plaintiff attorneys the tools to effectively access, analyze, and present this critical evidence. In medical malpractice, eDiscovery is

particularly valuable as it allows attorneys to uncover evidence that might otherwise remain hidden in the vast expanse of digital data.

The eDiscovery process in medical malpractice litigation involves several key stages: identification, preservation, collection, processing, review and analysis, and production. Each stage is crucial for building a solid case, from identifying potential sources of electronic evidence to ensuring that relevant data is shared with opposing counsel as required by legal procedures.

Identification

The identification stage involves determining which electronic systems and devices may contain relevant evidence. This stage includes hospital databases, email servers, personal devices used by healthcare providers, and any other digital platforms where patient information might be stored. Attorneys must work closely with IT professionals and eDiscovery experts to ensure that all potential sources of evidence are considered.

For example, in a medical malpractice case involving a surgical error, the attorney might need to identify all the electronic systems used during the patient's treatment, including the hospital's EHR system, the surgeon's notes stored on a private device, and any digital logs of the surgical procedure. By thoroughly identifying these sources, the attorney can ensure no critical evidence is overlooked.

Preservation

Once potential evidence is identified, it must be preserved to prevent spoliation, which refers to the destruction or alteration of evidence. This phase involves securing data to ensure it remains intact and unaltered. Legal holds may be issued to prevent the destruction of relevant information. Preservation is critical in maintaining the integrity of electronic evidence, as any alterations or deletions can undermine a case.

In practice, preservation might involve issuing a legal hold to the hospital's IT department, instructing them to preserve all relevant electronic records related to the patient's treatment. This process could include emails, EHRs, digital images, and other forms of electronic communication. Ensuring proper data preservation is essential to maintaining its admissibility in court.

Collection

The collection phase involves gathering electronic evidence in a forensically sound manner. This phase ensures that the data is collected without altering or damaging it, maintaining its integrity for use in court. Attorneys must ensure that collection methods comply with legal standards and that all relevant data is captured.

For example, in a medication error case, the attorney might need to collect electronic records from the hospital's pharmacy system, the patient's EHR, and any communications between the prescribing physician and the pharmacy. By using forensically sound methods, the attorney can ensure that this evidence is preserved in a legally defensible manner.

Processing

During processing, the collected data is organized and prepared for review. This phase may involve converting files into accessible formats, removing duplicates, and indexing information to facilitate efficient analysis. Processing helps attorneys focus on the most relevant data, streamlining the review process and reducing costs.

For instance, if the attorney has collected thousands of emails related to a surgical error case, they might use eDiscovery tools to filter out irrelevant communications and focus on those most likely to contain evidence of negligence. This process saves time and ensures that the attorney can focus on the most critical aspects of the case.

Review and Analysis
In this stage, attorneys review the processed data to identify relevant information. Advanced tools and technologies, such as predictive coding and data analytics, can streamline this process and uncover critical insights. By analyzing electronic evidence, attorneys can build a compelling narrative that supports their case.

For example, in a birth injury case, the attorney might use predictive coding to quickly identify communications referencing specific concerns about the delivery process. By focusing on these critical pieces of evidence, the attorney can build a narrative demonstrating how the healthcare provider's actions led to the injury.

Production
Finally, relevant data is produced and shared with opposing counsel as legal procedures require. This stage ensures that all parties have access to the necessary evidence to support their claims or defenses and is essential in maintaining transparency and compliance.

In a medical malpractice case, production might involve providing the opposing counsel access to preserved and processed electronic evidence, such as EHRs, emails, and digital logs. Ensuring proper production is critical to maintaining the integrity of the legal process and ensuring that both sides have a fair opportunity to present their case.

Challenges in eDiscovery

While the eDiscovery process can be advantageous for a practice, it also presents several challenges and considerations. Handling sensitive medical information requires strict adherence to data privacy and security regulations, such as the Health Insurance Portability and Accountability Act (HIPAA). Managing large volumes of data can be overwhelming, necessitating efficient data management strategies and advanced eDiscovery tools. Attorneys must comply with legal and ethical standards governing the eDiscovery process, including court rules and guidelines. Additionally, the process can be resource-intensive, making cost management a critical consideration. By addressing these challenges, plaintiff attorneys can effectively integrate eDiscovery into their legal strategies.

Data Privacy and Security
Handling sensitive medical information requires strict adherence to data privacy and security regulations, such as HIPAA. Attorneys must protect patient data throughout the eDiscovery process to prevent unauthorized access or breaches. This process involves implementing robust security measures and working with trusted eDiscovery providers.

For instance, when dealing with electronic health records in a medical malpractice case, the attorney must ensure that all data is encrypted and that access is restricted to authorized personnel only. Additionally, any data transferred between parties must be done securely to prevent potential breaches.

Managing Large Volumes of Data
Medical malpractice cases often involve vast amounts of electronic data, which can be overwhelming to manage. Efficient data management strategies, including the use of advanced eDiscovery tools, are essential to filter and prioritize relevant information without incurring excessive costs. Attorneys must balance the need for thoroughness with the practicalities of time and budget constraints.

For example, in a case involving a hospital's electronic health record system, the attorney might face millions of individual records. Advanced eDiscovery tools can help to sort, filter, and categorize this data, allowing the attorney to focus on the most relevant records without becoming bogged down in irrelevant information.

Ensuring Compliance with Legal and Ethical Standards
Attorneys must comply with legal and ethical standards

> "A well-defined strategy can guide decision-making and ensure consistency throughout the process."

governing the eDiscovery process. This compliance includes adhering to court rules and guidelines for preserving, collecting, and producing electronic evidence. Failure to comply can result in sanctions or adverse rulings. Attorneys must stay informed about evolving standards and best practices to ensure compliance.

For example, in some jurisdictions, the failure to properly preserve electronic evidence can lead to severe penalties, including the dismissal of the case. By staying informed about the latest legal developments, attorneys can ensure they meet all requirements.

Cost-Effectiveness

The eDiscovery process can be resource-intensive, making cost management a critical consideration. Attorneys should work with eDiscovery experts to develop cost-effective strategies that maximize the value of electronic evidence while minimizing expenses. This effort may involve leveraging technology to automate processes and reduce manual labor.

For instance, predictive coding and data analytics can significantly reduce the time and cost of reviewing large volumes of data, allowing attorneys to focus their resources on the most critical aspects of the case.

Best Practices for Plaintiff Attorneys

To effectively utilize eDiscovery, plaintiff attorneys should adopt best practices that enhance their ability to manage and present electronic evidence. These include collaborating with eDiscovery experts, leveraging advanced technology, developing a comprehensive eDiscovery strategy, ensuring thorough documentation, and staying informed about legal and technological developments.

Collaborate with eDiscovery Experts

Engaging with eDiscovery professionals can provide attorneys with the expertise and resources needed to navigate complex electronic evidence. These experts can assist in the identification, collection, and analysis of data, ensuring that it is handled in a legally defensible manner. Collaboration with eDiscovery experts can also help attorneys stay informed about the latest tools and technologies.

For example, an eDiscovery expert might assist an attorney in developing a strategy for collecting and analyzing electronic health records in a medical malpractice case. By working with experts, attorneys can ensure they use the most effective methods and technologies available.

Leverage Advanced Technology and Tools

Utilizing advanced eDiscovery tools such as predictive coding, data analytics, and artificial intelligence can streamline the review process and uncover critical insights more efficiently. These technologies can help attorneys focus on the most relevant information, saving time and reducing costs. Attorneys should explore available tools and select those that best meet their needs.

For instance, predictive coding can help attorneys quickly identify the most relevant documents in a large dataset, allowing them to focus their review efforts on

the information most likely to impact the case.

Develop a Comprehensive eDiscovery Strategy

Attorneys should develop a clear eDiscovery strategy at the outset of a case, outlining the steps for identifying, preserving, and collecting electronic evidence. This strategy should be aligned with the overall case objectives and consider the unique challenges of medical malpractice litigation. A well-defined strategy can guide decision-making and ensure consistency throughout the process.

For example, an attorney might develop a strategy that includes specific protocols for preserving and collecting electronic health records, emails, and other forms of digital evidence. By following a clear plan, the attorney can ensure that all relevant evidence is collected and preserved in a legally defensible manner.

Ensure Thorough Documentation and Chain of Custody

Maintaining detailed documentation and a clear chain of custody for electronic evidence is essential to upholding its integrity and admissibility in court. Attorneys should ensure that all actions taken during the eDiscovery process are well documented, and that evidence is securely stored. Proper documentation can also facilitate communication and collaboration among legal teams.

For instance, in a case involving a large volume of electronic health records, the attorney should maintain detailed logs of when and how the records were collected, who had access to them, and how they were stored. This documentation can be crucial in demonstrating the integrity of the evidence in court.

Stay Informed on Legal and Technological Developments

The field of eDiscovery is continually evolving, with new legal precedents and technological advancements emerging regularly. Attorneys should stay informed about these developments to ensure they use the most effective strategies and tools. Continuing education and professional development can help attorneys stay current and competitive.

For example, attending conferences or taking courses on the latest eDiscovery technologies can provide attorneys with the knowledge they need to stay ahead in this rapidly changing field.

Hypothetical Case Studies and Examples

Hypothetical scenarios can illustrate the potential impact of eDiscovery in medical malpractice litigation. For instance, in a scenario where a patient experiences a delayed diagnosis, eDiscovery could analyze electronic health records to identify instances of negligence. In another case involving a surgical error, accessing internal emails might reveal systemic issues within a hospital. In a birth injury case, eDiscovery tools could analyze digital imaging and audit trails to prove causation. These scenarios underscore the transformative potential of eDiscovery, enabling plaintiff attorneys to build stronger cases and drive positive changes in the healthcare system.

Hypothetical Case Study 1: Uncovering Negligence through Electronic Health Records

Imagine a scenario where a patient experiences a delayed diagnosis of a severe condition. Through eDiscovery, the plaintiff's legal team could analyze electronic health records (EHRs) to identify instances where test results were not communicated to the patient in a timely manner. This electronic evidence could be crucial in establishing a breach of duty, leading to a favorable settlement for the patient.

For example, in this scenario, the attorney might discover that the healthcare provider received the test results but failed to notify the patient promptly. By presenting this evidence, the attorney can argue that the delay in communication directly led to the worsening of the patient's condition, thereby establishing negligence.

Hypothetical Case Study 2: Revealing Systemic Issues through Email Communications

Consider a case involving a surgical error that leads to severe complications for a patient. Through eDiscovery, attorneys might access internal emails between hospital staff and uncover a pattern of inadequate training and communication failures. This evidence could support an individual malpractice claim and highlight broader systemic issues, prompting policy changes and improved patient safety measures.

For instance, if the emails reveal that the surgical team was not adequately trained or there were known issues with the surgical equipment, the attorney can use this evidence to demonstrate that the hospital's negligence contributed to the patient's injury. Additionally, this evidence could be used to advocate for changes in hospital policies to prevent similar incidents in the future.

Hypothetical Case Study 3: Utilizing Digital Imaging and Audit Trails

In a hypothetical birth injury case, complications during delivery result in permanent injury to the newborn. eDiscovery tools could analyze digital imaging and audit trails from the hospital's systems, revealing that critical monitoring equipment malfunctioned. This evidence could prove causation and secure a substantial award for the affected family.

For example, suppose the audit trails show that the fetal monitoring equipment failed to alert the medical staff to signs of distress. In that case, the attorney can use this evidence to demonstrate that the equipment failure directly led to the birth injury. By presenting this evidence in court, the attorney can make a compelling case for compensation.

Concluding Considerations

Integrating eDiscovery into medical malpractice litigation represents a significant advancement in pursuing justice for patients harmed by healthcare negligence. As healthcare systems increasingly rely on digital records and communications, effectively managing and analyzing electronic evidence has become essential for plaintiff attorneys. eDiscovery empowers legal professionals to uncover critical evidence, establish timelines, and identify patterns that can substantiate malpractice claims.

By leveraging advanced technologies and adhering to best practices, attorneys can navigate the complexities of electronic data and ensure that they present a compelling case in court. Complete Legal stands at the forefront of this transformation, offering comprehensive eDiscovery services that equip plaintiff attorneys with the tools and expertise needed to succeed. By partnering with eDiscovery experts, attorneys can enhance their legal strategies, improve case outcomes, and ultimately drive positive changes in the healthcare system.

As the legal landscape continues to evolve, embracing eDiscovery will be crucial for attorneys seeking to hold healthcare providers accountable and secure justice for their clients. The future of medical malpractice litigation lies in the effective use of electronic evidence, and those who master this domain will be well-positioned to lead the charge.

Neil McLean

Neil McLean is the Director of Client Success at Complete Legal, a regional eDiscovery provider that makes premium eDiscovery tools and leading expertise accessible to plaintiff's attorneys. Neil's 13 years working in litigation support, including Sales & Account Management, Project Management, eDiscovery Consulting, Forensics, and Data Acquisition. Learn more at completelegal.us.

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