Medical Malpractice Litigation: The Long and Winding Road

By Matthew Bauer, JD

The Beatles wrote a song entitled “The Long and Winding Road.” While it is doubtful the Beatles were talking about medical malpractice litigation, defendant health care providers are certainly justified in feeling as if their medical malpractice cases are long and winding roads, especially given the fact that over the course of its nearly fifty-year history SVMIC has defended multiple cases that were pending for more than a decade before finally concluding with a jury trial. Fortunately, there have been many cases defended by SVMIC that were dismissed in a relatively short period of time at various points during the litigation and for various reasons, as demonstrated by the two closed claims discussed below.

In some medical malpractice lawsuits, the plaintiff’s attorney simply sues all the health care providers identified in the patient’s medical chart, or they sue a health care provider due to mistaken identity. In these situations, the defendant health care provider will likely be dismissed from the lawsuit after facts are developed during discovery that show the health care provider is an improperly named defendant, as demonstrated by our first closed claim. The four-year-old male patient underwent a brain MRI under general anesthesia due to seizure-like activity. During the MRI, the minor patient decompensated, coded, and died after unsuccessful resuscitation efforts. The plaintiff filed a medical malpractice lawsuit against the anesthesiologist, CRNA Jane, CRNA John, the anesthesiology group, the MRI tech, the radiology group, and the hospital alleging the defendants breached the standard of care (SOC) by improperly administering anesthesia, by untimely responding to the minor patient's decompensation and code, and by improperly performing resuscitation efforts resulting in death.

In this lawsuit, CRNA John and the radiology group were improperly named defendants, which became clear as the facts developed during the litigation discovery process. First, CRNA John was listed on the hospital's MRI room assignment sheet, which appeared to be why the plaintiff's attorney named him as a defendant to the lawsuit. However, CRNA John did not administer anesthesia, monitor the minor patient, participate in the code and resuscitation efforts, or otherwise treat the minor patient. At his deposition, CRNA John testified he was not involved in the care and treatment of the minor patient. Additionally, CRNA John was able to explain that he was assigned to the MRI room after the minor patient coded because CRNA Jane had left the MRI room to participate in the resuscitation efforts. After these facts were developed during the discovery process, the plaintiff's attorney dismissed CRNA John because he never treated the minor patient, and he was therefore not a properly named defendant.

Second, the radiology group was named as a defendant to the lawsuit because the plaintiff alleged the radiology group was vicariously liable for the acts and/or omissions of its employee (the MRI tech) under the legal doctrine of *respondeat superior* ("let the master answer").   However, at her deposition, the MRI tech testified she was an employee of the hospital, not an employee of the radiology group. Additionally, the radiology group submitted an affidavit from a corporate officer confirming the MRI tech was not an employee of the radiology group. After these facts were developed during the litigation discovery process, the plaintiff's attorney dismissed the radiology group because the MRI tech was not its employee, and the radiology group was therefore not a properly named defendant.

Sometimes in medical malpractice lawsuits, the plaintiff's expert proof does not come in as expected during discovery, and the plaintiff does not have sufficient expert proof to maintain his/her medical malpractice claim against some or all of the defendant health care providers, as demonstrated by our next closed claim. The fifty-year-old female patient underwent CT-guided percutaneous needle aspiration of her thoracic paravertebral abscess. Radiologist Dr. Farmer read the patient's post-procedure imaging and did not note any retained foreign body. The patient subsequently presented to the ER with chest pain secondary to a migrated needle fragment shown on additional chest imaging, and the patient underwent thoracotomy to remove the retained foreign body. The plaintiff filed suit alleging Dr. Farmer breached the SOC by failing to recognize a retained foreign body (needle fragment) on the patient's post-procedure imaging causing chest pain and infection and necessitating thoracic surgery. During litigation, the plaintiff's attorney disclosed one SOC expert (Dr. Smith) to testify against Dr. Farmer.

“In medical malpractice actions, Tennessee adheres to a locality rule for expert medical witnesses. Claimants are required by statute to prove by expert testimony the recognized standard of acceptable professional practice in the community where the defendant medical provider practices or a similar community.” Shipley v. Williams, 350 S.W.3d 527, 532 (Tenn. 2011). During his deposition, the plaintiff’s expert, Dr. Smith, failed to establish that he had knowledge of the SOC for the community in which Dr. Farmer practiced or for a similar community. Consequently, the defense attorney for Dr. Farmer filed a Motion to Exclude Dr. Smith’s opinions because he was not qualified to offer standard of care opinions in the case secondary to the locality rule. Since the expert proof did not come in as expected, the plaintiff’s attorney was forced to dismiss the lawsuit against Dr. Farmer.

While it is a terrible feeling to be sued for medical malpractice, SVMIC policyholders can rest assured that regardless of whether the course of their medical malpractice case is long and winding, or short and straightforward, SVMIC will be with them each step of the way ensuring their interests are protected.
