

CONTRAST

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A publication of Endurance Specialty Insurance

Welcome to our second edition of *Contrast*. Published quarterly for healthcare professionals, *Contrast* is just one way Endurance demonstrates its commitment to providing insight and analysis to our valued clients and associates.

About Us

Endurance's Healthcare Liability division, led by Judy Hart, focuses on Excess Medical Professional Liability for multi-hospital systems, integrated delivery networks, university teaching hospitals and large specialty hospitals. Our clients are typically sophisticated purchasers who practice strong clinical risk and claims management.

Contact Us

Contrast welcomes your comments and suggestions. Please email us at jhart@endurance.bm, or contact our editor directly at 441-278-0441.

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Letter from the Editor

Thank you to all *Contrast* readers for their support of our inaugural issue last quarter. We hope you continue to find this publication of value to you and your colleagues. In this issue, we offer three articles of interest to our healthcare customers and partners. As the primary purpose of *Contrast* is to offer you relevant information about the defense of healthcare related professional liability litigation, I hope you find these articles insightful and helpful.

"20 Questions" again features the perspectives of a highly experienced jury consultant in a four question and answer format. In this edition, Dr. Richard Waites shares his views about how the medical malpractice litigation crises affects juror perceptions, whether to defend the damages aspects of catastrophic injury cases and more.

Louis Laska, long time publisher of *Medical Malpractice Verdicts, Settlements and Experts*, offers his observations on big verdicts in his article "Why Jurors Turn Against Doctors." His cautionary views about tort reform and the real cause of large verdicts are certainly food for thought.

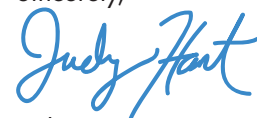
In this installment, we also offer some thoughts about the U.S. Supreme

Court's decision in the *State Farm v. Campbell* case. Although not a healthcare case, *Campbell* should be of real benefit in limiting, and in some cases even knocking out, punitive damage claims against healthcare defendants.

I want you to know that we at Endurance know that many of you, your organizations and professional associations have worked long and hard to see tort reform legislation passed in your states as well as at the Federal level. There have been notable successes, some defeats, and some measured steps forward. There is more work to be done, but we applaud everything you and the industry are doing to bring some sense of proportion to our litigation environment—it's vital to your business and ours as your insurance partner.

Thank you again for your interest in *Contrast* and I look forward to providing more insight in our next edition.

Sincerely,



Judy Hart
 Executive Vice President,
 Healthcare Liability
 Endurance Specialty Insurance Ltd.



Punitive Damages Russian Roulette:

Implications of the Campbell Decision for Healthcare Defendants

By Scott Crockett

The punitive damages traffic signal has changed from green to flashing yellow. First in *Gore v. BMW* and most recently in *State Farm v. Campbell* the U.S. Supreme Court has finally established some limits on the magnitude of punitive damages awards. It's good news for healthcare defendants.

"Justice Without Proportion Is Not Justice"

The headline from the *Campbell* case, decided in April of 2003, is the creation of a maximum ratio between the compensatory award and the punitive damages award: single digits. In the Court's words, "few awards exceeding a single-digit ratio between punitive and compensatory damages, to a significant degree, will satisfy due process" of law. It's not an absolute "bright line" that may not be crossed, but it's as close as the Supreme Court has been to one.

The Campbells sued State Farm alleging that it acted fraudulently, in bad faith and had intentionally inflicted emotional distress by its handling of the underlying suit against the Campbells, which had resulted in an excess of limits judgment against them. The Utah jury that heard the case awarded \$2.6 million compensatory and \$145 million in punitive damages. The trial court reduced the award to \$1 million and \$25 million respectively, but the Utah Supreme Court reinstated the original verdict. State Farm appealed to the U.S. Supreme Court on the basis that the award violated the US Constitution's due process of law provision.

While the single digit ratio should usually serve as an adequate benchmark, the Court anticipated circumstances where it would be inappropriate. For example, in a case where

a particularly egregious act has resulted in a small amount of economic damages, a higher ratio may be warranted. Conversely, when compensatory damages are substantial, a smaller ratio or even a punitive award equal to the compensatory award may be what will satisfy due process.

What constitutes "egregious" conduct? The Court provided guidance by fleshing out the criteria it used in *Gore v. BMW*. The "Gore factors" are:

- 1) the degree of reprehensibility of the defendant's conduct
- 2) the disparity between the harm and the size of the award
- 3) the difference between the award and potential civil penalties

Of these three factors, the Court said the reprehensibility of the defendant's conduct is the most important. In evaluating

reprehensibility, the court offered the following indicators: whether the harm was economic or physical; whether the conduct showed indifference to the health or safety of others; the financial vulnerability of the target of the misconduct; and

whether the conduct was an isolated incident or was intentional, repeated conduct.

It is hard to generalize about how the last two Gore factors may play out in a case involving a healthcare defendant. But the reprehensibility trigger is clearly the one most likely to be tripped by healthcare defendants:



healthcare mistakes nearly always involve physical harm (and often economic harm, too), nearly always involve the health or safety of others, and often involve a financially vulnerable plaintiff (e.g. cost of treatment).

These indicia of reprehensibility often give rise to the plaintiff's claim that the healthcare defendant put "profits over patients." It's a theme that resonates well with jurors and seemingly the U.S. Supreme Court.

One of the most important aspects of the Campbell decision is the extent to which the defendant's other acts or conduct, particularly conduct in other states, can be used as evidence at trial. The Court clearly said that repeated conduct, similar in character or nature, is evidence of reprehensibility. Equally, unrelated acts or conduct that bears no relation to the plaintiff's harm, however wrongful, clearly can no longer be admitted at trial. This decision should make it far easier for defendants to keep other unrelated events from being introduced at trial. In cases where punitive damages are sought defendants should aggressively seek discovery limitations and file motions in limine to combat the plaintiff's "pattern and practice" charges.

To put the Campbell decision into perspective, let's look at how it might apply in the case of three different types of healthcare defendants: hospitals and physicians, long term care providers and health insurers.

Punitive Damage Awards Against Doctors and Hospitals

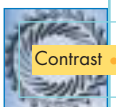
Medical malpractice cases have the potential to be high on the reprehensibility scale given that they involve personal and economic harm to the plaintiff. But in actual practice, punitive damages are pled but less frequently taken to

the jury in medical malpractice cases. More often they are used as leverage to obtain a larger settlement, or to poison the well only to be withdrawn at the close of the plaintiff's case, or in a few cases to overcome the defendant's admission of liability and get the "bad facts" before the jury.

There are several practical reasons why punitive damages can be unattractive to a plaintiff. First, punitive damages are taxable unlike compensatory damages. In many states, punitive damages are uninsurable or the conduct giving rise to the punitive damages award may be excluded under the defendant's liability policy, making it more difficult or time consuming to actually collect the award. Perhaps this explains why there are relatively few actual punitive damage awards against doctors and hospitals. According to a Rand study, punitive damages are awarded in only 1.5% of the medical malpractice cases tried to a jury.

But there are some significant exceptions. In 1999 a Texas jury awarded \$16.7 million compensatory and \$50 million punitive damages against a hospital. In 2001 a South Carolina jury awarded \$17.2 million compensatory and \$15 million punitive damages against a physician. But more typically, an Ohio jury in 2002 awarded \$650,000 compensatory and \$300,000 punitive damages.

What is notable about these awards is that the ratios were all within single digits given the size of the compensatory award (again, personal, physical injury is at issue). That being the case, and taking into account the low frequency of punitive damages awards against doctors and hospitals, Campbell's primary impact on medical malpractice cases may be to keep instances of other poor patient outcomes from being used at trial to support a punitive damages allegation.



Punitive Damages Awards Against Long Term Care Providers

It's no secret that the highest incidence of punitive damage awards against providers has come in the long term care setting. Some of the verdicts are as infamous as they are shocking: \$365,000 compensatory and \$94.7 million punitive in California (260 times compensatory); \$15.4 million compensatory and \$63 million punitive in Arkansas (only 4 times compensatory, but a huge compensatory award) and \$2.7 million compensatory and \$310 million punitive in Texas (115 times compensatory).

On average, long term care verdicts demonstrate much higher ratios than medical malpractice cases.

The Arkansas case (*Sauer v. Advocat*) is of interest because the appeal was decided by the Arkansas Supreme Court on May 1, 2003, after *Campbell*. The *Sauer* Court applied *Campbell* and the *Gore* factors to the circumstances of that case and found that 1) the defendant's conduct demonstrated a high degree of reprehensibility, 2) the ratio of compensatory to punitive damages was not shocking and was single digits, but 3) with regard to the third *Gore* factor, the highest previous sustained punitive damage award in Arkansas was \$3 million. As a result, the Court reduced the award to \$5 million compensatory and \$21 million punitive damages, maintaining the 4 times ratio in the original verdict.

On average, long term care verdicts demonstrate much higher ratios than medical malpractice cases. Reprehensibility issues are also, at least in the minds of jurors, more pronounced. Because many nursing homes are corporately owned with multiple locations there is a greater potential for the plaintiff to introduce evidence of repeated, similar conduct at other locations. Consequently, the *Campbell* decision should be of substantial benefit in long term care cases.

Punitive Damage Awards Against Health Insurers

Punitive damage awards against MCOs and health insurers are second to long term care cases in magnitude. Two of the more well known examples include the \$4.5 million compensatory and \$116 million punitive award (25 times compensatory) against Aetna in 1999 and the \$2.5 million compensatory and \$49 million punitive award (20 times compensatory) against Anthem (appeal decided in December, 2002). It would appear that the incidence of these enormous verdicts against health insurers has lessened, however, in light of changes to utilization review and physician compensation procedures.

Nonetheless, *Campbell* may offer a real measure of rationality when it comes to defending healthcare insurers. As discussed above, there is a greater potential for any healthcare defendant's conduct to be found to be reprehensible. Additionally, because many insurers operate in multiple states, you have the possibility of repetitive conduct or a pattern and practice later judged to be wrongful. Lastly, there tends to be a higher ratio of compensatory to punitive damages in the case of health insurers. It is therefore highly likely that the *Campbell* decision will be a positive development for health insurer defendants.

Conclusion

The *Campbell* case is hardly a get out of jail free card. The possibility of substantial punitive damages awards still exist. Under the guidelines expressed in *Campbell*, however, punitive damage awards should bear a greater relationship to the degree of harm suffered by the plaintiff, and the scope of inquiry about the defendant's conduct more confined to the events leading to the plaintiff's alleged injury. *Campbell* may not represent a sweeping change of the law, but for healthcare defendants it's a meaningful one.

Why Juries Turn Against Doctors

By Lewis L. Laska

Million-dollar medical malpractice verdicts have doubled since 1996. They now make up 8 percent of all malpractice claims actually paid. This, at the same time that verdicts for the defense remain the norm and the number of lawsuit filings has actually fallen somewhat. Why?

The quick – and partially correct – answer is that the cost of health care has skyrocketed. If a three-year-old must breathe on a respirator for the rest of her life, which is expected to last at least 25 years, she'll need a bigger award to cover the cost of that care.

But the truly big verdicts are due to something else. It's called a paradigm shift. Changes in the law, the tools available to plaintiffs lawyers and the attitudes of potential jurors have altered the playing field for doctors being sued. And they don't seem to have caught on. Instead of changing how they approach litigation, doctors want to cap malpractice awards.

Senate Republicans failed to get enough votes to break a mainly Democratic filibuster of just such a bill. The proposed legislation, which has already passed the House, would cap pain-and-suffering damages at \$250,000 and limit punitive damages to \$250,000 or twice the compensatory damages for economic loss, whichever is greater.

Of course, that loss was not the end of the damages cap. Doctors, hospitals, insurance companies and tort reformers will keep pushing it.

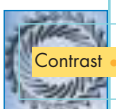
But their effort is a mere bandage for a serious wound. It won't cure the medical malpractice "crisis." Big verdicts will keep getting bigger until doctors face what's really going wrong in court.

JURIES' FOCUS

■ Plaintiffs' lawyers have learned to present a case built on anger. No, juries don't give big verdicts out of sympathy, although doctors still think that's the reason. Instead, over the last 10 years, jury consultants have taught plaintiffs lawyers to look for a reason to get mad. Lawyers build their case around the question, "What is it about the medical care in this case that makes you angry?"

Consider just one award last year in rural South Carolina – \$2.2 million in compensation, plus \$15 million in punitives, in a state where the average payout is about \$80,000. The doctor had mishandled a surgical procedure that alleviates chronic heartburn, a procedure that he was not fully qualified to perform. He then mishandled repair surgery, failed to seek another doctor's advice and failed to transfer the patient, leaving her severely handicapped. Here's how a juror explained the verdict: "We wanted to say to the medical profession that we don't want these kinds of people practicing medicine."

■ Lawyers have learned to put science first in explaining the standard of care. Trial lawyers demystify medicine by explaining the science simply, then adding the law. Doctors who fail to have a science-based answer to defend themselves look like they're hiding behind the law. Here's what the jury hears: "Ladies and gentlemen of the jury, these are the forceps. When a doctor puts them around



a baby's head to assist delivery, he's supposed to put them this way, not this way, because that will crush the baby's skull or cause blindness. That's all the science we are going to talk about in this case. Nothing complicated. Nothing technical. It's just basic science – the same everywhere forceps are used to deliver babies. Same here as in St. Louis, Atlanta or Cincinnati. That's all this case is about. Oh, by the way, the proper method of using forceps has a legal phrase to describe it. It's called the 'standard of care.'"

EXPERT ADVICE

■ It's easier to find medical explanations and experts these days because of the Internet. Standard-of-care information pours off the Web. A nurse consultant can find the best medical literature and the names of the best experts just by spending a day surfing online. The chief reference for medical standards and guidelines, the 2002 Healthcare Standards Directory, is available online, updated daily. And experts, once found, are more willing to testify for trial lawyers who have really done their

The chief reference for medical standards and guidelines, the 2002 Healthcare Standards Directory, is available online.

homework, understand the medical issues at stake, and are not just looking for a talking head.

All too often, doctors walk into depositions (and court) and get zapped by medical literature they didn't know anything about. In some cases, the expert who produced that literature will be testifying against them.

■ The much-discussed Daubert ruling has now come full circle. The key 1993 Supreme Court decision in *Daubert v. Merrell Dow Pharmaceuticals* told judges to act as "gatekeepers" to keep out marginal or unqualified experts. Doctors and their defense lawyers heralded this decision as a

breakthrough – no more experts who just practice medicine out of the trunk of their car. But plaintiffs lawyers have since learned to use Daubert to the patient's advantage.

Because the judge is required to rule on the quality of the experts, those experts who do pass muster are essentially accredited in the judge's eyes. That can lead to a more positive, less skeptical attitude from the bench. And jurors pick up on the judge's "signal" that an expert is credible.

And so-called Daubert hearings are making their way into state, not just federal, courts. Such a hearing proved to be a key factor in a multimillion-dollar verdict in Nashville in April 2002, in which an error by the anesthesiologist led to the death of a man having his rotator cuff repaired. Nashville hadn't seen a similar verdict in 10 years.

■ Trial lawyers have started working together in so-called "bad baby" cases. In 1994, plaintiffs lawyers formed the Birth Trauma Litigation Group, affiliated with the Association of Trial Lawyers of America. The group's newsletter and seminars have catapulted lawyers up the learning curve with science-based arguments designed to overcome new defense theories.

Consider Erb's Palsy, a birth injury that damages nerves controlling the arms and hands, which is a fixture in the group's discussions. Members know about that damning Food and Drug Administration Public Health Advisory of May 21, 1998, regarding vacuum extractors. Too many doctors don't. Group members send "chain" letters to each other asking for depositions of "notable" defense experts. Some very big-name defense experts have been, well, inconsistent in their testimony.

Similar litigation groups focus on laparoscopic surgery, laser eye surgery and nursing homes.

UNSYMPATHETIC DOCTORS

■ Arrogance equals big verdicts. Doctors' arrogance coupled with the "stuff happens" defense makes jurors angry.

Research into the causes of malpractice has turned up not-so-startling evidence that physicians' behavior leads to malpractice claims. And behavior is based on attitudes – 44 percent of doctors say they are utterly exhausted, with 41 percent admitting they're so depressed that they have no hope that things will improve. Depressed, exhausted doctors can easily sound uncaring, especially during the stress of trial.

They may also embrace the "stuff happens" defense. But jurors don't. They don't understand why a doctor can't give a clear explanation for how a patient was injured. Jurors don't like it when they sense that a highly trained professional is shrugging his shoulders and saying, "Things go wrong sometimes."

■ Technology and television have changed how the public views doctors. Trial lawyers have learned that the best way to make a doctor tell the truth – or to squirm – is to put him in front of a camera. All serious cases now use videotaped depositions.

Likewise, the image of doctors has fallen. Like trial lawyers, they advertise. And today's television dramas often show them as volatile and troubled persons who sometimes tell lies. That's a far cry from earlier shows like "Dr. Kildare" and "Marcus Welby, M.D." Today, a viewer is more likely to see a lawyer confronting an ethical dilemma and getting it right. Just tune into almost any segment of "Law & Order."

■ Doctors have lost the moral high ground in their effort to limit verdicts. Just when self-interested physicians were lobbying the hardest for Congress to pass a \$250,000 cap on noneconomic damages, the tragic

death of Jessica Santillan, the 17-year-old girl who received an incompatible heart-lung transplant at Duke University Hospital in February, highlighted the careless underside of medicine. Add to this the news reports on the number of people who die from hospital- or doctor-caused complications, and the follow-up reports that nothing was being done to reduce the number of those deaths. Not good when potential jurors already fear that doctors are more interested in making money than saving lives.

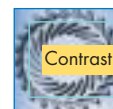
Of course, it doesn't help either that when doctors themselves are injured, they demand the same multimillion-dollar damages. An Indiana neurosurgeon who slipped and fell in a puddle of water in a hospital pantry in 1998 sued the hospital. The jury awarded him almost \$17 million for the injury to his arm. Was the award justified? Perhaps, but surely no more so than many other big verdicts.

Doctors have lost the moral high ground in their effort to limit verdicts.

These are some of the key reasons why awards have risen in malpractice cases. And what of the future? Politicians will keep arguing about caps. But the cries of outrage over repetitive malpractice "crises" – 1975, 1988, 1994, and today – are beginning to ring hollow. Look to courts to ban confidential settlements in all kinds of cases, including malpractice. And expect judges to find too much "reform" unconstitutional.

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20 Questions

Interview with Dr. Richard Waites, Attorney & Chief Trial Psychologist for The Advocates

Question: In the last 18 months there has been unprecedented publicity and debate about doctor strikes, high jury verdicts, injuries and deaths due to medical errors, high medical malpractice premiums, tort reform, and many other related issues. Do these news stories affect trial outcomes in medical malpractice cases?

Answer: Yes, they do, but not in the way many people think. Judges and jurors, like all of us, look at the world and think about life's experiences in complex ways. The public discourse about tort reform and malpractice costs is confusing to most people, but has led judges and jurors to ask questions in trial that they rarely asked before. Some of these questions help defendants while others do not. Thanks to doctor strikes, for example, some judges and jurors find themselves wondering whether a particular doctor in trial is more interested in his or her own gain than that of the patient. Judges and jurors are both confused and angered about doctors striking.

In general, however, judges and jurors are sympathetic with the goals of tort reform. Our research has shown that less than 3% of jurors are "Robin Hood" jurors who would vote for a plaintiff even if the defendants did nothing wrong. Judges and jurors want to feel that they made the right decision in a case. They are opposed to the idea of making someone rich in a lawsuit. However, they also believe that health care providers usually have more knowledge, power, and control over a medical result than do patients. They believe that doctors and

nurses should be responsible for any wrongdoing that breaches the standard of care.

The conventional wisdom seems to be that the way to lower jury verdicts is to increase the public discourse about tort reform. However, even without the benefits of tort reform, the overall "win" rate for health care defendants has continued to climb. This increasing success of health care defendants in the courtroom has been due primarily to their increased interest in understanding likely judge and juror perceptions about the facts of a particular case through the use of jury research and to the use of that information in making better decisions about settling the case or effectively defending it in court.

Interestingly, several studies have compared the decisions of jurors in actual lawsuits to the decisions of medical panels and insurance company reviews of the same cases. These studies have consistently shown that doctors who review other doctors' work in professional review panels are much more critical of doctors than are jurors. Reviewing doctors often begin their evaluation with a critical eye, whereas jurors generally have a much more positive expectation about health care providers and want to feel that they can trust them.

As a result of tort reform discussions, however, judges and jurors are more careful than ever to scrutinize a plaintiff's case. Recent studies have even shown that there is a strong correlation between a judge or juror's strong opinions about tort reform

(positive or negative) and their ultimate decision in a case. This can be useful information in jury selection.

Question: There is some perception that doctors, hospitals, and health care providers are not held in the same high esteem as they once were. Does your research bear out that perception and if so what are the implications for health care defendants?

Answer: Each year we are honored to work with health care providers and trial attorneys in cases in almost every state. As of now, we have not seen any decline in the high esteem that doctors, hospitals, and health care providers have enjoyed for decades anywhere in the country.

However, we have noticed that judges and jurors are beginning to ask more questions about the motives of health care providers because of the issues that have been raised lately in the news media. They seem to be willing to listen more attentively when plaintiff attorneys attack the character of a doctor, hospital, or other health care provider. I recommend that health care providers remain sensitive to public perceptions and that they conduct scientific jury research in risky cases whenever their budgets will allow it.

Question: Defense lawyers, trial consultants, and claim decision makers often debate the efficacy of presenting a damages defense in medical malpractice cases. What advice would you give trial lawyers and claim decision makers about this issue as they prepare for trial?

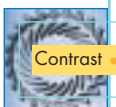
Answer: The questions about whether and how to mount a damages defense when you are contesting liability have plagued lawyers and health care providers for decades. The dilemma is a real one. If you haggle over the plaintiff's damages request by showing that "the request is inflated and it should be

lower," judges and jurors often feel that you must be admitting to some liability. You may undermine your liability defense. On the other hand, if you strongly deny liability and stand your ground on a \$0 damages figure without addressing the inflation in the plaintiff's request, you run the risk that Texaco encountered in its case with Pennzoil where a jury who might find liability has only the plaintiff's damages request to consider.

The underlying proposition is that there is such an animal as a true liability case or a true damages case. In actuality, only a few rare cases fall in these two categories. In 95% of cases, evidence and argument in the liability issues affects judges' and jurors' decisions about damages. Conversely, evidence and argument about damages often affect their decisions about liability.

The problem here is actually one that we create for ourselves. Our research shows that judges and jurors are quite capable of considering any combinations of defenses. Therefore, we have a great deal of latitude in addressing liability and damages issues. The challenge is more one of clarifying your position, so that judges and jurors do not get the wrong impression.

Although every case is different in some respects, the wiser choice is often to consider stating clearly that "we did not do anything wrong and we do not owe any money in damages...period." We have learned that a strong and unequivocal defense when allowed by the evidence is best. However, jurors may disagree with you on the liability



question and believe that damages are warranted. To cover yourself, you should always consider making your strong defense anyway and then stating almost in passing that "the plaintiff's damages are inflated" and "if you disagree with us and find that we are liable, that the correct amount ought to be \$_____." By offering a precise alternative amount, you obtain the benefit of creating a psychological anchor for jurors at a lower end of the damages spectrum that will not be there otherwise for them to consider.

My thinking about this issue has evolved over time. After working with juries and trial lawyers for more than 25 years, I now believe that you should always mount a strong defense to both liability and damages whenever you have any facts to support it. Let the jurors make the choice to negotiate the amounts they might award. The job of the defense is to give the jurors a credible and persuasive choice, not to make

concessions. The only appropriate time to make any concessions on the prime issue(s) is when there is no credible defensive argument that can be made. This is a rare situation in trial in my experience. As I have said many times, whenever you start making concessions, you start sliding down a slippery slope that may be out of your control.

The decision to make a concession on damages or any other matter should be

limited to gaining a verifiable tactical advantage. It is a truth of life that most people believe that someone who makes an admission against their interest must be telling the truth. With this mantle of

credibility, a party will usually have more persuasive power on the other issues in the case. Such admissions are often wise, for instance, when a health care worker has violated hospital policy, but not caused the damages alleged.

Jurors understand that the job of the plaintiff's lawyer is to get as much money as he or she can for their client and that the job of the defense lawyer is to minimize any recovery (preferably to \$0). They do not fault a defense lawyer for proposing that the correct number should be "\$0" and then attacking the plaintiff's numbers with an alternative number that is much lower. Jurors watch television and movie courtroom dramas. They have read fiction novels about courtroom characters. They have a keen understanding that a trial in a courtroom is a knife fight between two opposing parties who believe they are right. Jurors are okay with all that and do not fault a defense lawyer for mounting a strong and passionate defense on both liability and damages issues.

Question: What four things can health care defendants do to prevent uncharacteristically high or "runaway" verdicts in catastrophic injury cases?

Answer: Catastrophic injury cases are a special breed of case from a psychological point of view. Judges, jurors, and arbitrators usually believe that someone must have done something wrong. Otherwise catastrophic events would happen more often. Consequently, courtroom decision makers generally scrutinize the behavior of all the parties before, during, and after the incident, including the plaintiff and his or her family in order to understand what happened.

Generally in these types of cases, the alleged damages are quite high and the battle is quite intense. Our research shows that "runaway" jury verdicts are driven by jurors'



outrage that was not diminished by information from the defense.

For example, with reference to the McDonald's famous coffee case, the interviews of the jurors in that case printed in the Wall Street Journal revealed that they understood McDonald's to say that: 1) we know our coffee is often boiling hot, but we don't see the need to spend money monitoring it ('It's just coffee, after all. '), 2) we know we have 300-400 complaints about scalding coffee in our restaurants each year, but we don't intend to do anything about it, and 3) the plaintiff is a little old lady with frail skin that resulted in her receiving those 2nd and 3rd degree burns and that's not our fault.

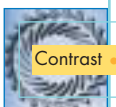
To the jurors, McDonald's demonstrated inexcusable arrogance and lack of sensitivity. Sometimes the remedy for a potential problem in avoiding a runaway verdict is simple and sometimes not so simple. It is easy to come into court and to express warmth, caring, and compassion for patients or to avoid an arrogant defense. It is not so easy to avoid a runaway verdict, for example, if there is some evidence that the doctor who performed a surgery was a known drug addict and a patient nearly bled to death in a routine surgery because the doctor was allegedly "asleep at the switch". A situation like that needs to be the subject of a serious jury research project.

It is easy for attorneys on all sides to over-evaluate some issues while under-evaluating others. However, because of the high risks in such cases the decision making process for risk managers, insurance representatives, and trial attorneys should be as methodical and emotionless as possible.

There are several things I would recommend while realizing that each case has different facts, legal issues, witnesses, and certainly different trial lawyer personalities.

1. Engage in jury research as early as possible to understand how a likely jury will evaluate the issues and the key evidence whenever your budget will allow it. There is usually a format that will fit almost any case budget nowadays. Focus group research conducted early in catastrophic litigation is a reliable and useful tool to use in helping you focus your discovery and use your resources wisely. Once key discovery is substantially complete and you are beginning serious settlement negotiations or trial preparation, you should test the strength and weakness of your case in a mock trial study. Such a study can provide an enormous amount of important information that will help you and your trial consultant to develop an organized game plan for successful trial or settlement strategy.

2. Be aggressive about asking hard questions (many of which can be answered in scientific jury research) such as, "Should we strongly deny any wrongdoing, or should we be more conciliatory?" It is generally a huge mistake to be compulsive in taking a hard-nosed approach that may lead to a litigation disaster while ignoring information that may wind up giving you a different approach and



lead you to a more successful outcome. On the other hand, compulsively admitting liability is usually a mistake also. Such an approach will usually increase an award, not reduce it.

3. Judges and jurors expect health care providers to be humanitarian, warm and caring when it comes to human devastation and tragedy. Every doctor, hospital, and nurse would be wise to show compassion and thoughtfulness in the courtroom, even when clearly denying any wrongdoing. By allowing anger or defensiveness about being sued to surface, they risk losing the rapport and understanding that they would otherwise gain from a judge or jury who would have a good impression of them.



4. Get to know an experienced and trustworthy trial consultant

who will be there for you when you need him or her. As one of my hospital risk management clients said to me recently over dinner, "I am a betting man and you are my research team to let me know where to place my bets. In addition, you help my race horses (our defense trial team) run their best race." It's hard for me to improve on that.

In my view, risk managers need some predictability about the likely outcome on the issues present in a particular case in order to make important decisions about the case. But more than that, some cases are going to be tried to a judge or jury. There is no avoiding it. In that event, it sure helps a lot to have a veteran trial consultant close by to help brainstorm a winning strategy with the trial team.

ABOUT THE AUTHOR

Richard Waites is one of less than 10 people in the United States who is both a board certified trial lawyer and a psychologist. He is one of the nation's most successful trial consultants and his clients include many of the country's Fortune 500 companies and high profile hospital and health care companies. He has authored more than 30 books and articles to help trial lawyers and company representatives understand how judges, juries, and arbitrators make decisions. Earlier this year, American Lawyer Media published his latest book, *Courtroom Psychology and Trial Advocacy*. Richard is the president and chief executive officer for The Advocates and Advocacy Sciences, Inc., one of the nation's leading full service trial consulting firms. The Advocates has offices in Atlanta, Chicago, Dallas, Denver, Houston, Los Angeles, Miami, New York, Orlando, Philadelphia, Phoenix, San Diego, San Francisco, Tampa, and Washington, D.C. The firm has a nationwide practice in all 50 states.

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