The Anatomy of a Trial:
Successful Outcomes When the Odds Are Against Your Clients

John E. Hall, Jr.

Hall Booth Smith, P.C.

191 Peachtree Street, NE, Suite 2900
Atlanta, GA 30303
Direct dial: 404-954-6927
Cell: 404-312-1456
JHall@hallboothsmith.com
John E. Hall, Jr., is one of the founding partners of Hall Booth Smith, PC. He specializes in the defense of high exposure cases, involving hospitals and medical malpractice claims. He manages and handles high exposure cases in over 20 states as National Counsel for several Insurers, Companies and Hospitals. He has extensive litigation experience, having tried in excess of 100 civil cases. Mr. Hall is licensed in Georgia, Tennessee, Alabama and North Carolina.
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I. Introduction

Medical malpractice actions carry with them a number of hurdles for the defense bar: (A) Healthcare providers experience a high volume of turnover in the employees who often had the most frequent contact with the resident/patient plaintiff (e.g. RNs, CNAs as opposed to higher tier employees such as administrators, physicians, medical directors); (B) Missing records create alleged gaps in treatment for the plaintiff to attack as breaches in the standard of care; and (C) an increasingly large breadth of medical records, staffing records, and compliance statistics allow the plaintiff to introduce end runs around the protective gatekeeping measures of Daubert1 and its state law progeny. Below provides hypotheticals with accompanying strategies, which were developed by our firm during a recent case wherein we were confronted with all three of the issues above.

II. Issues and Strategies to Success

“Such was the number of the [enemy], that when they shot forth their arrows the sun would be darkened by their multitude. Dieneses, not frightened by these words . . . [answered:] ‘If the [enemy] darken the sun, we shall fight in the shade.’”2

A. Addressing Voluminous Subpoenas to Former Employees

Albeit not as intimidating as a flurry of arrows threatening to blot out the sun, targeted, last-minute, colossal discovery requests by opposing counsel can prove to be an effective distraction strategy if one does not find a way to respond by embracing the problem and by “fighting in the shade.”

Take, for example, a case where opposing counsel intentionally abstains from any significant employee discovery until a few weeks before the start of trial. Plaintiff then proceeds to subpoena over fifty (50) of your client’s former employees. This is clearly a last attempt to find any hostile witnesses to testify negatively about your client's administration and the treatment provided to the Plaintiff by your client’s healthcare providers. Furthermore, assume there was a qualified protective order (“QPO”) in place that prevents you from discussing any matters related to protected health information (“PHI”). What do you do?

First, you must identify who you need to speak with and how you will reach them. Take the notice of subpoenas filed with the court and develop your list of employees to contact. Next, take the time to review any and all existing information about the former employees your client already has on file. Then, conduct a brief online background search of these individuals in order to find a last known address as well as a phone number where possible. Finally, select a private investigator to assist in tracking down any remaining former employees you are not able to personally locate.

For those individuals you are able to make contact with, identify who you are, and explain that opposing counsel plans on subpoenaing them for trial. Furthermore, if a QPO is not in place, limit your conversation to exclude any PHI – keep the focus on their general impressions of your client and determine if Plaintiff has already approached them and whether or not they plan on testifying. Be sure to note that they do not have to speak to you or the Plaintiff’s attorneys, but remind them that the subpoena will require them to show up at trial.
With this in mind, make this an opportunity to share what you plan on asking them at trial so that they can be properly prepared for their testimony. By framing the conversation in this way you add value to them and they will be more likely to keep the conversation going. Further, you show that you are not the “bad guy” in this situation and are not looking to surprise them – something everyone hopes to avoid.

B. Responding to Allegations of “Missing Records”: Ensuring Providers Get Credit for Patient Care

Much like contacting the fire department when one notices his or home has been set ablaze – identifying whether yours is a “missing records case” often results in a better outcome when done sooner rather than later. The ability to identify and confront this problem, however, is dependent on taking a proactive approach to requesting files from your client as soon as possible and having them assessed by the appropriate personnel to organize and identify deficiencies in the charting.

Take for example a scenario where the records are voluminous (e.g. if the case involves a resident of a long term care facility with an extensive admission in that facility) or where the records are difficult to access (such is the case with some rural facilities or facilities that possess less than ideal storage practices for their records), in either of those scenarios third party services such as Pendulum, LLC. can prove a useful resource for locating and organizing these records. In any event, it is crucial to identify whether a case is a “missing records” case on the front end so that counsel has adequate time to assess and develop strategies to combat what otherwise will be categorized as gaps in patient care and, ultimately, deficiencies in the standard of care.

Two key strategies in attacking any recognized potential deficiencies in the medical record are: (1) identifying the key witnesses that provided regular care to the resident or patient and subsequently capturing their testimony early; and (2) exploring a more globalized approach to your records search, wherein defense counsel can supplement an incomplete record of a certain task by finding evidence that the task was completed and documented in another portion of the patient/resident’s overall chart.

As to the first strategy, witnesses who are able to speak to the actual care a resident or patient received can play a significant role in resolving or at least mitigating the damage that a missing record inflicts on a case. Often clients can become overwhelmed at the prospect of identifying and keeping contact with the key staff that provided care during the time period in question. Typically, however, that practice will not be difficult even with a group of sixty to seventy (60-70) people; the key lies in discovering a subset of three to five (3-5) people that defense counsel can develop a defense based on even if theirs is a more tangential relationship to the resident/patient.

The goal is to identify these three to five (3-5) key witnesses early and develop a relationship with them and subsequently protect this relationship over the next two to three (2-3) years of the life of the litigation. This is done through recurrent contact. Taking the time to familiarize yourself with these individuals and making a good first impression will pay dividends over time. This practice allows counsel to build a case on likable personalities and defend the facility based on people versus administrators.

The second strategy, depends on the defense counsel’s ability to explain that, in certain instances, though one portion of the chart may not contain an entry another portion of the resident/patient’s chart may serve as a record that the certain task at issue was, in fact, completed and, thus, supplements its incomplete counterpart. For instance, imagine the Plaintiff developed a sacral ulcer during his residency at the defendant facility. Skin assessments were clearly required by the plan of care yet none were documented in the two (2) week period that the ulcer developed. Further, the wound care nurse responsible for these missing notes was a former employee who was uncooperative or otherwise absent.
Our first step is to identify the types of records that could contain the information we are seeking. Obviously, in a pressure ulcer case, the first option would be skin assessments – but those are missing in our hypothetical. Therefore, the second step requires finding an alternative source for filling the alleged gap of information created by the missing record. In this case, assume the wound care nurse responsible for creating the missing record is unavailable so her testimony is not helpful or available to supplement the deficit in the records. Therefore, we need to identify what other records might reflect skin assessments or total body assessments during the time period in question; one way of quickly finding such records is to approach the facility’s administrator or director of nursing. These individuals have a unique understanding of what types of records document certain activities and can save valuable time in this process.

By approaching the appropriate staff you may discover that, in this hypothetical facility, the nursing progress notes also contained regular skin assessments of the residents – and, upon reviewing the nursing progress notes, discover that in fact wound treatment and skin assessments were performed during the period in question. By effectively employing this approach in conjunction with securing favorable testimony from another healthcare provider, say another wound care nurse that also participated in the resident’s care, you will effectively combat the Plaintiff’s arguments anchored in these missing records.

C. Staffing Experts, Daubert, and the Admission of Summary Evidence

Modeled after Rule 1006 of the Federal Rule of Evidence, many states allow the admission of “a summary, chart or calculation to prove the content of voluminous writings, recordings or photographs that cannot be conveniently examined in court.” In an effort to avoid challenges to questionable methodology for determining appropriate staffing levels, we have seen the plaintiffs’ bar rely on the state law equivalent of Rule 1006 to present purported summaries of staffing data without having to contend with Daubert.

For example, assume the Plaintiff raised allegations of understaffing, and identified a CPA as their staffing expert. However, during her deposition, the accountant refused to clearly identify her opinions. She repeatedly emphasized that she had prepared “summaries and findings.” This is a transparent attempt to avoid the rigor of Daubert, by repeatedly emphasizing the expert has no opinions. Assume that, in Plaintiff’s response in opposition to a Daubert motion to exclude the CPA from testifying, the Plaintiff responded that the CPA’s testimony was “primarily that of a summary witness, although her ability to explain the data and terminology is based on her particular expertise.” In other words, the staffing expert is intended to testify about CMS expected labor tables for the facility without going as far as offering any opinion testimony as to understaffing at the facility.

In this scenario, fully expect that the “summaries” will contain comparisons of CMS “expected” labor tables to what will be represented as “actual” staffing levels at the facility. However, the “summary evidence” will clearly be presented in a manner designed to suggest the facility was understaffed insofar as bar graphs and similar graphics will attempt to highlight and accentuate the difference between “actual staffing levels” and “CMS expected labor tables.” Expect plaintiff to use terms such as “expected staffing levels” to further lead the jury to their intended conclusion. The strategy described above is an increasingly familiar tactic intended to avoid a thorough and sifting cross-examination of a foundational matter, i.e., the relevance of CMS expected labor tables to any inquiry and analysis of adequate staffing levels at the facility.

By claiming not to have any opinion on whether the facility was staffed adequately to provide care and treatment to residents, counsel for the plaintiffs anticipates the jury will conflate “expected” labor with “required” labor and conclude on their own – without the need for an express expert opinion – that the facility was understaffed. Given the simplicity of the graphs together with the complexity of non-opinion testimony about expected labor tables, patient per day hours and other novel concepts, the jury could easily be
expected to conclude that any level of staffing below the CMS expected labor tables amounted to a standard of care violation.

A summary witnesses may testify to prove the content of voluminous writings but cannot offer opinion testimony as to such content without satisfying the requirements of Daubert. However, a comparison, by its very nature, is a method applied to evaluate concepts within a field or discipline. Accordingly, any summaries that contain comparisons are inherently predicated on opinions about the reliability and relevance of the data being compared. At the early stages of litigation, defense counsel should challenge the relevance of CMS expected labor tables to the issue of adequate staffing.

Be prepared to highlight the flaws in the methodology used to determine CMS expected labor tables, the limitations of relying on a system that was developed as a prospective payment system for Medicaid services, and the absence of expert testimony about the reliability of utilizing resource utilization group (“RUG”) scores to determine whether a facility was understaffed.

III. Conclusion

As is apparent from the issues addressed in the hypotheticals above, defense counsel for healthcare providers must take a proactive approach to recognize the potential hurdles plaintiff may introduce to either distract counsel or artificially shift the burden to the defense.

Each of these problems can be effectively addressed if steps are taken to recognize and face the problem early – whether that means getting to know the state of your client’s records, getting in touch with your witnesses, or attacking the plaintiff’s attempt to slip in expert testimony in the form of a “summary witness.”

Endnotes

2 George Rawlinson, Herodotus the Histories 602 (1997).
3 Fed. R. Evid. 1006
4 Id.