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When a Defensible Claim Goes Sour: Defending Spoliation of Evidence Claims

By Dawn A. Sallerson and Patrick E. Poston

Let us assume you have a credible defense to the negligence allegations as to the care and treatment provided by a doctor, hospital, medical group, or medical device manufacturer. For that matter, a claim or suit may not even be brought or filed against such medical care providers or manufacturers relating to patient care. However, consider a potentially relevant piece of evidence – x-rays, a chart, specimens, or a medical device – has gone missing and the plaintiff and/or a defendant has raised a spoliation of evidence issue in your case.

The Illinois Supreme Court recognized negligent spoliation of evidence as a cause of action which can be stated under existing negligence law in *Boyd v. Travelers Ins. Co.*, 166 Ill. 2d 188 (1995). Subsequently plaintiffs' attorneys have increasingly turned to spoliation claims as a potential backdoor to recovery in questionable medical malpractice liability cases. While this is a developing area of the law, particularly for medical malpractice cases, we will examine the evolution of this theory as well as offer some practical points to defending these cases.

Spoliation 101- The Basics

In *Boyd*, the Illinois Supreme Court stopped short of recognizing negligent spoliation as an independent cause of action. However, the *Boyd* Court did hold that an action for negligent spoliation can be stated under existing negligence law. Spoliation claims are derivative of an underlying claim. To prevail on a claim for negligent spoliation of evidence, a plaintiff must show that:

1. Defendant had a duty to preserve the evidence;
2. Defendant breached that duty by losing or destroying the evidence;
3. The loss or destruction of evidence proximately caused the plaintiff's inability to prove an underlying lawsuit; and
4. Plaintiff suffered actual damages as a result.

Martin v. Keeley & Sons, Inc., 979 N.E.2d, 22, 27 (2012).

The general rule in Illinois is that there is no duty to preserve evidence. In *Boyd*, the Supreme Court promulgated a two prong test to establish an exception to the no-duty-to-preserve rule and impose upon the defendant a duty to preserve evidence. In order to establish an exception to the no-duty-to-preserve rule, the *Boyd* test requires a plaintiff to show that:

1. An agreement, contract, statute, special circumstance, or voluntary undertaking by affirmative conduct has given rise to a duty to preserve evidence on the part of the defendant; and
2. A reasonable person in the defendant's position should have foreseen that the specific evidence at issue would be material evidence in potential civil litigation.

Only if both prongs of the *Boyd* test are established is there a recognized exception to the no-duty-to-preserve rule. *Jones v. O'Brien Tire and Battery Service Center Inc.*, 374 Ill.App.3d 918, 925 (5th Dist. 2007); citing *Dardeen v. Keuhling*, 213 Ill.2d 329, 336 (2004).

Additionally, the plaintiff must demonstrate that, but for the defendant's loss or destruction of the evidence, the plaintiff had a *reasonable probability* of succeeding on the underlying suit. *See, e.g. Cosgrove v. Commonwealth Edison Co.*, 315 Ill.App.3d 651, 657 (2d Dist. 2000). Plaintiff need not show that he or she *would* have prevailed. A plaintiff cannot recover for negligent spoliation if the underlying claim is barred. *Babich v. River Oaks Toyota*, 377 Ill.App.3d 425, 431 (1st Dist. 2007).

Is there a Duty to Preserve? The First Prong of the *Boyd* Test

While an agreement, contract[1], statute or voluntary undertaking to preserve evidence may be relatively straightforward, the "special circumstances" exception is undeniably more subjective. Illinois courts have not precisely defined a "special circumstance" in the context of recognizing a duty in a spoliation of evidence claim. *Martin v. Keeley & Sons, Inc.*, 979 N.E.2d 22, 30 (2012). However, the Illinois Supreme Court has shed light on factors that may establish special circumstances which give rise to a duty to preserve evidence in the medical malpractice context.

In *Miller v. Gupta*, 174 Ill.2d 120 (1996), the plaintiff filed an action for malpractice and spoliation of evidence against her physician for the destruction of her x-rays. The trial court had granted the defendant physician's motion to dismiss with prejudice. The trial court order, however, was entered prior to the Supreme Court's decision in *Boyd*. In light of the *Boyd* court's subsequent recognition of spoliation of evidence as an action that can be brought under a standard negligence theory, the court ultimately remanded the case back to the trial court to determine whether special circumstances existed to support a duty to preserve the plaintiff's x-rays. In its rationale for sending the case back to the trial court, the *Miller* court discussed several facts which it believed may give rise to special circumstances sufficient to establish an exception to the no-duty-to-preserve rule:

1. Plaintiff's medical malpractice attorney requested the plaintiff's x-rays from her doctor;
2. The doctor obtained the x-rays and placed them on the floor of his office prior to taking them to the hospital for copying;
3. The doctor admitted that his wastebasket was located three feet from the x-rays;
4. A housekeeper assigned to clean the doctor's office testified she regularly disposed of x-rays near the trash; and
5. The housekeeper stated she believed the x-rays were thrown out when she cleaned and were later destroyed by the hospital.

In contrast, in *Dardeen v. Keuhling*, 213 Ill.2d 329 (2004), the Supreme Court refused to find a special circumstances exception to the no-duty-to-preserve rule. In *Dardeen*, a plaintiff was injured when he fell in a hole on a brick sidewalk next to defendant's home. The homeowner reported the incident to the insurer and was told she could remove bricks from the area to prevent further injury. The plaintiff returned later that day to examine the hole but took no photographs. Subsequently, the homeowner removed 25-50 bricks from the area. In finding that the insurer had no duty to preserve the bricks, the Supreme Court noted that:

1. Plaintiff never contacted the defendant to ask for the preservation of evidence;
2. Plaintiff never requested the evidence from the defendant;
3. Plaintiff never requested that defendant preserve the sidewalk or even document its condition;
4. Plaintiff did not photograph the sidewalk when he returned; and
5. The insurer never possessed the evidence at issue and never segregated it for the plaintiff's benefit.

[1] It is worth pointing out in the instance of an explanted medical device as the basis for a spoliation claim, many patient consent forms contain boilerplate language authorizing the physician and hospital staff to dispose of any hardware or parts removed from the patient's body.

The Supreme Court has further stated in *Martin v. Keeley & Sons, Inc.*, 979 N.E.2d 22, 32 (2012) that in order for special circumstances to support the existence of a duty to preserve evidence, "something more than possession and control are required, such as a request by the plaintiff to preserve the evidence and/or the defendant's segregation of the evidence for the plaintiff's benefit."

The Second Prong of *Boyd* - Reasonable Foreseeability

Equally important is the second prong of the *Boyd* test - whether a reasonable person in the defendant's position should have foreseen that the lost evidence would be *material to potential civil litigation*. While any reasonable foreseeability argument may tend to be fact-centric to a particular case, this second prong seemingly provides substantial fodder for the defense of spoliation claims within the context of medical malpractice cases. Contrary to what many plaintiffs' medical malpractice lawyers may believe, healthcare providers are healthcare experts, not litigation experts. Illinois courts judge legal foreseeability based on "what was apparent to the defendant at the time of his now complained of conduct, not what may appear through exercise of hindsight." *Cunis v. Brennan*, 56 Ill.2d 372, 276 (1974). Thus, depending on the factual circumstances of your case, the reasonable foreseeability prong of the *Boyd* test may provide strong factual and/or policy arguments against the imposition of a duty to preserve evidence for the *purpose of pending litigation* upon a doctor, hospital, or medical group.

The lack of reasonable foreseeability prong may prove to be a substantial dispositive basis for a motion for summary judgment and/or, given the potentially fact-based nature of this argument, more likely as a key defense at trial. Notably, reasonable foreseeability is a significant hurdle for the plaintiff's burden of proof in spoliation claims against health care providers. If the plaintiff is unable to establish such reasonable foreseeability at trial, then this will carry the day for the defendant health care provider with a defense verdict.

Physician-Patient Fiduciary Relationship as an Argument to Establish a Duty to Preserve

Plaintiffs may attempt to exploit the physician-patient fiduciary relationship in an effort to create a special circumstances exception to the no-duty-to-preserve. While the *Miller* Court's discussion of special circumstances notably lacked any reference to the physician-patient fiduciary relationship, there is some basis in Illinois case law that in certain contexts a fiduciary has a duty to preserve evidence. *See Combs v. Schmidt*, 2012 Ill.App.2d 110517 (2d Dist. 2012) (Citing to trustee cases for proposition that fiduciary relationship creates duty to preserve); *see also Fuller Family Holdings, LLC v. Northern Trust Co.*, 371 Ill.App.3d 605 (1st Dist. 2007). However, those cases are distinguishable given the nature of a trustee's fiduciary relationship with a beneficiary (i.e., the entire basis of the relationship is to hold something in trust) as opposed to the physician-patient fiduciary relationship. *See Witherell v. Weimer*, 85 Ill.2d 146, 159 (1981) (Noting fiduciary nature of physician-patient relationship is entwined with the trust placed in a physician's superior medical skill with respect to patient health); *Neade v. Portes*, 193 Ill.2d 433, 445 (2000) (Noting fiduciary duty of physicians is synonymous with malpractice standard of care).

Put simply, the physician-patient fiduciary duty exists *within the context of patient care*. This is entirely distinct and separate from a duty to preserve evidence. The Illinois Supreme Court has acknowledged the distinction between a medical provider's duty with respect to patient care and the duty to preserve evidence. The Illinois Supreme Court has stated that a negligence action for spoliation is predicated upon a breach of the duty to preserve evidence relevant to litigation and has nothing to do with patient care. *Orlak v. Loyola Univ. Health System*, 228 Ill.2d 1, 9-10 (2007) (Noting case involving spoliation claim against hospital was inapposite to plaintiff's malpractice claim because it arose from a duty to preserve evidence as opposed to a duty regarding patient care); *See also Cammon v. W. Suburban Hosp. Med. Ctr.*, 301 Ill.App.3d 939, 950 (1st Dist. 1998) ("[T]he fact remains that the damages suffered by the plaintiff in [a spoliation] case arise from the defendant's destruction of evidence, not the breach of a medical standard of patient care."). Thus while this may be an argument the plaintiffs' bar attempts to push to expand the viability of spoliation actions in medical malpractice cases, there are strong arguments to contradict the use of a physician-patient fiduciary duty as the basis for a duty to preserve evidence.

Other Considerations - Statute of Limitations

The Illinois District Courts are split on the applicable statute of limitations period for a negligent spoliation of evidence claim. In *Schusse v. Pace Suburban Bus. Div. of Regional Transp. Authority*, 334 Ill.App.3d 960, 970 (1st Dist. 2002) the First District applied the catch-all five year statute of limitations to a spoliation of evidence claim, 735 ILCS 5/13-205. However, a later First District case held that once the statute of limitations expired for an underlying products liability case, the plaintiff "could not proceed with his negligent spoliation action because the negligent spoliation action is a derivative action and has the same limitations period [as the underlying case]. . .". *Babich v. River Oaks Toyota*, 377 Ill.App.3d 425, 432 (1st Dist 2007). Additionally, two recent Second District decisions have imposed a two year statute of limitations period for spoliation claims deriving from an underlying negligence action for personal injury. *Wofford v. Tracy*, 2015 IL App (2d) 141220 (2d Dist. 2015);

Skridla v. General Motors Co., 2015 IL App (2d) 141168-U. The *Wofford* Court reasoned that the two year limitations period set forth in Section 5/13-202 was proper where plaintiffs only sought recovery for personal injuries. *Wofford* at ¶ 34, 35 ("We conclude that, because spoliation is a derivative cause of action, the limitations period of the underlying negligence action . . . applies."). Similarly, in *Skridla* the Second District reasoned that where spoliation claims are derivative of an underlying personal injury action the applicable statute of limitations is the two year period for personal injury claims. Illinois courts have applied the discovery rule to spoliation of negligence claims. See *Schusse* decision, referenced above.

Conclusion

Defending spoliation claims can create a secondary layer to the defense of medical providers in malpractice cases. As the plaintiffs' bar continues to push these claims in the medical malpractice context, we will inevitably receive further guidance from Illinois courts in this underdeveloped area of case law. In the event you find yourself involved in a spoliation of evidence claim, the information contained here should provide you with a solid framework for navigating and credibly defending such suits and/or claims.

How the Affordable Care Act Can Reduce Damages Awards

By Russell L. Reed, Jason K. Winslow and Blair P. Keltner

The Patient Protection and Affordable Care Act ("ACA") of 2010 makes significant changes to the health insurance model in the United States. In medical malpractice litigation or other lawsuits involving catastrophic personal injury, these changes could dramatically reduce the amount of money needed to compensate tort claimants fairly for future medical care. The following examples illustrate this point:

> **Ex. 1. Before the ACA:** A tort claimant with a Life Care Plan estimating annual future medical expenses of $50,000, and a life expectancy of 20 years, was entitled to recover **$1,000,000** in future medical expenses ($50,000 x 20 years = $1,000,000).
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> **Ex. 2. After the ACA:** A tort claimant can purchase the same $50,000 worth of annual future medical expenses at a drastically reduced rate, which is equal to the out-of-pocket maximum for individual health insurance plans under the ACA ($6,850 in 2016). Over that same 20-year life expectancy, then, a current tort claimant would incur only **$137,000** in out-of-pocket expenses ($6,850 x 20 years = $137,000). Therefore, some argue that an award of $1,000,000 in this scenario after the ACA would result in a windfall recovery to the tort claimant in the amount of **$863,000** ($1,000,000 - $137,000 = $863,000).

This article explains:

1. What changed under the ACA;
2. Why these changes should reduce damages awards; and
3. How to challenge damages claims after the ACA

What Changed Under the ACA

The ACA made significant changes to ensure future tort claimants cheaper access to future medical care and treatment. These changes include the following provisions:

- The **individual mandate** requires all individuals to purchase health insurance or face penalties.
- The **guaranteed issue** provision prohibits health insurers from excluding coverage on the basis of pre-existing conditions, and the **community ratings** provision prohibits them from charging unhealthy individuals higher premiums than healthy ones.
- The **out-of-pocket maximum** limits expenses for the insured (in 2016, $6,850 for self-only coverage and $13,700 for coverage other than self-only).
- Plans must offer **essential health benefits** including:
  - ambulatory patient services
  - emergency services
  - hospitalization
  - maternity and newborn care
  - mental health services and addiction treatment
  - prescription drugs
  - rehabilitative services and devices
  - laboratory services
  - preventative and wellness services
  - chronic disease management
  - pediatric services

Why the ACA Will Most Likely Reduce Damages Awards

Before the ACA, Courts routinely prohibited tortfeasors from reducing damages awards by amounts paid from "collateral" sources, such as public sources or private insurers. In some cases, this resulted in tort claimants receiving payment not only from the tortfeasor, but also from their insurers, resulting in what some have labeled an unfair "windfall" or "double-recovery." Courts justified this seemingly unjust result on public policy grounds. Changes made by the ACA call into question whether these public policy justifications are still valid, as set forth more fully below.

Public Policy Justification	ACA Change	What It Means
Before the ACA, most tort claimants paid for future health care costs out-of-pocket because: ■ Inability to work and obtain employer-based coverage ■ Health Insurers' ability to exclude coverage based on pre-existing conditions ■ Income limitations on public assistance	Guaranteed Issue	The ACA guarantees coverage now and in the future, even with pre-existing conditions.
	Community Ratings	Prohibits insurer from charging higher rate to insureds with pre-existing conditions
	Out-of-pocket Maximums	Health care and treatment costs are dramatically decreased by imposing caps on the amounts of out-of-pocket expenses that insureds can incur.
Before the ACA, true windfall recoveries were **rare** because: ■ Not everyone had insurance; ■ Attorney fees and costs were deducted from recovery; and ■ Health insurers had subrogation rights to recoup covered expenses	Individual Mandate	Windfall double recovery may become nearly certain in most cases because torts claimants are required to maintain insurance. ACA health insurers do not have an express right of subrogation under the new law
Before the ACA, reducing recoveries may have discouraged tort claimants from purchasing or keeping insurance coverage: ■ Viewed as punishing the diligent Plaintiff who purchased insurance	Individual mandate	Plaintiffs are required to purchase health insurance coverage or face penalties, which should be a sufficient incentive to comply with the law. In 2016, those who do not comply must pay 2.5 percent of household income, or $695 per person, whichever is greater.
Before the ACA, reducing recoveries may have resulted in unjust enrichment to Defendants: ■ Viewed as allowing tortfeasor Defendants to escape responsibility for the full extent of their actions	Essential Health Benefits	Defendants are still responsible for compensatory damages (i.e., pain and suffering, loss of enjoyment of life, etc.) and the ACA does not cover out-of-pocket expenses incurred for certain services, such as home modification, transportation, recreation, and home health care.

How To Challenge Future Medical Expenses Claims

To challenge Plaintiff's valuation of future medical expenses, we offer several suggestions:

- In states where the collateral source rule is particularly strong (such as in Illinois), file a bench brief relating to the changes made by the ACA and their implications on the collateral source rule.
- Hire experts and develop a defense life care plan that identifies which projected future life care is covered under the ACA, what such care would cost if billed in full, and reduce it to the amounts of out-of-pocket expenses incurred during the period of projected future care.
- Cross-examine Plaintiff's Life Care Planner and other experts on whether they considered the ACA's impact on the true cost of Plaintiff's future life care needs.
- Seek judicial notice that the ACA is the "law of the land."
- Move *in limine* to prohibit Plaintiff from introducing the billed amounts for past medical services as evidence to prove the reasonableness of future medical projections when an ACA plan has or will provide coverage.
- Apply the state statutory rules for reductions of awards post-trial. For example, in Illinois, seek reduction of jury damages awards for medical expenses in the way contemplated by 735 ILCS 5/2-1205, which allows for up to a 50% reduction in the judgment for collateral source payments made by entities without a right of subrogation, excluding the medical expenses incurred for the treatment in which the negligent act occurred, insurance premiums, and direct costs paid by the claimant.
- Offer to buy and maintain the ACA plan for the life of the injured tort claimant.
- Focus settlement negotiations or mediations on the gross disparity between Plaintiff's life care plan and one that considers the reductions available after the ACA, as well as the uncertainty Plaintiff may face in convincing the Court to allow unrebutted evidence of future medical expenses at trial.

While these strategies might assist defense counsel in the short term to mitigate the inherent unfairness of allowing windfall recoveries, hopefully courts will reconsider whether continuing to prohibit reductions in damages awards by payments made by "collateral" sources makes common sense since adoption of the ACA.

Hinshaw Representative Matters

Attorneys involved: Scott Cockrum and Ami Anderson of Schererville

Facts of case: We represented a local ob/gyn who was alleged to have negligently performed laparascopic surgery on a patient with a very complicated medical and surgical history. Prior to surgerty, the plaintiff complained repeatedly of severe abdominal pain. The defendant physician recommended the removal of her left ovary (the right had been removed by him in a prior surgery). During the procedure, the defendant physician was not able to find the plaintiff's ovary. Approximately three days after the procedure, the plaintiff was readmitted for a bowel perforation. Plaintiff alleged that our client should have referred the case to a specialist instead of performing the surgery.

Trial Strategy: At trial, plaintiff focused on damages, and presented significant expert testimony regarding the plaintiff's life and physical condition after the bowel injury, including two colostomies and loss of bowel tissue during the necessary repairs with extensive medical expenses and lost wages. However, they failed to provide sufficient evidence to establish that the defendant physician was negligent in recommending the procedure, performing the surgery or treating the condition post operatively. Conversely, Hinshaw presented expert testimony clearly establishing that the surgery was warranted and that the plaintiff merely suffered a known complication of which she had been informed prior to the procedure and prior to signing an informed consent. We paid little attention to the damages claimed and focused on the standard of care.

Result: After five days of evidence and argument, the jury deliberated for approximately five hours before returning a defense verdict.

Attorneys involved: Dawn Sallerson and Patrick Poston of Belleville

Facts of case: The plaintiff had numerous complications from prolonged intubation during a double breast reconstruction surgery, including permanent damage to her vocal cords. She sued the hospital and surgeon for her medical expenses (which exceeded $500,000), future

medical expenses for anticipated medical procedures and treatment, and her past lost wages and future lost earnings. However, the medical malpractice case was dismissed for lack of a certificate of merit. The suit was not refiled within the one year within which the action could be refiled and was dismissed with prejudice. Our client was her counsel in a medical malpractice case against the hospital and surgeon. The plaintiff alleged that our client negligently failed to refile the action thereby foregoing her recovery on a meritorious medical malpractice action. Plaintiff asked for court ordered mediation prior to trial. The plaintiff/patient pre-mediation demand was in the multiple seven figures.

Strategy: Using careful review of the plaintiff's medical records and history, as well as other personal health factors predisposing her to a complicated surgical and post-surgical course, we argued that she would not have prevailed on her underlying medical malpractice action regardless of the statute of limitations issue. This position was comprehensively detailed in our mediation brief which helped the mediator persuade the plaintiff/patient and her counsel of the difficulties they would have in proving their case to a jury.

Result: We obtained an extremely favorable settlement at mediation for an amount significantly less than plaintiff's demand. Both our client and his insurance carrier were delighted with our defense and the result.

Attorneys involved: Greg Snyder and Jennifer Johnson of Rockford

Facts of case: Illinois wrongful death suits are generally brought in the name of an administrator or personal representative of the patient-decedent's estate for the benefit of the decedent's next of kin. Probate rules govern the appointment of a personal representative, and in most cases, the process is rather uninteresting and not controversial in the context of a medical malpractice case.

However, in a recent case, the proceedings in probate court were instrumental in obtaining a dismissal with prejudice of a wrongful death suit. The plaintiff/administrator claimed she was the sole descendent and sole heir to her mother's estate. She further claimed her mother died after undergoing a complicated hernia repair and that the death was due in part to our Internal Medicine physician's alleged failure to timely diagnose and treat sepsis following surgery.

Strategy: Our investigation and social media searches revealed the plaintiff/administrator was neither the biological, nor the adopted, daughter of decedent. Rather, she was a niece who had been represented as a daughter from the time of her birth. Even though her birth certificate indicated that the patient-decedent was her mother, the plaintiff had known the truth since she was a teenager. Further complicating her particular situation, the Plaintiff was a convicted felon – a fact that precluded her from ever serving as administrator under Illinois law.

Result: The case was ultimately dismissed with prejudice following a single deposition with no settlement payment.

Attorneys involved: Paul Estes and Jesse Placher of Peoria

Facts of case: The case involved the death of woman in her 60s due to thyroid cancer. Around 2002, the patient developed a mass on the front of her neck which was approximately one inch in diameter. Her family physician determined that it was a benign cyst based on her history and the physical examination. He did not order a biopsy or any imaging of the mass. Four years later, she returned to report intermittent hoarseness and a concern that the mass was growing. The family physician determined that if it had grown, it was only minimal. He nevertheless referred the patient to an ENT for evaluation of the mass and her hoarseness. The ENT took a history and performed a physical exam and laryngoscopy. He confirmed that the nodule was a benign cyst and that it was not causing any impingement on her vocal cords. He did not order a biopsy or any imaging to confirm his diagnosis, but he offered to remove the nodule (which would have resulted in a pathology evaluation). The patient never requested removal. In late 2007, the patient began experiencing ptosis of the left eye, later determined to be Horner's Syndrome. By 2008, she developed shoulder pain and chronic hoarseness. The family physician referred the patient to a different ENT, who ordered an ultrasound guided fine needle aspiration of the mass and confirmed it was a benign cyst. However, a chest CT ordered by the family physician out of concern for a lung tumor revealed another mass near the thyroid. Ultimately, that mass was found to be an extremely aggressive form of thyroid cancer. The patient underwent extensive treatment, but died in 2009.

Plaintiff filed suit against multiple individuals. We represented the ENT and his personal corporation. The family physician and his group also proceeded to trial. Plaintiff alleged that if both physicians had performed a more thorough exam, they would have found that the mass at issue was connected to the thyroid (which imaging later confirmed). Had they correctly determined that the mass was connected to the thyroid, the standard of care would have required an ultrasound, which would have revealed the thyroid cancer. Had the thyroid cancer been diagnosed earlier, particularly in stage I or II, she would have likely survived.

Trial Strategy: We presented an ENT expert that opined that our client's history, examination and laryngoscopy were reasonable and within the standard of care, and imaging was not required. He opined that it may not have been possible to determine that the mass at issue was connected to the thyroid at that time, no matter what measures were taken. We also presented a thyroid cancer specialist who testified that the thyroid cancer was not present until 2007 (and thus was not present in 2006 when our client treated the patient). He also testified that because the cancer was extremely aggressive, it may not have been large enough to be seen by an ultrasound until it was in stage III or IV, at which time the patient was not likely to survive anyway.

Result: Plaintiff's counsel asked for $7,275,500. The jury was out for a little over two hours before finding in favor of all defendants. The jurors' initial vote was 11-1 in favor of our client.

Attorneys involved: Rhonda Ferrero-Patten and Natasha Steele Patel of Peoria

Facts of the case: A 42 year old male was found unresponsive in a pool of blood at home due to a suspected drug overdose of two medications. He was placed on a ventilator and transferred from a regional facility to the ICU at our facility. The diagnosis was suspected overdose and GI bleed. The patient was placed on SCDs, but anticoagulation medication was found to be contraindicated by the team. An endoscopy was performed and found no active bleed, but the patient was still considered to be at risk for re-bleed. The patient was preparing to be transferred out of the ICU on day 3 and suddenly collapsed, arrested, and could not be revived. An autopsy revealed that the patient died from a pulmonary embolism. The decedent was survived by his wife of over 20 years and six children.

Trial strategy: We represented the hospital for the conduct of two resident physicians. The co-defendant was a critical care attending physician. Plaintiff alleged that the patient's initial unresponsiveness was due to the PE, which was not diagnosed or properly treated with anticoagulation. Defendants argued that the patient did not exhibit signs or symptoms of a PE until his arrest on the third day. As such, he received appropriate treatment.

Result: Plaintiff requested $3-5 million. The jury found in favor of all defendants.

Attorneys involved: Jill Munson of Milwaukee

Trial Strategy: We represented multiple care providers. The case hinged on the applicable standard of care, and we argued for a jury instruction that the certified nursing assistant's conduct should be judged based on the instruction that applies to a skilled technician. We managed to ward off contentions from the plaintiff that a nurse we were representing was not our client (thus our communication with her was not covered under attorney-client privilege) and arguments that the hospital incident report should be released.

Result: Defense verdict.

Attorneys involved: Mike Malone and Jill Munson of Milwaukee

Trial Strategy: The patient narrowed her claims over the course of discovery, leaving the claim that the defendant neurointerventionist violated the standard of care when he decided to occlude a vertebral artery prior to a planned surgical resection of a spinal cord tumor that abutted the artery. The medical issues were complex, several specialists were called to testify and the patient testified as to the impact of the stroke she experienced.

Result: Defense verdict.